Long-term effects of a randomized policy experiment on quality improvement in the Philippines

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ABSTRACT

We investigate the possible long-term effects of a randomized policy experiment conducted in the Philippines between 2003 and 2008. The policy experiment, known as the Quality Improvement Demonstration Study (QIDS), consisted of a large-scale community level policy intervention in 30 hospitals. Five years after interventions were discontinued, we re-surveyed doctors who had previously participated in the experiment to determine if the intervention effects continue to persist. The hospitals had been randomly assigned into two intervention sites plus control sites. The first policy intervention was an expanded health insurance program targeted to young children. The second was a pay-for-performance scheme to hospital staff conditioned on improving the quality of care. The objective was to evaluate the effects of these two interventions on the quality of hospital care and the health status of children. After three years, both QIDS interventions were found to have short-term impacts. For our follow-up study, we collected data from February to August 2013 on previously participating doctors to assess whether hospitals in the treatment sites continue to have better quality compared to those in the control sites. We specifically test whether quality measurement and performance feedback, last documented in August 2008, might provide a sufficient inoculum that persisted over time in the intervention sites relative to controls. A hypothesis is that clinical skills, once acquired, would become routine and not deteriorate establish a culture of performance and quality expectation. Alternatively, they may also diminish with disruptions in measurement, feedback, and incentive. We found that the intervention sites continued to have significantly higher quality compared to the control sites. The previously documented quality improvement in intervention sites appears to be sustained; moreover it was subject to a very low (less than 1 percent per year) rate of decay in quality scores.
Evaluating the impact of RBF implementation on maternal and child health practices in Northern Uganda

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ABSTRACT

Background: The Northern Uganda Health programme (2011-2015) is part of the UKaid-supported Post-Conflict Development Programme and focuses on generating evidence on the extent to which Results-Based-Financing (RBF) is an efficient and effective financing mechanism, compared with more traditional input-based financing (IBF), for improving access to, and quality of, health care among 31 private-not-for-profit health providers (PNFPs). Methods: We evaluated the impact of RBF implementation on clinical practices after one year of implementation using matched case-controls for labour monitoring during delivery (n=952) and three cross sectional studies (n=4752) for malaria, pneumonia and diarrhoea case management from Health Management Information System data in the 31 PNFPs. Results: The occurrence of any labour monitoring using a partograph was very low in both RBF and IBF regions and in perinatal deaths (cases) and live births (controls) at baseline (<15%). However, after one year there was more chance of a mother being monitored in the RBF region, particularly in those with a positive birth outcome (Odds Ratio [OR]:3.5; Confidence Interval [CI]:1.1-11.2). Although both RBF and IBF regions improved their clinical practices for pneumonia and diarrhoea case management, the adjusted odds of a child receiving correct pneumonia treatment were five times higher in the RBF region compared to the IBF region after one year and those of a child receiving correct diarrhoea treatment were almost six times higher in the RBF region. There was no significant difference in changes to compliance with malaria treatment protocol between RBF and IBF facilities from baseline to year one. Conclusion: RBF implementation has resulted in some early improvements in adherence to clinical guidelines by health care providers. Factors contributing to this include closer monitoring by data verifiers and incentivisation of specific practices but this seems to be less effective in cases requiring more sophisticated management protocols.
Evaluating the impact of health systems interventions using administrative data: Evidence from Results Based Financing Project in Zambia

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ABSTRACT

Background Zambia has introduced a Results-Based Financing (RBF) approach with a focus on maternal and child healthcare. RBF is widely seen as one innovation in health financing with the potential to strengthen health systems and improve health outcomes. In RBF, a principal entity provides a financial or in-kind reward, conditional on the recipient undertaking a set of pre-determined actions or achieving a pre-determined performance goal. Utilizing administrative data, we assess the impact of on utilization of incentivized and non-incentivized services in rural health facilities that commenced in April 2012. Methods In a three-arm quasi-experimental study, 30 districts from rural provinces triplet-matched on key health systems and outcomes were randomly allocated to: RBF, input-based financing equivalent to RBF and control. Data from the health management information system were collected on incentivized, non-incentivized and health system indicators from January 2010 (two years prior to intervention) to December 2012 (nine months of program exposure). A facility-matched difference-in-difference analysis was undertaken for all indicators to observe the trend in service utilization. Results/Discussion While comparing between the RBF and input-financing districts, significant gains were observed in antenatal visits (p=0.045), family planning attendance (p=0.002), institutional delivery by skilled personnel (p=0.019). Between RBF and control districts, there were notable improvements in antenatal visits (p=0.005), malaria prophylaxis for pregnancy (p=0.002), postnatal care (p=0.011), skilled delivery (p=0.031), and immunization of infants (p=0.011). However, no changes were observed while comparing the input-financing with control districts. There were no significant differences on non-incentivized indicators in any of the districts signifying little spill-over of RBF. Conclusion From the analysis of administrative data, the study shows that the RBF approach can achieve significant gains in the utilization of incentivized services within a fairly short time in contrast to the traditional input-based financing. Keywords: administrative data, results-based financing, difference-in-difference, Zambia
Demystifying the science of delivery: exploring the role of theory-driven process monitoring and evaluation to strengthen the health results based financing project in Zimbabwe

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ABSTRACT

Background: Zimbabwe’s health Results Based Financing (RBF) project is a fee-for-services mechanism which finances health providers based on the achievement of pre-defined services delivered. The project has pioneered provider-purchaser service delivery contracts for a well-prioritized, high-impact package of 16 maternal and child health services at the rural health center (primary) level and five emergency referral services at the hospital (secondary) level. While the project is accompanied by an impact evaluation, we undertook a process monitoring and evaluation (PME) guided by a program theory to understand the contextual factors under which the RBF project operates in Zimbabwe. Theory-driven PME is best suited for exploring the causal pathways of effectiveness in a realistic scenario. Methods: We developed a peer-reviewed theory of change consisting of several program impact pathways (PIP). To validate the PIPs, we employed a sequential mixed methods approach utilizing quantitative and qualitative methods. Project databases provided quantitative data, while qualitative data were obtained through interviews with key stakeholders in select sites in the intervention districts. Results and Discussion: The findings validated most of the PIPs. The interactions between project design, implementation and effectiveness were influenced by contextual factors at health facility, district and community levels. For example, the prevailing power structure at the facility level prompted the design of individual incentives in a way that incentivized the nurses-in-charge more than the primary counsellors, irrespective of level of effort. The level of knowledge and perceived autonomy at health facilities positively influenced need-based planning. Despite having adequate funds, some facilities faced shortages of commodities when the Ministry's procurement and financial management guidelines delayed their procurement processes. Gender insensitivity led to perverse behaviors by some community leaders, e.g. women were penalized for delivering at home irrespective of their cultural and geographic barriers to care.
Engaging Aboriginal people in health regional governance is associated with greater improvements in health outcomes in Australian health reform

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ABSTRACT

Aims: There is growing evidence that providing increased voice to vulnerable or disenfranchised populations is important to improving health equity. In this paper we will examine the engagement of Aboriginal people and organisations in local governance reforms associated with the Indigenous Health National Partnership Agreements (IHNPA) in Australia and its impact on the uptake of health assessments. Methods: The sample included qualitative and quantitative responses from 188 people involved in regional governance in Aboriginal health. The study included data on the uptake of Aboriginal health assessments and potentially preventable hospitalisations from July 2008-December 2012. The eligible population was 83190 in 2008/9, 856986 in 2009/10, 88256 in 2010/11 and 90903 in 2011/12. Logistic regression was used to examine the relationships between organisations within forums and the regional health service use outcomes. The independent variables included before and after the IHNPA, state, remoteness, level of representation from Aboriginal organisations and links between Aboriginal and non-Aboriginal organisations. Results: The introduction of the IHNPA was associated with a shift in power from central government to regional forums. This shift has enabled Aboriginal people a much greater voice in governance. The results of the analyses show that improvements in the uptake of health assessments and reduction in potentially preventable hospitalisations were associated with stronger links between Aboriginal organisations working with other Aboriginal organisations and between non-Aboriginal organisations working with Aboriginal organisations. Higher levels of community representation were also associated with improved uptake of health assessments in the IHNPA. Conclusions: The findings suggest that the incorporation of Aboriginal organisations and community members in regional planning may play an important role in improving health equity. This study makes an important contribution to understanding the processes through which the incorporation of disadvantaged groups into governance might contribute to health equity.
Enabling the lived experience to inform refugee health care services

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ABSTRACT

This presentation focusses on strategies for developing research capacity using the peer researcher model. This model develops the research capacity of the community and enhances the quality of information available from 'hard to reach' communities to inform the health service development. Methods Three qualitative projects were undertaken with communities from refugee backgrounds in Brisbane, Australia. They aimed to understand the barriers and enablers to accessing primary health care. Two were formal research studies and the third involved extensive community consultation. All investigations used the peer researcher model. Researchers were recruited from the refugee communities. Key to the methodology was the inclusion of a training program (including research methods and principles delivered over 10 weeks, or 50 hours) and ongoing support and mentorship. In the first project, five peer researchers documented the experience of refugee families who had recently arrived in Australia. The second project involved three young adults from refugee backgrounds who documented the experiences of young people from their communities. Ethics approval was granted for these research projects. The third project involved extensive community consultations with women from refugee backgrounds. Results People arriving in Australia from refugee backgrounds expressed considerable confusion with the complexity of the health system. Cultural issues impeded health consultations. Efforts to build trust often misfired or were misconstrued. Racism was commonly reported. The building of trust between refugee communities and health providers and enhancing health literacy were identified as essential elements for a successful model of care. Discussion points This peer led research is a novel strategy that gave voice to the lived experience of many refugee communities. Enhancing the research capacity within the refugee communities, has also enabled genuine community engagement with the health providers, offering opportunities to enhance community capacity, improve health literacy and build trust with a focus on improving health outcomes.
Perceptions of unprotected sex and contraceptives use among Ethiopian female migrants

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ABSTRACT

Introduction: Females on migration process can face unwanted pregnancies, unsafe abortions and sexually transmitted infections including HIV/AIDS. But no study focused youth female migrants and exposing factors; unprotected sex and contraceptives non-use. Many Ethiopian young females; from rural, having primary or lower educational and, very low contraceptives knowledge and use levels, are moving to Arab States as maids. Middle men - locally known as 'delala' to mean brokers: mediate or facilitate passport and VISA processing and accommodations (may take two to three months) for these females and are entitled to have sex with them, particularly in Addis Ababa. Temporary separation from family can expose for casual sex and sexual violence heighten vulnerability, unprotected sex and its consequences, deny their long-term ambition of getting better paying jobs overseas. More importantly, pre-departure training is not given by language they understand. Objective: To assess youth migrant's perceptions on risks of unprotected sex and use of contraceptives to reduce its consequences during migration process. Method: Mixed-method with convenient and purposive sampling was applied. Semi-structured questionnaire and in-depth interviews were used to collect data from 258 and twelve Ethiopian youth female migrants to Arab States. Quantitative data were analyzed using SPSS version 17. Qualitative data were thematically analyzed. Result: Low levels of knowledge about the meaning of unprotected sex (33.5%) and importance of contraceptives (42.53%), and practice (34.5%); hampered by shame, inaccessibility, mixed feelings and non-existing pre-departure training. Unprotected sex inflicted by middlemen 112 (55.2%) and sex for money exchange 66(32.5%) were common concerns. Perceived risk of unprotected sex 98(56.3%) favored using contraceptives. Eighteen (24.0%) respondents reported unprotected sex that significantly associated with ever using contraceptive methods (P-value<0.001). Conclusion: These migrants are at risk of the consequences of unprotected sex. Increasing awareness on the importance of contraceptives use is critical, their reproductive health right.
Enrolment of older people in social health protection programs in West Africa - does social exclusion play a part?

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ABSTRACT

Background: Although the population of older people in Africa is increasing, and older people are becoming increasingly vulnerable due to urbanisation, breakdown of family structures and rising healthcare costs, most African countries have no social health protection (SHP) for older people. Two exceptions include Senegalese Plan Sesame, a user fees exemption for older people and Ghanaian National Health Insurance Scheme (NHIS) where older people are exempted from paying premiums. Evidence on whether older people are aware of and enrolling in these schemes is however lacking. We aim to fill this gap. This is the first study that has tried to explore the sociocultural, political, and economic dimensions of social exclusion in the context of SHP programs for older people. Methods: Data were collected by two household surveys conducted in Ghana and Senegal in 2012. A series of regressions were conducted to determine whether vulnerability to social exclusion is associated with lower enrolment rates and compare these results across NHIS and Plan Sesame. Results: Sociocultural, political and economic dimensions are all significantly related to enrolment in Plan Sesame, indicating that individuals at risk of social exclusion are less likely to enrol in the scheme. Results from Ghana suggest that individuals at risk of social exclusion in the political domain are less likely to enrol in NHIS, although the economic and sociocultural indices are not significant. Discussion: Our study indicates that neither scheme has yet achieved equity in enrolment for older people. Efforts should be taken to specifically enrol older people in rural areas, ethnic minorities, women and those isolated due to a lack of social support. Consideration should also be paid to modifying scheme factors such as eliminating the registration fee for older people in NHIS and creating administration offices for ID cards in remote communities in Senegal.
Exclusion from the supplementary nutrition programme (SNP) and village life: Lived experiences of 'dalit' women in a Gujarat village

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ABSTRACT

Introduction: ‘Dalits’ in India remain one of the most subjugated and exploited groups of people facing multiple discriminations. Data reveals that ‘dalits’ form a large percentage of the target population end up not utilizing Integrated Child Development Services (ICDS). This study attempts to identify and understand community perspectives on exclusion of ‘dalits’ from ICDS and other aspects of community life.

Methods: The study was carried out in one of the four villages, as part of four short ethnographies on exclusion and self-exclusion from the Supplementary Nutrition Programme (SNP). The objective was to understand the socio-economic and political consequences of being a ‘dalit’, particularly in accessing SNP. Findings: ‘Dalit’ - women in the village belonged to landless families having no cattle. They opined that ‘dalit’ identity was still considered ‘impure’ and ‘dirty’ by the majority village population. Dalit women reported that their social interactions with members of other communities were minimal and marked by derogatory attitudes, bordering on verbal abuse. Their occupational choices were limited to construction and diamond industry work, for which they had to seek employment away from their own village.

Discussion: Despite constitutional protection as well as other legal and social protection frameworks that guarantee and facilitate access to all rights enjoyed by a citizen of India, ‘dalits’ face critical denial of rights on the basis of their caste and gender identity. Their non-participation in SNP is compounded by their poverty and social exclusion. This has major implications for the well-being and economic productivity of the next generation. Policy makers, administrators and health professionals involved in delivering the ICDS need to pay urgent attention within the context of a democratic society that promises equal rights.
Agents, not defaulters: rural people with disabilities, primary health-care workers, and how they co-construct access to health-care

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ABSTRACT

Background: People with disabilities living in rural areas in South Africa are extremely vulnerable to exclusion from the health system. South Africa's public health service is undergoing major changes, under the title of 're-engineering primary health care' and 'universal coverage'. This presents an opportunity to overcome such exclusions, but research is needed to inform measures to address the problem. Methods: This qualitative study is comprised of eleven in-depth case-studies exploring the interactions between people with disabilities and health-care workers, from multiple perspectives, over the course of a year, with additional historical background. Interviews, observations and focus groups were used to build up a detailed picture of the interface between the actors and explore the mechanisms through which inclusion/exclusion takes place. Results: The study highlights the key points in the access process at which health system exclusion takes place. These include initial lack of information about services, 'falling out' of the system due to missed appointments, the choice not to invest in service access due to low expectations or negative interactions with health-care workers, and other system failures which discourage continued engagement. The case of mental illness is highlighted as a community-identified crisis in health services for people with disabilities. Discussion/conclusion: This multiple case study highlights the complexity of the process of accessing/providing health care for people with disabilities from rural areas. The agency of the person/people seeking care is revealed, in contradiction to an attitude prevalent among health-care workers that such people are 'defaulters' who 'don't care'. Significance for field-building topic: This research reveals the mechanisms whereby vulnerable people may be excluded from the health system, and thereby points to systemic solutions to address inequities in access.
Health worker migration between and within private not-for-profit and public sectors: lessons from post conflict Northern Uganda

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ABSTRACT

Background Understanding health worker migration is vital if responses to the global health workforce crisis and planning for people-centered health systems are to be effective. Available literature indicates that health worker migration occurs across countries and between rural and urban areas. Limited evidence exists regarding migration between and within sectors, especially in conflict-affected areas. The study aimed to understand health workers’ career paths, motivation as well as factors influencing their intention to stay in (or leave) one sector for another during and after the conflict in northern Uganda. Methods Life history interviews were conducted with 26 health workers in selected districts of Acholi sub-region, Northern Uganda, in 2012. Participants were working in private not-for-profit (PNFP) and public health facilities. Results The study findings indicated that there was movement within and between PNFP and public sectors in the Acholi sub-region. Whereas some health workers stayed in one sector for their whole career due to loyalty to their starting sector, others tended to move between PNFP and public sectors. In some cases, migration was influenced by insecurity as a result of the conflict. Among factors that influenced their movement from public sector to PNFP were: the desire to share work experiences with expatriates and to benefit from comprehensive incentive packages. Factors influencing migration from PNFP to public sector included: perceived decrease in workload and better salaries, greater freedom to engage in dual practice, enrollment in the public pension system, increased chances of engagement in short-term training and an expectation of better (more inclusive) management. Conclusion If communities are to have their needs addressed, it is useful to stabilize the workforce in both sectors. In post conflict areas where the PNFP sector plays an important role, attention needs to be paid to making their workforce terms and conditions more competitive relative to the public sector.
Do financial incentives work in attracting health workers to rural areas? Evidence from four less-developed provinces in western China

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ABSTRACT

Background: Rural areas, especially in relatively less developed western rural China, are still plagued by the problem of much lower health service capacity due to shortage of qualified health professionals. Therefore, how to attract and retain qualified health workers in rural under-served areas in China, is a critical issue to be addressed with more research evidence and policy changes. Methods: Based on incentive theories, satisfaction and behavioral theory, this study conducted investigations on random sampled 828 health workers (represent stock) and 300 medical senior students (represent future supply) in four rural provinces of western China to figure out their job willingness and consideration. Qualitative methods included literature review, individual interview and group interview. Descriptive quantitative methods were used to identify differences of incentives among medical facilities. Pearson's correlation analysis was introduced to identify incentive factors. Besides, principal component analysis and factor analysis was applied in further classification and analyzing of 29 indicators of incentives. Results: 1. Severely shortage of human resources is common in each facility, especially in county hospital. 2. Differences of health workers' job satisfaction among facilities and cadres, titles, education degree are statistically significant. 3. Work reward, work load, training and career developing opportunity and respect of community are essential factors that health workers mostly concern which need to be considered and improved as soon as possible. 4. Rural original medical students are more likely to remain to practice in remote areas. 5. Equal work reward as urban areas, work stability, and more chances to gain promotion and training are prerequisites for students to work in rural areas. Conclusions: Both financial and non-financial incentives work in attracting health workers to rural areas. But financial incentives alone are insufficient in recruitment and retention, multifaceted strategies might work better.
Evaluation of the Zambian Ministry of Health's Health Workers Retention Scheme

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ABSTRACT

Background: The Ministry of Health (MOH) established the Zambia Health Workers Retention Scheme (ZHWRS) in 2003, placing various cadres of health workers in remote areas. The MOH, with support from Zambia Integrated Systems Strengthening Program, evaluated the ZHWRS in March 2013 to assess implementation progress, achievements against targets, impact on health service utilization, and sustainability.

Methods: ZHWRS evaluation used a multi-data source research design, complemented by literature review of retention schemes in Southern Africa. Quantitative and qualitative data was gathered through interviews with scheme members, training institutions, district medical officers (DMOs), health facility in-charges and ZHWRS management. A two-stage sampling design selected 25 districts and then 10 facilities per district, sampling 134 facilities and training institutions and 513 respondents. Data analysis used SPSS and content analysis.

Results: The MOH placed 1023 (61.8% M, 38.2% F) of the 1400 targeted health workers on ZHWRS by December 2012. Nurses/midwives accounted for the highest enrolment (37.6%), followed by lectures/tutors (22%), medical officers (14.6%), environmental health technologists (14.3%), medical licentiates (5.2%), clinical officers (4.3%) and medical consultants (2.2%). ZHWRS successfully distributed 69.4% of enrolled health workers to the most remote [category C and D] districts. Interviewed DMOs indicated that ZHWRS improved quality of services, increased community's health service utilization and reduced referrals. 94% of respondents reported inconsistencies and delays in the financial and non-financial allowance payment. Retention of lecturers/tutors did not increase enrolment capacity at training institutions. Five Southern African countries provide diverse non-financial incentives in their retention schemes and use the Human Resource Information System for planning and monitoring.

Discussions/conclusions: ZHWRS is instrumental in attracting and retaining critical health workers, but requires strengthened management, monitoring systems and communication across the MOH human resource system. The MOH is developing a ZHWRS sustainability strategy. Future ZHWRS evaluations are recommended on a five-year basis, with continued research on eligibility criteria.
How to retain qualified human resource for health (HRH) in 'difficult regions' (rural, remote or conflict area) in Senegal

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ABSTRACT

Background: To achieve Universal Health Coverage, the equal distribution of qualified HRH is indispensable to ensure the access to the quality health services. Senegal faces difficulties in retaining qualified HRH in difficult regions in spite of multiple interventions. Major documented determinants to influence on retention of HRH in various countries are quite context specific. The culture, religion, language, and social system affect those factors. In Senegal, the Islamic country with French social system, the determinants to retain qualified HRH has not been well analyzed.

Methods: Qualitative study to identify the determining factors for the retention of qualified HRH in Senegal. In-depth interview consisted in 2 parts: to 110 medical doctors, nurses and midwives who are currently working for more than 2 years in eight difficult regions defined by Ministry of Health (MoH); to those who started working but returned to urban area within 2 years. Key stakeholder interviews and focus group discussion were also organized with regional/district health officers and governors.

Results: The most commonly mentioned advantages working in difficult area was 'acquisition of experiences in medical cases rarely seen in urban area', followed by 'Self-satisfaction due to strong trust and respect from community'. The first concern when appointed to difficult area was lack of local information including culture, language, and living conditions. Once settled in that area, separation from family member was the main obstacle to keep working for long terms. Transparent HRH management system by MoH is critical, including duration of assignment, information on vacant posts, and democratic apply system to those vacant posts even from difficult areas.

Discussion/Conclusion: Although commonly reported factors such as continuous education and working environment were seen, we also found specific factors in Senegal. Positive deviance found in this study should be used to improve the HRH policies and strategic plans in Senegal. 296 words
Posting and transfer practices in the health sector: what do they mean for health workers?

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ABSTRACT

Background: Practices of assigning health workers posts and transfers undercut health systems. Health workers may request posts or transfers that are inconsistent with health system goals of equitable coverage, while decision-makers may grant these requests or make decisions for punitive or other reasons. Posting and transfer (P&T) practice feeds maldistribution of the health workforce, absenteeism, corruption, and patronage.

Methods: P&T is rarely broached explicitly in the literature, and when it is, it is often narrowly described as corruption. We drew on a multiplicity of literatures to assess the theoretical and knowledge landscape of P&T and to better understand the people at the centre of P&T practice. The critical interpretive synthesis method, as described by Dixon-Woods, facilitated an expansive review that surfaced theoretical and empirical challenges. The iterative process of review and synthesis entailed exploration of historical, social science, anthropological, public administration, and health systems literature, as well as print media. This abstract focuses on the findings related to health workers.

Results: The role of health care workers in P&T is often presented through the lens of rational choice theory, with health care workers holding geographic preferences based on calculations related to (il)licit income, political power, and quality of life. Anthropological literature suggests that some health workers experience P&T as an avenue for garnering and demonstrating their power, while others may experience P&T as a way they are forgotten or abused by the system, undercutting their morale and motivation.

Discussion/conclusion: Health care worker experiences of P&T may be germane to reaching universal coverage, as they shape distribution and morale. More explicit integration of P&T into work on retention and morale could elucidate avenues for improvement. Moreover, examining P&T as a negotiated outcome among people with divergent personal preferences and professional motives would add insightful nuance to the rational choice perspective.
**Valuation and cost effectiveness of Rural Incentive Packages for new physicians in Lao PDR**

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**ABSTRACT**

Background: Health workers in developing countries disproportionately locate in urban settings - resulting in even more severe shortages in rural areas. We analyze a discrete choice experiment (DCE) from Lao PDR conducted in May 2011 among medical students to determine which components and incentive packages would most efficiently increase voluntary rural entry among new physicians. Methods: First, we analyze the DCE data from the Lao PDR medical students (n=329) to determine the implied willingness to pay (WTP) for each component of rural incentive packages including transportation, housing, education and professional advancement. Second, we compare the implied valuations of each component with the actual expected cost to the Lao PDR government based on a separate costing survey. Lastly, we apply relative risk measures derived from the DCE to estimate how to what extent different proposed incentive packages would increase additional rural entry by recent medical school graduates. Given existing WHO estimates of the effects of health worker density on health outcomes, we generate cost effectiveness ratios for each of the 15 different voluntary rural incentive packages proposed for Lao PDR. Results: In the valuation (WTP) analysis, we find that implicit individual valuation of incentive components is frequently less than the cost to the payer. Nevertheless, many of the 15 rural incentive packages examined were cost effective (relative to the WHO standard of 3x income per capita) when we account for the expected indirect health benefits generated by improving the distribution of new physicians. Discussion: Combining DCE analysis with costing surveys is an effective way for countries to compare the perceived value of components of rural health worker incentive programs with actual cost. It is also important to also account for the value of the expected health benefits when evaluating rural incentive packages for health workers.
The politics of decision-making in Sexual and Reproductive Health: Experiences from Kenya

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ABSTRACT

Background: Although critical, power, politics and interests are often not given sufficient attention in health systems and policy research. Recent scholarship has challenged this positivist bias, arguing that health systems and policy are complex social and political phenomena, and efforts to understand/improve their functioning need to go beyond positivism. This study sought to contribute to this emerging recognition of complexity in health systems and policy processes. With a focus on discursive power, the study examined the drivers/inhibitors of policy reforms in sexual and reproductive health (SRH) in Kenya, particularly the adoption of the internationally-supported human rights framework, in order to generate learning for future reform efforts. Methods: Three policy processes - Adolescent Reproductive Health policy, Sexual Offences Act, National Reproductive Health Policy - were deconstructed. Data collection involved 54 in-depth interviews with state/non-state policy actors, field-notes from participation in meetings, and a review of media content, parliament Hansard, policies, reports, and academic publications. Findings: Study revealed that four powerful framings of SRH - moral, cultural, medical, human rights - underpinned by actor interests, values and ideas, mediate the interaction of actors, knowledge, and context in policymaking processes to determine reforms. The moral and cultural framings, which are supported by powerful institutions (government/parliament/religious), dominate policymaking. Although the medical framing has partially unsettled the moral/cultural frames to facilitate some reforms, it remains highly moralized, effectively marginalizing sensitive issues. The internationally-supported rights framing is marginalized because it threatens the power of dominant actors (male politicians/religious leaders). The result is policies that omit sensitive SRH issues - abortion, adolescents- access to contraception, sexual minorities. For Kenya to realize comprehensive reforms, efforts must challenge underlying interests of control that underpin the powerful framings. Conclusions: Findings demonstrate that health policy-making is a complex phenomenon driven by competing powerful framings of SRH, which prioritize certain issues while marginalizing others. Findings highlight the significance of social and political aspects of health systems.
Exploring the interactions between medical professionals and Global health initiatives in the Nigerian health system: A case study of the Health Systems Strengthening (HSS) initiative of the Global Fund in Nigeria

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ABSTRACT

Background: Recently, increasing attention has been given to behavioural and relational aspects of health systems, placing 'actors' at the core. Indeed, health systems comprise numerous actors, and one of the most important and influential is the medical doctor, playing a vital role in policy transfer at the national level (Benson, 2013). The influence of medical professionals stems beyond shaping the implementation of health policies, to also potentially altering the policy content and process (Koon & Mayhew, 2013). In low- and middle-income countries (LMICs) the health system is a dynamic mix of multiple stakeholders, including supra-national organizations, Global Health Initiatives and Non-Governmental Organizations (Samb et al., 2009), resulting in an environment where contesting interests and values are competing for relevance and authority. In Nigeria, such conflicts of interests have resulted in strikes due to competing attempts at 'professionalization' by other health professionals and medical doctors' attempts to safeguard their primal role within the health sector. Methods/results: This research examines interactions between medical doctors and other health professionals in health policy making and implementation of the Global Fund grant in Nigeria, exploring issues concerning professional dominance and how it relates to task shifting and relegation of staff from participation in various activities. We use a qualitative methodology involving key informant interviews and board meeting observations. Here, we present an in-depth understanding of the policy process (ie. the proposal writing, implementation monitoring and evaluation) of the Global Fund's Health Systems Strengthening initiative, focusing on the power distribution and dynamics of the health professionals involved. Discussion: Whilst dominance by medical professionals has favoured a more biomedical approach to intervention strategies, often leading to low community participation and resulting in decreased demand for these health services (any reference?), there is little previous knowledge on the power distribution and dynamics of health professionals in LMIC settings.
Catalysing scale-up of people-centred maternal and newborn health innovations within the health systems of Ethiopia, Uttar Pradesh, India and northeast Nigeria: building a conceptual framework

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ABSTRACT

Purpose Development partners commonly introduce innovative practices and technologies to improve health in low-income settings. Yet many innovations that are found to be effective are slow to be translated into policy and implemented at scale. Understanding the factors influencing scale-up is therefore important. We undertook a qualitative study exploring scale-up of maternal and newborn health (MNH) innovations funded by development partners in Ethiopia, Uttar Pradesh in India and northeast Nigeria. 150 semi-structured interviews were conducted in 2012/13 across the three settings with government officials, development agencies, civil society, professional associations and academics. Our study tested a conceptual framework of scale-up of MNH innovations within the health systems of low income settings. We were informed by literature on complexity science; health policy analysis; health systems and health services research; and diffusion of innovations.

Focus/content The paper presents our field-tested framework spanning agenda setting, policy formulation, implementation and community uptake consisting of the following domains: Persuading government to adopt and finance innovations at scale by: embedding scale-up in programme design and allocating time/resources; designing scalable people-centred innovations; building implementer capacity; effective advocacy and presenting strong evidence; involving government; invoking policy champions/networks; aligning innovations with health systems/priorities; strengthening harmonisation among external programmes. Supporting government to scale-up innovations by: contributing to policy strategies, guidelines, protocols and training curricula; capacity strengthening government health systems and staff including regulatory environments, management and human resource systems. Diffusion of innovation acceptance and uptake by communities: involving mass/local media and community opinion leaders; establishing community mobilisation teams and training role models.

Significance The paper is aimed at governments, donors, implementers and academics with an interest in scale-up and diffusion. Our framework suggests that implementers, donors and governments need to adopt multiple steps to catalysing scale-up - hence there is no magic bullet solution to scale-up.
The politics of universal health coverage in Kenya: Preliminary findings from an interpretive analysis of revenue collection policies

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ABSTRACT

Background: With support from the international community, a movement towards universal health coverage (UHC) is gaining momentum. Yet little is known about the process by which national policymakers make sense of the complicated UHC agenda and create policies to support it. In 2014, a qualitative interpretive study, using a well-established framing approach from political science, was conducted to gain a better understanding of how Kenya is undertaking finance reform to improve equity and move towards UHC. The proposed research is the first to look at how framing and equity influences political priority for competing finance policies in health. Methods: This study used interpretive methods to collect qualitative data from documentary sources and key informant interviews. In-depth, semi-structured interviews were conducted with 42 policymakers, stakeholders, and researchers. Data were coded and analyzed using Schon and Rein's frame-critical approach. Results: Preliminary findings suggest that the interplay of ideas, in addition to interests and institutions, had a distinct and powerful influence on political priority for revenue collection policies. Changes to revenue collection policies often reflected the vagaries of political theater, impassioned rhetoric during policy contestation, and the influence of powerful ideas that shape the terrain of debate. This study preliminarily identified several frames that were constructed with perceptions of financing problems, solutions, and potential recourse for action. Equity was seen as an underlying value by some to strengthen revenue collection policy in the Kenyan health sector, but did not serve as a consistent guiding principle throughout each step of the policy process. These data, therefore, question if Kenya is actually moving closer to UHC. Conclusion: These preliminary findings provide insight into the influence of political contestation on the policy process, global movements on national level policy-making, and notions of health equity on health financing reform. (study is ongoing)
Assessing health access for vulnerable women in conflict settings: a cross-sectional study from West Darfur, Sudan

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ABSTRACT

Background: Darfur was beset by conflict in 2003 with major escalation in 2004. To assess the impact of displacement on maternal and newborn health, we conducted a retrospective population-based survey in four localities in West Darfur in 2008. We assessed the neonatal mortality, child mortality, and coverage of maternal and newborn health interventions during the five-year period ending in 2008. Methods: We employed a three-stage cluster survey method with probability of selection of sample points proportional to population size. Selection of households and married women of reproductive age (MWRA) were based on systematic random selection. MWRA were asked about their pregnancy history through a structured questionnaire. Retrospective mortality data was collected based on pregnancy history. Neonatal mortality was calculated as a percentage of deaths over live births. Results: Survey data were obtained from 892 MWRA interviews, reporting a total of 1367 live births. The calculated cumulative neonatal mortality rate from 2003 to 2005 was 33.2, declining to 19.3 following the implementation of a comprehensive maternal and child health program from 2006 to 2008. Analysis of prevalence of key interventions revealed low coverage during the critical time for maternal and neonatal survival. There was a significant association of neonatal mortality with lack of access to skilled birth attendant and with camp residence. There was no association with parity, literacy or age. For many health indicators, coverage of services was significantly different between camp and non-camp residents. There were no significant differences in indicators between internally displaced persons and local community residents, although the advantaged group varied depending on the indicator. Conclusions: To reduce preventable maternal and neonatal deaths in conflict-afflicted states, comprehensive assistance needs to massively be scaled-up to increase coverage of evidence-based interventions, especially for communities residing outside camps, and especially in the critical period during labor, delivery and postpartum.
Barriers to health service access for sexual and gender minorities in South Africa

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ABSTRACT

Background Little is known about lesbian, gay, bisexual and transgender (LGBT) people's health care experiences in South Africa, but anecdotal evidence suggests significant barriers to accessing care. This study aimed to document LGBT people's experiences in order to analyse to what extent public health facilities are responsive to the health needs of sexual and gender minorities. Methods An on-going qualitative study in 2 SA provinces comprised of 30 semi-structured interviews and 2 focus group discussions (FGD) with LGBT health service users and representatives of LGBT organisations. Data were analysed within the framework of the International Covenant on Economic, Social and Cultural Rights General Comment 14 (availability, accessibility, acceptability, quality of care) following a grounded theory approach. Results All interviewees reported discrimination based on sexual orientation and/ or gender identity, encompassing all four elements of the General Comment 14: 1) Availability: Lack of public health facilities and services 2) Accessibility: Refusal to provide care to LGBT patients 3) Acceptability: Articulation of moral judgment and disapproval of LGBT patients, forced subjection of patients to religious practices 4) Quality: Lack of knowledge about LGBT identities and health needs, leading to poor-quality care All but one respondent had delayed or avoided seeking care. None had sought out accountability or complaint mechanisms. Reasons for this were either fear of repercussions, or the belief that homophobia was so pervasive in the health system that any complaint would be met with the same homophobia. Conclusion SA public health facilities are largely not responsive to the health needs of LGBT people, and this has negative consequences for the uptake of health services among sexual and gender minorities. Current complaint and accountability mechanisms fail LGBT people who experience homophobic discrimination in the health system. There is an urgent need to challenge health care workers' attitudes towards LGBT patients.
Assessing health system responsiveness to men's need in Malawi: Results from International Men and Gender Equality Survey (IMAGES)

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ABSTRACT

Background For almost every health condition common to men and women, the outcome for men tend to be poorer. Nevertheless, men seek help and use health services less frequently than women. Not much is known about the health system and provider related issues that influence men's behaviour. Objective To explore health system and provider related factors that influence men's health seeking behaviour. Methods We conducted a national cross-sectional study involving 1000 men and 500 women drawn from all the three regions of Malawi. Multi methods approach composed of both quantitative and qualitative studies was adopted. Probability proportion to size was used to select study areas while participants for quantitative study were chosen using multi-stage sampling. We also conducted ten focus group discussions with community members and 35 key informant interviews. Descriptive and thematic analyses were adopted for quantitative and qualitative data respectively. Results Most men reported that the health services they want are available in their areas, yet not all of them seek these services even in times of need. In general, we found that over 60% of men did not seek any kind of health care for over one year compared to around 40% of women. We explored this further using the qualitative tools and several reasons were provided. Most men expressed discontent with being assisted by a female health worker, lack of confidentiality by some providers and being mixed with women in waiting rooms. They called for establishment of specific sections for men in health facilities. Conclusion Apart from the outside factors which obstruct men from seeking care, service providers and the health system in general also play a crucial role. While men's needs are evident, most health systems are too slow to respond to their concerns. We recommend a shift from provider to people-centred health systems.
Introducing a tool to Measure Gender-Sensitivity of Health Facilities in Afghanistan

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ABSTRACT

Background: In Afghanistan, gender-related barriers hinder equitable access to and use of the healthcare system. Routine collection of data on the gender sensitivity of a health facility can support policy and program interventions aimed at better gender mainstreaming. Methods: A tool was developed to measure a facility’s gender sensitivity using well-established quality of care standards, while considering the Afghan context. The gender-sensitive themes include policies and guidelines, facility structural characteristics, distribution of human resources, in-service provider trainings, quality of service provision and data use. This tool was pilot tested in 21 facilities across four provinces (Kabul, Herat, Kandahar and Nangarhar) from September 2013-January 2014, covering five facility categories: basic health center, comprehensive health center, district hospital, provincial hospital and private facility. Results: Preliminary findings show a lack of complaint mechanisms in facilities for employees/patients, with <10% of facilities having an anonymous suggestion box. Emergency transportation is mostly available in larger and private facilities for referring patients or to transport providers. In >75% of facilities, multiple patients were being examined in the same room at one time, with no privacy. Despite financial incentives, there persists a shortage of female providers, especially in remote provinces. Hospital administrators in smaller facilities of remote regions were uncomfortable discussing gender-based violence and long-term family planning methods, especially sterilization. Women face challenges in accessing health facilities, primarily poverty and inability to leave home alone. Discussion: The findings suggest the need to improve the equitability of services, such as provide more female healthcare providers, gender-sensitize providers, ensure privacy of patients and work with communities to increase utilization of services. The tool is being integrated into the Ministry of Public Health's routine monitoring systems. This tool will enhance the field of measuring gender sensitivity, use of the tool can help ensure people-centered health services.
Your Health Our Concern; Our Health Whose Concern?: Perceptions of injustice in organizational relationships and processes and front line health worker motivation in Ghana

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ABSTRACT

Background: Taking a perspective of frontline health workers as internal clients within health systems, this study explored how perceived injustice in policy and organizational matters influence frontline health worker motivation; and the consequent effect on workers' attitudes and performance in delivering maternal and neonatal health care in public hospitals. Methods: It consisted of an ethnographic study in two public hospitals in Southern Ghana. Participant observation, conversation and in depth interviews were conducted over a sixteen month period. Ethical approval and consent were obtained from relevant persons and authorities. Data were typed, coded and analyzed using qualitative analysis software Nvivo 8. Main themes identified in the analysis form the basis for interpreting and reporting study findings. Findings: Findings showed that most workers perceived injustice in distributive, procedural and interactional dimensions at various levels in the health system. At the national policy level this included poor conditions of service. At the hospital level it included perceived inequity in distribution of incentives, lack of protection and respect for workers. These influenced frontline worker motivation negatively and sometimes led to poor response to clients' needs. However, intrinsically motivated workers overcame these challenges and responded positively to clients' health care needs. Discussion and conclusion: It is important to recognize and conceptualize frontline workers in health systems as internal clients of the facilities and organizations within which they work. Their quality needs must be adequately met if they are to be highly motivated and supported to provide quality and responsive care to the external clients they interact with. Meeting these quality needs of internal clients and creating a sense of justice in governance arrangements between frontline workers, facilities and health system managers is crucial. Consequently, intervention measures such as creating more open door policies, involving frontline workers in decision making, recognizing their needs and challenges and working together to address them are critical.
Trust and motivation in the health sector: a systematic review

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ABSTRACT

Background: Dedicated and motivated health workers (HWs) are central elements of people centred health care systems. They play a major role in delivering efficient and effective services, and are likely to improve patients’ experience in their health seeking behaviour. Trusting relationships have been identified as a possible source of intrinsic motivation and as enabling cooperation among HWs and their colleagues, supervisors, managers and patients. This paper presents findings of a review of empirical studies providing evidence on the determinants of motivation, specifically considering the potential influence and determinants of workplace trust. Workplace trust involves fair treatment and respectful interactions between individuals.

Methods: Five electronic databases were searched for articles published for the ten year period 2003 to 2013. To be included, articles had to report findings from relevant empirical studies on HW motivation, job satisfaction and retention. Data extraction involved consideration of determinants of motivation and how trust relationships influence it, by identifying how studies directly or indirectly mention and discuss relevant factors. Thirty articles from both developing and developed countries that met quality and inclusion criteria were appraised and subjected to thematic synthesis and analysis.

Results: Motivational factors directly and indirectly linked to workplace trust relationships include: respect; recognition, appreciation and rewards; supervision; teamwork; management support; autonomy; communication, feedback and openness; and staff shortages and resource inadequacy. The review indicates that workplace trust relationships have impact on the intrinsic motivation of HWs, and have consequences for retention, performance and quality of care.

Conclusion: Human resource management and organisational practices are critical in workplace trust and HW motivation. The review is inconclusive on how trust and motivation interact and operate for retention, performance and quality of care, and this should be explored. Assessment of the levels of motivation, values and factors that encourage workplace trust and relationships should be undertaken.
The role of a 'Pay for Performance' (P4P) scheme in motivating health workers at different levels of the Primary Health Care (PHC) System in Tanzania

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ABSTRACT

Background Tanzania's health system is currently coping with low worker motivation coupled with severe shortages of staff, medicines and supplies. A P4P scheme designed to motivate health workers towards providing better quality of maternal and newborn health (MNH) care was piloted in Pwani region of Tanzania. The Scheme included biannual cash bonuses to health workers, their facilities and managers at district/regional level based on achievement of pre-defined performance targets for specific MNH services; improved data reporting; enhanced performance monitoring; and greater facility financial autonomy. This presentation discusses the effect of P4P on health worker motivation at different levels of care. Methods Document review and qualitative interviews with national level key informants and health workers and their managers from 15 health facilities across 5 districts, between December 2011 and May 2013. Results P4P has the potential of motivating health workers and their managers, and stimulating initiatives to overcome system constraints. Motivation is a result of financial and non-financial incentives. The Scheme has the greatest positive effect in facilities that are adequately stocked, staffed, supervised, with all health workers receive performance payments. Differential bonus payments for those providing 'targeted' and 'non-targeted' care, a focus on performance of P4P services, and the practice of reallocating harder working staff members to targeted services to boost facility performance, can impact negatively on team spirit and collective responsibilities, with undue attention to quantity rather than quality of care. Performance targets are system based, with some facilities in a better position to meet their targets. P4P risks undermining 'non targeted care', of demotivating health workers most in need of support, and of increasing inequities between facilities. Conclusion P4P needs to be redesigned with a view to equity and universalism and within the context of the broader health systems reforms before its potential roll out. Collaborators and Funding: Evaluation undertaken in collaboration with London School of Hygiene and Tropical Medicine, UK, and Chr. Michelsen Institute, Norway. Funded by The Norwegian Government.
Effectiveness of an intervention programme of caring for clinical nurses by nurse managers in China

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ABSTRACT

Objective To explore a series of effective human caring interventions to care for clinical nurses. Methods The clinical nurses in 26 pilot departments of human caring in a tertiary hospital were selected as intervention objects. The interventions include: building human caring model, improving nurse managers’ caring ability, setting up a caring group for nurses, psychological counseling, caring behaviors of head nurses, strengthening implementation and supervision of caring work. 273 clinical nurses from pilot departments were recruited (93 nurses were investigated before the intervention and 180 were investigated after the intervention) and were investigated with a job satisfaction questionnaire formulated by the Ministry of Health in China. Results The mean scores of overall job satisfaction, teamwork satisfaction, nursing work satisfaction and career prospects were improved (\(p<0.01, p<0.05\)). Conclusions Caring for nurses contributes to improving nurses’ job satisfaction which is meaningful for nurses retention and high-quality nursing service. It is recommended to strengthen the human caring for clinical nurses.
Using multiple measures of motivation to understand job satisfaction among rural health workers

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ABSTRACT

Background: Ghana is among the countries advocating for human resource development to improve primary care outcomes. The biggest challenge for Community Health Nurses (CHNs) and Officers (CHOs) is their lack of motivation largely due to professional isolation and lack of support. They are often deployed to remote areas where there are limited opportunities for career advancement. The Community Care Hub in Ghana is a pilot to address some of these challenges through distribution of mobile phones with tools to improve clinical performance, mentorship, learning opportunities and connectedness among health workers. Methods: To understand job satisfaction and motivation, we employ a range of methodologies. All 240 CHNs and CHO in 4 intervention districts respond to a short electronic survey, a clinical knowledge assessment and a module to assess their social networks. These data are supplemented by information from 75 in-depth interviews of CHNs, CHO and their supervisors. Additional data include routine monitoring and qualitative data from program implementers on the processes and outputs related to the interventions. Results: The use of multiple methodologies allows for data triangulation and iteration during the project. Motivation and satisfaction is expected to increase over time with the introduction of supportive technologies. However, continuous monitoring of usage and repeated in-depth interviews allow evaluators to isolate which components of job satisfaction are being addressed and how the new technology is influencing those changes. Short surveys, built onto the intervention platform, are an inexpensive and easy way to gain valuable information about program effectiveness in mHealth. Discussion: This paper will highlight the aspects of job satisfaction that can and cannot be addressed through technology. This has implications for improving motivation and retention of health workers in rural or isolated settings. We recommend strategies for improving health worker satisfaction and the role that technology can play in this process.
Money isn’t everything, but it helps; Understanding Health Worker motivation and retention in rural Cambodia

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ABSTRACT

Health workers in low- and middle-income countries are often confronted with unrealistically low public salaries and cope by combining salaried public service with fee-for-service private practices. However, this dual practice can contribute to absenteeism and poor health worker performance in the public sector. Understanding the incentives health workers face, both financial and nonfinancial, is an integral component of developing people centered health systems, maintaining a skilled workforce, improving quality of services, and reducing informal payments. In Cambodia, incentive schemes introduced to improve the quality and availability of health workers include: - Allowing managers autonomy over setting performance-based contracts for their staff; - Formalizing payments for services through user fees; - Paying output-based cash incentives for facility deliveries; - Project-specific salary top-ups from donors. We present findings from The Cambodian Health Worker Professional Development survey, which collected detailed information on salaries and incentives, socio-demographic and employment characteristics, as well as management practices, motivation, and dual practice from a representative sample of over 1,200 health workers. Our findings describe a fragmented health financing landscape with large variations in payments made to health staff. We show that salary top-ups can have a powerful impact on health worker motivation and increase adherence to working hours, particularly when linked to strengthening accountability and performance management. However, relative equity in pay, within and across facilities, can be as important as absolute pay in increasing motivation. Furthermore, there is a larger variance within schemes than between for quality, absenteeism and motivational outcomes, indicating that factors such as good management and supervision are key to successful implementation. Finally, non-financial incentives can be as powerful as financial ones in motivating health workers to stay in the public sector. Our findings have implications for implementing incentivization schemes, management practices and autonomy in resource poor settings, including designing results-based financing programs.
Resource and support systems for community health workers increases demand for quality services and community participation in Uttarakhand

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ABSTRACT

Background: In 2005, India's National Rural Health Mission introduced use of accredited social health activists (ASHAs), CHWs receiving performance-based remuneration, to serve as an interface between the community and the public health system. Hilly terrain, scattered settlements, and poor road connectivity in Uttarakhand adversely affected ASHAs' reach and potential remuneration. Methods: Under the USAID Innovations in FP Services Project (2005-2012), Futures Group provided technical assistance to the State Government of Uttarakhand to design a pilot to improve the effectiveness of selection, training, mentoring, and support for ASHAs. Under 'ASHA Plus' ASHAs covered flexible populations, were reimbursed for a wider range of services, trained in micro-planning tools and management information systems (MIS), had job aids and tools for record keeping. The government established a State ASHA Resource Centre, State ASHA Mentoring Group, and District ASHA Resource Centres. Results: Comparison of baseline (2006) and 2007-2008 MIS data indicated improved service uptake: 3 ANC visits (30% to 59%); early pregnancy registration (35% to 49%); and institutional births (27% to 58%). Community-level outcomes: better outreach to underserved areas, awareness of health schemes, demand for quality services, and community monitoring; at the systems level, increased linkages between service delivery points and response, record keeping, and interaction with other health cadres. In 2009, the government scaled up coverage in six districts (0.26 to 3.13 million people). In 2010, it expanded the supervisory system, the remuneration package, and established ASHA resource system statewide. Conclusions: Minor policy and systemic changes to suit local context, and strengthening capacities of CHWs can improve service uptake, accelerate improved health outcomes, and increase social participation and monitoring, with equitable service delivery leading to empowered communities.
Abstracts of the Third Global Symposium on Health Systems Research: 30 September – 3 October 2014

The Science and Practice of People-Centred Health Systems  Cape Town South Africa

Thursday 2 October 2014
16.30 - 18.00
Meeting Room 1.41

Political decentralization and programmatic devolution: A realist evaluation from rural India

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ABSTRACT

Background: Despite an enabling legal framework, India continues to struggle with making political and programmatic decentralization/devolution an effective vehicle for people-centered, responsive health systems. Health outcomes lag far behind the Millennium Development Goal targets. The study problematizes sectoral approaches to health care delivery and examines the possibility of convergence between programmatic and political decentralization in the context of the National Rural Health Mission (NRHM). It explores the potential for community health workers (CHWs) to engage with elected representatives (Panchayati Raj or PRI members) in contributing to agreed common goals; and unpacks the real time challenges faced by these actors, who interface most closely with the communities to be served.

Methods: Semi-structured interviews with CHW and PRI members in two rural districts of South India provide the narratives for a realist evaluation of the dynamics between community-level actors, the context and the processes that critically influence key health outcomes. Results: Active engagement between CHWs and PRI members is constrained by: (i) differing measures of success: the former respond to program targets, while the latter are responsive to perceived political payoff; (ii) unequal power: PRI members see themselves in the 'drivers' seat' when joint decision-making is required; (iii) gender: CHWs are usually young women, easily dominated by older, male PRI members; and (iv) poor technical capacity of CHWs, which increases their sense of disempowerment.

Discussion: Decentralization is not only about 'funds, functions and functionaries'; it is also about recognizing and supporting inter-sectoral action at the field level. There are spaces where open dialogue between CHWs and PRI members is possible, to understand each other's expectations and lived experience, and develop mutual understanding and openness to joint action. Capacitating community workers to utilize such opportunities effectively and build on their inter-dependency is critical to the success of decentralization.
Trust and team work matter*: Community health workers’ experiences of integrated service delivery in India

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ABSTRACT

The need for comprehensive and integrated service delivery to strengthen primary health care has been the major thrust of the National Rural Health Mission (NRHM) that was launched in 2005 to revamp the rural public health system in India. Though the logic of horizontal and integrated service delivery to strengthen health systems has long been acknowledged at policy level, empirical evidence on how such integration operates is rare. This paper, in this context, discusses the experiences of village-level health workers in integrating immunization with broader maternal and child health services through outreach sessions like the Village Health and Nutrition Days. The paper draws on ethnographic field work conducted in the state of Odisha, India in 2011-2012 that involved in-depth interviews, observations and focus groups discussions at the community and sub-district levels. The findings show that for the community health workers, the notion of integrated service delivery goes well beyond technical mixes of health services. Crucially they perceive ‘building trust with the community’ (beyond trust in health services) and ‘team work’ (among the health workers) as critical to integrated service delivery, although acknowledging the challenges posed by differential training, salary, status and role. However, the NRHM primary health care ideology - which the community health workers espouse - is in constant tension with important elements of the Indian public health system. These include the exigencies of narrow indicators used for health system performance; the highly hierarchical health bureaucratic structure that rests on top-down communications and the institutionalized privileging of statistical evidence over field-based experiences. The evidence in the paper shows that it is important to capture the perspectives and experiences of the community health workers to unpack notions of integration and facilitating effective community engagement with formal health systems.
Informed, organized and empowered: poor rural women’s negotiations for health and its social determinants in Uttar Pradesh, India

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ABSTRACT

Uttar Pradesh state in India has high maternal mortality, and ranks near the bottom in terms of human development indices. Documented cases about poor rural women in UP who attempted to access reproductive health services indicate that they faced disrespectful behaviour, harassment for informal payments, downright negligence or denial of care. Similar disrespect and denial is reflected in women’s experiences of seeking other state-provided services that impact upon health, such as subsidised food-grain provision, supplementary nutrition, schemes for employment guarantee or social security, and help when facing violence. These transactions reveal a culture of impunity embedded within asymmetrical power relations, when the women happen to be poor, non-literate, or from marginalized social groups like Dalits, tribal groups, and religious minorities.

In response a strategy used by the NGO SAHAYOG in partnership with the grass-root organization Women’s Health Rights Forum (MSAM) and local CBOs in several districts, was to promote women users’ participation in monitoring their entitlements. Through capacity-building based on Paolo Freire’s methodology, women analyzed their own experiences; gained information about their entitlements from the various departments; and built skills to monitor services using pictorial tools. After carrying out local monitoring of selected aspects of health and nutrition services, women presented the findings in annual non-adversarial dialogues with district officials each year. In addition the skills enabled women to negotiate entitlements within other schemes for rural employment, social security and decentralized budgeting. The cycle of capacity-building, citizen monitoring and regular dialogue has built the skills of poor women in negotiating improved quality services from government departments, and establishing their credibility as a source of real-time feedback about the services. The active participation of informed, organized and empowered women users has promoted a culture of answerability among frontline workers, providers and district managers, towards more respectful, accountable and better quality services.
The power quandary - the role of local elites and powerful others in community-based health development

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ABSTRACT

Background: Community empowerment and mobilization are commonly seen as critical in creating demand for basic services, although existing power structures may impede or enable translation of demand into supply. This paper examines these dynamics using data from four case studies conducted as part of a larger study that assesses community-based efforts to empower urban poor communities in Bangladesh, and mobilize demand for equitable primary health care services. Methods: We used observations, focus groups, key-informant interviews and in-depth interviews with project stakeholders, including community members, project staff, and service providers in four health and infrastructure improvement projects (UPPR in Barisal and Tongi, BITA in Chittagong and DSK in Dhaka), to explore the processes, outcomes, and challenges of working with communities to meet their needs while leveraging existing service providers and power structures to deliver appropriate services. Findings: Political engagement with local power structures was evident in all case studies, with examples of powerful elites lending their name to increase credibility of projects, applying pressure on non-corporative stakeholders, and arranging for the provision of resources (funds for free medication, accommodation for satellite clinics). Engagement of political leaders was seen as desirable by both community and project staff, given their key role in mobilising resources, influencing external agencies, and potentially increasing the sustainability of project activities. However, levels of engagement varied, with corresponding impacts on project outcomes and sustainability of services. NGOs contributed by mediating the relationship between the community and the political agents. Conclusion: While leveraging existing power structures to mobilise the provision and/or support for community-based services that previously disempowered communities could not access, there is the risk that project activities may serve short-term political agendas rather than contribute to sustainable systematic changes.
Sharing learning on close-to-community health programmes across different contexts: A south-south technical assistance capacity building model

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ABSTRACT

Focus: There is increasing interest in the role of close-to-community (CTC) programmes in supporting people centred health systems. We need to better understand which approaches work best at-scale in different country contexts and are potentially transferable. The REACHOUT consortium (working in Bangladesh, Ethiopia, Kenya, Malawi, Indonesia, and Mozambique) aims to build capacity for research and delivery on CTC programmes through implementing and evaluating of two cycles of quality improvement (QICs) to strengthen CTC services in each context. Within REACHOUT country contexts there are diverse approaches to retention, motivation and supervision of CTC providers, mechanisms to support service quality and referral. Purpose and significance for field building dimension: REACHOUT's capacity development strategy includes South-south technical assistance to ensure that we build on the strengths and context embedded experiences of all partners in designing, implementing and evaluating the QICs. Here we report on the purpose of developing this novel south-south capacity building approach, the process of matching (following identification of strengths and weaknesses) carried out across and between partners and the learning and capacity development generated through immersion in diverse CTC programmes. For example, BRAC in Bangladesh can offer expertise in supervising, retaining and motivating community health workers through their extensive programmes of 97,000 shasthyashebika who have impacted on maternal mortality. Whilst Kenyan based LVCT can offer experience in community referral, and peer supervision with positive impacts on community based approaches to addressing HIV. REACHOUT partners (researchers, policy makers and practitioners) can visit and 'immerse' themselves in CTC programmes in other contexts to inform their own QICs. Following each south-south exchange, visitors and hosts will be asked to reflect on what they learnt through the process and implications for quality, effective and equitable CTC programmes within their own contexts. The target audience is people interested in capacity building models and/or CTC programmes.
Experience of care and equity in Quebec province following the primary health care reform: what is the impact of the type of PHC organization?

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ABSTRACT

Background In the early 2000s, Quebec initiated major changes in its healthcare system, creating new models of primary health care (PHC). The reform partly aimed to reduce inequities between socioeconomic groups. We examine the association between experience of care and socioeconomic status (SES) for different models of PHC. Methods Data were collected from a population-based telephone survey (n=9180) held in 2010 in two regions of the province of Quebec. Analyses were performed with indices relating to different dimensions of experience of care: Accessibility; Process of care: continuity, comprehensiveness; Outcomes of care: perceived results of care, exposure to preventive services. Comparisons were made between levels of SES and repeated after controlling for type of PHC organization (new models: family medicine group (FMG), network clinic (NC), combined FMG and NC; older models: group practice, solo practice, community health center (CLSC)). Results Accessibility is globally comparable for all levels of SES; when we control for type of PHC organization, it is higher for low SES in CLSCs and solo practices. Continuity is globally less favorable for lower SES; differences exist between levels of SES in all models except FMGs. Comprehensiveness and perceived results of care are less favorable for lower SES globally; differences in favor of the higher SES are greatest in NCs and group practices. Exposure to preventive services is globally more favorable for the higher SES; only CLSCs show no differences between levels of SES. Discussion Considering that lower SES people have more needs for services, CLSCs and solo clinics appear to be the only equitable models for accessibility; all models appear inequitable toward the low SES for process and outcomes of care. Among new models, GMFs seem more equitable than NCs. CLSCs remain the most equitable. We conclude that apparent inequities in experience of care vary according to different models of PHC.
Respectful and non-abusive care during childbirth in Addis Ababa, Ethiopia: a case from Saint Paul's Hospital Millennium Medical College (SPHMMC) and three Catchment Health Centers

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ABSTRACT

Background: Lack of respectful and non-abusive care at birth may encompass many points along a continuum that spans dignified, patient centered care, non-dignified care, and overtly abusive maternal care. Poor quality of service is one among the various reasons for not giving birth at health institutions.

Methodology: A facility based study was conducted in August 2013 to quantitatively assess the prevalence of disrespect and abuse (D&A) during childbirth in the study area using 28 verification criteria. A total of 173 mothers who gave birth at the study institutions and 57 service providers were interviewed. Data were collected using a structured and pre-tested questionnaire by female data collectors and SPSS version 16 was used for analysis. Results: Disrespect and abuse was identified to be practiced in 96.5% (at least one report among the 28 criteria) of the deliveries surveyed. Failure to maintain women's right to information, lack of informed consent, and failure to maintain choice/preferences; all forming a single indicator, were the common problems reported by 95.4% of clients followed by leaving mothers without attention (39.3%). Though the level of practice of D&A was found to be very high, only 12.7% of mother claimed to have been disrespected and abused during childbirth, which shows that there is normalization of D&A in the study area. Mothers who delivered at hospitals were more likely to be left without attention (AOR=2.08, 95%CI: 2.08, 33.2). Besides, 77.2% of providers reported that disrespecting mothers based on any specific attribute was practiced in the three months preceding the survey. Conclusions: Disrespect and abuse was highly practiced by service providers and normalized by clients. Further studies need to explore why D&A is normalized. Thus, we recommend a concerted effort to increase the awareness of service providers on D&A to help them provide women friendly services during childbirth.
Disrespect and abuse during childbirth in Tanzania and its influence on perceptions of the health system

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ABSTRACT

Background: Despite efforts to reduce barriers to utilization in Tanzania, facility delivery remains low and maternal mortality high. Disrespect and abuse of women during childbirth has not been thoroughly explored as a deterrent to institutional delivery. We examined the association between disrespectful and abusive treatment during childbirth and satisfaction with the delivery experience, perceived quality of care, and likelihood of recommending the facility for delivery using a cross-sectional study design. This is one of the first quantitative studies assessing disrespect and abuse. Methods: Interviews were conducted in Tanga Region, Tanzania with women on discharge after delivery at eight health facilities. A randomly selected subsample of the women was re-interviewed 5-10 weeks postpartum. For both datasets, three multivariable logistic regression models evaluated the association between demographic and delivery experience factors and (1) delivery satisfaction, (2) quality of care for delivery, and (3) likelihood participants would recommend the facility for delivery. Results: 1779 women participated in the exit survey and 593 women were interviewed again in their homes. At both time points, reported disrespect and abuse during childbirth was associated with substantially lower satisfaction with delivery (exit: OR 0.23, 95% CI 0.16-0.32; follow-up: OR 0.17, 95% CI 0.11-0.26), lower likelihood of ranking quality of care for delivery as excellent or very good (exit: OR 0.54, 95% CI 0.34-0.85; follow-up: OR 0.55 95% CI 0.28-1.09), and reduced likelihood of recommending the facility for delivery (exit: OR 0.21, 95% CI 0.14-0.32; follow-up: OR 0.47, 95% CI 0.24-0.90). Discussion/conclusions: Our study highlights the importance of poor interpersonal care during childbirth, specifically disrespectful and abusive treatment, as a contributor to patients’ assessments of the health system. Efforts to increase facility delivery and thus decrease maternal mortality must go beyond attention to technical components of quality and include the right to be treated with respect during childbirth.
The variance in understanding of the health rights of vulnerable groups in the Sundarbans, India

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ABSTRACT

Background: Certain vulnerabilities like livelihood uncertainty, exposure to frequent climatic shocks, physiological status, ethnicity, age, sex or economic condition, place additional barriers in the way of accessing health care for vulnerable sections of population in socio-climatically challenged Indian Sundarbans delta in West Bengal, India. The study aims to explore the gaps both from the perception of special groups regarding their vulnerability in terms of maternal and child health rights and how other health system actors views these groups. Method: Six scoping FGDs with community leaders and mothers of varying age group and ethnographic observation for two months had identified “special groups” that included people depending on forest products, crab collectors, 'tiger widows' and people living on the embankments in three geo-climatically distinct villages in Indian Sundarbans. Five case studies of mothers were taken from each group followed by in-depth discussion with grassroot level health providers (four in each village). A right-based explanatory analytical approach was used to analyze the data. Results: The process and causal elements of vulnerability showed dependence upon structural and aptitude gaps within the existing health system. The knowledge gap of grassroot providers about the special needs of these groups further aggravated the non-acceptability of the health care services. Daily struggle for existence of the "special groups" in geo-climatically vulnerable areas exhibit their unfelt need for health care leading to participation gaps in the existing health system. Absence of linkages with locally dominant community groups and civil society has further constrained their voices for basic health rights. Discussion and significance of the field building dimension The findings of the paper points to a lack of systemic understanding of the rights of these "special groups" due to perception variance and calls for infusing health systems with further dialogue to raise visibility and responsiveness for protecting their health rights.
In search of patient-centred care in middle income countries: The experience of diabetes care in the former Soviet Union

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ABSTRACT

Background: There is now widespread acceptance, at least in political and policy declarations that the patient should be at the heart of the health system. The resulting model of patient-centred care has been advocated on moral, ethical and instrumental grounds and is seen to provide greater equity and more attention to patient rights. In this study we apply the principles of patient-centred care to assess how health systems in middle income countries shape the experiences of patients with a common chronic disease and their care providers.

Methods: We performed a multi-method health system appraisal, which included semi-structured interviews with patients with diabetes, health professionals and key informants. We selected interviewees by purposive and snowball sampling. In total 340 respondents were interviewed in five countries: Armenia, Belarus, Moldova, Russia and Ukraine. Data were analysed according to a coding framework that was developed by three researchers, who then uncovered salient themes, similarities and differences between the five countries.

Results: Access to and consistent use of services was hampered by lack of coordination and financial weaknesses in the health systems. In many cases, lack of external support for individual patients left friends and family as the main providers of emotional and logistic support. Patients were not expected to have a say or challenge the decisions concerning their treatment.

Discussion: This study is the first to address the barriers to patient-centred care from the perspective of users and front line providers in this region. Our study identifies system-level responses that could improve the health system responsiveness in delivering care for people with diabetes and, by extension, other chronic diseases. These relate to skill-mix and task-shifting, locating chronic disease management in non-specialised services. However, reforms will only address needs and expectations of patients if they are also involved in the decisions that affect their care.
Engaging multiple stakeholders: A strategy to address disrespectful and abusive behavior during childbirth in Tanzania.

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ABSTRACT

Abstract Background: Disrespect and abuse (D&A) during childbirth has been said to hamper the ongoing efforts to promote health facility delivery. Moreover, little has been documented on its impacts on the outcomes of maternal health services. Methods Following findings of a baseline study on prevalence and drivers of D&A in facility-based childbirth in Tanzania, a stepwise strategy was used to engage key stakeholders to share the results, generate feedback, and mobilize efforts to forge specific interventions to promote respectful maternity care. Results The initial dissemination goal was to determine driving factors and impacts of the observed disrespect and abuse. In view of this, a dissemination meeting with maternity wards health care providers and hospital administrators was convened, where participants were lead to internalize and reflect on the findings, validate and relate them to their daily practice. To further disseminate and determine feasible interventions to mitigate D&A, a second meeting assembled the municipal medical officer of health (MMOH); key council health management team members involved in planning and supervision of maternity health services; health care providers; and hospital administrators. The key output was consensus on potential interventions to promote respectful maternity care. Further, a small task team was formed to review and incorporate stakeholder inputs in designing the potential interventions. The third and final dissemination was to a much wider audience including health and human rights' experts from governmental institutions, local and international organizations. We achieved wider dissemination of findings and gathered stakeholder inputs on the rationale, feasibility and sustainability of proposed interventions. Conclusion: Addressing D&A during childbirth is sensitive and challenging. Involvement of key stakeholders across all levels has shown to be an essential step in achieving successful sensitization and effective engagement, instilling ownership, and ensuring sustainability of proposed interventions.
Learning from a national initiative to develop health research capacity in Malawi

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ABSTRACT

Background The Health Research Capacity Strengthening Initiative (HRCSI 2008-2013) was a national systems-strengthening programme in Malawi designed to provide competitive awards for individuals (pre- and post-degree) and institutions. We independently evaluated the performance and impact of HRCSI, noting successes and challenges. Methods The evaluation process, data collection tools and interview guides were informed by published evidence and the experience of the Malawian-UK-Canadian evaluation team. Data was obtained from reports, databases, and face-to-face or telephone/Skype interviews. Within stakeholder strata, 30 (of 173) interviewees were selected randomly or because of specific in-depth knowledge. Data was synthesized under three themes - start up, outputs and sustainability. Results Start-up was difficult primarily because of over-ambitious targets and unrealistic assumptions about existing national capacity for grant-making. In its second year, HRCSI streamlined management processes and financial systems, and improved accountability. Outputs: A National Health Research Agenda (2012-2016) was a key project output that facilitated alignment of research priorities with Malawi's health plans. HRCSI supported 50 MSc/PhD students and >400 undergraduate projects ranging from basic to social science. It produced a 'step-change' in the number of high calibre scientists and fostered interest in research. HRCSI established novel national strategies for managing research processes and funding, and produced guidelines and tools; however, application processes, feedback, and release of funds remained problematic. Sustainability: Between 2011-13 HRCSI had significantly improved research systems, processes and leadership in Malawi but further strengthening would be needed for HRCSI to be effectively integrated into government structures and sustained in the long-term. Discussion Key lessons for broader research capacity-development were that structures, systems and processes for grant-making should be established and piloted prior to calling for applications, and that partners' roles and responsibilities should be clarified. Building on their learning from HRCSI, one funder has created regional research hubs to bring oversight closer to recipients.
Medical Students for Health Systems and Services (MS-HSS): An incentive-based program to introduce health systems perspective to medical students

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ABSTRACT

Purpose: With collaborative efforts of key national authorities, MS-HSS was launched as an innovative program to introduce health systems perspective to medical students in Thailand. This paper describes program characteristics and lessons learned from the first year of implementation with specific examples.

Content: Medical students voluntarily participated in the program after they were informed through words of mouth about some incentives such as opportunity to attend international conferences. Initial discussion was conducted with each group of students to identify potential health systems research topic that concur with their current knowledge and career goal of medical training. Some class assignments were also encouraged to be used as a starting point. A few tailored lectures were conducted to fill potential gaps of essential knowledge such as conducting literature review, data collection and analysis, abstract and manuscript preparation. Budget for essential expenses was set aside. A committee was formed, consisting of 'talented and friendly' faculty members nominated by students, to oversee the program and make decision on resource utilization. At least ten projects have been launched in the first year, one student received the Prince Mahidol Award from a project on system-wide improvement of critical care whereas a project on comparative analysis of medical licensing examination systems across Southeast Asian Nations was orally presented and won the Patil Award at AMEE 2013. Another national survey project exploring factors affecting decision of newly graduated physicians in choosing potential practice areas was chosen and supported in the Second Global Symposium in Beijing. Significance: Traditional approach to integrate health system perspective into currently packed medical curriculum for Generation Y students is unlikely. This paper proposes a systematic development of an incentive-based program to help medical students to understand and be able to integrate health system perspective into their basic science and clinical competencies.
Developing People-centred public health professionals in LMICs: Evidence of impact through three MPH programmes

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ABSTRACT

Introduction In building people-centred health systems, a key strategy is to ensure that Public Health professionals engaged in further learning are exposed to these values, and educated to address people-centredness through their daily actions. Three institutions (SOPH, UWC, South Africa, KIT, Netherlands and INSP, Mexico) which offer Master of Public Health (MPH) programmes geared towards low and middle income countries evaluated programme impact. This paper focuses on findings relevant to building people-centred health systems. Methods Mixed methods were employed, comprising an online survey of graduates (2005-2010) in which they rated the impact of the MPH against seven validated core competencies, two of which were people-centred, as well as 36 validated impact variables, 26 in the workplace and 10 in relation to society (Zwanikken 2014). Of these variables, 9 were selected as people-centred (Kaim 2013; WHO-WPRO 2014). Qualitative data were obtained through in-depth interviews with between 8-12 clusters of graduate, peer and supervisor per institution, total 84; only those themes providing evidence of people-centred impact have been reported. Results and discussion The graduates ratings of MPH impact provide evidence of significant development of people-centred competencies, 53%-72%, as well as workplace impact, with ratings ranging from 44.6% to 62.9%. The ratings for people-centred impact on society are lower although 4/10 of them were people-centred: 41.7%- 54.9%. These findings were corroborated by the qualitative data: graduates acknowledged their MPH training in their efforts to strengthen equitable health provision; there was widespread focus on disadvantaged target groups and good evidence of involving community members in health action. Graduates reported a new recognition of the cultural dimensions of health problems. Several graduates addressed successfully gender issues and even 'mainstreamed gender' in programme activities. However, it is argued that without coupling education with leadership development, the impact of people-centred Public Health professionals will remain limited.
Equipping medical graduates to address health systems challenges in South Africa: An expressed need for curriculum change

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ABSTRACT

Background Stellenbosch University aims to enhance health systems knowledge and skills for undergraduate medical students in order to empower graduates to address challenges experienced when working, especially in rural and underserved areas. Methods We firstly defined health systems research and strengthening competencies for medical graduates through a literature review, and consultations with experts. We then compared the learning outcomes in terms of knowledge, skill or attitude in the sixty-four module guides for all theoretical and clinical modules of the curriculum to the competencies required. Learning outcomes were assessed by matching the verb contained in the learning outcome to the appropriate level of Bloom's taxonomy. Lastly, a survey of recently medical graduates was conducted to assess their perceptions of whether their training equipped them to address health systems challenges in the environments where they worked after graduating, and additional training requirements. Results and discussion HSSR is covered to varying degrees in the curriculum. Foundational competencies are covered at a basic knowledge level. Teaching is not integrated throughout the curriculum. The survey yielded 38% response rate. From the 189 respondents, 63 (33.3%) agreed while 67 (35.4%) disagreed that the training prepared them to address health system issues. 128 (67.7%) agreed that it is important to learn health system research in the undergraduate curriculum. 'I can't recall that we were taught anything on the health care system, so I would add as much as possible management skill training diplomacy'. The most prevalent themes suggested were: health system knowledge, leadership and management, problem solving, community service, evaluation method, health economic theory. Young doctors suggested that improvement can also be made through practical, problem-oriented health system research training during internship. Conclusion: The curriculum is being adapted so as to prepare students according to the Health system context and environment where they are expected to work.
Individual and socioeconomic disparities in health seeking behaviors and out of pocket payments in the Gaza Strip in 2013: Results from a households survey.

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ABSTRACT

Background: Different population groups in Gaza Strip use the services of a pluralistic health system and spend part of their income on health. Nonetheless , little is known about disparities between them in seeking health care and paying for it. Methods: A survey interviewed a random sample of 760 households in July 2013 in the Gaza Strip, with structured questionnaire to inquire about health-seeking behavior and the out of pocket payments. Spending 20% of income or more by a household on health was considered as a Catastrophic Health Expenditure (CHE). ?² tests were done to compare difference between grouped variables. Results: The occurrence of CHE differed by the refugee status ( p=0.026) and by living inside or outside refugee camps ( P= 0.006), by having a patient with a chronic disease and by the income quintiles ( both P<0.0001), where 129 (41.2%) out of 313 households from lowest income quintiles encountered CHE , compared to 209(27.5%) among the entire sample. People in general have good access to health services, and they initially have chosen free of charge services and those offered at nominal users fees for medicines and diagnostic tests. The choice was more pronounced among those with lowest income quintile(P=0.0088), who avoided private for profit providers for acute illnesses. However, a proportion of health services users, without statistically significant difference among income quintiles, have sought the care of second health providers in addition to initially chosen ones. Most of second providers were private . Conclusion: Although the poor households avoided using costly health services, they spent a higher proportion of their income on health. This suggests that improving quality and responsiveness of health services offered on free of charge or at low cost basis could decrease financial burden of ill health on the poor in the Gaza Strip.
Assessing current and projected costs of non-communicable diseases in Zimbabwe: The case for investing today to prevent unsustainable costs tomorrow

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ABSTRACT

Disease and economic burdens are growing in all countries due to non-communicable diseases (NCDs), calling for investment in interventions that prevent future morbidity. Finance ministries facing competing concerns need persuasive information on these costs and their distribution, to allocate new resources for such interventions. This study in Zimbabwe explored the current costs of treating NCDs, and the projected direct and indirect costs to health services, economy and households, should resources not be mobilized for improved intervention. Zimbabwe’s ten most common NCDs and their levels and costs of service utilization were identified by triangulating survey, health information system and available service cost data for 2012. Actuarial projections were made for these top 10 NCDs, in terms of their prevalence and utilisation rates, and their direct and indirect costs to 2030, taking economic projections and demographic changes into account, using cost of illness and economic growth approaches. The research showed that for these top 10 NCDs alone, assuming no major intervention to control them, their direct annual costs to the health sector calculated at $39.86 / capita in 2012 (compared to $93/ capita total health spending) will rise by 44% to 2030. However, the projected rise in indirect costs to the economy and households will be sharper and more significant, estimated in the analysis to rise to $3.6bn by 2030, similar to findings in a 2011 World Bank study. Avoiding such costs calls for improved domestic financing to implement known cost effective measures in the health sector and to implement cross sectoral policies that minimize risk of NCDs. We raise the limitations we encountered in the available data, but argue that the strength of direction of our findings means that this should not be used to delay the investment in proven cost effective interventions for early detection, prevention and mitigation of NCDs.
Using evidence to shape health financing: Building a Health Financing Strategy from the ground up in Malawi

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ABSTRACT

The health financing literature recommends that countries to use national health accounts and other evidence based information to develop health financing policies and strategies (Sambo et al, 2011). WHO also recommends that health financing strategies be ‘home grown’ or developed with extensive local stakeholder involvement (WHO, 2010). In the Malawi Health Sector Strategic Plan 2011-16, the Government of Malawi recommended developing a national health financing strategy. However, there was very limited evidence available on the health financing situation in Malawi to inform the strategy. To overcome this dearth of information and ensure Ministry ownership and approval of the health financing strategy, the USAID-funded SSDI-Systems program, in collaboration with the Clinton Health Access Initiative, assisted the Ministry of Health (MoH) to outline and implement a systematic, comprehensive, and evidence-based process of health financing strategy development. The participatory and consultative process followed four steps: (1) generating evidence on the financing functioning of the Malawi health system and proposing financing options; (2) assessing the potential and feasibility of the proposed financing options; (3) synthesizing the evidence and prioritizing the financing options; and (4) developing the health financing strategy. The development of health financing strategy in Malawi has been unique in its extensive use of evidence and feasibility testing during the strategy development process. It has helped to outline equitable, efficient and sustainable, resources generation mechanisms and has included key MoH stakeholders in the data analysis and decision process, to gain buy-in for options selected. The process has resulted in a strategy which includes a mix of revenue generation, risk-sharing (pooling), and purchasing mechanisms and is projected to reduce the resource gap, thereby improving long term financial sustainability for the health sector needs in Malawi. Once approved by the MoH, the strategy will be ready for effective implementation without extensive piloting.
Opportunities to strengthen spending for effective, equitable, and efficient primary care in India and Ethiopia: What can we learn from resource tracking and management assessment

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ABSTRACT

Background Effective use of health resources can make a difference in program success, especially in developing countries whose resources for health are scarce and flows often unpredictable. A number of different issues cause problems with resource flows that impact programs at district and lower-levels. We apply an analytical framework for financing to resource tracking and management (RTM) through rapid assessments for India and Ethiopia. Methods The rapid assessments use an end-to-end RTM framework, consisting of resource mobilization, allocation, utilization, productivity, and targeting. Our focus is resources received and use to identify areas to strengthen capacity and systems at lower-levels, leading to direct impacts on public health providers to improve both countries primary care systems. Results The assessments find significant impediments affecting both countries’ ability to allocate, utilize, and target finances more efficiently and effectively to improve health outcomes through primary care. Overall, both countries need strengthening in their bottom-up planning process, improvement in absorption of funds mainly by overcoming delays in submitting expenditure statements, and should analyze financial and physical output data jointly to assess efficiency of spending. India uses population norms to allocate resources while Ethiopia captures resource need and inequalities. Additionally, programs that target the poor in India use below poverty line registration system, while Ethiopia uses a community-identified approach; both are inaccurate with errors of inclusion and exclusion. Discussion/Conclusions Opportunities exist in both countries to address key challenges presented, and develop work that focuses on providing improved evidence that lead to policies and programs that promote more efficient, effective and equitable primary care delivery systems. Furthermore, examples of successful innovations that address these challenges that could be better documented and scaled-up. We conclude with suggestions on ways forward to improve financing for people-centered and equitable health systems.
Universal Health Coverage in Vietnam and Bangladesh: Different routes for the same goal?

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1 World Bank

ABSTRACT

Background: To reach Universal Health Coverage (UHC), different policy routes are possible. While the literature massively debates on health financing policies, limited evidence exists on the role of communities and people-centered approaches in achieving and sustaining equitable UHC. Two LMICs embarked on the road to UHC, Vietnam and Bangladesh, have chosen different routes to expand health coverage for their population. Vietnam introduced a national insurance program in the 1990s, which has gradually enrolled 60% of the population including the poor. The benefit package has been mainly provided by the public sector, while community interventions have remained relatively limited. Bangladesh has taken a different route through massive community engagement, women empowerment and people-centered health approaches. Methods: Through standard health policy analysis and political economy methods, the study assesses the contents, the sequence, the actors and the effects of Bangladesh and Vietnam's approaches towards coverage expansion and financial protection. The study draws lessons for other LMICs that are looking for people-oriented, equitable and sustainable approaches toward UHC. Results: The study shows that community approaches have been effective in Bangladesh to reach out the poor and the rural, while challenges have also emerged in reducing incidence of catastrophic spending in the absence of national pooling system. In Vietnam, strategies to target and integrate the poor, including through community-based means testing, allowed effective enrollment to the national insurance program. However, state-driven interventions, for instance for improving quality of public service delivery, have allowed to keep system less fragmented and more harmonized than in Bangladesh - a key pathway to UHC. In both settings, community approaches have proven to be necessary but not sufficient to reach UHC. While community-based organizations have played a critical role in influencing national policy-making toward UHC in Bangladesh, Vietnam's approach has become more and more inclusive over time, in particular since the UHC movement took growing importance in the global arena.
Exploring pathways for universal coverage in Cote D'ivoire

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ABSTRACT

Recent conferences and organizations have set universal health coverage as a goal to reach for health systems. In many countries where there exists a weak social security net, there is a need to conduct a reform of the entire health system. Designing a universal health insurance scheme can be difficult in a heavily indebted country which is also in a post-conflict context. In Cote d'Ivoire, a recent attempt of the government to provide for health care for all the population has resulted in a high debt. Some questions can be raised: Can Cote d'Ivoire afford a public health insurance scheme in the next three years? Is it possible for the government to ensure care for all people who cannot afford to pay a contribution? Which option will be more equitable? The aim of this paper is to explore possible pathways to universal coverage in Cote d'Ivoire. Using simulation technique, two main scenarios, one with lump-sum contribution and another with a mixed contribution scheme, are tested and compared in the SIMINS software on the basis of equity and financial sustainability criteria. A large range of macrodata on economic performances, health care utilization, costs and population dynamics are used. Preliminary results suggest that unless the government progressively complies with the Abuja Declaration, it will not be possible to introduce such a scheme without increasing public debt. In addition, the country could wait for two more years before introducing the scheme to run a completely sustainable scheme from the first year of launch. Besides, all the poor can receive health care without paying for it. However, formal sector pensioners need to receive special attention because their total out-of-pocket spending could be very high. Finally, using a universal lump sum contribution doesn't appear to be the best option.
Achieving fairness in health system financing on the path to universal health coverage: A case study of Uganda

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ABSTRACT

Introduction Health care financing in most low income countries is characterized by low government expenditures, high direct out-of-pocket payments (OOPs), reliance on donors and fragmentation. Using a case study of Uganda, we assess whether and how government is paying attention to fairness in health financing on the path of Universal Health Coverage (UHC). Methods We conducted key informant interviews with a sample of 24 policy makers and service providers at all levels of the health system. Analysis of qualitative data involved transcribing the recorded interviews and grouping findings under themes. Furthermore, we reviewed literature and analyzed secondary data sets (World Health Organization Health Accounts database and Uganda National Household Survey 2009/10). Results Health care in Uganda is financed through public, donors and households resources. Even in the absence of user fees in public facilities, low public expenditure has compromised the quality of services leading to increased use of private providers. This has resulted into increased OOPs. Although general tax financing in Uganda is fair (kakwani index=0.047), it contributes much less to total domestic health financing compared to OOPs. These OOPs are catastrophic, impoverish about 4% of all Ugandans and result into increased inequality. Although there exists voluntary health insurance, it is on a small scale and fragmented limiting cross subsidization. There is a proposal for a National Health Insurance scheme as a means of moving towards UHC. It includes establishing a social health insurance scheme (covering public sector employees) and scaling up the voluntary insurance schemes to cover private and informal sector employees and their dependents. While this proposal has support from key policy actors, its implementation raises concerns of equity and feasibility. Conclusions To achieve fair UHC, Uganda needs to reduce reliance of OOPs and move towards prepaid health care financing based mainly on increased tax-based financing.
Whose UHC? Reflections from a national consultation on the role of community in relation to Universal Health Coverage in India

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ABSTRACT

With the exception of India's High Level Expert Group on Universal Health Coverage (HLEG-UHC), there have been few gestures towards community participation as a component of UHC reform in India; the state's emphasis at least in most policy pronouncements- has thus far focused on financial mechanisms and service coverage. In November of 2013, a national consultation was convened to deliberate upon what the voice and action of community could be in relation to India's vision for UHC. The meeting comprised senior practitioners and activists who have been intimately involved in community mobilization, grassroots work, and civil society action related to health in the country. This germinial event was centred around questions a) Exploring the conceptual understanding of the present and future role of community-based formations and organizations in UHC and b) Strategizing around policy recommendations to strengthen the role of community based formations and organizations in UHC in India. Discussions on conceptual understandings noted that India has great diversity of community formations and organisations. This diversity should be mapped, with attention to the legitimacy and representativeness of community-based organisations, as well as their alignment to the principles and goals of UHC. The group was not able to achieve consensus on the following themes, and called for greater reflection and dialogue on a) how to involve especially vulnerable and marginalised groups; b) whether or not to endorse the insurance-based model of UHC; and c) to what extent private for profit and other stakeholders should be engaged with. In relation to advancing policy, an urgent need was articulated to reach out to various stakeholders on the meaning and aspirational aspects of UHC. Given that health is a state subject, consultations at those levels were encouraged. Finally, a call was made for placing UHC and of health reform on electoral agendas, as part of India's upcoming elections.
Building on community-based health insurance to expand national coverage: The case of Ghana

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ABSTRACT

Background: Enacted in 2003, Ghana's National Health Insurance Scheme (NHIS) is a prominent model for African countries striving to achieve universal health coverage. It is a uniquely ambitious model: the only one in sub-Saharan Africa that aims to provide a standardized, nearly comprehensive and portable package of health benefits to all residents, which collects most of its revenues from dedicated taxes. The NHIS is the product of a half century of health financing policy development and a decade of experimentation with community-based mutual health organizations (MHOs). Methods: Through a review of the literature and interviews with key stakeholders and individuals who were intimately involved with the transition including national-level policymakers, district health insurance scheme managers, and development partners, this paper investigates Ghana's experience scaling up MHOs into a centralized national program. Focusing on the opportunities and limitations that other countries could experience in trying to leverage community-based health insurance (CBHI) for national-level (universal) health coverage, this paper draws lessons from Ghana. Conclusion: Though MHOs had substantial limitations, their proliferation in the 1990s facilitated the scale-up of NHIS. CBHI brought benefits to select populations that likely exposed both the general population and policymakers to the benefits of prepayment for healthcare. In Ghana, politics played a large role in the creation of the NHIS; electoral pressure heavily influenced the design and creation of the centralized system in an effort to break from the prior government's approach. In sum, other countries should consider several pros and cons with iterative building on CBHI, 'big bang' centralized reform, or a Ghana-like combination.
Reducing impoverishment from health payments: impact of universal health care coverage in Thailand

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ABSTRACT

Background Thailand achieved universal health coverage (UHC) in 2002 by introducing a tax-financed health insurance scheme, the UHC scheme, to approximately 47 million of Thais. With the comprehensive benefit package and clear objectives in ensuring equitable access to essential health care, this paper aims to assess the impact of UHC on household impoverishment due to direct payments for health care costs, especially the informal sector households. Methods This study employed secondary data analysis of the nationally representative household surveys, Socio-Economic Survey: a) to estimate the number of households being impoverished by payments for health care prior to implementation of the UHC policy (1996, 1998, 2000, and 2002) and thereafter (2004, 2006, 2007, and 2008); and b) to compare findings with a counter-factual UHC-absent scenario, using segmented linear regression analysis. In addition, descriptive and difference-in-difference (DID) analysis of health impoverishment from health expenditure is employed. Findings At the national, regional, and provincial levels, the proportions of households falling below the poverty line declined gradually during the study periods. Without UHC in 2002, a total of 100,604 households nationwide would be impoverished by out-of-pocket payments for health care in 2008. The UHC policy in the same year could reduce the number of health-impoverished households by 37,628 (37.4%), which is equivalent to 0.2 percent of 19 million households nationwide. Reduction in health-impoverishment in the informal sector and mixed groups was stronger than in the public sector. UHC-mitigated health impoverishment was also found at the sub-national level. Impoverishment in the poorest rural Northeast dropped from 3.4% in 1996 to 2.3-2.4% in 2002-04 and 0.8-1.3% in 2006-09. Conclusions Comprehensive benefit package and zero copayment at point of services are key contributing factors in reducing health impoverishment. In addition, the extensive geographical coverage of health infrastructure, adequate finance and functioning primary healthcare are other contributing factors.
Shaping healthcare systems by juridification: Discussion of how attempts on regulating healthcare by law can harm and promote the aim of reaching social health equality

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ABSTRACT

Purpose In this paper, we discuss how different approaches of juridification may influence the distribution of individual healthcare and its impact on social health equality. There is wide agreement that major determinants of health are found within other social areas than healthcare. With the exception of legal implementation of human rights to health, there has been little focus on how legal regulations of healthcare can impact on the distribution of health within societies. The purpose of this presentation is to i) draw attention to this understudied field, ii) encourage political authorities to be precautious in order to avoid unintended consequences of juridification, and iii) to sketch relevant concerns for further healthcare system research. Focus/content We start by an analytical distinction between different types of juridification in healthcare systems. We continue with a discussion of the ambiguous implications of juridification on the distribution of health in a population. Further, we discuss the relationship between juridification and professional discretion, and argue that discretion in required in order to avoid reinforcement of social inequalities in health within healthcare. The discussion allows us to identify substantive research questions for future empirical investigations. Significance Our discussion supports a better understanding of potential impact of juridification on the distribution of healthcare. In the absence of empirical studies of this impact, we provide reasons why political authorities of healthcare systems should be precautious in the implementation of legal regulations as a means to obtain social equality in health. Also, our discussion helps identify new empirical research questions that are relevant to address for any healthcare system aiming for social equality in health. Targeted audience This theme should be of interest to politicians, patient organizations, administrators, healthcare personnel, patients and their next of kin.
Health systems, transitional justice and some conditions for 'righting' unacceptable health care services: street-level reflections from urban South Africa

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ABSTRACT

Background: Transforming repressive institutions into respected instruments of justice is a key transitional justice goal, necessary for the social reconstruction of fragile and post-conflict states. Yet, little attention has been given to the role of health systems - and those who work in them - in facilitating or obstructing such change. We situate South Africa's right to access health care as part of a broader socio-political endeavour to 'bring justice' in the aftermath of apartheid and argue that providers tasked with delivering health services are a gauge of both individual and institutional transformation. Methods: Through eight urban-based cases drawn from the Researching Equity in Access to Health Care (REACH) project (2008-2012), we consider 'typical' access barriers to antiretroviral therapy, tuberculosis treatment and maternal deliveries, and explore patient and provider responses to inaccessible care. We ask whether these responses ameliorate or compound access barriers and explore some conditions for bringing justice to street-level interactions. Results: A profound set of extra-organizational, structural factors condition the lives of patients and providers and ultimately set limits on the accessibility of care. Yet, if left unchallenged, negative street-level bureaucracy may compound access barriers and perpetuate a wider culture of disempowerment, deprivation and poverty - ongoing structural violence - for citizens, while positive provider practices may be ameliorative. Discussion/conclusion: Situated between state and individual, health care providers should be well positioned to facilitate human rights and promote justice in fragile and post-conflict societies. However, they may also be agents of resistance, capable of frustrating efforts at social reconstruction. Strengthening street-level accountability and engendering respectful, empathetic provider practices are important conditions for improving access to health services and bringing justice to societies moving away from authoritarianism towards democracy. Additionally, developing a shared language and conceptual approach to health systems and transitional justice may strengthen the goals of both.
Public hospitals in search of distinction: New public management and upper-class patients in the Ethiopian Health System

McKnight, Jacob

ABSTRACT
Background: In the last decade, the reach of business-inspired 'New Public Management' (NPM) has stretched well beyond its origins in Western public sectors as modernising African governments have sought to improve health systems. NPM reforms have been subject to much scrutiny in the West, but the effects of similar programmes in less-developed countries are poorly understood. This paper will build a theory of NPM reform that is more suited to African contexts. This theoretical extension is developed through an examination of one of the most important and potentially representative on-going public health reform efforts in Africa—the transformation of the entire Ethiopian hospital system into an NPM-style administrative regime. Methods: Drawing on Consumer Culture Theory, I conduct a detailed Bourdieusian consumer analysis to understand the consequences for patients seeking care. Ethnographic interviewing was conducted with 81 patients from different class positions and their very different strategies to access health services were explored through home visits and observation. Discussion: In investigating these health-seeking journeys, it is apparent that many poor and rural patients are not recognisable as the 'customers' described in the reform documents, and are largely ignored by the reformists. By contrast, rich, urban patients represent dominant classes in the Ethiopian market for health and it is their logics and practices which are prioritised. In pursuit of upper-class patients, hospital managers spend funds on: attracting expensive clinicians to their hospitals; new equipment; and improving the façade of the hospital. Meanwhile, seeking to generate funds to pay for these activities, managers seek to stop 'leaking profits' associated with fee-waiver systems and other loss-making activities. Conclusion: In poorer areas, the profit model envisioned by management fails as managers spend their limited resources on attracting high-end customers but attract only poorer patients who are unable to pay for care at a premium.
Exploring stakeholder perceptions of Universal Health Coverage through human rights and health systems frameworks across eight countries

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ABSTRACT

Introduction: Despite a global push towards Universal Health Coverage (UHC), the concept itself is not without debate. With an aim to inform the global dialogue, a qualitative study was undertaken to explore the viewpoints of stakeholders across eight countries ‘Bangladesh, Chile, Ghana, Pakistan, Tanzania, Thailand, Turkey and Viet Nam’ on UHC. A rights-based approach and a health systems approach were used to analyze how stakeholder groups view challenges and drivers of different approaches to UHC policies.

Methods: Stakeholders interviewed for this study were selected from policy maker, civil society, and funding organization positions. Interview write ups were analysed through two frameworks: WHO’s health system building blocks and a human rights framework. Results present the extent to which 1) health system building blocks were included in discussions of UHC; 2) mentions made of human rights components; and 3) discussion of cross cutting issues such as gender and inclusion of the private sector. Results: Across all countries, financing systems and leadership and governance were mentioned by almost all respondents (95%) followed by service delivery (68%), the health workforce (61%) and medical devices (59%). Information systems were least mentioned, often when probed about monitoring and evaluation of UHC (30%). Interestingly, stakeholder concerns were focused on similar building blocks across higher income and lower income countries. In terms of human rights components, accessibility and quality were most often stressed by respondents, with equality, participation, and prioritization of the most vulnerable close behind. Discussion: This study found stakeholders to be relatively more concerned with equitable financing, governance, quality, gender equity and role of the private sector. To address these challenges, investments in a robust primary health care system, user-focused, people-centered care, collaboration across sectors, and community participation in encouraging political will and sustaining accountability were among the drivers stakeholders highlighted in helping to promote UHC.
Experiences of how patients are involved in tracking fellow patients back to HIV chronic care at a Health Centre III in Uganda

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ABSTRACT

Background Health systems originally designed for acute conditions need to adjust and adapt approaches to address health challenges due to chronic conditions. The intervention aimed at developing innovations involving patients to minimize patient loss to follow-up in HIV care and improve adherence to antiretroviral therapy. Method The USAID Applying Science to Strengthen and Improve Systems (ASSIST) Project, working with the Ministry of Health, supported 3 health facilities in Mityana District to improve HIV chronic care through training in quality improvement and monthly on-site coaching. Facility teams gathered in October 2013 to share experiences on how they identified gaps affecting attainment of goals like patient retention and developed and implemented changes. The team at the health center III decided to address loss to follow-up (patients missing their scheduled clinic visits for three consecutive months) by holding a quality improvement meeting with four expert patients in attendance. After the meeting, expert patients started reviewing charts of all the 420 patients that have ever enrolled in treatment. Charts for patients that were lost to follow-up were sorted out for follow-up with the expert patients by either visiting them at home or telephoning them. Results Of the 420 charts reviewed in September 2013, 25% (103) belonged to patients who had been lost to follow-up. While four of these had died and three had self-transferred to other facilities, 96 were in the village receiving no treatment at all. With the involvement of the expert patients 53 (55%) of the 96 patients had returned to the HIV clinic by the end of December 2013. Expert patients continue to follow up the rest to encourage their return to care. Conclusion Patients are an untapped resource with expertise that when well utilized, bridges health care system gaps like staffing shortages, in low-resource settings.
Finding adapted and effective approaches to continuing professional education in family medicine in Tajikistan

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ABSTRACT

Background While continuous medical education (CME) is essential for health workers professional development and quality health services, evidence on effective and adapted CPE approaches in low-income settings including Central Asia is scarce. In Tajikistan, an emphasis on disease control programs like HIV/AIDS and tuberculosis has resulted in a plethora of training workshops and incoherent, non-systemic approaches. As part of a medical education project, we tested sustainable, tailored CME approaches for family medicine. Methods Various CME approaches were outlined and tested, whereby CME was seen as a set of integrated activities and measures at family medicine level aimed at workforce development and patient quality assurance. Activities were built around collaborations between Tajik and Swiss education experts representing different CME institutions. Possible approaches, including clinical practice guidelines development and utilization, audit and practice visits, peer-review groups, and benchmarking were piloted in six districts with monitoring by national and international CME experts. Results / Conclusions Professional self-regulation has for a long time been the main quality assurance method in Tajikistan. Peer review group, introduced in 2007 as an additional instrument, have been meeting regularly in six districts. Groups consisting of 6 to 10 family doctors of nurses with coverage of around 80% of family practitioners, discuss cases studies or problems relevant for primary care, like hypertension or referral to narrow specialists. Sometimes, a specialist is invited to present a particular topic, for example in the area of endocrinology. Albeit initially opposed by national educational authorities, continuous collaborations between Tajik and Swiss CME experts and monitoring and assessment of the peer review groups indicated that this form of CME has received positive and encouraging results with substantial knowledge increase and improved professional practice. More generally, the introduction of peer review groups as quality assurance tool in Tajikistan has shown to be an effective, adapted and well-tailored approach to workforce development in a systemic perspective.
Improving child survival through management capacity building for District Health Management Teams and community empowerment in Uganda: Lessons learnt from the CODES project

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ABSTRACT

Background Previous studies have demonstrated that the failure to successfully scale up child survival interventions include failure to prioritize interventions most likely to prevent deaths and absence of community involvement. A management and dialogue intervention was designed focusing on management capacity of District Health Management Teams (DHMTs) to identify and prioritize interventions that improve child survival based on district specific data. It included community empowerment through community dialogues based on Citizen Report Cards (CRCs) and U-Report surveys as a means of post-dialogue follow-up. Methods Qualitative case study design to explore how the intervention was adopted and implemented in five districts in Uganda and lessons learnt from this process. Districts were purposively chosen from 30 with the highest expected absolute numbers of annual under-five deaths and high poverty score. The unit of analysis was the adoption of the intervention by the District Health Management Teams and its alignment within the Health Management Systems. Results More constructive dialogue and better coordination between the service providers and the community is needed. District generated data was generally not used for planning. Bottleneck, causal and management analyses systematized the prioritization and planning process. Quality improvement should have targets and milestones and embedded in routine district activities. Peer-to-peer meetings are mechanisms for joint learning and reflection of useful practices. CRCs from community specific data encourage constructive community dialogue. Dialogues should be aligned to already existing structures. Response rates for U-Report were very low. Discussion and conclusion Bringing together service providers and the community to be jointly accountable for service delivery through constructive dialogue and planning is a people centered approach that can improve the quality and access of services for already existing policies and guidelines. The community should be empowered to play a more active role in planning for service delivery.
Developing a problem-solving reflex: training a health workforce for mainstreaming nutrition

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ABSTRACT

Introduction: While Bangladesh has made significant achievements in reducing maternal and child mortality, 41% of under-five children remain stunted. Recognizing the multifactorial determinants of malnutrition, the National Nutrition Services (NNS) is leading efforts to support delivery of nutrition specific and sensitive interventions through health and non-health sectors. However, lack of capacity in public health nutrition is a constraint to coordinating cross-sectoral approaches. With UNICEF support, a short course on Public Nutrition was designed to prepare a new cadre of District Nutrition Support Officers (DNSOs) on the technical and management aspects of mainstreaming nutrition. Methods: Over a two week period 12 DNSOs and 5 zonal supervisors received training on the technical aspects of nutrition interventions, followed by a series of active learning sessions on essential skills for mainstreaming nutrition delivered by academic nutritionists, NNS officials, health and non-health sector specialists, and UNICEF staff. The ABCs of bottleneck analysis and problem solving were applied to address the actual field experiences of zonal supervisors. Stakeholder analysis techniques and general management principles of coordination, collaboration, and networking were discussed in relation to actual case scenarios. Role play was used to develop skills in effective communication and coordination, while skills in data for decision making were honed through the analysis of real-time monitoring data. Results: DNSOs were enthusiastic about the applied approach to public nutrition training. Appreciation of the complexity of mainstreaming highlights the importance of developing a problem-solving reflex, and creating strong networks of support and sharing among fellow DNSOs, key resource people, and intersectoral partners. Interest in this problem-solving approach to training for nutrition mainstreaming has been expressed by a variety of global institutions supporting mainstreaming capacity development.
Exploring health facilities' experiences in implementing the Free Health Care Policy (FHCP) in Nepal: How organisational factors influenced the implementation of the User-Fee Abolition Policy?

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ABSTRACT

Background Previous evidence of user fee removal suggests a lack of understanding about how organisations influence the implementation of abolition or exemption policies. This study examined an Asian implementation experience of user fee abolition policy (Nepal's Universal Free Health Care Policy). Methods The study makes a unique contribution to the existing evidence base since it explicitly applies organisational theory within a carefully designed, rigorous multiple case-study analysis to deepen our understanding of the organisational and 'people' factors influencing implementation of fee removal. Degree-of-fit analysis and testing of the study's initial propositions draw out analytic generalizations for consideration in other contexts in and outside Nepal. Mixed methods were used for data collection, including document reviews; key informant interviews at district/central levels; in-depth, semi-structured interviews; focus-group discussions; and indicators on utilisation and quality changes over time. Results The study found the rapid increase in service utilisation by the poorest groups was sustained at a higher level over the following 8 months in all facilities. The key implementation challenges were similar to African experiences e.g. sudden utilisation increase, insufficient or delayed inputs [drugs and compensation funds]; insufficient workforce; increased physical workload; and resulting reduced quality of services that hampered attitudes of health providers and their relationships with clients. However, good intra-/inter-facility relationships, adequate staffing, well-oriented providers, and the existence of previously trained, better-informed/skilled health management committees were found to support implementation in facilities that experienced higher utilisation increases and better quality indicators over time. Discussion/Conclusions Through detailed analysis, the study highlights the importance of anticipating and addressing the effects of organisational and 'people' factors among front-line managers and health workers on policy implementation. Community governance groups were also identified as important actors outside the facilities who exercise agency and could support or possibly hinder the implementation of centrally driven reform.
Changes in incentives for clients: local experiences from a demand and supply side intervention for maternal health

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ABSTRACT

Background. Although existing evidence suggests that voucher schemes provide more targeted services to vulnerable groups, there is much less empirical evidence about the underlying processes that bring about this change. This paper explores the influence of incentives provided by a demand (vouchers for transport and services) and supply side (refresher training, support supervision, provision of basic equipment and supplies) intervention that was implemented in two districts in eastern Uganda, on the behaviour of clients. Specifically it looks at changes in incentives for the clients and responses to these changes. Methods. The intervention employed a quasi experimental design. Data was derived from 16 focus group discussions with women of reproductive age and structured interviews with 189 FGD participants. Quantitative data was analysed and presented using descriptive statistics. Qualitative data was analysed using thematic analysis. Results. The majority of women reported that it was a lot easier to access transport during the project period (56% (ANC care), 77% (delivery care) and 56% (PNC). Informal payments were not completely eliminated, 46.3% of those who received delivery services reported to have paid some money. The mean amount paid for delivery services was 4.6 USD. The response by the males was mixed. Some of them responded by showing their wives more support and care during the pregnancy period while a few seemed to have responded negatively by giving up all their responsibilities. Conclusions and recommendations. Improved material and psycho-social support, active mobilization by transporters and improved client health worker relationships were useful for the successful delivery of the incentives that targeted clients. This highlights the importance of intersectoral collaboration in improving the utilization of maternal health services. Hence, implementers should engage locally existing social networks, including local transport providers in initiatives aimed at increasing utilization of maternal health services.
Why don't elders benefit from targeted user-fee exemptions? A qualitative analysis of barriers to accessing information in Senegal

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ABSTRACT

Background Launched in 2006, Plan Sesame is a national user-fee exemption scheme aiming to improve access curative healthcare among elders (aged over 60). However, the majority of elders do not benefit from the scheme. Only around 50% of elders know of Plan Sesame and only 33% of them are aware of the services covered. This paper aims to determine the causes of lack of awareness. Understanding this is crucial for improving access to healthcare for elders. Methods 19 focus group discussions (FGDs) and 34 in-depth interviews with elders were conducted across four regions of Senegal in 2013. Interviewees were drawn from a nationally representative household survey and were selected according to whether they: were informed / not informed of Plan Sesame; had used / not used health services in the last year; and had received / not received a user-fee exemption. Transcripts were analysed in Nvivo10 using deductive coding. Results The goals of Plan Sesame were seen by elders to resonate with their needs. However, in practice Plan Sesame exacerbated inequalities in access to care, due to poor implementation and underlying social exclusion. Information on Plan Sesame was scarce; this disadvantaged female, poor, and poorly educated elders who lacked access to information in general. Many elders did not access care when they were sick due to geographic and anticipated financial barriers, and perceptions of poor quality of care; as a result, they did not learn about Plan Sesame from health sector workers. Among elders who did access care, health sector workers were perceived to purposefully withhold information on Plan Sesame due to concerns about losing income from user-fees. Elders belonging to privileged social groups were more adept at overcoming these barriers. Conclusions User-fee exemption programmes for elders require stronger outreach strategies tailored to those who are vulnerable and socially excluded.
An impact evaluation of a voucher program in increasing uptake and reducing inequities in Maternal Healthcare Services in Cambodia: Evidence from a difference-in-differences analysis

Bajracharya, Ashish1; Bellows, Ben1

1 ASSOCIATE, POPULATION

ABSTRACT

Background: Recent gains in maternal and reproductive health (RH) service utilization and outcomes in Cambodia have been substantial. Careful disaggregated analyses, however, reveal equity gaps in RH service utilization with average gains masking significant socio-economic inequalities. To supplement national social health protection (SHP) programs such as the Health Equity Fund, alternative financing strategies such as demand side financing (DSF) vouchers are being tested to increase access, utilization, equity and quality of maternal health and family planning services for poor women. Methods: We present results from a rigorous quasi-experimental study evaluating the impact of a targeted pro-poor RH Voucher program in three operational districts in Cambodia. Using a Difference-in-Difference (DiD) technique, we analyze pre- and post- intervention outcomes in the use of antenatal care (ANC), facility delivery and postnatal care (PNC) among eligible poor women. Changes in equity in these outcomes are also examined using Concentration Curve analyses. Results: DiD results show that RH Vouchers had significant impacts on the uptake of the attendance of 4 or more ANC visits (DiD estimate: 9.7 percentage points higher in voucher areas compared in control areas; p<0.01), the uptake of facility based delivery services (DiD =12.5%; p<0.001), and the uptake of PNC by skilled providers such as nurses and midwives (DiD=10.4%, p<0.001). Gains were also seen in the uptake of Long Acting Reversible Contraceptives (DiD=4.9%; p<0.001). Preliminary equity analyses utilizing equity ratios indicate that differences in RH use between poor and non-poor fell at higher rates in voucher areas compared to control areas. Discussion: This study presents evidence that DSF vouchers are associated with accelerated uptake and improved equity of RH services in Cambodia where improvements in healthcare utilization have not always been equal. Pro-poor strategies aimed at removing demand barriers can provide useful experience as the government develops a universal health coverage strategy.
Community based HIV prevention strategies with incentive awards in Zambia

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ABSTRACT

Background: Community compacts aim to increase HIV prevention activities in their communities by use of agreements or ‘compacts’ that are incentive based. Description: Each community compact model defines a community differently: a rural health facility and its catchment area, a church congregation and family members, a city township divided in zones. The 71 communities have designed their programs and incentive structures through dialogue with community stakeholders (traditional chiefs, religious leaders, local government, and civil society). Involved community members have gained new skills such as psychosocial counseling, HIV finger-prick testing and HIV awareness. The incentive a community receives is based on achievement of set outcomes that include the proportion of meetings held out of those planned, proportion of successful referrals by service type and the number of people trained by service type. HIV prevention service uptake from referrals: 3944/4042 (97.6%) for ART, 3055/3472 (88%) for VCT, 304/305 (99.7%) for PMTCT, 560/565 (99.1%) for couples counseling and 280/316 (88.6%) for male circumcision. Incentives are determined by each community to benefit the community. One public/private partnership has formed: a garbage removal service in an area covering 40 communities. Other community incentives include a computer, a grinding mill, hospital bedding and mother's shelters. Lessons Learned: Fears about introducing incentives early in the life of the project or the impact of incentives on the quality of the programs have dissipated. Referrals and linkage to care have increased as the community works towards their goals. Community members and congregations can now talk about HIV. Not easy to partner with the local private sector for a sustainable incentive structure. Next steps: In the last year of the compact projects we will work towards sustainable community structures that will continue their partnerships with private companies to improve community health.
Determining the financial and primary health impact of adopting universal HIV treatment strategies: A multi-country analysis in Malawi, Rwanda, Swaziland, and Zambia

PLEASE SEE SEPARATE EMAIL SENT FOR ALL THE AUTHORS AND AFFILIATION DETAILS.

ABSTRACT

Background: Recent research has shown that broader treatment access can have a significant impact on HIV incidence. When formulating national health policies to expand access to HIV treatment, there is a need to understand whether and how increased resource needs could impact availability of both financial and human resources for other health priorities. Methods: We developed a mathematical model based on prior work, to estimate the HIV patient volume under different treatment scale-up scenarios using local epidemic data from Zambia, Malawi, Rwanda and Swaziland. In costing these scenarios, we accounted for expected changes due to an increase in asymptomatic patients and adoption of innovative models of care. A workload-based demand model was then built using Stata to calculate human resource requirements in three of these contexts. Findings: Initial findings suggest that if programs are run more efficiently and funding does not decrease significantly over time, treatment scale-up can be feasible within existing funding for HIV. However, some countries could face constraints if spending patterns remain unchanged. Furthermore, while scale-up may not crowd out funding for other health priorities, it could impact general human resource capacity at facility level. Conclusions: This analysis will enable governments to assess the impact of various ART scale-up scenarios on non-treatment and non-HIV health priorities. Data will provide Ministries of Health with an assessment of short-term affordability and longer-term sustainability of alternative scenarios, both in terms of financing and human resources.
The dynamic and impact of the community-based antiretroviral distribution model in Tete province, Mozambique; findings of a qualitative research

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ABSTRACT

Background: To improve retention on ART, Médecins Sans Frontières, the Ministry of Health and patients piloted a community-based antiretroviral distribution model through Community ART Groups (CAG) in Tete, Mozambique. By December 2012, almost 6000 patients on ART had formed groups of whom 95.7% were retained in care. We conducted a qualitative study to evaluate the relevance, dynamic and impact of the CAG model on patients, their communities and the healthcare system. Methods: Between October 2011 and May 2012 we conducted 16 focus group discussions and 24 in-depth interviews with 105 key informants from five major stakeholder groups involved in the CAG model. Audio-recorded data were transcribed verbatim and analyzed in Nvivo using grounded theory approach. Results: Six key themes emerged from the data: 1) Barriers to ART, 2) CAG functioning, 3) Benefits for CAG members, 4) Impacts beyond the groups, 5) Setbacks, and 6) Future expectations of the CAG model. The model provided cost and time savings, and mutual peer support resulting in better adherence to ART. The active involvement of patients in their care led to increased uptake of services, and transformation of identity of group members. Potential pitfalls highlighted included limited access to CAG for those most vulnerable to defaulting, and a high dependency of counsellors. Conclusion: The CAG model resulted in a patient empowerment improving the ART retention. It also sparked a reorientation of healthcare services towards the community and strengthened community actions. Successful implementation and scalability requires (a) the acceptance of patients as partners in health, (b) adequate resources, and (c) a well-functioning monitoring system.
Strengthening national strategic planning and prioritization: Rwanda's experience

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ABSTRACT

Background In a context of competing priorities and limited resources for health, funding must be allocated to the highest impact interventions. However, national strategic plans and budgets are often un-prioritized, calling for far more than the resources available and therefore cannot be used. High-level costing exercises do not facilitate prioritization and disease specific plans are rarely linked to sector-wide plans. In March 2013, the Government of Rwanda recognized the need for reform, beginning with HIV. Methods Rwanda developed a robust HIV National Strategic Plan that was grounded in epidemiological evidence, prioritized, and could be operationalized. We used an activity-based costing approach. Prioritization began with high level decisions on which activities or populations to include. With a view towards improving efficiency, duplicative activities were identified and integrated. Cost effectiveness analysis and financial gap analysis informed targets. Analysis was conducted in Excel, drawing on epidemiological projections from Spectrum. Results This process transformed Rwanda's $1.5 billion 5-year HIV National Strategic Plan into a cost-effective $1 billion plan. The total fit within available resources, but was projected to have the same impact as the initial plan, reducing mortality from 5,000 to 2,500 people per year and reducing new infections by two-thirds. The plan was used to advocate for increased national ownership of Global Fund resources. It has since been translated into an operational plan used for stakeholder coordination, budgeting and implementation. The process is being institutionalized across disease areas. Discussion While activity-based costing is not new, it is not often used and prioritization is thought of as a political, high-level process. Decision-makers need evidence to prioritize different tactics. In Rwanda a robust, quantitative process was used to develop a plan that will allow the country to achieve national goals with available resources. The process is now being replicated.
The impact of a multi-stakeholder problem-solving program on increasing enrolment in Ghana's National Health Insurance Scheme: a cluster-randomized controlled trial

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ABSTRACT

Background: Low enrolment in health insurance schemes especially among the poor is a pressing concern in low and middle-income countries embarking on social health insurance as a financing strategy to achieve universal coverage. New evidence on approaches to increase enrolment and reach the poor is urgently needed. This study aims to implement and evaluate the impact of a multi-stakeholder problem-solving program on extending enrolment in Ghana's National Health Insurance Scheme. Methods: Thirty districts with 3,300 households were surveyed in a cluster-randomized controlled trial. Fifteen districts were randomly assigned to intervention and 15 to controls. A longitudinal cohort was surveyed in 2009 and followed up in 2011. Principal component analysis was used to analyse perceptions as barriers to enrolment and multivariate regressions to estimate the effect of the intervention on reducing these barriers and on increasing enrolment. Difference-in-difference estimation model was used to assess the net effect of the intervention on enrolment. Findings: The MSPS program was able to significantly increase enrolment in the intervention districts by 7% ([95% CI 0.005 -0.136] p=0.036) from 34% to 41%, which is a 21% increase over baseline. Almost a third of this increase can be attributed to the reduction of perception barriers related to schemes (inconvenience of card collection, its inadequate opening hours, and mistrust of its staff) and providers (staff respect and compassion, and preferential treatment towards non-insured clients). The intervention also improved utilization of outpatient services by 17% ([95% CI 0.069 -0.27] p=0.001) i.e. from 13% to 30%, an increase of 130% over baseline. Interpretation: Our study has demonstrated the impact of a MSPS program on increasing enrolment in Ghana's health insurance scheme. This shows the potential of a MSPS program as a viable strategy for increasing voluntary enrolment in insurance schemes in Ghana and other LMIC.
Effective strategies for providing prepaid insurance and universal coverage to informal sector workers in low- and middle-income countries: the state of the evidence

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ABSTRACT

Background: In many low- and middle-income countries in the Asia Pacific region more than 50% of total health expenditure comes from out-of-pocket expenditure, and the incidence of catastrophic health expenditure is significant. Different prepayment mechanisms have been applied, including social health insurance, tax-based schemes or combinations of both. Often, the informal employment sector comprises a majority of the national population, in some cases exceeding 80%. How to include this population segment effectively in prepaid health insurance schemes is therefore a critical question. Methods: We carried out a literature review of available evidence using a ‘realist’ lens to identify contextual factors and conducted semi-structured interviews with 20 experts from the Asia Pacific region (national governments, international development partners and academia) to identify the major drivers of and barriers to pre-paid insurance schemes. Results: We analysed 30 peer-reviewed and 21 ‘grey’ literature from Africa and Asia. There are a multitude of different approaches to health financing for the informal sector, but few strategies proved successful. Essential to success are strong leadership expressed through legislation, subsidizing the poor and near-poor after corresponding pre-identification, and creation of large, shared risk-pools. Neglecting the supply-side caused reduced enrolment rates. The most relevant contextual factors included the size of the informal sector, the impact of a shallow income gradient in the lower quintiles, and the capacity of government administrations to address insurance and social protection issues. Discussion: In LMICs, the informal sector of the population lying between the poorest and the best-off is often overlooked. There is no sense of existing best practice on how to provide prepaid health coverage to this large group. This review in combination with expert knowledge pinpoints effective approaches and most relevant contextual factors in support of decision makers being confronted with various options.
How many poor people go without health care because of its cost? The case of Central America

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ABSTRACT

BACKGROUND. At the 2012 Beijing global HSR symposium, Sudhir Anand memorably criticized the standard practice of measuring the potential benefit of health insurance in terms of the catastrophic expenditures and impoverishment that it could prevent. One of his principal arguments, previously raised by others, was that this practice omits the possibly significant increased use of health services by people, especially poor people, previously unable to afford them. The proposed presentation would introduce the findings of an initial empirical assessment of this criticisms validity. METHODS. The method used would be one proposed by Rodrigo Moreno-Serra and colleaues in a 2011 PloS Medicine article. It features use of data from household expenditure surveys that include information about the reasons behind the decisions of respondents who do not seek health care when ill. This information would be combined with information about overall household and health care expenditures, to compare the prevalence of foregone health care for financial reasons across economic groups, and with catastrophic expenditures and impoverishment. A search for suitable data sets led to the selection of Guatemala and Panama for this initial effort. While not representative of the developing world as a whole, these country surveys had questionnaires that were particularly well suited to exploring the issues of interest, and very similar to one another. And they also covered countries at the opposite ends of the Central American development spectrum. FINDINGS. For these two countries, Anand was right. The non-use of services, which was concentrated especially among the poor, was much more prevalent than either catastrophic payments or impoverishment. DISCUSSION. Just because Anand was right about these two countries, however, does not mean that his critique is universally applicable: a preliminary look at African data seems to suggest a different pattern there.
Using complex adaptive systems lens: the dynamics of Mexico’s Seguro Popular policy adaptation

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ABSTRACT

Background. In 2003, Mexico’s Seguro Popular was introduced to provide health insurance to Mexicans who were previously not covered by any kind of health insurance. While the policy documented several successes over the past ten years, its operation has changed from its original design. The objective of this study is to understand the complexity and dynamics that contributed to the modification and adaptation of the policy by the system and its actors as a first step towards understanding the consequences of the creation of the new order in the achievement of its ultimate goals. Methods. Data collection were conducted through 4 Seguro Popular’s external evaluations between 2007 and 2012. Data included information on financial flows as well as interviews with managerial and technical staff at national and state level around the allocation mechanisms and the challenges of implementation. The qualitative data were used to extract the changes in the policy, current and new actors and their responses to the policy. A causal loop diagrams was developed to depict these dynamics and the feedback loops that resulted from the implementation experience. Results. Seven core design elements of the policy have changed over the ten years of the policy’s implementation and in each case, the National Commission that is the overall responsible for implementation of the policy introduced modifications to the regulatory framework in response to the resistance or reactions of the different actors. Several Complex Adaptive Systems phenomena were identified including network emergence, resistance to change, history dependence and feedback loops. Conclusions. Systems thinking expanded our capacity to understand this complex policy in a much more insightful and realistic way, providing much richer and meaningful interpretation of the effects of the policy and a better understanding of how and why it was adapted in the course of its implementation.
Social Exclusion of Women in a health financing scheme in Karnataka, India

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ABSTRACT

Introduction Indian women face exclusion at home, at work and in public life. Female heads of households shoulder the burden of being the sole breadwinner but face social stigma. Women in male-headed households have a lesser role in decision-making. This is the first study examining whether (and how) women are excluded from the India's Rashtriya Swasthya Bima Yojana (RSBY), the national health financing scheme for five members in below the poverty line households, and if so how can it be made gender-inclusive.

Methods We conducted a longitudinal survey (n= 6040 eligible households); stakeholder interviews (n=42) with government and insurance agencies, doctors and civil societies; group discussions (n=23) with eligible individuals; and qualitative interviews (n=14) with members excluded from RSBY. We conducted multivariate analysis using logistic regressions; grounded theory principles were applied to analyse the qualitative data.

Results Female-headed households are less likely to be aware (OR 0.8, p>0.05), Muslim female headed households (OR 0.167, p>0.05) and tribal female-headed households (OR 0.22, p>0.005) are less likely to enrol in RSBY. In 75% of five member households, some male and female members were not enrolled but in 44% only women over 14 years were not enrolled. Those with less developed social networks are less likely (OR 1.54, p>0.1) to get enrolled. We found that women suffer from an internalised sense of inferiority, they lack a sense of entitlement or the capacity to demand inclusion in social welfare programs, and face social antipathy. Conclusion For a more inclusive, equitable and gender-sensitive RSBY, awareness campaigns must target vulnerable women. Their social networks, where information is disseminated and collective capacities fostered, should be improved. To address intra-household exclusion, the scheme should enrol the entire household or enforce more than one female member is insured. Disaggregated geographical enrolment data to identify female exclusion could effectively target resources.
The No Balance Billing Policy: Establishing and improving financial risk protection among sponsored patients in the Philippines

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ABSTRACT

BACKGROUND To strengthen the thrust of Philippine government towards universal health coverage, the Philippine Health Insurance Corporation (PhilHealth) implemented the No Balance Billing (NBB) policy in 2011 as corollary provision to case-based payment system. The policy aims to provide financial risk protection for PhilHealth's poorest members under the Sponsor Program. NBB applies when a sponsored patient is admitted in any government hospital for any of the 23 most common medical conditions and procedures paid as case payment, i.e. no additional fees shall be paid by the sponsored patient above the packaged rates. The study assesses the implementation of the NBB policy, identifies the reasons for out-of-pocket spending incurred by sponsored patients and determines the corrective measures being done by government hospitals. METHODOLOGY An exit interview was conducted in 315 government hospitals covering all sponsored program members or their dependents admitted for any of the 23 case rate conditions. Results of the exit surveys were then provided hospitals directors to elicit the corrective measures adopted by the hospitals. RESULTS/DISCUSSION: Of the 6657 respondents interviewed, 93% incurred out of pocket expenditures. The reasons for OOP incurred by respondents include drugs, medical supplies, blood, laboratories/diagnostics and professional fee. As response to the survey results, the hospitals directors implemented various corrective measures, including: 1) adoption of schemes to avoid OOP for sponsored patients; 2) consignment contract through Public Private Partnership (PPP) to ensure availability of drugs; 3) proper dissemination of NBB policy to hospital personnel and patients; and, 4) imposition of sanctions to non-compliant private doctors affiliated in government hospitals. SIGNIFICANCE FOR SELECTED FIELD-BUILDING DIMENSION: Social exclusion and health inequities determine poor health, particularly among the poor. The implementation and assessment of NBB policy ensures that the national health insurance program achieves its goal of providing financial risk protection, especially for the poor.
Integrating mobile phone interventions within district health systems: a text-messaging platform for reproductive health referral in Tanzania

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ABSTRACT

Background Drug stores in Tanzania are only licensed to sell non-prescription, pre-packaged drugs such as analgesics. But evidence has shown that they also sell 'prescription-only' drugs such as antibiotics. This has significant public health implications. To facilitate patients' and drug stores' access to prescriptions from these facilities, an intervention designed to increase the uptake of sexual and reproductive health (SRH) services in government health facilities was implemented for 18 months in Mwanza Region, Tanzania. Methods Nested in a cluster-randomised trial, the intervention was implemented in a cohort of 52 drug stores, 15 dispensaries and 3 health centres in Magu and Sengerema Districts. Using a mobile phone-based application, an electronic referral platform hosting a text messaging system, configured with a toll-free number on telephone numbers of drug store attendants, dispensary and health centre clinical officers referred patients from drug stores to health facilities. Quantitative data collection was electronic through the system's web-database. Qualitative follow up was done using focus group discussions and in-depth interviews with the patients, drugstores, dispensaries and health centres. Data analysis was done using STATA 10.1 (quantitative) and NVivo 10 (qualitative). Results The system has achieved a 45% increase in SRH service uptake at the health facility level after referral from drug stores. Referral uptake is influenced by the type and severity of the SRH condition, sex and age of the patient. Attitudes such as lack of confidentiality, distance to health facilities and lack of friendliness also played a role. The intervention has fostered productive collaborations between health facilities and drugstores. Discussion/Conclusions The platform has demonstrated that SRH service uptake can be enhanced by use of mobile phones. The platform can contribute to the strengthening of health management information systems. Through government channels, the district health authorities are currently exploring how the intervention can be adopted as standard practice.
Different models of hospital-community health center collaboration: An examination of variations in quality and efficiency of care for patients with chronic diseases

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ABSTRACT

Background: In recent years, in order to provide patients with seamless and integrated health care services, some models of collaboration between public hospitals and community health centers (CHCs) have been piloted in some cities in China. This study examines the nature and effects of these collaboration models. Methods: Three cases - one for each of three different collaboration models - in three Chinese cities were selected to examine variations in quality and efficiency of care for selected chronic diseases, using 'structure', 'process' and 'outcomes' indicators, descriptive statistics, Pearson χ² inspection and ordinal logistic regression. Results: The Direct Management (DM) Model in Wuhan exhibited better structure indicators than the other two models. In terms of patients' satisfaction, there were no statistically significant differences in patients' perceptions of communication between hospitals and CHCs regarding their illness. Patients from the DM Model had odds of being in the 'satisfied' category that were 28.9% less than those from the Loose Collaboration (LC) Model in Nanjing. Staff in the DM Model had the highest satisfaction level (77.6%) with respect to patient referral. Close to a quarter of the patients in the DM Model perceived their current health condition as better than in the previous year, which was the highest among the three models. Overall, the efficiency indicators were lower in the LC Model than in the other two models. Conclusions: Communications between hospitals and CHCs and among care providers were generally inadequate. Many of doctors were not knowledgeable about the nature of collaboration and their enthusiasm was not high. Publicity about hospital-CHC collaboration is inadequate, resulting in low awareness among patients and even among health professionals. Further research to examine the nature and the strengths and weaknesses of different models could help guide the future development of hospital-CHC collaborations.
Is gatekeeping effective in shifting balance from hospitals to primary care facilities? Early signs from a pilot in rural Beijing

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ABSTRACT

Background A district in Beijing, China, is piloting gatekeeping for hospital services covered by the New rural Cooperative Medical Scheme (NCMS), in order to shift the current health system towards one centred on community and primary care. Methods In an ongoing nonrandomized control trial, two townships have been chosen to implement a gatekeeping policy since August 2013. The policy requires patients to see the community health centres and be referred before they visit secondary and tertiary hospitals and claim reimbursement for outpatient services, while in the other 15 non-pilot townships patients have freedom to choose providers, though the reimbursement policy favoured visits to lower level facilities as was the case in pilot areas before the reform. The community health centres in pilot areas manage fund for outpatient expenses at all levels of care. We compared outpatient visits and expenditures of the enrollees from the pilot and non-pilot townships during the fourth quarters of 2012 and 2013 using the NCMS claims database. Results In non-pilot areas, number of outpatient visits per enrollee has increased by 22.29% at primary care facilities, and decreased by 1.85% at hospitals. In pilot areas, number of outpatient visits per enrollee has risen by 5.56% at primary care facilities and decreased by 43.08% at hospitals. Outpatient expenditure per enrollee at primary care level has risen in both pilot areas (by 13.04%) and non-pilot areas (by 60.55%). On the other hand, expenditure per enrollee at hospitals has dropped by 34.3% in pilot areas and risen by 4.01% in non-pilot areas. Conclusion The early results of the pilot suggest that gatekeeping seems useful in controlling the number of visits to and expenditures at outpatient departments of hospitals. On the other hand, the policy appears less effective in increasing utilization at primary care level.
Relevance of women's characteristics in supporting counter-reference mechanisms in perinatal care. The case of Varela, Buenos Aires, Argentina

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ABSTRACT

The ability of health systems to meet population needs relies heavily on the organization of their networks of care, particularly on the referral and counter-referral systems. Beyond formal and informal modes used by physicians in the referral of patients, the decision of attending to primary health care posts after delivery show the need to enhance women's ability to decide. The purpose of this paper is to analyze the counter-referral of perinatal patients from the network's central hospital to primary health care centers and the role of people's behavior on improve effective care. One of the largest public hospitals in the Province of Buenos Aires was selected, and a binary choice econometric model was tested, where the probability of attendance by newborns and women after delivery to the counter-referral control was tested based on a set of explanatory variables related to the characteristics of women and their families (age, education, family members, etc.), delivery risk proxies, and the quality of health care network in producing a programmed counter-referral consultation. Results show that women characteristics are key elements in continuing formal health care after pregnancy. Particularly, history of care and single marital status statistically significantly increase the chances of newborn to be taken to the center to the programmed control, as well as provide more chances to keep formal track of women's post-delivery. In addition, the larger the span of time between exiting the hospital and the date of programmed consultation provided by the physician, the lower the chances of giving continuity to the patient-health system contact. From a public policy perspective, the paper brings evidence of the importance of strengthening hospital-health posts coordination, and the need to open participatory spaces for patients as active determinants of inclusive and effective health care systems.
Strengthening health facilities for maternal and newborn care: experiences from rural eastern Uganda

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ABSTRACT

Background In Uganda, maternal mortality ratio and neonatal mortality rate are high at 438/100,000 and 27/1000 live births, respectively, mainly due to poor quality of care. We present experiences of building health facility capacity for maternal and newborn care based on WHO health systems building blocks Methods This study was part of the Uganda Newborn Study (UNEST) which was implemented between September 2009 and August 2011 in Eastern Uganda. The aim of UNEST was to develop and adapt a maternal/newborn community care package linked to health facilities and evaluate its effect on maternal/newborn care outcomes in order to inform policy decisions in Uganda. We built capacity of frontline health workers through training, support supervision and mentoring at one district hospital and 19 lower level facilities. A once-off supply of essential medicines and equipment was done to address critical gaps. Minimal infrastructure adjustments were done to cater for sick newborn babies and Kangaroo Mother Care. Data collection was part of routine process monitoring. Results A total of 72% of frontline health providers of maternal and newborn care in 19 lower level facilities and one district hospital were trained. The mean score of the post-test was 68% compared to 32% in the pre-test. Health facility utilisation for delivery care increased by 27%; from 2700 to 3435 in two years. 85% of low birth weight babies admitted were discharged alive. The reduction in mortality of sick newborn babies was 47% over the two-year period. Conclusion Facility health system strengthening is possible even in poor resource settings and is associated with improved newborn survival. Although training of health workers is crucial, it should be followed with support supervision and mentoring to enable knowledge and skills retention. Countries with similar settings can learn from our experiences in improving maternal and newborn care.
Reduction in under-five mortality following Quality Improvement Interventions to Improve Triage and Emergency Care: Case studies from two hospitals in northern Ghana.

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ABSTRACT

Background The high demand for good quality hospital care for children in developing countries is not being adequately met. While there is the need for emergency care for the critically ill children in Ghana, emergency care tends to be one of the weakest parts of hospital systems. This Quality Improvement (QI) work is to describe a number of QI strategies to improve triage and emergency care for the critically ill children in this neglected area in Ghana. Methods Quality Improvement teams of the hospitals used QI tools to analyze both outpatient department and admission cases in their hospitals. Underlying this was the observation that children including the critically ill were not prioritized. They identified priority areas to improve hospital care for the critically ill under-five children by redesigning the processes of care. Results The results show that there has been over a fifty per cent reduction in institutional under-five mortality in the hospitals after the introduction of the changes. Tamale Central Hospital, recorded a 51.4% reduction in mortality between July 2010 and December 2013, from a mean of 24.9 to 12.1 deaths per 1000 admissions. There was a 52.1% reduction in mortality in Tamale West from a mean of 38.4 to 18.4 per 1000 admissions between May 2010 and December 2013. Conclusions Our results suggest that simple and inexpensive interventions are associated with decreased under-five institutional mortality rates. Strengthening hospital systems through the QI approach need to be prioritized to strengthen hospital systems in developing countries. Keywords: emergency care, triage, critically ill children, Ghana
Evaluating the outcome of quality improvement in health facilities on newborn mortality in three central districts in Malawi: a theory based approach

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ABSTRACT

Context: A cluster-RCT of a combined facility-community intervention showed 22% reduction in newborn mortality at population level. However, no significant effect was observed for either of the interventions individually. This paper describes a theory-based approach to evaluate the results of the QI arm of the trial only. Methods: We developed a phased research strategy. First, we describe the intervention design and initial theory of change as envisaged by the program leaders. Next, we explain why the intervention did not have a significant impact on neonatal mortality, by reviewing well-informed hypotheses from successful QI interventions against data available from our evaluation fieldwork. The empirical data consists of mixed methods, synthesizing data from a variety of sources including monitoring and surveillance data, health facility resources survey, staff motivation and knowledge survey conducted as part of the process evaluation of the intervention. We then look at complexity of the intervention and its context to hypothesize how this might have influenced the results. Results: Some elements of successful QI such as creating densely networked community with strong horizontal links, harnessing data as a disciplinary force, bear strong resonance with our study. Despite these essential ingredients being present, there were no discernible effects of the QI intervention on neonatal outcomes either at facility level or at population level. We hypothesize that some of the contextual factors such as a ban on Traditional Birth Attendants causing subsequent increase in facility deliveries without concomitant increases in staff and complexity factors such as the length of time for the intervention to take effect, might provide possible explanations for seeing no effect of the interventions. Conclusion: The study uses innovative research methods by providing a systematic description of the intervention using established framework and by focusing on a generative hypotheses to analyse the outcome of the intervention.
Barriers in use of partograph in different health facilities in Bangladesh

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ABSTRACT

Background The partograph is an effective tool to monitor progress in labour to take decision for intervention and referral if needed. Despite more than 50 years of efforts, still the partograph use rate is low in resource poor settings. In Bangladesh, there is a dearth of data on factors related to low use of partograph which is important to know to promote its use. Method A facility assessment was conducted in all the health facilities providing obstetric and newborn care services in 24 districts in Bangladesh during May-September 2012. The study was conducted about 2275 different health facilities in Bangladesh. The relevant data for this study were extracted from those collected by the 'review of partograph' module of the Averting Maternal Deaths and Disability (AMDD) tools. The questions were asked about use of partograph in the last one year from the date of interview. Result In all the health facilities partograph was used only 2.9% cases of deliveries for monitoring progress of labour in the last three month. Among the causes of unavailability for partograph use, the most common cause was identified that 89.3% facilities had lack of supply of partograph form. The second major causes was identified that 56.4% facilities had untrained provider or providers didn’t have sufficient training to provide the services and 33.3% facilities mentioned that their providers didn’t have enough time to fill up the partograph form. Conclusion In Bangladesh, where population-based cesarean section rate have risen to 17% (about 60% of all facility deliveries are conducted by cesarean section); the use of partograph needs to be promoted. Necessary measures needs to be taken to ensure supply and training. Policies should be taken to introduce mandatory use of partograph in all the facilities providing delivery care services in the public and private sectors in Bangladesh.
Reduction of maternal and neonatal mortality in the province of Jujuy, Argentina, through the implementation of a national complex intervention locally adapted.

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ABSTRACT

Background: The province of Jujuy is located in the Argentine Northwest. Since 1990, its maternal and neonatal mortality rates have been among the highest in the country. In 2010, the provincial government adhered to the Safety and Family Centered Maternity Hospitals Initiative launched by UNICEF country office within the framework of its national action plan. Objectives: a. to describe the process, outcome implementation results and maternal and neonatal mortality trends after implementing a complex intervention (SFCMH Initiative) at a provincial level. Methods: A situation analysis based on the MORES approach and a provincial plan was developed and implemented. Results: In the last 3 years all maternal deaths were analyzed with a root-cause analysis and all tertiary maternity hospitals implemented a scorecard to monitor quality of health care. Transfer of pregnant women and high-risk babies among the three levels of care has been systematized. Through the realization of indigenous assemblies, priority problems and possible solutions from the perspective of these communities have been identified and communicated to the provincial Minister of Health. Even when it is still premature to determine sustainable impact on maternal and neonatal mortality, a negative trend has been observed in both rates since 2005 (triennial MMR * 10.000 LB= 9, 8 in 2005-2007; 7,6 in 2008-2010; 6,8 in 2011-2013; 31% reduction and triennial NMR * 1.000 LB =10,5 in 2005-2007; 9,7 in 2008-2010; 7,7 in 2011-2013; 27% reduction). For the first time since 1990, in 2013, only one maternal death occurred in a 1-year period. Conclusions: Although a secular trend effect cannot be ruled out as a possible explanation of these changes in the MMR and NMR, it is reasonable to affirm that the provincial plan has played a significant contribution to the strengthening of the local health system and the reduction of maternal and neonatal deaths.
Using Community Dialogues as a capacity strengthening and research tool for health workers

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ABSTRACT

Background: Despite strong policies, maternal and infant mortality rates for South Africa remain very high for a middle income country. It is widely hypothesised that maternal, newborn, child and women health (MNCWH) services are not being utilised effectively by women. Objectives The main aim was to ascertain why people are not accessing Basic Antenatal Care Services through community dialogues. A secondary objective was to video record the Community Dialogues as a tool to strengthen healthcare worker capacity to facilitate community dialogues in future. Methods: A total of nine Community Dialogues were conducted in three provinces of South Africa. Facilitated Community Dialogues were chosen as the most appropriate method to create community awareness and demand for the use of MNCWH services. The study population included 630 participants; consisting of women, men, representatives of societal sectors and stake-holders supportive of women and children. Transcripts, facilitators written notes and audio and video recordings were analysed thematically. Results Although women have some awareness and knowledge of antenatal and post-natal care; acting on this knowledge conflicts with strong cultural beliefs and practices. Lack of transport to the health facility was a problem for those living in rural and farm areas and concerns were raised regarding perceived lack of confidentiality at the clinics. Women also shared their challenges related to breastfeeding after they returned to work. Conclusion Cultural beliefs and practices often underlie the underutilisation of MNCWH services and there are substantial benefits to using Community Dialogues to uncover these hidden challenges to policy implementation. Community Dialogues may be appropriately used as a training tool towards a more democratic and people centred policy implementation process. Healthcare workers who understand the fundamentals of active community engagement are more likely to respond appropriately to their community needs and thus potentially improve the environment for policy implementation.
A systematic review of the effectiveness of strategies to improve health worker performance in low- and middle-income countries

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ABSTRACT

Background: Health workers (HWs) play essential roles in delivering health care. In LMICs, however, HW performance is often inadequate. Methods: To characterize the effectiveness of strategies to improve HW performance in LMICs, we conducted a systematic review of 15 electronic databases, 30 document inventories of international organizations, and bibliographies of 510 reviews and other articles. We included studies meeting commonly accepted criteria for methodological adequacy (e.g., trials with comparison groups). After screening citations, data from eligible reports were double-abstracted and entered into a database. Effect sizes were estimated as risk differences and adjusted for effect modifiers, such as baseline performance level. Among several possible outcomes types, this analysis focused on HW practices (e.g., correct diagnosis and treatment). As studies often had multiple outcomes, we calculated a summary measure: the median effect size (MES) for all primary outcomes from a study. Results: We screened >105,000 citations, 829 reports met our inclusion criteria, and 141 studies included HW practices. Numerous strategies have been studied, usually with multiple intervention components. The median MES across all studies was an improvement of 10 percentage-points (interquartile range [IQR]: 4, 24 percentage-points). Strategies that tended to have higher effect sizes were training + group problem solving (median MES = 25 percentage-points, IQR: 8, 49) and training + supervision (median MES = 17 percentage-points, IQR: 7, 27). The provision of printed or electronic information to HWs as a single strategy was generally ineffective (median MES = 0 percentage-points, IQR: -6, 6). Contextual and methodological heterogeneity made comparisons difficult. Conclusions: Effects of interventions to improve HW practices varied substantially, although strategies with training and either group problem solving or supervision seemed more effective. Standardization of methods would facilitate efforts to synthesize the evidence. Results from this review should inform decision-making on how best to improve HW performance in LMICs.
Research based capacity building of primary health care in Rwanda. A physician assisted, training oriented supervision of health centers. An ongoing study

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ABSTRACT

Background Evidence shows primary health care is a crucial component in building a cost-effective health system offering equal access to appropriate health services. Rwanda has an extensive primary health care system with health centers nationwide. A national monitoring system requires district hospitals to supervise performance of health centers. At the heart of supervision is a relationship between a supervisor and a supervisee. There are indications that this relationship in Rwanda is characterized more by inspection and performance evaluation than support and problem solving. Studies are needed in low-resource-settings to describe this and the type of supervision taking place, from the view of both supervisors and supervisees. Also, the role of primary care physicians in supervision is unclear. Objectives and methods 1) To understand characteristics of supervision of health centers, and the relationship between supervisors and supervisees, through a qualitative study primarily using focus group discussions. This study will guide an intervention: 2) To measure effects of introducing physician-assisted, training-centered supervision at selected health centers. With a repeated measures design, changes in indicators over time will be compared to control sites to evaluate the impact of the intervention. This will be accompanied by a cost effectiveness analysis to orient key policy and decision makers. Perspectives Many low-income countries spend resources on supervision without clear policies to define the objectives, methods and expectations. Our study will explore methods for training-centered supervision that may be adapted in low-resource settings such as in Rwanda, including what role a primary care physician may play in the supervision team. Results of this study will be included in a strategy for local, national and international advocacy to key decision makers within the healthcare system.
Nurse-initiated and managed antiretroviral therapy (NIMART) in practice, education, policy, and regulation in the east and southern Africa region: A survey of 16 countries

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ABSTRACT

Background: Achieving new global goals for HIV treatment and elimination of mother-to-child transmission in sub-Saharan Africa depends on expanding a nurse-led model of antiretroviral therapy (ART). This survey characterizes the implementation of NIMART in 16 countries in the east and southern Africa region, with a focus on quality assurance as defined in the 2008 WHO Task-shifting Guidelines. Methods: A survey was conducted of senior nursing leadership teams from 16 countries in the east and southern Africa region (Table 1) who attended an African Health Professions Regulatory Collaborative (ARC) meeting in Pretoria, South Africa in June, 2012. Each team comprised the four senior-most nursing positions in each country: the Chief Nursing Officer, the Registrar of the Nursing/ Midwifery Council, the head of the nursing /midwifery association, and a lead from nursing/ midwifery academia. Respondents completed one structured group questionnaire for their respective country. Data were analyzed in an Excel database. Findings: Eleven (69%) teams reported NIMART occurs in the practice setting in their countries, including for pregnant women (11) and pediatric clients (5). Mozambique and Tanzania teams indicated NIMART was not practiced, and these countries have the lowest ART coverage rates in the region. In the 11 countries practicing NIMART, seven (64%) countries reported NIMART is formally authorized in policy, regulation, or law. The majority of countries do not include NIMART in the scope of practice, continuing professional development, licensing examination or other quality assurance mechanisms for nurses and midwives. NIMART instruction is conducted through in-service training in all 11 countries, and through pre-service education in only five countries where NIMART is practiced (46%). Conclusion: NIMART is practiced widely in the region, and national policy authorization is common. However, further investment is needed in pre-service education and quality assurance mechanisms to ensure long-term sustainability and quality of NIMART service provision.
Building capacity to open-up the staff appraisals in Malawi: Moving from a confidential to an open performance management system in the public sector.

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ABSTRACT

Performance management is a participatory process between employees and their supervisors that links the individual's work plan and performance to the overall strategic objectives of the Ministry or Department. On paper, the Government of Malawi moved from a 'closed' performance management system for the public service to an 'open' system in 2008. Under the closed system supervisors were not obligated to share nor discuss a supervisee's performance appraisal with the employee. Not only did this remove an element of transparency from the promotion/demotion cycle but it also did not provide the employee with feedback necessary to improve their work performance. The open system aims to improve work performance and productivity of civil servants by measuring employees' performance against an approved workplan, rewarding and sanctioning good and bad performers and addressing barriers to an individual's effective performance. In practice, however, the open system was not rolled out to the health sector until 2013, when the process was piloted by the Ministry of Health's (MoH's) Human Resources Department, with USAID assistance under the SSDI-Systems project, in three districts. The SSDI-Systems and MoH staff built the capacity of eligible staff to develop performance workplans and supervised the roll-out process. Pilot assessment results demonstrate great enthusiasm among staff due to the open nature of the system, agreed upon performance indicators and enhanced transparency when conducting staff appraisals. Results also indicate that changes in the training process are necessary to ensure staff are aware of and are able to appropriately participate in the performance appraisal process. USAID's SSDI-Systems program will continue to support the MoH to roll-out and institutionalize the open system. The roll-out will use revised and simplified teaching materials and a more-structured cascade approach to training to reach all eligible employees.
Dissatisfied patients in China: what matters?

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ABSTRACT

Introduction Patient satisfaction is a focal concern of healthcare delivery and an expected outcome of medical care. In China, much of the debates around violence against doctors are taking place. The growing tension between patients and health service providers has adversely influenced the overall state of the healthcare system in China. Patient satisfaction has been recognized as an important concern and an urgent issue in China's healthcare reform. The first objective of the present study is to investigate whether and to what extent the differences in patient satisfaction attributed to patient, hospital, and medical market characteristics. Our second aim is to explore the major reasons for patient dissatisfaction. Data and Methods Data from 2007-2010 Urban Resident Basic Medical Insurance Survey is used in this study. 13,336 patients are selected conditional on healthcare utilization. Analysis of satisfaction is based on outpatient utilization and inpatient utilization respectively. Satisfaction was measured as ordinal variables. OLS and Ordered Probit model are applied to investigate the determinants, respectively from perspectives of patients, providers and medical market. Blinder-Oaxaca decomposition is employed to detect the contribution proportion of each confounder. Main findings Results indicate gender, education and insurance status of patients are significantly relative to patient dissatisfaction. Higher-rank providers are found to positively relate to patient dissatisfaction. Medical markets with higher value of Herfindahl-Hirschman Index and higher proportion of non-public health providers significantly reduce patient satisfaction. Meanwhile, the survey indicates medical charges and service attitude of providers are the most important reasons for patient dissatisfaction. Conclusions Improvements on patient satisfaction is an urgent task associated with Chinese healthcare reform. Evidence from the analysis of nationally representative data identify the attributes of dissatisfied population, and indicate the necessity of reform of hospitals and medical market.
People-centered care approach: an alternative strategy for better utilization of first line health services? An action-research project from Burkina Faso

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ABSTRACT

Burkina Faso has increased public investment in health sector over the past three decades which emphasized on availability of health facilities with a little interest paid to quality of care. The rationale of these reforms was that an improved availability of health services would lead to an increased utilization rate and thus translate into better health for the people. Despite this, the utilization health service has remained unsatisfactory. Many factors underlie this situation in health facilities among which the lack of responsiveness of health workers to people felt needs resulting in a dissatisfaction of the latter. We developed an action-research protocol under the assumption that the development and implementation of people-centered care will lead to a greater willingness of people to use health services and consequently contribute to a better uptake of care. For this purpose, our analysis of people centeredness was based on a conceptual framework which includes five key dimensions of people-centered care. we also used an analytical model which allows us to document structural-organizational, methodological and socio-cultural problems. Our analysis showed that people dissatisfaction of their interaction with health staff strongly influences health services utilization. The people-centered practices calls for a paradigm shift among caregivers, peoples and the community to achieve a sustainable goals towards better health of people. Finally we came to the conclusion that an improved availability of health services is necessary but is not enough to increase utilization of health services and that a people-centered approach tailored to the context could be an effective alternative strategy to ensure better utilization of health services. Keywords: people-centered care; First line health services; Action-research project; local health district; Burkina Faso.
The impact of disrespect and abuse during childbirth on user satisfaction and future care-seeking intentions

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ABSTRACT

Background: Facility-based childbirth is widely promoted as the most effective means of reducing maternal mortality. However, facility-based delivery rates remain low in many regions even where high antenatal care use suggests women are able to access health services. Increasingly, the role of poor interpersonal care during delivery “often manifested as disrespectful and abusive behavior” has been recognized as a potentially significant deterrent to women seeking facility-based delivery. This study sought to quantify the prevalence of experienced disrespect and abuse (D&A) during childbirth in a large hospital in Dar es Salaam, Tanzania and assess the impact of experienced D&A on women’s satisfaction and future care-seeking intentions. Methods: 2000 systematically sampled women were interviewed three to six hours post-delivery. Women were asked about their experiences during childbirth, including experienced D&A. In this study, the impact of D&A on satisfaction and future care seeking intentions was assessed using log binomial regression analysis adjusted for demographic factors. Results: Women who reported D&A during delivery were significantly less likely to report being satisfied with their childbirth experience (p<0.0001). Additionally, these women were more likely (p<0.0001) to state that their experience during delivery influenced their decision on where to deliver in the future. In bivariate analysis, women who reported D&A were less likely (p<0.0001) to plan to deliver their next child at the same facility, however this difference did not persist when controlling for demographic factors. Women who reported D&A were less likely (p<0.0001) to recommend the facility to other women for delivery services. Conclusions: This study is one of the first to quantitatively demonstrate that experience of D&A is associated with decreased user satisfaction and intended future care-seeking. These results suggest that the provision of respectful, dignified, woman-centered care may lead to more satisfied patients, increased uptake of quality services, and improved maternal health outcomes.
Patient satisfaction with Primary Care Services in Turkey

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ABSTRACT

Health policymakers have agreed that health systems should respond to the needs and expectations of the citizens who use them. Despite the recognition of the importance of citizen satisfaction with their health systems, this outcome can become lost in monitoring and evaluation frameworks relative to the more straightforward policy objectives of improving health outcomes and financial protection. However, from a politicians' standpoint it can be critical to both the adoption and implementation of any health reform effort. Without public support for reform, politicians may not be able to get legislative approval for proposed policies and can subsequently be voted out of office. This focus on improving citizen satisfaction with the health system was central to the objectives of Turkey’s recent Health Transformation Programme (HTP) that reforming the country's entire health system between 2003 and 2012. In particular, the HTP sought to improve satisfaction with the primary health care services through the introduction of the Family Medicine System. This system was gradually implemented in all 81 provinces in Turkey between 2005 and the end of 2010. Using the Turkish Patient Satisfaction with Primary Health Services Survey data from 2010, 2011 and 2012, we analyze whether the introduction of the Family Medicine System led to differential increases in patient satisfaction with number of aspects of primary health care service delivery. We also assess whether these changes were focused in areas of the country with lower socioeconomic development levels to test whether the introduction of the Family Medicine System met the equity objectives of the HTP. This analysis will show whether Turkey's investments in its primary care system led to improved citizen satisfaction with health service delivery. Their approach to Family Medicine may serve as an example for other countries seeking to increase utilization and access of primary health care services.
When is a skilled birth attendant not a skilled birth attendant? When she works alone. Qualitative research with health providers in Western Nepal.

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ABSTRACT

Background: Obstetric emergencies are rare but when they occur they escalate rapidly and require a team of trained health workers to prevent a mother dying. Yet, in our attempts to improve the proportion of women having a skilled birth attendant (SBA), a critical MDG5 indicator, we have trained and subsequently deployed many SBAs to remote health facilities where they often work alone, expected to be on call 24 hours. The Government of Nepal has introduced tailored SBA training, and has posted more than 4000 SBAs to refurbished facilities across the country, many in very remote districts. While this improves the MDG5 indicator, these SBAs may not be sufficiently enabled to provide life saving obstetric care. This research focused on identifying the essential components of the SBAs' enabling environment in a hill district of Nepal.

Methods: Qualitative research methods included semi structured interviews with 22 practicing SBAs within Palpa District, Western Region, Nepal; an FGD with ten SBA trainees; and in-depth interviews with five key informants. Results: Essential components of an enabling environment identified by the study participants included ongoing professional support for SBAs, infrastructure, adequate supplies and drugs, and a timely referral pathway in the event of obstetric complications. All sole practicing SBAs stated that they were unable to safely manage life-threatening obstetric complications without the assistance of at least one other trained SBA. Discussion/Conclusion: Maternal health guidelines should be modified to include adequate provision of the identified enabling factors in addition to the deployment of SBAs. In Nepal, SBAs should be posted with another SBA if the goal of reducing maternal deaths through timely management of obstetric complications is to be achieved. The presentation will focus on the challenges of providing 24 hour obstetric service in remote settings. When is an SBA not an SBA? When she works alone.
Negotiating professional sensibilities and public health necessities: A case study of India's efforts to introduce mid-level healthcare providers

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ABSTRACT

In 2002, the province of Chhattisgarh in India, with the lowest health human resource densities in the country, and perhaps in the world, introduced a 3-year course to train medical professionals to serve in rural areas. The initiative faced a fair share of hurdles including legal action by the Indian Medical Association and 3 major student strikes. This resulted in dropouts, lesser enrollments and finally closure of the course in 2008. However, this unique one-time endeavor led to deployment of more than 1000 Rural Medical Assistants in under served remote areas, which had been struggling to find any qualified doctor for years. Subsequent assessment of RMA revealed that their knowledge, skills and patient satisfaction were at par with MBBS doctor in delivering primary healthcare. Assam, in 2006, initiated a similarly structured 3-years Rural Health Practitioner (RHP) Course, with much better organized legal support. By March 2013, 370 RHPs were placed in Health Sub-Centers thereby upgrading them to fully functional curative, preventive and promotive units. The learnings from past experience led to a more sustainable effort Chhattisgarh and Assam experiences, studied and communicated appropriately, have shaped the perception of policy makers in India, who now recommend a mid-level cadre through a 3-year Bachelor of Rural Health Care Degree Course and posting them as Community Health Officers in Health Sub-Centers. However institutional barriers remain, showing that there is much more to decision making than merely the existence of evidence.
ABSTRACT

Background: The health supply chain is often the weakest link in achieving health-related millennium development goals, such as improving maternal health, reducing child mortality, and combating HIV/AIDS, and malaria. It is estimated that up to one-third of the world’s population has limited access to medicines. Without trained professionals to manage health supply chains, health supplies do not reach the patients who need them. The People that Deliver (PtD) Initiative has been active in seven focus countries since 2011, (Burkina Faso, the Dominican Republic, Ethiopia, Indonesia, Liberia, Mozambique, and Namibia), with much to be learnt from their experiences as they focus on this area. Methods: Semi structured interviews and focus groups were used to determine the barriers and enablers to country based improvements in the area of human resources (HR) development within health logistic and supply chain cadres, in six PtD focus countries. This case study approach used a consortium of country based interns, academia and implementing agencies, supported by the University of Copenhagen and PtD Secretariat. Manual thematic analysis was used to assess the data. Results: An average of 15 interviews and two focus groups were conducted in each country. Interviewees included: government officials, academia, personnel from health supply chains, and development agencies. Common enabling themes for the progress of HR in countries were: engaged leaders, communication between stakeholders and working with an agreed plan. Common barriers included: a lack of academic capacity, insufficient funding and the capacity of government departments. Conclusion Strengthening quality of care for populations will require low income countries to improve their health logistics and supply systems. The development of human resources systems to support the cadres engaged in this work is essential. This study provide insights regarding the barriers and enablers to country based change which will be used to support countries and development partners to further improve health logistics and supply chains.
Improving access to and rational use of medicines at the community level using a new pharmacy assistant cadre in Malawi

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ABSTRACT

In Malawi, health facilities and the communities they serve often suffer from a lack of life-saving medicines, primarily due to weak supply chain systems, poor pharmaceutical management, a lack of data on medicines consumption, and inadequately trained personnel. VillageReach, in partnership with the Malawi Ministry of Health, the Malawi College of Health Sciences, and the University of Washington Global Medicines Program, is working to address these key barriers to medicines availability by implementing a new approach to the training, deployment, and support of an enhanced Pharmacy Assistant cadre. In Malawi, the pharmaceutical workforce is responsible for managing the medicine supply chain and overall pharmaceuticals management. However, trained pharmacy personnel do not currently work at the health center level, leaving clinical and front-line health workers to manage pharmacies and logistics duties at the service delivery point. In order to understand the impact of training and deploying Pharmacy Assistants at health centers on medicines availability and use, a three-year, quasi-experimental, multiple-time point, health center and population-based study is being conducted. This presentation will first describe preliminary results from program data [qualitative and quantitative], which reveal that Pharmacy Assistants significantly improve information management, storeroom conditions, and dispensing standards at the health center level. Second, a description of the impact evaluation and presentation of data from the baseline survey collected in March 2014, and quarterly health center level data from the intervention and comparison sites will be presented. The hypothesis is that trained pharmacy personnel working at the health center level will significantly improve the availability and rational use of medicines in communities. The results of the impact evaluation will be used to provide recommendations for policy makers, logistics practitioners, program managers, and donor representatives interested in strategies for improving human resources for medicine supply chain and pharmaceuticals management.
Inclusion of users' perspective on the evaluation of mental health services: experience from a discharge program in Buenos Aires province, Argentina

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ABSTRACT

The inclusion of mental health service users' perspective in the evaluation of services contributes both to its validity and quality, and to the protection of rights of individuals with mental illnesses. In this sense, it becomes a key component of the building process of people-centered health care systems. While the development of evaluations that take into account mental health services users' views is increasing, the practice still lacks diffusion in real-life settings, that is, incorporating them in everyday service management practices, especially in certain parts of the world. In this study, users' perspective on a discharge psychiatric program for women in Argentina is described and analyzed, with emphasis on the strategies that facilitate the inclusion of their perspective on service evaluation. For doing that, a qualitative study was carried out with 56 users of a discharge program associated to a psychiatric hospital in the southern zone of Greater Buenos Aires, at the Buenos Aires Province, in Argentina. The qualitative methodological tools used were participant observation, records analysis, questionnaires, and focus groups. The results show that mental health workers' use of narrative language (as opposed to a more technical way of addressing to users), and the focus on users' 'everyday life' concerns are variables that promote the inclusion of users' perspective. Results also raise a discussion about what it means to 'include' the users' perspective, being proposed that it refers to the building of the indicators and the evaluation from the user's perspective, what is conceptualized as the 'care' perspective -in contrast to 'health care'.
Assessing health system mechanisms for hypertension management in Northern Tanzania - a patient perspective

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ABSTRACT

Introduction: Non-communicable diseases (NCDs) are an increasing challenge to health systems in low-income countries. The recent past was focused on communicable diseases such as HIV, however Tanzania is currently facing the emerging burden of NCDs. Hypertension affects approximately 30\% of Tanzanian adults and is a significant risk factor for cardiovascular diseases that will greatly affect population health. Applying a methodology developed by the London School of Hygiene & Tropical Medicine, this study conducts a multi-method appraisal of the Tanzanian health system regarding hypertension management and control from a patient perspective.

Methods: The appraisal was undertaken across two regions in northern Tanzania. Drawing from a literature review, semi-structured interviews were conducted with key informants, health professionals and patients, exploring hypertension management. The study aims to identify modifiable system-level barriers to effective hypertension management. Interviews were transcribed, coded using NVivo software and analysed using a conceptual framework.

Results: Preliminary findings indicate significant discord between policy and reality of patient experiences; the Ministry of Health has developed a NCD strategy, yet little progress has been made in delivering programmes. Public clinics are poorly resourced and staff are unable to manage hypertensive patients effectively. There is little emergency care available for patients with acute events related to hypertension. Poor drug procurement at a national level affects a patient's ability to access anti-hypertension drugs. There is also a lack of patient awareness on the chronic nature of hypertension, resulting in poor drug adherence.

Discussion: In Tanzania, little provision of care is currently available for the growing number of patients with hypertension. It is suggested that community-level awareness and mHealth technology initiatives could be effective given the appropriate support from policy level, as has been proven in managing HIV/AIDS. However more research on the effectiveness of interventions for NCD management in low-income countries is required.
Patients' experiences of MDR-TB diagnosis and treatment initiation with the introduction of new rapid molecular diagnostic tests in South Africa

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ABSTRACT

Background New rapid molecular TB diagnostic tests were introduced in South Africa and promised to improve TB programme management. However, little is known about how such potential is translated into rapid identification of multidrug resistant tuberculosis (MDR-TB) and initiation of treatment. We explored patients’ experience of being diagnosed and initiated on MDR-TB treatment with the existing MDR-TB Plus line probe assay algorithm (LPA) and the newly introduced Xpert MTB/RIF algorithm (Xpert), to better understand their experience.

Method We reviewed patient records and conducted in-depth qualitative interviews with 23 patients diagnosed with MDR-TB via LPA (12) and Xpert (11) in Cape Town, exploring their pathways into care. Thematic analysis of interviews was done to identify the main trends of patients’ pathways into care.

Findings In both algorithms care experiences were characterised by patient and health system delays. Patients often recognised the seriousness of their symptoms late and delayed seeking health care, often avoiding public sector clinics as the first point of care. Delays in receiving a MDR-TB diagnosis were due to avoidable health system problems such as incorrect diagnostic requests, poor co-ordination and communication of test results and inability to follow-up patients in the community. Receiving test results was frequently experienced as ‘chaotic’ with multiple clinic visits and long waiting times. With LPA, awaiting prescriptions and medication from the central TB hospital contributed to delay. In some cases with Xpert, a rapid diagnosis was received and the pathway to treatment was rapid and uncomplicated.

Discussion and conclusion Patient and health system factors resulted in delays in health care and limited the potential benefit of rapid TB diagnostics tests in both algorithms. To achieve the full benefit of rapid TB diagnostic tests, interventions are needed to increase appropriate health seeking behaviour and to address avoidable health system delays.
A patient-centred approach for assessing health system mechanisms for hypertension management in Malaysia

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ABSTRACT

Introduction: The growing burden of non-communicable diseases in middle-income countries such as Malaysia demands models of care that are appropriate to local contexts and acceptable to patients in order to be effective. We describe a multi-method health system appraisal to inform the design of an intervention to improve hypertension control. Methods: A health systems appraisal was undertaken in the capital, Kuala Lumpur, and poorer-resourced rural sites in Peninsular Malaysia and Sabah. Building on two systematic reviews of barriers to hypertension control, it employed analysis of survey data, documentary review and semi-structured interviews with key informants, health professionals and patients. The analysis was from a patient perspective, exploring the main modifiable system-level barriers to effective hypertension management, following patients as they move through the health system. Interviews were transcribed, coded using NVivo software and analysed using a conceptual framework. Results: The proposed intervention must take account of how Malaysian patients seek treatment in both the public and private sectors, and from western and various traditional practitioners, with many patients choosing to seek care across different services. Patients typically choose private care if they can afford to while others attend the heavily subsidised public clinics. Hypertension clinics are often overwhelmed by the number of hypertensive patients attending, so health workers have little time to effectively engage with patients. Treatment adherence is poor, with reasons often linking to the widespread belief in traditional medicine that view hypertension as a transient disturbance rather than a permanent asymptomatic condition. Drug supplies can be erratic in rural areas. Discussion: The study uncovered major patient-related barriers to the detection and control of hypertension. Appropriate models of care must take account of the patient perspective if they are to have any realistic chance of success. We will discuss the implications for health systems research.
Promoting access to NCD Medicines through a social health insurance benefit package: Early lessons from a pilot in the Philippines

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ABSTRACT

Background: In the Philippines, the burden of non-communicable diseases (NCDs) is growing, with the number of diabetics alone estimated at 7.8 million by 2030. Even with aggressive prevention efforts, the growing case-load will be a major challenge for the health system. The Philippine Health Insurance Corporation (PhilHealth) is piloting in selected sites an outpatient medicine benefit for NCDs for sponsored members. Dubbed the Primary Care Benefit 2 (PCB2) Package, it aims to improve access to medicines with hypertension, diabetes and dyslipidemia. This early lessons review is part of an embedded implementation research initiative accompanying the pilot. Methodology: We explored the extent that the benefit package contributed to people-centered care by analyzing the design using the domains described in the WHO People-centered Health Care Policy Framework. We also examined the early lessons from the pilot via key informant interviews and review of the program database. Results and Discussion: The strength of PCB2 is its ability to influence service providers through appropriate incentives to deliver clinical interventions through efficient mechanisms of care delivery. However, it remains very weak in contributing to the domain around self-management and empowerment of patients. For example, it has no incentives for patient education in the design. In Pateros where it was first implemented, vertical analysis of coverage shows that among the 242 estimated eligible to receive the benefit package (from the 10,075 population of sponsored members), less than 100 have been screened and only 5 have availed of the package since it was implemented in October 2013. Conclusion: Analyzing the extent that social insurance benefit packages contribute to patient-centered care allows decision makers to improve the design of these packages including appropriate incentives that promote patient empowerment. Early lessons point to the need to balance cost-containment elements in the design with improving access to the benefit.
Local producers of health care supplies: employment and quality outputs as part of people-centred care

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ABSTRACT

Background Despite increasing recognition that health systems are deeply influenced by social and economic context, the systems are still generally studied as sectors in isolation from the industrial sectors, and their production workforce, that supply their inputs. This research paper reintegrates a consideration of that workforce into the concept of ‘people centred’ systems. Methods Missing and poor quality supplies is a known constraint on the access of populations in many low and middle income countries to quality health care. This paper draws evidence from a two year study in Tanzania and Kenya of the local and import supply chains into the health sector, and the scope for improved local production of quality supplies to strengthen the health sector. The project methods include fieldwork on health sector experiences of supply chains, and the perspectives of industrial producers and wholesalers in both countries. Results The presentation will summarise: the experience and views of health facilities and shops on the quality and availability of locally made supplies, the problems of shortages and quality, and the scope for improvement; the extent to which the health sector in each country is generating industrial employment and investment in each country in a variety of industrial sectors; the contrasting trends in local industrial supplies in each country; and the scope for more ‘joined up policy’ to recognise the requirements of local industrial producers and their employees and the scope for strengthening quality local supplies. Discussion Presents some thoughts on the interconnection between industrial employees and the health sector workforce, and the scope for building on synergy between their needs and capabilities.
The process and practice of diagnosis: a system perspective

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ABSTRACT
This paper focuses on strengthening diagnostic capability in low resource health settings. Expectations about the impact of new diagnostic technologies are high but are not accompanied by an appreciation of how such technologies work in practice. Specifically, the systemic and people-centred nature of diagnosis is overlooked. This paper presents an empirically grounded 'diagnostic system' framework which conceptualises diagnosis as a complex and plurality governed process. Insights are presented from research into the development and implementation of new laboratory enabled diagnostics for Lassa fever in Sierra Leone. A multi-sited ethnography across village, clinical and laboratory settings traced diagnostic processes. Empirical data of how Lassa fever is dealt with in these contexts informs the concept of the diagnostic system, a heterogeneous assemblage of tools and people each with their own practices, perspectives, networks and interests. Multiple understandings of disease are negotiated and co-produced with evolving diagnostics, and with emerging diagnostic pathways. This conceptualisation of the diagnostic system advances an understanding of diagnosis which is people-centred and recognizant of the complexity and plurality of health care. This paper is significant in that it applies a complexity lens to an issue of great importance to health system strengthening, with practical implications for policy makers and diagnostic developers. By qualitatively exploring the perspectives and interactions between actors in the diagnostic system it contributes to a fuller understanding of the de-centred, unpredictable and emergent nature of diagnosis, and the system qualities which are needed to improve disease management. Attention is drawn to the limitations of linear and algorithm based surveillance policies and diagnostic protocols and the need for these to be balanced with the knowledge of patients and healthcare workers. An original contribution to the emerging literature on the sociology of diagnosis is made by highlighting the importance of practice, emergence and multiplicity.
A geographical approach on medicines subsidies policies

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ABSTRACT
Background: Brazilian constitutional right to health includes access to medicines as one of its components. In May 2004, Brazil’s government announced ‘Farmacia Popular’ Program (FPP) as a new mechanism to improve the Brazilian population’s access to medicines. Under FPP, a selected list of medicines is subsidized by the government and provided in public and private pharmacies. The aim of this study is to describe the historical stages of the FPP and to identify associated changes in the geographical accessibility of medicines over time. Methods: We performed documentary review and an ecological study using a pharmacy facilities density (PFD) index at national and subnational levels from 2002 to 2013, using data from FPP. We used geographic information system mapping to allow visualization of the PFD ratio on thematic maps. Results: In general, we noted important differences in growth of the PFD ratio coincident with the phases of the FPP. In the public sector, the program started in 2004 and by 2006 there was an increase in the numbers of participating pharmacies, stabilizing in 2009. In the private sector, the program started in 2006; by 2009 the PFD ratio had increased substantially, and it continued to grow through 2011. There was an increase on FPP coverage in most regions between 2006 when the private pharmacy component started and 2013, but pharmacies remain unequally distributed across geographical regions. Specifically, the wealthy areas in the South and Southeast have higher coverage, with lower coverage mostly in the North and Northeast, areas with the most need for access to medicines, health care and other basic services such as potable water and sanitation. Discussion/conclusions: There was a substantial increase in the number of pharmacies over time, mirroring the phases of the FPP. This has led to greater program coverage and has potentially improved access to FPP medicines in the country. Nevertheless, disparities remain among the regions.
Access of high cost medicines under UHC in Thailand: the organized efforts

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ABSTRACT

In Universal Health Coverage access of high cost medicines is one of controversial issues especially where resources are limited like Thailand. At the beginning the ThaiUHC scheme covered medicines inclusively under capitation, but later on high cost medicines have been separated under specific services budget item, the so-called central reimbursement (CR). The CR is to respond health care providers' need for a number of high cost services, this is considered a risk protection strategy. The coverage of high cost medicines was thus started in 2010. The UHC selected drugs under the J2 group of the Thai Essential Drug List (EDL) to exercise. In order to assure patient access, reimbursement by drug method was selected. Hospitals that need the J2 drugs are required to register the target patients and key in the requested information in order to get reimbursed through logistic system according to the quantity approved. The method was criticized, at the beginning for fear of medicines quality; lower the purchasing power at the local level. Annual meetings with hospitals' pharmacists were held to disseminate the strategic policy and exchange experiences for continuous improvements. The expenses were monitored closely together with patient utilization results. The current system, central management, gain better acceptance by hospitals. In 2014 OP and IP capitation is 2084.90 baht per head while CR is 271.33 baht per head of which 3.53 % accounts for the high cost medicines. The J2 drug expenses has increased form 7.8 million USD to 20.18 million USD since 2010, which is still manageable. The number of patients increases in line with satisfaction from heath practitioners. However, there are complaints from both providers and patients that there are many more high cost medicines inaccessible, especially those that concern expensive biopharmaceuticals, personalized medicines and the like. Therefore, the strategy to ensure access of high cost medicines is still dynamic and challenging.
Digame, pourquoi viene?' Patient orientation in physician-patient communication in primary healthcare centers in Nicaragua.

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ABSTRACT

Introduction. Provider-patient communication skills and the patient-centered approach, although internationally accepted as basic competences for healthcare providers, are hardly considered in the medical curriculum of most Latin American medical faculties. In Nicaragua, as well as in other developing countries, the biomedical model is the predominant concept and poor communication is widely prevailing in public services. The aim of this research is to describe and evaluate physician-patient communication in medical encounters in primary health care settings in Nicaragua. Health centers from Managua, Rivas and Matagalpa were involved. Methods. Two hundred and seventy-seven consultations from 19 physicians were recorded. The videos were coded in SPSS 16 database and analyzed using the 'Calgary-Cambridge guideline to the medical interview'. Sum scores of CGG items were used to look at specific communication skills: gathering information, building a relationship, achieving shared understanding, shared decision making and closing the session. Results. Mean scores for all communication measures were very low. Especially items that considered involving the patient scored extremely badly: in 40.1% of all consultations none of the skills aimed at achieving shared understanding were ever used. In 51.3% no shared decision making skills were demonstrated at all. In 70% of the consultations, over 75% of the time was spent taking notes. Correlation analysis using GEE model for clustered data showed that only consultation length and time spent by the physician writing notes were significantly correlated with shared understanding (0.001) and building the relationship (0.001). Physician and patient gender, age and number of interruptions showed no significant correlation with communication scores. Discussion/Implications. Few attempts have been made to improve provider-patient communication in Latin America through training of medical students and doctors; there is a great need of research and training in communication skills and the patient-centered approach as a means to improve quality of care.
Critical analysis of the potential for improving healthcare for patients living with chronic illness through e/m-health solutions in the South African Public Health System

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ABSTRACT

Background: The phrase ‘the potential of e/m-health’ has been widely used since the exponential rise in cell phone connectivity and ownership. Minimal research into the applicability, acceptability and appropriateness of e/m-Health exists. This study critically evaluates the potential for the use of digital and networked communication technologies to 1) enhance healthcare and 2) become normalised as part of care provided by public facilities. Methods: The MRC Wits-Agincourt Rural Public Health and Health Transitions Research Unit’s study site is in rural northeast South Africa. The population density is 107500 with many people dependent on government grants. Primary qualitative data is being collected through observation at four primary care clinics, interviews with chronic disease patients, women attending for antenatal care, nurses, community members and policy makers (district, provincial and national). Results: Preliminary findings from nurse interviews suggest some of them access health information for their work on their personal phones. Most nurses considered themselves to have little or no computer literacy. Interviews with patients suggest few use the Internet. Phone sharing was not common with most patients having their own phone. Some chronic disease patient's use their cell phones in relation to their health issue on an almost daily basis, setting reminder alarms for medication, calling or being called by family about their health. Younger patients use chat apps (WhatsApp/Mxit) to give and receive support from friends or family. The resource to purchase airtime restricts Internet access via cell phones. More elderly patients often rely on grandchildren to read messages due to poor eyesight and literacy. Conclusion: Early results suggest that cell phones are being used in relation to health to varying degrees as their use becomes normalised in the community. Enhancing healthcare through the use of digital networked communication has potential where its implementation is integrated with this normalisation.
Community-based health systems in the urban slums in Bangladesh: What are the challenges, opportunities and links between formal and informal close-to-community providers?

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ABSTRACT

Background: Different types of formal and informal close-to-community (CTC) health service providers operate in Bangladesh. However, gaps remain in the evidence-base on the roles, responsibilities and performance of CTC providers. For ensuring quality of care understanding the inter-relationships between formal and informal CTC providers and their linkages in the context of community-based health systems is crucial, particularly in the context of urbanisation in Bangladesh. Methods: We aimed to understand the context in which CTC providers operate in urban slums in Bangladesh with respect to sexual and reproductive health. We conducted a qualitative study including 12 focus group discussions with community (married) men and women, 32 semi-structured interviews with formal and informal CTC providers and 24 in-depth interviews with clients of menstrual regulation services (manual vacuum aspiration to safely establish non-pregnancy up to 8-10 weeks after a missed menstruation period). Results: We found that informal CTC providers are well accepted in urban slums for all types of health problems. They are more acceptable to the community in terms of their availability, accessibility and affordability, for health seeking behaviour and treatment support while formal CTC providers remain as the second choice. Consequently, formal CTC providers have to work very hard to build rapport and gain the trust of community members; they face challenges of workload and limited incentives. In addition, limited training and supervision and absence of effective referral links between various health providers are the key areas that affect (formal and informal) CTC providers performance in the field of sexual and reproductive health. Conclusion: The unsystematic nature of the Bangladeshi health system creates segregation between formal and informal providers. Establishing closer communication, coordination and appropriate referral between formal and informal CTC providers is required to build more effective and equitable community health systems in urban slums in Bangladesh.
Exploring trust in maternity care: a qualitative study in peri-urban Kenya

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ABSTRACT

Background: Trust in providers and in health facilities is important to understand care-seeking, quality and accountability of health systems. In a low-income country like Kenya, barriers to maternity care-seeking and receipt of quality services depends on a range of financial, logistical, structural, environmental and experiential factors. Little has been explored in terms of trust: a relational concept that provides a distinctive lens to understanding responsiveness at the facility during the critical stage of labor and delivery. This study explores the meaning, relevance, and determinants of health systems trust in a maternity care setting. Methods: Focus groups (n=8) with recently delivered women (RDW), pregnant women and male partners and in-depth-interviews (n=33) with RDW, providers, management, and community health workers were conducted in and around a public sub county-level hospital in a peri-urban area in Central Kenya. Data were audio-recorded, transcribed into Kiswahili and translated into English. Textual analysis involved inductive and deductive coding of themes, memo writing, consulting field notes and discussion with collaborators. Results: Trust was found to be a relevant concept in maternity care settings; it reflects notions of dependability, open communication, honesty, competence, confidence, fidelity, fairness, confidentiality and systems trust. Trust in providers did not always agree with trust in the health facility, nor were these notions evenly represented across relationships or respondents. Perceived quality and experiences, administrative processes, facility capacity and reputation, levels of corruption, provider empathy and respect, education and empowerment, and community-provider feedback mechanisms affected people's trust in maternity care. Discussion/Conclusions: Understanding how trust is built or undermined in maternity care has implications for individual and community perceptions of quality in the broader health system. It offers a glimpse into how to enhance responsiveness of facilities to women's needs during labor and delivery and lessons may be transferable to treatment of other vulnerable groups.
Translating knowledge, promoting action: Insights from research in Uganda and Zambia to make health systems more responsive to health workers' needs and rights

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ABSTRACT

Background: Women are the majority of the health workforce, but we know little of their lives, needs, working conditions, and career opportunities. To address gender discrimination and inequality 'important steps toward making health systems responsive to workers' it is essential to illuminate gender and human resources for health (HRH) challenges. Data collection techniques such as life history interviews, focus group discussions, gender reports from HRH information systems, document review, and surveys can provide multifaceted insights into gender-related factors affecting productivity, retention, career progression, and satisfaction.

Methods: We present three studies that examined health workforce gender issues. Using a mixed-method gender discrimination and inequality analysis approach, one study was conducted in a large public health system in Uganda and a second in a small private-sector health system in Zambia. The third study used life history interviews to examine how gender shaped professional experiences during and after conflict in northern Uganda. Results: The mixed-method studies found patterns of occupational segregation, negative stereotypes of female leaders, sexual harassment, and unequal opportunities in recruitment or promotion of female health workers. In northern Uganda, gender influenced workers' decisions to enter the health workforce, upgrade skills, and remain in or leave the workforce, as well as coping strategies and work roles. Conclusions: Disseminating the results of gender-focused workforce studies can promote stakeholder awareness, understanding, and ownership of gender issues. Dissemination strategies included training; case analysis; role playing; engagement in formulating conclusions and recommendations; and implementation of a gender mainstreaming roadmap. Over time, new knowledge about workforce gender issues can translate into organizational change and HRH policies and management actions that are more responsive to health workers' needs and labor rights. HRH leaders and managers, researchers, and gender justice advocates can benefit from addressing gender-related challenges and considering ways to make health systems more responsive to workers.
Role Stress among Nurses in India

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ABSTRACT

Background: Role Stress (RS) is an important concept that has not been studied much in public health. RS is experienced when the inter-relationship between the self and various roles a person occupies has an imbalance or imbalance between the focal role and various other roles that others play in the organization.

Methods: The study aimed at assessing the Role Stress (RS) among 84 Auxiliary Nurse Midwives (ANM) in one district, India. Stratified sampling technique was used for selection of ANM working government health centres. A structured instrument with established reliability and validity called Organizational Role Stress was used to measure 10 dimensions of RS based on 5 point Likert rating scale that contained 50 unidirectional negative statements, 5 for each dimension.

Results: The highest role stress among ANMs was experienced for Resource inadequacy followed by Role overload and Role stagnation. Resource Inadequacy indicates that ANMs feel quite frequently that they do not have adequate amount of resources, full facilities, financial support as and when required and no support from the high levels authorities. Role Overload indicates that ANMs feel that there are too many expectations from their role by several people which gives them a feeling that sometimes they have so much work that they are not be able to prioritize which work is more important. Similarly Role Stagnation means that ANMs feel frequently that there they do not have enough opportunity for future growth.

Discussion: Understanding the concept of role and role stress is important as the study results indicate high Role Stress experienced by the ANMs. More focused research on the RS in needed in the public health system.
Community Health Workers programs: Opportunities to contribute to broader social change.

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ABSTRACT

Background: Community Health Workers (CHW) and other close to the community providers are increasingly a part of public health programs in low and middle income countries (LMIC). Central to most CHW program designs is a commitment to Empowerment of CHWs and Promotion of Social Equity. We present here a critique of how these notions are operationalized in practice and reflect upon opportunities for improving CHW programs from different perspectives.

Methods: We present an analysis of the discourse encountered during a systematic review of literature on the design and functioning of CHW programs in LMICs (143 studies were included, double-read and analyzed), and 6 country case studies (Indonesia, Ethiopia, Malawi, Mozambique, Kenya, Bangladesh).

Results: Empowerment of CHWs and Promotion of Social Equity are discursive formations that are well entrenched in CHW program designs in LMICs but not systematically operationalized. CHW programs often fall short in empowering CHWs and challenging existing social and gender inequities. For instance, contrary to expectations, CHWs are sometimes selected by local elites and remain beholden to them. Gender roles, social expectations and relations, and incentive arrangements intersect to shape experiences of CHWs in different contexts. We found that CHW positions are often insecure and lack professional development opportunities. While increasingly the onus is on CHWs and CHW programs to solve the problem of health access, inadequate attention is given to the experiences of CHWs themselves, both as health providers and as social beings.

Discussion: There is need to firmly move beyond a narrow and instrumentalist approach to CHWs. CHW programs must make explicit efforts to take a developmental and empowerment perspective when engaging with CHWs in order to empower and support this vital cadre and maximize their opportunities to contribute to social change, gender equity and people centered health systems.
Anxiety and depression among medical students: a nationwide survey in China

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ABSTRACT

Background: Medical students may experience high risk of mental disorders due to high pressure. The study aimed to explore the prevalence of depression and anxiety and their correlates among medical students in China. Methods: We conducted a nationwide survey across China among medical undergraduates based on a questionnaire composed of demographic information, life events in the last four weeks, and validated Chinese versions of the revised Life Orientation Test (LOT-R), 21-item Beck's Depression Inventory (BDI), and Zung's Self-rating Anxiety Scale (SAS). Results: The mean age of the 9010 medical students was 20.7 (standard deviation: 1.6) years. 37.9% were males, 45.6% majored in clinical medicine or dentistry, and 39.5% came from urban areas. BDI and SAS scores indicated 19.4% and 13.4% had symptoms of depression and anxiety. Male students were more likely to have higher prevalence of depression ($P<0.001$), and those majoring in non-clinical and -dental courses showed higher prevalence of anxiety ($P<0.001$). The age ($P=0.001$ and 0.014) and year of study ($P=0.001$ for both) were associated with prevalence of both depression and anxiety. Mother's education and the location of household (rural or urban) were associated with higher prevalence of depression, while father's education and monthly household income per capita were associated with higher prevalence of either. Higher pessimism rendered lower prevalence of both mental disorders ($P<0.001$). After controlling for statistically significant basic characteristics, life events in the past four weeks such as worries for current study and future work, burden due to peer competition, financial difficulties, interpersonal relationship crisis, alcohol drinking, cigarette smoking, and lack of sleep were predictors of risk of both depression and anxiety, while physical exercises correlated with lower risk (all $P<0.001$). Conclusions: Depression and anxiety are prevalent among Chinese medical students. Medical universities should adopt change in curricula to improve students' mental health.
The experience of nurses working in a tuberculosis hospital in South Africa: An ethnographic study

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ABSTRACT

South Africa has one of the highest rates of TB infection, morbidity and mortality. Nurses play a key role in TB management, but little research has explored the lives and work of TB nurses. This study explores experiences of nurses working in a TB hospital in Western Cape. It examines their motivations, career histories, and personal relationships with co-workers, family and community; their experiences of working in sensitive and drug-resistant TB environments, and attitudes towards infection risk. The study adopts a qualitative approach and employs ethnography. It uses observation, interviews with 30 nurses and PhotoVoice as data collection methods. Fieldwork took place over 6 months in a TB hospital in Western Cape. Thematic analysis was conducted with NVIVO. The study considers the extent to which the TB hospital can be conceived of as a ‘total institution’ in accordance with Goffman’s (1961) typology. It concludes that key characteristics, such as isolation from the outside world, ‘security’ and surveillance levels, ‘batch living’ and uniform treatment of patients were present. The rationalisation of everyday life was reflected in work hierarchies, task orientation and a monotonous routine. Within this nurses have a dual role; they are both enforcers of the rules and subject to them. The hospital had infection control protocols but nurses deviated from these through risky behaviours, in ways that suggest attempts to maintain personal autonomy in a highly regulated environment, and which drew on alternatives of fate and faith. Significant attention is needed to invest in the welfare of nurses in this high risk environment. Incentives are needed to support adherence to safety protocols, including continuing education and a rewarding career structure. Discussions between universities and regulatory bodies need to address where TB nursing sits in terms of qualification status, career opportunities and ultimately consider TB nursing as a speciality.
Enabling health worker performance in challenging conditions: The role of relationships

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ABSTRACT

Enhancing the performance of front-line health workers serving vulnerable populations is crucial for redressing inequities. Traditional approaches have focused on modifying individuals' behavior through guidelines and incentives, however complexity science suggests that individual performance is a manifestation of the nature of relationships connecting actors within a system. This study examines the social environment of the practice of front-line auxiliary nurses (AN) in rural Guatemala in order to identify patterns of relationships in the health system that enable performance. Mixed methods provided an integrated view of the organizational context of the regional health system of Alta Verapaz. Interviews were conducted with ANs, community supporters, and managers in primary and secondary care facilities. Theory-driven case studies of health post supervision were conducted, and the participatory method of concept mapping was used to analyze views of health workers, district and regional managers on support mechanisms for performance. The nature of working relationships with community supporters and managers was central to ANs' motivation to confront challenges in practice. ANs were enabled through relationships with community supporters based in collaboration towards mutually-valued goals. Relationships to managers guided by instrumental focus on attainment of standardized ministry goals provided limited support. Managers oriented by a holistic understanding of ANs' needs and the shared professional goal of improving patient care were more successful in enabling AN motivation. 'Organizational climate of support across levels' was identified by health-system actors as top priority for improving performance, characterized by respectful treatment, attention to psycho-social well-being and accompaniment in problem-solving. This study suggests that enhancing the supportive nature of relationships among ANs, managers and the community is an important mechanism for enabling performance in challenging conditions. The combination of qualitative, theory-driven and participatory methods provided multi-levelled insights into the operation of human support in this context, and indicated relevant directions for action.
Intersectoral action at district level: the Cape Winelands Liaison Committee

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ABSTRACT

Background: Intersectoral action (IA) remains one of the most weakly adopted principles of primary health care. In the Cape Winelands District (Western Cape Province, South Africa) a Liaison Committee was established to support IA between several provincial and local government departments. Methods: Qualitative case study methodology was employed to describe the Winelands Liaison Committee, the enabling factors that support it and the challenges and opportunities for IA in the district. The case was selected as a rare example of a functional intersectoral structure at this level. Key informants from all member departments were interviewed and documents relating to the committee were reviewed using a document analysis template. Interview data was analysed using a thematic content analysis approach and triangulated with document data to develop a unified understanding of the structure and functions of the committee. Member checking was employed. Results/discussion: The Winelands Liaison Committee was built on the principle of mutual benefit, and projects contributed significantly to the goals of each partner. Recognition of shared upstream factors and the potential to optimise resource use motivated participation. The formal structure was supportive of equal power relations and shared ownership, and having members with appropriate decision-making power was key. The informal relationships between members filtered down to service delivery level and were instrumental. Despite requiring intensive input in terms of time and effort, these relationships were perceived to be beneficial to integrated service delivery. Examples of projects under the governance of the committee are described. Conclusion: IA at district level is needed to support integrated service delivery and effectively implement strategic level policies. A policy framework for IA at district level is needed to allow such action to be fully effective and support sustainability. This case study adds to the literature describing how IA can be implemented in district health systems.
Urban health governance in Bangladesh

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ABSTRACT

Background The speed of urbanization and rapid growth of health markets in urban Bangladesh have overwhelmed the capacity of government to regulate, plan or ensure quality or equity. Existing policy frameworks are ambiguous in defining responsibilities for urban health service provision between relevant ministries and government agencies. This study examines the configuration of urban health stakeholders around the provision of MNCH-FP among the urban poor. Method Following document review and key-informant interviews, a list of stakeholders was prepared, and stakeholder consultations through group and informal discussions were organized and conducted. Codes and data displays were created with the purpose of examining three levels of understanding: their specific roles and responsibilities vis-a-vis the health of the urban poor, their interrelations and power influence, and stakeholder engagement around addressing policy gaps. Results Government, service providers, media and other civil society groups, donors and beneficiaries were identified as contributing to MNCH-FP in urban areas. Study findings suggest that there is absence of coordination among ministries though each ministry has an individual mandate to provide health services for poor people. Sensitization of media and other civil society groups is important in efforts to hold stakeholders accountable to the needs of the poorest. Perhaps most critical is the development of a long-term urban health strategy that engages private, NGO and public sectors, works across health related ministries, and anticipates the emerging health needs of urban citizens. Conclusion Creating a dedicated governance structure on urban health with a mandate to coordinate among ministries and provide strategic leadership around implementation is needed, accompanied by supportive policy change.
Exploring the governance of the Guatemalan health system: power relations affecting decision-making and its implications for equity

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ABSTRACT

BACKGROUND: The governance of a health system is related to decision-making processes that affect directly or indirectly the health system. In Guatemala, despite a progressive legal framework and the promise of different elected governments to tackle health inequities and the social exclusion of indigenous populations, there have been few relevant changes and resource allocation to rural areas is stagnated. This study aimed to a) map-out institutional spaces and the actors that play a role in influencing the decision-making b) identify the mechanisms that actors use to exercise influence and their motivations. METHODS: A conceptual framework with four key variables was applied: a) actors b) power sources c) rules of the game d) transparency and accountability. Sources of information were in-depth individual interviews with key informants that have been involved in decision-making and secondary published data. Collected information was analyzed using ethnographic methods (power mapping, review of documents, legal framework and published data). RESULTS: The study identified twelve different actors that exercise influence in the decision-making process- the ministry of health being only one of those actors-which also include Parliamentarians, international cooperation agencies, medical and pharmaceutical industry, local governments, social movements and several others. By reviewing the legal framework, it was identified that seven of those actors exercise influence through non-formal and non-regulated procedures that might even be qualified as illegal. In addition, some actors have greater power resources to influence decision-making than others and several of them seek personal gains (i.e. contracts to sell medical supplies and medicines, hiring personnel loyal to their interests). CONCLUSION This exploratory study demonstrates that decision-making in health systems is a highly complex process with both technical and political features and with many vested interests which are not always supportive of the public good. SIGNIFICANCE FOR FIELD-BUILDING Using ethnographic methods to research power relations in health systems decision-making.
African Health Profession Regulatory Collaborative (ARC) for Nurses and Midwives: a learning community engaged in regulation strengthening in East Central and Southern Africa (ECSA)

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ABSTRACT

Purpose/focus: Health professional boards regulate health workers' training, licensure and practice, yet do so with limited resources. This has been apparent as increased reliance on task shifting of HIV services from doctors to nurses has generally occurred without regulation necessary to support these enhanced professional roles. ARC aims to strengthen regional standards, regulatory frameworks, organizational capacity and nursing and midwifery leadership in the ECSA region. ARC's breakthrough organizational change framework, adapted from the Institute for Healthcare Improvement, employs a short-term learning system interspersing learning sessions with action periods. ARC convenes regional meetings of the 17 ECSA countries, awards regulatory improvement grants, provides targeted technical assistance to grant implementation teams, and brings teams together for progress reports and mutual learning. The teams strategically represent the Ministry, the Registrar, the Professional Association and academe. In addition, the project is systematically evaluating project impact though a capability maturity matrix. Significance To our knowledge, this is the first regional approach to strengthening regulation and enhancing professional standards using a learning collaborative. Country teams' progress attests to the success of ARC's model. ARC's approach encourages country ownership of nationally-identified projects developed, proposed and implemented by country teams. It also fosters regulation stakeholder collaboration and strengthening of nursing and midwifery leadership. Likewise, it fosters south-to-south learning and capacity building; countries facing similar challenges learn from each other. Projects have resulted in health system strengthening in areas such as legal frameworks to support task sharing, updated scopes of practice, and continuing professional development mechanisms. ARC is a strategic investment in health systems and human resources capacity building and is funded by PEPFAR and the US Centers for Disease Control and Prevention (CDC). This model could be considered for adoption in other countries or regions, and even across different health cadres. Audience: Health professionals, educational institutions, ministries of health, health policy law experts, country legislators, and the public, the ultimate health system consumers.

Nelson, Iboro

ABSTRACT

Background: Twenty-two (22) years after the advent of HIV in Nigeria in 1987, the progressive increase in its prevalence coupled with the massive social change especially the number of orphan children affected and those made vulnerable by the epidemic, MSH with the support of USAID began implementation of community-based support for orphans and vulnerable children (CUBS) project to support Nigeria National Priority Agenda for Vulnerable Children. In Akwa Ibom State, the government had passed into law a bill on child right but a combination of factors such as high poverty level, fallen family and communal structures and values, illiteracy, superstitious belief in child witchcraft and the growing HIV epidemic over the years continued to expose children to greater health, social and psychological difficulties and risks. Methods: A major objective of the project is strengthening community structures to improve the well-being of the vulnerable households while providing community-based, family centered services. CSOs engaged by the project facilitated the establishment of Child Care Committees (CCC) as well as revival of Villages and Ward Development Committees to support advocacy and sensitization on emerging health and social issues within the communities. This aligns with one of the 8 priority areas of concern in the State Strategic Health Development Plan; community participation and ownership. Result: The outcome of the above have been community ownership of health and well-being of the children and increased leadership capacity for supporting high-impact health initiatives of the government including population use of insecticide treated bed nets especially for children under age 5 and pregnant women, exclusive breastfeeding practices, condom use for HIV prevention, etc. Conclusion: Strengthening community structures for managing health processes remains one approach to boosting the primary health care and positioning it to contribute to the improvements of the national health indicators.
Abstract

Background: Uganda's National Health Policy (2010-14) asserts that Health Unit Management Committees (HUMCs) - together with Village Health Teams (VHTs) - have helped to increase participation of beneficiaries in planning and monitoring of community health programs (Ministry of Health, 2009). This paper explores the experiences and perceptions of community stakeholders with regard to HUMCs as an institutional structure for their participation in health governance. In particular, the paper describes the situation of community participation through HUMCs, the mandate and status of HUMCs, as well as community and stakeholder perspectives on, and commitment to participation or facilitating community participation in health governance through HUMCs. Methods: This work has used participatory action research methods to engage grassroots communities, community health workers, members of HUMCs, health workers, health facility in-charges, program managers, as well as leaders at the community and local government levels in the districts of Kiboga and Kyankwanzi districts in central Uganda. The program of work has involved training and capacity-building; building networks; sharing of experiences; and testing local systems for participation. It has also involved student internships, regional meetings to share experiences and best practices in community participation in health system governance. Conclusion: The HUMC strategy to community participation in health system governance has created a potential conflict of interest by allowing health providers to be part of service monitoring structures. There is need for interventions to build capacities of HUMC members, local leaders, health workers and communities in order to identify and exploit opportunities for using HUMCs to realize the right of communities as beneficiaries of public health care to participate in the governance of the health system and realizing the right to health. Indeed, commitment to community participation in health governance needs to be matched by allocation of resources to facilitate HUMCs and other structures created for the purpose.
The role of interface played by health committees in west and central Africa

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ABSTRACT

Background: The Bamako Initiative (BI) aimed at achieving universal health coverage (UHC) through Primary Health Care (PHC), with among major principles community participation (CP) and strengthening management skills for Local Health System stakeholders. As part of the strategies for UHC, many African countries, established health committees as representatives of the communities and as the interface between communities and health services. In 2004, the world development report linked poor performance of the health services to a lack of accountability. The same report put emphasis on the way in which citizens foster quality services by requesting accounts of health care providers and decision-makers. Now that African countries are embracing UHC, CP comes back as a prerequisite for successful implementation of strategies for UHC. Methodology: In three countries (Benin/Democratic Republic of the Congo/Guinea), qualitative research of experiences with health committees was conducted in order to draw lessons on the use of Health committees as the interface and as an approach to improve social accountability. Data were collected through individual interviews, FGD, as well as observation document and record reviews. Results: The study shows the role of health committees as the link between health services and the communities, the influence they have on management of health services and their role in social accountability. The analysis includes: i) capacity of these committees to understand users’ expectations and to transmit these to health service providers ii) their role to improve acceptability of health services by the communities and iii) their tasks in accountability. The study also identifies good practices and lessons learned from health committees, daily experience as well as internal and external factors underlying these good practices. The results will facilitate better understanding of the health committees, role within the health system in order to reach UHC.
The VOICES initiative to strengthen Village Health Committees in two Indian states: findings of implementation research

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ABSTRACT

Introduction: India's 480,000 VHCs are crucial platforms for community engagement for health. Under the National Rural Health Mission, VHCs have been envisaged as local participatory bodies bringing frontline workers, local elected officials and community members together for planning, delivery and monitoring of health services. VHCs require strengthening through enabling institutional mechanisms and environments to realise the goal of better health action at community level. Methods: The findings reported are from the first phase of implementation research on an institutional support package to enhance community engagement in 100 villages in Rajasthan and Tamil Nadu. Research methods are primarily qualitative and draws on actor-centered implementation analysis. Data was collected through in-depth interviews, focus group discussions, observation and documentation of organisational processes and review of selected indicators on process and outcomes. Analysis follows the 'framework' approach, combining inductive and deductive process. Results: Study findings demonstrate the influence of policy and social contexts in determining the pathways and mechanisms for intensified community engagement. In Tamil Nadu, with a more hierarchical health systems, committees faced challenge from reflecting purely system priorities to becoming fora for articulating community voice and playing a larger social role moving beyond monitoring of a narrow package of core health services. Rajasthan, while having a policy environment more open to community engagement, faced hindrances from the social context of status of women and marginalised communities. Discussion: VHCs in both states require institutional support to understand their roles and responsibilities, and to function as institutions that are truly representative of communities and their interests. The pathways to strengthening them varies due to the health system and social contexts they are embedded in. The study contributes to new knowledge on community engagement by VHCs, and provide valuable comparative perspectives and evidence for scaling up institutional support for VHCs across geographies.
Enhancing governance and health system accountability for people centered healthcare; Potential of community scorecards in Afghanistan

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ABSTRACT

Background and Objective: The premise of patient centered care is to empower patients to become active participants in the care process and receive health services that are designed on their needs and preferences. Though Afghanistan has made enormous progress in ensuring coverage, service utilization and quality continues to be suboptimal, as evidenced in the balanced scorecard performance assessments. In the United States and other African and Asian communities, community scorecards (CSC) have demonstrated to enhance social and public accountability and responsiveness from service providers. This study was undertaken to determine the CSC feasibility in fragile contexts in Afghanistan, to jointly engage service providers and community to design patient centered services with the objective of demonstrating outcomes of perceived quality and service delivery. Methods Six NGO managed facilities were randomly selected in three provinces and communities in their catchment area were selected for the study. Employing a multi-stakeholder strategy, community leaders, members, councils, health providers, NGO managers, provincial directorates, etc were engaged in a 5 phase process to jointly identify structural and service delivery indicators, score performance and subsequently develop action plans for instituting improvements, through participatory research methods. Over 470 community members, 90 health providers, and 30 provincial ministry staff participated in the performance audits. Results: Structural capacity indicators including number and cadre of service providers, water and power supply, waiting rooms, essential medicines, equipment etc scored low in the first round (30-50%). Provider courtesy and quality of care received high scores (>90%). Unrealistic community demands for ambulance, specialists etc were mitigated by informing communities of their entitlements based on standards described in the essential package of services. The joint interface meeting facilitated transparent dialogue between community and providers and resulted in creative and participatory problem solving mechanisms. These results indicate the potential of the CSC as a promising social accountability tool for patient centered care.
Communities reclaim the Health system, making services
People-centred: Lessons from community monitoring and
planning of Health services in Maharashtra, India

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SATHI

ABSTRACT

Community based monitoring and planning (CBMP) of health services in Maharashtra state of India is a powerful participatory approach for improving accountability and quality of health services. Linked with widespread and significant impact, CBMP is now being implemented in nearly 1000 villages across 20 districts of Maharashtra, making it unique in the health sector in India. CBMP was launched in 2007 as part of the National Rural Health Mission framework in selected states. In Maharashtra the process has progressively expanded, being organized at village, PHC, block, district and state levels. Health officials, elected representatives, civil society organisations and community members participate in monitoring and planning committees at each level, where community awareness generation, regular community assessment of services with public report cards, action oriented dialogue in committees and mass public hearings are organised. Complementary community based planning aims to improve participation and appropriateness regarding use of health facility level funds. Multi-dimensional study of CBMP taking into account two major external evaluations, interviews of diverse stakeholders, documentation of stories of change, analysis of successive rounds of CBMP data, and patterns of utilisation of local budgets, validates substantial improvements in accountability, responsiveness and services across varied CBMP areas. Effective innovations identified as CBMP lessons: interactive methods to ensure rights based community participation; appropriate community feedback through relevant and user-friendly tools; regular multi-stakeholder dialogue and mass accountability events; chain of reinforcing actions across health system levels; coalition of rights oriented civil society organisations; system of entitlements with official sanction for community accountability; and positive engagement with providers. CBMP is now being generalised to new districts and villages, while being extended to child nutrition services. An approach enabling communities to substantially reorient Health system governance from below, making this people-centred, CBMP has significant potential for generalisation to other social settings and public services.
Promoting Governance and accountability through active citizen participation: A case study of the Mera Swasthya Meri Aawaz project (My Health My Voice)

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SAHAYOG, INDIA

ABSTRACT

I. Background Maternal mortality remains unacceptably high in many parts of India; at the same time ICT is increasingly being used to promote maternal health and mobile phones are viewed as effective means to address ‘demand side’ challenges to maternal health. However mobile phones have not been used to track service side barriers such as demands for illicit fees which act as a deterrent to access care. The Mera Swasthya Meri Aawaz (MSMA) project of SAHAYOG was designed to test whether an open-source software (Ushahidi) could be used to increase citizen-led activism in documenting illicit fees charged for maternal health care services that, should be free in Uttar Pradesh, India. This system was designed to enabled reporting of informal payments anonymously, thus ensuring witness protection. II. Methods Used With the visual evidence of the informal payments produced through Ushahidi, women's groups and SAHAYOG advocated for decreasing the practice of informal payments for maternal health services in government facilities. III. Findings i) Data shows that it was an acceptable method of monitoring, as is reflected in the 873 reports of illicit payments made at 40 public health facilities to the hotline between January 24th to May 24th 2013 ii) The project provided women with information and tools to strategize more systematic actions. iii) It was well received by health officials who found the technology appealing and took action to improve the situation IV. Discussions and Conclusion: i) The project proved that poor, rural women were able to use mobile phones to make confidential complaints thus bursting the myth that illiterate women could not use modern technology. ii) It enabled community women to call for accountability without being victimized as it provided anonymity. iii) Technological innovations alone are not sufficient to promote greater accountability - active citizens participation is need to stop illicit demands
Healthy Dialogue: Community based monitoring improves informed choice and quality of care of family planning services

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ABSTRACT

India started its national family planning programme in 1951. Distortions were introduced in the programme when an obsessive fear of population growth introduced coercive components like targets, incentives and penalties, and quality of care was given short shrift with rapidly conducted sterilisation camps. After signing on to the Program of Action of the International Conference on Population and Development, the Government of India made many changes in the way the family planning programme was designed and implemented. Method specific targets were abandoned, standard operating procedures and quality assurance mechanisms were introduced. Today the Government of India has shifted its programme focus from female sterilisation to a more spacing and temporary methods based approach. However India being a federal state the provincial governments determine the manner in which programmes are delivered on the ground and coercion, targets, a camp based approach and extremely poor quality continue to this day. This paper will describe the use of a community based monitoring methodology for understanding the quality of care and informed choice elements of the family planning programme in a selected number of districts in two of the most populous states in the country, Uttar Pradesh and Bihar. This methodology has been developed within the auspices of the National Rural Health Mission which includes community based monitoring as an integral component of community participation as well as of accountability mechanisms. The paper will describe the different components of this approach, which includes community entitlement awareness, community enquiry using participatory tools, the preparation of report cards summarising community experiences and sharing of this report card with health department authorities. The paper will discuss the results of the results of applying of this methodology and its relevance in improving the quality and bringing publicly provided health services closer to marginalised communities.
Fostering social accountability in the health services: A case of community based monitoring of health services in selected districts in South Africa

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ABSTRACT

Participatory civil processes have been shown to be effective in improving the quality of public services. Commonly known as social accountability, proactive involvement of ordinary citizens in the delivery of health services can potentially improve health outcomes. In South African, existing accountability mechanisms within the health system include clinic committees and use of suggestion boxes. However, these mechanisms rely on proactive public participation, which is often lacking. Moreover, clinic committee representatives are often nominated rather than proposed from the communities. It is against this backdrop that Soul City began implementing the community based monitoring (CBM) project which aims to improve the quality of health services through building the capacity and confidence of ordinary citizens to hold the services to account. The CBM project was implemented in 9 communities in 3 districts. Trained CBM teams were tasked with creating a system for monitoring the quality of services that they received at their local clinics. Within 3 months of operation, the CBM teams had encouraged other users of the services to rate their experiences and identify areas of improvement. The teams reported increased dialogue with facility management and clinic committees. Through this engagement, the teams began assisting in areas in which they felt they could contribute such as queue management, filing and administration, clearing and packing the pharmacy and holding exit interviews with patients. In another facility, CBM teams began addressing patient rudeness and impatience, which they felt contributed to the hostility of the clinic staff, encouraging patients to make use of the available mechanisms to voice their concerns. Overall the project has reported promising outcomes, with public enthusiasm and interest to better understand how the services function, the resources available and any gaps that exist. The CBM model has the potential to facilitate meaningful community participation in primary health care.
Access to quality health services in rural areas: Experience of the use of community score cards in three pilot regions in Burkina Faso

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ABSTRACT

In a context such as Burkina Faso where development challenges are enormous, where the institutions responsible for the control of public action are relatively weak and where the State is engaged in a process of decentralization, Participatory Monitoring and Evaluation (PM&E) can be a sustainable and effective way of improving people's access to quality social services, particularly in the health sector. Thus, a pilot PM&E project has been implemented since 2010 in three regions of Burkina Faso (the Cascades region, the Central Plateau region, and the Sahel region). The project objective is to strengthen the capacity of communities, through a series of activities, including training in the use of Community Score Cards (CSC), to get them to identify major problems in terms of health in their community, then through the CSC, to work on their resolution and better involvement of all stakeholders. In each region, three municipalities (total of 9) were selected for the implementation of the project. Since it is intended to check generalization of the findings of the pilot, an impact evaluation of the project is planned later on. Thus, three control municipalities were selected in each region, and a baseline study were conducted in the 18 municipalities. By using CSC, representatives of the community (Village Development Committee, Management Committees of Health Centers, etc.) are involved in the diagnosis, planning, monitoring and evaluation of health services. They highlight a number of problems in health and question the district medical officer and other local officials. In turn, these officials also have an opportunity, through regular meetings, to present the challenges they face and encourage more support of the population to health actions they take. The objective of the paper is to present the first lessons of this pilot experience of PM&E in rural areas in the health sector.
Changing the landscape of Health Systems through community engagement: Role of Community-Based Organizations in emergency referral for Maternal and Child Health in Middle Island, Myanmar

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ABSTRACT

Background: Middle Island in Myanmar was badly hit by the Cyclone Nargis in 2008. After the disaster, many Non Governmental Organizations (NGOs) implement and support for establishment of Community-Based Organizations to engage in health activities. The study aimed to describe the role of Village Health Committee (VHC) in community-based emergency referral for Maternal, Newborn and Child Health (MNCH). It also describes success, challenges and sustainability of VHCs.

Method: Cross-sectional study was conducted in Middle Island in 2013. Document review of records from 125 villages for three years; six focus group discussions with women; twelve in-depth interviews with mothers experienced of emergency referrals and 18 key informant interviews with Basic Health Staff (BHS), key persons from VHCs, volunteers and Save the Children staff were conducted.

Results: VHCs were formed with community members and volunteers after the Cyclone Nargis with funding support from Save the Children. Most respondents highlighted that health knowledge and access to health services improved after formation of VHCs. Numbers of emergency referrals increased about five times over three years. All emergency referral cases obtained supports (travel cost from VHC and free medical cost if hospitalized). Among 125 villages, 48 villages (38.4%) had community's contribution for VHC fund and they had well functioning VHCs. Strong commitment of community; and well coordination among VHCs, BHS and Save the Children were observed in well-functioning VHCs. Most common barriers for emergency referral were variations for defining emergency; over-demand of community for referral supports; and attitude of BHS.

Conclusion: Sustainability of VHCs depends on availability of funding, accountability for fund management, capacity of VHC members and stewardship of VHC activities by BHS. It is suggested encouraging community contribution to emergency health fund to obtain ownership of community. The findings from this study were taken up by Department of Health and implementing partners.
Improving the community's role in Health Systems
Strengthening through community core groups as illustrated
by behavior change towards marriage and births registrations
in DR Congo

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1 IMA World Health and Democratic Republic of Congo
2 IMA World Health and USA
3 Baertracks and Democratic Republic of Congo

ABSTRACT

Background Civil society groups are indispensable in Health Systems Strengthening. In eastern DR Congo, the Ushindi project emphasizes this critical element. Ushindi is a five-year USAID-funded project managed by IMA World Health to overcome Sexual and Gender-Based Violence (SGBV). The project assists a population of 1.1 million in ten health zones (HZ) using a holistic approach, including psychosocial, medical, legal and economic activities to support SGBV survivors. Ushindi uses an innovative model based on core community groups for changing the community's behaviors and increasing the rights of women and children through various interventions. One important activity is the promotion of civil recognition of births and marriages by registration with local authorities, i.e. through legal marriage and birth certificates which traditionally are neglected. Methods In 2013, IMA conducted a Mid-Term Evaluation, led by an external evaluator, to train its project personnel as a participatory evaluation team. The team's evaluation examined project activities from qualitative and quantitative perspectives. Results Quantitatively the team found that Ushindi made excellent progress in increasing access to SGBV care and treatment, including psychosocial counseling (58%), legal services (58%), medical care (53%) and economic re-insertion of survivors (45%). The team also learned anecdotally from local authorities about increases in marriage and birth registration. Intrigued by this qualitative finding, the team conducted a quantitative research of civil records and found that registration of marriage and births had increased by more than 400% in project-assisted HZs. Discussion/Conclusions To clarify whether this increase was due to project interventions or to external factors, data was compared between an assisted HZ (Komanda) and a neighboring unassisted HZ (Mambasa). The findings indicate a positive impact in project-assisted HZs. Ultimately, the increase of birth and marriage registration leads to healthier and safer lives for the survivors supported through this holistic SGBV project.
Civil society perspectives on policy and implementation of Indonesian maternal and child health programmes: a qualitative study

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ABSTRACT

Background: The UN Commission on Information and Accountability (COIA) recommended that each country develop an accountability framework that includes a strong role for Civil Society Organizations (CSOs) to improve policy and accountability for maternal and child health programmes. Since there is no formal mechanism for CSOs to fulfil this role, a coalition of Indonesian CSOs piloted an initiative to obtain the needed inputs. The coalition reviewed maternal and child health activities (MCH) in 2013 and then offered suggestions to government on improving related policy and accountability. A study explored the perspective of the participating CSOs with regard to this process. Method: A qualitative study was conducted through focus group discussions with representatives from CSOs, family empowerment and faith-based organisations as well as other relevant agencies. The study assessed the experience of participants in the development and monitoring of MCH programmes in 12 representative provinces of Indonesia. Results: CSOs viewed that while some local governments had useful MCH policies, the influence of civil society to ensure accountability was limited by lack of access to data and consultation with them. CSOs expressed the concern that local politicians are biased towards infrastructure development as compared to programmes with broad social benefits, while communities themselves are largely unaware of both the obligations of government to deliver good MCH services as well as their right to receive such services. Discussion: Civil society organisations may improve accountability for MCH programmes by strengthening grass-root participation in advocacy and monitoring of equitable results, especially for marginalised groups. At the same time, CSOs should more aggressively seek to obtain information on MCH policies and budgets, as is their right under Indonesian law. Increased grassroots participation and awareness coupled with better informed advocacy from civil society may be expected to improve accountability.
International nongovernmental organizations and health systems strengthening: Changing roles and expanding opportunities

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ABSTRACT

Purpose: Health-focused international nongovernmental organizations (INGOs) have the opportunity to strengthen national health systems. At the same time, INGOs sometimes engage in practices that weaken these systems, including creating management burdens through parallel systems of data collection and commodity distribution, and introducing distortions into local labor markets by hiring staff away from public systems. In May 2008, several INGOs created the NGO Code of Conduct for Health System Strengthening. Although the Code generated initial interest, its impact appears limited, with only 57 INGOs signing on to date. This research seeks to understand the most appropriate role for INGOs in health systems strengthening. Focus: This study asks how INGOs can help rather than harm national health systems. A comprehensive literature review identified evolving concepts regarding health systems strengthening and the changing role of INGOs. These concepts informed a mixed-methods study design, comprising an online survey of INGO staff members (headquarters- and country-based) and key informant interviews with INGO leaders and global health experts. The research explores factors preventing the NGO Code of Conduct from gaining momentum, and assesses the interplay between INGOs and other actors in the rapidly changing global health landscape. Significance: The research proposes opportunities for better application of the NGO Code of Conduct and modifications that may make it more useful, while shedding light on why more INGOs have not endorsed the Code. More research is needed on the practical application of the concept of country ownership, to ensure that ministries of health and governments are capable of managing health system coordination and that all actors, including INGOs, engage in systems strengthening. Target audience: This research will help INGOs, ministries of health, governmental stakeholders, and funding agencies engage in self-reflection and become more aware of challenges faced by INGOs, while helping INGOs safeguard against inadvertently doing harm.
The rhetoric of accountability: rethinking district management and leadership in complex health systems

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ABSTRACT

Purpose: As the interface between policy formulation and service delivery, district managers have multiple responsibilities for policy interpretation, resource deployment, and leadership. Much of their managerial obligation is to be accountable for realising district performance through appropriate planning, budgeting, and monitoring. Yet often, health system arrangements are not ordered to optimise this function. Frequently, weaknesses in district management and leadership are credited to individual competences rather than systemic bottlenecks. Thus, capacity strengthening interventions focus mainly on individual skills acquisition without considering organisational contexts to facilitate desired governance and leadership practice. In this presentation we share insights from ongoing research related to such issues, by exploring concepts of complex leadership as one way to better understand how the mismatch between health system arrangements and managerial mandates hinders responsiveness, accountability, and overall district performance. Content: In Ghana, district health systems are characterised by 'command-and-control' hierarchies where resource uncertainty is a significant feature of the organisational context. District managers are constrained by highly-centralised decision-making around human, financial and material resources, yet have moderate decision-space for programming. We borrow from complex leadership theory, which expands traditional management and leadership approaches beyond personal attributes of influence, towards more contextual constructs of management and leadership. Complex leadership acknowledges that managers cannot control for an unknowable future. At best, they become 'triggers' for enabling conditions that foster organisational creativity, learning and adaptability, and bridge the bureaucratic and bottom-up functions of the system. Such an analytic orientation centres district managers within the organisations they are embedded, and links their actions directly to the organisational structures which bind them. Thus management and leadership emerge as outcomes of systemic interactions. Field-building significance: Despite theoretical advancements, empirical evidence is limited. We propose further research to support the design of complex management and leadership interventions. Target audience: Researchers, policy-makers, managers, development partners.
Public accountability and the need for meta-governance: a study of District Health Management Teams in Ghana

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ABSTRACT

Background: In two local health systems in Ghana, I examined the accountability relations and practices of the Ghana Health Service management teams, framing these against the governance arrangements and relations with local authorities and INGOs. Significance field-building dimension: The study explores public accountability practices in a pluralistic local health system. Methods: Comparative case study design based on realist inquiry in Ghana, with data collection consisting of 83 in-depth interviews, review of policy documents and District Health Management Team and INGO annual reports and routine data. Results: None of the main actors achieved full public accountability. Both state and non-state actors have strong vertical accountability systems, but weak or absent systems to account to the public. This is due (at least in part) to the potential for a role conflict of the DHMT. The DHMT is formally mandated to oversee and coordinate all health actors and activities in the district and they are responsible for the performance of the health sector. Additionally, they manage first line health services, implement disease control programmes and the Community-based Health Planning and Services Initiative, a national policy to extend health services into the community. They also engage as partners with (I)NGOs, which allows them to fill gaps in service delivery or obtain additional resources. Discussion / conclusion: If the DHMT is responsible for health sector performance in pluralistic health systems - as is the case in Ghana - this means that also non-state actors (both private and (I)NGOs) need to be held accountable. Arguably, the local health system needs a meta-governor, or in other words, an actor that monitors and enforces effective accountability practices. This function must be framed in a commonly agreed governance framework that defines its mandate and role, but that also ensures that the public can effectively exercise its voice.
Does decentralized health management and leadership practices influence the performances of Community Health Fund? Experience from Iramba and Iringa Districts in Tanzania

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ABSTRACT

Introduction In early 1990s Tanzania introduced user fees in the health sector. To counteract the detrimental effects of the user fees, various types of health insurances were introduced, including Community Health Fund (CHF), which is a voluntary pre-payment scheme, targeting 85% of the rural population. While the country enrolment of the CHF is low (7.9%), there are marked variations among districts. This presentation underscores the role of decentralized health management and leadership practices in the uptake of the CHF in Tanzania. Methods A comparative study of good performing (Iramba) and poor performing (Iringa) districts was conducted. Questionnaire and in-depth interview were administered to the Council Health Management Team (CHMT); Council Health Service Board (CHSB); Health Facility Committees (HFCs); Health staff; and local government officials. Minutes and other documents were used to verify and triangulate the data. Thematic approach was used to analyse the data. Findings In Iramba, the CHMT established incentive schemes that are offered to health facilities in charge, CHF coordinator, HFCs, and the CHSB contrary to Iringa where health staff and committee members were lowly incentive. While, the CHMT in Iramba controlled drug stock-out through monitoring and auditing, in Iringa district, there was persistent drug stock-out. CHMT’s effective supervision of the health facilities and monthly meetings by the HFCs in Iramba as opposed to quarterly meetings in Iringa, contributed to marked variations in the CHF performance. Positive political support of the local government officials and constant sensitization of community made Iramba stay far ahead of Iringa with regard to the CHF performance. Conclusion Decentralization has provided some decision-making space for the CHMTs to improve health service management. The performance of the community-based health financing largely depends on the personal initiatives of the top-district health leaders, particularly the CHMT, CHSB and local government officials.
Does splitting districts harm public health system performance? Evidence from Uganda

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ABSTRACT

Background: Between 2005 and 2010 Uganda repeatedly split its 56 districts to create 114 districts. Each split created new administrative posts and required new infrastructure. The effect on health system performance is unknown. Methods: We used administrative data from Uganda’s HMIS system to assess health system performance using as key indicators: Antenatal visits, Institutional deliveries, DPT3, Cotrimoxazole, Fansidar, Condoms, and Outpatient attendances - all per 100,000 population. Fixed effects and OLS models regressed performance against having split last year controlling for time trends. Results: Becoming a newly split district in the last year led to statistically significant declines in rates of antenatal visits and institutional deliveries, HIV positive deliveries. There were statistically significant increases in total under-five outpatient attendances, DPT3 coverage, condom distribution, and deworming. No statistically significant change was observed in coverage with new attendances for under-5 children, ARV therapy, cotrimoxazole, or fansidar coverage rates per 100,000. Discussion: Hardships faced by fledgling district had their greatest effect on maternal health service delivery. District managers were able to adapt to improve coverage in child health interventions after splitting. The analysis is limited by possible under-reporting of district performance and the short time span of the observations. We explore the extent to which people-centered deliberation is used to adapt to system change through related qualitative work. Conclusions: Splitting effects on new district performance varied across districts and lines of service. District managers leveraged people-centered processes, such as public-private partnerships, to cope with imposed changes and related challenges. We encourage input from district health leaders to describe mechanisms used for coping. Significance for field building: A major restructuring of the Ugandan health system led to adaptation. Local managers coped well with change. More attention to the processes used to cope will reveal how much they have responded to the needs of the community.
Bottleneck reduction and increases in coverage of integrated community case management using a participatory District Health Systems Strengthening approach in Diema district, Mali

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ABSTRACT

Background The Ministry of Health in Mali and partners have trained over 2,000 community health agents (CHAs) to deliver integrated community case management for diarrhoea, malaria, and pneumonia to children 2-59 months. To support this, District Health Teams were trained in an iterative District Health Systems Strengthening (DHSS) process, including 1) review of the potential impact of interventions provided by CHAs 2) data collection for tracer interventions 3) participatory bottleneck and root-cause analysis, and identification of corrective actions with local stakeholders and 4) implementation of corrective actions. The aim was to trigger corrective actions in order to reduce bottlenecks and improve coverage of interventions provided by CHAs. Methods A pre/post design without comparison groups was used in Diema district. Data from two successive DHSS iterations were collected using LQAS surveys of CHAs and households, and documentation from the District Health Team meetings with community stakeholders on bottleneck and root-cause analyses, and corrective actions. Results In the first DHSS iteration, low careseeking to CHAs was identified as the main bottleneck. Root causes included financial barriers, weak demand generation, and low supervision of CHAs. District and community stakeholders reduced consultation fees for curative services by two-thirds, undertook social mobilization, and reinforced monthly supervision of CHAs. After six months of implementation, caregivers reporting financial barriers as the main barrier to careseeking declined from 83% (CI 76%-90%) to 53% (CI 43%-63%), careseeking to CHAs for fever improved from 37% (CI 27%-47%) to 79% (CI 70%-88%) and treatment by CHAs with ACTs within 24 hours of the onset of illness improved from 8% (CI 2%-14%) to 32% (CI 22%-42%) with similar results observed for diarrhoea and suspected pneumonia. Conclusions The DHSS approach, particularly participatory analyses, enhanced decision-making at district and community levels and contributed to significant improvements in careseeking and timely treatment by CHAs.
A rational-planning approach to village health worker placement for strengthening community-based provision in Myanmar: an exploratory study

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ABSTRACT

Background With its context of ongoing political reforms, Myanmar faces substantial health challenges - including maternal, infectious, nutritional and increasingly also chronic disease - and lags behind its neighbours in progress towards health-related Millennium Development Goals. To help address health-system challenges including weak infrastructure, costs, health-worker shortages, remoteness and rurality, non-state providers have supported government task-shifting to community-based workers and broadened access to essential services. However, existing community-based provision has proven to be resource intensive and unsustainable for non-state providers. This study explores factors affecting village health-worker (VHW) usage in Myanmar and how a rational-planning approach might improve VHW placement and service sustainability.

Methods A literature review, indicating distance (e.g. from a VHW or health facility) and density (i.e. VHW:population ratio) as candidate measures for a rational-planning approach, was used to inform interview guides. In-depth interviews were conducted at community (i.e. 54 service-users, 15 VHWs, 8 village committees) and national levels (i.e. 14 programme managers) and analysed thematically. ArcGIS software was used for spatial modelling of proposed changes to VHW placement.

Results Little has been published on rational planning in resource-constrained settings or on the Myanmar health system. Community-level interviews showed distance as primary and density secondary in choosing healthcare. Decisions were moderated by perceived acceptability, particularly trust or familiarity, which sometimes superseded accessibility considerations. National-level interviews highlighted concerns about rational-planning approaches and task-shifting generally. Initial spatial modelling highlighted efficiency gains from rational VHW placement.

Conclusions Findings support the relevance of distance (i.e. accessibility), density (i.e. availability), and acceptability as criteria for VHW placement in this setting and contribute to broader debates on human-resource planning for people-centred services in resource-constrained settings. Further study is needed on measuring success, to ensure planning reduces costs of provision without reducing acceptability, accessibility and responsiveness significantly.
Scaling up community participation for Health in Chhattisgarh, India: A Realist Exploration

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ABSTRACT

Background: Community participation for health (CPH) encompasses a range of actions involving citizens and communities in planning and delivering health services, holding them accountable, and mobilizing demand. CPH is increasingly recognized as being essential to the achievement of Universal Health Coverage, especially in Low and Middle Income Countries (LMIC), yet there are few reports of CPH being successfully undertaken at a large scale. We undertook a retrospective study on the decade-long experience (2002-2012) of Chhattisgarh state, India, of supporting CPH at scale. Methods: We undertook a retrospective realist evaluation study to understand the 1) mechanisms through which, and 2) contexts in which CPH had been scaled up in that state. Qualitative research methods were employed, including policy document review (n=40), in-depth interviews with health system actors and community stakeholders (n=79) and focus group discussions (n=6) with community health workers. Data were analysed thematically following the ‘framework’ approach. Results: Our analysis revealed interlinked mechanisms and contexts of scaling-up CPH. The formation of a new state in 2000 reportedly provided a favourable environment for governance innovations, such as the creation of a State Health Resource Centre (SHRC) - a 'hybrid' organization involving state and non-state institutions. Multiple constituencies including the state bureaucracy, NGOs and aid agencies, were engaged in creating and supporting the SHRC and its programmes. Programme goals and operations tended to be explicitly aligned with broader, local agendas of community mobilization. The SHRC's attempts to recruit, and equip personnel with technical as well as softer 'social' skills were helpful in sustaining community engagement. Finally, conscious efforts to ensure bipartisan political support facilitated endorsement of the programme across political regimes Discussion: A combination of relevant mechanisms and contexts for scaling up CPH were elicited. This investigation produced a useful set of themes for further testing in other LMIC settings.
Good governance at grassroots, a strong link for community health intervention: A case study from rural Tanzania

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ABSTRACT

Background Tanzania has been implementing decentralization by devolution strategy for three decades, a system which entails the transfer of powers, functional responsibilities and resources to local government authorities. While the strategy is commended for its contribution to health sector and Millennium development goals the role of grassroot governance bodies is rarely investigated. A trial on Community Health Agents (CHA) is underway in three rural district of Tanzania testing hypothesis that deploying well trained Community Health Workers with salary and systems support will accelerate attainment of MDGs 4 & 5. CHAs deliver package of Maternal, Neonatal and Child Health services including integrated community case management.

Methods We conducted longitudinal qualitative studies to examine implementation effectiveness for CHA intervention. These comprised of 56 in-depth interviews and 15 Focus Group Discussions from June-July 2012; followed by 35 interviews and 2 focus groups a year later. Participants included CHAs, CHA supervisors, health providers, village leaders, men with children under 5 and women with children under age 1. We also reviewed implementation records. Results Governance at village level emerged as a contextual factors affecting the intervention. Village council and village assembly provided convenient contact point for organizing and executing CHA recruitment, CHA selection and promoting acceptance of intervention. Good relations between leaders and community were associated with better attendance in village assembly where all residents aged 18 years and above meet to discuss matters of local importance. Village assemblies were utilized for informing and reassuring communities on interventions safety, clarifying misconceptions and mobilizing resources. ‘Supportive’ and ‘trustworthy’ leaders invited CHAs to participate in village council plans, let them address community during village assembly and helped with solving daily challenges compared to villages whose leaders were perceived as uncooperative or untrustworthy. Conclusion Good governance at grassroot level important for effective implementation of community interventions.
Enhanced participation in preparing and ownership of district annual plans by community health workers, through the introduction of evidence-based planning in Indonesia and the Philippines

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ABSTRACT

Background: Community health workers frequently report disengagement from annual planning and budgeting processes, and lack supervision. Accordingly, their attention to local data collection and quantitative program appraisal is often weak. Evidence-based planning (EBP) encourages the collection and use of local health status and program indicators to inform health planning, and the ownership of this data and these plans by grassroots personnel. We report on improved community health worker engagement during two-year pilots of EBP of maternal and child health (MCH) services in Indonesia and the Philippines. Method: EBP has been piloted in three districts in Papua, Indonesia and three cities in the Philippines since 2012. Local academics and health personnel were trained to facilitate data collection and use, to inform prioritisation and budget allocation, according to perceived local needs. Local government support was sought and evaluated. Qualitative and quantitative appraisal of EBP has been undertaken both independently and by program staff. Results: Local community- and clinic-based health personnel greatly appreciated the increased engagement involved in their participation. The process required heightened understanding and ownership of data collected and decisions made. Moreover, many of the newly-prioritised interventions specifically improved health human resources, better preparing them for participation and enhancing career planning. Official government support for EBP (letters, funding, committees etc.) official was evident in most locations, auguring well for its sustainability. Discussion: EBP is an approach to sub-national health planning that improves the engagement and, potentially, morale of community-based personnel. Our two-year pilot in rural and urban areas of two south-east Asian nations indicates that it is feasible and should be sustainable, provided local government support and capacity to facilitate the process is maintained. A longer-term impact on the collection and quality of health program performance data and community health status indicators is anticipated, through the enhanced participation of local personnel.
ABSTRACT

Objective The paper will compare a selection of health and social care systems to summarize the regional experiences, to identify the key lessons learnt and to propose policies for integrated social and health systems development for ageing populations. Scope Current policies of health and social care systems will be compared across the fastest ageing populations in the leading economies of Asia (Japan, Singapore, Hong Kong, Korea and Taiwan), within the context of rapid demographic, epidemiological and socio-economic transitions. Methodology This is developed as part of an NUS Initiative for Health in Asia (NIHA) project for comparative health policies and systems in Asia. Data Sources - A common conceptual framework of comparative systems and policies is adopted, using a standardized format to report data of health and social care systems. An initial screening process consisted of a comprehensive review of the literature and secondary sources to select key national health and social care policies for further comparisons. Comparative Systems Analysis - The detailed studies are supplemented and validated with data obtained directly from the countries concerned and by identified key informants who are national experts or members of existing health policy/health systems research networks. Results A general classification of policies and systems to respond to the health and social needs of the ageing population is constructed according to the systems components of provision; financing; regulation; and stewardship (governance), the degree of integrating vertical levels (primary prevention; acute; intermediate and long term care) and horizontal sectors (public; private and voluntary). A typology of common challenges and policy responses are generalized within the contexts of the different systems. Evaluative criteria are also proposed to compare the long term effects of these policies on health and social care systems in terms of efficiency, equity, quality and sustainability.
Development of a composite indicator to measure the extent of Universal Health Care in India

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ABSTRACT

Background: Provision of Universal Health Care (UHC) is considered as a major health policy goal in many low and middle income countries. We developed a methodology to compute single composite indicator to measure the extent of UHC in India. Methods: Data from a large scale cross-sectional household survey covering more than 275,000 individuals in Haryana state was used to estimate the coverage of various services which are being considered to be essential for inclusion in the benefit package in India. The services covered maternal health, child health, family planning, under-5 child care services and curative care. Services of both preventive and curative nature were covered. Financial risk protection and quality of care indicators were also included. In order to account for wealth-based distributional differences in service coverage, concentration index and inequality-adjusted service coverage was estimated for each indicator. These indicators were aggregated into a Composite UHC Indicator (CUHCI) using two methodologies - geometric mean; and weighted average in which weights are derived by applying factor analysis and multiple linear regression. All 21 districts in Haryana state were ranked based on the CUHCI. Sensitivity analysis was performed to estimate the effect of individual indicators and weighting on the Composite UHC Indicator (CUHCI). Results: Inequality-adjusted coverage of complete antenatal care, full immunization among 12-23 months children and institutional care for delivery were 20%, 64% and 77% respectively. Increase in poverty headcount (at $1.25 PPP) and catastrophic health expenditures as a result of hospitalization was 15% and 27% respectively. Overall coverage of UHC ranged from 12% in Mewat district to 70% in Kurukshetra district. Although there is high correlation between the CUHCI among unweighted and weighted estimates (r=0.74), district rankings changed significantly. Conclusion: Measurement of a composite indicator of UHC remains a useful metric for assessing progress of various strategies to universalize health care.
Methods for understanding interplay between Public Perceptions, Utilization and Quality in Health Systems

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ABSTRACT

Developing people-centered health systems requires understanding the interplay between the quality of services provided and how the public perceives these services. The Cambodia Health Markets Study, part of a larger research initiative first implemented in India and currently in the field in Lebanon, has 3 components: (i) Participatory Resource Assessment (PRA) where all providers serving sampled villages were mapped, geocoded and assigned unique codes. (ii) Household survey that includes details of inpatient-, outpatient-, and pregnancy-related utilization of health services, as well as detailed modules on perception of services linked to specific providers coded in the PRA. (iii) A Quality of care study that measures adherence to checklists, treatments, diagnoses and fees through 1) Facility Surveys; 2) Medical vignettes in which hypothetical medical cases are posed to a provider; 3) Participant observations in which an enumerator observes real interactions between the provider and patients; and 4) Patient exit surveys, short questionnaires administered to patients observed during the participant observations. Of those identified as doctors in Cambodia, 55% had no formal medical training. The average village market was served by 6.2 private, 1.3 public, and 4.3 public paramedical staff. MCH care was largely sought in public facilities, whereas 75% of visits for illness or injury were in the private sector, half of which were to untrained providers. The key reason for choosing a particular facility was recommendation from a friend or perception of better quality of services and was not related to actual quality of services. While quality of care was poor in both sectors, the private sector better met patient's expectations including unnecessary demand for IVs and injections. Our research presents an innovative method for understanding health markets as a whole in resource poor settings and has implications for targeting interventions, regulating and licensing dual practice, and improving quality of care.
Taking a health systems perspective in the evaluation of a new first-line regimen for tuberculosis

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ABSTRACT

Background Cost-effectiveness analyses are often required to support the programmatic adoption of new technologies. However many fail to take into account how health care provider and patient behaviours in the ‘real world’ impact both costs and effectiveness of new technologies. Using the example of a new shortened TB regimen, REMox, we outline different approaches to including health systems in the estimates of cost-effectiveness by comparing results with full guideline adherence to those with non-adherence by patients and providers. Methods Comparison of individual-level simulations of a cohort of TB patients in four countries (Bangladesh, Tanzania, Brazil, South Africa), including empirically collected data on costs and local practice statistics. Results Overall, the introduction of a shortened new first-line TB treatment in these countries will likely be cost-effective. However, the magnitude of the predicted cost savings from a health system perspective will vary according to health system performance. These cost savings resulting from a reduction in the length of treatment are larger where guidelines are adhered to - which may balance investments in interventions to support patient and health worker adherence to guidelines. For example, in South Africa, cost savings increased from US$13 mean cost per patient to US$225 as guidelines were adhered to. This trade-off tends to be more pronounced in countries where the health systems costs are higher and also where community-based treatment is less available. Discussion/conclusion We argue that economic evaluations of new technologies should present results for different implementation scenarios aiming to inform different levels of policy making - and provide guidance on the types of health systems investments required to support new technologies. At a global level, guidelines or internationally accepted policy targets might provide a suitable framework for recommendations. However, local policy makers will be better served if economic evaluations build real world health system constraints into the analysis.
Community participation in health systems for responsiveness: program-based research in Asia, Africa and Latin America

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ABSTRACT

Purpose: To make health systems more responsive to the needs of vulnerable communities where the burden of disease is highest, systems of collaboration between communities and health systems are needed. Focus: Systems of collaboration for governance and mutual accountability can build on existing social and political structures as well as catalyze new forms of interaction that can be institutionalized to make health systems more responsive. Significance: To help governments assess the effectiveness of different collaboration models that can be institutionalized, USAID’s Child Survival and Health Grants program is supporting operations research embedded in programmatic settings in Liberia, Benin, Bangladesh and Guatemala implemented by international NGOs. Various research designs and examples of the use of findings for policy decisions will be presented. This will stimulate a discussion of implementation research designs in real-world settings that lead to informed policy decisions for community collaboration. In Guatemala, communities are participating in collecting and analyzing data to ensure effective health system decisions about targeting resources and services in a culturally appropriate manner; and monitoring for continuous quality improvement and timely decision-making. In Liberia, communities are participating in instituting and sustaining Maternity Waiting Homes, where pregnant women await delivery near health facilities, to increase the proportion of women who deliver in a facility and facilitate timely access to quality MNC services for women and their newborns. In Bangladesh, to improve collaboration between private and public systems, a new approach called the Peoples’ Institution Models’a community-based organization (CBO) comprising several smaller women’ s and men’ s groups is working to organize and mobilize communities for health and social change. In Benin, community participation in an Improvement Collaborative is being implemented to improve the performance and retention of CHWs for a sustainable community health system and improving child health outcomes.
Documenting the implementation of the revised Community Health Fund (CHF) scheme in the Dodoma region of Tanzania: a mixed methods study protocol

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ABSTRACT

Introduction: Process evaluation of complex public health interventions helps to open the 'black box' when determining the impact of such interventions. Process evaluation is rare in the Micro Health Insurance (MHI) domain; in particular in relation to the assessment of innovations aimed at improving enrollment rates. Understanding implementation processes of innovations that address wider determinants of enrollment in MHI schemes might help to improve enrollment rates. Our aim is to describe the protocol of a study that systematically evaluates the processes of implementing an innovatively redesigned CHF program in seven districts of the Dodoma region of Tanzania. Methods: The study is grounded by a conceptual framework which rests on the Diffusion of Innovation Theory and the Implementation Fidelity Framework. This study employs a mixed methods design to understand the implementation processes of the intervention. The study utilizes multiple data collection tools (questionnaire, Focus group discussion, in-depth interviews and document review) and aligns the evaluation to the Theory of Intervention (ToI) developed by the research team. We will quantitatively measure program adoption, implementation fidelity and their determinants. Data will be collected from implementers at program (N=12), district (N=36) and village (N=300) levels. We will conduct qualitative exploration of responses of stakeholders to the intervention, contextual factors and moderators of adoption, implementation fidelity and sustainability. Using STATA 13, both descriptive and bivariate analysis of variables will be done. Qualitative data analysis will utilize the Framework method assisted by Nvivo software. Conclusion: This research is set to contribute to the understanding of the processes of implementing MHI interventions and helps to place the results of the intervention in context. In addition, it might help to inform future roll out of the intervention.
The Context Assessment for Community Health tool - investigating why what works where in low- and middle-income settings

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ABSTRACT

BACKGROUND: The gap between what is known and what is practiced results in patients not benefitting from advances in healthcare and unnecessary costs for clients and health systems. The Promoting Action on Research Implementation in Health Services (PARIHS) framework posits three elements influencing successful implementation of new knowledge (1) evidence, (2) context in terms of coping with change, and (3) facilitation needed to ensure change. A strong context is considered key to warrant an environment receptive to change. Tools for systematic mapping of aspects of context influencing implementation of new knowledge has been developed for and are being used in high-income settings. METHODS: The development of the Context Assessment for Community health (COACH) tool departed from the PARIHS framework. Earlier no tools for systematic assessment of context were available for low- and middle-income settings. The development of the COACH tool was undertaken in Bangladesh, Vietnam, Uganda, South Africa, and Nicaragua in six phases; (1) Defining dimensions and draft tool development, (2) Content validity amongst in-country expert panels, (3) Content validity amongst international experts, (4) Response process, (5) Translation and (6) Evaluation of psychometric properties amongst 690 health-workers in the five settings. The tool has been validated for use amongst physicians, nurse/midwives and community health workers. RESULTS: The COACH tool has 49 items and measures the following eight aspects of context: Leadership, Work culture, Monitoring services for action, Sources of information, Resources, Community engagement, Commitment to work and Informal payment. CONCLUSION: We foresee that the tool can be applied to; (1) address and act on locally identified shortcomings of the health system to increase effectiveness for health system strengthening, (2) guide planning and promote adaptation of interventions to the local context in low-income settings and (3) evaluate, understand and compare process and outcome indicators of healthcare interventions.
How does responsiveness reporting behaviour differ for different social groups and what does this mean for equity measures? Results from cross-sectional household survey data from 64 countries

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ABSTRACT

Health system responsiveness encompasses attributes of health system encounters, from the user's perspective, in eight domains: being treated with dignity, autonomy (involvement in decision-making), confidentiality, clear communication, prompt attention, access to social support, quality of basic amenities and choice of providers. A spectrum of methodological research has demonstrated the feasibility of measuring health system responsiveness. Within this field, there is increasing focus on the measurement of reporting behaviour heterogeneity, which refers to non-random differential use of the reporting scale, unrelated to the object measured. Reporting heterogeneity compromises comparability across countries and between population subgroups, with important implications for equity assessments. This paper describes a systematic approach to studying reporting behaviour with a focus on individual-level variables, while taking into country level dependency. Data were extracted from 150,000 respondents and 40 vignette questions across 8 domains in 64 countries from the World Health Organization's World Health Survey. Assessing reporting behaviour asked whether a sub-group's responses could be explained by their use of a contracted, elongated or shifted scale. For the final 8 variables tested (sex; age; education; marital status; use of inpatient services; perceived health (own); caring for close family or friends with a chronic illness; the importance of responsiveness compared with other health system goals), there were stronger, more frequent patterns of scale elongation or contraction, than scale shifts. A factor's pattern of effect on the scale more often has the same form across domains. The strongest effects were for education, health state, familiarity with caring for friends or relatives with chronic health conditions, and the importance of responsiveness. Prompt attention, quality of basic amenities and confidentiality domains have covariate's effects that are particularly country-dependent. Comparisons between groups differing in education should be undertaken with caution. But stratified analyses and other simple techniques can be used to ensure robust assessments of equity in responsiveness.
Do academic knowledge brokers exist? An exploration of research-to-policy networks of faculty from six Schools of Public Health in Kenya

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ABSTRACT

Introduction: The potential for academic researchers to facilitate knowledge exchange and policy influence is advancing. Anecdotal evidence infers that faculty at Schools of Public Health (SPHs) have been recognized as playing a knowledge brokering (KB) role and serving as agencies of and for development. However, the empirical evidence for this role remains undocumented. Methods: Using a census approach, we administered sociometric surveys to academic faculty across six SPHs in Kenya. Academic KBs were identified using Social Network Analysis (SNA) in a two-step approach: First - by ranking individuals based on 1) Number of policymakers they know; 2) Number of peers who report seeking them out for advice on knowledge translation; and 3) Their position in the network as 'connectors' between researchers and policymakers. Then - by triangulating the three scores and re-ranking individuals. Those scoring within the top decile across all three measures were considered KBs. Results: Using SNA, we identified 7 KBs out of 124 full time faculty who participated in the survey. They represented 4 SPHS, only 1 was female, and 3 held positions of leadership. Those scoring high on the first measure were not necessarily the same individuals scoring high on the second. Participants were also situated in a wide range along the ‘connector’ measure. Conclusion: Academic KBs do exist in Kenya and SNA is a valuable tool in identifying them. We propose that a combination of three scores, rather than reliance on the traditional use of ‘connector score,’ captures the nuances of these roles. Varying scores on each metric within faculty indicate varying strengths in their individual networks - with some more established than others. This has implications for Kenyan SPHs interested in building capacity for KBs, leveraging existing KBs, and building coalitions so as to contribute to evidence-informed health policies and ultimately people-centered health systems.
Reframing the role of the media in knowledge translation:
Exploring mass media and journalists' potential in Sub-Saharan African context

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ABSTRACT

The role of mass media in knowledge translation for evidence-informed health policy-making is largely unexplored, especially in low- and middle-income countries. This study aims at exploring knowledge translation practitioners’ perceptions on the mass media and journalists' potential roles in promoting evidence-informed health policy-making. Key-informant interviews were conducted with members of established knowledge translation platforms in seven Sub-Saharan African countries. Data analysis was carried out as qualitative content analysis, following an inductive reasoning. Knowledge translation practitioners had a variety of perceptions on the involvement of journalists, as representatives of the mass media, in promoting evidence-informed health policy-making. Journalists were seen as transmission channels for knowledge translation relevant information, but also as media experts who could use their expertise or the tools they can access to improve knowledge translation platforms’ functioning. When perceived as equal partners, therefore, as sources of knowledge for the evidence-informed health policy-making processes, journalists were seen as knowledge translation 'doers' whose involvement could potentially advance this field. Resulting from these findings is a conceptual framework that integrates knowledge translation and communication theory, helps clarify the role of journalists as stakeholders in evidence-informed health policy-making and provides insight into the functioning of knowledge translation platforms. Further research is needed to evaluate the practical relevance of this framework, targeted at knowledge translation practitioners, as well as to clarify the mass media and journalists' potential role in promoting socially participatory evidence-informed health decision-making and policy-making.
Local partnerships for global challenges: Lessons from local intersectoral work for tobacco control and health promotion

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ABSTRACT

Abstract Purpose/ Objective: Globally there has been a growing momentum towards including Health in all policies. Tobacco control is one such area of public health where this concept has been utilized by many advocates to further the goal of health promotion. In 2011 six millions people died due to tobacco use of which nearly 80% were from low and middle income countries. These countries offer tobacco industry a safe haven due to their struggling economies and weak tobacco control legislations. India has strong tobacco control legislation more than a decade old, but implementation of the same is lacking. Our goal was reduction in prevalence of tobacco users and protecting people from the associated morbidity. Technical content Mid and high level administrative/ political, media and legal advocacy were the main tools utilized. The key actors affected directly or indirectly by our work included tobacco users, non-users, law enforcers, political class, bureaucrats, legal experts, media in various forms, empowered patient groups, networks of other NGOs/ individuals working in the field of tobacco control etc. This rich interaction at state, district and local level was a key determinant for health promotion in our experience of tobacco control. Target audience Health advocates working on various public health issues, policy makers, researchers to help translate science into policy and action, self help group representatives. Significance Our work has helped understand the dynamics of inter-sectoral work from the bottom up as well as the top down approach. What have been the effects of focused efforts to ensure stringent implementation of a law on various actors of the system? How steps and decisions taken by individuals within the system bring about impactful changes? We want to share with a wider audience these and other learning from our experience of local inter-sectoral people centered action.
Data visualisation: Making health systems data accessible to support people-centred health systems

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ABSTRACT

Purpose Tailoring health systems to individual needs will require more data than ever. But simply having data isn't enough -- we must also make this information available to relevant stakeholders in an easily accessible format. Effective data visualisation can: help us to understand trends and patterns on both the supply and demand sides of health systems; help pinpoint health systems gaps and support decision-making processes; support stronger accountability to the end-users of the system; and help users to navigate their way through complex health systems. Focus This presentation will focus on GoogleFusion Tables as a simple mechanism to support data visualisation and accessibility. It will examine several examples of how social network mapping and geographic mapping have informed decision-making processes in health system strengthening as a means to demonstrate how other researchers can also use the tool. Significance Knowledge is power - and yet information asymmetry is rife in health systems. Using innovative techniques to make data about health systems available and engaging to wider audiences can help to break down those knowledge and power asymmetries, which can facilitate the advancement of more responsive, accountable and people-centred health systems. And while health systems researchers currently have increasing data sets, our ability to visualise and understand these data remains basic, and the data often remain hidden from the end-users of the health system. This session aims to be a first step in changing this situation. Target audience This presentation will be particularly relevant to researchers and research communicators and other knowledge intermediaries interested in making large data sets available and meaningful to a wider audience, such as policy makers and the news media.
ABSTRACT

The potential of community health workers (CHW) to strengthen health systems is clear; however, often their introduction is incompatible with the wider health systems and community structures. CHW projects may sustain better access and demand for interventions, but their impact wanes at scale when scale up loses the programmatic ingredients of pilot success. Community-based family planning programs are susceptible to these ends. They are commonly integrated into maternal and child service modalities; their effectiveness depends on the referral-level services and actions which mitigate constraining contextual factors, but difficult to replicate at scale. This paper describes an approach for addressing those challenges in a community-based family planning project in rural Tanzania. In 2013, the Ifakara Health Institute (IHI) launched a program for introducing the injectable contraceptive, depo-medroxyprogesterone acetate (DMPA) into the work package of a CHW worker cadre known as Wahudumu wa Afya ya Jamii, WAJA. Implementation shifted away from single method promotion to emphasize people-centered care coherent with the wider community structures and health system. This focused on quality of care, reproductive choice, users' perspectives and needs, program management and service delivery systems and social context. Formative research guided program planning and the formation of facilitation teams in districts and learning communities. There, participatory processes led to strategies for sustaining community participation and support linkages with the formal health system. Program monitoring and quality assurance methods were used to study service quality, client and stakeholder perceptions and experiences with task-shifting DMPA, adherence to action plans on community participation and health system support linkages, and the implications of method introduction on management and service delivery systems. Facilitation teams led dissemations at district and national levels, providing a platform for knowledge transfer and planning for scaling up DMPA task shifting. The outcomes and implications of this approach are reviewed and discussed.
Clustering of care facilities: participatory decision making for improving emergency obstetric care facilities distribution in Maluku Tenggara Barat (MTB) District, Indonesia

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ABSTRACT

Background: In an archipelago country with huge geographical and climate barriers such as Indonesia, it is a challenge to determine number and distribution of Emergency Obstetric Care (EmOC) facilities. Participatory decision making (PDM) method provides a way to find a locally-appropriate criteria for facility distribution. This study describes PDM processes in re-organizing EmOC facilities in Maluku Tenggara Barat (MTB) District, Indonesia. Method: Four workshops were conducted between 2008-2009 to seek a consensus on the criteria of clustering population and islands and determining the geographic allocation of EmOC facilities. All key stakeholders at district and sub-district level, including traditional and religious leaders, were involved. The results were compared with those from Service Availability Mapping (SAM). Result: Workshop participants identified the following criteria to be considered in the clustering of population and islands: geographical proximity, readiness of the facilities, cultural similarity, natural resources and economic potential, and community preference to travel. Two island-clusters with one comprehensive EmOC facility in each cluster were formed. Each cluster covered 30-70 thousand people spreading over hundreds of islands. Within each cluster, one or two basic EmOC facility was set at strategically-separated islands. Results from the PDM conformed with those of SAM, which showed a proper distribution of EmOC facilities within 50 km2 coverage. The number of maternal complication treated had increased almost doubled in 2013 compared to 2009. Barriers during the PDM included lack of knowledge and conflict of interests among the stakeholders. Negotiation and persuasive communication continuously took place to overcome the barriers. Conclusion: Participatory approach may act as a reliable tool in decision-making processes especially for area-specific problems. Further study is required to determine the effectiveness of current EmOC facility distribution to reach the most deprived women. Target audience: Stakeholders in developing countries with similar geographical barriers.
ABSTRACT

Objectives: The goal of this project was to understand the perspectives and attitudes of Argentine health researchers regarding the use and impact of health research in policy-making in Argentina, and explore how research might successfully be translated into health policy. Design/methods: This study used 20 semi-structured, in-depth qualitative interviews which were conducted in Argentina's rural northwest and the capital of Buenos Aires. Interviews were analysed by inductive thematic coding and memo-writing. Results: Researchers discussed their personal experiences with research-to-policy mechanisms, their understanding of the ingredients of policymaking and the role of trust in knowledge translation. Barriers and facilitators were found to be nested within a hierarchical model including political governance, bureaucratic processes, institutions, communities of practice and, at the individual-level, researcher capacity and research availability. Trust and determinants of research availability, as well as the Argentine socio-political context, are important considerations for evidence-informed policymaking. The development of a researcher-centred framework helps to identify opportunities for researcher involvement in policy processes. Conclusions/policy implications: For donors and development agencies interested in health research capacity building, this research demonstrates a need for investment in building capacity and training health researchers to interact with the public policy world and enhancing research communications and transferability to decision-makers. It also highlights an opportunity to invest in implementation research platforms, such as health policy research and analysis institutions. Significance: This research focusses on the supply side of the research-to-policy spectrum in Argentina, explores researchers’ roles in evidence-informed decision-making, and proposes a new framework for thinking about how researchers interact with (and can influence) their working environment. This work is relevant in contributing to laying the groundwork for building national health research systems and to align research efforts with health system action in Argentina, and to other LMICs. We provide specific recommendations directed to policymakers, researchers, and donors/development agencies.
Understanding the influence of research syntheses to support knowledge translation in Uganda and Zambia: A multiple case study

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ABSTRACT

Background: Evidence briefs for policy are a relatively new form of research synthesis being prepared as part of knowledge translation efforts. There has been an increase in their production - particularly among those in the WHO’s Evidence Informed Policy Networks (EVIPNet) - but very little is known about whether or how they influence the policy process when prepared for a priority policy issue. Methods: A multiple case study design was adopted to assess whether and how evidence briefs prepared for priority policy issues in Uganda and Zambia influenced the policymaking process they were prepared to inform. Four cases were sampled, multiple data sources were collected, and analysis was driven by Kingdon’s agenda-setting framework and the ‘3i’s’ framework. Two potential pathways of influence were considered: a longitudinal influence on the ‘3i’s’ that influences future policy outcomes, and a cross-sectional interaction with existing political factors in the ‘3i’s’ that results in proximate outcomes. Results: In two of four cases, the policy issue had a long-standing position on the governmental agenda, and both ‘no go’ (three cases) and ‘go’ (one case) decisions were explained as a result of the influence of existing institutions, interests, ideas, and external factors. In three of four cases evidence briefs influenced the policy process through a longitudinal pathway by initiating potential shifts in the way actors perceived the policy issue. In one case, evidence briefs initiated incremental policy change through a cross-sectional interaction with existing ideas and institutions. Conclusions: This study is one of the first comprehensive accounts of how evidence briefs prepared to inform health system policy processes have influenced them. It provides a rigorous approach to undertaking evaluations of health system knowledge translation strategies and may assist those preparing evidence briefs to think through the factors that shape the policy process they are working within.
Contextual influences on the role of evidence in health policy development: insights from India and Nigeria

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ABSTRACT

BACKGROUND: The context is a complex and important influence on decision-making, affecting degree of responsiveness and people-centred health systems. Although theoretical frameworks to understand context are available, limited empirical research exists exploring contextual influences on evidence-informed health policymaking. This presentation compares contextual influences on evidence role in health policy development within two large countries within their continents: India and Nigeria.

METHODS: In each country, the contextual influences on the development of three specific health policies were explored. The study was guided by a conceptual framework, developed from the literature. Context includes factors at three levels: macro (e.g. political and resource environment), meso (e.g. organisation's roles and practices) and micro (e.g. individual values and preferences). Data was collected using 72 in-depth interviews with key policy actors and document reviews, and analysed using framework approach.

RESULTS: All policies were perceived as evidence-informed. Both formal (e.g. research) and informal (e.g. experiences) evidence were used in India; in Nigeria reliance was mostly on formal evidence. Key macro-level facilitators of evidence-informed decisions were international treaties driving reform agendas, leadership changes and political will. Key constraints included limited resources and opposition from powerful actors. At meso-level, civil society was particularly influential in India; whereas international agencies had greater role in policy decisions, including evidence use, in Nigeria. At micro-level, individuals had different understandings of what constitutes 'robust' evidence for policymaking, shaping their evidence preferences and decision-making practices.

DISCUSSION: Understanding context is essential in ensuring responsiveness of policy decisions to the needs of key policy actors within people-centred systems, for example through recognising actors' agendas and interests. Powerful civil society can catalyse greater recognition of citizens voice through communicating informal evidence, as we found in India; and influential donors can favour costly surveys, thus undermining use of evidence from government health information systems, as in Nigeria.
Assessing how much confidence to place in the evidence from systematic reviews of qualitative research: a new tool

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ABSTRACT

Background Systematic reviews of qualitative research are increasingly used to bring together findings from primary qualitative studies. However, it is difficult to use these findings to inform policy development for health systems because methods to assess how much confidence to place in these findings are poorly developed.

Objectives To describe a novel tool for assessing how much confidence to place in evidence from reviews of qualitative research. Methods The Confidence in the Evidence from Reviews of Qualitative research (CERQual) tool was developed through review of existing tools; discussions within a working group; and piloting of the tool on three systematic reviews. Results The CERQual tool bases assessments of confidence on four factors: the methodological quality of the individual studies contributing to a review finding; the coherence of each review finding; the relevance of a review finding; and the sufficiency of data supporting a review finding. Methodological quality is assessed using a quality-assessment framework for qualitative studies. Coherence is assessed by looking at the extent to which a review finding is based on data that is similar within and across multiple individual studies and/or incorporates explanations for any variations across individual studies. Relevance is assessed by determining to what extent the evidence supporting a review finding is applicable to the context specified in the review question. Sufficiency of data is assessed by an overall determination of the degree of richness and/or scope of the evidence and quantity of data supporting a review finding. An overall judgement of the confidence in each review finding is made based on these assessments. Conclusions The CERQual tool provides a transparent method for assessing the confidence of evidence for findings from reviews of qualitative research and may facilitate the use of these findings in health policy development processes and programme management.
Measuring motivation of health care providers - development and multi-country validation of an innovative tool to investigate the 'intrinsic motivation crowding out effect'

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ABSTRACT

Performance-based financing (PBF) has received enormous attention from LMIC governments and development partners in recent years. PBF schemes attempt to compensate for the lack of incentives for high performance inherent in traditional input-based health financing systems by linking provider reimbursements to measurable performance indicators. PBF critics, however, fear that the introduction of financial incentives might lead to shifts in health care providers' motivational profiles rather than increasing overall work motivation, 'crowding out' the idealistic reasons that drive many providers in resource-limited settings - the wish to help others, to do good, to enhance one's reputation and self-worth. We will investigate the motivational consequences of performance-contingent financial incentives in the context of PBF schemes in Malawi, Burkina Faso, and the Republic of Congo. To date, no measurement instrument detailed enough to detect such complex changes in motivational profiles has been used in the - mostly qualitative - available studies on health care provider motivation. The few quantitative studies conducted operationalize motivation either in terms of its behavioral correlates, or in terms of a basic intrinsic-extrinsic motivation dichotomy, often assumed to be mutually exclusive rather than complementary. Building on Deci and Ryan's (1985) Self-Determination Theory (SDT), we developed and tested a Likert-type scale for use in structured interviews. Our instrument goes beyond the intrinsic-extrinsic dichotomy, concurrently assessing the complementary types of motivation postulated by SDT, from intrinsic task enjoyment, to idealistic and self-worth enhancing motivations, to motivation induced by financial incentives or other external forces. We discuss our tool's unique potential to deepen understanding of health care provider motivation and its determinants and behavioral consequences. We illustrate the tool's theoretical framework, structure, psychometric properties, and practical application using baseline data from PBF impact evaluations in Malawi, Burkina Faso, and the Republic of Congo.
Focusing on the health workforce to achieve key health priorities: methods for estimating sector-wide gaps using an example of Mozambique

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ABSTRACT

Purpose Recent techniques allow ministries of health to analyze health system needs against available resources. Such analyses allow governments to increase system sustainability and advance on universal coverage and higher quality. The OneHealth tool, a strategic budgeting tool, allows analysts to link scale-up plans of disease programs with the planned recruitment and staffing strategy in the public health sector.

Focus/content We present results from Mozambique to illustrate the methodology. In collaboration with the Ministry of Health, the USAID-supported Health Policy Project applied OneHealth to cost the country’s Health Sector Strategic Plan 2014 - 2019 (PESS). We partnered with the Department of Human Resources to understand long-term health workforce needs. The PESS has ambitious increases in service delivery and many labor-intensive interventions. We obtained the number of staff by cadre available over 2013-2017 based on current plans. We analyzed the number of full-time equivalent (FTEs) health workers needed across disease programs, based on the labor intensity of all health interventions. Labor intensity in terms of minutes was estimated from secondary sources and in-country expert opinion.

Significance Our methods expand on the capabilities of the OneHealth tool and allow for detailed analysis of potential gaps by health worker cadre and level of system. In Mozambique, our results suggest large emerging gaps for generalists, specialists, obstetricians, and gynecologists. Major programs contributing to the gap can also be identified at the level of the specific intervention. Reducing maternal and infant mortality rates are key priorities of the PESS; however, the gap analysis demonstrates a deficit in MCH-related cadres.

Target audience The presentation will cover the approach in detail. Our methods offer a compelling alternative to population-based ratios to estimate future health workforce needs by connecting to actual service delivery targets. The methods we have identified can be adopted by analysts within Ministries of Health, especially departments of human resources.
But I wrote it down! Experience of using diaries to promote reflective practice among district health management teams in three African countries.

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ABSTRACT

Background: In action research (AR) studies people plan, act, observe and reflect together to bring about change in their organisation. Creating a record of this process of change so that learning is more and can be shared with others is a challenge. We searched the literature for tools used to document change in AR studies. We considered learning histories and diaries and opted for diaries. This presentation will share our experience of selecting diaries for the PERFORM project and introducing it to District health management teams (DHMTs) as well as highlight the difficulties of using this tool for reflective learning. Methods: The research is taking place in three districts each in Ghana, Tanzania and Uganda. The DHMTs supported by researchers in each country and Europe, plan, implement and evaluate specific Human resource (HR) and health system (HS) bundles of interventions aimed at strengthening the district health system and improving workforce performance. Each DHMT keeps a diary of their activities which is updated and discussed periodically. Results: DHMTs are keeping records of the implementation processes and outcomes of the interventions in their diaries. We initially introduced the same diary format to all 9 districts. However, with time, each country modified the format to suit their needs highlighting the fact that individual and group needs differ between contexts. The DHMTs set aside time, to discuss their activities to find out what factors contributed to success and what they can improve next time. Discussion: DHMT members are busy so it is often difficult to routinely meet as a group to discuss their activities using the diary. However, setting aside time to reflect on their actions and drawing lessons from them habitually will not only be beneficial for achieving project goals but also help them sustain these benefits beyond the lifetime of the project.
Human resources for health in Peru: Recent trends (2007 - 2013) in the labour market for physicians, nurses and midwives

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ABSTRACT

Background: Peru has been consistently catalogued as a country with a shortage of health workers, i.e. <2.3 workers per 10,000 inhabitants. This study used data from 2007 - 2013 to examine the number of physicians, nurses and midwives that are trained, what they do after completing their degrees and how many then start working for the national health system. Methods: Data from the Ministry of Health (MOH) and the National Assembly of Deaneries was combined to see whether the estimated shortage for these professionals within the national health system could be met before 2030. NB: The gap in health professionals is based numbers of essential medical procedures required to provide universal health coverage, according to MOH estimates. Results: In 2007 - 2011, the average percentage of applicants that entered medical, nursing and midwifery training was 10%, 41% and 50% respectively. During this period, 8,919 physicians, 14,071 nurses and 4,837 midwives completed their degrees. In 2007 - 2013, virtually all physicians, 62% nurses and 85% midwives carried out their Urban Rural Marginal Service (SERUMS), which qualifies them to work for the national health service. However, only 28% physicians, 37% nurses and 33% midwives started working for the national health services after completing their SERUMS. If the national health service continues to absorb health professionals at these levels, it would take until 2027 to meet the MOH estimated shortage of physicians. If this absorption rate were doubled (i.e. 56% of physicians joined the national health service after their SERUMS), then the gap could be met by 2020. Conclusions: Peru's shortage of health professionals within the national health system is not due to a shortage of professionals in the labour market. This dynamic had not been described before and challenges current assumptions of human resources needs in the Peruvian public sector.
Does the delivering of basic primary health care services in rural communities fit urban settings? The case of Ghana's Community-Based Health Planning and Services

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ABSTRACT

Background Globally, populations continue to grow whilst the social amenities necessary to sustain them are diminishing, resulting in the onset of several new health challenges especially among the urban poor. To help ameliorate this situation, an innovative urban primary health system was introduced, based on the milestones of the rural Community-Based Health Planning and Services (CHPS) in Ghana. This paper provides an overview of the most innovative experiences discovered while addressing these urban poverty health issues, including the process of deriving constructive lessons needed to inform discourse on the design and implementation of the sustainable Community-Based Health Planning and Services (CHPS) model as a response to urban health challenges in Southern Ghana. Method This research was conducted during the six-month pilot of the urban CHPS programme by a team of researchers involved with the implementation activities in two selected areas acting as intervention and control. The challenges encountered, lessons learnt and the adoption of new strategies in the intervention area tailored to the urban setting have been documented in this manuscript. Results The findings from the implementation activities revealed that many of the best practices derived from the rural CHPS experiment could not be transplanted to poor urban settlements due to the unique organizational structures and epidemiological characteristics found in the urban context. For example, constructing Community Health Compounds (CHCs) and residential facilities within zones, a central component to the rural CHPS strategy, proved inappropriate for the urban sector. Night and weekend home visits schedules were initiated to better accommodate urban residents and increase coverage. Conclusion The need for improved urban health services remains a challenge. However, current policy guidelines for the implementation of a primary health model based on rural experiences and experimental design requires careful review and modifications to meet the needs of the urban settings.
The effects of Community-Based Health Planning and Services (CHPS) on contraceptive knowledge and use, reproductive preferences, and health: case of Kassena-Nankana district of northern Ghana

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ABSTRACT

Introduction: The government of Ghana introduced the Community-Based Health Planning and Services (CHPS) programme with the aim of improving access to health care including family planning services. This study therefore examined the extent to which CHPS has changed gender customs of introducing and using contraceptives in the Kassena-Nankana District (KND) of Ghana. Method: The study was qualitative and data was collected between June-September 2012. Sixteen focus group discussions were conducted with men and women and 68 in-depth interviews with community leaders and health workers. Deductive content analysis was performed using QSR Nvivo 10 software. Results: Findings showed that CHPS has contributed in a positive change of perceptions, attitudes and behaviors of community members on FP resulting to greater acceptance and use of contraceptives. People are now opting for smaller family size and trust that contraception is useful for birth spacing and limiting. Many respondents noted the reduced mortality of children in recent years, due in part to childhood immunizations provided by CHPS, as a contributing factor in the increased acceptability of FP. Notwithstanding the general acceptance of contraceptive use, there were still issues mentioned about the side effects of contraceptives such as infertility or difficulties to conceive. In a patriarchal system such as the KND in which men have power, women's autonomy is usually repelled by men. Respondents attested that a husband must approve for the use of contraceptive by the wife. Male involvement and participation in the provision of FP was therefore very crucial. Conclusion: Community-based Health Planning and Services has contributed to a change of attitudes towards family planning services as more people are now more acceptable to family planning service as a result improved health and survival of women and children. To further improve and sustain the use of FP services, programmes targeting males should be strengthened.
Strengthening the community system to increase access to people-centered care: A qualitative study of an improvement activity in Ethiopia

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ABSTRACT

Background: Ethiopia seeks to improve access and utilization of services by training and deploying Health Extension Workers (HEWs) to rural wards (kebeles) to provide health education, prevention, and basic curative services. In October 2011, the USAID Health Care Improvement Project mobilized existing groups to form community improvement teams in 18 kebeles across two woredas (districts) in Southwest Shoa. This was to strengthen linkages between communities and the health system to improve the capacity of community groups to support HEWs and create people-centered care. Methods: In September 2012, a qualitative evaluation of the intervention examined the perceived effect of using improvement teams to strengthen the link between the community and the health system, and support HEWs. Three kebeles were selected based on accessibility. Seventeen semi-structured interviews were conducted by an experienced Ethiopian qualitative researcher. Interviews were audio-recorded and iterative thematic analyses performed. Results: Prior to the intervention, HEWs were only able to identify around 15 pregnant women monthly. After mobilizing community-level improvement teams to support HEWs, the number of pregnant women identified increased to 259 by June 2012 at 9 health posts. The number of pregnant women tested for HIV increased from 36 in September 2011 to 191 in June 2012. After working with community groups, HEWs felt that their reach had increased and expressed. One HEW said, 'There is no member of a household who cannot be reached now. Each improvement team knows who is pregnant, who is lactating, who has a latrine, who sleeps under a bednet.' Zone Health staff stated, 'This is a cost-effective and innovative initiative.' Conclusion: In Ethiopia, the quality of community-level services continues to be impaired due to limited community support of HEWs. Community groups can be an effective means of strengthening a community health system, supporting HEWs to decrease workload while increasing service coverage.
Impact of Group Newborn Care Motivational Interviewing in a Maternity Waiting Home (MWH) Setting on Mothers' Knowledge and Practice in Rural Eastern Province of Zambia

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ABSTRACT

Background: The ‘one-size-fits-all’ approach used in the provision of Essential Newborn Care Health (ENC) Health Education (HE) to pregnant mother has not allowed the mother to acquire sufficient ENC knowledge and be able to adequately care for her newborn baby, as 60% of medical information discussed in an encounter is forgotten. This has led to high newborn mortality, 25-45% in the first 24 hours after birth, 3/4 in the first week, at the global level. This study evaluates the impact of a MWH based Safe Motherhood Action Groups members (SMAGs) led Group Newborn Care (GNC) Motivational Interviewing (MI) - GNC-MI, on increasing maternal knowledge and practice of ENC, and its impact on early neonatal mortality and mortality.

Methodology: This is a prospective RCT involving 1,266 pregnant mothers (waiters) admitted in six Mission MWHs, in rural Eastern Provinces of Zambia. Ordinarily SMAGs' do not give HE in MWHs. This study brings them into the MWHs, in the intervention arm, to deliver the ENC package to the waiters, using Motivational Interviewing, through four sessions of nine encounters, using pre-designed MI-Stages of change Flowcharts.

Results: Twelve Midwives trained in EmONC, 30/120 SMAGs trained. The SMAGs' GNC-MI manuals developed (for trainers and participants). Data collection tools developed. By September 2014, this ongoing study will generate data on: prevailing newborns care practices and care seeking for complications; the effect of the GNC-MI on the mothers' knowledge and practice of ENC; the barriers and enablers of ENC; and the incidence of early neonatal morbidities, the burden of neonatal morbidity and mortality. Conclusion: Motivational Interview, which is participatory, is the key in leading mothers and their families from the current high-risks newborn care practices, towards improved ones, through a path of least social, cultural economic, and spiritual resistance to change. HE does not do it!
Exploration of experiences and factors that influence enrollment to the community-based tuberculosis program in a rural area in Kweneng East District, Botswana.

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ABSTRACT

Background: Tuberculosis (TB) is one of the major public health concerns in Botswana. It is the second largest cause of morbidity after HIV (MoH, 2010). To address this problem, the government of Botswana introduced a community TB care (CTBC) program in 2004, with the intention of improving access, affordability and reducing workload for staff, thereby improving TB treatment outcomes (MoH, 2011). The program enrolment has however been low, falling below the 75% enrolment target. The aim of this study was therefore to assess the experiences of TB patients and those of their health care providers, and to identify factors influencing TB patients’ enrolment in the CTBC programme in a rural district in Botswana. Methods: Qualitative research methods were used to collect data and these included interviews and focus group discussions with TB patients. Forty seven participants were purposively selected from among nurses, TB supporters, health promoters and TB patients. Thematic analysis was used to analyse the data. Results: The findings of the study revealed that factors influencing enrolment in the CTBC program revolved around health care worker training, health education, DOT and health system organization. TB patients were not well informed about the community TB care program. Most patients were not given the opportunity to choose their preferred program. Some of those enrolled in the CTBC program did not practice DOT due to practical socio-economic challenges. Most of the HCWs were not trained on program implementation, and hence neither understood how to implement it or roll it out to patients. The health system itself was found to have challenges of management support, staff shortage, drug shortage, and transport shortage which all affected programme enrollment. Conclusion: The study found that health system factors were more responsible for low enrolment in the CTBC program than individual characteristics, socio-cultural and even socio-economic factors.
Situating patient-centred paradigms of care within people-centred health systems: a critical examination of initiatives to support the self-management of chronic lifelong conditions in low-resource settings

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ABSTRACT

Background: Do frameworks promoting patient-centred care necessarily advance principles of people-centred health systems? The paper addresses this question by examining self-management of chronic lifelong conditions in low-resource settings. Advocates have argued that self-management initiatives promote patient agency, improving health literacy and retention-in-care. Through analysis of a study of community health worker (CHWs) in South Africa and a review of literature on community-based initiatives to support self-management, the paper discusses the challenges for achieving patient-centred care that is also context-sensitive, embedded in a health system that is responsive and inclusive. Method: Qualitative fieldwork conducted in Western Cape (2011/2012) focused on the practice of CHWs. Primary research was complemented by a literature search of databases using terms including self-management, community-based care, expert patients, patient support networks, and biosociality. Findings: The study of CHWs reveals how the balance of patient rights and responsibilities has to be negotiated in a context where people face socio-structural barriers to achieving biomedical prescriptions for self-management. Yet in this setting, as elsewhere with limited state resources, people have of necessity devised strategies for managing chronic illnesses. They resort to a plurality of therapeutic traditions and health markets, where a range of intermediaries (such as CHWs) broker access to health-related services. The literature on community-based initiatives for self-management argues for the value of expert patient networks but also raises caveats regarding adequate referral pathways and safety nets, and the exclusion of certain patients from disease clubs. Conclusions: Self-management should be conceptualised within a shifting health knowledge economy. It remains a challenge to achieve a balance of responsibility in provider-patient relationships that ensures empowerment is not merely a discourse but a reality, and that patients do not feel that state interventions have left them abandoned without adequate support. In this regard, partnerships with non-governmental and private sectors merit further attention.
Effects of a large donor-led maternal health program on health providers and health system users: a quasi-random evaluation in Uganda and Zambia

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ABSTRACT

Background: Saving Mothers, Giving Life (SMGL) is a $280 million public-private initiative that aims to dramatically reduce maternal mortality. In 2012-2013 the partnership implemented a large set of health system upgrades and activities to stimulate demand for facility delivery in eight rural districts in Uganda and Zambia. Methods: As part of the strategic implementation evaluation of SMGL, we conducted surveys with women after facility delivery and with health providers in health facilities in four SMGL and two comparison districts in each country. Using multivariate logistic regression analyses we examined the association between perceived quality of care and, separately, provider obstetric knowledge and satisfaction and the SMGL intervention, controlling for potential confounders. Results: We interviewed 2488 women (93.1% response rate). 655 maternal health providers completed the knowledge test (97.9% response) and 1267 providers in maternity and other wards completed the satisfaction survey (96.4% response). Women in Ugandan SMGL districts were more likely to rate the quality of their delivery care as ‘excellent/very good’ (OR 2.7, p<0.05) than women in non-SMGL comparison districts. SMGL providers had a 7.8% higher knowledge score in Uganda and 8.6% higher in Zambia than non-SMGL providers. There were no differences in job satisfaction, or intent to stay in the current position among providers in SMGL vs. comparison district. Discussion: The large SMGL intervention had a positive, modest effect on provider knowledge in Uganda and Zambia and a positive effect on women’s and provider ratings of quality of care in Uganda. The stronger results in Uganda may have been due to more intensive health system reforms, facilitated by contiguity of SMGL districts and proximity to the capital. There were no effects on provider job satisfaction suggesting that short-term programs have limited impact on providers’ perception of their work.
Real time monitoring of performance of special new born care units in India and follow up tracking of newborns after discharge.

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ABSTRACT

Background and Purpose: Government of India has made huge investments to strengthen facility based new born care to address high neonatal mortality with 470 special new born care units (SNCUs) established at district level across India. The State of MP in central India with a population of 72 million and highest neonatal mortality rate in the country took lead and achieved universal coverage in all 50 districts. However there was no system to monitor performance of these units and follow new born after discharge. UNICEF in 2012 supported government of MP in developing an online monitoring system to monitor quality of care in SNCUs and follow up after discharge. Focus/Content: The system records information of admitted new born and generate real time reports on more than 125 parameters like, admission profile, outcome by weight and maturity, causes of death, disease specific mortality, congenital malformations, antibiotic usage, duration of stay, comparison between SNCUs etc. This is used by program managers to monitor quality of care, compare performance of different units and guiding policy for new born at state and national level. Follow up after discharge is done till one year with reminder SMSs sent to family and community worker. Significance: This system has been adopted by Government for national scale up, already covering 175 SNCUs in 5 states with 250,000 new born registered making it biggest neonatal data base in India. Once scaled fully, will add half a million new born annually, subsequently private sector units will also be included. The data base has guided policy decisions like introduction of antenatal steroids; Kangaroo mother care, foetal nurses in delivery room, CPAP for premature babies, ROP screening, supportive supervision and follow up OPDs. Target Audience: SNCU staff, district and state managers, policymakers, academic institutions, research scholars.
Registered drug shops are preferred for treating acute febrile illness in rural Uganda

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ABSTRACT

Background: Under-five child mortality in Uganda is still high and majority is caused by easily treatable pneumonia, malaria and diarrhoeal diseases among the poorest people. One of the reasons for these deaths is the lack of timely access to proven life saving medicines. This hinders progress towards attainment of MDG 4 target by 2015. To increase access to quality medicines and diagnostics for child febrile illnesses, Makerere University School of Public Health (MakSPH) in collaboration with WHO Alliance for Health Policy and Systems Research, is doing a project to assess the potential to deliver quality integrated care for malaria, pneumonia and diarrhoea using integrated community case management (iCCM) strategies and tools. Hence, an assessment was conducted to determine baseline care seeking preferences. Methods: A baseline household survey interviewed caregivers of children under-five years. The study protocol and data collection tools had been reviewed and approved by Research and Ethics Committees at WHO, MakSPH and Uganda National Council of Science and Technology. Results & Discussion: A total of 2606 households were surveyed. The main childhood diseases reported included fever (70%), cough (77%), and diarrhoea (40%) convulsions (16%) Most households use private drug shops to purchase medicines to manage these illnesses. Use of drug shops was attributed to long distances to public health facilities, availability and reliability of drug stocks at drug shops, perceived high quality of services, and options for credit. Interventions that target public health facilities are likely to miss many healthcare seekers especially the poor in rural distant areas. Conclusion: Drug shops are the convenient and preferred outlets for rural poor communities, and therefore need to be included in interventions such as iCCM strategy. Significance for the selected field-building dimension: This abstract presents findings from the baseline assessment prior to introducing a health system intervention in drug shops to improve access to and quality of care for under-five children.
Strengthening the home-to-facility continuum of care through mHealth intervention: Findings from a quasi-experimental evaluation research in rural Malawi

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ABSTRACT

Background: Access to health services is often hindered by distance and cost. Much of the preventative and curative maternal, newborn and child care can be provided effectively at the community level; however, this potential has not yet been fully explored. An mHealth project was implemented in rural Malawi, using a toll-free hotline offering protocol-based health information and advice, facility referrals, and personalized automated tips. The objectives of this paper are to assess the project's effect on the uptake of home-based care, and to test if utilization of home-based care resulted into lessened pressure on health facilities for minor illnesses. Methods: A quasi-experimental design was used in a designated intervention and control district. Baseline and endline surveys were conducted with pregnant women and caregivers of children under 5. The outcome variables were: a) Use of home-based practices for child health and b) Use of facility-base care, proxied by visit to a health facility for a child with fever. Unadjusted and adjusted difference-in-differences estimates are used, comparing the intention-to-treat (ITT) and the treatment-of-the treated (TOT) models. Results: The multivariate analyses show a positive TOT effect of the intervention on the aggregate home-based care practices, driven primarily by a large change (of about 25 percentage points) on a child's use of a bed net among children whose caretaker used the hotline. There is also a substantial reduction in health center visits for fever (by almost 60 percentage points). Conclusion and Significance to Field: Users of the evaluated service were provided with appropriate information and guidance, from facility referrals and locations of available essential medicines to steps on treating minor illness at home. This decreased unnecessary and often difficult trips to health facilities. mHealth interventions such as this are a promising option for task-shifting and strengthening quality and accessibility of care, particularly in hard-to-reach areas.
How to set up effective teams and team meetings to support improvements in supply chain practice among community health workers: Experiences from Malawi and Rwanda.

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ABSTRACT

Background: In Malawi and Rwanda, community health workers (CHWs) treat children under five for pneumonia, diarrhea and malaria. Results from 2010 baseline surveys of the community supply chain in both countries identified poor coordination between CHWs, health centers (HCs) and districts as barriers to product availability at the community level. To strengthen coordination and problem solving between these levels, SC4CCM tested an approach that established multi-level teams and used existing and new meetings for community health supply chain improvement. Methods: In both countries, teams were established with membership from CHW, HC and district levels around common concepts of setting goals, using data to drive improvements, a structured approach to problem solving and collaborative action planning. In Rwanda, the approach was derived from successful examples of Quality Collaboratives (QCs) implemented to improve clinical practice at district and higher levels. In Malawi teams were introduced to complement a mobile health reporting system. In 2013, the project conducted a mixed-method evaluation in both countries. Results: In Malawi, CHWs in team-supported districts had 14% fewer stockouts than those in comparison districts, while in Rwanda, CHWs in QC districts had 25% greater availability of the 5 community health products on the day of visit than the comparison group. Elements that drove effectiveness of teams included: training on setting goals, clear guidelines on how to conduct meetings and follow an agenda, a structured approach to using data to identify challenges, solving problems and tracking actions for supply chain improvements. Conclusion: Given that CHWs are at the last mile of the health care delivery system and supply chain, and are often not highly skilled, establishing teams that link supervisors and district management to the CHWs, creating a culture of problem solving to target ongoing challenges and using existing meetings in a more effective way can significantly improve supply chain practices and outcomes.
Incentives for motivating and retaining Community Health Workers (CHWs) and their relative importance; Insights from Discrete Choice Experiment in Morogoro rural-Tanzania

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ABSTRACT

Background There is paucity of evidence for community health worker (CHW)'s incentive preferences and expectations or aspirations. The aim of this study was to explore measure and compare incentive preferences and aspirations among CHWs in Morogoro region in Tanzania. Methods We used the Discrete Choice Experiment (DCE) approaches to elicit incentive preferences among CHWs in Morogoro region in Tanzania. we explored the attributes (i.e. incentives) and levels using literature search and in-depth interviews. we used fractional factorial approach to design the experiment considering both the analytical requirement and choice question format, we collected data using the designed DCE questionnaire. we undertook statistical analysis using the multinomial probit (MNP) and mixed logit regression to model respondents' choices as a function of the incentive scenarios. Results The multinomial probit (MNP) regression results show that a guarantee or possibility of future paid employment is relatively important shaping decision for CHWs job uptake followed by personal growth and development, amount of financial compensation and provision of transport are relatively important incentive in motivating and retaining community health workers. Also, mixed logit regression show that taste for incentive preference varies with the CHWs sub groups; male CHWs prefer personal growth and development incentives compared to female CHWs. Female CHWs prefer a guarantee or possibility of future paid employment compare to male CHWs. Generally, Non financial incentives are more preferred than the financial incentives. Conclusion The evidences of various aspirations and possible behaviors of community health workers and subgroups enables or inform policy-makers in crafting better policies for motivating and retention of the CHW where they are needed. CHWs, policy makers should design the incentives by considering CHWs incentive preferences and expectations as incentive effectiveness is a function of individual preferences and aspirations. Significance Evidence about incentive preferences are scanty in the community health system.
Local mentorship for CHWs in India: why are policies not implemented?

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ABSTRACT

Background: Community health worker programmes are a prominent form of community engagement, and occupy a key role in Indian health policy. Locally supportive institutional arrangements, such as mentorship support, are being recognized as crucial determinants of CHW performance, especially in large-scale programmes such as India's. This study was conducted on the ASHA Sahayogini CHW programme in one block(sub-district) of Rajasthan state, to understand how mentorship policies are translated into action in real-world settings. Methods: Following a 'bottom-up' approach of policy implementation analysis, the study explored the implementation of mentoring support through the perspectives of the participant actors including CHWs, CHW mentors, health systems actors, and community representatives. The qualitative methods used included in-depth interviews, focus group discussions and document review, and data were analysed using 'framework' approach. Results: Several aspects of mentorship policies were found to be poorly implemented. Instances of implementation gaps included non-availability of personnel to provide mentorship, poor capacity building for mentors, lack of actual mentorship support provided, absence of regular planning and review, no evaluation of mentorship, and limited involvement of health officials, local political bodies and civil society. A range of factors were linked to these gaps, including ambiguities in written policies and guidelines, lack of role clarity amongst different actors, absence of strategies to address recurrent human resource gaps, power relations that subordinated CHW supervisors to health systems staff, and poor coordination between different actors and agencies. Conclusions/Discussion: The study underlined the importance of strengthening institutional arrangements for ensuring CHW mentorship, through clearly articulated policies, consistent review and capacity building of actors at different levels of the system. In particular, CHW mentorship programmes call for enabling environments and support for designated mentors, by way of adequate remuneration to ensure retention, capacity building, performance review, and ensuring their empowerment and respect within the systemic hierarchy.
Incentive strategies for community health workers “what works?” Case studies from five African countries

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ABSTRACT

Background: In Africa health workers from the formal sector are often supported by informal ‘community health workers’ (CHWs) who are critically placed to provide responsive health services appropriate to their communities. They usually work on a voluntary basis or receive limited remuneration, but general human resource management principles apply to supporting them to ensure their effective contribution to health programmes. However there is limited knowledge about how different types of financial and non-financial incentive strategies work as part of wider staff management systems to maximize the effectiveness and minimize the turnover of CHWs. Methods: Case studies of CHW programmes in the Democratic Republic of Congo, Ghana, Senegal, Uganda, and Zimbabwe were conducted to provide an in-depth understanding of the strategies for supporting and managing CHWs. Document reviews, in-depth interviews with programme managers, CHW supervisors and community members involved in managing CHWs, and focus group discussions with CHWs were conducted in each country. Data were transcribed, translated and analysed using the framework approach. Results: Key findings from the case studies are organised around the following themes: the effectiveness of non-financial incentives to attract and retain CHWs e.g. increasing job satisfaction, career pathways; the use of financial incentives in reducing CHW turnover; the effectiveness of different performance management strategies such as supervision; and the use of other support measures including training and supply of equipment to maximise the effectiveness of CHWs. Conclusions: Using a mix of appropriately designed financial and non-financial incentives and other support measures it is possible to improve the sustainability and performance of CHW programmes, thus enabling underserved populations to gain better access to appropriate health services. These are important lessons for any programmes currently or planning to use CHWs.
Understanding the impact of dynamic interactions between workplace and interpersonal trust on service quality and responsiveness in four Zambian primary health centres.

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ABSTRACT

Background: Human decisions, actions and relationships that invoke trust are at the core of functional and productive health systems. Although widely studied in developed settings, comparatively few studies have explored the influence of trust on health system performance in low- and middle-income countries (LMICs). This study examines how workplace and inter-personal trust impact service quality and responsiveness in primary health services in Zambia. Methods: This in-depth multi-case study included four health centres selected for urban, peri-urban and rural characteristics. Case data included provider interviews (60); patient interviews (180); direct observation of facility operations (2 wks/centre) and key informant interviews (14). Interviews were recorded and transcribed verbatim. Thematic analysis incorporated inductive and deductive coding guided by Gilson et al's (2005) trust in health services framework. Results: Findings demonstrated that providers had weak workplace trust influenced by a combination of poor working conditions, perceptions of low pay, and experiences of inequitable or inefficient health centre management. Weak trust in health centre managers' organizational capacity and fairness contributed to resentment amongst many providers and promoted a culture of blame-shifting and one-upmanship that undermined teamwork and enabled disrespectful treatment of patients. Although patients expressed a high degree of trust in providers' professional qualifications, repeated experiences of poor quality or unresponsive care undermined their trust in providers' service values and motivated patients to complain or circumvent formal service-systems in an attempt to secure better or more timely care. Conclusion: Lack of resourcing and poor leadership were key factors leading to providers' weak workplace trust and poor service quality, which fed a perverse cycle patient-provider relations in the four health centres. Findings highlight the importance of strengthening investment in structural and organizational management to strengthen providers' trust in their employer(s) and colleagues, as a entry-point for developing both the capacity and a work culture oriented towards respectful and patient-centre care.
Impact of leadership & governance on clinical and physicians' outcomes in Public Hospitals in India

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ABSTRACT

Impact of Leadership & Governance on Clinical and Physicians' outcomes in Public Hospitals in India

Background: Public hospitals in India are managed by clinicians, selected on service seniority with no management or leadership training. Poor financial and operational autonomy makes management of these hospital rather difficult, leading to inefficiencies affecting both clinical and physician outcomes. This study is to understand the physicians' perspectives on leadership and governance and how they affect the clinical and physicians' outcomes. Methodology: Responses from 482 physicians working in secondary care public hospitals in the states of Tamil Nadu and Kerala were analysed. A purposive sampling of physicians with a minimum of 2 years experience was chosen. A questionnaire based on Likert's scale was developed using literature survey, group discussions was validated using a pilot study. The final questionnaire has 10 items each for governance and leadership, 6 items for clinical outcomes and 3 items for physicians outcomes. Findings: Data was analysed using factor analysis (EFA) and multiple regression. Factor analysis revealed significant loadings of all items (0.61 to 0.82) and grouping into 'planning' and 'autonomy' under governance and 'staff orientation' and 'managerial expertise' under leadership dimensions. Results of multiple regression showed a strong and positive relationship between governance and clinical outcomes (R² = 0.21) and physicians' outcomes (R² = 0.25). Similarly leadership showed a strong association with clinical outcomes (R² = 0.27) and physicians' outcomes (R² = 0.25). Discussions: The study highlighted importance of a well articulated annual plans, regular meetings of hospital development committee, operational flexibility under governance and recognition for good work, impartiality in handling staff matters and 'leader as a role model' under the leadership dimension. The need to delegate financial and administrative powers to public hospitals and the importance equipping the leadership with managerial skills has been reiterated in this study.
Information to support people-centred human resource management

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ABSTRACT

Background The holy grail of health information system research is discovering how to generate and make easily available the sort of information which strengthens evidence-based decision making. The importance of people’s perspectives is recognised as designers of systems and users of information, but the bias is towards quantitative information for high-level users (district managers and above). But what are the information needs of managers on the ground, those who manage the people who deliver the health services; and how can health information systems support this? Two key decision-making processes for health system strengthening are considered: managing absenteeism and managing work allocation. Objectives Identify key decisions that primary care facility managers make in managing absenteeism and work allocation, the information used and how it is generated. Methods An in-depth case study design over three years was used within a Participatory Action Learning Research approach. Four facility managers participated as co-researchers. Results The facility managers used a range of information much of which was drawn from observation or learnt through experience; it was rich, local and detailed information about staff as individuals and collectives, about their context and the service needs. The nature of information required varied across different time scales with current local information needed for on-the-spot problem-solving (which dominated the facility managers’ daily routines) and quantitative information needed for longer-term operational design. Both were found to be enriched by reflective learning which surfaced important tacit knowledge about how to manage the system and the people in the system. Informal information was essential to validate, interpret and act on the formal health information. Discussion This research contributes conceptually to the field of health information for management by exploring the types of information used and when, and makes recommendations on how to support the local generation, harvesting and use of relevant information.
Assessing primary health care nurse management competencies: is there a gap?

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ABSTRACT

Background In South Africa, nurses managers play central roles in primary health care (PHC) facility management, and it is postulated that the roles and responsibilities of nurse managers working at health facility and sub-district level will undoubtedly increase as the health sector policy terrain changes. The aim of this study is to describe the methodology for the development of tools to measure competencies among nurse managers working at PHC level in South Africa, and to present on results of the assessments. Methods International and local literature on measuring health manager competencies and local policies and publications describing the roles and responsibilities of nurse managers especially within the context of PHC re-engineering were reviewed. Formative qualitative research to inform the development of tools was conducted. Results Three tools were developed (1) a quantitative Likert-scale based competencies assessment tool containing questions covering a range of broad competencies (2) a seven-questioned practical exercise to assess nurse managers numeracy and health information skills, and (3) a focus group discussion guide covering key competencies categories as presented in the Likert-scale questionnaire. Four-hundred and sixty eight managers (92% female) from five provinces were surveyed. Self-assessed competencies were highest for organising, leading and controlling and communicating, and worst for planning, analysing and community assessments. Clinic managers performed worse than any other PHC manager type. Most managers performed poorly on practical exercises testing health information skills. Discussion This study presents a multicomponent approach to assessing competencies, and results reveal that PHC nurse managers possess the knowledge, but lack ability to translate and apply practical knowledge into practice. They are also constrained by external and ‘self’ factors, and the results highlights a potential gap between training and the ability ‘to do’ providing important information to inform capacity building training for health care providers who also function as administrators and managers.
When and how does social accountability influence providers' and policymakers' responsiveness in health service delivery in developing countries?

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ABSTRACT

Background Social accountability refers to approaches whereby groups of citizens mobilize, voice their concerns and demand accountability to improve the responsiveness, quality or equity of health systems. Despite the promises of social accountability strategies, little is known about their outcomes and the circumstances under which they produce outcomes for particular groups or issues. This presentation summarizes the results of a study that reviewed the available evidence for the effect of social accountability on health policymakers' and providers' responsiveness. Methods Social accountability interventions are conceptualized as complex social interventions for which a realist perspective is considered the most appropriate way of synthesizing existing evidence. The synthesis is based on a preliminary program theory of social accountability that has been tested through an iterative process of primary study searches, data extraction, analysis and synthesis. The review was conducted between April 2013 and July 2014 by a team of four reviewers. Results A total of 110 published and non-published (grey) quantitative and qualitative studies were included. The social accountability initiatives identified in the papers exist along a continuum: formal or informal, engagement through representation or direct participation, initiated by governmental or societal actors. They produce changes in health service delivery, social policy, regulations and medical science and in the overall democratization of health systems. The historical context of social mobilization, participants' sense of entitlement and obligation with regard to equitable treatment, and external support among others, influence the scope and outcomes of social accountability initiatives. Discussion/conclusions The authors expect to provide important inputs for the conceptualization of people-centeredness of health systems and services, particularly with regard to the dimensions of voice, accountability, participation, inclusion and responsiveness. The findings may further help policymakers and programme managers to develop approaches on how to foster citizen-driven initiatives to support the emergence of people-centred health systems.
Towards people-centred health systems: a conceptual framework for the analysis of primary health care governance in low- and middle-income countries

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ABSTRACT

It remains a challenge to meet the aspirations for primary health care (PHC) systems in which people have the right and duty to participate collectively in planning and implementing PHC. While there is evidence that communities can develop innovative, practical, culturally acceptable strategies to address their needs, little is known about how this functions in PHC. Insights for understanding, analysing, evaluating and designing people-centred PHC governance models are scant in the literature. Analyses of governance have largely focused on top-down structures, and efforts to understand the role of communities in PHC have often ignored their potential capacity for bottom-up governance. To broaden the analysis of PHC governance, we apply a framework in which community engagement is conceptualized as collective governance, informed by empirical research and analysis of collective action for common-pool resources such as fisheries and forests. The framework defines levels of governance (constitutional, collective and operational) by who has the power and responsibility to make, change, monitor and enforce rules governing demand and supply of services. Using examples from the Nigerian health system, we demonstrate how the framework can be used to analyse PHC governance and how relations between levels of governance can affect access to services and service delivery outcomes. The conceptual framework and the analytical approach we propose show that efforts to strengthen PHC systems must recognize and support the roles and potential of bottom-up governance in responding to unsatisfied demand for PHC services; and that, in designing PHC governance, policy-makers should not concentrate responsibility but should promote governance at more than one level, while aiming for clear lines of accountability. The framework can facilitate the analysis of PHC governance and of case studies and evaluations to assess the relations between bottom-up and top-down governance, access to services, service delivery and health outcomes.
Unique governance and partnership strategies for private non-profit health providers: People-centered strategies for faith-based providers?

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ABSTRACT

Through a slow development of relationships, private faith-based non-profit health providers (FBHPs) are slowly becoming integrated into national health systems. There is emerging health policy and systems research (HPSR) on FBHPs that demonstrate unique characteristics that make them particularly "people-centered", such as core values emphasizing accountability to the poor, to the local communities that own them, to funders and patients, and increasingly to their national health systems. However, FBHP leadership often struggle to protect core values such as justice and equity in the face of increasing financial, operational and systems challenges. This paper highlights some of these unique challenges facing FBHPs. This paper balances practitioner experience and findings from recent empirical research through deliberate practice-research engagement. The practitioners' perspectives emerge as a result of three ongoing collaborative networks that focus on improved governance of FBHPs in Africa and the USA. The research findings emerge from two empirical case studies (completed in 2012 and 2013, and conducted in Ghana, Malawi, Cameroon and the USA) which focus on issues such as contracting, community engagement and public private partnership. This paper speaks to the theme of "governance, accountability and participation", and also to the thematic working group on private providers. The results demonstrate that managers in FBHP systems must develop specialized competencies and innovative strategies not commonly found within public or private-for-profit providers. For example, budget allocation must be aligned with specific organizational values, and being owned by "the community" adds a particular people-centered imperative. This session would be of interest to those interested in the improved integration of public and private components in national health systems by better understanding key governance considerations high on the agenda for FBHP leadership. (This abstract was submitted as a panel and would benefit from a process which is inclusive of both practitioner and researcher perspectives)
People-centered health systems and Corruption: A global survey of health managers’ perceptions of the causes of, and recommended ways to reduce, health sector corruption

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ABSTRACT

BACKGROUND Corruption adversely affects access to healthcare worldwide, especially in countries with poor governance, low transparency, and weak accountability. The factors that encourage corrupt practices in health systems affect both the health workforce and patients. Ways to mitigate these factors are of critical interest to all engaged in international public health.

METHODS In July 2013, the LMG project conducted an online survey of health managers and leaders across 95 countries to assess perceptions of corruption in the health sector. The survey was completed by 1,076 respondents. Three of the sixteen survey questions were open-ended and qualitative, which were coded and analyzed using QSR NVivo 10.

RESULTS One-third of survey respondents were from middle- and low-income countries scoring between 8 and 38 (0=highly corrupt to 100=very clean) on Transparency International’s public sector Corruption Perceptions Index. The highest reported instance of corruption, in our survey, was healthcare professionals exploiting clients’ access to care by seeking bribes, kickbacks, or informal/illegal fees. Qualitative responses cited health workers’ need to augment their low salaries, poor working conditions, low morale, greed, and lack of role models in leadership positions as factors contributing to corrupt practices. Respondents also reported that patients’ lack of knowledge of their rights and illiteracy were barriers to care; this facilitated corruption as their lack of knowledge often meant that patients did not dispute or report corrupt practices.

CONCLUSIONS Addressing corruption is not a zero sum game. The health workforce’s needs and patients’ rights must both be addressed and enforced to reduce instances of corruption. Patients must be sensitized to their rights and mechanisms for redress through civilian ombudspersons, oversight committees, and patient rights groups. Health workers need clear job descriptions; on-time pay; monetary and non-monetary incentives (continued credits, certifications); and transparent policies for career growth and promotions. Legal measures against corrupt practices are also important.
Socio-cultural and service delivery dimensions of maternal mortality in rural central India: a qualitative exploration using a human rights lens

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ABSTRACT

Background Despite the avoidable nature of maternal mortality, unacceptably high numbers of maternal deaths occur in developing countries. Considering its preventability, maternal mortality is being increasingly recognized as a human rights issue. The objective of this study was to explore socio-cultural and service delivery related dimensions of maternal deaths in rural central India using a human rights lens. Methods As part of a qualitative study design, verbal autopsies were conducted for 22 cases of maternal deaths during 2011 in Khargone district of Madhya Pradesh province in central India. Relatives of the deceased women having witnessed the circumstances leading to death were interviewed. The data were analysed by using thematic analysis. The 'three delays' framework was applied to classify the factors associated with maternal deaths. These factors were further examined by their linkages with the essential elements of a human rights approach. Results All 22 deceased women tried to avail medical assistance in occurrence of obstetric complications but various factors delayed their access to appropriate care. The underestimation of complication symptoms by family members, gender inequity hindering women's decision-making power and negative perceptions regarding delivery services delayed decisions to seek care. Transportation problems and care seeking at multiple facilities delayed reaching appropriate health facilities. Negligence by health staff and unavailability of blood and emergency obstetric care services delayed receiving adequate care after reaching health facilities. Conclusions This study concludes that normative elements of a human rights approach to maternal health, i.e. availability, accessibility, acceptability and quality were not fully upheld. The deceased women were unable to claim their entitlements and the duty-bearers could not fully meet their obligations despite their conscious efforts to improve maternal health. In order to prevent maternal deaths, further concentrated efforts are required for better community education, women's empowerment and health systems strengthening to provide appropriate, timely and high quality services.
Increasing health equity and access to skilled birth delivery for the poor: evidence from the PATHS2 project within northern Nigeria

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ABSTRACT

Background Equitable access to skilled birth deliveries at health facilities can significantly reduce maternal deaths. The Partnership for Transforming Health Systems Phase 2 (PATHS2) introduced and supports an emergency transport scheme in some States within northern Nigeria. This study evaluates this pro-poor intervention as a strategy for improving access to skilled birth delivery services. Methods A total of 5000 and 10,000 households were assessed at baseline (2009) and midline (2012) respectively using structured questionnaires. Study respondents were asked various questions including barriers to accessing ANC and delivery services in health facilities during the baseline and midline surveys. Respondents were categorized into different wealth quintiles and data was weighted to adjust for differences in sample sizes during both surveys. Results In Kano State, the proportion of respondents in the poorest wealth quintile at baseline (59.5%) relative to midline (46.4%) who indicated transportation as a barrier decreased by 28% (p<0.001). Within the second poorest wealth quintile the proportion of respondents reporting transportation as a barrier to accessing delivery services reduced by 24% (p<0.001) from baseline (30.9%) to midline (25.0%) periods. In Jigawa State, the proportion of respondents in the poorest wealth quintile at baseline (44.6%) relative to midline (37%) who indicated transportation as a barrier reduced by 21% (p<0.001) while in the second wealth quintile a reduction of 24.7% (p<0.001) was observed from baseline (46.2%) to midline (37%) survey periods. There were no significant decreases in the proportion of respondents who indicated that transportation is a barrier to accessing skilled birth delivery services among the middle to richest quintiles of respondents in both States. In rural areas in Kano State, the proportion at baseline (95.7%) relative to midline (85.5%) who indicated that transportation was a barrier reduced by 11.9% (p<0.001). Conclusion These findings demonstrate that PATHS2 through its emergency transport scheme is significantly addressing the 'transportation challenge' and distance of households to health facilities as barriers to accessing skilled birth delivery services particularly for the poor. The results from PATHS2’s end-line survey in 2014 are expected to more strongly demonstrate and substantiate this evidence.
An equity analysis of institutional delivery uptake and maternal mortality reduction in context of cash transfer program (JSY): results from nine states of India

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ABSTRACT

Background: Access to skilled birth attendance (SBA) and emergency obstetric care (EmOC) are critical to reduce maternal mortality; however SBA coverage was the least equitable in countdown to 2015 countries. Only 13% pregnant women in poorest population quintile of India delivered in health facilities against 84% in richest (2005-06). To address this inequality, in 2005 Indian government launched conditional cash transfer (CCT) program (JSY) for promotion of institutional deliveries (ID). MMR reduction was expected faster in poor population with anticipated increased ID and disproportionately high MMR among them. We assess JSY’s consequences for inequality in ID and maternal mortality. Method: All 284 districts from nine states were ranked based on socioeconomic (SE) status. Using grouped data concentration curve (CC) and concentration index (CI) were derived for ID and caesarean section (proxy for EmOC), and CI was decomposed. Slope and relative index of inequalities (SII&RRI) in MMR was estimated using division level data. Results: CC for ID in 2007-09 was closer to the equality line than in 2004-06 (pre-JSY), and CI decreased from 0.1620 (pre-JSY) to 0.1038. Degree of inequality in EmOC availability contributes 33% to overall inequality in ID, followed by that of male literacy (22%) and proportion of poorest households in district (16%). Caesarean in three poorest district quintiles was <2% with CC lying below equality line and CI of 0.2413. SII for MMR in 2010 was -135, suggesting richest division has 135 points lower MMR than the poorest. RII was -0.49, indicating 49% less MMR in richest division. Reduction in MMR was four times higher in richest divisions between 2007-09 to 2010. Conclusion: SE inequalities in ID, although reduced, persist after CCT. Higher MMR in poor areas with slow decline, inequalities in EmOC availability and factors contributing to inequalities revealed CCT alone is not sufficient to achieve equity in maternal health.
Equity, justice and safety in maternal health: Evidence from rural Karnataka, India

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ABSTRACT

Background: Equity and justice are the hallmarks of people-centred health systems. Just cultures are also considered essential for safety in health organisations. However, justice in the context of safety is a limited notion focused on the creation of a learning culture for health workers. We explore the relationship between equity, justice and safety in maternal health by considering the needs and rights of both health workers and patients. Methods: Our research is based in Koppal, the most backward district in Karnataka (India). We analysed equity, justice and safety in the public health system from (1) the beliefs, behaviours and customs that contributed to preventable harm, as captured by detailed qualitative verbal autopsies of all maternal deaths (N=33) and near misses (N=3) in 67 villages between April 2008 and March 2011; (2) perspectives of a sample of government doctors and staff nurses from across the district, as captured by in-depth interviews. Results: The autopsies revealed a public health system riddled with hazards and errors that contributed significantly to preventable maternal mortality. Piecemeal safety protocols and processes were weakened or distorted in a resource-scarce organisational culture by discriminatory and inequitable rationing. The management of pregnancy-related risks was unsystematic and guided by culturally-biased notions of severity. Routine obstetric practices reflecting informal learning in medical/nursing schools were often abusive or harmful. Maternal death reviews pitted individual families against individual providers, masked system failures and perpetuated a culture of blame. Health workers operated in a milieu that incentivised concealment, blame shifting and responsibility-shirking. Conclusion: Safety can be assured by health systems only when it is embedded in organisational cultures that respond uniformly to health needs (and voices) across social divisions, reduce the scope of discriminatory practices and abuses of power, and enable continuous learning.
Are reproductive and maternal health services becoming more equitable? Evidence from a 30-country market segmentation analysis

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ABSTRACT

Background: Nearly fifteen years after the commitment to achieve the millennium development goals (MDGs), disparities in reproductive health (RH) and maternal health (MH) are still reported. While the push to achieve universal health coverage (UHC) throughout the world has led to increased coverage of health services at a population level, some evidence shows that, with some exceptions, focusing on global targets has exacerbated inequities, especially for services that are not always included in national health financing schemes. It is therefore important to understand where the equity gap for MCH and RH indicators has narrowed, and why. Methods: We conducted a market segmentation analysis to examine disparities in utilization of key RH and MH services across socioeconomic levels. Using data from Demographic Health Surveys in 30 countries we constructed concentration ratios of utilization of services across wealth quintiles, using a time/country invariant wealth index, to draw comparisons across countries and over time on three key indicators: use of antenatal care; facility deliveries; use of modern contraceptives. We then performed multivariate regression analysis to examine determinants of equity, paying close attention to factors such as economic status, literacy, proxies for governance, dummy variables marking the initiation of Global Fund and PEPFAR, and proxies for domestic policy changes, such as social protection, total health spending from government, and other measurements of infrastructure and urbanization. Discussion: Findings showed that the policy environment plays a substantial role in closing the equity gap in RH and MCH utilization. The session outlines a number of recommendations for policy strengthening and draws conclusions about the role of policy in creating equitable, fair, people-centered health systems. Conclusion: This presentation has implications for helping to identify the factors that are most important in bringing about people-centered, equitable reproductive and maternal health services, and the results have broad implications for informing the post-2015 agenda.
The route to induced abortion access among urban and rural women in the coastal region of Kenya

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ABSTRACT

Background: Unwanted pregnancy and unsafe abortion continue to be of concern to public health and a social challenge in Kenya sustaining the high maternal morbidity and mortality. The current paper explores the route to induced abortion access through women's emic experiences. This helps to gain deep levels of understanding of how social and legal contexts impinge on abortion-related decision-making entrenching the inequities in abortion care access. Methods: Ethical Review Committees of three different institutions granted the study ethical clearance. Using qualitative research methodology, 108 women of diverse backgrounds participated in individual in-depth interviews by use of a semi-structured interview guide. The audiotaped data were transcribed, typed in Word processing and imported in QSR N6 software to facilitate management of large amounts of data for analysis. Results: of the forty-nine women reporting abortions 27 had their first abortion by unsafe means. Financial resource is the major determinant of type of abortion accessed by women regardless of type of relationship with men. Geographical remoteness is a serious limitation to safe abortion access by women. Those with female connections who have previously aborted safely or unsafely are likely to follow a similar route. Legal barriers heighten stigma and secrecy increasing delays. Paradoxically, stigma and stress are less when abortion occurs within the confines of marriage because it is not viewed as a rejection of motherhood. Conclusions: This study concludes that the route to induced abortion access is complex and replete with incremental delays at each stage in the process of service seeking increasing the risk for complications and implied multiple costs for the women. Hence, second trimester abortions will remain a common feature among the few women survivors admitted in gynaecological wards for treatment of complications. Inequities in abortion care access among diverse women will persist and need urgent redress.
Title: Enhancing implementation through evaluation: Reflections on an innovative evaluation of a national chronic disease program

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ABSTRACT

Background Indigenous Australians experience high rates of chronic disease, poor health outcomes and short life expectancy compared to the general Australian population. From 2009-2013 the Australian Government committed $AUS805.5 million to improve prevention and management of chronic disease for Indigenous Australians. The program was implemented nationally in a diverse and complex primary health care environment. This paper describes the approach and key learnings from an innovative, place-based, formative evaluation of this program.

Methods An evaluation conducted in 24 sites across Australia aimed to identify local-level problems and innovations during early implementation of the program. Evaluation design used mixed-methods drawing on quality improvement principles, comprising five six-monthly cycles of data collection, analysis and reporting. Data sources included administrative, billing, interview, community focus group and clinical data. Rigorous data analysis included ‘member checking’ and full-team analysis workshops. Progress reports in conjunction with six-monthly workshops with funding body managers enhanced data interpretation and understanding of site level implementation issues and needs. Stakeholders in each site were provided with regular feedback on key findings and evaluation progress. Results The evaluation approach and methods were able to identify contexts that provided implementation challenges and supported successes. They highlighted areas for program refinement, to facilitate implementation across urban, rural and remote primary health care delivery settings. Aspects of evaluation design that were key to informing refinement of the program and enabling stakeholder engagement will be discussed, using supporting examples. Lessons from the experience of conducting this evaluation and the relative value of different aspects of the evaluation from the perspective of the local stakeholders will be described. Discussion/Conclusions This model of evaluation appears to have potential to make a significant contribution to enhancing effectiveness of new system-wide primary health care programs and could be considered for application more broadly in health and other sectors.
Using participatory action research to identify and act on determinants of women`s health in remote Aru health district, North eastern DR Congo

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ABSTRACT

Aru Health District on DRC has a maternal mortality rate (MMR) of 4500 / 100,000 births, nearly three times the national average. IPASC, a non-government health organization implemented participatory research and action in the district to address this. In a first stage of interviews and focus groups, health professionals and health centre committee members (76 total) identified the high level of home delivery with untrained traditional birth attendants as reasons, but the 63 women identified the cost of deliveries and the poor condition of local maternity facilities as barriers. The women wanted to be stronger in solving their problems. Building on capacities developed in the pra4equity network in EQUINET, IPASC facilitated participatory research sessions with women to further explore these determinants and the possible actions. The women identified various measures, including sensitization sessions, self-organizing in women groups, setting up women based insurance schemes for funding their needs during maternity and improving and reinforcing mothers` local initiatives for improving income, creating a network of support for health promotion and uptake of services. Once their own financial resources had improved, the women reflected on the learning from these actions and proposed to improve the available maternity services. As they did not see the health centre committee as effective, they managed this themselves, making the bricks and buying materials to rebuild the maternity building with their resources, while IPASC assisted with materials for the delivery room. If during antenatal care a woman presents with high risk factors, the group now advances funds for her to visit the referral hospital without delays and after delivery provide psycho social support. Subsequent to these interventions, maternal health has improved and deliveries at the health centre have increased from 6 to 35 monthly.
Improving social accountability in maternal health: implementing participatory action research with a realist perspective

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ABSTRACT

Purpose In DR Congo and in Burundi, a research coalition works with NGO-partners to develop evidence-informed interventions to improve responsiveness of maternal health services to the needs of women. The coalition introduces a novel approach to collect and use evidence for intervention design fitting local needs. This approach is promising and has challenges; these are presented and discussed targeting researchers and implementers interested in social accountability. Significance: Social accountability aims to improve responsiveness of health services to local needs and include citizen engagement, partnerships and inclusion of human rights values. Citizen engagement at local level is particularly important in fragile states and post-war societies, which are characterized by weak government systems and poor health indicators. Of crucial importance is the use of local expertise of women, NGOs and health providers. In facilitated joint cooperation, local interventions are explored to increase quality of maternal health services. The results of these emerging practices are analyzed against the assumptions on how these actions are supposed to work. Using a realist perspective we document what works for whom in which contexts. In this way we place social accountability, in an emerging action research design, in context of theoretical framing and concept development. To date, discussion of baseline data between researchers and implementers have led to a plan of action to adapt existing activities and improve social accountability for maternal health services. Implementing participatory action research with a realist perspective has its conceptual and implementation challenges. Although this offers good potential of feasible and sustainable evidence-based interventions, aligning implementers' and researchers' perspectives and goals requires careful rapport-building, common language and joint learning opportunities.
The last one heard: The importance of an early stage participatory evaluation for a community health worker programme implementation

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ABSTRACT

Background Despite the Paris Declaration on Aid Effectiveness’ recommendations to monitor and evaluate the implementation process, the systematic involvement of project beneficiaries remains low and limited, especially during the formative stages of a project cycle. This study aimed to investigate early perceptions of a new maternal and child health programme taking place in North Rukiga, Kabale District of southwestern Uganda from a user perspective. Our primary objective was to better understand how feedback from the target communities could subsequently be used to inform and iterate existing programmes. Methods We employed cross-sectional qualitative methods and a phenomenological approach conducting 9 focus group discussions and 8 in-depth interviews with a total of 76 female participants across 6 different sites using purposive sampling. Transcripts were translated and transcribed before being subjected to a top-down thematic analysis, whereby themes were arrived at inductively. Results Predominant themes identified programme strengths with beneficiaries reporting confidence in both the programme and the relationships forged with community health workers. The women exhibited pride in the knowledge they had gained and described improved spousal involvement. Beneficiaries also identified a number of programme challenges including barriers to adopting the behaviours promoted by the programme, and highlighted issues with programme dependency and perceived ownership of the programme. It also emerged that community health workers were not reaching the entire population of intended programme beneficiaries. Conclusions This research provides support for the importance of an early stage participatory evaluation of beneficiaries’ perceptions of health programmes. Our results show the value of conducting evaluations in the early phases of programme implementation -providing timely feedback as well as recommendations for programme adjustment or re-alignment, to increase programme success and improve overall health outcomes.
Adapting the positive deviance approach to be an innovative health services research method. An example of retention in care in antiretroviral treatment in Ethiopia.

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ABSTRACT

Background: In many settings, with similar conditions and resources, certain health facilities are performing considerably better than others. We adapted the 'power of positive deviance' and applied it to improve retention in care (RiC) in health facilities providing antiretroviral treatment (ART) in Ethiopia. Methods: We developed a 6-steps mixed methods approach to identifying best performing health facilities (positive outliers) and their uncommon and beneficial practices that explain their good performance (positive deviants), and for enabling poor performing facilities (negative outliers) to adopt these practices. The 6 steps: (1) Measuring RiC in all health facilities providing ART; (2) Selecting pairs of positive & negative outliers; (3) Interviewing and observing practices in outliers to understand variability; (4) Analysing findings and developing RiC framework; (5) Designing and implementing intervention of transferable management practices; & (6) Monitoring and evaluating results. Results: The study found that RiC needs four pillars of transferable activities: (1) RiC promoting activities by health staff; (2) RiC promoting activities by community-based organizations; (3) patient information systems; & (4) coordination of all this. Good practices from each of these pillars can be transferred through formative supervision. At the onset, RiC on ART varied between 83% and 100% per year. After disseminating transferable RiC promoting practices to all health facilities, RiC improved considerably in all negative outliers and variability in RiC decreased to between 90% and 97% per year. Discussion: The positive deviance approach can be used as a method of disseminating good practices and improving health systems performance. After in-depth study to understand why facilities are positive and negative outliers, health services managers get insight in health service management practices that are feasible in their context and that can be transferred through supervision. We are currently elaborating the positive deviance approach to improve skilled attendance at birth in Ethiopia and Cambodia.
Measuring quality improvement interventions and context for a health system strengthening programme in three provinces in South Africa: a reflection on measures and outcomes

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ABSTRACT

Background: A comprehensive description of quality improvement (QI) interventions and contexts is required in order to spread best practices. We report on our experience developing a monitoring, evaluation, and reporting (MER) strategy of a quality improvement learning collaborative (QIC) aiming to improve elimination of mother-to-child-transmission of HIV (eMTCT) outcomes in South Africa. Methods We conducted a series of workshops to review and update the programme logical framework and evaluation questions. To assess impact, we adopted an interrupted time series study design to allow the use of historical control group techniques for patient outcome data. We identified various local conditions that could influence the outcomes of interest and developed a system of monitoring the experience of the collaboratives participants using the Kirk Patrick framework. A validated measure to assess the quality improvement maturity was adapted for use with participating health facilities. Routine programme monitoring tools were developed to track plan-do-act and study (PDSA) cycles for health system changes tested to improve quality of care. Results Analysis of data has led to the understanding of programme performance by the use of run charts and time series analysis using routine monthly PMTCT data from the sub-districts. In addition process and proxy indicators have been identified to enable tracking of testing of health system changes to improve performance. The assessment of health facility quality improvement maturity has helped us identify influencing factors and to understand differences in locations as well at various health system levels. Significant association of quality improvement maturity with key eMTCT outcomes has also allowed us to priorities support for participating stakeholder. Discussion/Conclusions Our MER strategy has allowed us to assess progress, identify influencing factors, and describe differences in locations and enable reporting and data use amongst stakeholders participating in the QIC.