Health Systems & MNCH Outcomes in West Africa

A study of Conducive and limiting Health Systems factors to improving mother, new born and child health in West Africa

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BACKGROUND

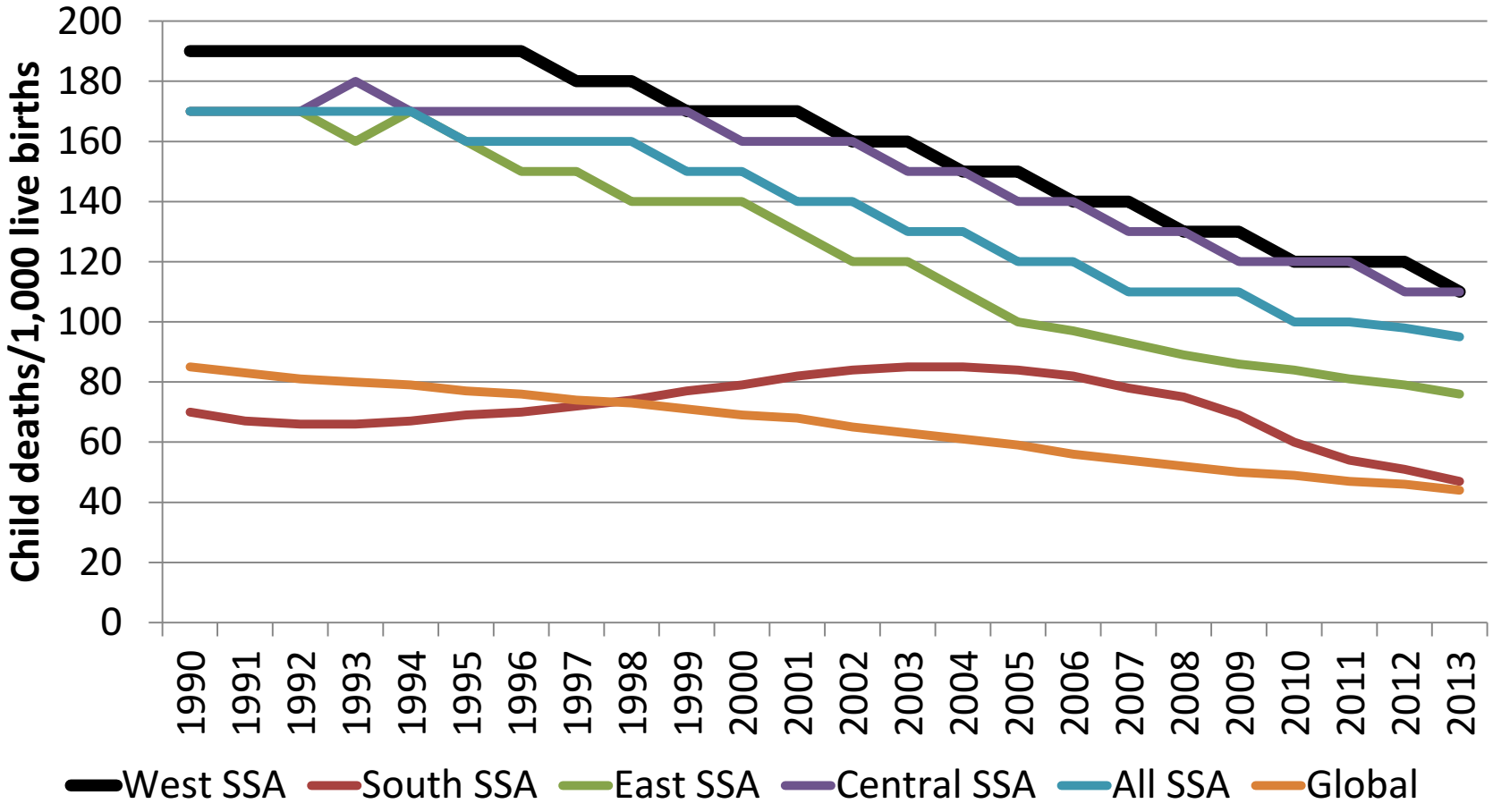
West Africa

- 15 countries
- About 350,000 people
- Multiple cultures
- 3 official languages (English, French, Portuguese)
- Hundreds of indigenous languages
- GDP per capita in nominal US$ ranging from $ 452 in Niger to $ 3,632 in Capo Verde (2014)

- Source: http://www.nationsonline.org/oneworld/map/west-africa-map.htm

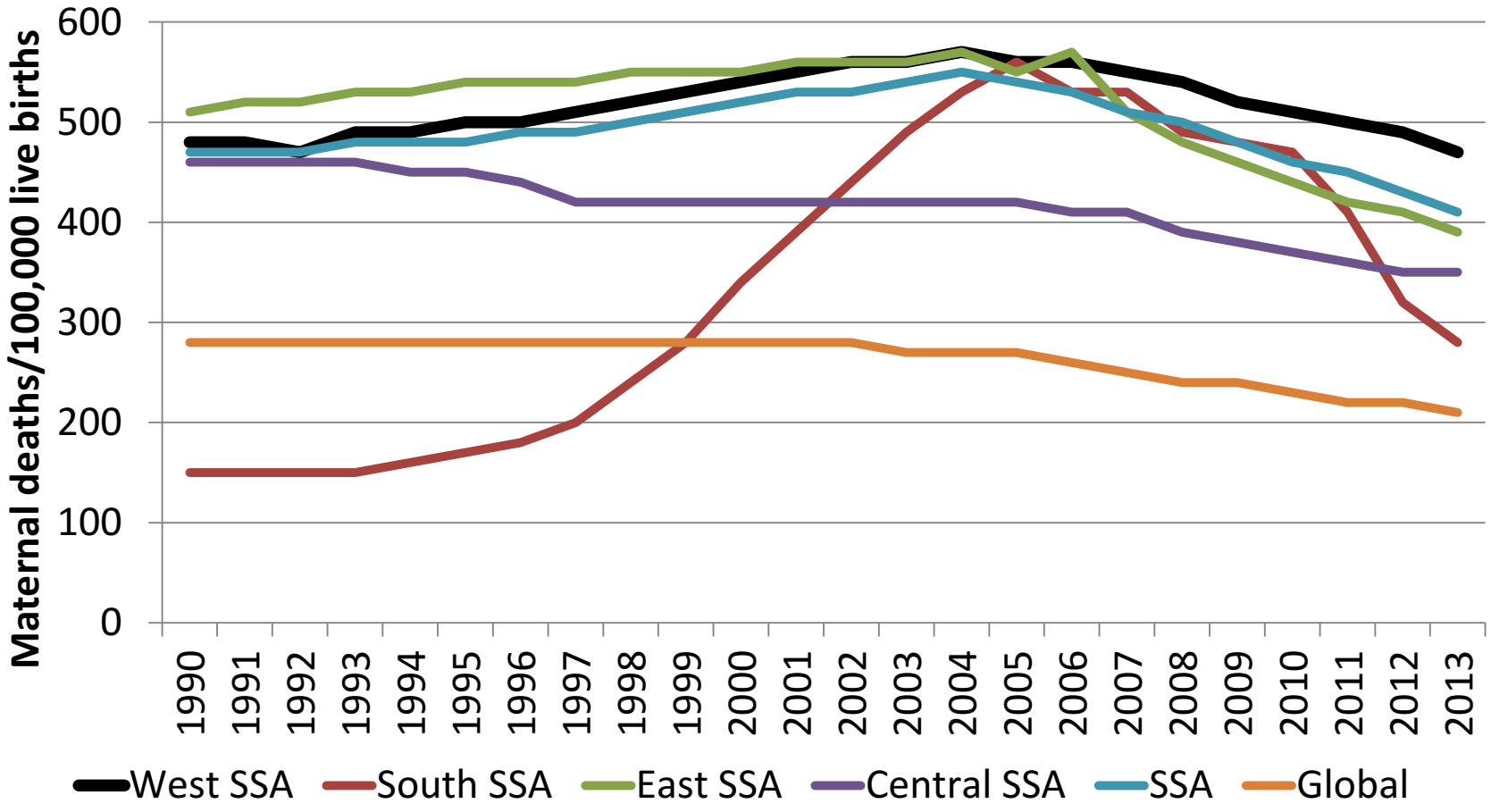
Child Mortality trends in West Africa against global and SSA

(Source of data: IHME July 2014. GBD 2013 data. https://www.healthdata.org/results)

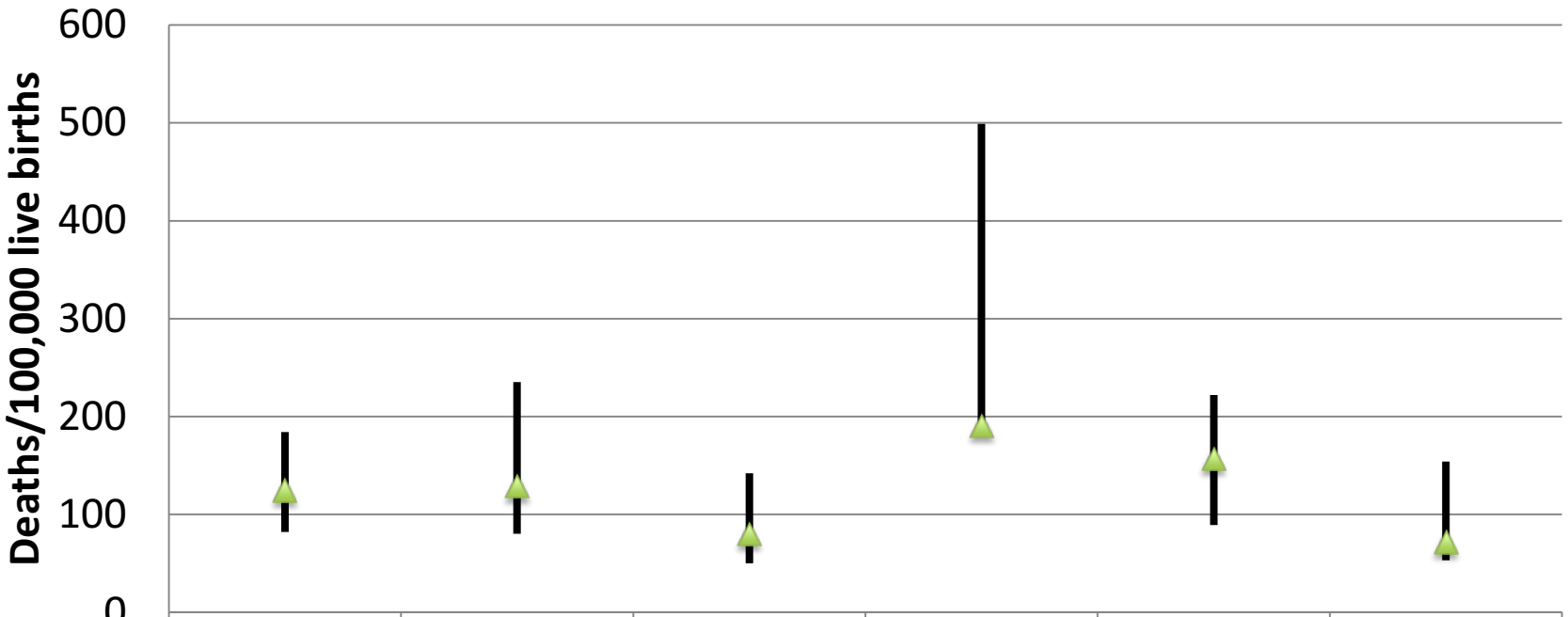


Maternal Mortality in West Africa compared to global and SSA

(Source of data: IHME July 2014. GBD 2013 data. https://www.healthdata.org/results)



Between & within country variation in 0-5 yrs mortality in West Africa (Demographic and Health Survey [DHS] data}



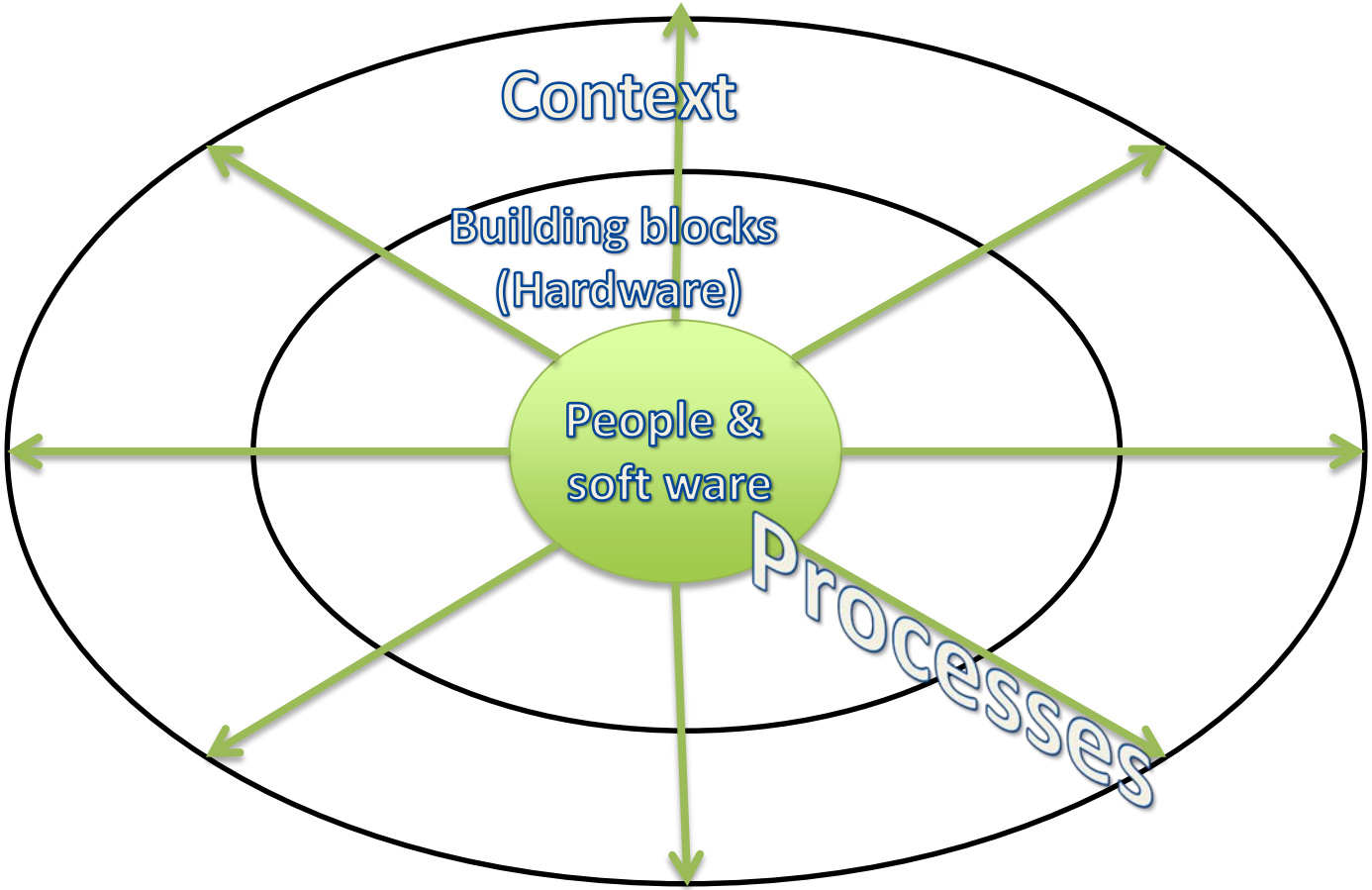
	Benin (2006)	Burkina Faso (2010)	Ghana (2008)	Mali (2006)	Nigeria (2008)	Senegal (2010)
Higest	184	235	142	499	222	154
Lowest	82	80	50	196	89	53
▲ Mean	125	129	80	191	157	72

Objectives

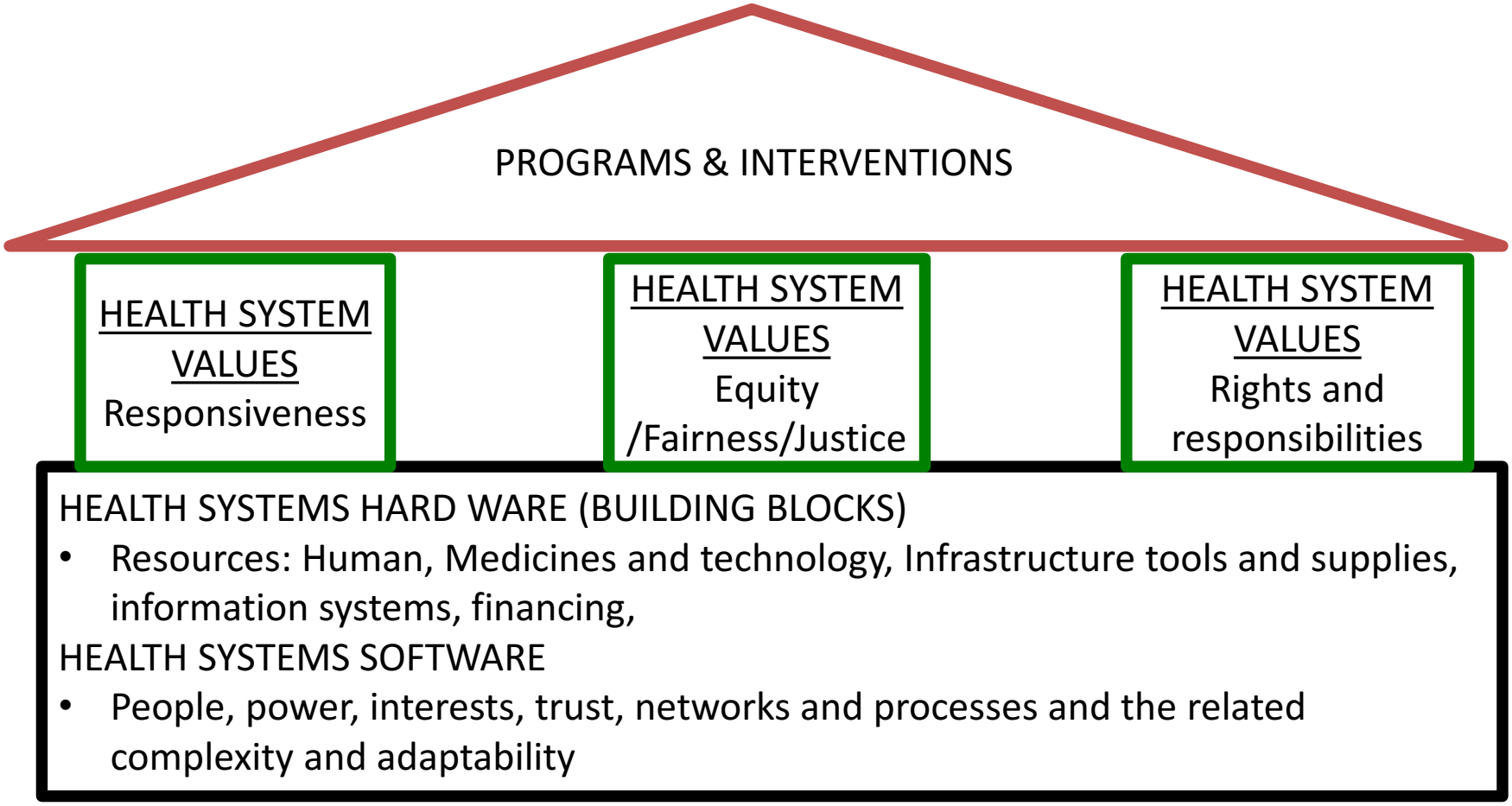
- To understand health system factors that have facilitated or limited the attainment of Maternal, infant and child health outcomes improvement in West Africa.
- Specifically to review the ‘what’, ‘how’ and ‘why’ of conducive and limiting health systems factors to implementing effective Maternal, New born and Child Health (MNCH) interventions and attaining improved MNCH outcomes
- FOCUS: West Africa with a particular focus on the six countries of the WAHO IMCHA project namely, Benin, Burkina Faso, Ghana, Mali, Nigeria, and Senegal.

CONCEPTUAL FRAMEWORK

People and processes at the center of health systems



Health Systems as the foundation that supports programs & interventions



Methods

- Mixed methods descriptive and analytic multi-country study
- Data collection through a non exhaustive desk review(scoping) of grey and published literature: Anglophone and Francophone
- West Africa in general and Benin, Burkina Faso, Ghana, Mali, Nigeria and Senegal in particular
- Time frame for search = 1990 - 2015.

Methods: KI interviews

- Purposive from list of contacts provided by WAHO of in country national & mid-level key actors and stakeholders and health system and MNCH
- Government, Non Governmental, Development Partners
- 40 KI interviews
  - Six (6) each in Burkina-Faso, Benin, Mali and Senegal;
  - 5 in Nigeria
  - 11 in Ghana
- All interviews by same two team members (one Anglophone and one Francophone) using face-to-face, telephone and Skype.
- Ethical clearance from GHS ERC
- Informed consent: Where permission was given interviews were recorded, otherwise notes only

FINDINGS

Interventions

- Mortality Audits
  - Community (verbal) audit
  - Facility based reviews
  - Confidential enquiry into maternal death
- Near miss Audits
- Criterion based clinical audit
- Referral
- Electronic /Mobile based Health interventions
- Task shifting

- Financing interventions
  - Out of Pocket (OOP) Users fees introduction, reduction, or removal interventions
    - Exemptions e.g free C/S, antenatal, delivery etc.
    - Community Based Health Insurance (CBHI)
    - National Health Insurance (NHIS)
  - Conditional Cash transfers
  - Performance based financing
- Preventive care
  - Ante natal
  - Post natal
  - Family planning

Software

- People as internal (providers) and external customers (clients)
- Responsiveness of organizations and institutions to responsiveness needs of internal customers
  - Lack of respect /respectful treatment
  - Burnout (Emotional exhaustion, Depersonalization)
  - Act by reducing motivation and reinforcing negative attitudes
  - Some staff found “internal resilience” to counteract

Software

- External customer issues – People as clients
- Knowledge /Awareness/Education and counselling e.g.
  - danger symptoms
  - Awareness of policy on free delivery care at the health facility, high level of awareness among women of ANC services
  - Health care staff advice to pregnant women to delivery at facility
- Expectations and related issues e.g. why they need to be referred when there is a nurse in the community facility
- Beliefs e.g.
  - Cultural inhibitions
  - Beliefs about blood transfusions etc. etc.
- Gender issues (*another group is studying this in detail)
  - Women must be well-behaved and justify less obvious needs in an unequal bargaining process with ambivalent recourse opportunities
  - Women may suffer delays in or exclusion from healthcare
  - Women's low self-esteem and their domestic power imbalance

Software

- Responsiveness as value manifested in outcome
- Client experiences of:
  - intimidation and being scolded
  - limited choices
  - “silent” treatment
  - lack of privacy.
- Negative provider attitude towards clients e.g. Poor skilled birth attendant attitude as reasons to use home birth and refuse skilled attendant
- Availability of caring midwives at health facilities as reasons for facility based care seeking

Software

- Equity as value manifested in outcome
- In relation to clients (external customers)
  - Staffing inversely related to poverty and level of need
  - Fee removal disproportionally benefiting the wealthier groups. (Mali)
  - Women in the poorest income group less likely than other women to seek care even when insurance is available.
  - Women in the poorest income group are less likely to be insured, despite the modest and heavily subsidized enrolment
  - The richest households had more decline in out-of-pocket payments
  - The rich benefited more than the poor
  - Evidence of reductions in inequalities of access with removal of out of pocket user fees
- In relation to providers (internal customers)
  - Perceived inequity in distribution of incentives

Hardware - Governance

- Limiting factors
  - Nature and Depth of implementation of decentralization
  - Insufficient decentralised decision-making authority
  - Decentralization policies that do not address public accountability of those who decide and act
  - Leadership and interpersonal relations among staff
  - Higher level officials failure /refusal to recognize, acknowledge and deal with the frontline worker resource availability, motivation and constraints
  - Top down approaches to policy making, inadequate consultation, inadequate dissemination
  - Adhoc decision making& priority setting relying predominantly on individual enthusiasm leaving room for bias

Hardware - Governance

- Conducive factors
  - Softened institutional power hierarchies
  - Egalitarian team functioning e.g. shared decision making and responsibility for results
  - Facilitation of local innovation and continuous improvement
  - Multi-stakeholder, multi-level participation in governance to improve decision-making and accountability

Hardware – Medicines & Technologies

- Shortages, inadequacies, non availability of essential medicines, tools, supplies (includes blood) and technologies
- Infrastructure problems
- Availability of essential equipment, medicines, tools, supplies and technologies
- Construction of infrastructure

Hardware – Human Resources

- Factors affecting motivation and attitude
  - Internal customer responsiveness issues (see under software)
  - Hardware
    - Poor conditions of service
    - lack of work place protection
    - Remuneration
    - Availability /access to resources (equipment, tools and supplies, work environment)
    - An opportunity to gain additional education was the most important factor for midwifery students in deciding where they would eventually work

Hardware – Human Resources

- Numbers
  - Shortages of health care workers in all categories and at all levels
  - Poorly implemented and managed task shifting
  - Mal-distribution
  - Well implemented and managed task shifting (includes appropriate capacity building, supervision and support)
- Competence and skills (include training and capacity building)
- Performance Incentives and disincentives

Hardware – Service Delivery

- Service Availability
  - Lack or availability of various levels of service
  - Location /Distance from clients
- Transportation
  - Poor/lack /inappropriate transportation and ambulance systems
- Communication
  - Between health workers (within facility, referral related)
  - Between health workers and clients
- Care in facility
  - Infrastructure challenges affecting care
  - Delays in care on arrival
  - Care during referral transportation
  - Service delivery procedures
-

Hardware - Financing

- Inadequate program financing
- Out of pocket payments (OOP)
- Conditional Cash transfers
- Effect of OOP modified by other barriers e.g.
  - Service availability and perceived quality
  - HR issues

Hardware – Information Systems

- Quality of information& documentation in medical files and records
- Gaps in data influences the quality of data for decision making and priority setting e.g. low awareness of scale on MN mortality
- Traditional priority setting tools do not reflect long term benefits of preventive interventions such as FP
- Low transparency of information on budgets and outcomes
- Significant potential to improve access to and use of data for decision making
- **Vital Registration systems**
  - mandatory but is implemented poorly
  - Under-resourced Department of Births and Deaths Registry
  - Improvement in the civil registration /vital statistics system (supports maternal death audits)
- Communicating information e.g. Organization of attention generating events to create visibility for issues

Context

- Social and Cultural
  - Other household and community members influences on care seeking and decision making
  - Low status of women, lack of control over decision making, low value on girls education
  - Rural versus Urban residence
  - Religion
- Economic
  - Microeconomic – Individual and household SES
  - Macroeconomic context
- Political
  - Transitions
  - Ideologies
  - Priorities
  - Champions
- International /Global
  - International agendas e.g. MDG, SDG
  - Donor priorities
  - Global Economic factors

Context – Other systems

- **Roads and public transport**
  - Poor quality roads, sometimes rendered inaccessible; Poor public transport availability and networks
- **Security**
  - e.g. armed robbers at night affect referral transportation and time (Ghana); Armed conflict in Northern regions of Mali
- **Communications**
  - Poor mobile network connectivity especially in the more rural parts of the district
  - Language barriers
- **Education**:
  - e.g. Literacy (mothers education) predicted use of safe motherhood care
- **Water and Sanitation**
- **Food and Nutrition**

PULLING IT ALL TOGETHER

Figure 8: Explanatory Theory /Framework – Context, Health Systems and MNCH outcomes

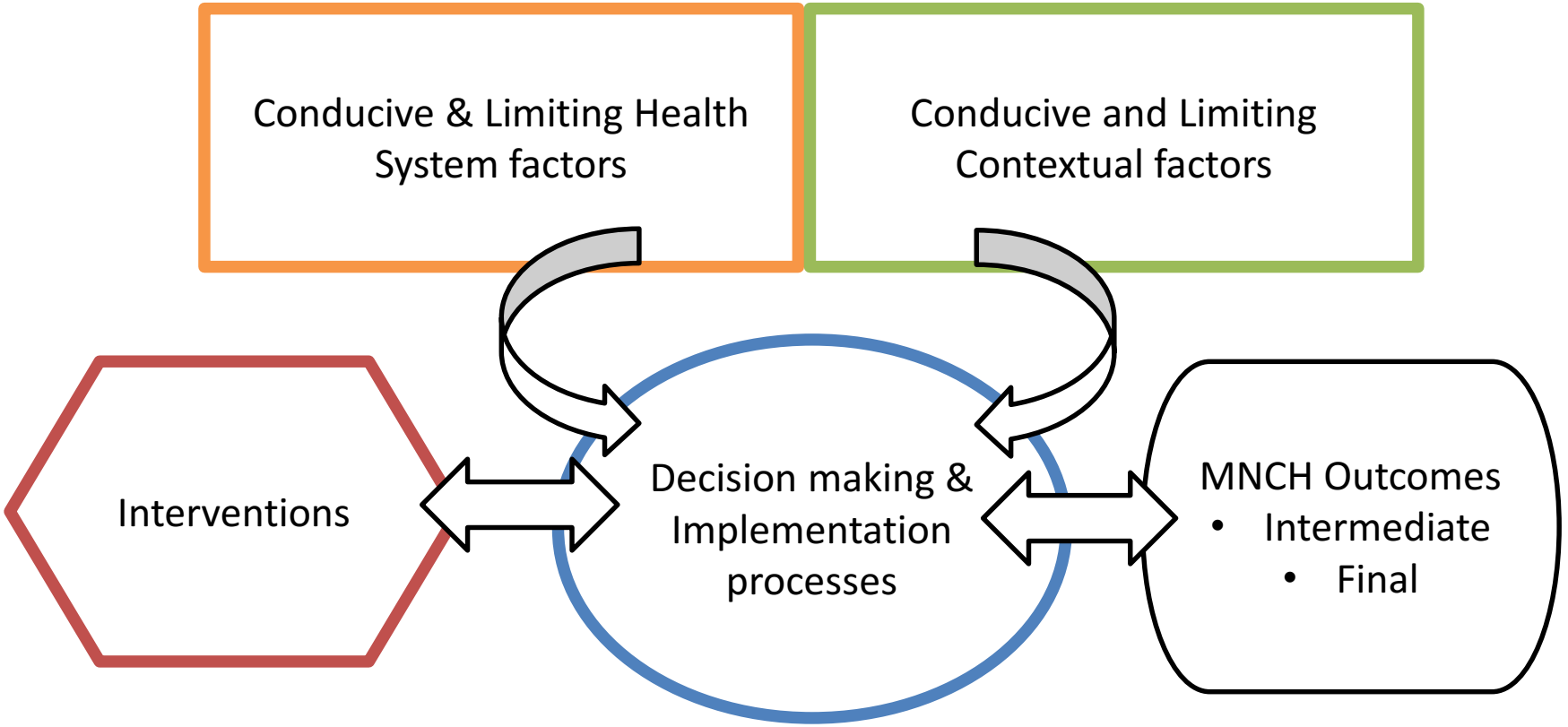


Figure 9: Illustration with Emergency Obstetric Referral

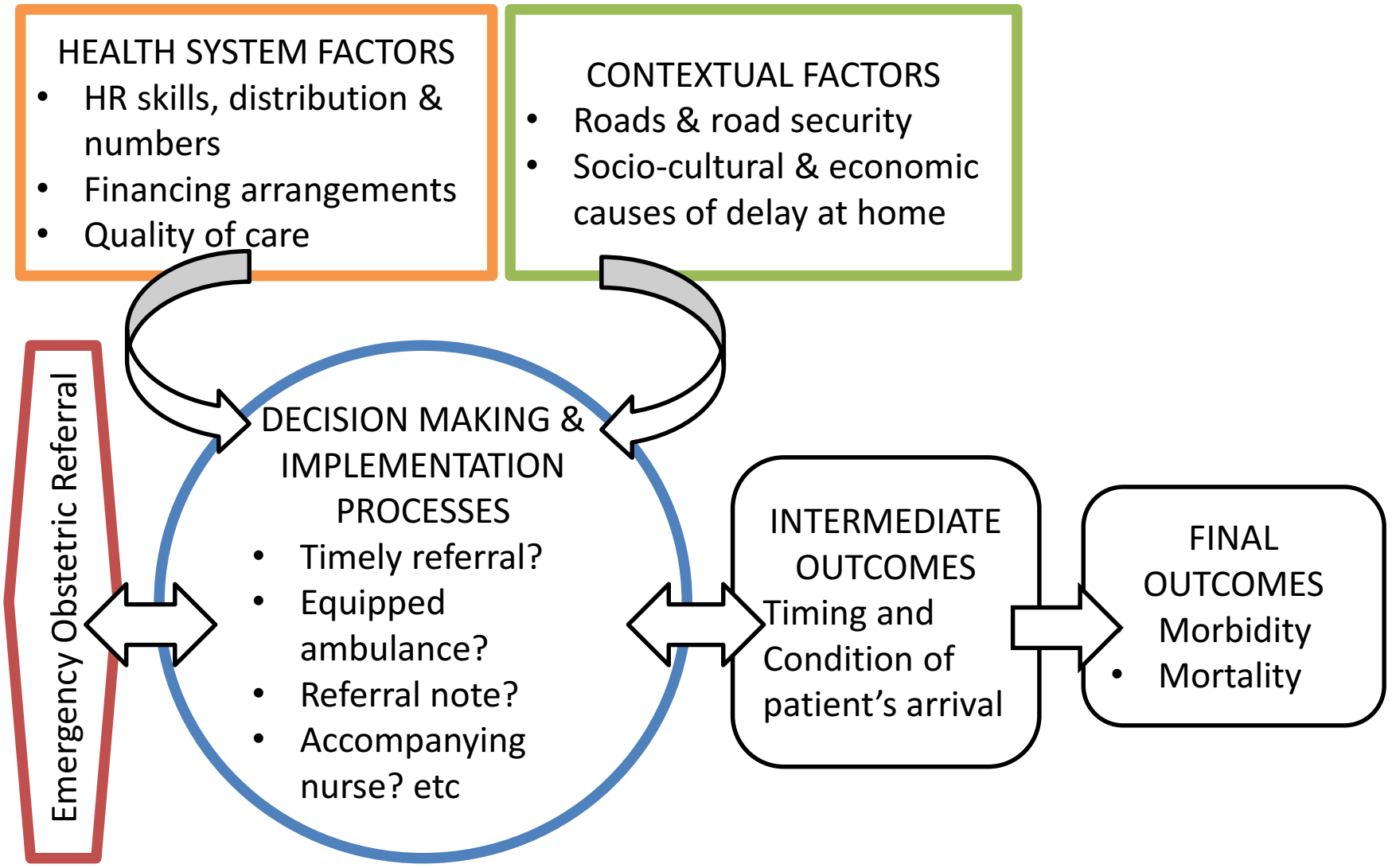
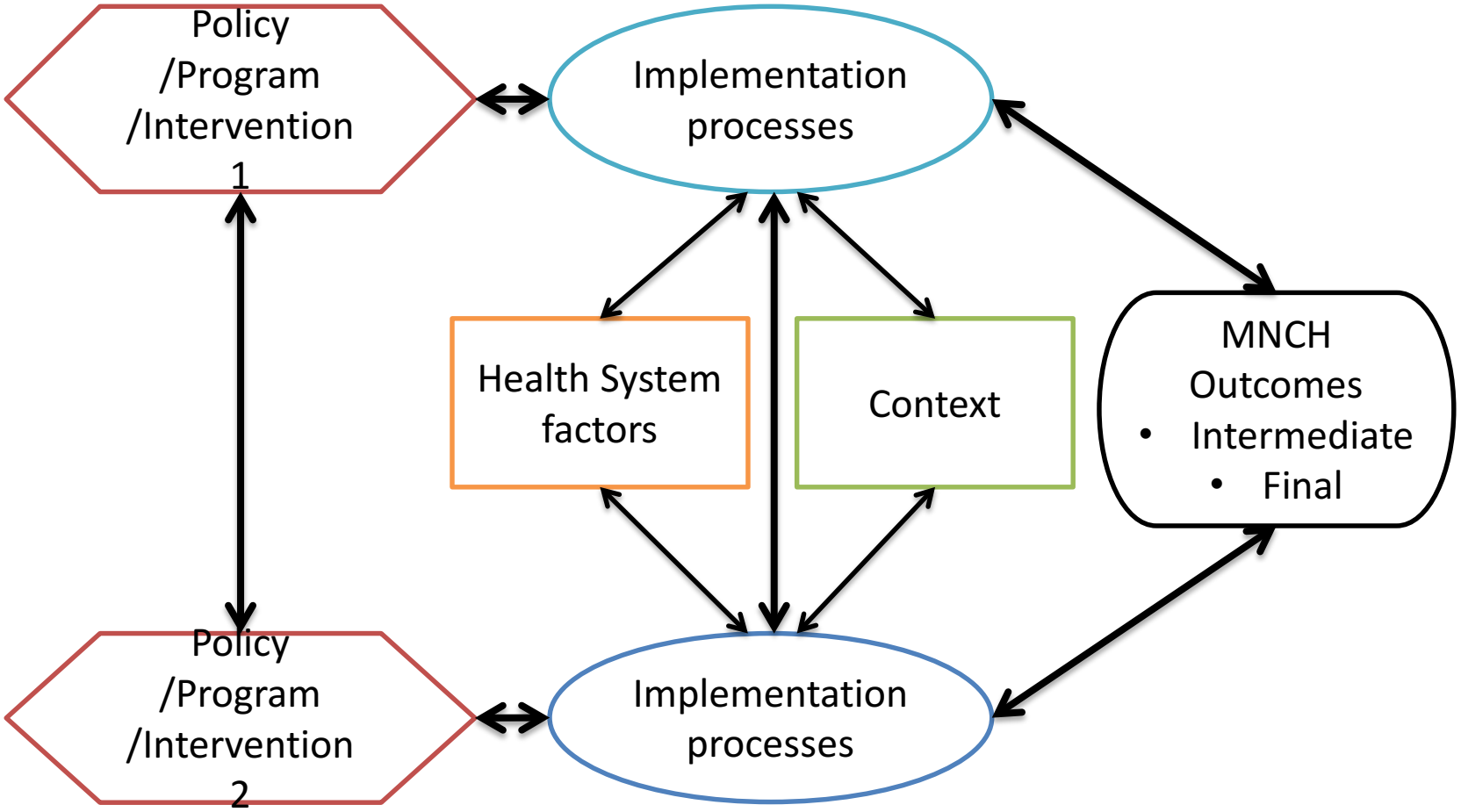


Figure 10: Superimposing complexity: Multiple interacting programs



Conclusions

- The conducive and limiting factors are generally mirror images of each other.
- However almost all the papers reviewed turned up more limiting than conducive factors.
- Approximately for any one conducive factor described, there were 4 limiting factors
- Confirms that there is much outstanding work to strenghthen health systems in the sub-region.

Conclusions

- Achieving MNCH outcome improvements can only happen when strengthening HPS is done together with putting MNCH interventions in place
- The separated research and practice communities working in HPS and MNCH need to be brought together to think and work together

Next Steps

- Complete report
  - KI interview analysis
  - Give KI (who want to) opportunity to read and make any comments before public dissemination
  - Final report
- To inform policy and practice community: Work with WAHO to:
  - prepare Report summary briefs
  - Prepare Advocacy and Policy briefs
  - Disseminate in sub-region and support use of information in decision making and practice
- Publish to inform scientific community

Research Team

- Irene Akua Agyepong(1,2),
- Aku Kwamie (1,2),
- Selina Defor (1,2),
- Edith Frimpong (1,2),
- Genevieve C. Aryeetey (2),
- Abdallah Ibrahim (2),

  - 1 Ghana Health Service, Research and Development Division
  - 2 University of Ghana School of Public Health