Preventing Maternal Death from Postpartum Hemorrhage in Yemen

Well over a half million women die during pregnancy and childbirth each year, 99 percent of them in developing countries. A quarter of these women bleed to death, most (90 percent) from the complications of postpartum hemorrhage (PPH).

PPH occurs when the uterus fails to properly contract after childbirth, and bleeding from blood vessels in the uterus is not controlled. Most cases of PPH occur within 24 hours after birth. Without immediate and proper medical attention (appropriate drugs, blood transfusion, surgical intervention) women with PPH will probably die.

Studies show that the higher the proportion of deliveries attended by skilled health personnel in a country, the lower the country’s maternal mortality rate (MMR). In developing countries, a small number of women have access to first-level, minimally equipped facilities. Far fewer deliver in hospitals that can provide good case management, appropriate equipment and supplies, and specialized care when needed. The majority of women deliver at home and in communities where there is poor access to skilled providers, medical equipment and supplies, and transport to good emergency services.

Yemen’s MMR is very high, 850 per 100,000 live births. Eighty-four percent of deliveries take place at home, unattended by skilled personnel. Complications from childbirth are due mainly to PPH.

To help resolve the problem of Yemen’s high MMR, PHRplus/Yemen sponsored the participation of five midwives at a conference on “Preventing Postpartum Hemorrhage: From Research to Practice” in Bangkok in January. Three of the midwives are from the USAID-targeted governorates of Amran, Shabwa, and Al-Jawf; also in the group were the Director of the Community Midwives Training Project and a PHRplus consultant who is also a midwife.

They joined more than 80 other participants from Southeast Asia, the Middle East, Africa, and the United States at the conference, organized by JHPIEGO’s Maternal and Neonatal Health Program, USAID’s Asia/Near East Bureau, the World Health Organization, the Royal Thai government, and Chulalongkorn University. Presentations focused on PPH.
Partners for Health Reform plus
National Health Accounts Subanalyses Measure HIV/AIDS and Reproductive Health Spending

That developing countries suffer disproportionately from health problems is well known. For example, according to UNAIDS, HIV/AIDS is the principal source of disease burden in the developing world, and it is currently the primary cause of death in Africa. In sub-Saharan Africa, average life expectancy has plummeted to 47 years of age and in certain countries it is expected to fall further, to about 30 years. More than half million women die each year from complications related to pregnancy and childbirth; 99 percent of these deaths occur in the developing world.

To understand government and private spending to combat these health problems, the PHRplus National Health Accounts (NHA) team is working with a number of international organizations – Joint United Nations Programme on HIV/AIDS (UNAIDS), World Health Organization (WHO), the World Bank, the Regional AIDS Initiative for Latin America and the Caribbean (SIDALAC), the Organization for Economic Co-Operation and Development (OECD), and others – to develop an internationally accepted NHA “subanalysis” methodology that will standardize tracking of resources for specific health problems. A standardized methodology will help national health systems evaluate health care program options and adjust resource allocation policies to best meet the health care needs of their populations. It also will allow them to compare their performance to that of other countries.

In addition to international coordination, PHRplus is working with several NHA regional network member countries to implement NHA subanalyses.

▲ At a workshop in November 2003, PHRplus helped Rwanda launch a second round of NHA to measure total 2002 national health expenditures; the round includes two subanalyses, on spending for HIV/AIDS and tuberculosis care and for reproductive health services. The workshop was broadcast on national television and radio, and covered extensively by print media.

▲ A PHRplus workshop in Kazakhstan in December trained NHA teams from the 11 nations in the Commonwealth of Independent States regional network in the general NHA methodology and HIV/AIDS subanalysis.

▲ Training workshops that included the HIV/AIDS subanalysis also were held in late 2003 in Zambia and Senegal.

▲ PHRplus is helping Egypt and Jordan to conduct subanalyses on reproductive health services.

For further information, contact cheri_rassas@abtassoc.com ▲

For further information, contact roselyn_ramos@abtassoc.com ▲

For further information, contact cheri_rassas@abtassoc.com ▲

studies conducted in a number of developed and developing countries that sought strategies and best practices for implementing large-scale programs to prevent and treat PPH and incorporate them into an action plans to combat PPH. Findings repeatedly indicated that active management of the third stage of labor (AMTSL) routinely reduces the risk of PPH. Giving women the uterotonic drug, oxytocin, immediately after childbirth is probably the single most important intervention to prevent PPH. AMTSL is effective where health facility staff work collaboratively and can incorporate AMTSL into routine care. Too often, however, staff resist change, facilities are short of staff, or drug supply and management is lacking.

The Yemeni midwives prepared a conference poster that described the health status of women in Yemen and programs to improve maternal health status. They also presented a country action plan that addresses the areas of policy, training, supervision, and drug logistics, the latter including the regular supply, appropriate storage, and safe provision of uterotonic agents used to effectively manage the third stage of labor.

The Yemeni Ministry of Public Health and Population has developed guidelines for AMTSL, but an enabling environment does not exist. Strong advocacy will be required to convey the magnitude of the PPH problem in Yemen to policymakers, communities, and other stakeholders, and to find champions to energize them to take action. The plan of action developed by the midwives is a step in this direction.

For further information, contact cheri_rassas@abtassoc.com ▲

NHA tracks health care expenditures from financing sources, such as governments, donors, and households; through financing agents, such as ministries of health and insurers; to the ultimate uses of funds.
Ensuring that Peruvian Public Health Insurance Reaches the Poor

In a recent speech to Peru’s Congress, the new Minister of Health highlighted an innovative methodology, spearheaded by PHRplus, to ensure that financial assistance for health care indeed reaches the very poorest in the population.

The Seguro Integral de Salud (Peru’s Integrated Health Insurance), SIS, which funds the provision of maternal, child, and adolescent public health services, has approved the adoption of an “individual targeting methodology” to identify users of care who will be eligible for reduced user fees or subsidies. This methodology (Sistema de Identificación de Usuarios, or SIU) will profile users in terms of objective criteria: demographic information, housing characteristics, asset ownership, and geographic location. The SIU will reduce “leakage” that allows subsidies for the non-poor (current leakage to the non-poor accounts for 38 percent of the annual SIS budget of more than $50 million). The SIU also will permit the SIS to more efficiently target its resources to the poor, because fees can be set on a sliding scale, according to the user profile and ability to pay.

The decision of the SIS to adopt this targeting methodology came about as a result of a joint analysis by PHRplus, the SIS, and the National Association of Social Workers in the Health Field (Asociación Nacional de Asistentas Sociales de Salud).

PHRplus’ technical assistance to the SIS was focused on three areas: validation of the criteria on which subsidies are based, evaluation of the political environment for individual targeting, and development of guidelines to implement the new targeting system. In order to incorporate lessons learned from elsewhere in Latin America, PHRplus chose a consultant who earlier designed and implemented the most successful individual targeting system in Latin America, the Colombian SISBEN (System for the Selection of Beneficiaries of Social Programs) to lead its technical assistance team. Over 10 years, SISBEN has provided local governments with a cost-effective technical instrument to direct social expenditures to the poorest and most vulnerable groups. The SIU, while specific to Peru, was able to benefit from lessons learned in the Colombian experience.

To encourage adoption and proper use of the new methodology, PHRplus developed an advocacy strategy for workers both inside and outside the health care system. For example, to make sure that social workers understand the importance of using observable and verifiable information to identify users of care, PHRplus sponsored three workshops, in Lima, La Libertad, and San Martin. PHRplus also reached out to key stakeholders in other social sectors, such as the Ministry of Economy and Finance, the Presidency of the Council of Ministers, and the Ministry for Women and Social Development, to encourage use of the SIU as a common targeting system for a range of subsidized social programs, such as the Vaso de Leche and other food supplement programs.

For further information, contact kathleen_novak@abtassoc.com

Senegal Formalizes a National Mutual Health Organization Plan

A broad mix of key stakeholders involved with mutual health organizations (MHOs) in Senegal met in the Thies region on January 14-16 to review a strategic plan for further MHO development in that country. The approximately 80 participants included staff from the Ministry of Health and other government agencies, MHO managers, community leaders, health care providers, representatives of MHO support structures, and external partners. It was the first time that all interested parties gathered to discuss a national strategy.

To encourage adoption and proper use of the new methodology, PHRplus developed an advocacy strategy for workers both inside and outside the health care system. For example, to make sure that social workers understand the importance of using observable and verifiable information to identify users of care, PHRplus sponsored three workshops, in Lima, La Libertad, and San Martin. PHRplus also reached out to key stakeholders in other social sectors, such as the Ministry of Economy and Finance, the Presidency of the Council of Ministers, and the Ministry for Women and Social Development, to encourage use of the SIU as a common targeting system for a range of subsidized social programs, such as the Vaso de Leche and other food supplement programs.

For further information, contact kathleen_novak@abtassoc.com

Partners for Health Reformplus, April 2004
Partners for Health Reform plus, April 2004

Partners for Health Reform (for community-based MHOs) and national professional organizations (for their own MHOs); as well as an analysis of the role of support structures in MHO development, produced by the Concertation. Evaluation results were then incorporated into the strategic plan.

Workshop recommendations included five strategic directions for the national plan: (i) develop capacities for implementing, organizing, and extending MHOs; (ii) strengthen capacities of actors who develop MHOs; (iii) implement communications plans to promote MHOs; (iv) develop effective partnerships among actors; and (v) strengthen state support of MHO development. A draft of the national MHO strategic plan that includes these recommendations will be completed in April and presented to a validation workshop in May. The plan will then be incorporated into the national health development plan (Programme National de Développement Sanitaire du Sénégal) in June.

For further information, contact jessica_rushing@abtassoc.com

Quick Response Limits Meningitis Outbreak in Ghana

The three-year collaboration between PHRplus and the National Surveillance Unit of the Ghana Health Service/Ministry of Health paid off recently, in the successful control of a meningococcal meningitis outbreak in Kassena Nankana district in Upper East Region. In December 2003, when the first cases of meningitis were detected, health personnel promptly implemented the Integrated Disease Surveillance and Response (IDSR) strategy for disease surveillance. Local health facilities, in collaboration with district and regional personnel, identified, investigated, and responded to the outbreak. This proved effective in limiting the outbreak to 66 cases and two deaths.

Since 2001, PHRplus has worked with the National Surveillance Unit (NSU) to adapt and implement for Ghana the Africa regional IDSR strategy developed by WHO/AFRO and the U.S. Centers for Disease Control. The PHRplus-NSU collaboration first published Guidelines for Integrated Disease Surveillance and Response in Ghana, a roadmap to the operation and function of IDSR for more effective health services particularly regarding 23 priority diseases, including meningitis. They then trained health facility staff to implement the strategy (see Highlights, May 2002, April 2003).

While IDSR in Ghana is a national strategy, PHRplus efforts are focused on three regions in the northern part of the country (Northern, Upper West, and Upper East). These regions have been identified as particularly vulnerable to periodic outbreaks of infectious diseases. PHRplus has supported these regions to build the capacity of facility staff to better identify, report, and respond to cases of disease.

In the recent outbreak, facility workers applying standard case definitions and communicating effectively with district and regional teams were able to quickly identify the meningitis and treat those affected according to established guidelines for effective case management. Public information efforts were stepped up. Regional staff used information collected by local facilities to organize effective “mop-up” immunization campaigns in Kassena Nankana and neighboring districts to further contain the outbreak; more than 20,000 people were vaccinated.

The region and districts continue to monitor the situation closely. The National Surveillance Unit, regional partners, and PHRplus will use data generated during the outbreak to review the effectiveness of the strategy as well as its implementation.

For further information, contact jim_setzer@abtassoc.com

Using Geographic Information System Applications for Health in Yemen

PHRplus is developing a health GIS (geographic information system) for the Republic of Yemen to allow national- and governorate-level health officials to visualize and understand health issues, and make decisions more easily.

A GIS links data from surveillance systems, surveys, and health information systems (HIS) where their common reference points are geographic locations, such as health facilities or districts, or another spatial reference. The GIS, combined with HIS data, can provide evidence-based rationale for a variety of applications in a health care system:

▲ Improve distribution of preventive and curative care
▲ Enhance facility utilization
▲ Target resources to meet health care services demand
The Influence of Social Participation on Success of Community-Based Health Financing

How critical is social participation to the success of community-based health financing (CBHF) schemes?

As public health systems in developing countries are increasingly unable to finance growing demand for services, national governments and international donors look to CBHF schemes to protect relatively poor populations from the financial risks of illness. The WHO’s Commission on Macroeconomics and Health calls such schemes the most promising domestic financing strategy in low-income countries.

PHRplus, and previously PHR, has helped to establish new CBHF schemes in West Africa for more than five years. In doing so, PHRplus has developed methods of working that depend on extensive social participation at the community level, consistent with CBHI’s roots in traditional community “solidarity” initiatives. However, it is not clear how successful these schemes will be if mandated by government and rolled out rapidly across countries, without the same degree of community consultation and social participation.

PHRplus developed a conceptual framework and is implementing a study to examine how different forms of social participation are used at different stages of scheme development. Through in-depth interviews with project field staff and focus group discussions with scheme and community representatives in nine PHRplus-assisted and other selected schemes in Senegal, PHRplus is documenting who participates, how they participate, modes of working with various stakeholder groups, and the perceived effects of participation. Special attention is being paid to how poor and vulnerable members of the community are incorporated into scheme participation processes. The project hypothesizes that inclusive social participation leads to scheme stability, sustainability, and equity.

Findings from the study will shed light on how feasible it is to roll out CBHF schemes rapidly, and will also provide those assisting the development of schemes with insights as to how effective their community mobilization approaches are. Preliminary findings will be available in late spring.

For further information, contact cheri_rassas@abtassoc.com

For further information, contact raj_gadhia@abtassoc.com
Addressing Informal Payments for Health Services in Albania

In many countries where health care is theoretically free but resources — for salaries, drugs, and other components of service — are severely limited, care is effectively rationed. An “informal payment” may procure the services, supplies, or drugs that are otherwise unavailable, and be the difference between life and death — or be perceived as such, on the part of the patient. Are such payments sincere gifts? Bribes? Are providers comfortable taking them? How do they affect the broader health system?

In Albania, there is growing concern about the extent of informal payments for health care services and their potentially detrimental role in hampering ongoing efforts to improve the health system in terms of quality, efficiency, and equity. PHRplus recently conducted two analyses that delineate the scale of informal payments for health services, the process through which such payments are made, and patient and provider perceptions about the payments. The 2002 Albania Baseline Health Survey, a survey of 2,000 households and 26 health facilities in three districts, provided information on out-of-pocket health care payments and health care utilization patterns. PHRplus also conducted a qualitative study on informal payment involving health care providers and the public in the same areas in 2003.

The findings suggest that informal payments are widespread and substantial across a wide range of health services. These payments are especially significant for inpatient care where out-of-pocket expenditures (official fees, informal payments, and gifts) can be catastrophic particularly for poor households. The analyses also highlight important discrepancies between the providers’ and the public’s perceptions — the majority of the public described informal payments as being a misuse of power by health care providers, whereas most providers perceived payments to be patient contributions toward the cost of care, payments for additional services, or simply gifts. Both groups believe, however, that the practice is driven by a lack of trust in the health system.

These results from Albania, together with research findings from other central and southeastern European countries, provide important new insights into the role that informal payments play in care-seeking behavior and patient-provider interaction. The findings also reveal how informal payments that stem from a misuse of power and lack of accountability can affect the process of health reform. For example, informal payments can affect whether a needed service or procedure is provided, or they can cause a client to switch doctors frequently — in other words, they may affect continuity, quality, and efficiency of care. PHRplus will work with the government of Albania to determine appropriate policy options to reduce or eliminate informal payments in alignment with the government’s health sector goals.

In most countries, informal payments are “payments to institutions or individuals in cash or in kind made outside official payment channels for services that are meant to be covered by the public health system.”


They were arguing about whether the baby would live or die and…
I had the impression that I was dying, while [the doctors] quarreled about who would be the one to take the money.
(New mother in Albania)

We are losing our humanity.
(Nurse in Fier, Albania)

PHRplus will publish a report on the baseline survey in spring 2004, and on the qualitative survey in summer 2004.

For further information, contact Kate Stillman at kate_stillman@abtassoc.com.
Tanzanian District Health Teams Use Integrated Disease Surveillance and Response Data to Improve Performance

Involving local health personnel in data collection and providing them immediate feedback fosters motivation and encourages improved performance, as was recently demonstrated in Tanzania, where PHRplus supports implementation of Integrated Disease Surveillance and Response (IDSR), a strategy that enables health facility and district staff to quickly identify and respond to infectious disease outbreaks, thereby reducing morbidity, mortality, and cost.

In January and February, staff from PHRplus and its local partner, the National Institute for Medical Research (NIMR), visited all 12 intervention health districts. The original intention was to collect baseline data on the performance of district IDSR systems and then gradually develop capacity of district health teams to monitor their own performance. However, during pre-testing of data collection instruments in a non-project district, the health team insisted that the visitors provide immediate feedback, pointing out that “different people and organizations often come to collect data, but [we] seldom hear from them again.”

NIMR complied, holding a debriefing meeting to discuss how the team could begin to implement improvements, and then following up with a written report of the findings. The debriefing session – which focused on the quality of surveillance reporting and management of disease outbreaks – became the model that the data collection teams followed in all subsequent visits to health facilities and districts.

According to records of one district office, a health facility had failed to submit the required weekly surveillance reports for the quarter prior to the visit. Yet when the facility was visited, the clinical officer produced copies of all reports that had been sent to the district office. Report transmittal via local public transport was shown to be the problem. This led to a discussion about how communication might be improved and alternative means to submit reports were proposed.

In another district office, the data collection team found a weekly health facility report that included cases of cholera, yet when questioned, the District Health Officer (DHO) insisted that there had been no cholera for three years, that the person completing the report was not “qualified,” and that the reported cases probably were not cholera. When asked if the district had investigated the reported cases, the DHO admitted that he had not seen the report, that the staff had not told him of the reported cases, and that, in fact, action should have been taken. This situation demonstrated that reported information must be taken seriously.

PHRplus provided district health teams more complete results during IDSR training that followed the data collection visits. This allowed the teams an opportunity to compare their performance to that of other districts – another valuable lesson.

For further information, contact debbie_gueye@abtassoc.com

PHRplus Initiates Studies on Systemwide Effects of Global Fund

Monies disbursed by the Global Fund to Fight AIDS, Tuberculosis and Malaria, as well as other significant sources of funding for these diseases, will undoubtedly affect the broader health care systems of recipient countries. To support research that helps country level and global stakeholders understand such effects on health systems, PHRplus has led an effort to create the Systemwide Effects of the Fund (SWEF) Research Network.

At a PHRplus-organized workshop in Oxford, England, in October, SWEF members (see box) and country-level
The SWEF Network is a collaborative network of organizations in the North and South that currently includes:

- Miz Hasab (Ethiopia)
- Curatio International Foundation (Georgia)
- Instituto Centroamericana de la Salud (Nicaragua)
- Consultants in Benin
- International Health Policy Program (Thailand)
- Health Systems Trust (South Africa)
- PHRplus
- London School of Hygiene and Tropical Medicine
- Institute of Tropical Medicine Antwerp
- MEASURE Evaluation and Rational Pharmaceutical Management Plus
- IBF International Consulting

Policymakers refined a research protocol drafted by PHRplus for examining the system-wide effects of the Global Fund, and they developed guidelines to help researchers relate and report findings to policymakers. The research will seek to identify and assess process effects within the health care system (such as policy or operational changes), health system performance, and to some degree, service utilization and coverage of non-focal diseases. The country studies will concentrate on four thematic areas, namely the effects of the Global Fund on: policy processes, public/private mix, human resources, and pharmaceuticals and commodities. SWEF members have also developed research instruments for qualitative and quantitative components of the research, which will be adapted to fit the context of each study country.

The SWEF Research Network will conduct case studies in up to 10 countries in Africa, Asia, Latin America, and Eastern Europe. Country studies already underway include:

- Benin and Ethiopia (PHRplus);
- Georgia and Nicaragua (IBF International Consulting in collaboration with Curatio International Foundation and the Instituto Centroamericana de la Salud); and
- Cambodia (Institute of Tropical Medicine Antwerp).

SWEF research is funded by USAID, the European Commission, and other donors. To learn more about the SWEF Research Network and download a report on the conceptual framework or research protocol, please see www.PHRplus.org/swef.html.

For more information, contact kate_stillman@abtassoc.com

Partners for Health Reformplus focuses on the following results:

- Implementation of appropriate health system reform
- Generation of new financing for health care, as well as more effective use of existing funds
- Design and implementation of health information systems for disease surveillance
- Delivery of quality services by health workers
- Availability and appropriate use of health commodities

Nancy Pielemeier, DrPH, Project Director
Catherine Connor, Deputy for Operations
Steve Mason, Deputy for Finance
Sara Bennett, PhD, Research Advisor
Marty Makinen, PhD, Financing and Systems Reform Advisor
Jack Galloway, Field Implementation Advisor

Abt Associates Inc.
4800 Montgomery Lane, Suite 600
Bethesda, MD 20814 USA
Tel: 301-913-0500 Fax: 301-652-3916
http://www.PHRplus.org
E-mail: PHR-InfoCenter@abtassoc.com

Managing Editor: Liz Nugent
Copy Editor: Linda Moll
Design and Production: Michelle Munro
Communications Coordinator: Zuheir Al-Faqih

A copy of Highlights is posted on our website, www.PHRplus.org