Citizens Vote to Prioritize Health Issues in Peru

For the first time in Peru’s history, the popular vote has been used to prioritize the health concerns of citizens. Over three days in November 2004, nearly 124,000 residents of the Lambayeque region, a mostly rural area in northwestern Peru, cast voluntary, secret ballots to determine the major health problems that they want targeted in the region’s five-year strategic health plan. (The table on page 2 shows the top five health priorities.) The referendum (consulta ciudadana) was part of the country’s move toward health system decentralization, one component of which is a more participatory health planning process.

The regional referendum is significant in three respects:

▲ The binding nature of the vote. Historically, governmental authorities and medical personnel decided health priorities. Here, they committed to working with the vote outcome.

▲ The breadth of enfranchisement. In addition to targeting the usual, primarily urban voting population, referendum planners made special efforts to motivate and facilitate the participation of rural residents, a group typically excluded from decision making in Peru. Students 14 years and older, and members of the military and police, also typically disenfranchised, were allowed to vote.

▲ Ensuring inclusion of rural preferences. It was decided in advance that the item that received the greatest number of votes from rural residents would become the first priority in the regional health plan, regardless of the urban vote.

The 11 topics listed on the ballot represented findings of a Health Needs Assessment developed by PHRplus that used existing data to project future health care needs in terms of epidemiological requisites, operational issues concerning both the delivery of and access to health care, and the financing of that care. Assessment findings were refined at a regional workshop attended by health authorities, health providers, and other health experts, as well as by civic organizations and individual citizens.

An information campaign, which began with the announcement of the referendum ballot, reached out to urban and rural citizenry. Campaign workers and citizen volunteers visited potential voters in their neighborhoods.

(Cont. page 2 “Citizens Vote in Peru”)
As part of developing a new immunization management information system (MIS) in Yemen, the Ministry of Public Health and Population and PHRplus/Yemen conducted a household immunization survey in the Thula district of Amran, a USAID target governorate. The survey revealed gaps in official estimates of immunization-eligible population groups and reasons for vaccination avoidance, produced evidence on which to modify Yemen’s vaccination strategy – and made sure that household members received the immunizations they were previously lacking.

The survey, conducted in February, was designed to achieve three main goals: 1) count the number of children under one year of age and women aged 15–45 years in the catchment areas of four health facilities; 2) determine their immunization status and provide vaccinations to eligible children and women; and 3) identify what prevents people from being immunized in a timely fashion or at all.

Following a one-day training, the survey was conducted by mobile teams consisting of three district health workers and supervisors. The teams were provided with data collection forms, registers, EPI (Expanded Programme on Immunization) vaccines, and vaccination cards.

Survey results showed that the actual target population differed from administrative estimates by as much as 20-30 percent, and that tetanus toxoid coverage of childbearing-aged women was only about half the reported one. Lack of female vaccinators, remoteness of health facilities, and rumored contraceptive effects of immunization were the leading reasons for people not getting vaccinations. As part of the survey, 120 children under one year were vaccinated for childhood diseases according to the EPI vaccination schedule, and 757 women of childbearing age received the tetanus toxoid vaccination.

After analyzing the survey results, the governorate and district EPI management modified the strategy for improving immunization coverage. It now places greater emphasis on outreach immunization work, health education of women, and use of female vaccinators. The work also helped integrate the immunization program and other programs that use the same primary data. Periodic house-to-house visits by health facility staff will become an essential tool for the new immunization MIS.

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Citizens Vote in Peru (Cont. from page 1)

homes. In all, approximately 1,700 volunteers supported the voting process, including taking mobile voting tables to military bases, police stations, schools, and public squares. Voting was supervised by Peru’s National Electoral Process Office with participation of an external team of observers including representatives from the United Nations, USAID, and various NGOs.

“The consulta ciudadana was intended to determine health priorities as a primary goal,” said Luis Deza, regional health director. “But more importantly, the vote addressed the fact that Peru’s rural population was accustomed to being excluded from government decision making. In the end, 123,627 citizens – 32 percent of them from rural areas – helped to set priorities and, more importantly, experienced possibly for the first time what enfranchisement means.”

PHRplus currently is working with the regional health council of La Libertad region to hold a similar referendum; 200,000 voters are expected to participate.

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<table>
<thead>
<tr>
<th>Priority Health Problems in Lambayeque</th>
<th>Vote*</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Insufficient sanitation services (water, sewage, garbage)</td>
<td>45,322</td>
<td>18.32%</td>
</tr>
<tr>
<td>2. Lack of access of the poor to health services</td>
<td>35,643</td>
<td>14.41%</td>
</tr>
<tr>
<td>3. Mental health</td>
<td>31,351</td>
<td>12.67%</td>
</tr>
<tr>
<td>4. Malnutrition</td>
<td>26,806</td>
<td>10.84%</td>
</tr>
<tr>
<td>5. Maternal health</td>
<td>19,876</td>
<td>8.03%</td>
</tr>
</tbody>
</table>

* Voters could select more than one priority.
Turning on the Lights in Habbaba

On a trip to the USAID target governorate of Amran last summer, the PHRplus/Yemen team visited the village of Habbaba, site of a public health center that serves 594 households from four surrounding villages. Despite mountainous terrain, the center appeared to be accessible; it also is well managed and well staffed, with a general practitioner, medical assistant, pharmacist, lab technician, primary health care worker, and two support staff. A midwife provides care to women. Services offered include reproductive health and family planning care, routine vaccinations, and health education. The center also houses a private, basic laboratory, operated by a private provider and financed by user fees.

But the center’s appearance of prosperity was deceptive: When asked what the center needed to quickly improve the quality of care offered, the staff pointed out two basic necessities, “electricity and a phone line.” Despite proximity to the electric power grid, the center could not afford a connection.

The situation at Habbaba is indicative of – even if less severe than – that faced by most rural health care facilities in Yemen, where allocation of public health funds is highly centralized and traditionally directed disproportionately to hospitals and to urban areas. Public sources spent approximately US$106 million in Yemen in 1998 (35 percent of total health care expenditures); very little is budgeted for operations and maintenance, which has led to inadequately supplied facilities. Many peripheral facilities throughout the country lack even staff (and thus remain closed); in Amran, only 31 percent of facilities have electricity.

Nationwide, only 24 percent of rural residents have access to government facilities (about 42 percent of the overall population has access). For many people, this lack of geographic access to an operating facility is coupled with lack of financial access; they can afford neither the direct fees charged for care and prescription drugs nor the indirect costs of transport to facilities. In traditional areas, women’s access to care also is limited by social constraints – the need for male escorts to the facility and the need to be seen by women health workers, who are not readily available at health facilities in most of the country.

As a result, Yemen’s health indicators are among the poorest in the world, and the economic constraints to improving them are particularly severe.

Despite its certain advantages, the Habbaba health center’s lack of electricity was a frustration to the dedicated staff. Electricity would improve access and efficiency: The center could extend its hours of service, consider obtaining more sophisticated equipment, and expand both its roster of services and catchment area. This would decrease referrals to the capital of Sana’a, about an hour to the south, and the additional expense and risks incurred by referred patients. A phone line would enable the Habbaba center to have a fax and to communicate with the Governorate Health Office and hospitals in Sana’a, to expedite referrals when needed.

Upon investigating Habbaba’s predicament, PHRplus found that the cost of connecting to electricity and a phone line would total less than $600. The Director of Health for Amran, who accompanied the PHRplus team, offered to cover electricity and phone bills from his budget.

By November, the Habbaba Center was connected and in January was presented by PHRplus with a phone/fax/photocopy machine. The USAID-funded Catalyst project (with which PHRplus collaborates in Yemen) provided autoclave (sterilizer) equipment and an ultrasound and ECG machine, on which the center’s physician was trained. To further improve services, PHRplus will provide VCR equipment to allow health education videos to be shown in the center’s waiting room, and Catalyst will do minor renovations to the facility.

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Market Analysis in Egypt Leads to Policy Reform

Since 1997, Egypt’s Ministry of Health and Population (MOHP) has been implementing a Health Sector Reform Program, the objectives of which include enhancement of primary health care (PHC), and social insurance that ensures equity in access to and financing of care to the entire population. Over the past five years, the MOHP has implemented a model of PHC in the governorates of Alexandria, Souhag, and Menoufia. When the Ministry asked PHRplus to coordinate replication of the model in the governorate of Suez, it also approved the project’s request to precede implementation of reform with a market analysis that would identify the strengths and weaknesses of the Suez health sector and provide a baseline from which reforms could be evaluated.

The analysis would inform the adoption and implementation of reform policies and actions at the governorate and district levels by gathering quantitative data on topics such as the behavior and perceptions of health care providers and insurers in both the public and private sectors; consumer utilization of and expenditure on care as well as willingness to pay for care; and the role of large employers and industry in providing coverage for health care. Data was gathered through a survey of 1,047 households, 20 focus group discussions, 50 key informant interviews, and secondary data analysis.

Suez officials announced analysis findings in November 2004. Key findings are the following:

▲ Rich households are less willing than other households to participate in insurance schemes; this also reduces risk sharing and equity in financing.
▲ The majority of patients seek outpatient care with the private sector and the uninsured are more likely to be hospitalized in private facilities.
▲ The majority of people in Suez value free choice of providers.

Since November, PHRplus has organized dissemination activities that include group discussion of the findings and their implications for policy. The governorate reform leaders are already using the findings to plan and refine reform activities and the MOHP has called for:

1) revision of the exemption policy (which exempts the poor and vulnerable groups from paying user fees) at reformed MOHP facilities to expand access for the poor and uninsured;
2) IEC (information, education, communication) campaigns to encourage well-off populations to enroll in the reformed MOHP facilities in Suez;
3) expanding coverage to secondary care;
4) developing contracting mechanisms to include NGO and private facilities; and
5) free choice for families to enroll at any reformed MOHP facility.

PHRplus will support the policy reforms by estimating the cost of expanded coverage and identifying mechanisms for financing.

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PHRplus Issues New Toolkits

PHRplus/Albania and Albanian counterparts developed and tested a series of tools designed to strengthen primary health care (PHC) services. The series comprises three toolkits: on improving PHC service delivery, on improving PHC quality, and on a new facility-based PHC health information system. The Ministry of Health is using the tools to scale up improved PHC in Albania. The tools can be adapted for use elsewhere.

The toolkit is available at http://www.phrplus.org/Pubs/Tool012_fin.pdf

The Egyptian Ministry of Health and Population and PHRplus/Egypt have created a Surveyor Guide and Hospital Standards for use in the accreditation of hospitals. The standards were developed with the participation of government, university, teaching, and private hospitals in Egypt. While the standards are specific to the Egyptian context, they meet the basic intent of international standards and are adaptable to other contexts.

The Surveyor Guide is available at http://www.phrplus.org/Pubs/Tool014_fin.pdf and the Hospital Standards link is http://www.phrplus.org/Pubs/Tool013_fin.pdf
Replicating PHC Reform in Albania

U.S. Ambassador to Albania Marcie Ries spoke to health care professionals from throughout Albania who gathered to discuss recent primary health care (PHC) reforms achieved in the Berat region and ways to implement similar reforms in their locales. In opening a conference held in Tirana on March 17, Ries recognized the significance of PHRplus’ support of the development of an integrated PHC model, calling it “…a gift that keeps giving.” After the successful pilot in Berat, the PHC model is now being expanded to other regions and institutionalized at the national level.

The integrated PHC model was developed and tested in the Berat region from 2002 to 2004. The model consisted of training in family medicine, quality improvement tools and processes, management improvements, a PHC health information system, and community awareness campaigns. At the conference, Albanian counterparts from the Ministry of Health and district directorates described the model’s interventions, achievements, and lessons learned and led discussions on replication in other regions. Many elements of the model are already being replicated in certain areas by the Albanian government and other donor organizations – including training for PHC doctors and nurses, the health information system, and revised patient medical records.

To evaluate the impact of the PHC pilot, PHRplus measured the impact of the interventions on PHC utilization and primary care providers. Peggy Cook, PHRplus chief-of-party for Albania, shared preliminary results from pre- and post-intervention surveys of 2000 households. Differences in performance in the pilot sites were evident and statistically significant. Use of modern contraceptives in the pilot districts increased from 4.5 percent in 2002 to 7.6 percent in 2004, compared to no change in the control districts. In the same time period, utilization of PHC facilities for chronic care increased 29 percent (from 50 percent to 65 percent) in the pilot facilities, compared to an increase of 13 percent (from 37 percent to 42 percent) in the control facilities. Bypassing of PHC facilities – a drain on resources for providers and patients – in the pilot sites fell from 43 percent to 23 percent, suggesting increases in quality of and access to PHC services, while bypassing in the control sites remained virtually unchanged.

Overall, the survey findings suggest that the pilot areas outperformed the control areas with respect to a number of key population-based indicators of family planning and health care use. A final and detailed report on the impact of the pilot project will be available in June 2005.

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How the Global Fund Affects Health Systems

Researchers studying the effects of the Global Fund to Fight AIDS, Tuberculosis and Malaria (GF) on the functioning of health systems met in Geneva, November 29–December 1, 2004, to share preliminary findings of their investigations.

The researchers are part of the Systemwide Effects of the Fund (SWEF) Research Network, a collaborative research network that seeks to understand how monies being disbursed by the GF affect the broader health systems of recipient countries. Understanding how major disease-specific initiatives like the GF both depend upon functioning health systems and affect those systems is critical as the numbers and scale of initiatives and donors increase.

SWEF country studies have been launched in Benin, Ethiopia, Zambia, Uganda, Mozambique, Tanzania, Nicaragua, Georgia, and Cambodia. (See Highlights, April 2004, for a discussion of study goals.) During the Geneva meeting, organized by PHRplus as key partner in the Network, researchers discussed preliminary findings arising from their country-level work, largely derived from baseline qualitative surveys. In many countries, the implementation of Global Fund-supported activities has been slower than anticipated and accordingly effects upon health systems are just beginning to emerge. Issues identified by the researchers are listed below, within the four thematic areas of the SWEF research framework:

▲ Policy Processes. Global Fund-related planning processes have been highly centralized, even within decentralized contexts; this lack of ownership at sub-national levels has led to problems as countries begin to implement GF-supported activities.

▲ Public/Private Mix. Global Fund support has contributed to innovations in public/private arrangements in several countries. In one study country, the principal recipient is a nongovernmental organization (NGO), planning is done by local-level consortia of government, NGO, and civil society, and activities are implemented largely by the private non-profit sector.

(Cont. page 6 “Global Fund”)
Tracking Patients to Improve HIV/AIDS Care in Zambia

As countries scale up antiretroviral therapy (ART) programs, the need for an information system to track the patients who receive HIV/AIDS services is critical to ensure program quality. To this end, PHRplus, working with the USAID-funded Health Services & Systems Program (HSSP), has supported the development and implementation of such a patient-based system. PHRplus has implemented the ART Information System (ARTIS), funded by the President’s Emergency Plan for AIDS Relief, in 10 major hospitals in Zambia.

ARTIS allows managers and physicians to track patients from their initial identification and screening through enrollment in the ART delivery program, and then in three HIV/AIDS service delivery areas: provider visits, laboratory monitoring, and pharmacy. ARTIS effectively standardizes patient, facility, and district reporting formats for ART services and is fully integrated into the current national health management information system (HMIS), therefore strengthening the HMIS. Initially developed as a paper-based system for use in facilities lacking computer capabilities, ARTIS now is computerized, with software based on CareWare, a program developed by the Health Resources and Services Administration of the U.S. Department of Health and Human Services.

The benefits of ARTIS are various: First, the efficient tracking of patients improves individual patient management and thus the quality of care delivered. Second, tracking numbers of patients and services delivered allows facilities to better understand the demand on pharmacy, laboratory, and personnel and, thus, to better manage service delivery. Finally, by accumulating accurate data, ARTIS allows decision makers to monitor and evaluate care and use their findings for better health care system planning and policy development.

ARTIS is adapted to the health system using it: Prior to implementing the program in Zambia, PHRplus and HSSP worked with the Zambian Central Board of Health and other key stakeholders to conduct a rapid assessment of HIV/AIDS services provided in the hospitals, define and agree upon indicators to track the rollout of the national ART program, and structure ARTIS to serve the needs of both attending physicians and higher-level decision makers.

In September 2004, ARTIS was implemented for the first time in Livingstone General Hospital, in the city of Livingstone. A 15-member team of staff doctors, nurses, and pharmacists affiliated with the hospital’s ART clinic were trained to implement ARTIS. According to Dr. Daka, head medical officer of the ART clinic, the training went smoothly and “the system is (currently) working fine.” By entering new patients directly into the computerized version of ARTIS and transferring earlier patient files to the new system, the hospital has good data and can track all current ART patients more effectively than before. Once the system was running smoothly at Livingstone General Hospital, ARTIS was implemented in nine other hospitals in Zambia, with more than 320 health workers trained by the end of October 2004.

HSSP is supporting the continued implementation of ARTIS and will facilitate its expansion to district and clinic levels throughout Zambia.

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Global Fund (Cont. from page 5)

▲ Human Resources. None of the study countries had overarching national-level strategies to address the human resource constraints to scaling-up HIV/AIDS services. Some limited program-specific plans do exist, but these do not typically take into account the potential implications of rapid scale-up of disease-specific initiatives on the short- and long-term human resources needs of other health sector priorities such as maternal and child health.

▲ Pharmaceuticals and Commodities. Many countries had problems with the lack of consistency in the pricing of commodities, pharmaceuticals, and services supported by different funding sources, including the GF.

In general, GF-supported processes reveal long-standing weaknesses in health systems, but they can also exacerbate such weaknesses particularly in contexts where there are multiple parallel HIV/AIDS initiatives.

The context in which the Global Fund operates at global and country levels is increasingly complex in numbers and scale of donors and disease-specific initiatives. It is therefore critical that independent efforts like SWEF track the effects that these massive resources have on the health systems. The SWEF Research Network will do further surveys in many of the study countries, allowing for more in-depth and analytical consideration of system-wide changes.

For more information on SWEF research, please see www.phrplus.org/swef.html or e-mail kate_stillman@abtassoc.com ▲
Using NHA to Make Health Care More Equitable in Kenya

At a ceremony marking the official release of reports on Kenya’s National Health Accounts (NHA) and household health expenditures and utilization, Health Minister Charity K. Ngilu spoke on all the findings of the studies but emphasized the burden that out-of-pocket spending on health care poses to households. “It is alarming to note that 51 percent of all the expenditure is borne by households in a country where 56 percent of the population live below the poverty line.” She called it “absurd” that poor patients must sell household goods to pay for medical care.

More than 200 senior government officials, development partners, researchers, and private sector health stakeholders attended the ceremony marking the release of the NHA documents in Nairobi on March 29. The event generated extensive media attention – national television offered lengthy coverage of the meeting, and The Nation, the Kenyan national daily, ran a three-page article on the reports to inform the public of the findings.

The studies give Kenyan decision makers a clearer picture of health care access, utilization, and financing, and of existing health care insurance coverage – including gaps in access and coverage in terms of income, gender, and geography. The Minister urged members of Parliament to study the report findings and use them in policymaking. The information is relevant in a number of ways, perhaps most urgently in the ongoing development of the National Social Health Insurance Fund and a health strategic plan for 2005-2010, and achievement of Millennium Development Goals.

Mr. David Nalo, permanent secretary for the Ministry of Planning and National Development, which participated in field work for the studies, echoed the Minister’s remarks, pointing out that the findings should be used for appropriate policy implementation.

In addition to its look at overall health spending patterns, the NHA reviewed HIV/AIDS health care-related expenditures. While 17 percent of current health care expenditures are on the disease (slightly more than half from donors, 26 percent from households), many more resources are needed to scale up antiretroviral therapies. While Kenya may benefit from a new influx of external HIV/AIDS funds, Minister Ngilu questioned if “this concentration of donors on HIV/AIDS funding could compromise the fight against malaria and other causes of death,” and whether donor funding would be sustained.

This was the second round of NHA carried out by the Kenyan Ministry of Health (MOH). An introductory speech at the presentation ceremony noted the government had established ownership of the NHA process, with a dedicated national NHA team led by Mr. Stephen Muchiri of the MOH Department of Planning. PHRplus provided technical and financial support to the training, data collection, analysis, and report writing connected with the studies.

PHRplus continues to work with the NHA team in Kenya. At the request of the government, the project is assisting with furthering NHA institutionalization and evidence-based policymaking. Presently PHRplus is working with the MOH to use NHA findings to develop a framework to monitor the efficiency of government hospital resource utilization.

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New Project Director Named for PHRplus

“I’m honored to be given the responsibility to lead such a strong team of people and highly productive project,” said Dr. Marty Makinen, as he assumed the position of PHRplus project director at a leadership transition workshop on February 17. Makinen, who had served as PHRplus adviser for health financing and systems reform since the project’s inception, also is an Abt Associates Inc. vice president. He previously headed the USAID-funded Health Financing and Sustainability project and held senior positions in USAID’s ZdravReform and Partnerships for Health Reform projects.

Makinen, who holds a PhD in economics from the University of Michigan, has been with Abt for 20 years and helped start its international health practice. Though based in Abt’s Bethesda, Maryland, office during those years, he has spent extensive time working in the field, primarily in sub-Saharan Africa and the former Soviet Union but also in several countries in Latin America and Asia. In addition to his technical advisory position, he has been PHRplus’s primary contact for support to the Global Alliance on Vaccines and Immunization (GAVI). He has played a leading role in work performed for the GAVI Financing Task Force and assisted a number of countries to develop financial stability plans.

In addition to discussing his leadership plans at the transition workshop, Makinen took time to praise the tenure of now former director Nancy Pielemeier, saying that it “is daunting to try to live up to the leadership standard set by Nancy.”

Dr. Pielemeier has assumed duties of practice manager in Abt’s International Health Area, a position in which she will focus on strategic planning, oversee several projects, and coordinate programs such as HIV/AIDS.

Said Pielemeier, “I have enjoyed the opportunity to direct PHRplus and PHR before it, not only for the excitement of having been on the front lines of health system strengthening, but also for the privilege to have worked with visionary, dedicated, and caring colleagues around the world. It is exciting to see health systems issues coming to the top of the international agenda, as a result of this hard work and advocacy over the last decade. I look forward to keeping in touch and continuing to work together in different ways to achieve better systems for better health.”

PHRplus 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

Marty Makinen, PhD, Project Director
Catherine Connor, Deputy for Operations
Steve Mason, Deputy for Finance
Sara Bennett, PhD, Research Advisor
Jack Galloway, Field Implementation Advisor

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