id21 health highlights 22

health systems

communicating international development research

What influences health worker responses to health sector reforms?

In the past 20 years, a number of developing country governments have attempted to reform their health sectors in order to improve performance. These reforms have often failed to include the participation of the health workforce in planning and decision-making.

In the early 1990s, Bangladesh and Uganda launched launched programmes of health reforms to improve their health system's performance and delivery of care. Both countries have extremely low per capita spending on health and both face challenges in meeting the Millennium Development Goals.

This study looked at how health sector reforms affect health workers' motivation and performance in Bangladesh and Uganda. Interviews were held with 700 individual health workers and focus groups and key interviews were held with health managers, institutions and professionals in 2004.

The study found that:

- Reform planners failed to take the role of context into account in both Bangladesh and Uganda, assuming that health staff would passively implement the reforms.
- Unification efforts in Bangladesh gave rise to a power struggle and led to mistrust between the former family planning and health divisions.
- However, the workforce felt positive as they had hope that their salary payments would be paid more promptly due to changes in payment schemes.
- Rapid decentralisation with poor human resources management left Ugandan health workers insecure. Local authorities in power were influenced by resource shortages and nepotism.
- Closer ties to local leaders in the community had a positive effect on health workers. Leaders could lobby the government on their behalf for financial and human resources.

While staff may have been demoralised and resources in short supply, shifting authority and supervision to the rural districts gave communities an active role in shaping health service provision. The study lists five key recommendations:

- Reform planners should design reform objectives that improve health services for communities by encouraging a favourable response from the workforce.
- Reform planners should carefully analyse the context of the health system when designing reform objectives to identify elements that either support or present barriers to reform initiatives.
- Reform programmes should be flexible so that problems can be easily identified and resolved.
- Health workers should be involved in all stages of the reform process, and should understand the purpose of change and have confidence in the consultation process on which it is based.
- In evaluating the impact of reforms, an important criterion is that health workers' motivation and performance is affected by how they perceive their relationship with the community.

Tara Kielmann
Institute for International Health and Development, Queen Margaret University, Corstorphine, EH12 8TS, UK
T +44 (0) 131 3173735 **F** +44 (0) 131 3173494
tara.kielmann@qmu.ac.uk

'Health sector reforms and human resources for health in Uganda and Bangladesh: mechanisms of effect', *Human Resources for Health* 5(3), by Freddie Ssengooba et al, 2007
www.human-resources-health.com/content/5/1/3

Global public–private health partnerships

Tackling seven poor habits

Initially, much was expected of global public-private health partnerships, but enthusiasm has now waned, with concern raised over costs and unanticipated consequences. What bad habits impact negatively on their performance and what could make them more effective?

Public-private partnerships are meant to bring new resources, a business approach and a renewed sense of urgency to tackling diseases. These partnerships, such as the Global Alliance for Vaccines and Immunisation (GAVI) and the Mectizan Donation Program, bring together multiple public and for-profit private sector organisations in joint decision-making over global health problems.

A study by the Overseas Development Institute (ODI) assesses where these partnerships are going wrong and what they are doing well, and suggests how they could perform better. It finds that they have helped raise the public profile of certain diseases with regards to policy-making and have increased funding commitments. Many have, however, also developed seven 'unhealthy' habits, including:

- They are often 'out of sync' with the recipient country's national priorities, imposing instead the priorities of their donor partners.
- Many fail to adequately include representatives of all stakeholders on their governing bodies: of the 23 partnerships reviewed, representation of poor country constituencies stands at just 17 percent.
- They do not adequately adhere to critical governance procedures, such as clearly specifying partners' roles and responsibilities, screening potential partners, or performance monitoring.
- They do not adequately compare the costs and benefits of public approaches with private approaches.

Global public-private health partnerships should:

- undertake internationally agreed principals of good aid practice in order to integrate their work with national planning processes and to keep costs low
- seek to ensure a more balanced representation of stakeholders on their governing bodies
- carry out a realistic assessment of the true risks and costs of private sector involvement
- adopt standard operating procedures such as stating objectives, defining roles and regular partnership-wide planning
- improve stewardship by applying standards for the selection of partners, setting up systems to manage conflict of interest, and ensuring transparency and accountability
- ensure sufficient funding setting more realistic targets or identify partners that can fill in any financial gaps
- better managepartnership relationships, such as establishing staff rules and incentives, and clarifying tasks and roles.

Kent Buse
Overseas Development Institute, 111 Westminster Bridge Road, London, SE1 7JD, UK
T +44 (0) 1763 247042 **F** +44 (0) 20 79220399
k.buse@odi.org.uk

Global health: making partnerships work, Overseas Development Institute Briefing Paper 15, ODI: London, by Kent Buse and Andrew M. Harmer, 2007
www.odi.org.uk/publications/briefing/bp_jan07_global_health.pdf

Caring for yourself

Coping with illness in rural Bangladesh

When a household is affected by illness it responds by adopting a variety of coping strategies. Research suggests that household-level treatment strategies can provide effective ways of coping with the impact of illness on health and livelihoods.

One identified strategy is self-care. In Bangladesh a 35 percent increase in self-care has been documented over a period of five years. A study by Northumbria University's Disaster and Development Centre (UK) investigated the influences and implications of this behaviour in response to diarrhoea. The researchers describe how the availability of household assets influences this choice of treatment strategy and discuss why it is the main response to diarrhoeal illness in rural Bangladesh.

The research was conducted in 2004 in three villages in north-west Bangladesh. Questionnaires given to 208 people provided information on illnesses during the previous month and data on the households' livelihood activities and their available financial, physical, human, social and natural assets. The results revealed that self-care was, at 43 percent, the most common strategy for dealing with diarrhoeal disease. A range of households were then contacted to conduct 20 further individual interviews and 10 focus group discussions designed to find out the range of influences involved in the respondents' decision to practise self-care.

Findings included:

- Free access to a locally-available treatment influences treatment selection.
- The closeness of a household to a source of health care or medication influences their likelihood to use them. The cost and time constraints of travelling deterred those living further away from going to hospital or other health facilities.
- Improved understanding and awareness of health issues appears to have empowered people to diagnose and self-treat for certain illnesses.
- Dissatisfaction with the quality of government health facilities means some people prefer the services of drug sellers and pharmacists in the local bazaar.
- Some people are excluded from the health care system by inability to pay, through lack of either money, access to credit or membership of support networks that can provide financial assistance.
- Family and village networks provide a safety net. They can be a key factor in adopting self-care.

Some households have knowledge and support networks that enable them to successfully implement self-care. Others may be forced to select self-care through a lack of money or sources of credit. The challenge for policy is how to support self-care as an effective means of disease prevention and treatment. Policy implications include:

- Households need to understand the health care system and be involved in community networks to enable them to make informed choices.
- For patient empowerment to ensure safe and appropriate forms of self-care, greater attention on household poverty reduction is needed.
- Public health personnel must continue to provide education about rational drug use for diarrhoeal disease.
- Efforts to establish easier forms of access to the health care system for severe cases of diarrhoeal disease must continue.
- Self-care must not happen in isolation, but as part of a wider need to reduce vulnerability and promote household resilience.

Ross Edgeworth
Disaster and Development Centre, School of Applied Science, Northumbria University, Newcastle upon Tyne, NE1 8ST, UK
T +44 (0) 191 2273583 **F** +44 (0) 191 2273519
r.edgeworth@unn.ac.uk

'Self-care as a response to diarrhoea in rural Bangladesh: empowered choice or enforced adoption?', *Social Science and Medicine* 63, pages 2686-2697, by Ross Edgeworth and Andrew E. Collins, 2006

Removing childbirth delivery fees

The impact on health workers in Ghana

Ghana has a high maternal death rate and a relatively high rate of unsupervised births. The government recently introduced a childbirth delivery fee exemption scheme with the aim of increasing the use of public health services for deliveries. What impact has this had on health workers and traditional birth attendants?

The rate of maternal deaths in Ghana is high, with estimates ranging from 214 to 800 per 100,000 live births. Nationally, 45 percent of deliveries are carried out by a skilled attendant. From 2003 to 2005 the government introduced a scheme that exempts women from paying any fees associated with deliveries, the aim being to reduce the financial barriers to using maternal services.

A survey of health workers and traditional birth attendants was carried out by IMMPACT in Ghana in 2005 to assess the impact the new scheme has had on them. A questionnaire was issued to 374 doctors, nurses, medical assistants, public and private midwives, community health nurses and trained and untrained traditional birth attendants in the Central and Volta regions. The questionnaire asked their income, what they thought of the scheme, general motivation and individual and household characteristics. Deliveries in public, at missions and in private health facilities are included, but not those carried out by tradition birth attendants.

The findings show that changes have occurred since the scheme was introduced. Some of the negative effects have been balanced out by positive changes:

- Health workers showed a strong commitment to public services, evident in their long working hours (a mean of 54 hours per week for community nurses, up to 129 hours for medical assistants, 86 hours for public sector nurses and 109 for doctors) and lack of private practice.
- Health workers have experienced an increase in their workload but this has not seriously affected morale, nor are they unable to cope. The number of deliveries per week (for example, 19 for public midwives, 14 for doctors and nurses) was not excessive.
- The increase in workload for public sector health workers has been matched by an unrelated but timely increase in pay. Doctors are very well paid compared with other workers in Ghana. Traditional birth attendants reported a drop in client numbers and pay. The impact on private midwives was mixed.
- Health workers expressed positive and negative attitudes about the scheme. They appreciate that it has increased deliveries in health facilities, especially among poor people, but are concerned about unreliable payments by the government that are jeopardising sustainability.

These findings show that a fee exemption scheme that increases the demand for public health services while maintaining health worker salaries and their morale is feasible as long as it is managed well. This applies even in countries such as Ghana where human resources are restricted. However, this may be linked to the fact that Ghana's public health workers are generally paid well by the government compared with the average government employee.

Sophie Witter
IMMPACT, University of Aberdeen, Health Sciences Building, Foresterhill, Aberdeen, AB25 2ZD, UK
T +44 (0) 1224 555850 **F** +44 (0) 1224 555705
sophiewitter@blueyonder.co.uk

'Working practices and incomes of health workers: evidence from an evaluation of a delivery fee exemption scheme in Ghana', *Human Resources for Health* 5:2, by Sophie Witter et al, 2007
www.human-resources-health.com/content/5/1/2

id21
Institute of Development Studies
University of Sussex
Brighton, BN1 9RE UK

T +44 (0) 1273 678787
F +44 (0) 1273 877335
E id21@ids.ac.uk

Institute of Development Studies

id21 health highlights bring the latest research to health policymakers and practitioners with limited internet access. Please photocopy and distribute them to your colleagues. If you would like to subscribe free of charge, please send your contact details to the address above. id21 is hosted by the Institute of Development Studies and supported by the UK Department for International Development.

Keywords: health workers, health sector reform, health workforce, human resources for health, public-private health partnerships, self-care, household-level treatment strategies, childbirth delivery fees, traditional birth attendants