



How to measure the effects of a national policy on the district level: methodology and early results of FEMHealth

Dr Sophie Witter, scientific coordinator, FEMHealth



Beijing October 2012



FEMHealth partners

1. University of Aberdeen, UK
2. Institute of Tropical Medicine, Antwerp, Belgium
3. London School of Hygiene and Tropical Medicine, UK
4. Agence de Formation, de Recherche et d'Expertise en Santé pour l'Afrique (AFRICSanté), Burkina Faso
5. Centre de Recherche en Reproduction Humaine et en Démographie (CERRHUD), Benin
6. MARIKANI, Mali
7. Institut National d'Administration Sanitaire (INAS), Morocco
8. Institut de Recherche en Sciences de la Santé (IRSS), Burkina Faso

Eight partners; four focal countries in West and northern Africa; funded by EC; operating 2011-13



FEMHealth objectives

Improving the health of mothers and newborn through:

1. Improved methodologies for complex evaluations
2. Better evidence on fee exemption, its implementation and impact
3. Innovations in communicating evidence, with a focus on regional networks



1. Methodology – the objectives

Innovative but practical tools, including:

- Tool for mapping policy effects on local health systems (POEM)
- Development of realist case study approach
- Using near miss to assess impact on quality of care and health outcomes for mothers and newborn



2. Evidence – some of the questions we aim to tackle

Health policy questions:

- What are the drivers behind their introduction? How are policies transferred across contexts?

Health financing:

- How is the policy funded? How sustainable is it? How does the policy affect the burden on households? How are the facilities and health worker incentives affected?

Local health systems:

- How do they affect, and how are they affected by the local health system?
- What is their effect on targeted and untargeted services?

Quality of care and outcomes:

- What is their impact on the quality of care on offer to women and neonates?
- What is their impact on uptake of services and on health gains?

Overall:

- How cost-effective are the exemption policies?
- Do they reach those in most need?
- How do they affect other (non-financial) barriers?



3. Communicating research - objectives

- Pilot a 'community of practice' approach to disseminating learning (creating a network of researchers, policy-makers, technical staff and development partners), linked by theme and region
- Document its dynamics and evaluate its strengths and weaknesses
- If successful, establish a functioning network which survives beyond the project lifespan



Structure of session

1. How the POEM tool was developed – its approach – what it aims to do - *Fabienne Richard, ITM*
2. Early results from Benin – effects on health care organisation and services - *Jean-Paul Dossou, CERRHUD*
3. Early results from Mali – effects on community transport for referral system - *Brahima Diallo, MARIKANI*
4. Early results from Burkina – effects on the financial resources of the health facilities - *Patrick Ilboudo, AFRICSante & Sophie Witter, University of Aberdeen*



For further information, see: www.abdn.ac.uk/femhealth
and <http://groups.google.com/group/COP-Financial Access Health Services> (for CoP)



Second Global Symposium on health systems research - Beijing 31 Oct – 3 Nov 2012



Session

How to measure the effects of a national policy on the district level: methodology and first results of the FEM Health project.

Saturday, 3 Nov 2012

Introduction to the Policy Effect Mapping tool (POEM)

Fabienne Richard

Marchal Bruno, Dominique Dubourg & Vincent De Brouwere

Institute of Tropical Medicine, Antwerp



Quick Wins



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Institute of Tropical Medicine, Antwerp

Goal 4

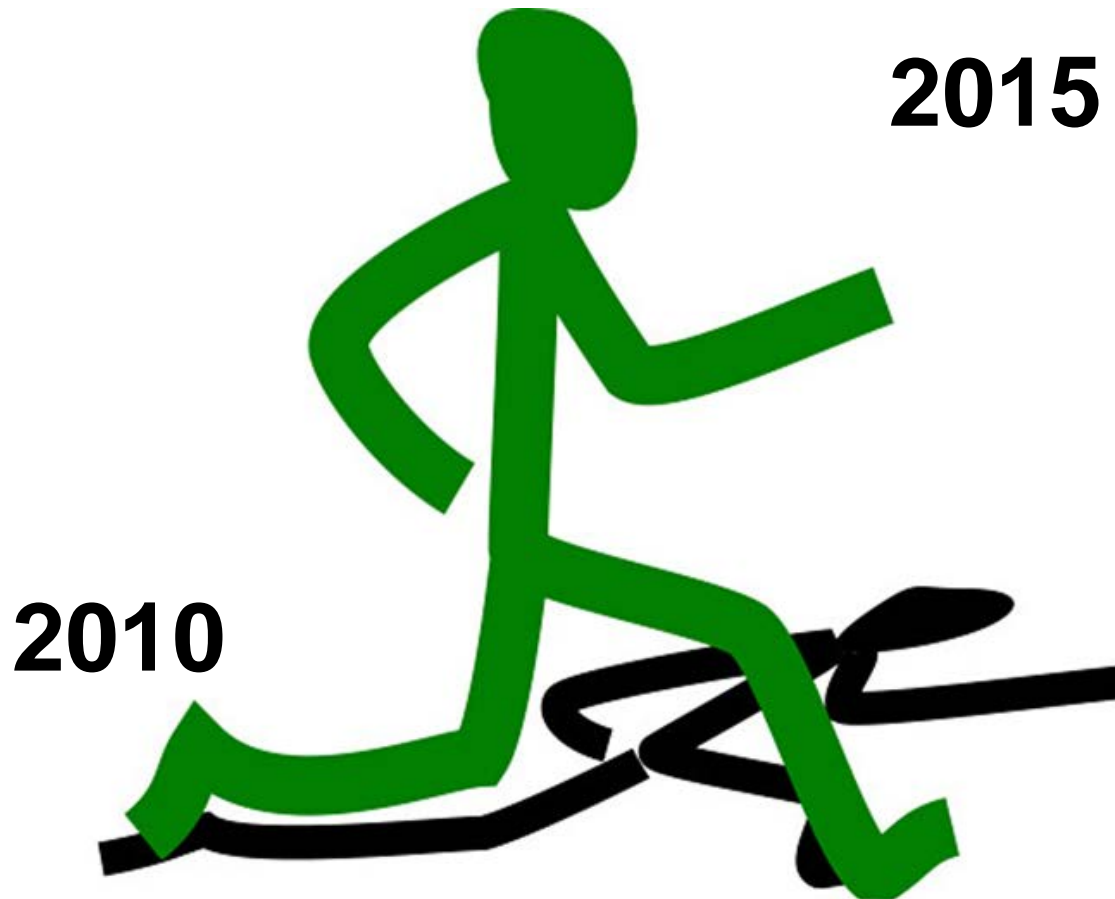
Reduce child mortality

Goal 5

Improve maternal health

Goal 6

Combat HIV/AIDS, malaria & other diseases



No cash, no care



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HIV, TB, Malaria



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Under 5



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Deliveries and C-section



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What are the **positive and negative** effects of this policy on both targeted and **non-targeted services** at the operational level?

Need for a framework adapted to local health system



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- 6 building blocks model (WHO 2007)

THE WHO HEALTH SYSTEM FRAMEWORK

SYSTEM BUILDING BLOCKS

SERVICE DELIVERY

HEALTH WORKFORCE

INFORMATION

MEDICAL PRODUCTS, VACCINES & TECHNOLOGIES

FINANCING

LEADERSHIP / GOVERNANCE

ACCESS

COVERAGE

QUALITY

SAFETY

OVERALL GOALS / OUTCOMES

IMPROVED HEALTH (LEVEL AND EQUITY)

RESPONSIVENESS

SOCIAL AND FINANCIAL RISK PROTECTION

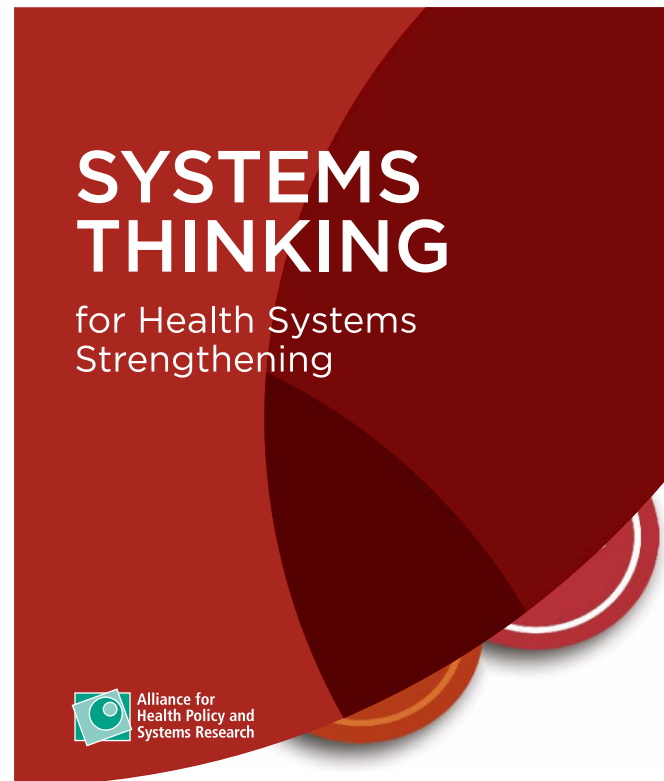
IMPROVED EFFICIENCY

- Focus on national health system
- Static model : no interaction between the blocks
- Community is missing !

EVERYBODY'S BUSINESS

STRENGTHENING HEALTH SYSTEMS TO IMPROVE HEALTH OUTCOMES

WHO'S FRAMEWORK FOR ACTION



From the 6 buildings blocks to a local health system model

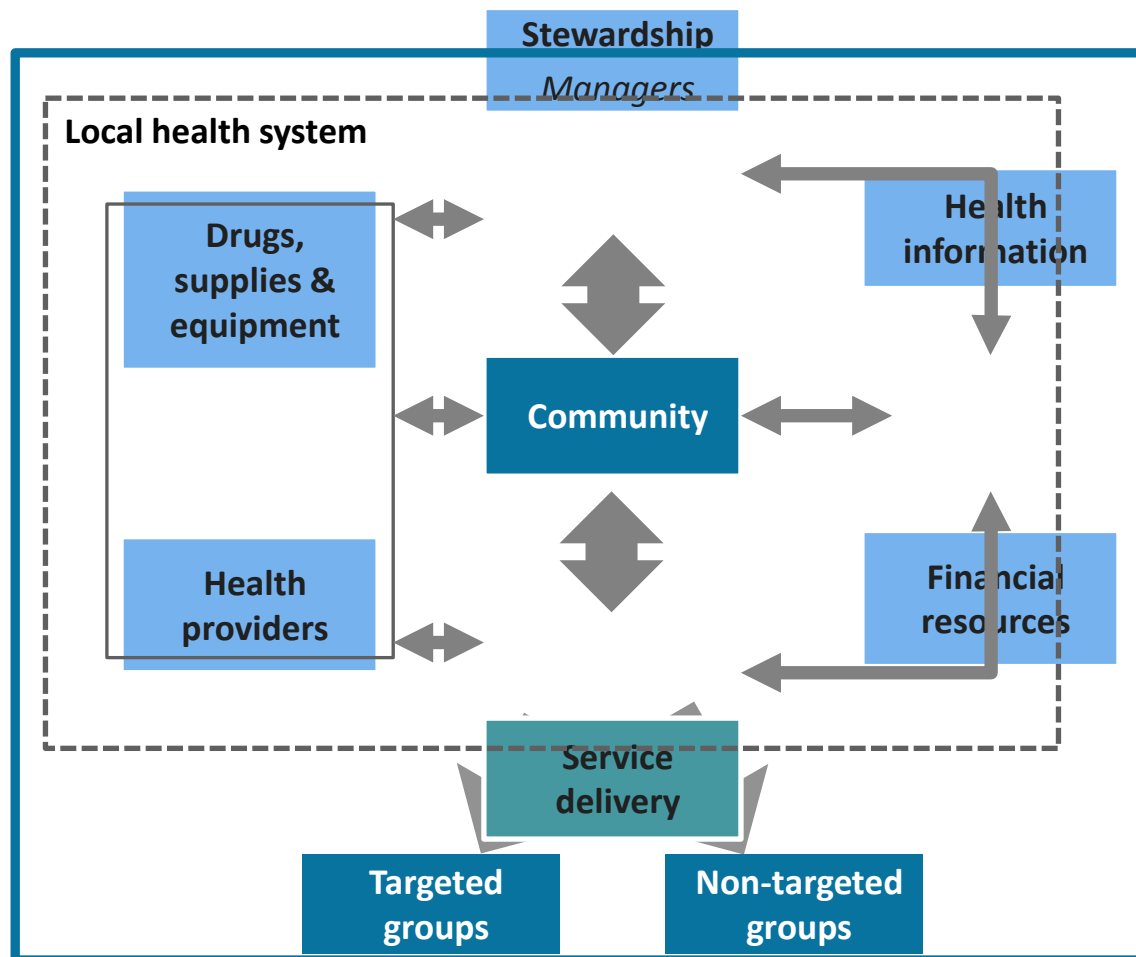


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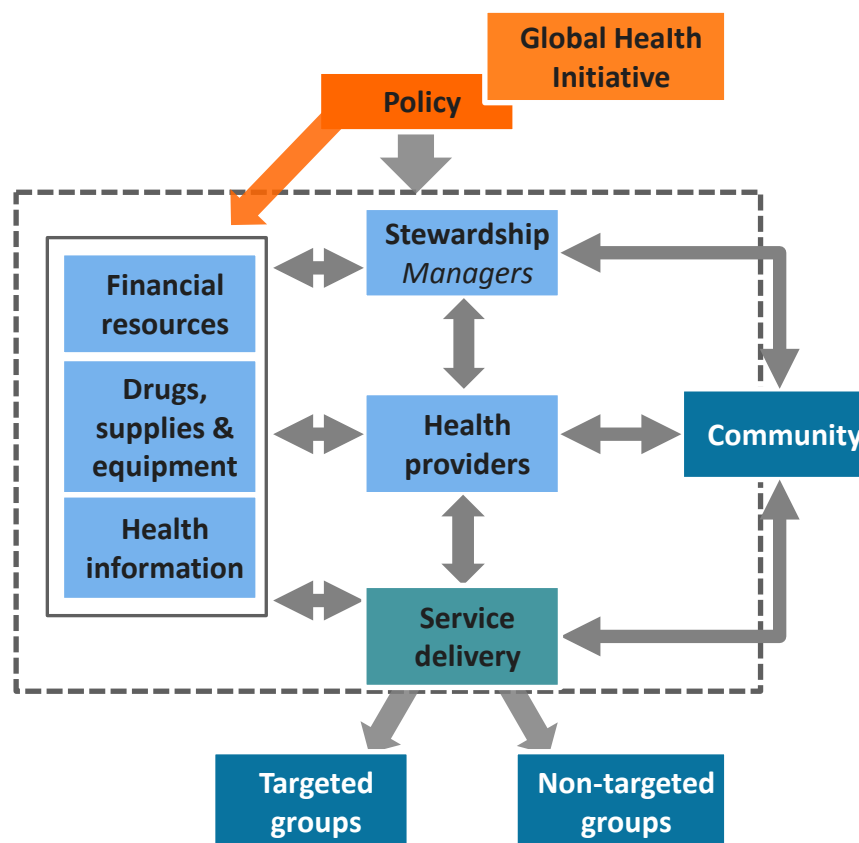




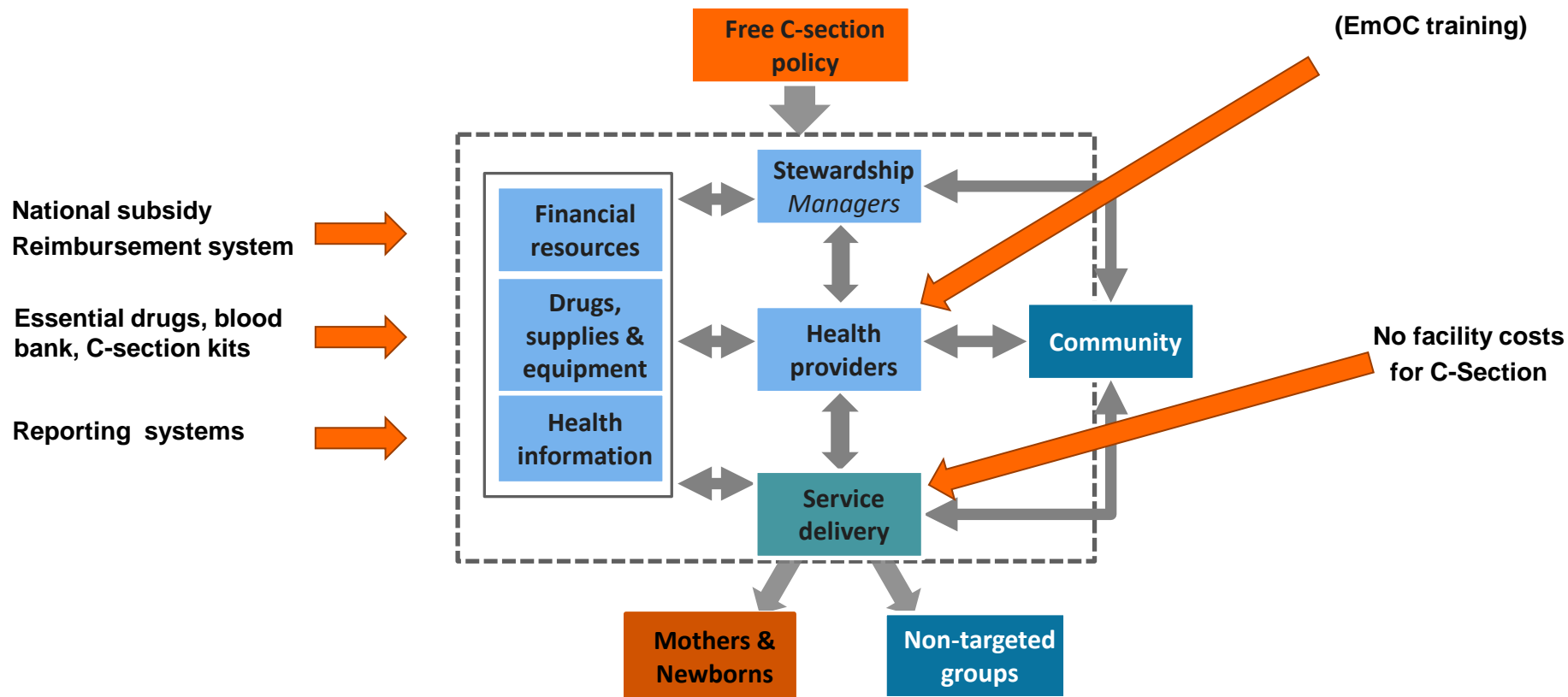
Core actors & functions of a local health system



How policies act upon a LHS



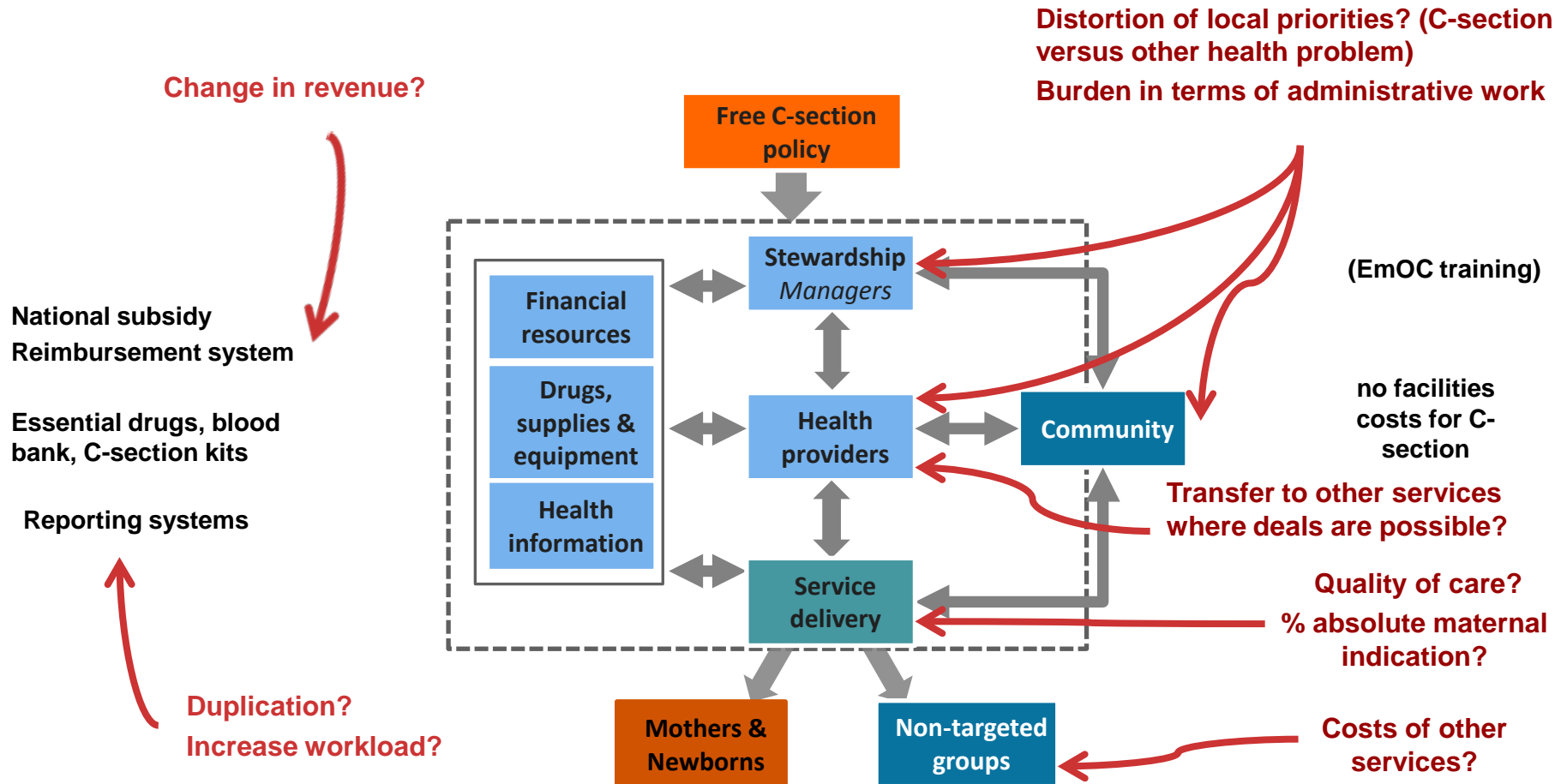
“Free C-section” policy



System-wide effects of Free C-section policies



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The Policy Effects Mapping Tool **POEM**

Developing POEM

- Identification of key dimensions of each function
- Selection of quantitative and qualitative tools
- Integration of data collection tools in “field-ready” tool
- Development of analytical guide to integrate quant. & qual. analysis

Sources of data:

- Semi-structured interviews (managers, health providers, community)
- Routine data from the health information system (hospital registers, monthly report,...)
- Participative observation
- Survey (patient & staff)

Opportunities

- Broadening the assessment of impact of programmes to
 - **core functions** of a local health system
 - **non-targeted** population **groups**
 - the **relations** between the system's actors & functions
- Raising awareness of district management teams – inducing reflexivity

Challenges

- Quality of routine data – but that is a result in itself!
- Making good sense of the data, because
 - POEM goes beyond 6 building blocks to include the dynamics between actors and influence on key functions
- ➔ Qualitative data analysis and integration of analysis requires specific capacity

Data collection

- February-October 2012
- 4 countries (Benin, Burkina, Mali, Morocco)
- 6 to 8 health districts in each countries

Data Analysis

- **Qualitative data:** N Vivo 10 (workshop in June 2012 in Rabat to develop a common coding tree)
- **Quantitative data:** Excel and SPSS (workshop in June 2012 in Bobo Dioulasso for the Financial tools)

POEM a tool in development... keep connected !



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Welcome | FEMhealth | The University of Aberdeen - Windows Internet Explorer

http://www.abdn.ac.uk/femhealth/

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FEMhealth

New Website Launched!

Visit our Programme Objectives page to find out more!

Learn More

Essential Links

- Community of Practice
- Towards4&5
- Impact

Welcome

Welcome to the FEMHealth website.

FEMHealth is a new research programme, funded by the EU, which runs from January 2011 to December 2013.

FEMHealth stands for 'fee exemption for maternal health care'.

News

RSS

30 October 2012

FEMHealth has high success rate in submissions to Beijing Symposium

12 June 2012



Effects of the free caesarean section policy on the provision of care and health services management: the case of Benin



Jean - Paul Dossou

Sourou Goufodji, Lydie Kanhonou, Patrick Makoutodé, Schadrac Agbla

Centre de Recherche en Reproduction Humaine et en Démographie (CERRHUD)





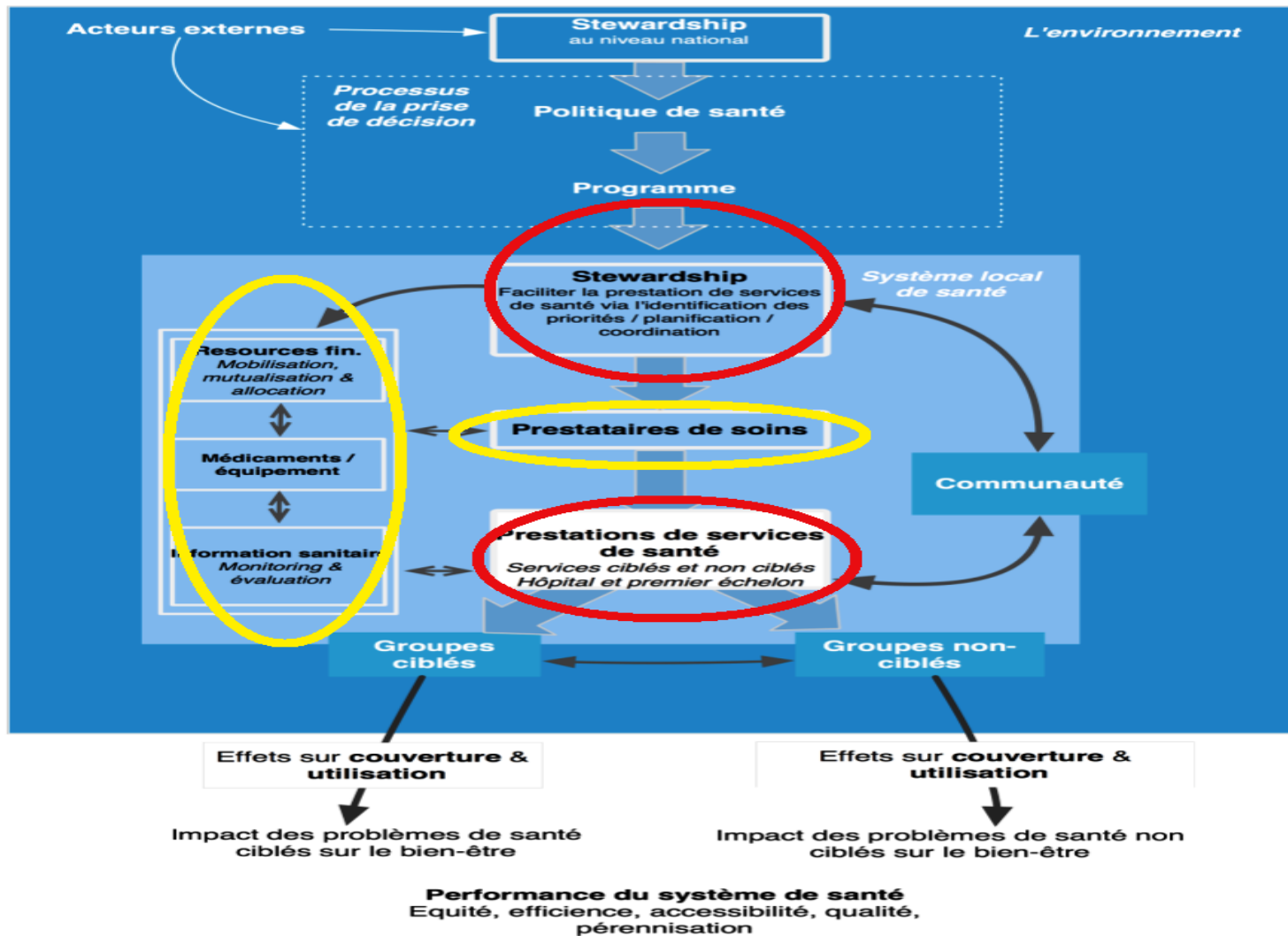
April, 1 2009



Same policy, Many kind of hospitals



Results



Local leadership and governance





Hospital management



Systematic extra fees



Less referrals, more release for ...



Financial resources increases





Drugs

- The need of drugs increases
- More breakings occure and lead to conflicts, increase informal drugs traffics and extra fees perception.



Health System Information

- The quality of Csection documentation improves
- Sometimes diagnosis are falsified to allow patients to be provided care for free.



Health workers



Health workers





Health workers



Provision of care



Provision of care



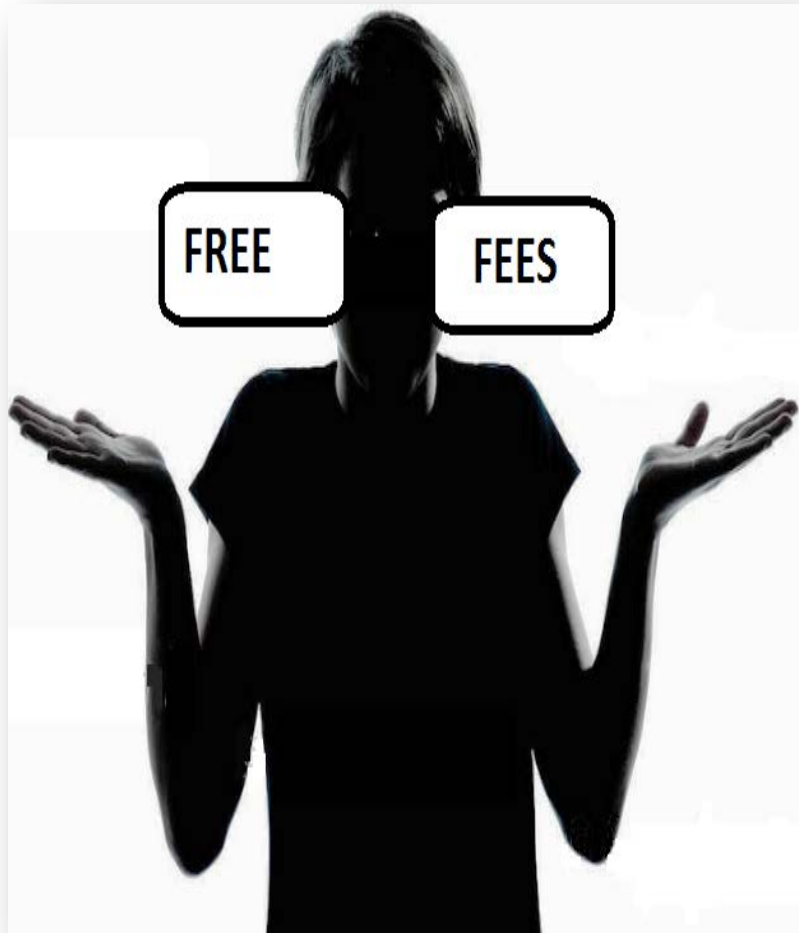
Health centers



Adaptation?



Community





Second Global Symposium on health systems research Beijing, Nov. 3rd, 2012

Impact of the free caesarean section policy on the community: the case of referral transport system in Mali

B.A. Diallo
MARIKANI



EUROPEAN UNION

Background

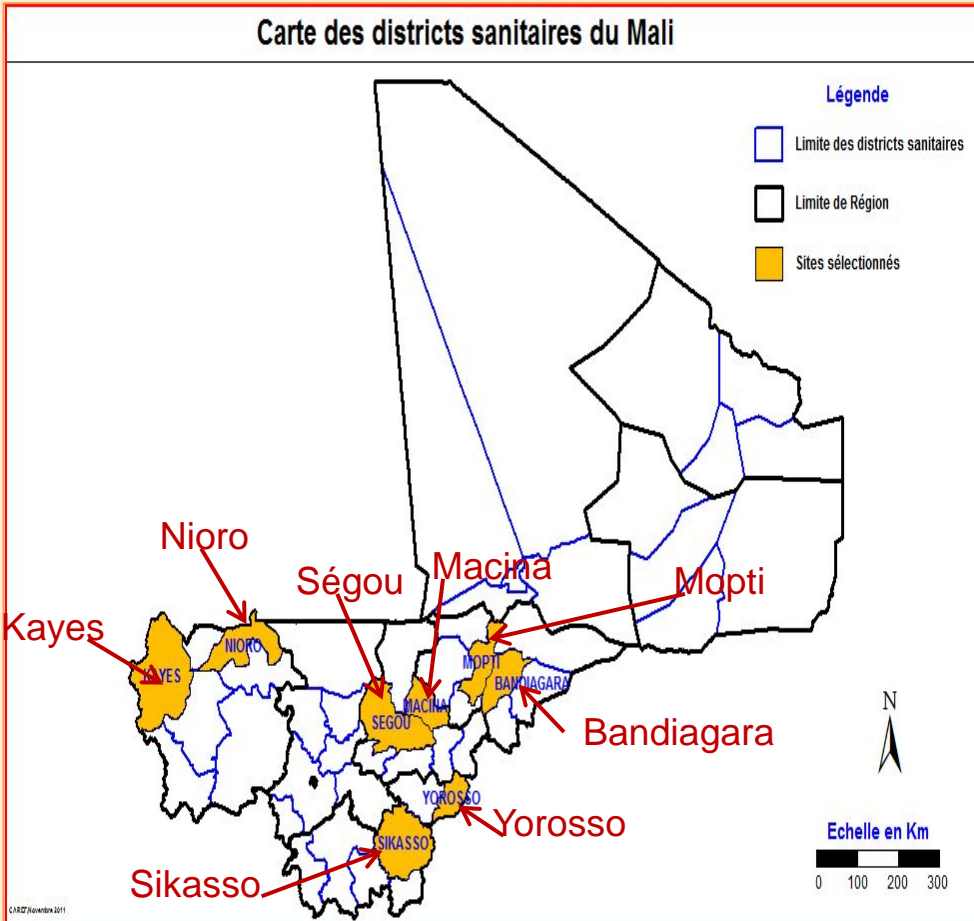


- 14,5 million people (2011)
- MMR = 464/100,000 lived births (DHS 2006)
- Free caesarean policy launched in June 2005
- Types of costs exempted:
 - Laboratory tests;
 - Drugs (limited to obstetric care);
 - Hospitalization costs;
 - Operating act; and
 - Surgical kits

Services delivered in the public health sectors

Methodology

Carte des districts sanitaires du Mali



Qualitative approach

In-depth interviews conducted with

Health workers:

- Regional Hospital (4)
- District hospital (CSRef) (4)
- Health centre (CSCoM) (16)

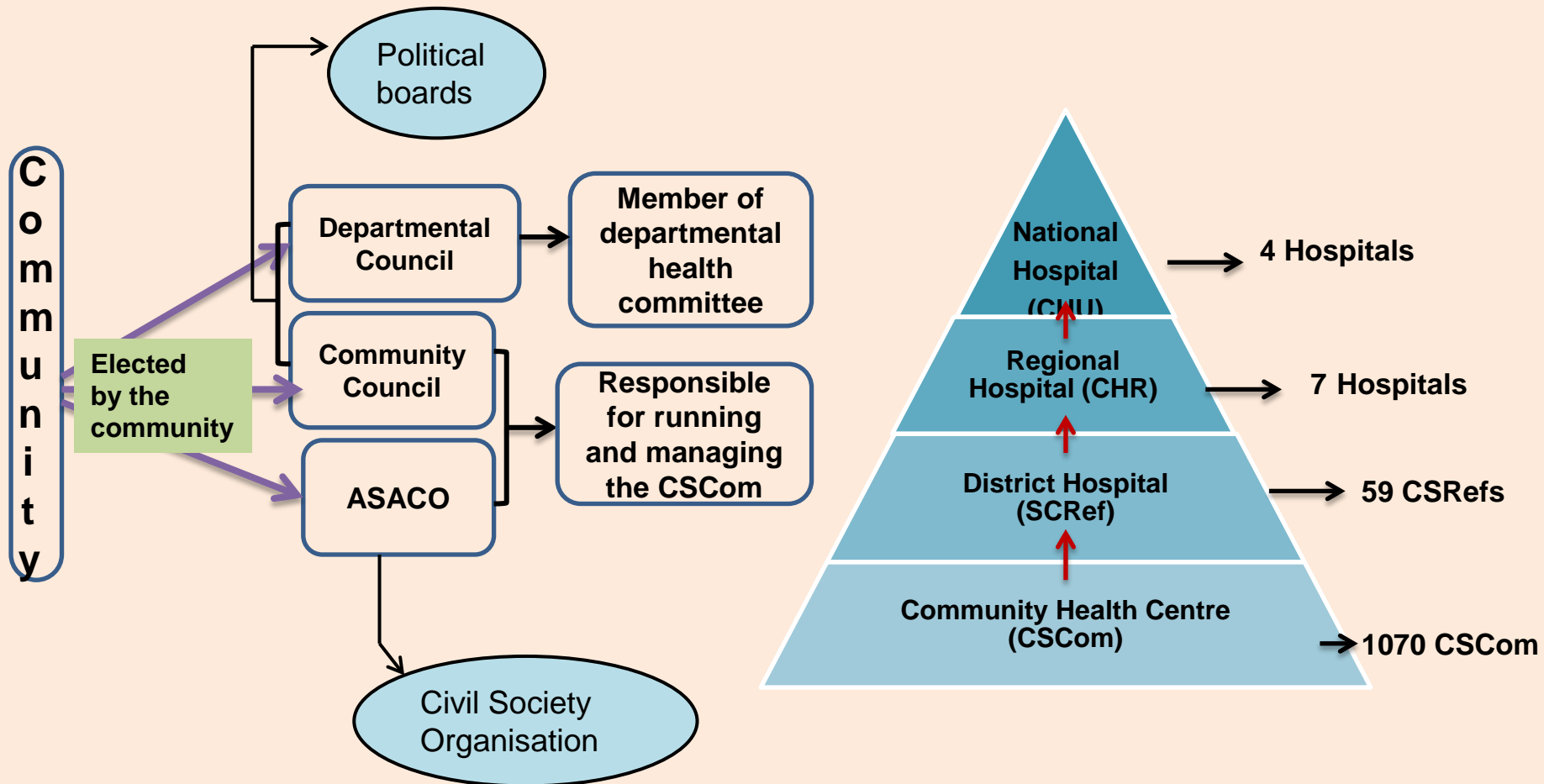
and the community members:

- ASACO (16)
- Community Council (16),
- Departmental council (4),
- Regional council (4)
- Regional Health representatives (4).

In total **87** interviews conducted



Community, a key actor in local health system





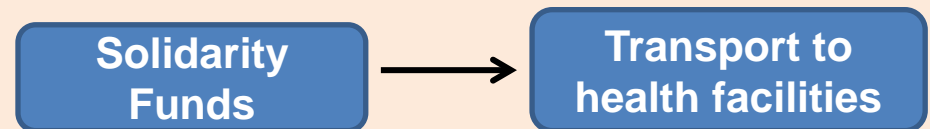
Health system & Referral

- Referral system first initiated in 1994 for obstetrical emergencies between different levels of health facilities.
- In 2000 a “*referral guideline*” was developed for harmonizing the system.
- New “*referral guideline*” adopted in 2005 with regard to the free caesarean policy. Community has been given a strong role: funding the referral system.

The referral system includes 3 major components:

- Essential obstetrical care
- Solidarity funds (reducing financial barriers)
- Transport and communication (reducing the second delay)

Our focus:



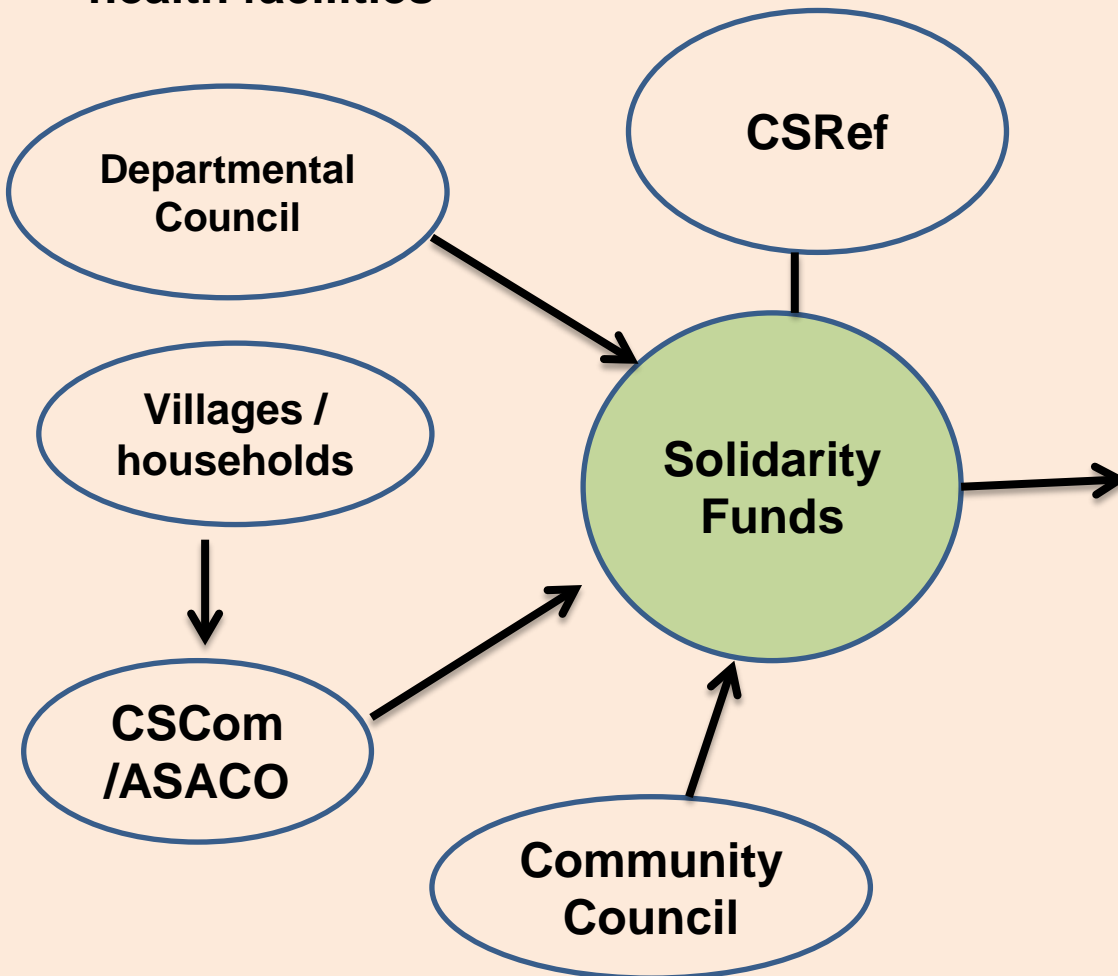
Before the “Free C-section” policy (from 1994-2005)





Referral transport system funding

System based on costs sharing principle within community key actors and health facilities

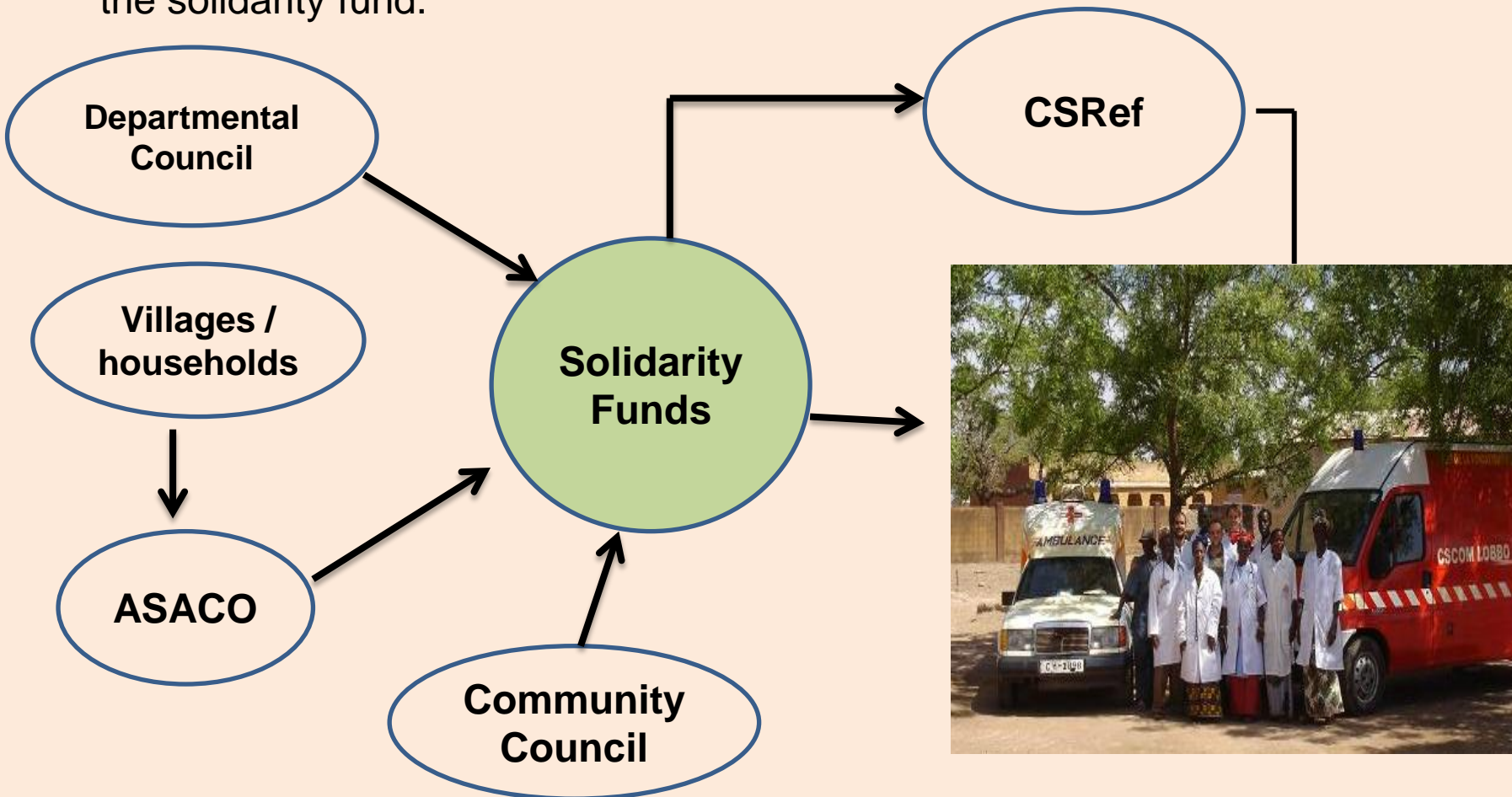




With the implementation of
the “free C-section” policy (from
July 2005)

Referral transport system funding

The district hospital (CSRef) does not contribute to the solidarity funds any more. Since the ambulances belong to it, the CSRef is rather reimbursed by the solidarity fund.





No single funding scheme

Flexible referral transport guidelines with no single funding scheme:

“With regard to the free C-section policy, we’ve elaborated the referral guideline. ... We’ve shared the responsibilities between actors. The Departmental council pays 10%, ASACO pays 45%, and the Community council 45%. That makes the 100%” (Departmental council member).

Every year actors’ contribution is estimated to support the solidarity funds (cost sharing principle).



Community financial capacity to support the referral transport system

Common discourse:

“before, the referral transport system was working very well but now with this new policy the solidarity funds is not working any more”.

A myth?

Based on our interviews:

Few communes had an effective solidarity fund before the implementation of the free c-section policy.



Effects on community contribution

Some villages contributed well at the beginning because they thought the policy applied to all obstetrical services (normal deliveries and complication cases). But since the policy is limited to the c-section, they became reluctant to pay for the solidarity funds. *“According to them, they are not obliged to pay their contribution since all services are not free of charge” (Asaco member).*



Different adaptations of the policy

- Selective application of the exemption of referral transport costs in the district :
“Instruction has been given to start with communes that have paid their contribution” (Community council member).

OR

- Obligation for the Communes to refund every woman who pays for the referral transport:
“During our last meeting, we decided that the commune has obligation to refund a woman in labor when she is charged for transportation” (Departmental council member).

Donors' support

Localities where the referral transport system is the more effective are the ones benefiting supports from donors:

–“Some partners provided a certain number of ambulances in 2009. I think it is UNFPA and UNICEF (Regional hospital accountant)”.

–“Canadian Agency is piloting an experience in three CSCom and had provided motorbikes-taxis to the remote villages (Departmental council member)”





Health providers views on the system

With regard to the referral transport system, the community representatives are valued as being incapable to fund the system:

–“When you require the community councils to contribute for running the referral transport system, they will never succeed. We should not give such responsibility to them because we’ve created the Community councils that cannot even support themselves” (Regional Hospital health worker).



Thank you !



Effects of the national subsidy policy for normal deliveries and emergency obstetric care on the finances of the health facilities: case study of Burkina Faso

Patrick ILBOUDO
Sophie WITTER
Nadia CUNDEN

AFRICSante and University of Aberdeen



Second Global Symposium on Health Systems Research, Beijing 31
October – 3 November 2012



Background on policy

- High MMR in Burkina: 300/100 000 (WHO, 2010)
- Factors include distance to facilities, costs & quality of care
- In 2006, government introduced delivery care subsidy policy
- In theory, functions as follows:
 - 80% of direct costs of normal deliveries subsidized at 1st level of care
 - 60% at the 2nd & 3rd level
 - 80% of the direct costs of EMOC are covered at any level
 - 20% of the policy budget is dedicated to indigent women
 - Indigents are exempted from paying fees
 - Transportation between facilities is free of charge
 - Facilities are reimbursed every 6 months for their costs



Objective of research

Within the overall framework of the FEMHealth project, this component asks:

5 years after its start, what are the effects of the policy on the finances on health facilities in Burkina Faso?

(which in turn affects the functioning and sustainability of the policy)

Hypothesis: failure to fully reimburse costs, or delays in reimbursements, will lead to a fall in quality of care and/or reintroduced charges of various sorts



Research tool

A financial flows tracking tool was used

Collects secondary data which can be collected retrospectively, looking at:

- Budgets & expenditure on policy
- Distribution of funds by area and delivery type
- Timing of payments
- Match to recorded activities
- Regularity and adequacy of funds arriving at facilities
- Wider facility financing (sources and expenditures)



Research methods

- Study sites in Burkina: 6 districts (Banfora, Bobo-Dioulasso, Bogandé, Gaoua, Houndé, Orodara, Yako)
- Data collected from national level and from a selection of representative facilities (1 university hospital, 2 regional hospitals, 4 district hospitals, 6 health centres)
- Structured data extraction into Excel sheets for analysis

Data limitations

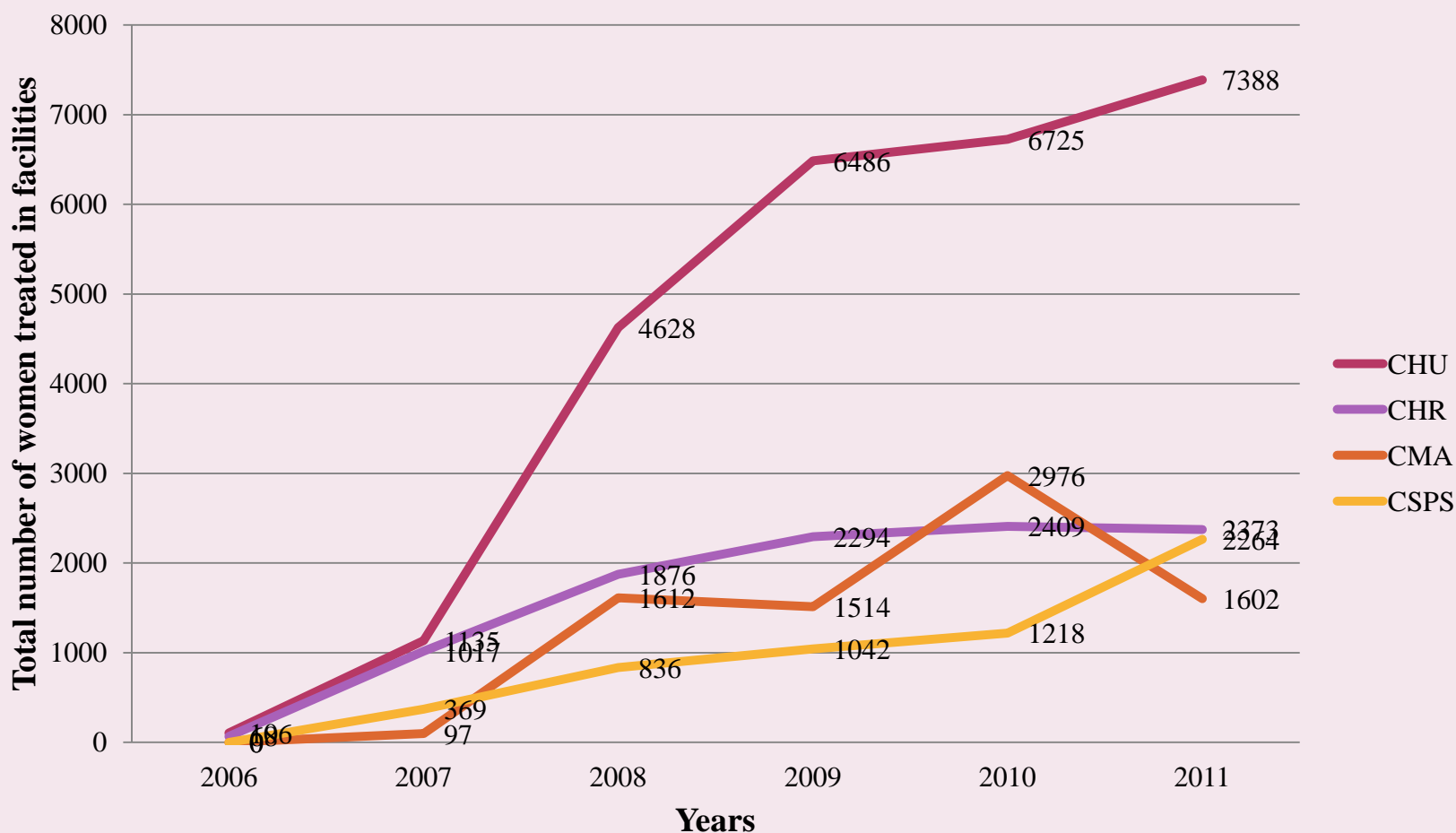
- Data incomplete, especially before 2009, and for district hospitals
- Some administrative staff unwilling to share data





Preliminary results – overall utilisation

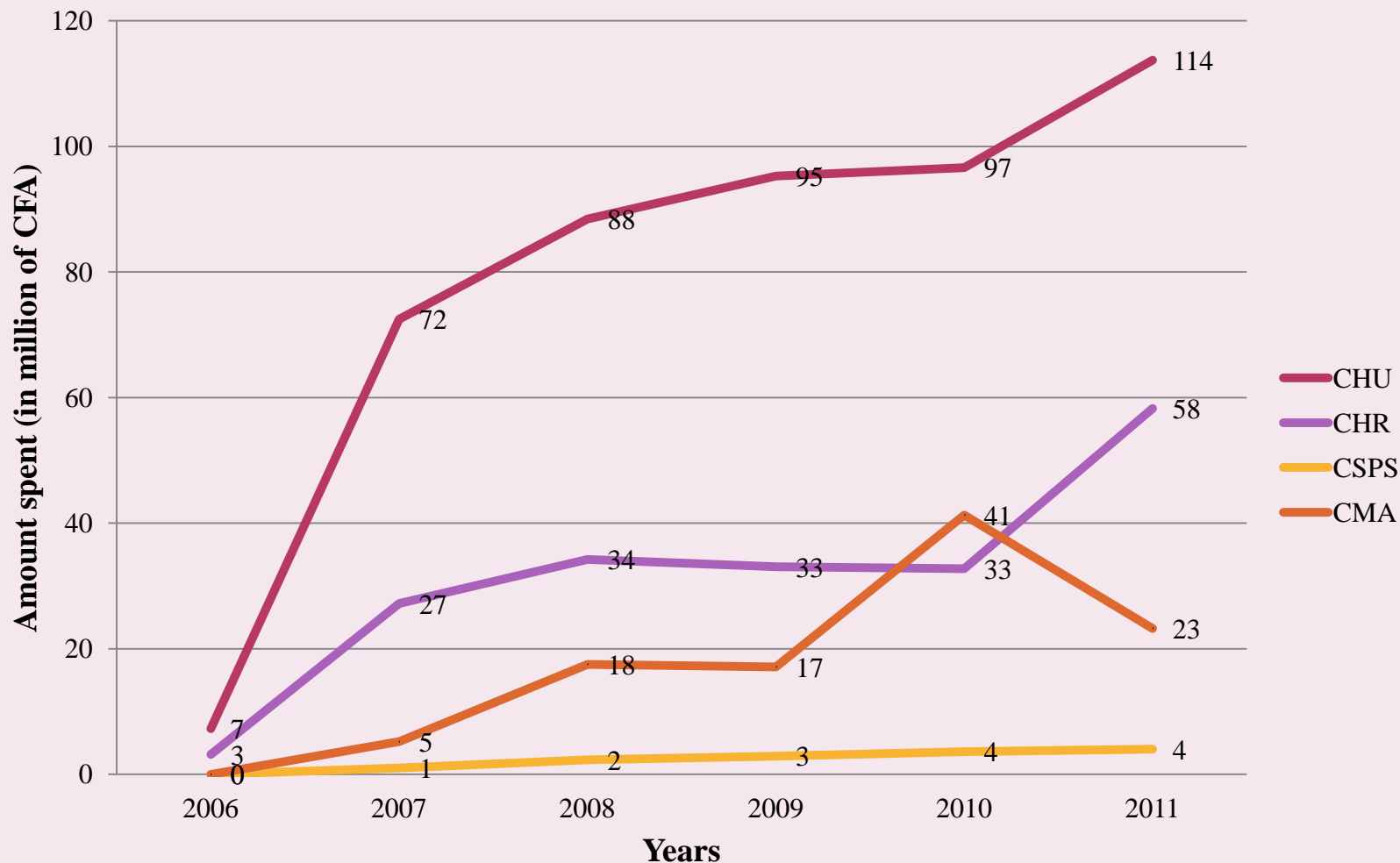
Figure 1: Evolution in numbers of women who benefited from the subsidy policy, by facility level, selected facilities





Preliminary results - overall expenditure

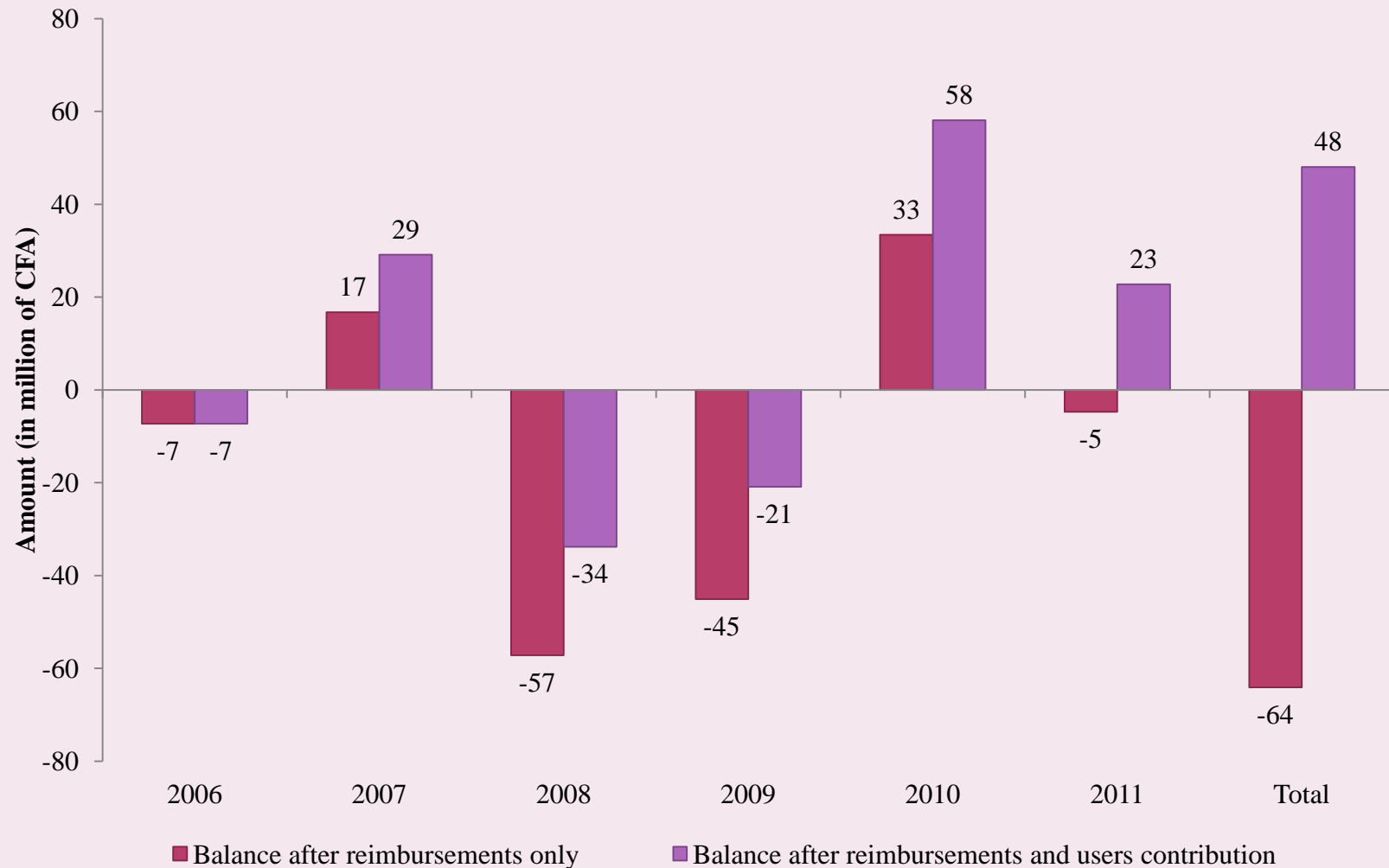
Figure 2: Evolution in expenditure on policy by facility level, selected facilities





Financial balance at university hospitals

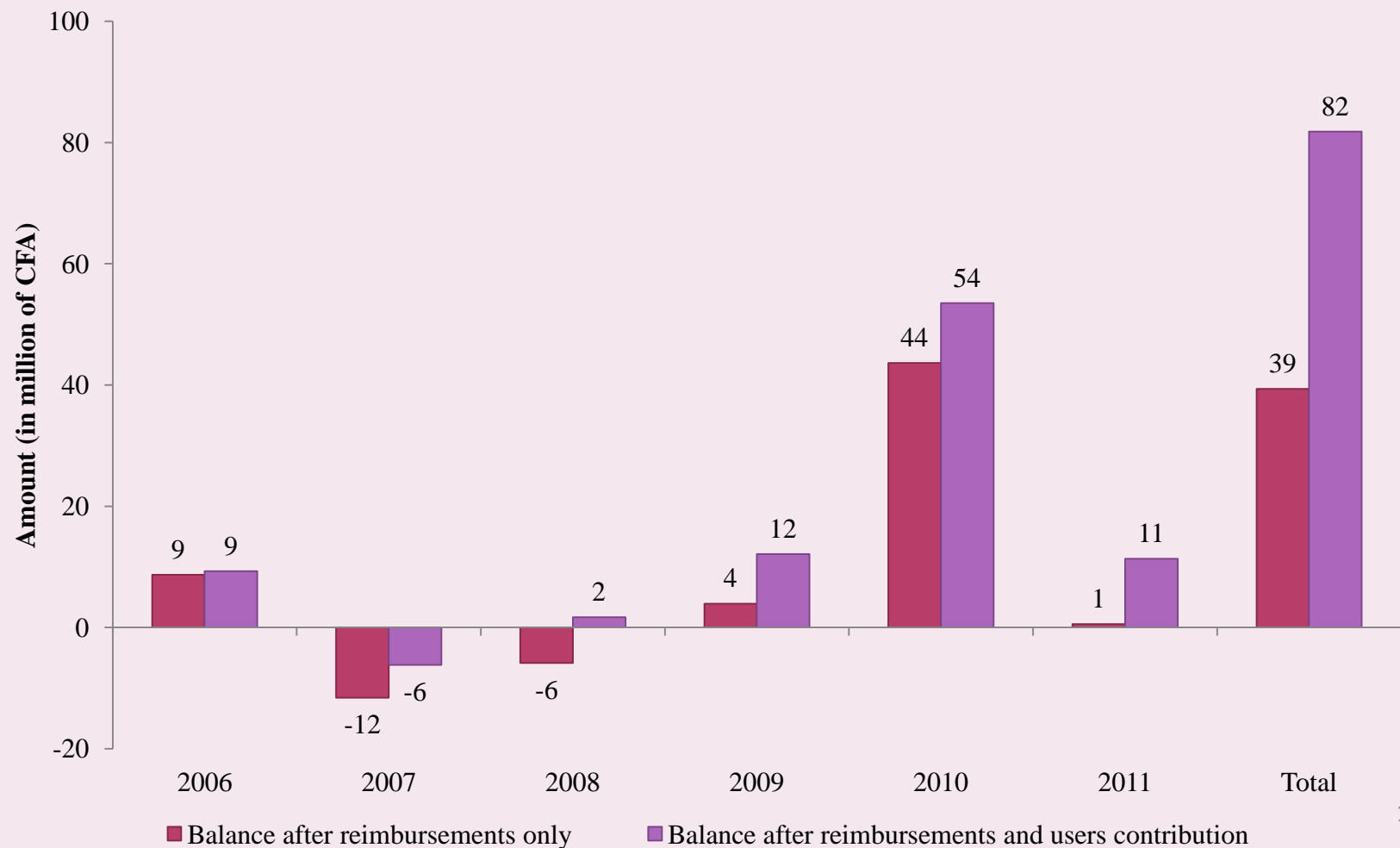
Figure 3: Balance of EMOC and normal deliveries programme per year at CHU level





Financial balance at regional hospitals

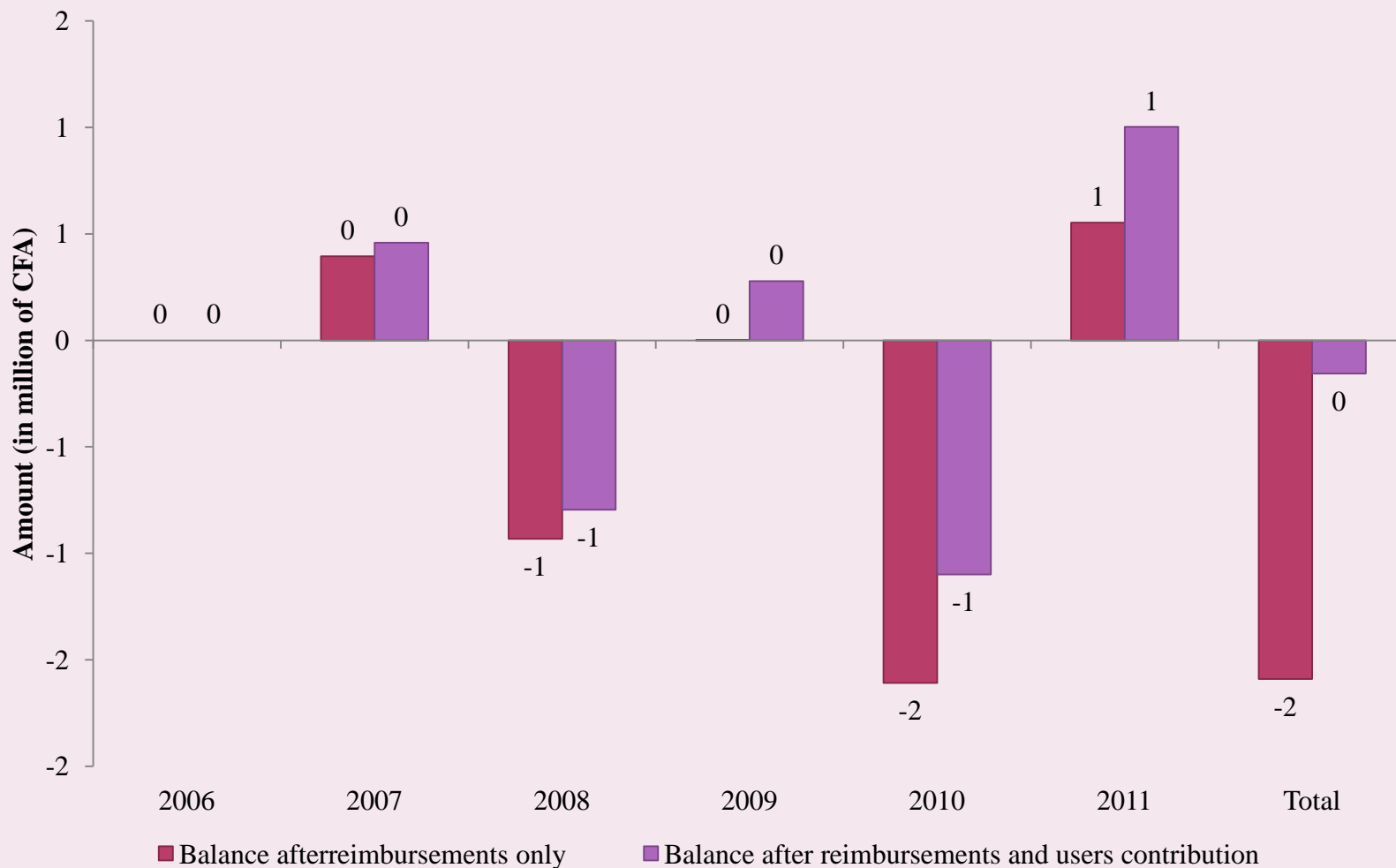
Figure 4: Balance of EMOC and normal deliveries programme per year at CHR level





Financial balance at health centre level

Figure 6: Balance of EMOC and normal deliveries programme per year at CSPS level





Discussion

- Overall, the policy seems beneficial for CHU and CHR
- Effects of policy at CMA and CSPS levels seem unclear, although it possible that it is beneficial too
- Reimbursements were not stable and regular leading to deficits in some years
- Almost no indigents benefited from the policy, according to the records we found
- Administration of the policy created additional workload, possibly leading to underreporting of cases treated at CMA level
- Overall, households contributing an average of around 25% of costs



Conclusion

- The Burkina Faso subsidy policy seems generally beneficial to facilities, but we need to finish data analysis and triangulate with qualitative findings
- Efforts are however needed to ensure regularity of reimbursements
- Reducing the administrative workload for health workers would increase policy impacts
- Re-thinking approaches to reach the indigent population is imperative (clear criteria; proactive identification in the community etc.)



Still to come....

- Unit costs of policy
- National level analysis of budgets & expenditure on policy
- Distribution of funds by area and delivery type
- How the policy fits in the context of wider facility financing and national health financing

Thank you!



How to measure the effects of a national policy on the district level: methodology and first results of the FEM Health project

Chair: Sophie Witter, University of Aberdeen, UK

Panel session description

User fee exemption for normal deliveries, caesarean sections and other obstetric complications has been introduced by many governments, especially in West Africa, in recent years. However, the current evidence base regarding the impact of this policy is not well developed, in part because of evaluation designs that are not able to capture all the necessary information for policy-makers to make informed decisions. Available evaluation frameworks focus on the impact of a policy on the health system at country level. No current framework focuses on the local health system level. Within the FEMHealth programme (EU FP7 project, www.abdn.ac.uk/femhealth), the Policy Effect Mapping tool (POEM) was developed to assess the effects of fee exemption policies for pregnant women on the local health system level. Starting from the 6 building blocks model of WHO and from ITM's dynamic health systems framework, it focuses on the key functions of health care organisations and local health systems, and the relations between them. This allows assessment of the effects of a policy not only on its target population, but also on other services and non-targeted population groups.

The aim of this session is:

- to present the key elements of the Policy Effect Mapping tool
- to present the results of the study that mapped the effects of the fee exemption policy in Benin, Burkina, Mali and Morocco
- to discuss with the participants the use of the POEM tool for other targeted policies or global health initiatives.

Individual Abstracts

1. Introduction to the Policy Effect Mapping tool (POEM)

Presenter: Fabienne Richard, RM, MPH, Department of Public Health Institute of Tropical Medicine, Antwerp, Belgium

Authors: Richard F, Marchal B, Dubourg D and De Brouwere V.

Key terms: Fee exemption, Maternal health, Health system research, Methodology, West Africa

Removal of user fees for Emergency Obstetric Care (EmOc) has much in common with other complex interventions. The change in policy can take different forms, and its introduction at large scale leads to variable implementation. The actual uptake of the policy depends on the actors involved and on local context-specific factors. Such unpredictable interactions occur with most health policy changes and with interventions from global non-state actors.

One of the aims of the FEMHealth project is to develop new methodological approaches for the evaluation of complex interventions in low-income countries. To date, there has been a proliferation of analytical frameworks for health systems and health system strengthening. The current frameworks are diverse in terms of focus, scope, and taxonomy. They mostly consider the national level, and not the local level. We developed the Policy Effect Mapping tool (POEM) to assess the effects of fee exemption policies for pregnant women on the local (district) health system. The tool allows us to trace the effects of the policy on targeted and non-targeted services to assess the local health system-wide effects. It starts from the key functions of health care organisations and local health systems, and the relations between them, using a multidisciplinary approach with mixed quantitative and qualitative methods (interviews with different stakeholders, use of routine data, and exit interviews). Since POEM is built around the core functions of a local health system, it can be applied to any targeted policy, programme or intervention of a global health initiative.

2. Effects of the free caesarean section policy on the provision of care and health services management: the case of Benin

Presenter : Jean-Paul Dossou, MD, Centre de Recherche et Reproduction Humaine et en Démographie, CERRHUD, Benin

Authors : Dossou JP, Goufodji S, Kanhonou L Makoutodé P, and Agbla S.

Key terms: Benin, Fee exemption, Maternal health, Health system research, District health management

In order to reduce maternal mortality, the Benin government has introduced several new strategies since 2006. The first strategy improved supplies of kits for obstetric emergencies at referral hospitals. In 2007, the second strategy introduced additional funding for EmOC services for the poorest women through Equity Funds (Fonds des Indigents). Third, in April 2009, a policy of fee exemptions for caesarean sections was introduced in 44 public and

private-not-for-profit hospitals. Hospitals are reimbursed US \$ 150 (FCFA 100,000) per caesarean section and covers laboratory tests, drugs, surgical kits, surgery, blood transfusion and a maximum of 7 days hospitalization. The policy does not cover complications.

We present the results of the POEM study that is currently being carried out in 7 study sites in 5 of Benin's districts to assess the effects of the fee exemption policy in the local health system.

Preliminary data indicate that some hospitals charge patients systematically extra fees for C-sections, arguing that the current rate is insufficient to cover actual costs. In contrast, other hospitals increased their revenue through the policy by better recovering their actual costs. Changes in referral patterns occurred, since hospitals that used to refer cases easily realised they can gain financially from performing C-sections. Preliminary analysis also reveals that providers at times falsify the diagnosis in favour of the patients, so that they can be provided care for free. This presentation will summarise the final results of the analysis of the effects of the policy on provision of care and health services management using routine data and interview with stakeholders.

3. Effects of the free caesarean section policy on the community: the case of Mali

Presenter: Brahim Diallo, Anthropologist, MSc, MARIKANI Research Centre, Mali

Authors: Diallo, B. A., Konaté, M.K., Traoré, D.

Key terms: Mali, Fee exemption, Maternal health, Health system research, Community participation, Solidarity funds.

In order to increase access to caesarean sections and to reduce maternal mortality, the government of Mali abolished user charges for caesarean sections in public sector facilities (district, regional and national hospitals) in June 2005. As a result, caesarean-section-related procedures (including hospital stay, drugs, laboratory tests or treatment for complications) are now provided free of charge. Reimbursement of costs incurred by facilities takes the form of kits for 'simple' or 'complicated' caesarean sections and reimbursement of actual costs up to a maximum of US \$ 60 (FCFA 30,000) for each caesarean section case. The State does not cover the cost of transportation; it is the already existing solidarity funds that are supposed to cover this.

The POEM study is currently carried out in 1 regional hospital and 1 district hospital in 4 regions of Mali. Preliminary analysis indicates that there has been little coordination of the locally organised solidarity funds and the centrally-managed fee exemption policy. Poor communication seems to have led to undermining of the solidarity funds for transport of patients, as communities no longer believe it necessary to contribute to the solidarity fund. This presentation will focus on the effects of the free C-Section policy on community participation and will be based on interviews with front-line workers and representatives of the population.

4. Effects of the national subsidy policy for normal deliveries and emergency obstetric care on the finances of the health facilities, the case of Burkina

Presenter : Patrick Ilboudo, Health Economist, Agence de Formation, de Recherche et d'Expertise en Santé Pour l'Afrique (AFRICSanté)

Authors : Ilboudo P, Sophie Witter, Nadia Cunden

Key terms: Burkina Faso, Fee exemption, Maternal health, Health financing

In 2006, Burkina Faso introduced a national subsidy policy for normal deliveries and emergency obstetric care. The policy covers 80% of direct costs of normal deliveries at the first level of care, and 60% of direct costs of normal deliveries at the second and third levels of care. It covers 80% of the direct costs of emergency obstetric care at any level. The remainder is charged to the women. The transport between facilities is free of charge for all pregnant women. Care is theoretically free of charge for indigent pregnant women.

We will present the results of the analysis of the effects of the policy on the financial resources of the health facilities. We focus on the timeliness and adequacy of the reimbursements, the use of the waiver system, the impact on funding of other services and the workload the policy creates. Preliminary results indicate that waiving of fees for indigent women is underused by front-line workers, although 20% of the budget of the national subsidy has been devoted to it. We found that the system of reimbursement, which funds facilities on the basis of their actual costs, is demanding in terms of administration work and data entry in the software package of the MOH. Administrators complain of the additional workload it creates.

Deadlines and logistics

- Session Proposals are **DUE** by 15 March 2012 at 23:59 GMT.
- The organizers must ensure that they have **AGREEMENT** from all participants to take part in the session before the proposal is submitted.
- The Session Organizer will be the main contact with Symposium Organizers for the session.
- All participants within organized sessions are expected to register and pay by the deadlines listed on the Symposium website.