



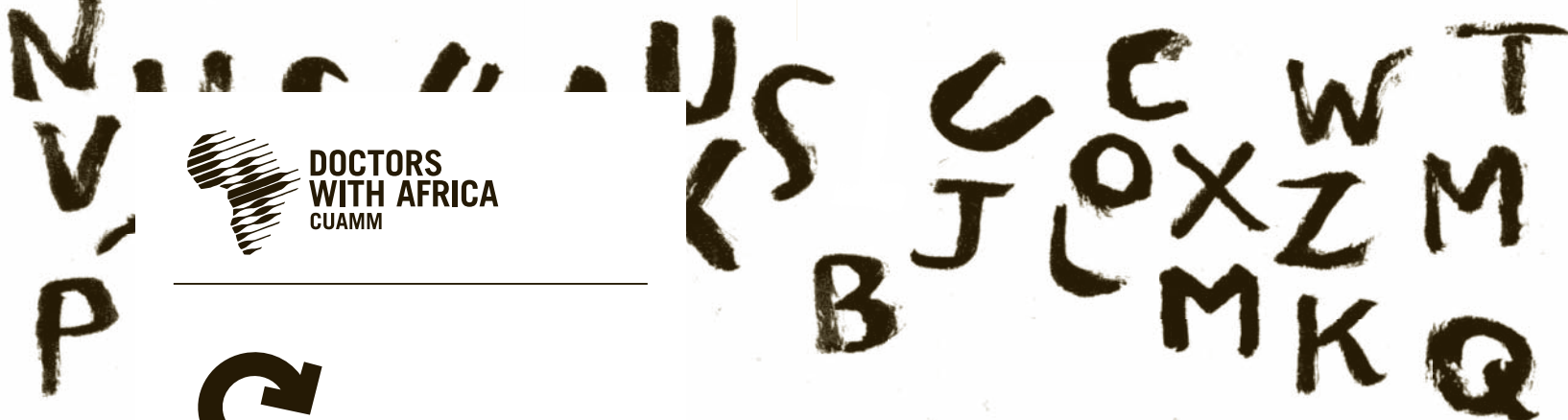
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**EDUCATION OF
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HEALTH PROFESSIONALS AS EFFECTIVE GLOBAL HEALTH ADVOCATES

The project “Equal opportunities for health: action for development”

Education, training, advocacy and public awareness raising play a pivotal role in the promotion of Global Health. Indeed, informed health workers can act as opinion makers and information multipliers as well as influence the elaboration of more equal health policies. To be more effective and promote a global health movement, coordinated actions and efforts as well as strengthening of networks are needed.

By / E. Bertotti and S. Foresi / Education and Public Awareness Department / Doctors with Africa Cuamm

G. Putoto / MD / DTM&H / MAHMPP / Strategic Planning Advisor / Doctors with Africa Cuamm

ABSTRACT

BACKGROUND

Education has proved to be one of the most effective investments in tackling the obstacles hindering the achievement of the right to health. Indeed, informed health workers can be effective opinion makers and “Global Health advocates” and can in turn promote more equitable health policies. This requires a cultural change in today’s health teaching and training, both at university and in the field of lifelong learning.

OBJECTIVES

Doctors with Africa Cuamm has been promoting the project *Equal opportunities for health: action for development* since May 2007, in order to: 1- expand global health teaching at Human Science Faculties and improve its quality and coordination; 2- make healthcare professionals accountable for promoting global health and health equity at all levels (including policy makers); 3- establish and strengthen strategic partnerships among universities, scientific societies, research and education centres, health institutions, non governmental organisations and public institutions to promote the definition of fairer and more effective health policies; 4- make public opinion more aware of global health and equity in health.

METHODS

The project, co-financed by the European Union, is implemented by 29 partners and associates representative of the health community from 6 Member States (Italy, Germany, Poland,

United Kingdom, Spain, Belgium), including universities, medical and students associations and non-governmental organizations. Main activities realized include: 1- mapping of actual under-graduate training courses in “Global Health” at Italian Medical Faculties; 2- development and sharing of a core curriculum in Global Health among participating faculties and delivery of a training of trainers; 3- delivery of training seminars at Hospital and Health Authorities and Associations on Global Health; 4- organization of an international conference, followed by preparation of a commitment paper stating future strategies.

RESULTS

1- Improved and coordinated teaching and training on Global Health has been started, covering nearly 50% of Italian Medicine Faculties 2- The International Conference delegates yielded a commitment paper detailing future teaching and lobby/advocacy strategies to implement effective and radical innovations in university education and health policies.

CONCLUSIONS

Education, training, advocacy and public awareness raising play a pivotal role in the promotion of Global Health. Indeed, informed health workers can act as opinion makers and information multipliers as well as influence the elaboration of more equal health policies. To be more effective and promote a global health movement, coordinated actions and efforts as well as strengthening of networks are needed.

THE PROJECT “EQUAL OPPORTUNITIES FOR HEALTH: ACTION FOR DEVELOPMENT”

A global approach to health

In today's globalized world, healthcare workers are called to embrace a global approach to health and have a clear understanding of social, cultural and environmental factors affecting health and illness. Given the various social and professional roles they play and the variety of contexts they work in, healthcare workers can in fact act as a pressure group and become activists in promoting the right to health for all and influence the elaboration of more equal policies. To promote an active role by the health community, a cultural change is needed as well as investment in education and training.

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Health is a fundamental and universal human right incorporated into international legislation. One of the pillars in the fight against poverty, health is essential for the full development of human potential, not only for the physical, but also for the intellectual and emotional growth of every individual, and for the development of the productive and learning capacities required in order to ensure economic well-being and social advancement, both of which, in their turn, are a necessary element to avert potential social imbalances and conflicts.

Guaranteeing health for all, means promoting equal opportunities, justice, development and peace. In today's globalized world, this seems one possible path, given the general agreement within the corpus of preventive and curative medical technologies; the scientific knowledge and financial resources now available; and, for the first time in history, the commitment of all nations to the fight against poverty in their pursuit of the eight ambitious Millennium Goals. The health objectives amongst these Goals concern malnutrition, cutting infant mortality rates, improving maternal health and controlling epidemics.

Notwithstanding this, even though at the global level there has been an overall improvement in people's state of health, this improvement has really only affected one section of the population: indeed, not only are the disparities between nations growing, especially those between the North and South of the World, but also the gap between social groups is widening within nations themselves. This latter is particularly clear and important in developing countries, where access to health services is difficult for people who are already economically and socially vulnerable, and this causes them to retrogress even further, deepening their poverty.

It is clear how in today's globalized world these inequalities are socially determined, avoidable, unnecessary and unjust. Therefore, they can be referred to as inequities, as they are unacceptable, not only economically and politically, but also at the ethical and moral level. A real and shared commitment is required in order to raise awareness to confront these inequities because - quoting Richard Horton, Director of the Lancet - “Children and mothers are dying

because those who have the power to prevent their deaths choose not to act. This indifference - by politicians, policy makers, donors, research funders, and civil society - is a betrayal of our collective hope for a stronger and more just society, one that values every life no matter how young or hidden from public view that life might be. It signifies an unbalanced world in which only those with money, military strength, and political leverage determine what counts and who counts. As health professionals, we should not accept this pervasive disrespect for human life”¹.

Only through collective action and mobilization for the creation of a movement to promote the right to health for all will it be possible to confront this indifference and raise awareness, in particular, among the health community. Given the various social and professional roles they play and the variety of contexts they work in, health professionals should be more aware of the importance of a global health approach and have a clear understanding of social, cultural and environmental factors affecting health and illness and of their ability and responsibility to influence them. Both as individuals and as members of professional bodies and public or private organisations, healthcare workers can in fact perform an important function as information spreaders and opinion makers. In other words, they can act as a pressure group for promoting a global approach to health and, by elaborating more equal health policies, become de facto activists in promoting the right to health thus helping to remove the barriers that stop the right to health from becoming a reality for all. Based on these premises, and seeking to mobilise public opinion so as to create equal opportunities for health, the Italian Ngo Doctors with Africa Cuamm has been promoting the project Equal opportunities for health: action for development, which, co-financed by the European Union, has been carried out from May 2007 to July 2009 in partnership with diverse institutions representative of the health community in 6 member states (Italy Germany, Poland, the UK, Belgium and Spain). Participants come from various areas: Universities, students' associations, health and hospital authorities, trade unions, research centres, scientific societies, non-governmental associations².

To mobilize an active role by the health community and in turn to promote more equitable health policies, a cultural change is needed as well as investment in education and training on global health at all levels, both at university and in the field of lifelong learning.

As far as academic teaching is concerned, mapping of undergraduate courses on global and international health at Italian Medicine and Surgery Faculties has revealed that current curricula are too heavily focused on national and predominantly clinical aspects and lack any global approach to health. Thus, they are not able to meet the needs and challenges of a globalised world. Global health is mostly taught in elective courses and there is poor coordination regarding contents, as also there is a diversified geographical distribution of courses, with a very few courses available in the South of Italy. With a view to increasing the number of courses and promote coordination, a proposal for a curriculum has been drawn up within the project, which includes six teaching modules, namely: Health and its determinants; The origins and development of health systems. Health as a human right; Globalisation and health; Inequalities in health and in healthcare assistance; Immigration and health; and, International health cooperation. This proposal has been circulated through the network of contacts which was set up during the mapping activity and was welcomed by University staff in almost all Italian Medicine Faculties, who – after participating in a training of trainers – have been promoting electives in global health in their own Faculties. Training and programming of new electives have favoured sharing experiences and good practices and reinforcing a pool of experts on global health who are able to act as promoters and advocates for the inclusion of such issues in the core curricula of Medicine Faculties.

Besides academic teaching, global health has been also promoted in the area of lifelong training through seminars and workshops organized in collaboration with local Health and Hospital Authorities. Using similar contents to those in the curriculum proposal, the seminars have sought both to raise awareness on global health related issues and to strengthen those social and professional competences and abilities which health workers today need if they are to operate in this complex, changing and global context. The seminars also tried to stimulate health workers to become active promoters of the right to health, both by working in the field of international health cooperation in developing countries and by advocating health policies that guarantee equal access.

In order to elaborate a common plan of action to promote and teach global health and to stimulate the creation and strengthening of strategic partnerships, an international conference “Equal

opportunities for health: action for development! A plan of action to teach and advocate global health” was held at the Department of Sociology of the University of Padova on 03-04 April 2009. This Conference – which was attended by 150 international participants representative of the health community – offered an opportunity to bring students, Faculty, professional staff, researchers, representatives of medical companies, health and education organisations/institutions, and health community members together to discuss health inequalities and other major challenges facing today’s health workforce, and to focus on proposals and projects to foster global health teaching and advocacy. Split into four working groups (teaching global health at schools of health and human sciences; life-long learning of health professionals on global health; the role of international health cooperation in advocating, teaching and implementing global health; and strategies for mobilising and sustaining financial and human resources to advocate and teach global health), such proposals have been collated into a final commitment paper which will be the basis for future action to update curricula and education patterns, to link academic teaching and professionalism, to promote interdisciplinary approaches and strengthen strategic partnerships.

As well as intervening at the level of training and advocacy, the project Equal opportunities for health: action for development has also been committed to raising awareness by organising workshops for promoters and activists who, in their turn, have been involved in organising workshops and awareness raising events. Furthermore, given the importance of disseminating information in order to mobilize public opinion, some publications have been drafted and published within the project, including the translation of the 3rd Report of the Italian Global Health Watch “Global health and development assistance”, the present issue of *Doctors with Africa Cuamm’s* “Health and Development” review, and the realization of the study “Sustaining equity in the private-not-for-profit sector in Uganda: a public responsibility” conducted by the Faculty of Health Sciences, Uganda Martyrs University.

Education, training, advocacy and public awareness raising play a pivotal role in the promotion of global health. Indeed, informed health workers can act as opinion makers and information multipliers as well as influence the elaboration of more equal health policies. To be more effective and promote a global health movement, coordinated actions and efforts as well as strengthening of networks are needed.

For more information, please visit www.mediciconlafrica.org/globalhealth.

1 Richard Horton, Countdown to 2015: a report card on maternal, newborn and child survival. *Lancet* 2008, 371: 1217-19.

2 Partners: OISG, Italian Global Health Watch; Department of Medicine and Public Health, University of Bologna; Department of Public Health, University of Florence; SISM, Italian Medical Students Secretariat; Nuffield Centre for International Health and Development at the University of Leeds, United Kingdom; Redemptoris Missio Foundation, Poland; action medeor e.V., Germany. Associates: Department of Environmental Medicine and Public Health,

University of Padova; Department of Public Health and Microbiology, University of Turin; Department of Internal and Specialist Medicine, University of Catania; Department of Experimental, Environmental Medicine and Biotechnology, University of Milan; IRCCS Burlo Garofolo; Prince Leopold Institute of Tropical Medicine, Belgium; Medicus Mundi Spain; ONSP, National Observatory of Residents in Paediatrics; IPASVI, Padova College of Nurses; Medical and Dentists Association of the Province of Padova; Padova Hospital Authority; Doctors with Africa Cuamm support groups.

PRIMARY HEALTH CARE. NOW MORE THAN EVER

The World Health Organisation 2008 Report

Dr Margaret Chan, Director General of the WHO ended her presentation of the 2008 Report with these words: "There are no reasons why any country – rich or poor – should wait to begin moving forward with these reforms. (...) United by the common challenge of primary health care, the time is ripe, now more than ever, to foster joint learning and sharing across nations to chart the most direct course towards health for all".

By / G. Maciocco* / Department of Public Health / University of Florence

From Alma Ata to *Alma Ata* could be the underlying meaning of the WHO 2008 Report. A return to the past to rediscover and re-evaluate international health policies based on a formula as simple as it is powerful: "health for all". So let us toast the fact that "health for all" has returned to be part of the WHO lexicon. Dr Margaret Chan, Director General of the WHO ended her presentation of the 2008 Report with these words:

"There are no reasons why any country – rich or poor – should wait to begin moving forward with these reforms. (...) United by the common challenge of primary health care, the time is ripe, now more than ever, to foster joint learning and sharing across nations to chart the most direct course towards health for all".

THE DECLARATION OF ALMA ATA

Under the aegis of the WHO, a history making conference on Primary Health Care was held in September 1978, in Alma Ata, then still capital of the Soviet Republic of Kazakhstan. The conference concluded with a document, signed by almost every country in the World: the Declaration of Alma Ata is considered one of the landmarks of International health policy. We will quote some of the paragraphs:

- "...that health, which is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector".
- "The existing gross inequality in the health status of the people particularly between developed and developing countries as well as within countries is politically, socially and economically unacceptable and is, therefore, of common concern to all countries".
- "All countries should cooperate in a spirit of partnership and service to ensure primary health care for all people since the attainment of health by people in any one country directly concerns and benefits every other country".

- "Governments have a responsibility for the health of their people which can be fulfilled only by the provision of adequate health and social measures. A main social target of governments, international organizations and the whole world community in the coming decades should be the attainment, by all peoples of the world, by the year 2000, of a level of health that will permit them to lead a socially and economically productive life. Primary health care is the key to attaining this target as part of development in the spirit of social justice".

- "Primary Health Care forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and the community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process".

Thirty years later, after years of oblivion, the WHO feels it should rediscover the values enshrined in that document by dedicating the 2008 Annual Report to *Primary Health Care*, and adding a meaningful sub-title: *Now More Than Ever*. And it is not a banal reminder. It cannot be.

HOPE BETRAYED

The promise "health for all by the year 2000" has proved to be a mirage, a hope betrayed. Thirty years after that solemn commitment less than 20% of the World's populations live in social, economic and political situations that guarantee access to essential health care with no economic, geographical and cultural barriers. Equally, primary health care has struggled – and in many cases has failed to achieve its aim – of becoming the key to reaching an adequate level of health.

The paragraph below is taken from the Report: "Global and, increasingly, national health policy formulation processes have focused on single issues, with various constituencies competing for scarce resources, while scant

attention is given to the underlying constraints that hold up health systems development in national contexts. Rather than improving their response capacity and anticipating new challenges, health systems seem to be drifting from one short-term priority to another, increasingly fragmented and without a clear sense of direction.

Today, it is clear that left to their own devices, health systems do not gravitate naturally towards the goals of health for all through primary health care as articulated in the Declaration of Alma-Ata. Health systems are developing in directions that contribute little to equity and social justice and fail to get the best health outcomes for their money. Three particularly worrisome trends can be characterized as follows:

- health systems that focus disproportionately on a narrow offer of specialized curative care;
- health systems where a command-and-control approach to disease control, focused on short term results, is fragmenting service delivery;
- health systems where a hands-off or laissez faire approach to governance has allowed unregulated commercialization of health to flourish.

These trends fly in the face of a comprehensive and balanced response to health needs. In a number of countries, the resulting inequitable access, impoverishing costs, and erosion of trust in health care constitute a threat to social stability." (p. XIII)

REDISCOVER, RE-EVALUATE AND UPDATE THE VALUES OF ALMA ATA

According to the WHO 2008 Report, in order to offer an efficacious response to the challenges of health care today and to meet the expectations of populations we must re-discover re-evaluate and update the values of Alma Ata: values of equity, solidarity and social justice. Which can be done through four sets of fundamental PHC reforms (**Figure 2**).

1. Reform of universal health cover (to improve equity in health).

For 5.6 billion people in low- and middle-income countries, over half of all health-care expenditure is through out-of-pocket payments. This deprives many families of needed care because they cannot afford it. Also, more than 100 million people around the world are pushed into poverty each year because of catastrophic health-care expenditures.

Out-of-pocket payments for health care, and the consequent barrier to access to health services, are but one of the sources of health inequity. Deeply unequal opportunities for health, or rather the systematic differences in the state of health of diverse socio-economic groups are rooted in the socio-economic context in which they live and are the combination of income, social status, income and social status of where people live and work.

The struggle against health inequity is mainly played out in the field of the social determinants of health through interventions that include:

- reduction of social stratification, e.g. by reducing income inequality through taxes promoting equal opportunities for women and making free education available,
 - reduction of vulnerabilities, e.g. by providing social security for the unemployed or disabled, developing social networks at community level, introducing social inclusion policies and policies that protect working mothers, providing free healthy lunches at school
 - protection, particularly of the disadvantaged, against exposure to health hazards, e.g. providing safe water and sanitation, promoting healthy lifestyles, establishing healthy housing policies, etc.);
- The need to adopt such broad strategies could discourage some health leaders from intervening in the area of health equity as they may feel that health inequality is a societal problem over which they can have little influence. However, the Report warns - the problem of health inequality does involve them, directly. Many of their policy choices concern the way in which the health system exacerbates or mitigates health inequalities. "The question, therefore, is not if, but how health policy-makers can more effectively pursue strategies that are able to guarantee greater equity in the provision of health services".

The fundamental step a country can take to promote health equity is to move towards universal coverage: universal access to a wide range of health services, through a system of social security. This could be achieved – says the report – either through a tax based system (Beveridge model) or organised through a social health insurance system (Bismark model), or through a mix of both. The principle is the same: collecting pre-paid contributions on the basis of contributor's ability to pay and, using these funds to ensure that quality health care services are accessible for those who need them, without exposing them to the risk of catastrophic expenditures. Universal coverage is not, in itself, sufficient to ensure health equity for all – inequalities persist in countries with universal coverage – but it does provide the necessary foundation.

Using an original graphic (**Figure 3**), the report describes the three different dimensions of universal coverage.

- The breadth of coverage: expresses the proportion of the population that enjoys social health protection. Ideally no one should remain without cover but this objective may takes years to achieve through an incremental process of progressive expansion, as was the case in industrialized countries during the 20th century. However recent examples have shown that it is possible to achieve universal cover far faster.
- The depth of coverage: concerns the type and range of services made accessible by cover. Sometimes this type is called the "essential package of services" which is translated into Italian as LEA, Essential Level of Assistance (care). The size of the packet reflects the resources that a society is willing (or able) to allocate to health care.
- The height of coverage: is the portion of health-care costs financed by public resources. Almost all health systems require the patient to share costs. Sharing costs can be either a light or heavy burden (as a percentage of total cost of the service) and can involve a wide range of services from drugs, to specialist and diagnostic: the lower is the cost sharing the higher is the cover.

2. Service Delivery reforms (to make health systems people-centred)

This chapter opens with a quotation from William Osler (1849-1919), one of the founders of modern medicine: "it is much more important to know what sort of patient has a disease than what sort of disease a patient has". The Report takes a clear stance, in some ways novel, in favour of recognising the importance of the human dimension of health care. "Insufficient recognition of the human dimension in health and of the need to tailor the health service's response to the specificity of each community and individual situation represent major shortcomings in contemporary health care, resulting not only in inequity and poor social outcomes, but also diminishing the health outcome returns on the investment in health services".

Each individual has his or her own way of experiencing and coping with health problems within their specific life circumstances. Health workers have to be able to handle that diversity and manage to understand their patients' suffering and difficulties because - the Report argues - this is what people want their health worker to do. Unfortunately, many providers neglect this aspect of the therapeutic relationship, particularly when they are dealing with disadvantaged groups. Only too often, responsiveness and person-centeredness (respect for dignity, reserve, consensus, autonomy, speed of response, correct information, freedom of choice) are treated as luxury goods to be handed out only to a select few.

Over the last thirty years, a considerable body of research evidence has shown unequivocally, that person-centeredness is important to relieve the patient's anxiety. It has been shown that focusing on patients' needs (and not only on their illness), ensuring integration between diverse services and continuity of care heightens the efficacy of the care, improves the quality of life and reinforces the trust and compliance that facilitates the

integration of prevention and health promotion in the therapeutic response.

Today, rediscovering the "up-to-the-minute" principles of Alma Ata also means designing primary health care which is very different from that based on vertical programmes. Health care that, on one hand, shapes services to fit patient needs and promotes patient empowerment (accessibility, information, proactive, self-care) and, on the other, oversees a community and public health based approach (evaluation of community needs, citizen participation, struggle against health inequality/inequity, primary prevention interventions). (Table 1).

In conclusion, the second reform sought by the Report is that of making primary health care the hub of the health system: a) platform (hub) through which patients are led through the health, with mechanisms that guarantee continuity of care; b) a system that facilitates relations between patients and medical personnel within which patients are able to participate in decisions that concern their health and acquire the knowledge and the capacities they need to become active partners in the care process and to participate in decisions regarding their health; c) an organisation based on a team of professionals: Doctors, nurses and other health workers with specific, and often sophisticated biomedical and social skills; d) an organisation that encourages prevention, early diagnosis and promotion of health (Figure 4).

3. Public Policy Reforms (to promote and protect the health of communities)

People want to live in communities and environments which secure and promote their health. Primary care, with universal access and social protection, represents a key response to these expectations. However, both primary care and universal

TABLE 1 / ASPECTS OF CARE THAT DISTINGUISH CONVENTIONAL HEALTH CARE FROM PEOPLE-CENTRED PRIMARY CARE

CONVENTIONAL AMBULATORY MEDICAL CARE IN CLINICS OR OUTPATIENTS DEPARTMENTS	CARE BASED ON VERTICAL DISEASE PROGRAMMES	PERSON-CENTERED PRIMARY HEALTH CARE
FOCUS ON ILLNESS AND CURE	Focus on priority diseases	Focus on health needs
RELATIONSHIP LIMITED TO THE MOMENT OF CONSULTATION	Relationship limited to the programme implementation	Enduring personal relationship
EPISODIC CURATIVE CARE	Programme-defined disease control interventions	Comprehensive, continuous and person-centered care
RESPONSIBILITY LIMITED TO EFFECTIVE AND SAFE ADVICE TO THE PATIENT AT THE MOMENT OF CONSULTATION	Responsibility for disease-control targets among the target population	Responsibility for the health of all in the community along the life cycle; responsibility for tackling determinants of ill-health
USERS ARE CONSUMERS OF THE CARE THEY PURCHASE.	Population groups are targets of disease-control interventions	People are partners in managing their own health and that of the community

coverage lose much of their impact and meaning if they are not accompanied by public policies that cover every aspect of health from local to supra-national level and pursue healthy public policies for all citizens.

The report argues that these public policies fall into three groups:

- The first group is that of policies which ensure correct functioning of the health system: from those related to human resources to those for essential drugs, from quality control to accreditation, or from the use of technology to logistics.
- The second are those concerning public-health strategies: ranging from classical public-health and hygiene policies and health promotion at the local level (water, air, food, construction, waste disposal, etc.), to far more complex strategies of supra-national importance, such as checks on climate change, or preventing pandemics, or preparation of rapid response capacities to deal with catastrophes.
- The third group of policies are “*health in all policies*”, those controlled by sectors other than health but which can profoundly influence the health of the population on issues spanning from education to work and social security policies, from commercial, consumer policies to food issues which should give be due weight in relation to questions of health.

4. Leadership reforms: (to make health systems people-centred)

In modern states, governments are expected to protect health, to guarantee access to health care and to safeguard people from the impoverishment that illness can bring. Since the beginning of the 20th century, health protection and care have progressively been incorporated into the heart of the social contract between the state and its citizens.

The legitimacy of a government today rests firmly on its ability to respect this contract, thus it is considered normal that a state, the public sector, should shoulder the main burden of its population's health costs. Furthermore, as **Figure 5** shows, countries that spend most on the health sector are those with higher public spending overall. The exception is the USA where, even though public expenditure on health stands at 6.9% of GDP - which is slightly higher than the average for high-income countries (6.7%) - there is still a high level of additional private expenditure made on health. United States health sector under-performances on efficiency, quality and equity, are due to an absence of the government, which latter has effectively absconded from taking any responsibility for managing the system efficiently and, above all, for securing more equitable access to essential health care.

But by the end of the 20th century, from the 80s on, the principle of government responsibility for health and health care had begun to be eclipsed in a large part of the world. In the paragraph entitled “*Disengagement and its consequences*” the Report explains the reasons for this ruinous withdrawal, citing the cases of China and of many of the countries of central and eastern Europe and the Commonwealth of Independent States, where the sudden passage from total state control to total deregulation

has led to a spectacular deterioration in the system of health-care provision and social protection, particularly in rural areas. This has in its turn had severe repercussions on the general population's state of health and meant that catastrophic health spending has become a major cause of poverty for millions of families.

Government disengagement from health and health care responsibilities, better known as “structural adjustment” policies, has become part of the neo-liberal recipe for rescuing the economies of low and middle income countries. As if this were not enough, in the same period (80's-90s on), these same countries were hit by another calamity described as follows in the Report:

“For decades, the international community's health agenda – including that of WHO – has been structured around diseases and interventions (the so-called vertical programmes) rather than around the broader challenges being faced by health systems. While this agenda has certainly contributed to a better appreciation of the burden of disease affecting poor countries, it has also profoundly influenced the structure of governmental and quasi-governmental institutions in low- and middle-income countries. The resulting fragmentation of the governance of the health sector has diverted attention from important issues, such as the organization of primary care, the control of the commercialization of the health sector and” led to a crisis without precedent in human resources.

Governments – this is the hope, the appeal, made by the Report – must start looking after the health of citizens again and ensure that the public health care system functions by carrying out the reforms outlined in the points above.

But this requires a new type of leadership. A leadership that does not only oversee the bureaucracy of administration within the system but also knows how to invest in innovation and how to promote and encourage dialogue with a multiplicity of actors (stakeholders): from medical professionals to civil society organizations; from grass roots groups to researchers, to the academic world.

CONCLUSIONS

The WHO 2008 Report was presented, and the 30th anniversary of the Alma Ata Declaration commemorated, on the 14th of October, 2008, in Almaty (formerly Alma Ata, once capital of Kazakhstan). From Alma Ata to *Alma Ata* could be the underlying meaning of the WHO 2008 Report. A return to the past to rediscover and re-evaluate international health policies based on a formula as simple as it is powerful: “health for all”. So let us toast the fact that “health for all” has returned to be part of the WHO lexis. Dr Margaret Chan, Director General of the WHO ended her presentation of the 2008 Report with these words:

“There are no reasons why any country – rich or poor – should wait to begin moving forward with these reforms. (...) United by the common challenge of primary health care, the time is ripe, now more than ever, to foster joint learning and sharing across nations to chart the most direct course towards health for all”.

CONTRACTING EXPERIENCES IN SUB SAHARAN AFRICA

The case of Cameroon, Tanzania, Chad and Uganda Main findings of a Medicus Mundi International network study

In this paper we present the principal findings of a study conducted on the arrangement of contractual relationships between faith-based (FB) district hospitals in sub-Saharan Africa and public health authorities.

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INTRODUCTION

In this paper we present the principal findings of a study conducted on the arrangement of contractual relationships between faith-based (FB) district hospitals in sub-Saharan Africa and public health authorities. Contracting can conveniently be defined as "a voluntary alliance of independent or autonomous partners who enter a commitment with reciprocal obligations and duties, in which each partner expects to obtain benefits from the relationship" (Perrot & de Roodenbeke 2003).

Contracting is a health policy option that frames well in the desire to bridge the gap between public and private health care provision. Some situate contracting within the scope of the international and growing trend towards "marketisation" of health care delivery, involving the selective introduction of a range of market mechanisms within the public health system (OECD 1992, World Bank 1993, McPake and Ngalande Banda 1994, Mills 1997). Contracting is also consistent with the emergence of new

trends in public sector management, which identify private sector mechanisms as a solution to many of the problems currently experienced by the public sector in many parts of the world (Palmer & Mills 2006)

It has become a major tool in the integration of health systems as a means to improve partnerships between the public and the private not for profit sector and in the end enhance the performance level of Health Systems.

In parallel, many African countries have adopted partnership- and/or contracting policies and many more implemented formalized agreements, the latter often preceding the first.

With respect to their historical involvement in the provision of healthcare, a strong established reputation in quality of care and a still important share (facility and non-facility based organizations) in local healthcare systems, churches often have been privileged partners of African Ministries of Health (MoH) in their indisputable efforts to develop collaboration through formal arrangements with the PNFP Health sector. Those have materialized in the emergence

MEDICUS MUNDI INTERNATIONAL

Medicus Mundi International (MMI) is an international network of 11 private not-for-profit organizations³ working in the field of international health cooperation and advocacy. MMI aims at enhancing the quality and effectiveness of the work of its members and their partners through sharing know-how and joining forces. The network's key strategy is to strengthen the health system as a whole. Strengthening the private not-for-profit (PNFP) health sector is an essential aspect in this⁴; it further justifies by the close collaboration of most member with PNFP organisations at district level. In that respect, MMI has shown its interest in contracting for several years and contributed to put the issue of contracting between public authorities and PNFP organisations on the international agenda. Indeed, MMI launched a debate

on the repositioning of FB health facilities in national health systems⁵ already in the late 90's. Closer collaboration with local governments soon appeared as one of the options to achieve this goal, with contracting as a key tool and strategic priority⁶ for the network. This policy attention from MMI for contracting translated in several milestones: first, the organization of a technical meeting on contracting and PNFP's in May 1999, which laid the foundations for the 2001 WHA Declaration on the role of contractual arrangements; continuous advocacy amongst higher church authorities (i.e. Catholic bishops) in Episcopal - and Christian Health Associations' Conferences⁷; and the publication of operational contracting guidelines (2003) for district level health facilities.

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of framework agreements at central level and, at district level, devolution of public mission to FB hospitals or organizations. The expected effect of such policies, from the perspective of the public health authorities, was to arrive at an improvement of the public health sector's coverage and control capacity and application of National Health Policies. The expectation from the PNFP sector, on the other hand, was an explicit recognition of their major contribution⁸ to the health sector, and to find a response to the increasing need for collaboration with the public sector as a means to compensate their growing lack of resources. Today, however, little evidence is available on the impact of 'classical', input-based contractual arrangements between the two sectors. Indeed, available data mostly apply to single-country or case evaluations (Palmer & Mills, 2006). Contracting today is high on the international (scientific and policy) agenda, but with an obvious shift lately to innovative arrangements – i.e. performance (output) based financing (PBF)⁹ contracts – which tend to set the trend for new field experiences¹⁰ in Africa, policy and guidelines' development, data gathering and analysis and the production of scientific literature. No general analysis of specific contracting experiences linking the public and the FB, PNFP health sector in Africa was conducted so far. The purpose of the MMI study precisely was to contribute to fill those gaps. The paucity of the available evidence left MMI with a crucial but unanswered question: do the current contracting experiences between FB, PNFP facilities and public health authorities actually work? And if they work, what makes them work? If they are not successful what are the reasons or mechanisms explaining this lack of success? What future stand should MMI take vis-à-vis contracting? Should its involvement in the promotion of contractual arrangements between PNFP and public sector be pursued? If yes, on what terms?

Confronted with the need to assess the validity of its own strategic advocacy, the MMI Network commissioned the Institute of Tropical Medicine, Antwerp (ITM) with a study that would generate more insight on current public-PNFP contracting experiences in the African health sector and feed possible updates of its policy line. It was obvious from the start that the results of the study could and should also be relevant to local policy makers – both from the public and PNFP health sector –, with international stakeholders and the scientific community, as a means to generate knowledge and improve the situation where necessary.

The MMI study was conducted by the ITM between September 2007 and March 2009. Its results were made public by official launching of the end report in Geneva in May 2009. The present article aims at sharing its core findings with stakeholders and organizations familiar with and interested in Doctors with Africa Cuamm's activities and concerns, as one of the MMI-network's oldest and most active members. It also is a stepping stone in MMI's policy of broader dissemination of the study results within the local and international stakeholders' community.

METHODOLOGY¹¹

The methodological basis for this study rested on an analysis of multiple case studies. Five case studies were selected in 4 different countries: Cameroon, Tanzania, Chad and Uganda.

The choice of the specific case studies within the countries was conducted with the goal to achieve a selection that would be sufficiently representative of the diversity of current contracting experiences between Ministries of Health and FB facilities at district level.

Cases selected in Cameroon, Tanzania and Chad form a sample of direct, contracting experiences between public health authorities and FB organisations:

- The case of contracting-out district hospital services to a FB facility on a one-to-one (selective) basis: the situation of the Catholic district hospital of Tokombéré, North Cameroon;
- The case of district designated hospitals (DDHs) in Tanzania, illustrated by the example of Nyakahanga Lutheran DDH: a case of contracting of district hospital services to a FB facility within the framework of systemic national policy;
- The example of contracted delegation of district and district Hospital management to a decentralized FB organisation: the situation of Moïssala district to the Catholic BELACD¹² of Sarh (southern Chad).

In Uganda, two cases were selected that deal with service level agreements linking FB hospitals with PEPFAR¹³ recipients on the basis of output-based financing. Their inclusion in the overall study was motivated by their high learning potential for public and for FB actors confronted with the upcoming trend of output-based, disease-focused contracting with district-level facilities. A comparison with the more conventional input-financed contracts was moreover likely to provide us with additional insight on the modalities of success or failure of contracting experiments.

The selection process eventually resulted in the following sample:

- Firstly the contractual arrangements linking St Joseph (Catholic) Hospital in Kitgum (Northern Uganda) with 3 major PEPFAR recipients: Catholic Relief Services (CRS, USA), the Uganda Programme for Human and Holistic Development (UPHOLD, USA) and The AIDS Support Organisation (TASO, Uganda).
- Secondly, the Kabarole (Protestant) Hospital in Fort-Portal (Kabarole District), and its sole contract with CRS was chosen.

The general methodological framework of the study is inspired by the realistic evaluation method. The data analysis was conducted in 2 steps: in a first step, the focus was on each case study as an independent entity; the second consisted of a cross-country analysis aiming at identifying constant factors which could feed theoretical reflection on general modalities for success or failure of contracting experiments.

The study builds on stringent and detailed observation of field experiences. It is based on the analysis of mainly qualitative data, using largely descriptive and inductive methods. More specifically, the study is based on two pillars. Firstly, an extensive set of interviews, conducted at all levels of the health systems with public and FB sectors¹⁴. Secondly, a detailed documentary analysis was carried out at country level of contract and contract follow-up documents, FB and public policy papers, other historical documents.

Last but not least, from a methodological perspective, MMI proposed an assessment of the dissemination, use and perceived utility of the contracting guidelinesⁱⁱⁱ that were drafted and published back in 2003. This part of the study was nested in the overall MMI study and was conducted through a questionnaire addressed at individuals that supposedly constituted the target audience of the guidelines.

RESULTS

COUNTRY CASE-STUDIES

CAMEROON

The private sector holds 40% of the overall national health care provision; the PNFP sector in the country is mainly constituted by FB suppliers linked to 3 different organizations (OCASC, CEPCA, FALC ¹⁵). Contracting processes took off in the early 2000s with isolated pilot cases: FB Hospitals getting a district referral status, recognition of the churches' role in health care delivery, and focus on (publicly) underserved areas. Gradually, from 2001 on, steps were undertaken towards formalization of de facto contracting policies. A major event was the C2D ¹⁶ project launched in 2003, which brought in the necessary financial resources to give a real content to the contractual arrangements. Later a partnership strategy was developed (2003-2006) and model documents were established from 2007 on.

The setting that was investigated in the MMI study is Tokombéré hospital. It is a Catholic 160 bed hospital (OCASC network), situated in a rural areas in the extreme-northern province of the country. The hospital's ownership is in the hands of the Maroua-Mokolo diocese. Tokombéré hospital is characterised by a strong leadership coming from expatriate hospital directors bringing in external resources. The good reputation of Tokombéré hospital, and the health care it delivers, goes well beyond the district boundaries. The hospital de facto plays the role of district hospital since the early 90s, which was formalized by a contract between the diocese and the MoH in 2002.

The contract's objectives however remained vague with a poor definition of the respective obligations and responsibilities. There was, for instance, no specification of the mechanisms of allocation of funds to the hospital, no reference to any authority of the hospital on the public health centres, and no reference to the specific FB character of Tokombéré hospital.

The M&E mechanisms were poorly developed, communication between the stakeholders was not well organised, and there was no structure operating as a functional, problem-solving organ. Moreover, there was an obvious failure of the MoH to respect its commitments in terms of subsidies to be paid, allocation of staff, official recognition of the hospital as district hospital despite the regular requests from the medical director of the hospital. There was a low level of collaboration between the health centre network and the hospital, seriously hampering the functioning of the local district system in an integrated mode.

This case points to a role of the FB hospital of partial substitution rather than one of complementarities. The hospital functioned mainly on its own resources and the formal contract basically re-conducted the pre-existing situation, without major changes in terms of mutual relationships. It is clear that the level of knowledge on the contracting technicalities and on the institutional mechanisms needed to streamline these arrangements was insufficient, especially at peripheral level. The contracts would have needed revision and up-dating taking into account existing experiences in the country. Finally, there is the issue of sustainability: what will happen after the end of the C2D project?

TANZANIA

The Tanzanian FB – or *voluntary* - sector is the second biggest health care provider in Tanzania after the government sector ¹⁷. Collaboration between the FB sector and the government took off under President Nyerere's mandate right after independence. The government's control increased over the FB sector, which was not without creating tensions, while religious freedom was maintained leading to the 'Tanzanian model' of Public-FB collaboration. In the health care sector this translated in the recognition of the crucial role played by (rural, isolated) FB health facilities in terms of coverage. The government-FB collaboration was formalised in 1972 with the adoption of a decentralized, pyramidal health system: a number of FB hospitals then acquired the status of DDH, sealed by a formal contract. This enabled the State to compensate the shortage of public facilities while avoiding duplication. Contracts guaranteed public funding of the DDH's recurrent expenditures.

After Nyerere's death, a Memorandum of Understanding (MoU) was negotiated by the churches and pursued the collaboration while offering more protection to the FB-sector against public absorption (forced nationalizations, as they sometimes occurred under Nyerere's rule) and enabling access to external financing sources. Further steps gradually led to the adoption of a Public Private Partnership (PPP) as an official policy, still referred to in key documents and embodied by several governing organs ¹⁸. Moreover, old DDH contract models were revised in 2005 in accordance with the decentralization policy and a new type of operational contract ¹⁹ was created in 2007 for private (Voluntary Agencies) and public facilities, excluding hospitals. The Christian FB health sector today is well represented in the public health arena by the Catholic Social Services Commission (CSSC) – i.e. a platform that enjoys official recognition of the State - and its 5 regional coordination bureaux.

The MMI study in Tanzania focused on the case of Nyakahanga DDH (NDDH), a Lutheran hospital located in the north west of the country in the remote Kagera region. NDDH counts 200 beds and has been the property of Karagwe diocese since 1912. The hospital officially became a DDH in 1992. The NDDH's contract does not differ from the early model and has not been revised to fit the 2005 contracting document. As a consequence, the diocese's public counterpart remains the MoH, whereas DDHs ²⁰ created since 2005 deal with Local Government authorities. This is in obvious contradiction with the current decentralization system. The contract lacks a number of elements that are clearly provided for in the new model: e.g. a proper definition of the terminology and concepts referred to in the contract; the principle agreement of a M&E system to follow-up contracting policies; the replacement of the old Board of Governors (BoG) by the Hospital Committee as a facility's representative body; the backing up by a solid legal framework, etc.

The current management of NDDH's contracting relationship with the MoH takes place under the auspices of the BoG, but this body does not function in an optimal way. Monitoring of the contractual relationship is not properly done and supervisions remain erratic. In terms of provision of drugs, the public system faces frequent stocks out, compensated by NDDH on basket-funding and own resources. Available moneys are almost completely absorbed by the provision of care at the expense

of capital investments. These and other problems have led to a negative perception of the contractual relationship from the perspective of both the hospital and the diocese. The church's trust in the contracting relationship is deeply undermined and carries the seed for withdrawal - be it as a threat - to enforce improvement.

The Tanzanian contracting model is impressive because of its long-standing character and its large coverage. There is however a strong need to adapt to the evolving context. There are major problems in information and communication and many important policy documents are simply not available, especially at the peripheral level of the health system. Moreover, the current contracts established with DDHs ²¹ are in contradiction with the decentralization of the health system, resulting in impaired management and lack of problem resolution capacity. Decentralization itself remains incomplete, with unclear distribution of responsibilities. This leads to blurred and dysfunctional communication lines. Tanzanian FB facilities face growing difficulties resulting from the decrease in external financial and technical support. The limited capacity of current contracting arrangements to adequately compensate for this situation carries the seed for a deterioration of the partnership climate at peripheral level.

CHAD

Christian churches in Chad are still young but their facilities cater for about 20% of the national health coverage, the half being provided by Catholic hospitals and health centres (HCs) under the umbrella of the *Union Nationale des Associations Diocésaines* (UNAD). FB Christian facilities mainly concentrate in the South as a consequence of civil war where they filled the gap left by public authorities.

Hospitals and HCs were set on the health map from 1993 onwards, as a result of primary health care (PHC) policy implementation. As for Catholic facilities, their integration was also the result of an active request from the religious authorities. Legalization of church structures ²² and then the signing of first contracts gradually changed the - at first - informal collaboration.

Steps towards partnership formalization were taken as soon as 1999, with contracting being of NHP's strategic orientations ²³. A contracting policy (CP) was elaborated from 2001 on. It considers delegation of public service mission to hospitals as well as delegation of health districts' management ²⁴ to PNFP organizations. In practice most existing contracts were signed with FB organizations ²⁵, mainly for full delegation of district management, inclusive of potentially existing public district hospitals. This ambitious interpretation is barely to be observed elsewhere ²⁶.

Contracting experiments are set in the context of health sector decentralization which, however incomplete - forms the background of the CP. The Catholic church's social sector is itself organized according to a decentralized model: the UNAD coordinates technical bureaux - the BELACDs -, themselves responsible for coordination at diocesan level. The BELACDs bear responsibility for management activities in case of delegation of health district administration to the Catholic church.

Public sector organs, policy and operational documents mainly

include the 1) MoH directorate of NGOs (DONG) and the directorate of social sector organizations (DOSS); 2) The NHP and the CP itself; and 3) operational contracting guidelines. They translate in framework agreements at central level and operational contracts at peripheral level which are generally the result of active requests from churches' side. The positive reaction of the public sector can be explained by 4 main factors: the battered state of the health system after civil war; the pre-existence of dialogue; the recognition of the role and characteristics ²⁷ of the FB health sector.

Operational contracts aim at ensuring 1) the commitment of the State towards provision of Human resources, infrastructures, tax exemptions and training to PNFP counterparts; 2) the implementation and respect of the NHP by the latter. Participation of both parties in each other's decision making process is not foreseen formally but observed in practice; besides, sensitization activities were conducted and a preparatory training workshop (2004) attended by all key stakeholders. In total, a quite complete regulatory and operational framework, far more achieved than in other case-countries.

A good understanding and mutual perception is found at central level. Open-mindedness of government actors, quality of the partnership- and contracting framework, and means of direct and indirect support provided by the contracts are particularly valued by the PNFP sector. Real weaknesses however pop-up.

Our study considered the contractual delegation of Moissala health district's management to the BELACD of Sarh. The district is located 200 km away, in the Mandoul health prefecture, Southern Chad. Its capital, Moïssala, is home to the district hospital. The current situation is the result of a process that began in 1992 with the transfer of a Catholic hospital's equipment and human resources ²⁸ to the moribund district hospital of Moïssala. This project (TRABEMO) was followed by 3 main contracts which gradually delegated the management of the health district and district hospital to the BELACD of Sarh. Financial and technical support of external partners ²⁹ sustained this evolution.

Those far-reaching agreements were made possible by preexisting public-FB dialogue around the case of Béboro, consensus in view, goals and modalities, the weakness of the public health sector's representation and capacity in the South, the proven experience of the Catholic's ³⁰ and the willingness of external partners ³¹ to support the project. Few real barriers were there but the magnitude of the task and the risks for a Catholic organisation to bear management authority towards other FB institutions ³².

UGANDA

The FB health sector in Uganda owns about 30% of the country's health facilities, the majority belonging to Catholic and Protestant churches. These networks are represented by denominational health platforms: the 'Medical Bureaus' ³³. Pressure resulting from the decrease in financial ³⁴ and human resources ³⁵ pushed PNFPs to actively seek a formalized partnership with the public sector after a long period of informal collaboration. Grand principles of public-PNFP collaboration were set in a Memorandum of Understanding established in 1998, but partnership policy documents drafted by the medical bureaus in

2003 still await legal approval. FB hospitals nevertheless receive public subsidies, be it far below the level of needs. Medical Bureaus collaborate actively in order to unfreeze the process of legal recognition by the Public authorities and to promote the development of genuine partnership frameworks. An additional source of concern for the Medical Bureaus is the upcoming trend of the Presidential Emergency Plan For Aids Relief (PEPFAR) funding arrangements to directly contract with FB-facilities.

Uganda became a PEPFAR focus country in 2004. With a budget exceeding 280 million \$US in 2008, the American initiative is by far the biggest donor for HIV AIDS related funding, and more largely in the Ugandan health sector. Recent evidence (Oomman, Bernstein & Rosenzweig 2007 & 2008) however confirms the weaknesses many observers noted in the way PEPFAR uses and channels its funds. Monies largely remain out of sight and control of the public budget, thereby impairing the planning capacity at the MoH level. The problem is further aggravated by poor leadership at MoH level. The FB Medical Bureaus are even less involved. Overall, both the public and the PNFP authorities feel bypassed and lack the information required to adequately steer the process.

Our field research in Uganda targeted two FB hospitals involved in contracting agreements with PEPFAR recipients. The Saint-Joseph's Hospital (SJH) is a facility owned by the Gulu diocese and located in Kitgum, Northern Uganda. Since 2005, contracts have been signed with 3 different Ugandan recipient organisations of PEPFAR funds in order to address HIV-AIDS related needs ³⁶: UPHOLD, CRS and TASO. The agreements are constraining: they are extremely detailed, characterised by precise, indicator-bound objectives and activities, rigid descriptions of respective responsibilities and highly demanding monitoring & evaluation procedures. There is evidence coming from SJH that these PEPFAR contracts lead to some level of distortion of the supply of care (and in the allocation of the available human resources) in favour of HIV-AIDS related activities. Overall, the involvement of local public health authorities in these contractual arrangements remains limited.

On the positive side, however, is the fact that these contracts go together with regular trainings, intense M&E activities, and exchange opportunities with other beneficiary facilities. Reporting duties contribute to the development of a reflexive attitude amongst the providers. Last but not least, the contracts are respected by the donor. Overall, contracts with PEPFAR are well appreciated by the local FB and government authorities because of their predictability and trustworthiness.

Kabarole Hospital (KH), property of the Anglican church of Uganda, is the second hospital we investigated in our study. It is a relatively modest facility located in Fort Portal, Western Uganda. The first contract with PEPFAR goes back to 2005 and included prevention, treatment and care activities of HIV/AIDS. It is the only source of external support of KH and represents half of the hospital's annual budget. Many of the observations made with regards to SJH also apply to KH. Local health authorities remain largely positive, seeing PEPFAR interventions as a welcome complement to the limited resources currently available, and providing a valuable contribution in terms of health data generation. Sources of worry include the issue of sustainability of this support, the absence of fall-back strategies, the rigidity of donors, the lack of harmonization with existing procedures and policies, and the incompleteness of information shared.

KH critically voices the risk of HIV-AIDS activities developing into a preferential way, thereby skewing the offer of care and unbalancing staff allocation ³⁷.

Striking in our study is the difference in perception of PEPFAR contracts between central and peripheral level health authorities, as well from the point of view of the MoH as the FB-sector. There where the contracts are relatively well appreciated at the peripheral levels of the health system, there is huge frustration at the central level. This can be explained by the lack of involvement of the MoH and the Kampala-based Medical Bureaus of the various FB-organisations in the design and monitoring of the contracts. The PEPFAR programmes tend to develop as autonomous strategies that run in parallel to existing programmes designed at central level. The problems of weak leadership at MoH level and the incomplete decentralisation process further compound the situation.

The unsatisfactory relationship between public and FB-sector may well lead the latter to favour policies that contribute to secure their immediate survival, i.e. for FB-facilities at district level to increasingly opt for the predictable and trustworthy agreements with external organisations like PEPFAR. This may well bode ill for the future of FB-public partnerships.

CROSS-CUTTING CONSIDERATIONS

Comparative reading and analysis of the case studies allowed us to identify a number of common features among a variety of contracting practices. These constants provide us with an interpretive lens for the assessment of public-FBO contracting in SSA.

Current contracting experiments between the public and FB health sectors face great difficulties.

The 'crisis' at stake rests on a number of common elements. First of all, a lack of preparation: agreements come as novelties at peripheral level, do not benefit from capitalization of previous experiments, and are barely accompanied by adequate training. Second, the shortcomings of contracting documents themselves, marked by incompleteness ³⁸ and a poor integration in existing frameworks ³⁹, further aggravated by the absence of revision mechanisms. The latter translates in a heterogeneous contracting landscape – sometimes in contradiction with policies in vigour – where non-harmonized types of agreements co-exist.

Thirdly, all country-cases reveal a strong dichotomy between central and peripheral level ⁴⁰, further fragmenting the contracting landscape and pointing at the imperfection of health system decentralization processes. The latter negatively affects contracting experiences by impairing the follow-up of agreements, the set-up of structural responses to address the difficulties met, and the overall capitalization of experience. In a context of silent dysfunction of peripheral level, contracting arrangements carry the seed for impairment of overall partnership efforts at central level. More specifically, agreements suffer under limited and asymmetrical flows of information ⁴¹ and the absence or insufficient functionality of M&E mechanisms. Means of control and constraining appeal modalities are lacking, leaving the partners with little guarantees.

Eventually, the scarcity of financial and human resources is hardly alleviated by the signature of agreements. Governments do not always respect their commitments, or do so to a limited extent

only. Facilities therefore need to compensate financing gaps on their own or rely on external resources. Contracts deliver on expectations when backed by sufficient resources, as shown by examples of PEPFAR in Uganda or those of Moïssala district's first agreements in Chad.

Overall, success rather lies in the partnership processes at central level and the generalization of a public-PNFP dialogue than in operational contracting at district level. As far as classical agreements are concerned, the relational character of agreements tends to lead to static acknowledgement of pre-existing situations (e.g. a FB facility factually playing the role of a district hospital) rather than creating innovating organisational arrangements.

At best, the current format of contracting experiments thus seems to offer an inadequate answer to the stringent, underlying crisis of the FB health sector. It eventually contributes to worsen it as extended responsibilities come with the need for increased mobilization of financial and human resources. These difficulties seriously affect the FB health sector and remain largely underestimated by the public sector. The contracting agreements read – with some nuances – as a locus for disappointing, imbalanced relationships, benefiting to some extent the public sector while draining the FB sector.

This situation reveals a real risk of disintegration of the current partnership dynamic between the public and the FB sector in sub-Saharan Africa. Worrying signs already show up, some FB providers moving away from existing agreements or threatening to do so (Chad, Tanzania). The priority of immediate survival and the search for direct results stimulate the development of bilateral relations with external donors, at the potential expense of further integration of the health system. Some churches go further and call into question the very notion of partnership and the pursuit of facility-based involvement in the provision of healthcare (Uganda).

CONCLUSIONS & RECOMMENDATIONS

The particular case of PEPFAR contracts in Uganda provides a valuable and contrary point of reference, although not without risks. The latter are largely a consequence of the programme's disease focused character, its lack of adaptation to national context, and its limited flexibility and overall opacity.

On the positive side, the PEPFAR contracts' degree of specificity and predictability, the quality of the monitoring, steering and evaluation mechanisms, and the donor's respect of the commitments are elements that are lacking in too many other contracting experiences. These aspects might provide avenues

for a rereading and improvement of the contractual relations between churches and governments in sub-Saharan Africa.

Overall, raising awareness about the relative failure of current contract appears as a priority as it will condition collaborative research of adequate solutions. This would respond to a felt need in the field. Such response would definitely involve the donor community, as an improvement of the situation will obviously require complementary funding. Indeed, the paucity of resources at government level and the priority thus often given to public sector facilities and staff in funding clearly intervenes as a weakening factor in public-FB contracting. Targeted, sustainable international support to contracting processes and follow-up and managing organizations (public and FB) are both needed.

At the FB side, further professionalization appears as a mandatory requirement for future development. Adaptation and capacity to deal with the changing and increasingly complexity of the health system requires strong administrative, managerial and technical skills. It may also require a larger delegation of managerial authority to facility and diocesan level.

Overcoming the current balkanization of the contracting landscape will need to go through continuous and systematic optimization of existing agreements. This implies a revision of historical agreements in order to adapt them to partnership models. It is a mandatory step on the road to institutional embedding and further integration of the health system. A centralized, continuous account of contracting experiences should contribute to the development of an institutional memory. The latter, essential to enable appropriate capitalization of knowledge, is currently largely missing.

Last but not least, experiences studied in the MMI research show the need for tailored support to address the variety of peculiar situations. Central level policies and models - however appropriate and complete they may be - do not guarantee successful implementation and follow-up. The same applies to theoretical contracting guidelines, as those developed by MMIiv. Specific training, technical support and continuous steering are by far the tools mentioned as best adapted to the needs. Their benefits are further acknowledged by the case of PEPFAR contracts in Uganda and the effect of built-in, functional M&E mechanisms.

One question remains: whether output-based contracting models (as PEPFAR agreements are) could and should be systematized in the case of direct public-FB collaboration at district level. Our study did not explore this specific question. Neither did our research capitalize on quantitative data; we focused on qualitative findings. Nor was our goal to conduct systemic research on the impact of specific contracts on specific facilities. This important research agenda has still to be completed.

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- 3 CUAMM is one of the Network's member organizations.
- 4 www.medicusmundi.org/en/mmi-network
- 5 www.medicusmundi.org/en/topics/strategic-positioning/introduction
- 6 MMI Network Policy 2008-2010 : www.medicusmundi.org/en/intern/ga/mmi-general-assembly-2009/2009-network-policy/draft1/view
- 7 Soesterberg (2000), Kampala (2004), Cotonou (2005), Bangui (2006 & 2008), Bagamoyo and Dar Es Salaam (2007).
- 8 30 to 70% of health facilities in Africa are owned by the Church; they cater for an average of 40% of actual healthcare provision (WHO, 2006).
- 9 2005 saw Rwanda adopting PBF as a National Policy
- 10 Rwanda, Burundi, Cambodia, DRC, etc.
- 11 For detailed methodology, please refer to the MMI study report at www.medicusmundi.org/contracting
- 12 *Bureau d'études et de liaison des associations caritatives diocésaines*: bureau for survey and coordination of charity and development activities
- 13 Presidential Emergency Plan For AIDS Relief
- 14 For Uganda, PEPFAR- and PEPFAR recipient stakeholders were also interviewed.
- 15 *Organisation catholique de la santé au Cameroun; Conseil des églises protestantes au Cameroun; Fondation Ad Lucem.*
- 16 Contrat de développement et de désendettement
- 17 17.7% of facilities but almost 40% of hospitals
- 18 Health Sector Strategy, National Partnership Forum, Technical PPP working-group, MoH Partnership Unit
- 19 Service Agreement (SA)
- 20 Or better said, Council Designated Hospitals (CDH), with reference to the current administrative zoning
- 21 By the end of our study, adapted CDH contract documents were just starting to be applied to new facilities (e.g. Tosamaganga), the experience being to recent to allow appreciation of possible improvements. Moreover none of the older DDHs contracts had yet been revised to fit this model.
- 22 Legalization, Import authorizations, exemption of custom duties, framework agreements signed with the NGO's Directorate (DONG)...
- 23 The Churches actively participated in the intersectional roundtable discussions
- 24 A separate contracting policy for the pharmaceutical sector was originally planned but is still to be developed
- 25 UNAD but also EEMET (an Evangelical network)
- 26 Cambodia is the best documented other case: Lanjouw, Macrae & Zwi, 1999; Meessen et al., 2002
- 27 Quality of care, managerial & organisational skills, transparency
- 28 In fact an upgraded health center, located in Béboro and which served the district's catchment population as a referral facility. It filled the gap left by Moïssala's district hospital.
- 29 Medicus Mundi Navarra (MMN) and Misereor.
- 30 Béboro and the Goundi hospital
- 31 MMN and the World Bank's 'PASS' programme (Programme d'appui au secteur de la santé), later Misereor.
- 32 Protestant, Muslim and Bahai' health centers
- 33 Mainly: Uganda Catholic Medical Bureau (UCMB), Uganda Protestant Medical Bureau (UPMB) and Uganda Muslim Medical Bureau (UMMB).
- 34 Compensate withdrawal of traditional donors, frozen public subsidies, decrease of user fees, increasing running costs
- 35 High staff attrition resulting from low attractiveness of salaries and recruiting competition of the public sector
- 36 Especially antiretroviral treatment
- 37 Programme absorbing 21% of KH's staff, most of them dedicated; differences in salaries; obvious differences in available means, etc.
- 38 Vagueness or generality of objectives, insufficient definition of responsibilities, under developed M&E mechanisms, etc.
- 39 Partnership and contracting policies
- 40 Levels of information and knowledge, perception, involvement, etc.
- 41 Concentration of information at central level, information gaps incurring from level to level, delays, poor response of central and intermediary level public authorities to reports and complaints from the district level facilities, etc.

PBF: AN OPPORTUNITY FOR THE PRIVATE - NOT - FOR - PROFIT SECTOR?

An interview with Bruno Meessen¹

Anyhow, this will boost and confirm their innovative and strong performance capacity. Make no mistake though: as we have seen in Rwanda with PBF, public providers could very well wake up too. One way or another, the population will benefit.

By / D. Boulenger / MSc / Institute of Tropical Medicine, Antwerp - Health policy and Financing unit*

Where does Performance - Based Financing (PBF) come from? Is it new? And if it is, what makes it new?

The history of PBF in low-income countries is so far an accumulative process of experiences that have inspired one another. To my knowledge, a project led by Management Sciences for Health in Haiti was the first time that health service providers were contracted and remunerated according to their coverage rate performance. The classical input based approach and the implicit standard behavioral assumption behind the approach – local actors are always committed to making the best use of aid resources for their population – were thus abandoned. Results were deemed sufficiently impressive to be broadly disseminated. Interestingly enough, the contracting was with national NGOs, a category of actors traditionally perceived as highly intrinsically motivated.

In Cambodia, the strategy was applied to the public sector. It started also from another angle. In Takeo hospital, the contract aimed to smoothen the departure of the supporting NGO, without destabilizing the achievements. The contract stipulated a rather straightforward way to compute the remuneration: instead of the traditional input based approach, from then on the hospital had to be remunerated proportional to the revenue gained from users. This was a simple but already very powerful way to define 'performance'. In Sotnikum and Thmar Pouk, the strategy was used in health centers and the district hospital, but the objective there was supporting the financing of health facilities in order to increase staff revenue in an effort to combat discouragement among the staff. In Pearang, the model was pretty similar to the Haiti experience. The issue there was the need to boost coverage of maternal and child health care services. Cambodia has been crucial to the understanding of what is possible in contracting matters with public health providers. The third big development took place in Rwanda. There, one has gradually, but with strong leadership displayed by the health authorities, clearly entered

a reform logic, both with respect to the financing and the management of public or faith-based facilities. Without any question, Rwanda has been the first poor country to turn PBF into a strategic axis to develop its health system, and integrate the strategy unambiguously in the public budget. The scheme has also increasingly become more sophisticated in recent years in Rwanda, including in terms of quality measures.

Current knowledge on PBF learns us that there are a number of strengths and weaknesses. On the positive side, there are the improvements in performance, productivity, staff motivation, morale and interactivity, availability of (quality) documentation. On the negative side, there is the increased burden of administrative tasks, possibly at the expense of the delivery of care, the potential gaming, the possible distortion in care, etc. If the contractual arrangements in which the Faith-based facilities would engage take the character of PBF (or PBC i.e. Performance-Based contracting), how could positive elements be optimized and negative effects restricted?

In fact, I believe that we should avoid misunderstanding to begin with. Every type of contract has its strengths and weaknesses. The main drawback of the traditional input based contracts is the fact that they tend to reinforce the top-down bureaucratic logic and can deal a fatal blow to the sense of initiative of the managers of health facilities. Obviously low productivity is often the result.

With a contract relating payment to the achievements, one does not pretend anymore to decide in the place of managers on the 'how', rather one is very explicit on the results one is expected to produce. But obviously there are also downsides. The key question is whether the advantages outweigh the disadvantages. In my opinion, in a low coverage, low productivity and bureaucratic environment (e.g. the public sector), the PBF approach has obvious appeal.

Another frequent misunderstanding is to perceive health facilities today as functioning fully under an input-based approach. The

* www.itg.be/itg

truth is that user fees are an output-based mechanism; yet only curative services are charged; then, this creates an incentive to overlook preventive services. In Rwanda, the first move was to introduce PBF for preventive activities. Interestingly enough, the unit fees paid by the third-party for preventive services rapidly led health centers (especially faith-based ones which tended to over-develop their curative services) to pay much more attention to interventions with high impact for children and mothers.

Having said this, I want to stress two caveats of the approach: (1) there are numerous dimensions of the performance of health facilities that are extremely difficult to measure; in that case, PBF is probably not the right track; personally, I am very concerned about the efforts made by some to turn PBF into a general approach for the whole health administration. That looks dangerous. (2) The second caveat concerns the fact that sooner or later each way of financing has to be revised in order to correspond to new challenges. The difficulty in this respect is what is commonly referred to as 'path dependency': stakeholders refuse to drop a model that suits them just fine. For example, everybody agrees that the American health care system is today very problematic due to the incentives towards overproduction built in the system, yet it will obviously require an enormous amount of political capital and struggle by the Obama administration to reform this flawed system.

I see one major advantage of the PBF approach for Faith-Based Organizations: it acknowledges that their services should be remunerated as much as services provided by public facilities. In fact, the distinction between public and private loses much of its relevance. One must be vigilant that the government is fair in its treatment of the different types of providers, but there are institutional arrangements and principles such as the separation of functions that (can) mitigate such a risk. For the public providers, the main advantage is that the logical next step of the strategy is to award them more autonomy. In fact, their status moves closer to the status of FBOs. A problematic aspect in some countries is the family planning issue. Under PBF with a public aim, the purchaser may prefer to remunerate modern contraceptive methods. With PBF, the loss of income for FBOs refusing to offer these methods is obvious. But maybe this is not a bad thing.

Are the negative effects that we have documented in our research in Uganda (PEPFAR contracts with faith-based hospitals) intrinsically related to PBF or rather to other factors, e.g. deficiencies in the current PNFP/Public sector relationship?

The truth is that one ought to have a holistic vision of the institutional arrangements that structure the health system. In context A, the optimal contract will be this or that, while in context B, the ideal contract will be different. If the contract is set up the wrong way, perverse effects will result.

Relational contracts (still) are the rule in Public-/ Faith-Based health sector relationships. What about the application of PBF contracts in this specific context: is it indicated? And

what is your opinion about the future of relational contracts?

So far the main contract has been the convention. This type of contract is traditionally rather general and not specific to the health facility. The contract is thus what economists call 'incomplete', as is the case with public facilities. Furthermore, if I am correct, these conventions are quite vague in terms of duration. This means, among other things, that poor execution cannot really be sanctioned by the non-renewal of the contract. History has shown that governments were often the actors not respecting their financial commitment. This indicates a third shortcoming: FBO have no real means to sanction the government, as the main victims will be the population – a well-known problem for all those with a humanitarian commitment, i.e. intrinsic motivation.

The PBF contract is much more 'complete'; the health centre knows exactly how much it will earn if it produces the required amount of different kinds of activities. Furthermore, if the manager's individual income has a performance-based component, he gets immediately a reward for his initiatives and efforts. He does not need to worry anymore whether his good performance will be noticed by his superior and rewarded one day by a promotion. Such a rapid reward for effort is valuable in settings where the future is uncertain and needs quite urgent.

I believe that in the future more explicit performance related contracts could become the norm in low-income settings. Having said that, there will always be elements that are less suitable to contracting, like the response to a sudden epidemic.

The Faith-Based health sector is characterized by a high level of staff commitment, important intrinsic motivation and strong professionalism. The major problem in the Faith-based sector however is the increasing scarcity of financial and human resources, whereas the use of PBF with public sector facilities is precisely seen as a means to boost of staff demotivation and professionalism. Under these circumstances, would PBF be an appropriate strategy in contracting policies with the Faith-based sector? Or would you propose other contracting models than PBF to be considered in the case of the Faith-based sector?

One danger is obviously that extrinsic motivation could jeopardize or even crowd out intrinsic motivation. Nevertheless, I think that with a well conceived model one can avoid or at least decrease this risk. PBF is above all a way to remunerate health facilities and their management team. I do not like too much the emphasis on the performance related bonuses. That creates confusion in the minds of people: performance will always be broader than one can measure. But PBF is also a somewhat hidden strategy to increase the income of health staff without getting into an open conflict with the IMF. Hence, this might overcome part of the current brain drain problem. I believe that the faith-based sector has potentially a lot to gain from PBF. Anyhow, this will boost and confirm their innovative and strong performance capacity. Make no mistake though: as we have seen in Rwanda with PBF, public providers could very well wake up too. One way or another, the population will benefit.





MONITORING HOSPITAL PERFORMANCE FOR EQUITY

The contribution of Doctors with Africa Cuamm to the strengthening of African health systems

Dr Margaret Chan, Director General of the WHO ended her presentation of the 2008 Report with these words: "There are no reasons why any country – rich or poor – should wait to begin moving forward with these reforms. (...) United by the common challenge of primary health care, the time is ripe, now more than ever, to foster joint learning and sharing across nations to chart the most direct course towards health for all".

By / D. Carraro / Director / MD / Doctors with Africa Cuamm

By / F. Manenti / Head of the International Projects Department / Doctors with Africa Cuamm

G. Putoto / MD / DTM&H / MAHMPP / Strategic Planning Advisor / Doctors with Africa Cuamm

ABSTRACT

BACKGROUND

Allocative decisions in the health sector, especially in poor countries with limited information systems, are often taken on historical basis without possibility of linking them to specific outputs and results. Production processes of non for profit hospitals (NFPH) have hardly been analysed in sub-Saharan Africa and little is known about their performance in terms of efficiency and equity.

OBJECTIVES

To develop and use a managerial statistical tool to monitor hospital performance in order to address efficiency and equity over time.

METHODS

Based on literature a single output measure such as Standard of Unit of Output for Hospital (SUOP) was developed in Uganda¹. The SUO utilized outpatient visits as its measurement unit and allocates different weights to hospital services (inpatient, deliveries, antenatal clinic, vaccinations), thereby allowing the total volume of activities to be quantified². Then, four indicators were applied: volume of service outputs/SUOP, productivity of staff/SUOP, average expenditure/SUOP and user fees/SUOP. These indicators provided some indicative information

about hospital utilisation, productivity, efficiency and equity respectively.

RESULTS

By applying SUOP, since 2006 it has been possible to monitor utilisation, efficiency, productivity and equity of 12 NFPH hospitals in Angola (one), Ethiopia (one), Tanzania (three) and Uganda (seven) supported by Doctors with Africa Cuamm. Nine Hospitals have a proportion of annual revenues from user fees ranging from 6% to 30%. For three Hospitals user fees, on the contrary, represent more than 50% of their income. The result achieved by the first group of hospitals is made possible because of the application of lower fees, the introduction of flat rate mechanisms, the capacity to get more external aid and government subsidies.

CONCLUSIONS

The results can not be generalised because of different hospitals size and setting. However, simple performance tool such as SUOP, can support hospital managers to link input and output. Equity, as well as other dimensions of hospital performance, can be monitored. Based on this, a more equitable user fees system can be applied as interim measure to protect the poor while waiting for the much needed universal health care.

¹ Pro-Poor Health Services: The Catholic Health Network in Uganda, World Bank, Findings, 2005, 246

² SUO-op formula = (15x n. Ip) + (n. Op) + (5 x n. Del) + (0,2 x n. Imm.) + (0,5 x n. ANC)

ST LUKE CATHOLIC HOSPITAL, WOLISSO

This hospital, founded in 2001, offers one of the most demanding challenges for Doctors with Africa Cuamm. The challenge is just how to match quality of treatment with equity and accessibility, efficiency with efficacy, specialist interventions with the development of services in the surrounding area. On the one hand, the mission is to offer services mainly to the poorer strata and, on the other, there is the risk of mainly curing only the better off - these too are challenges Wolisso faces. This article presents a detailed analysis of the functioning of the hospital. The way services are used, the case-mix, quality and equity.

By / S. Accorsi, P. Farese / Italian Cooperation / Ethiopia

F. Manenti / Head of the International Projects Department / Doctors with Africa Cuamm

CONTEXT

St. Luke Catholic Hospital and College of Nursing in Wolisso is a private, not-for-profit, hospital owned by the Ethiopian Catholic Church. It is located in Wolisso, the capital of the South West Shoa Zone in the Oromia Region, the largest and most densely populated region in Ethiopia.

It is the main hospital for the whole area, which has a population of about 1,750,000 people. The Hospital also houses a College of Nursing.

It was founded, in 2001, by the Catholic Church in Ethiopia which needed a College of Nursing to train its own personnel who, in the early 1990s, were having difficulty entering Government run courses. Today, it is a 164 bed hospital, with general and specialist outpatient and admission services as well as various specialities.

There are general outpatient clinics for both adults and children, an antenatal clinic, a chronic illness clinic which also treats AIDS, and other specialist clinics: surgery, orthopaedics, gynaecology, oculists, dentistry and otorhinolaryngology (ENT). These two latter clinics are opened when outside consultants come.

As regards admissions, there are various wards: medical, paediatric, maternity and gynaecology, general surgery, orthopaedics and traumatology as well as a delivery room, five operating theatres, two laboratories and diagnostic services - radiology and scans.

There is also a Public Health Department, which works to promote prevention in the District of Wolisso and, increasingly, in other districts too, in collaboration with the Zone Health Office. Each year thirty nurses graduate from the Nursing College. Furthermore, for the past two years the hospital has been collaborating with the University of Jimma and the Oromia Regional Health Office to train fifty Health Officers per year: the role of a Health Officer lies somewhere between that of a qualified nurse and a doctor.

The early years of the hospital's existence were not easy: there was a low level of access, and a low level of credibility among both the local community and the government authorities.

This was mainly due to the fees charged to patients, which were high and not calibrated according to the pathology treated, but also to a lack of efficiency within the hospital because of the high number of hospital personnel with respect to the volume of patients.

Only after user fees to patients were lowered, management costs rationalised and local government authorities involved in making the structure financially sustainable, did the negative image of the hospital change and, in a short time, it came to be considered a model of public - private partnership, supplying quality services at accessible fees for the general population.

In 2005, the St. Luke Catholic Hospital of Wolisso was cited as an example of "best practice for the Health information System" in an evaluation document presented by the *Health Sector Development Programme II* of the Ethiopian Ministry of Health.

FOREWORD

As regards the reform of the Health Information System that is currently underway in Ethiopia, attention has focused both on the use made of information when taking evidence based management decisions and on the place where the information studied is generated and gathered (e.g. hospitals, health centres, Local health Authorities etc.).

Local managers and those who supply health services need this information in order to match available resources to patient needs and achieve the best possible results at a sustainable cost. These choices are particularly complex in situations where there are high levels of mobility and limited resources. Below is an analysis of costs, of services and productivity, of the epidemiological profile, of the results and of the quality of services offered by the St. Luke Catholic Hospital of Wolisso. The analysis is based on information gathered by the information System and during routine hospital operations.

Case-mix, the services offered, their quality and, in particular their equity and accessibility for the population are also studied as are the results of treatment, from which an evidence based

(empirical) model of the decision making process has been extrapolated.

USE OF SERVICES

The volume of both outpatient and admission activities at St. Luke Catholic Hospital and College of Nursing, has been steadily rising since the hospital was first opened in 2001: the average

yearly volume of activity for the three year period 2005 – 2007 was: 52,000 patient examinations and 7,600 admissions (see **Table 1**).

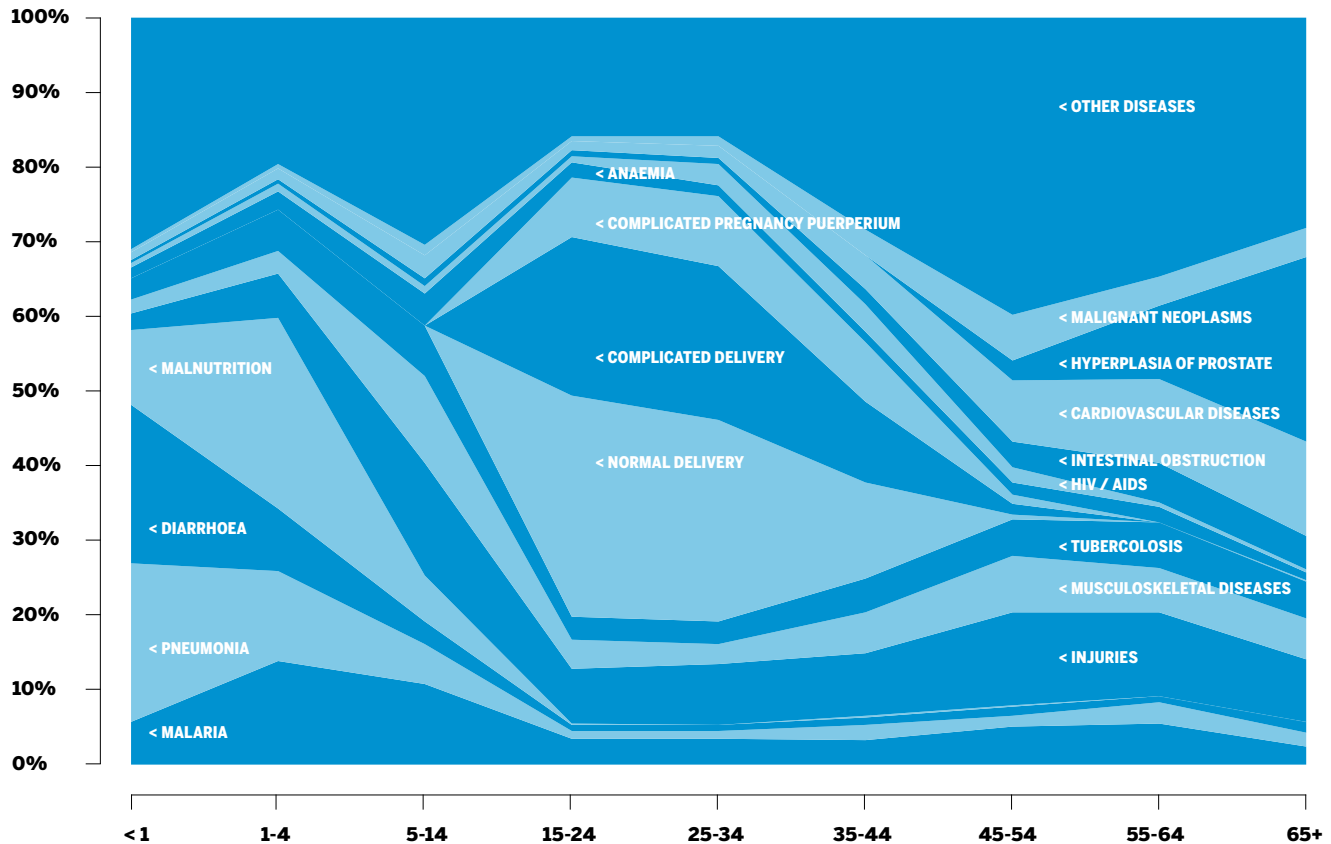
This description of the hospital's activities will focus on the period 2005 – 2007 in order to trace changes in the way services are being used.

The **total number of outpatient examinations** in this three-year period was 157,155 (57,268 in 2005, 47,088 in 2006 and 52,799 in 2007): the sharp drop in 2006 was mainly due to

TABLE 1 / USE OF SERVICES SUPPLIED BY WOLISSO HOSPITAL (2001-2007)

	2001	2002	2003	2004	2005	2006	2007	January – June 2008
Outpatient activities								
Total number of outpatient attendances	14,620	20,570	32,059	42,110	57,268	47,088	52,799	28,051
Of which outpatient examinations for children under 5 years	n. a.	1,241	2,397	5,215	10,929	8,277	9,930	5,039
Average daily number of outpatient attendances	57	80	125	168	222	189	212	217
HIV/AIDS Clinic: patients registered but not eligible for antiretroviral therapy	-	-	-	-	-	584	894	524
HIV/AIDS Clinic: patients who have started antiretroviral therapy	-	-	-	-	-	287	333	179
Admissions								
Total number of admissions	2,032	3,312	5,332	6,521	7,985	7,182	7,816	4,029
Major surgery	242	332	696	1,237	1,693	1,908	2,607	1,293
Total number of births	391	635	852	1,078	1,554	1,820	2,213	1,320
Of which Caesarean births	59	96	166	249	428	533	497	247
Caesarean births: % of total births	15%	15%	19%	23%	28%	29%	22%	19%

FIGURE 1 / REASONS FOR HOSPITAL ADMISSION (IN PERCENTAGES) WITH RESPECT TO TOTAL NUMBER OF ADMISSIONS IN THE PERIOD 2005-2007, BY AGE GROUP



the fact that an AIDS Clinic was opened in April 2006 and a doctor had to be moved from outpatient services to cover this antiretroviral Clinic. This problem was resolved by employing two more doctors in the last two months of the year, indeed total outpatient examinations rose again the following year.

In the same period a total of 29,136 examinations were carried out in the Paediatric Clinic (10,929 in 2005, 8,277 in 2006 and 9,930 in 2007).

Antenatal examinations rose steadily each year from 7,710 in 2005, to 9,023 in 2006 and to 10,237 in 2007.

The total number of **vaccinations** administered also rose over the same period from 11,918 in 2005, to 14,675 in 2007, for a total of 38,282 in the period 2005-07.

The **total number of patients admitted** to hospital in the period 2005 – 2007 was 22,983 with average rate of **bed occupation** of 86.9%, and **average length of stay** of 6.6 days giving a turnover of 52.2 patients per bed per annum.

The **number of major surgery operations** carried out also rose, from 1,693 in 2005 to 2,607 in 2007.

As for the **obstetric services** offered, of the 5,587 births in the hospital between 2005 and 2007, almost half (43%) were births with complications, amongst which were 1,458 Caesarean sections.

This is the main hospital for the whole Zone (which at times takes patients from other Zones): one fifth of the patients attending were from the town of Wolisso, and one quarter (25.3%) from the Wolisso District, but the majority of patients came from outside the District (54.9%).

The **prevention services** supplied by the hospital include an Antenatal Clinic, Vaccination and the voluntary test for AIDS (total for this latter: 7,475). The hospital also offers a service to prevent maternal-foetal transmission of the HIV virus as well as anti-retroviral services for 333 patients who began treatment in 2007.

EPIDEMIOLOGY AND CASE-MIX

The case-mix plays an important role in managing hospital resources and is important both from an epidemiological and a management point of view.

Because the profile of pathologies is “dynamic”, any changes must be identified fast in order to respond to new needs and quickly make any necessary adjustments to the organisation of services.

Figure 1 shows percentages for the 16 main causes for hospitalisation, by age group, in the period 2005 - 2007.

REASONS FOR HOSPITAL ADMISSION AND GENDER RATIO

Maternity is the main reason for admittance (25.2%) followed by trauma (7.9%), malaria (5.9%), respiratory infections (5.4%) and birth complications (4.9%).

More women were hospitalised than men (59.7%) mainly because most admissions were for maternity and obstetric-gynaecological pathologies.

If, however, we exclude these two latter, then men are hospitalised more often than women. More specifically, the male/female ratio is particularly high in the case of trauma (injuries) (M:F ratio = 2.6) and for skeletal muscle pathologies (M:F ratio = 1.8).

LENGTH OF STAY

One important factor that greatly affects the use of resources is the length of stay in hospital. This is measured using the following main indicators that explore the question "length of stay" from various angles: total number of Bed Days, reason for admission and, Average Length of Stay (ALOS) for each reason for admission (see **Table 2**).

For example, during the period 2005 – 2007, the hospital in Wolisso provided a total of 148,016 bed days for all admissions. The highest number of bed days for one reason only, birth, was 19,382 (13.1% of all bed days with ALOS of 3.4 days), followed by trauma, with 18,393 days (12.4%), then malnutrition (13,489

TABLE 2 / REASON FOR ADMISSION AND LENGTH OF STAY

Reason for admission	no: of admissions	% of admissions	no: Bed days	% Bed days	Average length of stay
Birth	5,650	25.2%	19,382	13.1%	3.4
Trauma/injuries	1,759	7.9%	18,393	12.4%	10.5
Malnutrition	1,003	4.5%	13,489	9.1%	13.4
Skeletal muscle Pathologies	984	4.4%	10,624	7.2%	10.8
Tuberculosis	870	3.9%	9,744	6.6%	11.2
Respiratory Infections	1,203	5.4%	8,807	6.0%	7.3
Other reasons for admission	10,908	48.7%	67,577	45.7%	6.2
Total	22,377	100.0%	148,016	100.0%	6.6
Caesarean births: % of total births	15%	15%	19%	23%	28%

and 9.1% respectively), skeletal muscle pathologies (10,624 and 7.3%), tuberculosis (9,744 and 6.6%) etc.

On the other hand, if we only look at the first six reasons why patients are admitted to hospital in terms of the length of the average stay required for that reason, we see (**Table 3**) that while they make up only 22% of the number of admissions for these six reasons, they are 37% of bed days, thus consume a disproportionate amount of the available resources.

If we consider the main causes of admission in terms of ALOS for pathologies with more than 50 admissions in the period, then malnutrition is top of the list, with an average length of stay of (13.4 days), prostate hyperplasia and tuberculosis are joint second (11.2 days), skeletal muscle pathologies and osteomyelitis next (10.8 days) and lastly trauma (10.5 days). The average length of stay depends on the complexity of the cases treated.

There are various ways of reducing the average length of stay: by altering treatment protocols for pathologies (the most

efficacious), by introducing new technologies, by integrating hospital admission services with outpatient services and / or by improving the efficiency of all services and implementing early discharge policies.

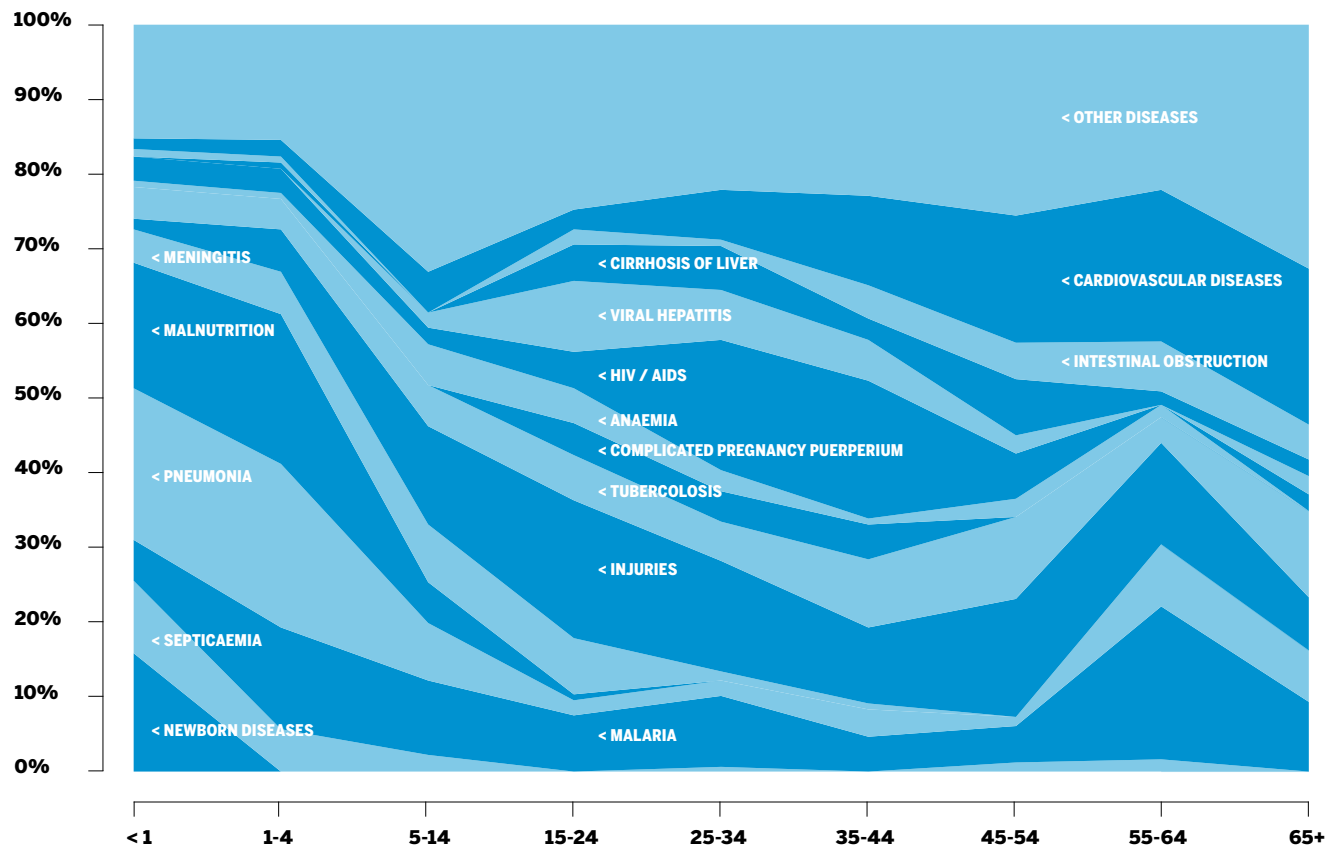
Analysing the number and percentage of bed days in terms of the frequency with which patients are admitted and the length of stay is a good indication of the relative burden various pathologies put on hospital services. Infectious diseases were the main reason why patients were admitted: however these patients were usually hospitalised only for short periods so they consumed less, thus impinged less on hospital services.

On the contrary malnutrition, traumas and 'non infectious' illnesses all weighed more heavily on available hospital resources when measured in terms of bed days.

It should also be noted that for trauma cases one should calculate cost not only in terms of bed days, but also in terms of both primary outpatient care and of rehabilitation after

TABLE 3 / FIRST SIX REASONS FOR HOSPITALISATION: THOSE WITH LONGEST AVERAGE BED-STAY

Reason for admission	no: of admissions	% of admissions	no: Bed days	% Bed days	Average length of stay
Malnutrition	1,003	4.5%	13,489	9.1%	13.4
Prostate Hyperplasia	280	1.3%	3,141	2.1%	11.2
Tuberculosis	870	3.9%	9,744	6.6%	11.2
Skeletal muscle Pathologies	984	4.4%	10,624	7.2%	10.8
Trauma / injuries	1,759	7.9%	18,393	12.4%	10.5
Non neonatal tetanus	51	0.2%	480	0.3%	9.4
Other reasons for admission	17,430	77.9%	92,145	62.3%	5.3
Total	22,377	100.0%	148,016	100.0%	6.6

FIGURE 2 / CAUSES OF DEATH, PERCENTAGES OF TOTAL CAUSES OF DEATH, BY AGE GROUP, BETWEEN 2005 AND 2007

discharge. Indeed it has been estimated that trauma cases cost most of all the pathologies among the age groups most subject to incidents (Norton, R. et al, 2006).

IN-HOSPITAL MORTALITY

Figure 2 shows the distribution of hospital deaths, the proportion of deaths for a specific cause with respect to the total of deaths and, the specific mortality by pathology for the first sixteen causes of death.

Traumas are the main cause of death (10.4% of all deaths) followed closely by respiratory infections (9.5%), malaria (8.6%), cardiovascular diseases (7.2%) and AIDS (7.1%).

Viral hepatitis, neonatal illnesses and AIDS have the highest death rate (34.3%, 20.7% and 19.7% respectively).

The total number of deaths is slightly higher for males but there is marked similarity between the sexes in the case of the more important causes even though there is one important difference: women have a higher death rate from viral hepatitis (M:F ratio=0.1) and a much lower death rate for trauma (M:F ratio=3.2).

Infectious diseases are the reason for 33.5% of admissions and 58% of the reasons for death, while non infectious pathologies are the reason for both one third of admissions and of deaths (36.9% and 39.7% respectively).

The rest of the deaths are associated with maternity which accounts for 29.3 % of hospital admissions and 2.3% of the reasons for death.

Thus it seems clear that a dual epidemiological burden is emerging at the Wolisso hospital, i.e. that of both infectious and chronic pathologies, where on the one hand there is a persistent, recurring group of infectious pathologies and, on the other, a progressive increase in chronic pathologies and traumas.

This will lead to major changes in the volume and composition of the demand for health services, with a more complex case mix and with higher costs for these services.

GENDER ANALYSIS

It is clear from **Figure 1**, which shows the reasons for hospital admission, that women are hospitalised more often than men. However this is mainly because of the high number of admissions for maternity and gynaecological cases. If one excludes women in the reproductive age group (15-44 years), then males are hospitalised more often than all other groups. There is also another gender linked difference which emerges among children: males are admitted to hospital more often (58.4%) than females (41.6%). This same gender difference has

also been found in other developing countries and seems to be associated with the socially ascribed “greater importance” of boys who are thus seen as worth investing more in. This creates a difference in access for girls and boys when families have to decide who to spend their, often scarce, resources on for health problems. (Victora, C.G. et al., 2003)

There are major differences regarding admissions for patients of reproductive age: three quarters of female admissions are for complications during pregnancy; however for men, trauma is the main cause of admission. There are no marked gender differences in the reasons for admission of children.

Nor are there are major gender differences in the cause of death either, except for among adult males admitted for traumas which are often the result of road or work related accidents or of violence or high-risk behaviour e.g. alcoholism etc. (Nordberg, E, 2000, WHO, 2002a). These differences clarify what is meant by “gender differences” in health, which are essentially the result of social, cultural and religious diversities and have nothing to do with gender as a biological and genetic characteristic but which, nonetheless, determine different degrees of susceptibility to illness for men and women. (WHO, 2002b)

changes in processes are affecting and modifying service quality itself. Different indicators can be used to evaluate the quality of services, starting from the general mortality and then the mortality for each pathology (Donabedian, A. 2003). In Wolisso, 92% of the patients discharged had improved, 1.5% had not got any better, 1.3% discharged themselves and 5.2% died in hospital. Half of these latter died within 48 hours of admission. Mortality for specific pathologies shows, more precisely, the severity of each pathology and the efficacy of its management - including correct use of recommended protocols. In the period studied viral hepatitis had the highest specific death rate (34.3%) followed closely by septicaemia (34%), non neonatal tetanus (31.4%) and lastly, cirrhosis (22.4%). The high mortality of viral hepatitis (probably Type E) is associated with the lethal nature of the disease during pregnancy, thus it is also an indirect cause of maternal death. Diverse aspects of the quality of Health Services can be measured: for example efficiency, efficacy, equity, accessibility, appropriateness, acceptability, continuity of care and confidentiality.

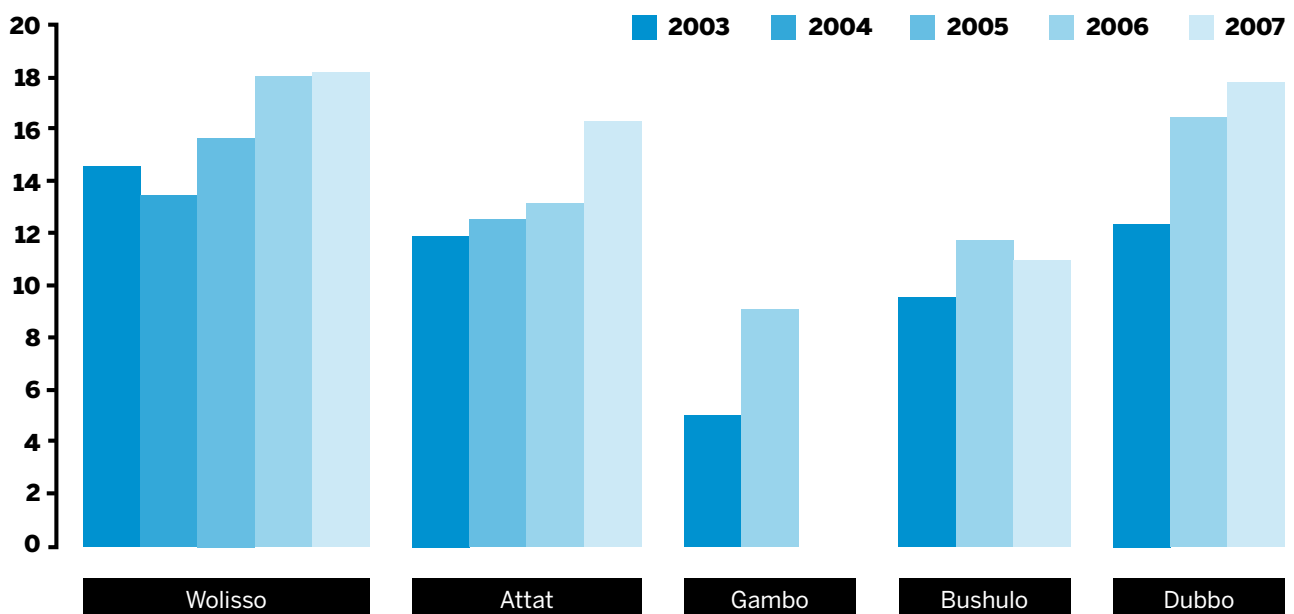
It is important to have National or International standards available with which to measure the quality achieved. At Wolisso, a set of indicators based on International standards, and experience, which have been adapted to meet the specificities of the local situation are being used, along with an audit of perinatal and maternal mortality (WHO, 2002c). Among these indicators are the general rate of post-operative infections (3.4% in the period 2005-2007), that for Caesareans

RESULTS AND QUALITY

Managing a health service also means evaluating the quality of the services offered, both in terms of results and of how

FIGURE 3 / COMPARISON OF SUO IN ETHIOPIAN CATHOLIC HOSPITALS 2003-2007 / ABSOLUTE VALUE OF SUO 2003-2007

User fees/SUO 2003-2007



(2.4%) and that of antenatal mortality (1.2%), mortality is recorded up to the moment before the patient's discharge from hospital. Furthermore, the rational use of drugs prescribed for outpatients has been monitored by checking on the percentage of antibiotics and injectable drugs prescribed, on the average number of drugs prescribed per patient and, on the availability of drugs measured in terms of patients who did not receive drugs from the Hospital Pharmacy because stocks had run out (HST, 1999). In all, 50.7% of outpatients had been prescribed antibiotics, which was above the target set for the period but was probably due both to the fact that the Hospital covers a large catchment area and has to deal with a complex case-mix. Targets were however met for another three indicators: less than 10% of patients had been prescribed injectable drugs; patients were, on average, being prescribed only two drugs; and, less than 1% of patients had been unable to obtain their drugs from the Hospital Pharmacy.

Evaluation of a Health Service's efficiency can also be carried out from the point of view of the area its services cover and the way these services are being used. Of late greater emphasis has been placed on performance measurements, which could, for example, be defined as the cost per unit of service produced. This definition offers a basis for comparison between different performances and helps to identify "best practices" which can then be promoted. Obviously the availability of resources, quality of treatment and epidemiological profile cannot but be taken into account too when evaluating performance. High costs per unit of service could be the result either of a lack

of efficiency, or of high quality, or of the complexity of the pathologies treated: the case-mix must be evaluated together with costs and services supplied.

Recently the Ethiopian Ministry of Health (FMOH; 2007) commissioned a study of the unit costs of outpatient and admissions services with a view to setting up a National Insurance scheme which would start by offering cover to public employees. The cost of an outpatient service and hospitalisation (Barnum, H. et al, 1993) in the Wolisso Hospital was below the average of a sample comprising 27 hospitals (25 State Hospitals and two not-for-profit).

Using a simple indicator the Standard Unit of Output (SUO), which includes not only the costs of treatment services but also costs of prevention, it is possible to evaluate both the productivity of personnel and equity. This indicator was developed in Uganda (Mandelli, A. Giusti, D. 2005) and is currently being used there to monitor hospital performance nationally. It is defined as follows:

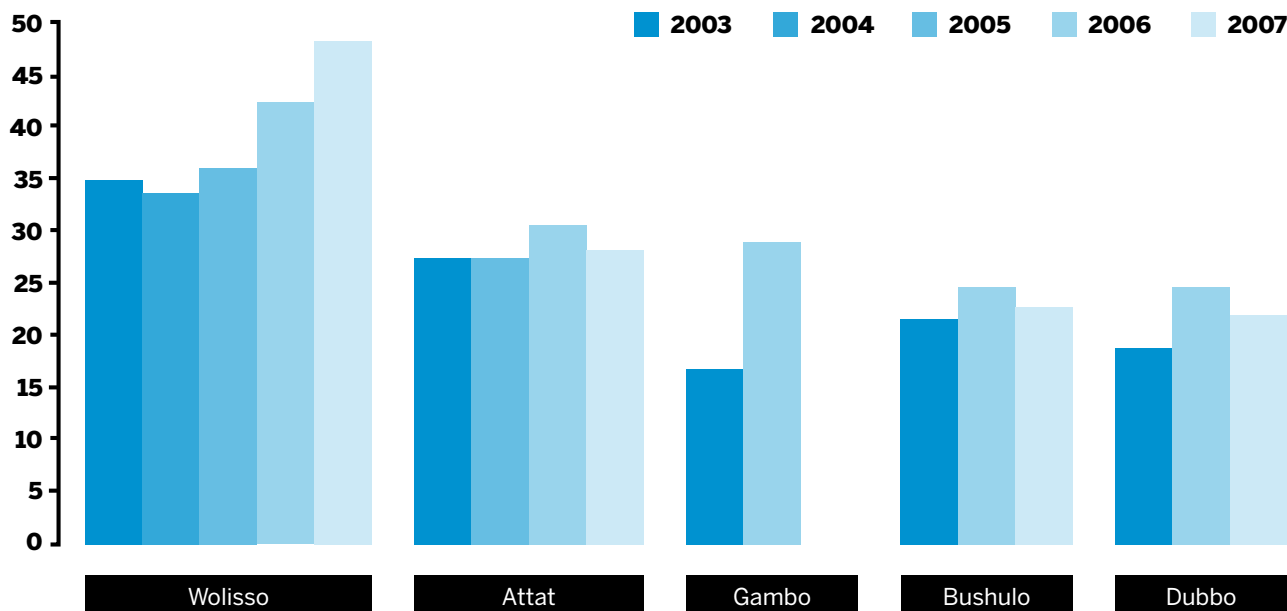
$$\text{SUO} = \text{no: outpatient visits (OPD)} + 15 \times \text{no: total admissions (IP)} + 5 \times \text{no: of births} + 0.2 \times \text{no: of vaccinations} + 0.5 \times \text{no: of antenatal examinations and checks on children's weight (MCH)}$$

Figures 3 and 4 (below) show a comparison between the Hospital in Wolisso and the other hospitals run by the Ethiopian Catholic Church. Costs are expressed in Ethiopian currency: 1 Euro equals 12.5 Ethiopian Birr.

It is immediately clear from the figure above that not only is St Luke's Hospital the one with the highest "production" because

FIGURE 4 / COST PER UNIT OF SUO 2003-2007

Costo/SUO 2003-2007



it is the hospital for the entire Zone, but also it is the one with the highest costs per unit of product. This latter is precisely because being the main hospital for the Zone it has to deal with a far more complex case-mix than the other hospital and carries out more major surgery, orthopaedic trauma surgery and so on. To this should be added the fact that costs have risen steeply over the past year; not only personnel costs, which account for about 50% of all recurring costs, but also the costs of materials for consumption (drugs and other materials).

EQUITY

As is well known, user fees (direct payment for health services) are one of the most iniquitous ways of financing health systems as they put the burden of the variable costs of treatment directly onto the patient. These systems are, however, often found in developing countries where both private and not-for-profit hospitals often do not receive 100% financial cover from donors and governments. These latter, in their turn are simply not able to finance a Public Health System through general taxation unless there is also community insurance (i.e. risk sharing) which, as yet, either does not exist or, if it does, is rarely applied. Direct payment by the patient of at least one part of the costs of the service they have received is an important way for many hospitals to cover the costs of the services they supply. In Ethiopia, patients have always had to make a contribution to the costs of treatment even in State run

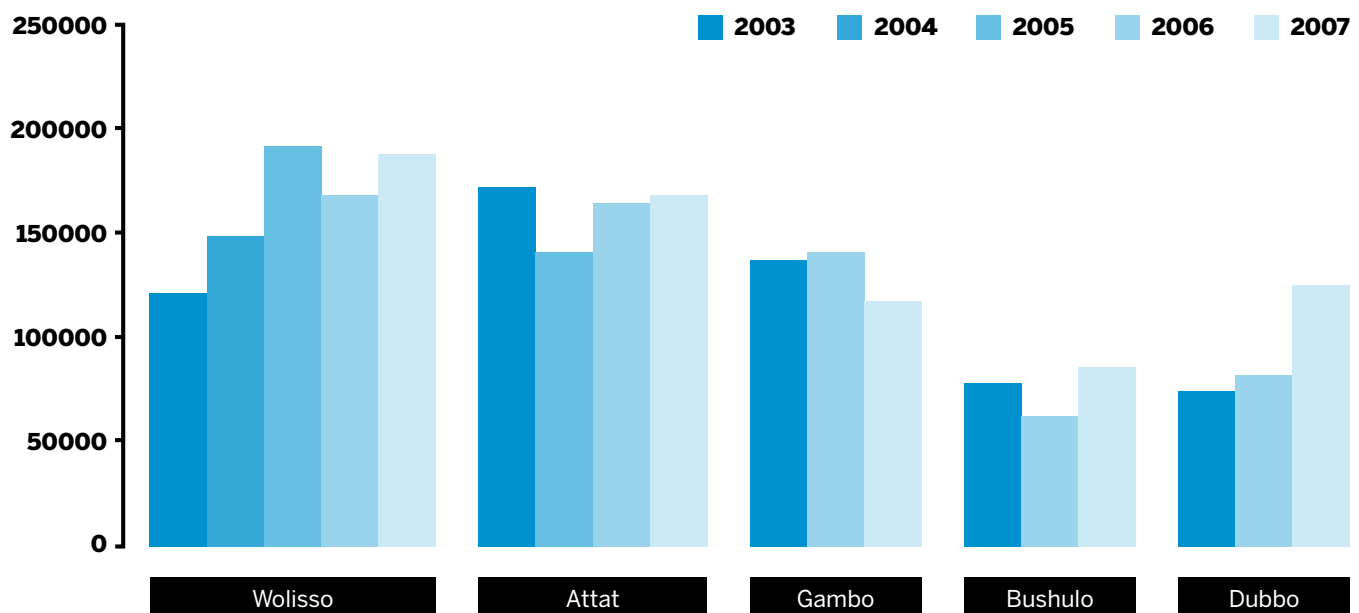
hospitals unless, that is, they were able to show a "Certificate of poverty", issued by their village headman, which exempted them from payment. On the other hand, it has commonly been found, even though it may not be officially recognised, that the patient may be subject to some form of 'payment' even within the public health system. It could be an "illegal" payment (a bribe) or a "legal" one, because they are directed to buy their drugs or other health aids in private Pharmacies, of which there are always many that operate outside of government institutions, because the material or drugs sought are "not available" from Government stocks. Or, they may have, or may have had to, "illegally" pay the headman to sign the Certificate of "poverty".

As stated above, Wolisso Hospital requires patients to pay a user fee for the services it supplies and in any case the question of payment does not stop anyone receiving emergency treatment which is always guaranteed. There is also a system for exemptions for people who are not able to pay the sum asked and, as each case is evaluated on its own merits, there can be total exemption. **Figure 5** (below) shows the "weight" of *user fees* per unit of product and, consequently, the cost, per unit of product, to the patient.

When compared with other hospitals run by the Catholic Church of Ethiopia, Wolisso and Dubbo turned out to be the most "expensive" for their patients. This indicator could be seen as offering a measure of the degree of equity in the system, if one presumes that the lower the payment per unit of product, the more equal, and the more accessible, will be the service.

FIGURE 5 / COMPARISON BETWEEN ETHIOPIAN CATHOLIC HOSPITALS OF USER FEES PER UNIT OF SUO 2003-2007

Confronto del SUO negli ospedali Cattolici Etiopi 2003-2007



In the case of the Wolisso Hospital, it should also be said that about one third of the direct payments from patients come from those who have undergone elective surgery, however, which make up less than 20% of admissions: this is because Wolisso uses a flat rate tariff regime with very different tariffs for each category of patients and for the different pathologies: for example admission in paediatrics costs the patient 50 Ethiopian Birr while major surgery can cost as much as 1,500 Birr, a Caesarean section costs 150 Birr and a normal birth 50, while admission to General Medical costs an adult 250 Birr. These tariffs are fully inclusive and cover bed stay, consultancy, diagnosis, surgery, drugs and health aids, food and nursing care. One indirect indicator of equity could be the percentage of patients who were exempted from payment. In 2007, 0.7% of outpatients and 2.3% of admissions were exempted from payment after their state of "poverty" had been verified.

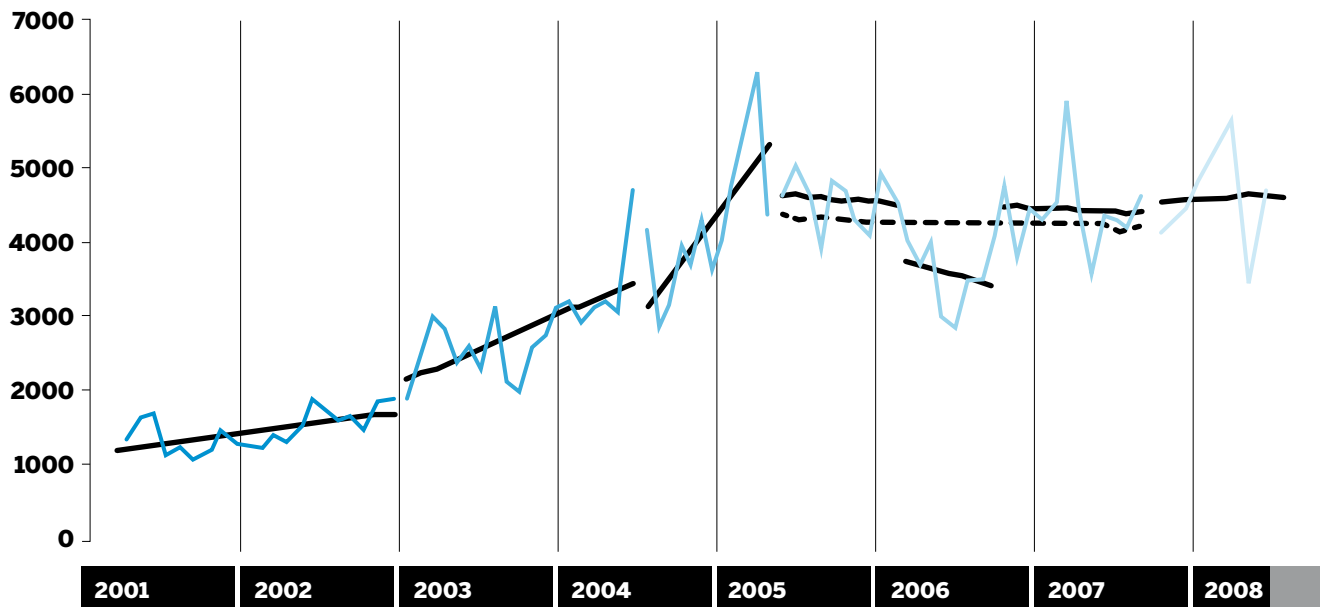
As stated in the introduction, user fees were, initially, one of the reasons why people proved reluctant to use the Hospital's services: indeed, the rate of exemption in the first two years of the hospital's operations was between 10-15%. Obviously this is not sufficient to be able to state that the hospital has become more equal and accessible, even though it certainly is more so now, than it was before. User fees contribute an important part of the hospital budget: in 2007 user fees covered 33% of the cost of services, and in the early years of the hospital they covered as much as 40% of such costs. **Figure 6** shows the trend in outpatient attendances in relation to the diverse tariff regimes applied.

After the first cut in tariffs in October 2002, outpatient attendances shot up, this trend became even more marked after June 2004, when not only were tariffs cut again but also a flat rate regime was introduced (this means that patients paid a set price once only, and not for each individual service, drug etc. used during treatment). The upwards rise levelled out in June 2005 and was stable for some time with a slight tendency to fall. The increase in tariffs in June 2005 and again in December 2007 are not enough to explain this "stabilisation" also because the flat rate regime has remained unchanged and the increase in tariffs has been minimal, or none for more vulnerable segments of society, i.e. for women and children. Probably it is more the case that the hospital has reached its maximum level of production given the condition of the infrastructure and the current level of personnel. This hypothesis is supported by the fact that even after the most recent increase (December 2007) the situation has remained fairly stable with, if anything a slight increase. Since 2005 there have been 200 outpatient attendances per day except in the period in 2006 when they dropped off considerably. But, as explained before, this was due to the fact an antiretroviral Clinic was opened in April that year: the fall off is clearly visible in Figure 6, as is the reversal of this trend which took place after two more doctors had been taken on in the following months.

The same trend can be seen in admissions which rose rapidly after the tariffs had been cut and stabilised once the maximum capacity of the hospital had been reached: in the period 2005 – 2007, bed occupation rate was 86.9%, average length of stay

FIGURE 6 / TREND OF OUTPATIENT ATTENDANCES IN RELATION TO VARIATIONS IN USER FEES

OPD trend and user fees Feb 01 - Jun 08



was 6.6 days and patient turnover rate was 52.2 patients per bed per annum. **Figure 7** illustrates the trend in admissions after variations in tariffs during the course of the hospital's existence.

CONCLUSIONS

The Wolisso Hospital has, in just a few years, achieved a good level of management performances as the high level of efficiency achieved in resource management shows. This hospital is the only one for Zone, an area with more than one million people. It has been lauded for the efficiency of its information system, for its poly – specialist services and for the quality of these services.

So as to maximise the use of resources, St Luke's has tried, to maintain a highly efficient, rate of bed occupation (equal to 85%) which they have achieved, notwithstanding both the progressive increase in the number of patients dealt with and the complexity of the case-mix treated, by keeping average length of stay low (6.6 days). When the Wolisso Hospital first opened it had 83 beds, now, due to the number of patients, it has expanded to 164 beds so as to reduce over-crowding which would negatively affect the quality of the service supplied. One expansion came with the decision, taken in 2006, to build an orthopaedic department with a dedicated operating theatre: given the increasing number of such patients being admitted and their incidence in terms of morbidity (bed days) and mortality.

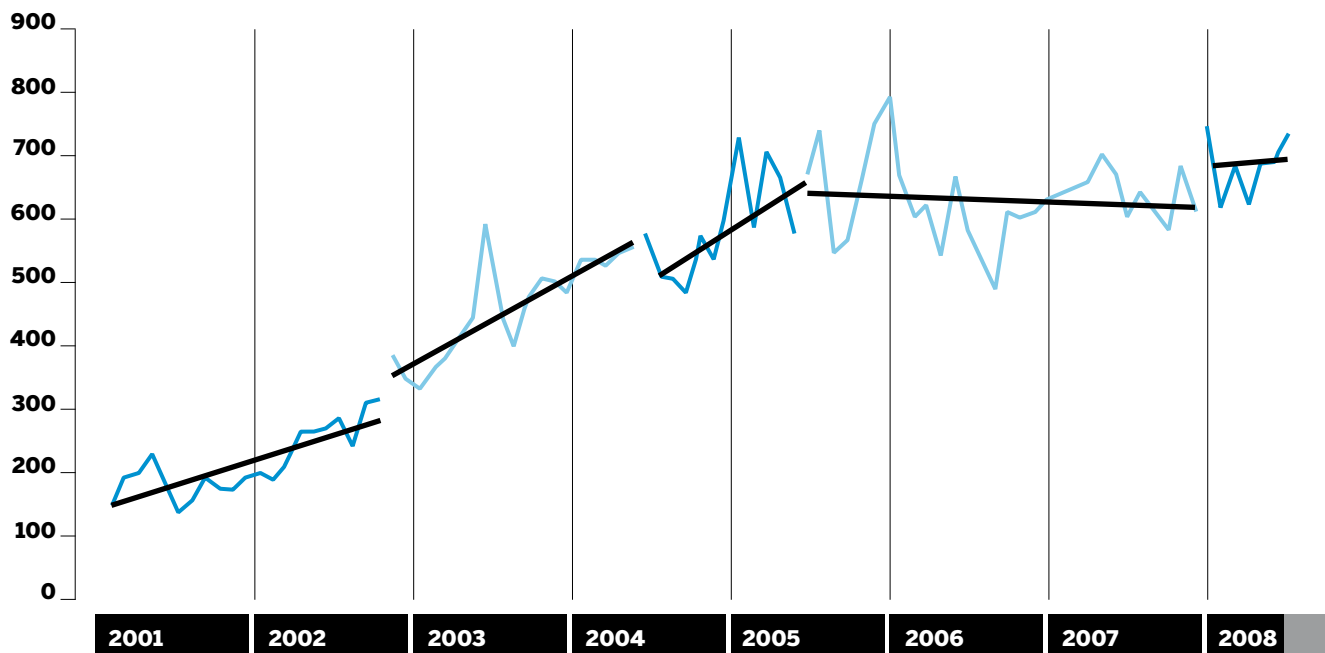
The efficacious use of data produced and gathered within the hospital has made it possible to manage the institution well and achieve its "public" health objective, that of meeting the health needs of the whole population.

However, notwithstanding the fact that 73.3% of patients admitted are women and children, (the flat rates are especially advantageous for these categories) and that the rate of exemptions has fallen to a very low percentage, it is, as yet, impossible to claim that there is equal access and equity for the whole population.

Indeed, population access to health services in general, and for maternity in particular, remains low. A recent survey carried out among women in the Wolisso District revealed that, in early 2008, only 20% of the women interviewed had given birth assisted by qualified personnel despite the fact that the Hospital is very near. On the other hand it should be remembered that the hospital is the only one for the Zone, an area where there are few other health structures and where even those available, and theoretically free of charges, show low patient access - as revealed by a recent survey which showed that 70% of Government Health Centres assist at less than 20 births per month.

There are various reasons why health services are little used. There are very few Health Centres in this area and in Ethiopia in general. This means that in order to reach these structures patients will have to travel and this affects the level of attendances as transport costs are often high, while the economic level of the population is low. This latter, together with level of education and ethnic origin also plays a determining role in access (or not) to services and so conditions outcome indicators (WHO, Bulletin

FIGURE 7 / TREND OF ADMISSIONS IN RELATION TO VARIATIONS IN USER FEES



2006 July 84). Today there is a major inequality in the level of cover provided by the services: a 31% difference between the poorest quintile and the richest, the gap has risen since 2000 when it was 26%. (Countdown Report to 2015).

It should not be forgotten that this is a private, although not-for-profit, hospital which needs to find sources for financing and maintaining itself. At present the money coming in from user fees is the only way of bridging the financial gap (about 30%) which is not covered by other funds. It will not be possible to abolish user fees unless an adequate health insurance system is set up, or, more public funds are allocated to the hospital (today the Government already covers 24% of recurring costs) or, private donors help to cover the missing 30%. However, even this will not be enough to guarantee accessibility and equity to the entire population so long as this hospital remains the only structure that functions at a good level in the whole Zone.

Further in-depth study needs to be carried out to find why access and use of health services remains so low.

In the meantime, in order to be able to continue to guarantee high standards of efficiency, and to limit (incorrect) use of the hospital as a means of meeting those health needs that are not met by the Zone Health System, Doctors with Africa Cuamm, together with the Council of Administration and Hospital Management has already begun a programme designed to reinforce the Zone Health System where it is working in collaboration with the Local and Regional Authorities. Indeed, only by creating an efficient and efficacious Zone Health System, one with a clear system for referrals from peripheral health units to the central Hospital, will we be able to contribute to ensuring access and equity in quality health services so as to guarantee health for all and thus contribute to the development of the local population.

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OUTCOME OF SEVERELY MALNOURISHED CHILDREN TREATED ACCORDING TO UNICEF 2004 GUIDELINES

A one-year experience in a zone hospital in rural Ethiopia

By / A. Berti, E. R. Bregani, F. Manenti and C. Pizzi / Doctors with Africa Cuamm

M. Bettinzoli / University of Brescia / Italy

ABSTRACT

Malnutrition still has a dramatic impact on childhood mortality in sub-Saharan African countries. Very few studies have tried to evaluate the outcome of severely malnourished children treated according to the Unicef 2004 guidelines and reported fatality rates are still very high. During 2006, 1635 children were admitted to the paediatric ward of St. Luke Catholic Hospital in Wolisso, South West Shewa, Ethiopia. 493 (30.15%) were severely malnourished and were enrolled in the study. We reviewed the registration books and inpatient charts to analyze their outcome. A mortality rate of 7.1% was found, which is significantly lower than reported in the literature. 28.6% of

deaths occurred within 48 hours of admission; the recovery rate was 88.4%; the drop-out rate was 4.5%. Early deaths were due to the poor condition of the children on admission, leading to failure of treatment. Late mortality was considered to be related to electrolyte imbalances, which we were unable to measure. The clinical skills of nursing and medical staff were considered an important factor in improving the outcome of malnourished patients. We found that proper implementation of WHO guidelines for the hospital treatment of severely malnourished children can lead to a relatively low mortality rate, especially when good clinical monitoring is assured.

TABLE 1 / CHARACTERISTICS OF THE STUDY POPULATION ACCORDING TO TYPE OF MALNUTRITION

	n (%)	Average age (months)	Average W/H ratio (NCHS)	Early death^a	Late death^b
Marasmus	178 (36)	24	60%	8	7
Kwashiorkor	315 (64)	18	75%	2	18

W/H: weight-to-weight; NCHS: National Center for Health Statistics

^a ≤ 48h after admission^b > 48h after admission**TABLE 2 / CO-MORBIDITIES ACCORDING TO OUTCOME IN MALNOURISHED CHILDREN**

	n (%)	Average age (months)	Blood transfusion	HIV positivity	Confirmed TB	Pneumonia	Sepsis
Improved	436 (88.4)	20	4.6%	4.0%	5.2%	8.7%	7.1%
Dead	35 (7.1)	34	8.6%	11.4%	14.3%	25.7%	31.4%
Self-discharged	22 (4.5)	19	0%	4.5%	18.0%	13.6%	0%

HELMINTHS AND SCHISTOSOMIASIS IN THE CITY OF BEIRA, MOZAMBIQUE

The prevalence of soil-transmitted helminths (STH: *Ascaris lumbricoides*, *Trichuris trichiura*, and hookworms) and schistosomiasis (*Schistosoma mansoni* and *Schistosoma haematobium*) was unknown in the coastal city of Beira, Central Mozambique.

Since before independence, marshes and rice fields near the residential areas of Beira create a habitat for the snail vectors of schistosomiasis. Poor hygiene and sanitation conditions favour STH.

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INTRODUCTION

The prevalence of soil-transmitted helminths (STH: *Ascaris lumbricoides*, *Trichuris trichiura*, and hookworms) and schistosomiasis (*Schistosoma mansoni* and *Schistosoma haematobium*) was unknown in the coastal city of Beira, Central Mozambique.

Since before independence, marshes and rice fields near the residential areas of Beira create a habitat for the snail vectors of schistosomiasis. Poor hygiene and sanitation conditions favour STH.

MATERIAL AND METHODS

In order to determine the prevalence of schistosomiasis and STH infections in the coastal neighbourhood of Chipangara, inside Beira, individuals were searched for *S. mansoni*, STH, and *S. haematobium*. Faeces samples were processed by the Kato-Katz method. Moderate/heavy intensity threshold was defined as following: ≥ 5000 epg for *A. lumbricoides*; ≥ 1000 epg for *T. trichiura*; and ≥ 2000 epg for hookworms. Urine samples were prepared by simple filtration through a Millipore membrane; two students supervised by a biologist searched the filters for *S. haematobium* eggs at 10x magnification.

The population was randomly divided into 4 groups based on age and profession at risk: children aged 2-6 years, either gender (Group 1); pupils aged 7-15 years, either gender (Group 2); adults older than 15 years of age, either gender (Group 3); rice farmers older than 15 years of age, either gender (Group 4). Samples size for each group was 200 individuals.

Individuals with a positive examination were treated with mebendazole and praziquantel.

RESULTS

From May to July 2004, 606 samples of urine and 497 samples of faeces were collected (one faeces sample and/or one urine sample for each person). Results for STH, single and multiple infections, and

S. haematobium infection are reported in tab 1 and 2 respectively.

497 individuals were searched for *S. mansoni* and soil-transmitted helminths by faeces examination, and 606 individuals for *S. haematobium* by urine examination. The prevalence rates of soil-transmitted helminths were 95,5% (95% CI 90–98,2%) in children aged 2 to 6 years; 97% (92–99) in aged 7 to 15; 76,4% (68,6–82,8) in aged >15; and 86,7% (77–92,8) in rice workers; *S. mansoni* infection was not detected in the study population.

The prevalence rates of *S. haematobium* were 2% (0,5–6,2) in children aged 2 to 6 years; 9,1% (5,8–13,9) in aged 7 to 15; 2% (0,5–6,2) in aged >15; and 1,2% (0,1-7,3) in rice workers.

CONCLUSIONS

Our results show that *T. trichiura* is a very common parasite in this suburb of Beira town. *A. lumbricoides* is less common and hookworm is rare although significantly more common in the rice field workers. Comprehensively helminths infections are highly prevalent in the inhabitants of all ages in the studied neighbourhood constituting a relevant public health problem for this population and possibly in other suburban areas in Beira.

All four the study groups have a prevalence of STH infections >75%, with a pick of 97% prevalence in schoolchildren, reflecting the age intensity profile of worm infections. Moderate/heavy intensity of infection is highly frequent (74%) in rice workers and relevant ($\geq 15\%$) in other groups. The high prevalence rates of helminths infections indicate to mass treat school-age children of this suburban population with benzimidazoles.

S. haematobium infection is present in the schoolchildren of the neighbourhood with prevalence close to 10%. Prevalence rates would probably increase by examining more than one specimen collected in successive days. However, the *S. haematobium* prevalence registered is sufficient to indicate mass treatments for schistosomiasis with praziquantel of schoolchildren.

The absence of *S. mansoni* infection suggests the lack of transmission in this coastal neighbourhood probably because of the absence of *Biomphalaria* specific snails.

TABLE 1 / PREVALENCE RATES OF SOIL-TRANSMITTED HELMINTHS INFECTIONS

Age group (years)	Sample size	Ascaris Lumbricoides	Trichuris trichiura	Hook-worms	Double infection	Triple infection	Total % positive	Total % Moderate/heavy intensity infection
2-6	133	68	125	2	66	1	95.5 (127/133)	16
7-15	133	90	119	6	86	5	97 (129/133)	15
>15	148	27	111	7	24	4	76.4 (113/148)	17
All ages	414	185	355	15	176	10	89.1 (369/414)	
Rice workers	83	42	72	12	30	12	86.7 (72/83)	74
Male	14	8	13	4	4	4	92.9 (13/14)	
Female	69	34	59	8	26	8	85.5 (59/69)	

TABLE 2 / PREVALENCE RATES OF S. HAEMATOBIIUM INFECTION

Age group (years)	Sample size	Positive for S. haematobium	% (95% CI)
2-6	Tot: 149	3	2 (0.5-6.2)
	Male: 69	3	4.3
	Female: 80	0	0
7-15	Tot: 220	20	9.1 (5.8-13.9)
	Male: 107	9	8.4
	Female: 113	11	9.7
	7-10: 93	8	8.6
	11-15: 127	12	9.4
> 15	Tot: 151	3	2 (0.5-6.2)
	Male: 60	2	3.3
	Female: 91	1	1.1
	15-35: 98	2	2
	> 35: 53	1	1.9
Rice workers	Tot: 86	1	1.2 (0.1-7.3)
	Male: 14	0	0
	Female: 79	1	1.4

EDUCATION OF QUALIFIED INTERNATIONAL HEALTH AGENTS: THE “JUNIOR PROJECT OFFICER” PROGRAMME

Doctors with Africa Cuamm has been promoting the “Junior Project Officer” Programme since 2002 in order to offer interested residents a training opportunity in a developing country and thus deepen their theoretical and practical skills in line with their specialisation courses.

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BACKGROUND

Qualified development agents with sufficient experience and skills, both in clinical and public health fields, are increasingly required in order to effectively strengthen local health systems.

OBJECTIVES

Doctors with Africa Cuamm has been promoting the “Junior Project Officer” Programme since 2002 in order to offer interested residents a training opportunity in a developing country and thus deepen their theoretical and practical skills in line with their specialisation courses.

METHODS

The Programme foresees:

- the participation in a training course aiming at giving basic knowledge on health services in Africa at Doctors with Africa Cuamm's HQs before their departure
- a training and work plan which is agreed with the Specialisation School Director
- a minimum of six month stay in an African country
- the assistance of an Italian senior medical doctor as tutor.

Doctors with Africa Cuamm covers the residents' insurance costs, whereas all the other costs are borne by the residents themselves. Residents could carry out their experience in one of the African countries where Medici con l'Africa Cuamm implement long-term development projects collaborating with relevant hospitals and health district facilities. The Specialisation Schools mainly involved in the Programme are: Paediatrics, Gynaecology, Internal Medicine, Hygiene, Surgery and Infectious Diseases.

RESULTS

From its start in the 2002, the Programme has involved 27 students of which nine residents in Paediatrics, two in Internal Medicine, eight in Hygiene, two in Community Diseases, three in Gynaecology, one in Oncology and two in Surgery.

The Specialisation Schools which took part in the Programme are the following:

- 1 /** University of Bari: Hygiene and Preventive Medicine
- 2 /** University of Bologna: Paediatrics
- 3 /** University of Ferrara: Paediatrics
- 4 /** University of Firenze: Gynaecology and Obstetrics, Hygiene and Preventive Medicine, Infectious Diseases
- 5 /** University of Modena and Reggio Emilia: Hygiene and Preventive Medicine, Paediatrics
- 6 /** University of Padova: Community Medicine, Hygiene and Preventive Medicine, Internal Medicine, Oncology, Paediatrics
- 7 /** University of Palermo: Surgery
- 8 /** University of Parma: Paediatrics
- 9 /** University of Pavia: Hygiene and Preventive Medicine
- 10 /** University of Rome “La Sapienza”: Internal Medicine
- 11 /** University of Siena: Surgery
- 12 /** University of Torino: Hygiene and Preventive Medicine
- 13 /** University of Trieste: Hygiene and Public Health
- 14 /** University of Udine: Paediatrics

On 24 October 2008, Doctors with Africa Cuamm signed an agreement with the University of Padova which confirms the training value of the Programme.

CONCLUSIONS

The Programme offers an important opportunity to health professionals to broaden their skills and knowledge in the field of global health, in view of their involvement in health activities both in Italy and in a developing country.

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