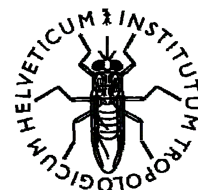
Strengthening People's Resources for Improved Community Health

Insights from Tanzania and Mali

Alexander Schulze, Novartis Foundation



Aims of the Presentation

- Outline conceptually the relevance of contextual determinants of ill health as well as people‘s resources for improved access and community health
(in particular factors outside the health system);
- Illustrate the relevance of these factors with (research) findings from Tanzania and Mali;
- Present possible key entry points to strengthen people‘s resources for improved community health within a primary health care approach, in the context of
  - Community Participation;
  - Intersectorial Action.

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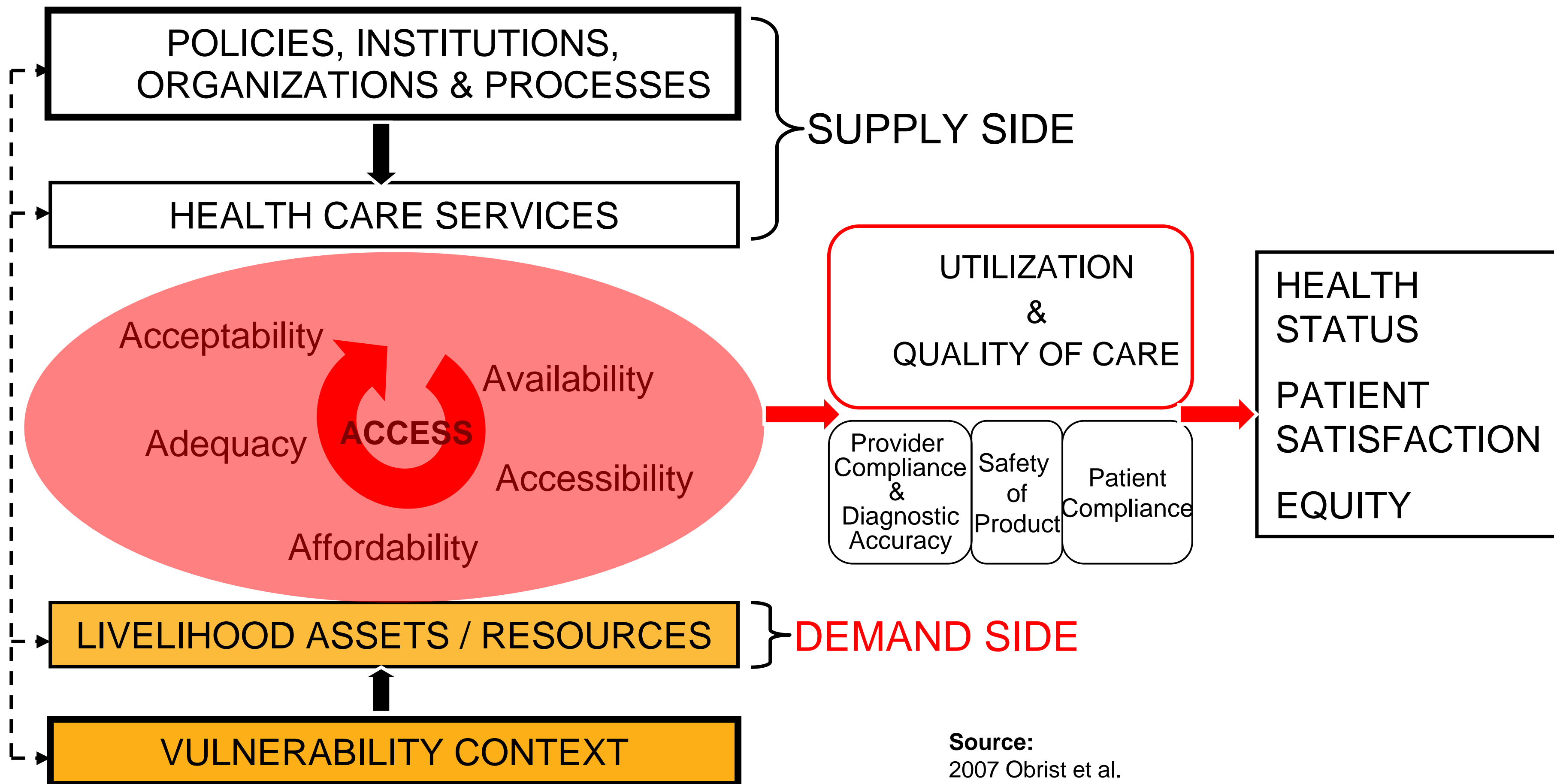
Framework for Community Access to Health Care in Contexts of Livelihoods



Source:
2007 Obrist et al.

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Types of Resources (Assets)

Livelihood Assets	Examples of Resource Strengthening for Improved Access to Health Care	Corresponding PHC Principle
Natural	Livestock raising as income generation	Integrated Approach with other Sectors
Physical	Agricultural equipment / inputs for higher productivity / income generation (cash crop)	
Financial	Health insurance coverage, free services, exemption mechanisms, micro credits	Utilization of Community Resources, Integrated Approach with other Sectors, Equity
Human	Sensitization of community, training & support for voluntary management of health facilities	Utilization of Community Resources, Participation
Social	Training & support of CHW coming from the villages they serve, feedback meetings / channels on health facility performance	Utilization of Community Resources, Trust & Solidarity Strengthening
Political	Information & sensitization on decentralization principles, rights & procedures (fund application etc.)	Decentralization

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The ACCESS Project in Tanzania (1) – Improving Access to Effective Malaria Treatment and Care

Partners:
Ifakara Health Institute (IHI)
Swiss Tropical Institute (STI)
District Health Authorities

Potential beneficiaries:
Children under 5, pregnant women and population in the Kilombero and Ulanga districts (618’000)

Duration: 2008 – 2011 (2003-2008)

- First project phase (2003-2008) with focus on identifying access obstacles;
- Project combining research, monitoring & evaluation with interventions targeting “supply and demand side”;
- Targeting malaria within a health system approach.

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The ACCESS Project in Tanzania (2) – Areas of Interventions

Access Dimension	Health Care System	Client / Patient
Availability and quality of health care services	Quality Improvement and Recognition Initiative (QIRI), Rapid Diagnostic Tests (RDT), Accredited Drug Dispensing Outlets (ADDOs) incl. Coartem	Clients‘ charter (rights)
Geographical accessibility	Partially ADDOs (MSH/TFDA Project)	-
Adequacy and acceptability	QIRI	Social marketing campaign on causes, symptoms and recommended / prompt / correct malaria treatment, patient compliance
Financial affordability	Strengthening of Health Facility Governing Committee & Council Health Service Board for improved community health fund management (Empower Project)	Strengthening of Women‘s Saving and Credit Cooperatives, Community Health Fund
Monitoring & evaluation	Quality of care and advice	Health seeking behavior

The ACCESS Project in Tanzania (3) – Main Findings and Results of Phase I (2003-2007)

- Strong overlap with regard to malaria between people‘s illness concepts and those of modern medicine;
- Changes in health seeking behavior: nearly 90% of analyzed fever cases in children under 5 treated with malaria drugs, also in the case of severe malaria;
- BUT: frequent delay of treatment (not within 24 hours), antipyretic often first drug taken; -> difficulty of mobilizing and converting resources into necessary cash;
- Poor quality of care (malaria case management); drug stock outs; low quality of drugs from drug stores (before 2007); ->
- Community coverage reduced from 100% to 23%.

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The ACCESS Project in Tanzania (4) – Phase II (2008-2010)

- More focus on interventions;
- Keep malaria related interventions (RDT, case management and provider compliance, patient compliance);
- More emphasis on general quality of healthcare due to its influence on malaria case management;
- More focus on people‘s resources (affordability) : micro-credit and income generation (women), community health funds (prepayment schemes).

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The ACCESS Project in Tanzania (5) – Main Features of Phase II

- Saving and Credit Cooperatives (SACCOs)
  - Pilot with 5 SACCOs and 160 women (900 beneficiaries in their households) in Kilombero and Ulanga districts, SolidarMed support for 2 WOSCAs and 430 women in Ulanga district;
  - Grants of 2,5-3 mio. Tsh, management strengthening, health education messages, conditions fixed (use of antenatal care, bed net, CHF etc.);
  - Monitoring on utilization of credits, effect on household's health, equity.
- Community Health Funds (CHF)
  - One CHF to be revitalized (Ulanga), one to be set up (Kilombero);
  - Management strengthening (e.g. collection and use of fees);
  - Sensitization of community leaders and potential members;
  - Monitoring (CHF management, effects on protection and equity).

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Initiative Accès in Mali (1) – Main Features

Partners:
•Regional health and social development authorities
•11 municipalities in the Region of Ségou including their community health associations and insurance schemes

Potential beneficiaries:
Population of 11 health areas in the Region of Ségou (164'257 people)

Duration: 2007-2009 (2011)

- Based on a pilot project (2001-2006);
- Inspired by framework developed by ACCESS Project for its regional scaling up and further refinement;
- Purpose: Improving access to primary healthcare services for rural population (along five dimensions & quality of care).

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Initiative Accès in Mali (2) – Areas of Intervention

Access Dimension	Health Care System	Client / Patient
Availability and quality of health care services	Infrastructure, medical equipment, qualified staff (e.g. medical doctor), provider compliance	-
Geographical accessibility	Range of preventative & curative services offered in village	-
Adequacy and acceptability	Emergency shift, opening hours, patient-provider communication	Sensitization of communities concerning health issues, use of health services, rights & duties at health centers
Financial affordability	Financial & administrative management	Health insurance, micro credit, income generation
Monitoring & evaluation	Quality of care, utilization rates, management	Financial protection, patient satisfaction

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Initiative Accès in Mali (3) – Challenges ahead

- Quality and management of primary healthcare services
  - Range, technical quality and organization of healthcare services;
  - Management of health services by Community Health Associations (comprehension of roles / functions, finances, personnel).
- Community-based health insurance schemes
  - One scheme with nearly 2’000 beneficiaries; two smaller ones with 400/250 beneficiaries; ->
  - Higher enrolment rates targeted through:
    - Management strengthening and supportive supervision;
    - Sensitization of potential beneficiaries (village gatherings, markets, radio etc.);
    - Linking of existing schemes, exploring ways of extending the benefit package (secondary level care);
    - Improving resource basis of households.

Initiative Accès in Mali (4) – Strengthening Livelihoods

Income generation activities

- Jatropha seeds for oil and biodiesel production *
  - 171 ha of Jatropha planted (as living hedges, pure cultures on less fertile land or in association with other crops);
  - A total of 221 individual farmers; 74 collective fields;
  - Technical support (installation/maintenance of fields, plant production);
  - First harvest in 2008, 50 FCFA/kg; motivation for the first year without harvest?*(with Syngenta Foundation – SFSA)
- Milk production*
  - Organization of producers in cooperatives;
  - Collection and selling of milk, quality control.

*(Syngenta Foundation - SFSA, *Vétérinaires Suisse sans Frontières* - VSF, Swiss Tropical Institute - STI)

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Initiative Accès in Mali (5) – Strengthening Livelihoods

Support for “village banks” of women’s associations*

- First round (2006): 10 banks with 548 women (3288 beneficiaries) received each 150‘000 FCFA (340 CHF);
- Return rate: 100%; 5’492’865 FCFA (13’000 CHF) at disposal through savings and interests after repayment of loans (1’500’000 FCFA) to the project end of August 2008;
- Second round (2008): 10 banks with 745 women;
- Technical support and monitoring;
- Linking women community health worker groups (sensitization on hygiene and nutrition) to micro credit?

*(with Syngenta Foundation – SFSA)

Conclusions and Outlook

- Relevance of Primary Health Care (PHC) systems as the backbone for health related interventions (MDG 4, 5, 6);
- Intervention with a disease focus can be combined with PHC (see ACCESS Project in Tanzania);
- Currently too much focus on supply side, hence more emphasis on clients‘/patients‘/people‘s resources needed;
- Decentralization process is key prerequisite;
- Integrated, but targeted approach & continuous backstopping at district/local level needed;
- Cooperation of different (local/national/international) parties.

Back Up

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Definition of Primary Health Care

„**Essential health care** based on **practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community** by means acceptable to them **at a cost that the community and country can afford** to maintain at every stage of their development in a **spirit of self-reliance and self-determination**.

It forms an integral part of both the countries' health system of which it is the central function and the **main focus of the overall social and economic development of the community**. It is the **first level 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 continuing health care process."

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Five Dimensions of Access – the Degree of Fit between Health System and Patients’ Resources

- **Availability (A1)**
  - The existing healthcare services and products meet clients’ needs.
- **Accessibility (A2)**
  - The location of supply is compatible with the location of clients.
- **Affordability (A3)**
  - The prices of services fit the clients‘ resources and ability to pay.
- **Adequacy (A4)**
  - The organization of healthcare services meets clients‘ expectations.
- **Acceptability (A5)**
  - The characteristics of providers match with those of the clients.

The Five As Under Real Conditions…

A1: What type of services exists?

A2: By what means of transport can they be reached?

A3: What are the direct and indirect costs?

A4: Do the opening hours match with daily schedules of the clients?

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The Five As Under Real Conditions…(cont.)

A5: Does the provider explain the treatment in simple terms and takes notice of local illness concepts and social norms?

Quality of Care: Does the provider comply with the treatment guidelines? Does the patient adhere to the treatment? Is the given treatment safe and efficacious?

Published Articles on ACCESS I Findings

- Obrist et al. (2007): **Access to Health Care in Contexts of Livelihood Insecurity: A Framework for Analysis and Action.** *PLoS Med* 4 (10): e308.doi:10.1371/journal.pmed.0040308.

- Hetzel et al. (2008): **Obstacles to prompt and effective malaria treatment lead to low community-coverage in two rural districts of Tanzania.** *BMC Public Health*, 8:317 doi:10.1186/1471-2458-8-317. http://www.biomedcentral.com/1471-2458/8/317.

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