INDEPTH Network Workshop report

Report prepared by Dr. James Akazili, Ms Samuelina Arthur, Mr.Titus Tei

<table>
<tr><td>Workshop Title Page:</td><td>Health Systems: Kick-off meeting of Universal Health Coverage project (Africa and Asia)
Date: 13th to 17th February, 2012
Venue: MJ Grand Hotel, Accra, Ghana
Hosted and Funded by INDEPTH Network Secretariat

Facilitated by :Dr Jane Goudge (Agincourt, South Africa), Dr James Akazili (Navrongo HDSS) and Prof Nguyen Thi Kim Chuc (Falabavi HDSS)</td></tr>
<tr><td>Names of INDEPTH sites that participated</td><td>A total of 12 participants from 3 countries attended the workshop. The INDEPTH Network secretariat was represented by two participants (Titus Tei and Samuelina Arthur). Below is the list of participating sites. For detailed list of participants see Appendix a

<table>
<tr><th>Site</th><th>Country</th><th>Number of participants</th></tr>
<tr><td>NAVRONGO HDSS</td><td>GHANA</td><td>3</td></tr>
<tr><td>KINTAMPO</td><td>GHANA</td><td>1</td></tr>
<tr><td>DODOWA</td><td>GHANA</td><td>1</td></tr>
<tr><td>FILABAVI</td><td>VIETNAM</td><td>2</td></tr>
<tr><td>DODALAB</td><td>VIETNAM</td><td>1</td></tr>
<tr><td>CHILILAB</td><td>VIETNAM</td><td>1</td></tr>
<tr><td>AGINCOURT</td><td>SOUTH AFRICA</td><td>1</td></tr>
<tr><td>INDEPTH NETWORK SECRETARIAT</td><td>GHANA</td><td>2</td></tr>
<tr><td>7 INDEPTH centres members</td><td>3 Countries</td><td>12 Participants</td></tr>
</table></td></tr>
<tr><td>Background</td><td>a) The rationale/justification for the workshop

Many low and middle income countries (LMIC), including Ghana and Vietnam continue to face difficulties in providing affordable health care for their citizens. This is aggravated by out-of-pocket payments that remain a significant source of financing (Bate and Witter 2003; McIntyre, Gilson et al. 2005). There is abundant evidence that direct payments for health care have negative consequences for the population, particularly the poor and vulnerable, to the extent that the poor often forgo seeking treatment from formal health care altogether. They sometimes seek to live as if they are not ill (Arhin-Tenkorang 2000; Russell and Abdella 2002; Xu, Evans et al 2003; O'Donnell, van Doorslaer et al 2008; Yates 2009). Carrin and Morris (2005) quantified the number of deaths in 20 African countries that occurred as a result of user fees and other direct payments. They obtained the startling figure of 3 million child deaths over the past 2 decades. For instance in Ghana some new born babies and their poor mothers were sometimes detained at health facilities because they could not pay for the services. Their husbands or carers would often have to work at these facilities for several days and sometimes weeks to cover the medical bills of the delivery (Nyonator and Kutzin 1999; Garshong, Ansah et al 2002).

Ghana and Vietnam are countries (within the INDEPTH Network) that have not only elected to pursue a policy path of universal health care coverage through taxation and pre-payment arrangements but have within the last decade provide financial protection to over 50% of their population. From health facilities data,</td></tr>
</table>

utilisation of health services (reflected in OPD per capita) in Ghana increased from 0.51 in 2004 to 0.81 in 2009 (Ghana Health Service 2009). Health facility data in Ghana for instance showed that cost of health care has increased after the introduction of the national health insurance (Ghana Health Service) and so those who are not covered under the present health insurance scheme are facing grave catastrophic direct health care payments if they have to use health care services and this could have impoverishing effect on poor households. There are also concerns about quality of health care in the health facilities due to increased use following efforts towards universal health coverage in Ghana and Vietnam. Poor quality generally makes the poor turn away from even subsidized services at public health facilities to patronize private services or not to seek care at all.

In a recent unpublished report for UNICEF by one of the implementers of this proposed study, Ahn (2011) writes: "Regarding access to health services, health visits (inpatient and outpatient) among the insured increased slightly from 1.79 visits in 2008 to 2.07 visits in 2010, mainly due to the increase in usage of outpatient services. Utilisation at the district and community level accounts for two-thirds of the total usage of outpatient services, while district and provincial health facilities account for nearly 90% of the services provided for inpatients. In 2008, only around 48% of insured people used their health insurance cards. Reported reasons include: indirect costs such as the cost of transportations the cost of caregivers and under the table payments, which are all much higher than what is reimbursed by health insurance agencies; cumbersome procedures involved in seeking health care services; the poor quality of public health services, especially for insurers; long waiting times; and unfair treatment. Moreover, ethnic minority people and workers of the informal sector were found to receive less expensive services when compared to non-poor patients with the same disease, age and gender."

Although there are some LMIC who are making efforts towards UHC only few countries have made significant gains in this direction. In Africa, Rwanda and Ghana stand out and among the Asia countries, Thailand and Vietnam have also made significant effort. However, Vietnam and Ghana are countries that are with INDEPTH Networks and have several years of demographic surveillance and that have informed the choice of these countries. Universal coverage, provided either through taxation, or a separate insurance fund, combined with improved provision of care (through better geographical distribution of human resources, facilities, and resources, as well as greater response to the needs of the poor), would lead to greater equity in access to care. However, such a reform requires, firstly, an assessment of the distribution of need for care, the utilization of care, quality of health care and the financial burden of care, by socioeconomic status. Inequities often revealed by such evidence provides the rationale for reform, and can be used to generate political and community support. With the demographic survey in place, the evidence can be tracked or monitored over time. Regular monitoring of equities of access to care is essential, quality of care, and a utilization pattern not only assess progress towards the objectives of the reforms towards UHC, but also provides evidence for policy and advocacy to support such reform.

Apart from assessing the effect of UHC on access, quality of health and utilization of health care services in Ghana and Vietnam, the study will also seek to explore the effects of reform efforts towards UHC on the poverty trend in these two countries. Evidence abound that direct health care payments or out-of-pocket payments particularly in LMIC are catastrophic and often have impoverishing effects on the population especially the poor segment of the people (Ataguba and McIntyre 2009). One of the goals of the study is to determine the coverage levels of the health insurance schemes in the two countries. With the DHSS platform, the

	study will be able to capture the actual coverage rates (membership status) of the population. The incentive to report higher coverage rates of the National Health Insurance scheme in Ghana for instance is making many districts to be inflating figures purported to be the coverage levels. Recently Oxfam study in Ghana revealed that the NHIS which have claimed to have provided financial protection to over 50% of the population in Ghana, is covering only about 18% of the population (OXFAM and ISODEC, 2011). This was (still is) vehemently contested by the NHIS Authorities and other civil societies.
Objectives of the workshop:	The workshop was organized to develop a common tool (questionnaire) to measure need, access, utilization and quality of health care services taking into consideration the commonalities and differences in the two countries of Vietnam and Ghana. The questionnaire will serve as an INDEPTH Network tool to be used in other centres and sites. Specific objectives of the workshop included: • To standardize the definition of some concepts, they included; Universal Health coverage, Social Economic Status, Need, Utilization, Access and quality of Care. • Discuss the research questions and methodology for the study. • To develop and standardize a tool for the data collection that will enable comparison between the two sites of Ghana and Vietnam. • Discussion of work/ implementation plan, communication strategies and plan for next meeting.
Activities carried out:	The sessions were organized in plenary and in working groups as well. At the end of each day, a general recap was made to highlight the main issues discussed (see **Appendix b** for the agenda). ***Day 1: February 13th Monday*** There was a welcome address by Jeannette Quarcoopome (a representative of the INDEPTH Network Secretariat, Accra). This was followed by a self introduction by participants. Dr. James Akazili made a presentation on the introduction/background, the aim of the study, the research questions, etc. According to him, the study dwells on universal health coverage, which is an aspect of the health systems. The study seeks to explore whether the health sector reforms were having the desired effects on the population, especially the poor and vulnerable. A discussion of some concepts on health systems was also made; they consisted of Universal Health Coverage (UHC), Socio-Economic Status (SES), Need, Utilization, Access and quality of care. This was to enable a common understanding of these concepts. ***Day 2: February 14th Tuesday*** The day started with a welcome address by the main facilitator (Dr James Akazili). The research questions as well as the methodology for the study were discussed. The scope of work required to answer the research questions as outlined in the proposal was discussed too. For a comparative study to measure the effects of the health reforms on health equity in the two countries, members agreed that the outlined indicators - health needs, utilization, access and barriers to access as well as the coverage of reforms (universal coverage) would have to be assessed with reference

to historical data. Relevant historical data from surveys in Ghana and Vietnam on indicators for pre and post NHIS implementation will be used and then compared to the findings of the study. Both Ghana and Vietnam have some information on pre and post health sector reforms (National Health Insurance) (See appendix c.)

There were also some presentations by representatives from Ghana and Vietnam on their DHSS (the background and current status). Paul Welega presented for the Navrongo Health Research Centre (NHRC) and Nguyen Ngoc Linh for the Filabavi Health Research Centre (FHRC). The FHRC covers 71 randomly selected clusters out of 352 in Ha Tay with a population of about 50,000. Updates of vital events are carried out every 3 months. On the other hand, the NHRC located in the Kassena Nakana district was established in 1992 and covers a population of about 152,000 in 30,000 households. Updates are conducted 3 rounds per year.

Like all DHSS, the two Centres' have no core funding and challenged by collection of data for add-on modules. It was therefore agreed that additional staff will be recruited to handle extra workload; however, it should be within the budget line.

Given the timelines, it was not possible to conduct a whole year survey that will account for seasonal variation in morbidity. Hence participants agreed that Filabavi in Vietnam could start its data collection from July and end in September, 2012. However, Navrongo could start from May and end in August, 2012.

Sampling strategy was also considered for the study. It was decided that, the sampling unit should be the household, but the unit of analysis will be individuals. A household head or any responsible member of the household will respond to questions, with the help of other members of the household. The sample size will be calculated based on the utilization of health care services and also by SES categorisation, instead of NHIS coverage by the respective DHSS areas.

Day 3: February 15th Wednesday

Participants grouped themselves into three (3) groups). The groups developed questions (study instrument) based on the key concepts: health insurance, need, access, utilization and quality of health care services. The groups made presentations on the draft questions for a general discussion and consensus.

Day 4: February 16th Thursday

The development of the questionnaire continued on the fourth day. Two groups were formed–the Ghanaian group and the Vietnamese group. The groups examined the draft questionnaire with respect to their country context. An acronym was carved out for the study, called **UNICO** (Universal Coverage).

Besides a presentation entitled "*How do we develop a communication strategy for this study"* was made by the communications Manager of INDEPTH Network. She highlighted several ways for drawing up a communication strategy. According to her, it was important to consider the audience in every research that we do, for example, key stakeholders, internal audience, community leaders etc. The tools and channels to be used in the communication process should also be considered. The tools included the media, publications, policy briefs, policy dialogues, presentations at seminars, workshops, conferences, face to face communication, etc.

Discussions/comments

- Do we have to persuade other centres to use the tool we are developing or

	have developed? • The working group needs to develop momentum as a health systems group. • The need to put the tool on the INDEPTH Network website after it has been piloted/tested • The need for policy briefs to be written on the objectives of the tool, its importance, guidelines in using it and on the health system project in general. • Can the results from this project be presented at ISC 2013? • The tool can be pasted on facebook with particulars of key working group members so that the public can give feedback. • The need for chat groups for the working group. ***<u>Day 5: February 17th Friday</u>*** This was the last day for the workshop. A further discussion on the draft tool was done by participants. An action plan for the project was drafted and agreed upon by all participants. The workshop ended around 1:00pm.
	At the end of the workshop the following was achieved: • Standardization of terminologies for the two countries of Ghana and Vietnam. • Identification of existing and new variables to be used for achieving the objectives of the study. • Development of a common tool (questionnaire).
Conclusion / Recommendations	
Appendices ***(See below)***	a) List of participants b) Workshop agenda c) Pre and post health sector reforms (pre and post NHIS) literature/data to be reviewed d) Action plan

Appendix a: List of participants

	Centre	**Country**	**Contact name**	**Contact e-mail**
1	Navrongo	Ghana	Dr James Akazili	akazjames@yahoo.com
2	Navrongo	Ghana	Mr. Paul Welaga	pwelaga@yahoo.com
3	Navrongo	Ghana	Mr. Philip A. Dalinjong	padalinjong@yahoo.com
4	Filabavi	Vietnam	Prof. Nguyein Thi Kim Chuc	Chuc.ntk@gmail.com
5	Filabavi	Vietnam	Mr. Nguyen Ngoc Linh	Nguyenngoc.linh@yahoo.com
6	Dodalab	Vietnam	Mr. Tran Khanh Toan	tktoan@yahoo.com
7	Kintampo	Ghana	Mr. Anthony	Anthony.kwarteng@kintamp

			Kwarteng	o-hrc.org
8	Chililab	Vietnam	Ms. Ngugen Thanh Ha	nth5@hsph.edu.vn
9	Dodowa	Ghana	Mrs. Doris Sarpong	doboakye@gmail.com
10	Facilitator	South Africa	Dr. Jane Goudge	Jane.goudge@gmail.com
11	INDEPTH Secretariat	Ghana	Mr.Titus Tei	Titus.tei@indepth-network.org
12	INDEPTH Secretariat	Ghana	Ms. Samuelina Arthur	samuelina.arthur@indepth-network.org

Appendix b: Workshop agenda

Monday, 13th February		
Time	**Activity**	**Chair/ Rapporteur**
9.00	Arrival (welcome)	James /Doris
9.10	Introduction of participants	
9.30	Welcome address by Indepth CEO	
9.50	Opening of the meeting/purpose	
10.30	Tea/coffee break	
11.30	Project outline	Chuc/ Doris
12.00	Discussion of project-overall	
1-2.00	Lunch	
2.00	Understanding the terminologies and measuring them (Universal health coverage-UHC, SES and Need)	Jane /Doris
3.30-4.00	Tea/coffee break	
4.00	Understanding the terminologies and measuring them (utilisation, Access and quality of care)	Jane/Doris
4.30	*End of session*	
Tuesday, 14th February 2012		
9.00	Discussion of study methodology	Toan/Anthony
	Tea/coffee	
11.00	Discussion of study sites/ DHSS of Navrongo and	Toan/Anthony

	Vietnam (Give brief background of existing data collection rounds, data collection technology, and existing relevant tools and studies)	
1.00	Lunch break	
2.30	Discussion of research questions	Paul/Ha
3.30	Tea/coffee break	
4.00	Questions and answers	Paul/Ha
4.30	End of session	
Wednesday, 15th February 2012		
9.00	Group work to develop questions for the study instrument	Group
	Tea/coffee	
11.00	Group work to develop questions for the study instrument	Group
1.00	Lunch break	
2.30	Presentation of group work	James/Linh
3.30	Tea/coffee break	
4.00	Questions and answers	James/Linh
4.30	End of session	
Thursday, 16th February 2012		
9.00	questions for the study instrument	
	Tea/coffee	
11.00	Group work to develop questions for the study instrument	Group
1.00	Lunch break	
2.30	Group work to develop questions for the study instrument	Group

3.30	Tea/coffee break	
4.00	Questions and answers	Jane/Philip
4.30	End of session	
Friday, 17th February 2012		
9.00	Discussion of work/implementation plan, communication, next meeting	Chuc/Anthony
	Tea/coffee	
11.00	Progess report, deliverables and start of work	James/Toan
1.00	Lunch break	
2.30	End of meeting	

Appendix c: Available data on pre and post health sector reforms (pre and post NHIS) to be reviewed/collected

Indicators	**Ghana**		**Vietnam**	
	Pre NHIS 2004	**Post NHIS**	**Pre NHIS 1992**	**Post NHIS**
Need		SHIELD 2007 (Implementation) Not Navrongo		-2002 National Health Survey and -1999 FB study
Utilization	Demographic Health Survey 1998 and 2005	SHIELD		-Ditto study -And other studies?
Access	DHS 1998	SHIELD		-FB 2001/2 children and elderly -FB 2002 -HH LSS 1993, 1998, 2008
Barriers		Shield		
Cost				

burdens				
NHIS coverage	LSS	LSS 2005		- FB 2011 -National Health Survey 2002 -Specific study for elderly 2008
Quality of care	Review of existing studies	Shield		-2002 National Health Survey -Satisfaction FB elderly Study2002/2008

Appendix d: Action Plan

Activity	**Person(s) involve**	**Timeline**
1.Questionnaire • Revise, distribute to everybody, get comments, make • Formatting	• James • Linh	• **By two weeks - 1stMarch** • **3 Days -3rd March**
2.Development of manual	**James and Chuc**	
3. Finalise proposal, and send to Chuc	**James**	**By mid March**
4.Translation	**Chuc**	**By end of March**
5.Sample size calculation a. Ghana **b.** Vietnam		By mid March
6.Full proposal for scientific committee and ethical review • Submit in Ghana / Approval • Submit in Vietnam / Approval	Ghanaian Team (James) Vietnamese Team (Chuc)	• End of March; Approval by end of June • End of April; Approval end of May
7.Translation, pre-test tool, pilot, and training fieldworkers • Ghana • Vietnam		• July • June
8.Secondary data analysis • Ghana • Vietnam		• August – Mid Dec • July-Mid Nov.

9.Full data collection and software entry • Ghana • Vietnam		• August – Oct • July- September
10 Data entry • Ghana • Vietnam		• Mid Nov • Mid Oct
11.Data cleaning • Ghana – Mid Dec • Vietnam – mid Nov		• Mid Dec • Mid Nov
12 Analysis workshop in Vietnam		• Mid Jan 2013
13.Continued analysis and write Up		• Feb – June 2013
14.National conference / dissemination		

Dissemination plan

1. Website – a page for UNICO project by Jeannette;
2. Flyer – one page summary by Jeanette with pictures!