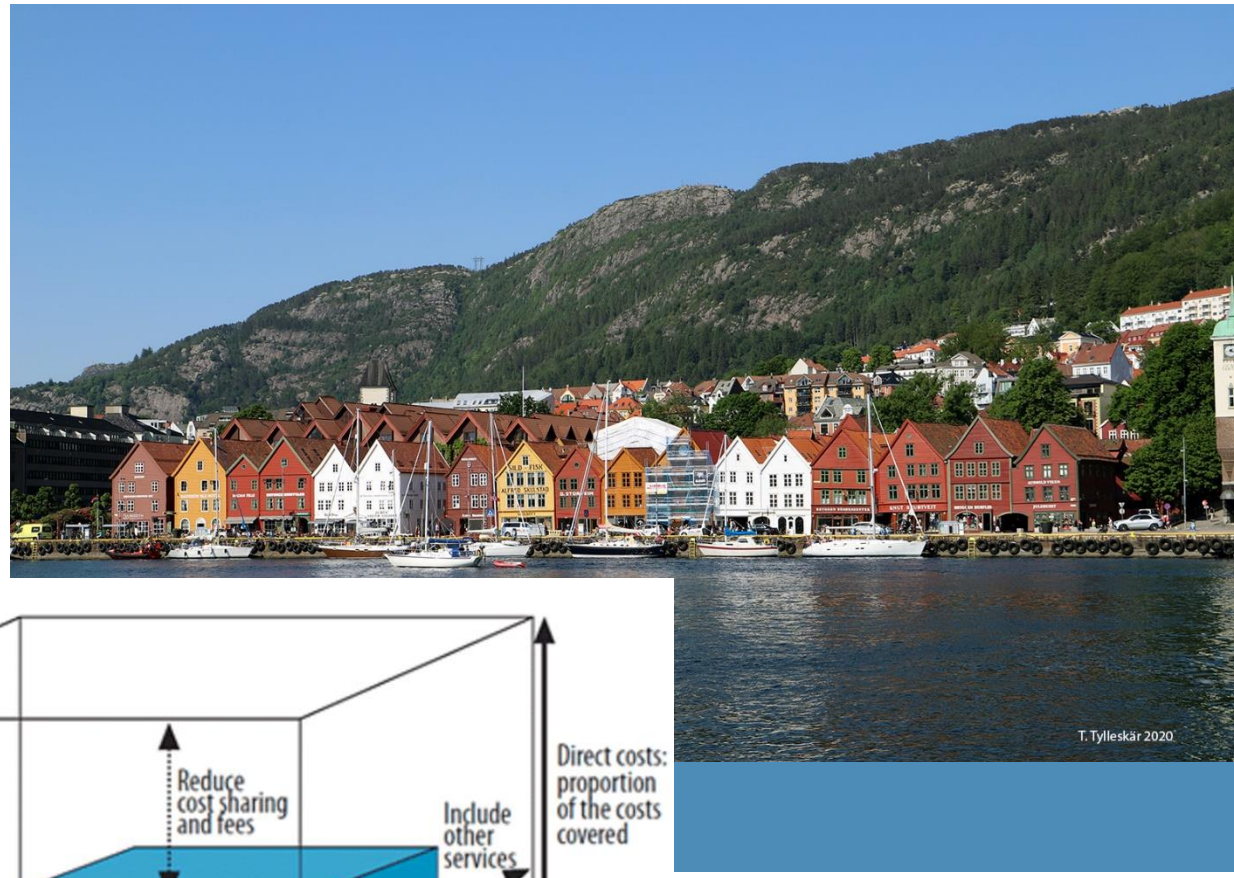
12TH
EUROPEAN CONGRESS ON
TROPICAL MEDICINE AND
INTERNATIONAL HEALTH
VIRTUAL FROM BERGEN, NORWAY.
28 SEPT - 1 OCT 2021

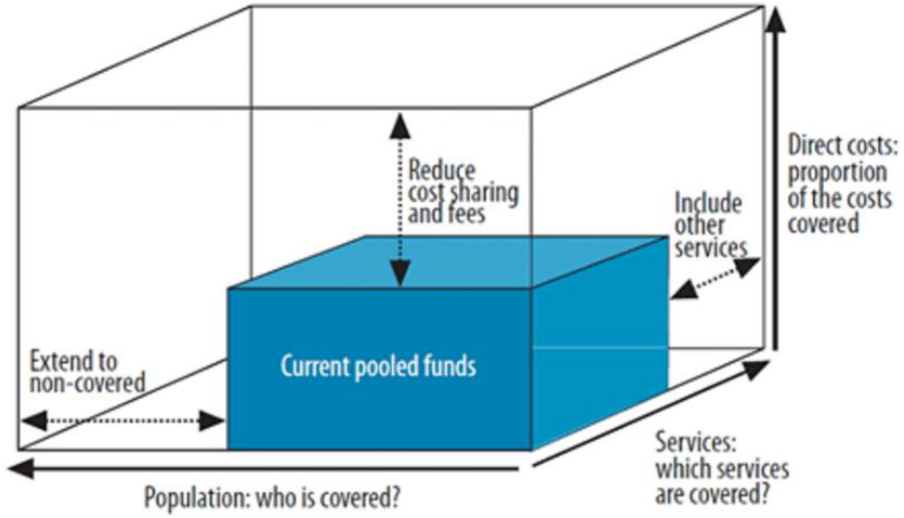
Building strong and effective institutions to achieve UHC in Western Africa

Introduction:

The challenges of ensuring policy coherence and building strong and effective institutions to achieve UHC

- "UHC means ensuring that everyone can obtain essential health services at high quality without suffering financial hardship" (WHO) = Global health objective no. 1

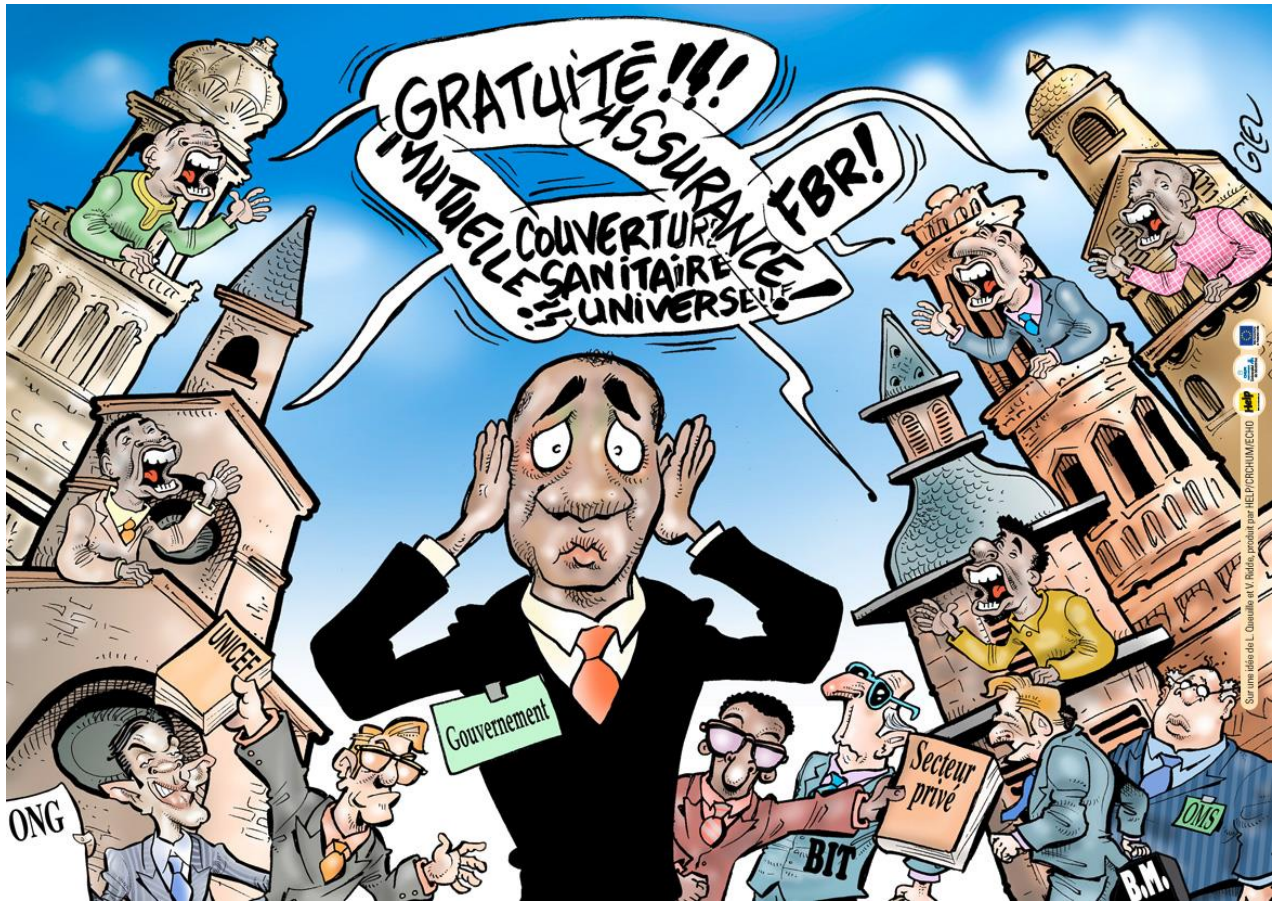




Three dimensions to consider when moving towards universal coverage

Introduction

- UHC = multidimensional concept
- Closely interconnected with:
  - PHC – HSS
  - Human rights – equity?
  - Social protection
  - Health financing reforms (SP…)
- UHC requests both:
  - Health services provision/essential service package/quality
  - Financing/financial protection
- Many stakeholders involved…
  - ⇔ Diverging interests!
  - ⇔ Trade-offs
  - ⇔ Priority-setting/decision-making
- Good institutions required



A tool for monitoring the performance of hospitals in Senegal using the AHP approach

- 1998 : hospital reform : business logic vs. administrative approach
- 2006 : evaluations attribute the same weight to all criteria
- Use of Donabedian's model to test a multidimensional performance steering tool in line with Result-Based Management
- Pairwise comparisons by 6 stakeholders (patient, decision-maker, hospital director, management board, clinicians, nurses)
- We used AHP and geometric mean to build matrix

Performance of hospitals in Senegal

- *AHP process*
- Defining the decision problem
- Developing a conceptual framework
- Setting up the hierarchy
- Collecting data from experts
- Employing the pair-wise comparison
- Estimating relative weights of elements
- Calculating the mean relative weights
- Following Saaty (1980)

Performance of hospitals in Senegal

Dimensions		Criteria		Sub-criteria		
Title	Local weight	Title	Local weight	Title	Local weight	Global weight
Structure	0.33	Human ressources	0.72	Medical staff	0.65	***0.15***
				Paramedical staff	0.35	***0.8***
		Equipment and facilities	0.28	Beds installed	0.59	***0.5***
				Basic equipment for patients	0.41	***0.4***
Process	0.44	Nosocomiales infections	0.45			***0.2***
		Information system	0.28	Completeness rate	0.6	***0.7***
				Promptitude rate	0.4	***0.5***
		Queue management	0.16			***0.7***
		Control of wage bill	0.11			***0.5***
Results	0,23	Efficiency	0,47	Average length of stay	0.79	***0.9***
				Bed occupancy rate	0.21	***0.2***
		Patient satisfaction	0.16	Waiting time	0.64	***0.2***
				Cleanliness	0.22	***0.1***
				Staff behaviour	0.14	***0.01***
		Financial balance	0.37			***0.09***
Total						***1***

Eliminating barriers to maternal health service utilisation in Nigeria: Is UHC sufficient?

- Nigeria health system = complex
  - ➢ Public sector
  - ➢ Private sector
    - ✓ Private-for-profit providers
    - ✓ Community-based organisations
    - ✓ Non-governmental organisation
    - ✓ Religious organisations
    - ✓ Traditional care providers
- UHC policy = (voluntary? social? state-led? health insurance
- 97% of women = No health insurance coverage
- MMR = 917/100,000 live births
  - 57% of women = No skilled birth attendant

Barriers to MHS in Nigeria

Interventions to improve MHS –

- ➢ Cash transfers
- ➢ Participatory health insurance schemes

❖ **Financial interventions ≠ increased MHS**

Cohen et al. (2017) in Kenya:

- ✓ Even with cash transfers, many women still used poor-quality facilities
- ✓ Decision-making on place of delivery was taken at the last minute and often disjointed

Baba-Ari et al. (2018) in Northern Nigeria:

- ✓ Provision of conditional cash transfers not sufficient for uptake of maternal health services
- ✓ Utilization of maternal health services may be determined by factors such as community and spousal influence

❖ **Other barriers?**

- ✓ Behavioural?
- ✓ Psychological?

○ Studies in developed countries = influence of behaviour on health services utilization

❖ **Behavioural Economics Tools**

- ✓ Locus of control (LOC)
- ✓ Personality traits (The Big Five)

LOC = Extent to which life's outcomes are determined by one's behaviour

- ➢ Developed by Julian Rotter in 1966 as part of social learning theory
  - ➢ Internal LOC
    - ➢ Life's outcomes based on individual's actions and behaviours
  - ➢ External LOC
    - ➢ Life's outcomes based on chance, luck or powerful others

Personality = enduring patterns of behaviour over time

- ➢ Measured by a taxonomy of traits = Big Five
  - ✓ Agreeableness -
    - ➢ How well an individual gets along with others
  - ✓ Conscientiousness -
    - ➢ Tendency to control impulses
  - ✓ Extroversion -
    - ➢ How individuals interact with others
  - ✓ Neuroticism -
    - ➢ Individual's emotional stability
  - ✓ Openness -
    - ➢ Willingness to try new things

Barriers to MHS in Nigeria

- **Aim** = to find association btw LOC and behavioural traits in MHS utilization
  - Cross-sectional community based study
    - ✓ Part of an intervention project to increase women's access to skilled maternal healthcare services in rural communities
  - Data collected at baseline & end line
- **Study population**
  - Women within the reproductive age (15 – 49 years)
  - Had a live birth within two years of the study period
- **Outcome variable =** Utilization of skilled birth care
- **Explanatory variables**
  - Locus of control - Measured using standardized scales
  - Personality traits - Measured using standardized scales
  - Women individual characteristics
  - Household characteristics

- **Findings**
  - ✓ 54% of women = No SBA at end line WRT baseline
  - ✓ 94% of women = No SBA = external LOC
  - ✓ Significant association btw LOC & MHS utilization

- Financial incentives for MHS -
  - Necessary but NOT enough!
  - Behavioural traits – LOC -
    - actual utilization of MHS

- To achieve UHC in Nigeria,
  - ✓ Address identified constraints and challenges that act as impediments to healthcare services utilization

Building a health insurance model that meets stakeholders' expectations in Benin?

- ARCH project:
  - State-funded, budget: 313 billion CFAF
  - TA from WHO and World Bank
  - Covers Medicare, credit, training and retirement insurance
  - Pilot phase of Health Insurance implemented since July 2019 in 3 HDs
  - Less than a year after the start of the implementation, 1,682 beneficiaries were supported for a total cost of 3,319,602 CFAF

Health insurance in Benin

Questions and main results:

Have the aspirations of stakeholders in this public policy been taken into account by its technical model?
How then was it developed? How is it perceived by its beneficiaries and its various stakeholders?

- Malfunction of the social protection policy steering mechanism
- Uncertainties on how the ARCH will relate to other initiatives
- Lack of transparency and communication on the part of the authorities on the management and steering process of the ARCH
- Difficulties of mutual understanding between Stakeholders

Explanations:

- ARCH formulation did not undergo a broad phase of social consultation to collect the aspirations of the different stakeholders; drew on the technical and political experiences of officials (administrators of the MoF and MOH, academics and technical agents of a few international NGOs)
- Not widely communicated to beneficiary populations CBHI institutions; sometimes contrary to their aspirations
- Health workers in charge of implementation neither sufficiently informed nor sufficiently motivated because they fear that the procedures for reimbursing health expenses will experience delays (as was the case with fee exemption scheme)

Translating UHC objectives into the legal framework in Benin and Senegal

The *legal* path towards UHC:

"Law" as a powerful tool for advancing UHC *(positive approach)*

"Law" as an obstacle to the establishment and implementation of UHC policies *(negative approach)*

UHC legal framework in Benin and Senegal

Senegal:

- Mutual health insurance (CMU – *Couverture Maladie Universelle*)
- Political priority
- CMU Agency
- 1. Implementing measures; 2. General law; 3. Financial arrangements (reversed logic from a legal point of view)
- The role of mutual health associations

Benin:

- ARCH (*Action pour le Renforcement du Capital Humain*)
- Political priority
- ANAM ▶ ANPS
- 1. Implementing measures; 2. General law; 3. Financial arrangements (reversed logic from a legal point of view)
- The role of mutual health associations

UHC legal framework in Benin and Senegal

Senegal:

- **Issues to be resolved**
- Financial arrangements : lack of clarity and guarantee
- Statute serving as the legal basis for the CMU : not yet adopted

- Voluntary adhesion

Benin:

- **Issues to be resolved**
- Financial arrangements : lack of clarity and guarantee
- Statute serving as the legal basis for the CMU : adopted, but uncertain effectiveness
- Mandatory adhesion
- Progressive implementation in limited areas of the territory

Thank you

Looking forward to your comments and questions