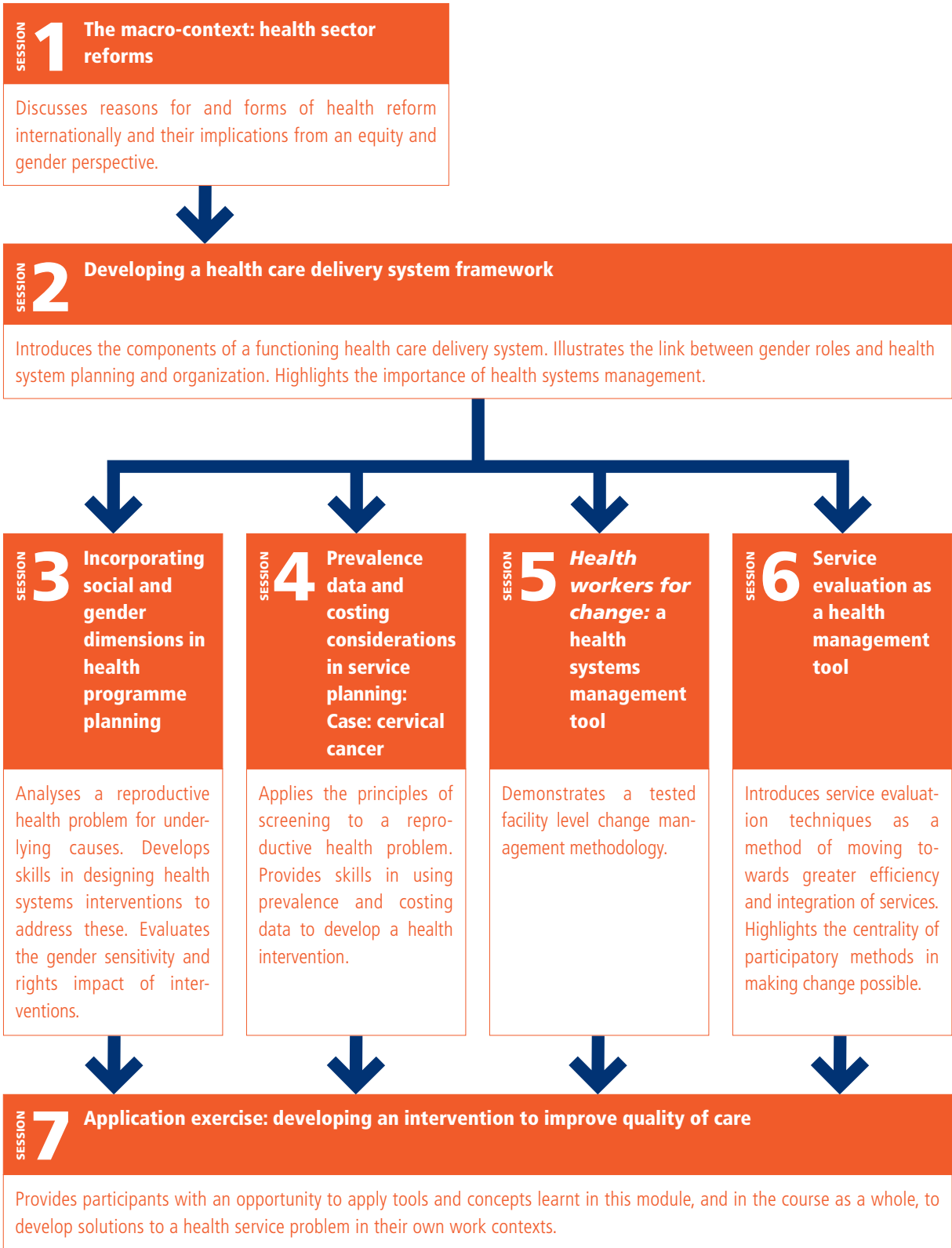


Module 6: **Health Systems**



Structure of the Health Systems Module



MODULE 6

Module brief

What participants should get out of the Health Systems Module

Participants will:

- understand the macro-economic environment within which health services are located;
- be familiar with the components of a well functioning health care delivery system and their interrelationship. The components include: health service organization, access, infrastructure, referral systems, technical competence, provider-client relations, drug supply and equipment maintenance systems;
- have explored methods of promoting gender equality and rights in planning, methodologies for change management and interventions to improve the way a health system works;
- have applied the concepts learnt in the module to develop solutions to one health service problem in their own area of work.

The thinking behind the module

The two dimensions of health systems are interrelated

Health systems experts are concerned broadly with two dimensions of health systems: the environment within which health services are delivered and the functioning of the health system in relation to service delivery. These are interrelated.

The environment

The environment in which health services are delivered includes: how resources are raised; how these are allocated between primary, secondary and tertiary levels of care, and between rural and urban areas; who provides services (the public-private mix); policy on community participation; and whether a health service uses a district based model or not.

The macro-economic environment often determines what is possible at country level, and is part of the environment within which health systems are developed. The macro-economic environment in which health services are developing today places contradictory demands on health policy makers and programme managers. On the one hand the ICPD *Programme of Action* calls for the expansion of services to reflect a life cycle approach to reproductive health, and for the provision of comprehensive reproductive health services within a

primary health care context. On the other hand, these changes are to be realized without additional resources and, in fact, in an environment characterized by cuts in public expenditure.

Service delivery

However, resource constraints in the health sector are not a unique feature of the current period. There are countries with limited resources whose populations have achieved a better health status than countries which are richer. One reason for this is the effective functioning of the health system in relation to service delivery (the second dimension of health systems mentioned above).

The functioning of the health system in relation to service delivery is concerned with how services operate at the service delivery point and the activities that support service delivery – drug supply, human resource management, training and supervision.

The module focuses on the micro-level

This module addresses issues in the organization of health service delivery at the micro-level, rather than macro-issues related to health financing and the allocation of resources at the sector level, personnel planning, legislation to regulate costs and set national standards for service delivery.

The module begins with an overview of the macro-economic environment and puts current notions about resource constraints in perspective. **The first session describes and discusses the variety of forms that health reform is taking and their potentially differential impact on women and men.**

The health systems approach

Sessions 2 to 6 look at what can be done by a policy maker, a health service provider, a health service manager or a donor within the current reality, to make services effective, more welcoming for service users and a better environment for health workers.

These sessions take a health systems approach to reproductive health services. The underlying premise is that providing a reasonable quality of services that meet people's needs calls for a similar, if not identical, range of actions, no matter which specific health programme we are concerned with. For example, to provide contraceptive services, a drug ordering system needs to exist, and so does a transport system, a financial system, and a monitoring system. The clinic must be staffed, the staff trained, an appropriate constellation of clinic based and outreach services have to be put in place, and so on. What is needed is the ability to get these systems to function irrespective of whether you are developing an HIV/AIDS programme or a family planning programme, antenatal and delivery services or interventions to identify, treat and manage communicable diseases ranging from TB to typhoid. To implement the ICPD Programme of Action, a functioning health care delivery system is required.

The second session in this module – "Developing a health care delivery system framework" – looks at the generic components of a well functioning health care delivery service system. This session defines the building blocks required to deliver health services. Day to day scenarios of the ways in which users encounter health services are explored. We unravel the impact of a poorly functioning health care delivery system on users and providers. Moreover, this session begins to explore the roles and functions of health service personnel in ensuring that there is a functioning health care delivery system. The centrality of good management to the efficient operation of health services is underlined. In this session components of a functioning health care delivery system are described. The components are essentially the same as those that are considered to be important in addressing quality of care. In this session we take this framework further by incorporating a gender and rights perspective.

Responsiveness

This sets the stage for the rest of the sessions, which provide insights into health service management as well as some skills. All these sessions have one common feature: responsiveness – health service planning that is cognisant of and responsive to the local social reality; management that is respectful of and responsive to health service providers; and health service provision and providers that are respectful of and responsive to health service users. There is a strong focus on participatory styles of management, transparent and accountable systems, and the organization and provision of services so that they promote gender equality and rights. Like the rest of this course, this will challenge the more conventional hierarchical and bureaucratic styles of health system management.

The module concludes with a session which assists participants to apply the insights from this module to developing solutions to a health services problem they face in their own work.

Looking through a gender lens

Each session examines the health care delivery system through a gender lens, primarily through questions raised by the facilitator using the data and scenarios provided.

Gender norms frequently determine women's access to services. For example, a woman's access to or control over money will determine whether she is able to pay for transport to reach health services and pay user fees. Gender norms also have an influence on who comes to health services. For example, if it is accepted that childcare is women's responsibility, then it is women who will bring children for child health services. If these services are poorly managed, women will have to spend a long time in queues and this will add to the demands on their time. Thus, we draw participants' attention to the ways in which gender norms differentially disadvantage women, and we promote the idea that improving the efficiency and effectiveness of health care delivery will relieve women's differential burden.

Redressing inequities

The sessions go further, to examine how health care delivery systems might not only recognize and address gender inequities but also contribute to redressing them. We argue that health care delivery systems can promote women's reproductive rights and autonomy, for example by not requiring that men agree with the provision of contraceptive or abortion services to women. Health care delivery systems can promote joint responsibility for sexual and reproductive health on the part of women and men, for example by organizing services and education based on the assumption that both men and women are responsible for child care, contraception, and practising safe sex.

Institutional inequities

The health care delivery system as a social institution also reflects and reinforces inequitable gender relations. For example, women are often over-represented in nursing positions or in remote rural clinics, while men constitute the majority of decision makers. The implications of this for the functioning of health services are also highlighted in this module.

Module outline

		Objectives Participants will:	Format of activities	Time: about 15 hours
Introductory session	Introduction to the module	<ul style="list-style-type: none"> ● be acquainted with the objectives and contents of the module 	Input	15 mins
SESSION 1	The macro-context: health sector reforms	<ul style="list-style-type: none"> ● be familiar with the background to and components of health sector reform ● understand the implications of health sector reform for the promotion of gender and social equity and rights 	Interactive input	2 hrs
SESSION 2	Developing a health care delivery system framework	<ul style="list-style-type: none"> ● know the various components of a well functioning health care delivery system ● understand that these generic components need to be in place and working in order for any health service interventions to be effective ● learn about the role of managers in making these components function ● begin to look at health service delivery issues through a gender lens 	Role plays Whole group discussion	2 hrs all together
SESSION 3	Incorporating social and gender dimensions in health programme planning	<ul style="list-style-type: none"> ● be able to analyse a reproductive health problem for underlying causes ● develop skills in designing health systems interventions to address these ● apply gender tools to enhance the gender sensitivity and gender equality of interventions 	Small group exercise Whole group discussion	1 hr 30 mins 1 hr 30 mins
SESSION 4	Prevalence data and costing considerations in service planning: Case: cervical cancer	<ul style="list-style-type: none"> ● be acquainted with the principles of screening and their application to service development ● understand the relationship between disease prevalence on the cost of screening services ● see the linkages between resource availability and epidemiological information about a disease, and decisions related to policy and services 	Input Simulation game Input	20 mins 1 hr 40 mins
SESSION 5	<i>Health workers for change:</i> a health systems management tool	<ul style="list-style-type: none"> ● have experienced demonstration of a change management tool ● have explored the interpersonal (provider-client) aspect of quality of care within a health services system framework, and from a gender perspective 	Small group exercise Whole group input	45 mins 30 mins
SESSION 6	Service evaluation as a health management tool	<ul style="list-style-type: none"> ● understand how records of clinic organization and time use (staff and patients) can be used as a management tool to promote the provision of integrated services ● be exposed to experiments which have succeeded in improving access and quality of services within existing budgets ● appreciate the value of participatory research methods and management styles 	Small group work concluding in a short whole group discussion	1 hr 45 mins
SESSION 7	Application exercise: developing an intervention to improve quality of care	<ul style="list-style-type: none"> ● have applied the tools and concepts learned in this module to develop solutions to a health problem in their work contexts 	Individual work Feedback from facilitator	2 hrs 30 mins

Introduction to the Health Systems Module

What participants should get out of the session



Participants will be familiar with the structure, contents and objectives of the Health Systems Module.

15 minutes

How to run the session



This is an input session.

Introduce the module using overheads from the Module brief:

- "What participants should get out of the Health Systems Module"
- "Structure of the Health Systems Module"
- "Module outline".

Clarify that of the two broad and interrelated dimensions of health systems – the environment within which health services are delivered; and the functioning of the health system in relation to service delivery – this module will focus, for the most part, on the second.

Highlight that each of the preceding modules have provided cumulatively the concepts, skills and information needed for application in this module. The Health Systems Module will be addressing on-the-ground issues to make positive change possible in the delivery of health services.

SESSION

1

The macro-context: health sector reforms

What participants should get out of the session

Participants will:

- be familiar with the background to and components of health sector reform
- understand the implications of health sector reform for gender and social equity.



1 hr
45 mins

1 hour 45 minutes

Materials

- Handout: "Health sector reform: background, components and gender implications"

Readings for the facilitator

1. Almeida C et al. Health sector reform in Brazil: a case study of inequity. *International Journal of Health Services*, 2000, **30(1)**:129–162.
2. Dahlgren G. The political economy of health financing strategies in Kenya. In: Chen LC, Kleinman A, Ware NC, eds. *Health and social change in international perspective*. Boston, Harvard School of Public Health, 1994.
3. Green A. *An introduction to health planning in developing countries*. Oxford, Oxford University Press, 1992: Chapter 5.
4. Standing H. Gender and equity in health sector reform programmes: a review. *Health Policy and Planning*, 1997, **12(1)**:1–18.
5. World Bank. *World development report 1993: investing in health*. New York, Oxford University Press, 1993.

Readings for the participants

Reading 4.

How to run the session

This session is a reading exercise on the gender implications of health sector reform, which may be done in groups to maximize peer learning. The groups report back to the whole group on key learnings, with inputs from the facilitator.

Activity: The gender implications of health sector reform



Step 1: Reading and summarizing

Divide the participants into groups of three or four. Distribute the handout to each participant.

Participants read the handout individually and write a summary of the main points as a group. The points to summarize are:

- reasons for health sector reform
- components of health sector reform
- gender and rights implications of these
- some examples from participants' country settings.

Groups are not required to make a formal presentation, but will be called upon to respond to questions in the big group.



Step 2: Discussion

Elicit from the whole group:

- reasons for health sector reforms
- components of health sector reforms
- gender and rights dimensions of these
- examples of how a specific health sector reform measure in their setting may have affected women and men, and different groups of women and men, differently.

What to cover in the discussion

The macro-economic environment

For more than two decades now, international economic forces have moved in the direction of reduced resources for the health sector in developed and developing countries alike.

The increase in oil prices in 1982 marked the beginning of a global economic crisis. Combined with the adverse, and at times worsening, terms of trade with respect to primary products, developing countries were pushed into a severe resource crunch. Developing countries had to go through Structural Adjustment Programmes (SAPs) as each measure taken to deal with the initial balance-of-payments crisis steadily worsened the situation.

Conditionalities required by International Monetary Fund (IMF) loans led to cuts in public expenditure, even as foreign aid was dwindling with industrialized countries experiencing an economic slump. Forced to borrow commercially from international banks,

developing countries came under an increased debt burden and resources available for public spending were further constrained. While the defence budgets of most developing countries were not significantly cut back, health sectors were faced with serious resource constraints.

This trend, of the health sector being severely strapped for resources, has continued through the 1990s and into the new millennium.

For developing countries that have been dependent on international aid for making even basic health care available to their populations, this has been a major crisis. New demands – such as those arising from commitments made at the ICPD for a reproductive health programme – have to be translated into action within the context of a serious resource crunch.

Two approaches – or a combination of both – have been advocated by the World Bank to bridge the resource gap in the health sector:

- contain costs and increase efficiency
- increase revenues through cost sharing.

A third approach – diverting funds from non-social development sectors (for example, defence) – has nowhere been seriously considered.

Diminished resources affect different groups differently

The various cost cutting options affect different population sub-groups differently. For example:

- Reducing the number of staff may affect women staff disproportionately because they are employed in the lower rungs of the hierarchy. This may in turn affect the utilization of services by women clients/patients. Further, some of the tasks being performed by front-line workers may drop off the formal health system, adding to women's informal care giving load.
- Decentralization of financing may mean that poorer provinces and communities have less access to resources for health; and in the battle for scarce resources, women's health needs could be given a lower priority.
- The move to cut public expenditure on interventions that are not cost-effective may affect poor women disproportionately: for example the non-availability of specialist services such as infertility services.

The introduction of cost sharing mechanisms such as user charges for health services may have a detrimental effect on the use of services by poor women who do not have ready access to cash or women who do not control cash in the household and have to seek permission to spend money. There have been few studies looking at the gender impact of cost recovery mechanisms, and these do not look at different sub-groups of women who may be affected – for example, different income groups, rural/urban residence, regions of a country, age groups, race/ethnicity.

Session developed by TK Sundari Ravindran



Handout

1 Health sector reform: background, components and gender implications

Based on key points from: Standing H. Gender and equity in health sector reform programmes: a review. *Health Policy and Planning*, 1997, **12(1)**:1–18; with additional inputs from Chapter 5 of Green A. *An introduction to health planning in developing countries*. Oxford, Oxford University Press, 1992.

Background

Health sector reform is not a new phenomenon. The health sectors of all countries have been experiencing changes and reforms for a long time. However, the term "health sector reform" has now come to stand for a particular set of policy prescriptions related to institutional and financial reforms and responding to a resource crunch in public spending.

The earliest calls for cuts in health sector spending date back to the 1980s, the era of Structural Adjustment Programmes (SAPs). A sharp increase in oil prices initiated by OPEC (Organization of Petroleum Exporting Countries) led to a balance-of-payment crisis in non-oil producing developing countries. Many industrialized countries also deflated their economies to cope with higher oil prices, and curtailed their imports.

Developing countries spiralled into an economic crisis as a consequence. The prices of commodities exported by developing countries fell in the world market, which meant that they had to export more in order to earn the same amount of foreign exchange. However, demand had also fallen. Unable to raise enough foreign exchange to meet the increase in oil prices, many developing countries had to devalue their currency. Still falling short, they sought IMF (International Monetary Fund) and World Bank loans. IMF conditionalities meant cutting public expenditure, including in health, which, during this period, was not considered an "investment".

Developing countries also started borrowing commercially from international banks, at high rates of interests. Debt servicing took a major toll on national resources. Devaluation also meant higher costs to service debts. More local currency was required to pay back the same amount of interest in foreign exchange. This also meant that cuts in public expenditure became necessary, and the health sector became severely strapped for resources.

Components

Two complementary strategies were proposed by the World Bank for bridging the resource gap in the health sector:

- containing costs and increasing efficiency through a combination of actions such as rationalizing drug use, using donor funds more effectively, reprioritizing areas for investing public health resources, increasing hospital efficiency, and enforcing more effective mechanisms for cost control and accountability

- increasing revenues through cost sharing using mechanisms such as promoting the private sector, charging fees for services, pre-payment schemes, community cost sharing systems and health insurance.

In 1993, the World Bank's *World development report* focused on "Investment in health", and outlined a series of principles and prescriptions to ensure that investment by governments in the health sector made sound economic sense. The latest generation of health sector reforms (HSRs) are influenced predominantly by these prescriptions, addressed particularly at financing, resource allocation and management issues, including:

- civil service reforms aimed at improving the efficiency of human resources by reducing numbers, reworking terms and conditions, changing skill mixes and improving monitoring of performance
- developing more effective financial and management systems and defining cost-effective interventions (e.g. basic minimum packages)
- decentralization, entailing the devolution of management and service provision decisions to district and other local level bodies
- developing new health financing and cost recovery options to complement public spending
- promoting the role of the private sector – creating competition between providers and establishing regulatory and health service contracting-out systems.

Sector-wide approaches (SWAPs) are a recent addition to the HSR agenda. This is an approach initiated by donors, in which donors relinquish specific project funding in return for a voice in the development of the national health sector strategy as a whole. [1]

SWAPs represent a continuation of several elements of the classic HSR agenda. However, they also represent shifts in some aspects of donor thinking. The first shift is the acknowledgement of the importance of national ownership of reforms, and the pivotal role of governments in this process. The second shift is represented by a concern that institutional reform should improve access to health care and health outcomes for the poor. The third shift is in the emphasis on involving a wide range of stakeholders – for example NGOs, the private sector, civil society groups – in the process of negotiating strategic plans for the health sector.

Gender implications

Commentaries on the effects of health sector reforms on health outcomes have drawn attention to both the direct and indirect effects on women. In terms of direct effects, most attention has been paid to the (hypothesised) effects of the imposition of user charges and the deterioration in the quality of services following cuts in health expenditure. The better documented examples of this relate to maternity care. A number of studies have reported an increase in home deliveries and delays in seeking care leading to worse maternal and infant outcomes. [2,3,4]

Indirect effects include the health consequences of increasing poverty. Gender differences in access to and control over resources and power at the household and other levels, and gender based division of labour, may cause

women to be more affected. Resource constraints at the household level may increase women's work load if they have to replace goods and services bought from the market with their own labour. Women may also bear a disproportionate part of the cuts in expenditure by denying themselves essential goods and services. This will impact negatively on their well-being.

A study discussing the effects of economic crisis on women's and children's health in the Dominican Republic, notes that although it did not produce a large scale increase in mortality, it did reverse a previous upward trend in health improvement, manifest in direct health indicators such as the maternal mortality ratio and the infant mortality rate. [5]

Reduction in the length of affordable in-patient stays, or avoidance of hospital care and increase in self-treatment are likely to impose greater time and labour costs on women.

Another study, in Mongolia, found that along with economic crisis, maternity rest homes were closing down. These were places where pregnant women in advanced stages of pregnancy could rest and get timely health care. They helped reduce deaths due to emergency obstetric complications and the closure of these centres is reported to have led to a dramatic increase in maternal mortality. [6]

As for gender implications of the HSR agenda of the 1990s, there is little empirical evidence and the potential impacts outlined below are more in the nature of hypotheses.

Because the workforce in the health sector is predominantly female, women health workers may be inadvertently disadvantaged especially if retrenchment is concentrated in the female sectors. Techniques for priority setting and monitoring, such as cost effectiveness analysis, may not incorporate gender equity concerns, at least in part owing to the limited availability of sex-disaggregated information on health and on workforce participation especially, in the informal sector of the economy where many women are employed. Decentralization raises some key concerns. For example, if district level or community based management structures make decisions on allocations which result in worsening gender equity, there may be no mechanisms available to attempt to redress the balance.

A great deal of concern has been raised about the implications of user charges and the promotion of the private sector for women's use of health services. For women with limited access to cash, there is no doubt that user charges would be a barrier to seeking timely, appropriate and adequate care. However, sex-disaggregated information on the use of services before and at various time points after the introduction of user charges would help in ascertaining whether or not this is indeed the case.

Health financing options such as private health insurance pose specific disadvantages to women. A majority of women in many developing countries may not have access to the resources to pay the premium because they are employed in the subsistence sector of the economy. Some crucial women's health needs such as obstetric services are not covered by many insurance schemes or carry a high premium. Abortion and family planning services are rarely covered.

There is as yet limited experience with SWAPs to comment on their gender impact. A key issue for SWAPs is the need and potential for incorporating women as stakeholders in the policy process.

References

1. Cassels A. *A guide to sector-wide approaches for health development: concepts, issues and working arrangements*. Geneva, World Health Organization, 1997.
2. Kutzin J. *Experience with organizational and financial reform of the health sector*. Current Concerns SHS Paper No.8. Geneva, World Health Organization, 1995.
3. Ekwempu CC et al. Structural adjustment and health in Africa. *Letter to The Lancet*, 1990, **336**:56–57.
4. Stewart F. Can adjustment programmes incorporate the interests of women? In: Afshar H, Dennis C, eds. *Women and adjustment policies in the third world*. Basingstoke, Macmillan, 1992.
5. Whiteford L. Child and maternal health and international economic policies. *Social Science and Medicine*, 1993, **37(11)**:1391–1400.
6. Kojima Y. *Women in development: Mongolia*. Manila, Asian Development Bank, 1995.

SESSION

2

Developing a health care delivery system framework

What participants should get out of the session

Participants will:

- be familiar with the various components of a well functioning health care delivery system
- understand that these generic components need to be in place and working for any health service intervention to be effective
- learn about the role of managers in making these components function
- begin to look at health service delivery issues through a gender and social equity lens.



2 hours

Prior preparation

- Prepare the role-plays based on instructions in the Notes for the facilitator
- Prepare the room for the role play as described in Activity: The health care delivery system wheel, Step 1 on p.398

Materials

- Notes for the facilitator: "Descriptions of role plays and questions for discussion"
- 7 blank pieces of paper
- 7 envelopes labelled
- role play characters, each individual character on a separate piece of paper, taken from Note for Facilitator
- props for the role play, suggestions on p.398
- overhead: "Questions after the role plays", on p.399
- newsprint with table on p.400
- overhead: "The health care delivery system wheel", on p.407

Readings for the facilitator

1. Tarimo E. *Essential health service packages: uses, abuse and future directions*. Geneva, World Health Organization, 1997.
2. Tarimo E. *Towards a healthy district*. Geneva, World Health Organization, 1991.
3. Timyan J et al. Access to care more than a problem of distance. In: Koblinsky M, Timyan, Gay J, eds. *The health of women: a global perspective*. Boulder, Westview Press, 1993.

How to run the session

This session is a participatory activity which should take place in a large room (desks should be moved to the edges to make a large empty space in the middle of the room). Volunteers are recruited to take part in a series of seven role plays while others observe.

At the end of each role play the facilitator asks a set of questions, the answers to which bring out an aspect of health care delivery system functioning, the role of managers in relation to this aspect, and the gender issues that the role play illustrates.

The room is set out in a wheel with the various management functions as the spokes. Each role play takes place in a different space in the room with the observers moving around from point to point.

Once all the role plays have been completed we have built a wheel with spokes, representing a health care delivery system wheel that can turn, move forward and deliver quality health services. This physical representation of the wheel reinforces the concept we are illustrating. The facilitator uses this same representation of a health care delivery system to summarize the session at the end. Since each role play illustrates a particular function of the health services system, each one has to be enacted.

Activity: The health care delivery system wheel

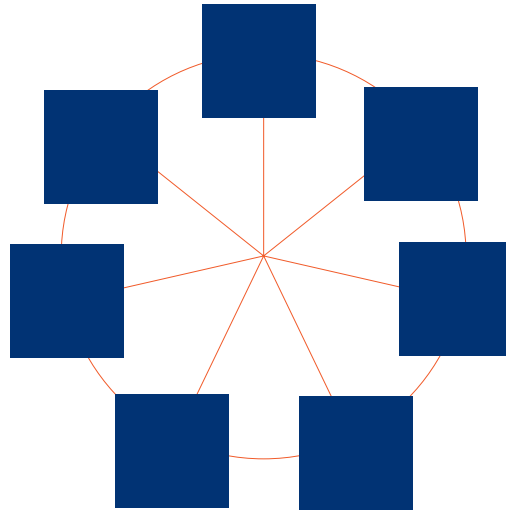


Step 1: Preparations

Do this step before you start the session.

Prepare the room

Clear a large space in the middle of the room. Place a blank piece of paper on the floor at seven points so that if you joined these points they would make a circle.



Prepare the role plays

Type out each character from the "Notes for the facilitator" onto a separate piece of paper. The role plays are numbered 1 to 7 and the characters have letters assigned to them. Label each envelope so that it indicates which role play and which character it corresponds to. In this way the people acting in a particular role play know who their fellow actors are.

Provide some props

It is useful to have a few props: a telephone, some shawls, a doctor's coat, etc. Look through the characters and bring appropriate props. This helps people get into their characters and adds a touch of realism, and humour. For example, if you bring a small cushion actors can stuff it under their shirt to pretend to be pregnant.



Step 2: Assign the characters and prepare to act

This session starts with all participants standing in a large circle around the room, with the desks moved well out of the way. Ask for 15 volunteers who are willing to participate in role plays. Give each volunteer the envelope which contains a description of the role play and of the character they are to play. You do not have to have men playing men or women playing women. Assign this at random – just give out the envelopes.

Explain to the actors and observers that seven role plays will be enacted during this session. All the roles are about service providers and service users in primary health care facilities. Tell the actors that they will

not know who the other characters are before the role play starts, but that this will quickly become clear.

Ask each actor to read her or his character and think about how they may act as this person. Give everyone a few moments to do this. Explain that you can help anyone who has a question. Maintain privacy when answering any questions, so that no one else can hear. Assist them in developing a plan for how they may act as their character by asking them questions rather than telling them what to do. For example, if someone acting the character of a nursing sister wants help, read the description with him or her and talk through how they imagine that person may feel, what circumstances they may be working in, etc.

Explain to the actors that observers need to get a flavour of the situation and that acting talent is not required. Everyone should remember that the actors are playing a role, and that what they do and say will not be seen as a reflection of their own personalities or opinions. Actors should remember also to face the audience, and talk so that everyone can hear.

Instruct observers to pay close attention to what the characters do and how they interact.



Step 3: The role plays and discussions

Call everyone not acting in role play 1 to gather around the first piece of paper on the floor. Actors with a 1 marked on the envelope should do their role play.

Start by introducing the situation and the characters briefly. For example: "We are at a clinic and we have a clinic nurse (point to the person playing the nurse) and a patient (point to the person playing the patient). This clinic has a referral centre that is 40km away and this is the clerk (point to the person playing the clerk) who books appointments and does other clerical work at the referral hospital."

Let each role play run for about five minutes, making sure that the aspect of health system functioning to be addressed by it emerges (See below). Stop the role play by firmly saying "Thank you".

Overhead Then facilitate a discussion about the role play using the following questions.



Questions after the role plays

- For each actor: How did it feel to play the role you played?
- For the observers: Describe what was going on in the role play. In your experience, is this a likely scenario? If not, how would the reality differ?
- What are the gender issues in the health service setting depicted in this role play? What major issue concerning health service functioning is illustrated?
- What action could be undertaken to improve service delivery in this situation?
- Whose role is it to ensure that the kind of actions you have suggested are undertaken?

(Suggestions for further questions on the gender issues in each role play are given in the notes for the facilitator.)

The role plays correspond to the following components of a health care delivery system:

1. provider-client relations
2. technical competence
3. referral systems
4. infrastructural requirements
5. access
6. organization of services
7. supplies and equipment systems.

Write the appropriate one down on the blank pieces of paper on the floor after each role play. You would write “provider-client relations” after the first role play, “technical competence” after the second, and so on.

Ask the group whose responsibility it is to make sure this aspect of the health service works well. List this on a sheet of newsprint with the following columns:

What they should do	Clinic staff	Health service managers	Community members

This list of the functions that are required for running a well functioning health service, fills up as we go through the role plays.

Once a role play is over, move the group to the next point on the wheel and start again until you have acted out each role play and moved right around the wheel.

Discussing the list of questions at the end of each role play is the core of this session as it draws out the essentials of a well functioning health care delivery system.

Summary

- Introduce the first role play
- The role play is enacted
 - Ask the group:
 - questions about the role play
 - questions about gender issues in the role play
 - to define which component of health care delivery system functioning is being illustrated
- Write the component of the health care system illustrated on the blank sheet of paper on the floor

- Ask whose responsibility it is to ensure that this component operates well
- Fill in the table
- Go on to the next role play
- Continue with this cycle for all seven role plays.

What to cover in the discussion

You will need to think on your feet, posing questions that will draw out the points we need to make about the functioning of the health care delivery system. Some examples are given below.

Role play 1: Provider-client relations

This role play is about an adolescent girl asking for contraceptives at a clinic, and the nurse's attitude to her. The role play usually ends with the nurse refusing to give the girl pills. The girl may be depicted as not challenging the decision, or as being assertive and demanding.

One gender issue that emerges from this role play concerns health providers' attitudes to appropriate sexual behaviour for girls. Girls are not expected to be sexually active in adolescence, and, even if they are, it is not seen to be appropriate for them to publicly acknowledge this by asking for contraception.

If it had been a boy asking for condoms, would the health provider have refused? Not likely. The same rules do not apply to boys and girls. It is important to show how health care delivery systems can reinforce prevailing gender norms. And it is worth developing this further to illustrate the public health consequences. For example, if girls feel they cannot use contraceptive services, providers lose an opportunity to offer them advice on barrier methods. This places girls at risk of sexually transmitted infections, including HIV, and of unwanted pregnancy. Negative attitudes on the part of service providers to providing contraceptive services for girls also represents an infringement of their reproductive and sexual rights.

Move the discussion on to what can be done to alter this situation. Some suggestions that have emerged from discussions like these have been: training to change attitudes, a better working atmosphere, and a performance appraisal system which includes provider attitudes and gender biases. These would be the responsibility of the health manager.

The discussion could also identify other attitudinal barriers that participants have encountered or are familiar with, and how these can be dealt with.

Role play 2: Technical competence

In this role play, because the nurse-aid who is standing in for the nursing-sister is not technically competent to handle the case of an infant with fever, she becomes rude to the mother.

Suggestions for change include planning to have multi-skilled people who can stand-in for each other, and not having vertical task-division; training personnel to handle difficult situations (such as the one depicted in the role play) with greater tact, training in inter-personal skills.

Would the same scenario have prevailed if the father had brought the child? The nurse-aid would still not have been able to provide appropriate care, but she may not have been rude.

It is also worth making the point that it is mothers who are expected to bring children to services, therefore when services cannot meet patients needs, it is usually women rather than men who bear the consequences. It is women who have wasted their time and money travelling to a service which cannot give her what she needs. Thus, because of gender norms, inadequate services impact differentially and detrimentally on women as compared to men. Improving the scope and quality of health care services, while not redressing gender inequality, will nonetheless improve women's lives.

In the discussion on how to improve the situation, participants often say that it is the management's responsibility to ensure that staff are appropriately allocated to clinics and that adequate training is provided to them.

Role play 3: Referral systems

The main issue in this role play is the breakdown of a referral chain for cervical cancer because the clerk in the referral centre does not answer the phone when health centres call in to make appointments for their patients.

The person who played the clerk explains her or his character to the group: The clerk has a very demanding job, of which answering the phone used to be a minor part. Following the policy decision to provide cervical cancer screening, the phone has not stopped ringing. The clerk is unable to cope, falling behind on the jobs she or he is expected to do routinely.

The issues that emerge relate to poor planning at a higher level, in not foreseeing the work load that would be generated by the new policy. Clear guidelines are needed about the roles and tasks of different staff members connected to this referral chain, and tasks redistributed if necessary. When a new policy is about to be implemented, its implications have to be discussed in a joint meeting of the staff members concerned – both those at the referral centre and at the health centres where screening is done. Clients using services should also have clear communications about what they are being screened for and what is to be done if they have a positive smear.

Gender issues around the patient's inability to find time for health care also surface in this discussion, and the implications of this for health services include being aware of women's time constraints and organizing the referral chain to take this into account (not repeated visits, once to collect the report, another time to fix an appointment with the referral centre, and so on).

Role play 4: Infrastructural requirements

In the health centre in this role play, there is no doctor on night duty. There is no ambulance and no phone, and so the lone midwife on duty has to instruct a woman in labour who arrives with heavy bleeding to make her own arrangements to go to the hospital 40km away.

The helplessness of the health provider emerges as an important issue for discussion from this role play. The community often blames and gets angry with the health provider. What are the solutions to this problem? How can such a situation be avoided?

Solutions suggested include:

- There should be a notice that at night time complicated deliveries cannot be handled at the clinic, and that women should go straight to the referral hospital.
- Danger signals in pregnancy, delivery and postpartum that require referral should form part of a public education campaign aimed at both women and men.

In the role play, the woman arrives by herself; driven by a man from her village, at her request. Where is the woman's partner?

- Men should be encouraged to take greater responsibility for women's reproductive health care. Health providers can counsel men on this, and health education campaigns can spread the message.

Encourage participants to share examples from their own experiences of where lack of infrastructure got in the way of effective health delivery. On some courses, lack of separate outpatient areas for men and women, lack of separate toilets, lack of child care facilities, lack of physical safety for clients and health providers (wherever clinics are located in remote areas) have been expressed as infrastructural constraints.

It is worth pointing out that it is frequently women who staff remote clinics and who are midwives and that it is a significant burden on providers in such a situation to deliver quality services. Further, health care for pregnant women is not the same as rare emergencies that may also require emergency transport. It is well known and predictable that a specific proportion of deliveries are likely to be complicated. Despite this, emergency transport for complications in delivery is not built into health care delivery systems. Point out that maternal mortality is high in poor countries specifically because emergency transport for women in labour is not routinely available. This is one example of the low value placed on women's lives.

Role play 5: Access

Many different kinds of barriers to access come up in the discussion following this role play. At the end of a very long morning, the provider is exhausted. A woman with a very sick baby has walked all morning to get to the health centre, and reaches it just before lunch break. She is very poor and badly dressed, and does not feel confident about going to the front of the queue to talk to the nurse about the urgency of the situation.

Besides distance as a barrier to access, there are many social barriers. Sometimes there are organizational barriers, for example when there are specific times when only pregnant women are seen, days when only immunization is done, and so on.

Better organization of services may improve access by reducing waiting time. Why was there a long queue even after midday in the clinic in this role play? There should perhaps be more staff in the mornings if there is usually a much larger crowd than in the

afternoons. Staff's duty rosters could be reworked according to users' needs and work loads at different times of the day or week, rather than following a rigid pattern in all health centres for all times of the year.

Gender questions include: why is it that the woman had no money to take a ride to the clinic? Why is it always women who bring sick children to the hospital, and usually by themselves?

Encourage participants to share other barriers to access that emerge from their own personal or work experiences. For example, absence of female staff, whether the staff are residing in the clinic, timings of the clinic, location, etc. The focus should be on barriers on the provider side, the user side having been discussed in Modules 2 and 3.

Role play 6: Organization of health services

This role play deals with the issue of the integration of services: a woman who has brought her child for immunization would also like to have her contraceptive injection, but she is told that this will not be possible.

Draw the links between the indicators that are used to measure if we are doing our jobs and the way clinics are organized. Because clinics have to report regularly on immunization coverage, the whole system is set up to meet this objective. Even if we define the job in narrow technical terms, i.e. to have a good immunization coverage rate, we still need to look at how services are scheduled, for example at whose convenience – the user's or the provider's. This is even more the case now that we are trying to provide comprehensive reproductive health services within a rights perspective. Integration of services helps meet client needs, is sensitive to their time constraints, and also makes for better health outcomes in an overall sense – improved reproductive health status – rather than achieving narrow technical targets such as high contraceptive prevalence rates or immunization rates.

There is scope for a detailed discussion on what constitutes integration. Is it one person providing multiple services, or many different services available under one roof? There can be no hard and fast rules. At health posts and clinics serving a small population, it may be unrealistic to employ several health workers, each providing a specific service. The health provider in such a setting should be able to deal with at least the bulk of problems and be able to refer the rest. In first referral units, it may make sense to provide many specialist services under one roof.

Role play 7: Supplies and equipment systems

In this role play the health centre has run out of antibiotics, so despite the medical officer's excellent diagnostic skills, she or he cannot help an infant with acute respiratory infection get appropriate services. This is a familiar story in many health centres, which results in frustration and demoralization for health providers who may have begun their careers with dedication and enthusiasm.

Issues to bring out here include how any one dysfunctional part of the service system undermines all other parts. For example, in this role play the doctor, while starting out excited about the new training and

trying to implement what she or he has learnt, may eventually give up and even be reluctant to go on another course because the skills are not implementable. Investment in training will be lost unless the total system is addressed.

The drug procurement, ordering and supply is not functioning in the health centre in this role play. It is likely to be the DMT which needs to see to this. Firstly, they need to have made sure the drugs are bought and budgeted for at the central or regional level. Sometimes, however, drugs are ordered but the ordering and supply systems are not operational. Sometimes it is not even the drug ordering and supply, but the fact that the truck to deliver the supplies is not working. The point to make is how the system as a whole needs to be addressed.

Other issues: payment of health providers

Alternative issues that are relevant in your location can be incorporated. For example, in many countries health workers find alternative ways of increasing their income. (See Session 5, “Health workers for change” where this is also dealt with.)

In China the issue came up in a role play as follows “A mother took her child to the hospital to see a doctor. The doctor said that the child needed an injection. The child did not like the idea of injection. And the mother also thought an injection was too expensive. So the mother asked the doctor whether some oral medicine could take the place of an injection. But the doctor disagreed, because an injection can make more money for the hospital. Finally, the mother had to buy an injection for her child.”

Again the facilitator can illustrate many issues – the power imbalance between health care providers and patients and how this may infringe on patients’ rights to make an informed choice. In the Chinese example, it is likely that alternative cheaper oral treatment is available and by refusing to give the mother this information the patient’s rights have been infringed. From a health systems point of view you may explore reasons for the health provider’s behaviour. Perhaps health care providers get very poor salaries or they work in an administrative system where salaries are not paid. Perhaps there is a poor supervision system where there is no monitoring of how services are provided. Again you would explore these and look at ways in which the system can be improved to try to prevent this kind of situation developing.

Other issues: accountability

Another issue that may be used as a theme for a role play is the accountability of the health care delivery system to poor women and men. In some developing countries, village and cluster health committees are being constituted to encourage the participation of women and men in planning and implementing health services. Community committees often have a majority of men, and are made up

of the more powerful groups in a community. In India, for example, poor women are yet to take part in these committees effectively. The committees are often used by health service providers to delegate responsibilities so that the providers' task is made easier, rather than for bottom-up planning or monitoring.



Step 4:
Pulling it all together



After you have completed all the role plays, invite everyone to sit down. Have an **overhead** prepared which illustrates the points on the wheel. Go through the list that you have been generating of the functions that are required and whose responsibility they are. As you go through each point on the circle the central role of good management will come out. Draw this in as spokes of a wheel. At the end you will have an illustration of the health care delivery system wheel, as in the diagram that follows.

Main points for closing this session

Pay attention to the generic systems issues

In order for health care delivery systems to function adequately, we need to focus our attention on the generic systems issues, such as drug supply, training and so on – the various points of the wheel that were developed in the role play

Good management is crucial

Good management, that builds health care provider capacity, competence and accountability, is essential and fundamental to adequately functioning health care services.

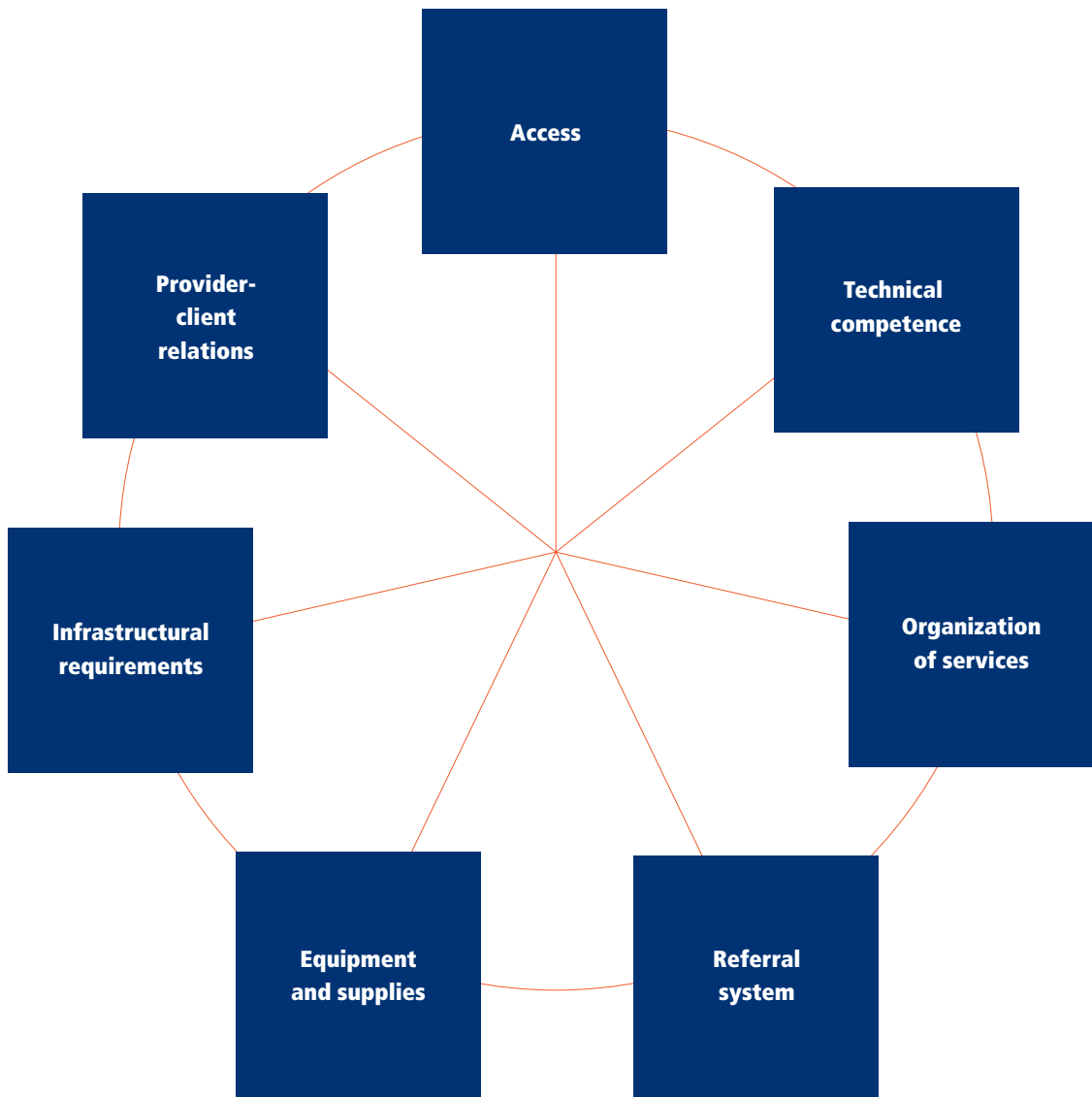
The gendered impact of poorly functioning delivery systems

Prescribed gender roles mean that when health care delivery systems function poorly, women in particular are negatively affected. Improving health care delivery systems will thus benefit women.

It is possible to increase women's autonomy and promote their reproductive and sexual rights within existing health services. Examples that come up in this activity include: encouraging men to take joint responsibility when women are in labour or for child care; and fostering women's control over their bodies by welcoming them at contraception services, irrespective of their age.

Session developed by Sharon Fonn

The health care delivery system wheel





Lecture
notes for
the
facilitator:

Description of role plays and questions for discussion

Here are the descriptions of the seven role plays and questions that you may ask to bring out gender issues.

Type out each role play so that each character is on a separate piece of paper. Put each character description in an envelope marked with the number of the role play (1–7), and the letter of the character (A, B, C). Character b from the role play on technical competence will, for example, be contained in an envelope marked “2b”. This will help each group of actors in a particular role play know who their group members are.

Role play 1: Provider-client relations

To set the scene before this role play begins you will say:

“Today is a busy day at the clinic. There is a long queue and it is also the day many people come for family planning.”

Character A

Today is a busy day at the clinic. There is a long queue and it is also the day many people come for family planning.

You are a teenager and you want to get contraception from the clinic. You know that you must rush as you can only go during break time at school. You are shy and scared about asking for what you want.

Character B

Today is a busy day at the clinic. There is a long queue and it is also the day many people come for family planning.

You are a nurse at the clinic. You have a child who is 14 years old and recently you realized she is pregnant. You are furious with her.

Questions to bring out gender issues in the discussion after the role play

- What if the teenager were a boy, would it be different?
- Who is responsible for preventing pregnancy, boys or girls?
- Is it acceptable for girls to have sex before marriage? Is it acceptable for boys to have sex before marriage? What does this mean in terms of how services are organized and in terms of trying to decrease teenage pregnancy?
- Is there any action that could be taken to promote women’s control over their own bodies?
- Is there any action that could be taken that would promote sharing the responsibility for contraception between men and women?

Role play 2: Technical competence

To set the scene before this role play begins you will say:

"We are in a clinic in a remote rural area. The clinic is usually staffed by a nurse's aid and a nursing sister. Today the nursing sister is off sick. The nurse's aid (point her out) is running the clinic. It is child health day.

Character A

We are in a clinic in a remote rural area. The clinic is usually staffed by a nurse's aid and a nursing sister. Today the nursing sister is off sick. The nurse's aid is running the clinic. It is child health day.

You are the nurse's aid. You have been working here for years and are used to the system. You usually help run all services with the sister. You do not have any diagnostic skills.

Character B

We are in a clinic in a remote rural area. It is child health day.

You are a mother and you know that your baby is not well. She has a temperature and although you have been giving her paracetamol for her fever, you know she is still not okay. She is always rubbing her ears and you want someone to examine her. The clinic is the only place you can go to, as there is no other health service delivery point. While it is far and you have many chores at home and other children and a household to care for, you decide to go to the clinic.

Questions to bring out gender issues in the discussion after the role play

- How could this situation be avoided?
- Who is responsible for making sure it is avoided?
- What are the consequences for the mother of her child not being examined?
- How may this impact on her time?
- What scenarios are likely to greet her at home when she returns?
- Would the same situation prevail if her husband had brought the child to the clinic? How might it be different?
- Would a father bring a child to the clinic?

Role play 3: Referral systems

To set the scene before this role play begins you will say:

“This is a clinic in a rural area. The clinic has begun screening for cervical cancer. Screening must be done at the clinic and patients need to be referred to the local hospital 15km away for treatment. Here is the nurse and the patient at the clinic (point them out), over here we have the clerk who works at the hospital (point him or her out).”

Character A

This is a clinic in a rural area. The clinic has begun screening for cervical cancer. Screening must be done at the clinic and patients need to be referred to the local hospital 15km away for treatment.

You are the nurse in the clinic and you know that you need to do pap smears on people who have a normal looking cervix. When you get back an abnormal result the person must be referred for a trained person to do a colposcopic examination and biopsy. You know it is very important for women to have the examination as you can prevent death from cervical cancer in this way. When women return to get their results you encourage those with abnormal results to go to the hospital even though it is far away and they must pay themselves for the transport. You always make appointments for them when the patient is with you by phoning the hospital. It is always a problem to get the hospital to make a booking because they often do not answer the phone.

A 45 year old woman has come back to the clinic to get her pap smear results. The results are abnormal and you try to convince her of the necessity of going to the hospital. You call the hospital to make an appointment for her.

Character B

This is a clinic in a rural area. The clinic has begun screening for cervical cancer. Screening must be done at the clinic and patients need to be referred to the local hospital 15km away for treatment.

You are a 45 year old woman and a mother of five children. You look after the children alone as your husband is away working in the city. You have little time to spare with all your responsibilities at home. You had a pap smear four weeks ago because the nurse insisted. You had not found the time to return for the results and anyway you were not ill. The home visitor came to find you at home to ask you to come to the clinic for the results. You come because you do not want to seem impolite to the home visitor and you do not want her to come again.

Character C

This is a clinic in a rural area. The clinic has begun screening for cervical cancer. Screening must be done at the clinic and patients need to be referred to the local hospital 15km away for treatment.

You are the hospital clerk. You do filing and your job also includes answering the phone to make bookings for clinic patients who have to be referred to the hospital. You have quite enough work to do without being

responsible for clinics as well. The hospital is very busy and anyway you are sick of it and you have decided that you will try to ignore the phone today as you have filing to get through and must respond to the patients who arrive to ask for directions in the hospital.

Questions to bring out gender issues in the discussion after the role play

- What would motivate the clerk to be more responsive to clinic staff needs? How could this be organized? Whose responsibility is this?
- Why does this patient find it difficult to take time off to look after her own health? What would make it easier for her? Who would need to be targeted in educational interventions to facilitate her being able to have time for her own health?
- If the patient were a male would the clerk have reacted the same way?
- If the patient were economically well off or had organizational or political clout, would the clerk have reacted the same way?

Role play 4: Infrastructural requirements

To set the scene before this role play begins you will say:

“It is night at the clinic. The night call nurse (point her out) is sitting in the clinic, available for emergency cases.”

Character A

It is night at the clinic. The night call nurse is sitting in the clinic, available for emergency cases.

You are the midwife on call for the clinic tonight. You are sitting in the clinic having some tea, thinking of going to bed as it is late. Night duty is always stressful. There is no one to talk to or to help if there is a problem. You have no phone in the clinic and the ambulance is located at the hospital 40km away on a bad road. It is worse now that it is the rainy season.

Character B

It is night at the clinic.

You are a pregnant woman who is having her third child. You have been in labour at home for six hours and now you see that you are bleeding. You are very scared and manage to get a man from the village to drive you to the clinic in his car. He is only helping you because you have begged him. He is concerned about the cost. You arrive at the clinic scared, in labour and bleeding.

Questions to bring out gender issues in the discussion after the role play

- What facilities are required in a clinic for them to be able to respond appropriately to this situation? What kind of systems would have to be in place to make this all happen? What could a manager do to make this happen?
- Under what circumstances would transport for women in labour be guaranteed? What would be required to make sure this always happened?

- What kind of action would promote women in this situation having more control over their own bodies and health?
- As it is both men and women who make and want babies, what kind of action would lead to men and women both having some responsibility for the healthy outcome of this pregnancy?

Role play 5: Access

To set the scene before this role play begins you will say:

“This is a busy clinic. It is almost lunch time and the queues are getting shorter at last. The nurse (point her out) is keen to take her lunch break and in the distance we see a patient (point her out) arriving hours after the clinic has opened.”

Character A

This is a busy clinic. It is almost lunch time and the queues are getting shorter at last.

You come from a very poor family. Your child is sick and has been for a few days. She has diarrhoea and you can see she is getting worse. You decide that things are very bad and you must get some help. You decide to walk to the clinic which is far from where you live. You cannot ask your husband for money. You begin early in the morning and get to the clinic at 12 noon. You are late as most people arrive at 8am. By the time you get there your child is hardly able to cry any more. You must join the queue. You wait for an opportunity to talk to the nurse who is busy with patients. Everyone in the queue is better dressed than you. You feel that everyone can see you are poor. You are a bit self conscious as you wonder how you look and how you smell after such a long walk in the heat with a sick child.

Character B

This is a busy clinic. It is almost lunch time and the queues are getting shorter at last. The nurse is keen to take her lunch break.

You are the nurse. You have been working all day and still the queue is long. You see people still arriving even at midday. You watch one woman come with a sick baby and sit in the queue. As you go for lunch break you walk past the woman with the sick child and stop to shake your head: “Why has she come so late?” But you can see how sick the child is. “Why”, you wonder to yourself, “did she not come earlier, and why did she not come to the front of the queue?”

Questions to bring out gender issues in the discussion after the role play

- Why would a woman not have money to pay for transport instead of walking?
- Why is it the woman who should bring a sick child to the clinic?
- What kind of action at health centres could be undertaken to promote the idea that both mothers and fathers are responsible for children’s health?

Role play 6: Organization of health services

To set the scene before this role play begins you will say:

“This is a clinic which provides a range of services and is organized to provide specific services on specific days. Today, it is child health in the morning, and people with chronic diseases like high blood pressure and TB come in the afternoon. The clinic does it this way to make for efficiency from the provider's point of view.”

Character A

This is a clinic which provides a range of services and is organized to provide specific services on specific days. Today, it is child health in the morning, and people with chronic diseases like high blood pressure and TB come in the afternoon. The clinic does it this way to make for efficiency from the provider's point of view.

You are the nursing sister at the clinic. It is a normal day at the clinic. Today is child health day in the morning and chronic care in the afternoon. These are always difficult days as the queues are long. You are trying to get through everything quickly. You have prepared the clinic for the two services that you are offering today and hope that you will manage.

Character B

This is a clinic which provides a range of services and is organized to provide specific services on specific days.

You are a mother and are bringing your child for immunization. You have a job and have had to take a day's leave. As you are a domestic worker you have to negotiate all leave days which is often a problem. You also want to get your contraceptive injection. You know it is due and you do not want to get pregnant. You are going to ask the nurse after she has immunized your child if you can please get your injection today.

Questions to bring out gender issues in the discussion after the role play

- The clinic has specific services on specific days. What does this mean for patients who want to get two services in a day? What does this tell you about the assumptions we have about women's time?

Role play 7: Supplies and equipment systems

To set the scene before this role play begins you will say:

“The medical officer in this clinic (point her or him out) has just been on a training programme on the treatment of the sick child. She or he is keen to implement what they learnt.”

Character A

The medical officer in this clinic has just been on a training programme on the treatment of the sick child. She or he is keen to implement what they learnt.

You are the medical officer. It was a great course and now you know to ask the mother the symptoms, how to examine the child, to look out for five important and common diseases of childhood (malaria, respiratory disease, dehydration, malnutrition, and measles). You examine the child by taking the temperature and listening to the chest and you are sure that the child has a respiratory infection. You tell the mother that because the child is breathing so fast and from what you found in the examination you know the child needs antibiotics. You explain this to the mother and you tell her to go to the clinic pharmacy to get the drugs and you give her a prescription.

Character B

Your child has been ill and you come to the clinic to get it checked. The child has a fever and is not eating and sleeping well. You are very worried.

Character C

You work at the clinic as the pharmacy technician. You take the prescriptions and give the drugs. You know that the pharmacy has run out of many drugs. A mother comes for antibiotics and you have run out. You tell her you have none and that there is nothing you can do about it. She can come back maybe next week when you may have some more in.

Questions to bring out gender issues in the discussion after the role play

- Is the training programme for treating the sick child successful?
- What makes it successful or not?
- What aspects of the health-services system are not functioning?
- What are the consequences of this? Are the consequences likely to be different for women and for men? In what ways?

SESSION

3

Incorporating social and gender dimensions in health programme planning

What participants should get out of the session

Participants will:

- be able to analyse a reproductive health problem for underlying causes
- develop skills in designing health systems interventions to address these
- apply gender tools to enhance the gender sensitivity of interventions.



3 hours

Materials

- Handout 1 “But why?”
- Handout 2 “Women and sexually transmitted infections”
- about 200 cardboard circles in 4 different colours, 50 in each colour
- 5 flip charts marked “A woman is infertile because of an untreated sexually transmitted infection” in its bottom left corner
- something to stick the circles on to the flip charts with, and blank flip charts
- overhead: “Do your interventions address gender and rights”, on p.418

How to run the session

This session starts with a small group activity in which participants explore a health problem (sexually transmitted infections) and develop potential interventions to address the barrier to an improved health outcome. They then evaluate these interventions for their gender sensitivity, and rework them. The second activity is a whole group discussion and consolidation of the major points by the facilitator. Note that this session builds on Module 2 Session 4 and Module 3 Session 6 specifically.



Activity 1: Exploring the problem of STDs

Step 1: Preparation

Do this step before you start the session.

Prepare cardboard circles, 6cm in diameter, in four different colours, about 10 of each colour for each group (40 circles per group).



Step 2: Instructions for the activity

Introduce the session, outlining the main objectives. Divide participants into groups of about six to eight members. Distribute Handout 1 with instructions for group work. Each group does the same exercise, which consists of three major tasks:

- analysing the reasons underlying a negative health outcome
- developing possible actions that will address these reasons
- evaluating these actions for gender sensitivity and rights impact (a simple way of assessing the rights impact might be to focus on discrimination).

Give participants five minutes to read through the handout and clarify any queries they may have.

You may choose to distribute an additional handout (Handout 2) on gender issues in sexually transmitted infections if your participants are not familiar with the issues concerned.

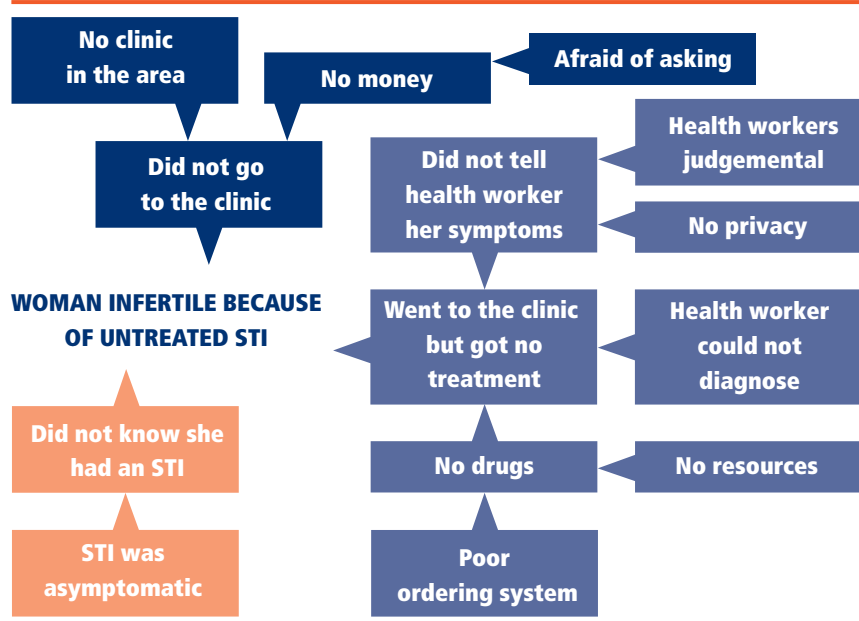


Step 3: "But why?"

Starting with the statement "A woman is infertile because of an untreated STI" written at the bottom left corner of a large sheet of paper, groups ask "But why?", write the reason out on a circle of coloured cardboard, and stick it next to the statement. Participants use the inputs from the Social Determinants and Rights Modules, and the first two Sessions of this Health Systems Module for their analysis.

They keep asking "But why?" until the line of argument is exhausted. Each reason has to flow directly from the one before, be written on a circle of the same colour, and clustered next to each other. Then participants begin again at the original statement and explore another reason why the woman did not get her STI treated.

Participants need to describe as many reasons as possible in as much detail as possible. Each circle should contain a single specific issue. For example, "culture" is not acceptable as a reason: the group must define what about the culture is the reason in this specific instance, for example that women are expected to have sex whenever their husbands want to.





Step 4: Actions After this has been done, the group then looks at the chain of events for each specific reason, and thinks of actions the health care delivery services system can implement to deal with or overcome this problem. To illustrate how the groups should attempt to develop responses, one line of argument and possible actions are presented below.

Developing possible actions that health services can take

Problem identified	Possible action by health services system
Too scared to tell health worker	Ensure privacy at the clinic.
Health worker judgmental	Run workshops with health workers, e.g. <i>Health workers for change</i> , which get health workers to look at their own behaviour and challenge victim blaming.
No drugs at clinic	Institute spot checks to make sure health workers behave in a professional manner.
Health workers could not diagnose STD	Institute a proper drug management system.
	Organize in-service training to ensure technical competence of staff.
	Develop treatment protocols.
Woman never knew she had an infection	Develop health education that includes signs and symptoms of common diseases.
Husband did not say he had an infection	Ensure both men and women are targeted with information, and stress the need to treat both partners and for partner notification.
No clinic nearby	Build new clinics so that people have access.
	Develop a transport system for people who live far away.



Activity 2: Making sure we have a gender and rights perspective



Step 1: Report-backs and discussion Each group in turn presents one reason and the chain of events. Ask questions after each presentation, challenging participants to clarify their line of reasoning, justify the actions they recommended and explain their feasibility and how these have a gender and rights perspective. Each report-back and related discussion should be done within 12 minutes or so, assuming there will be no more than five groups.

Experience with running this session shows that groups tend to develop actions related to health sector problems, like no drugs, no privacy, and health worker skills and attitudes. Problems related to gender, such as women not having money or being afraid to ask their husbands, are considered to be problems which the health system cannot do much about. Push participants to think through what can be done within health services so that women who are in such situations can access them: develop mobile services? have outreach workers or community volunteers? educate men?

You should plan on spending more of the discussion time on how gender and rights issues have been addressed. Services for women are often

assumed to address gender because they focus on women. Point out that this is not so, and that women's needs can be addressed without addressing gender issues (and, in fact, services for women can reinforce gender inequality) as maternal health services have tended to do for decades.

Go over each of these questions using an **overhead**.



Do your interventions address gender and rights?

- Do the interventions address gender issues? Has this been done from the users' as well as the providers' perspective?
- Do the interventions attempt to challenge existing gender and social relations?
- Have the potentially different impacts of this intervention on women and men (and on different groups of women and men) been considered?
- Have you ensured that any part of the intervention will not contribute to worsening the gender position of women (or of poor women in relation to those that are better off)?
- Could the interventions potentially violate any rights? Have you thought through the specific circumstances in which this could happen? For example, screening all women attending antenatal clinics for STIs.
- Do the interventions attempt to promote rights? Which rights do they promote?

Examples of interventions with gender implications include those requiring women to negotiate condom use, those requiring partner notification and so on. Partner notification also has rights implications. Elicit how participants plan to implement this without violating rights. Rights that may be upheld by the intervention include the right to information, access to public services, etc.

Step 2: Conclusion

In concluding, make explicit the ways in which this session draws on the Gender and Social Determinants Modules in the analysis of causes of the health problem, and the Gender and Rights Modules in examining the interventions from a gender and rights perspective.



10 mins

Main points for closing this session

Success depends on taking social and gender determinants into account

Planning health interventions calls for attention to more than the medical causes and technical details of a health problem. Social and gender determinants of health have to be specifically taken into account, and suitable actions planned to address these. If not, the interventions are unlikely to achieve their health objectives.

Analyse the gender and rights implications

It is not enough, when planning an intervention, to take into account the gender and rights related factors which cause a health problem. An analysis of the likely gender and rights implications of implementing the intervention is also needed. Interventions should never contribute to worsening gender or social equity or violate human rights.

Linking to the health systems wheel

Point out that the health systems intervention that people have come up with are similar to those that were illustrated in the health systems wheel exercise. This shows how the principles of addressing generic health issues can be applied to a specific reproductive health care problem like sexually transmitted infections.

Session developed by Sharon Fonn



Handout

1

But why?

You have been given a piece of paper with the statement “A woman is infertile because of an untreated sexually transmitted infection” written in the bottom left corner. You have also been given 40 cardboard circles, ten of each colour. You have 1 hour and 20 minutes in which to analyse the reasons underlying a negative health outcome – infertility resulting from an untreated STI – and develop possible actions that will address these reasons.



40 mins

Task 1: But why?

Starting with the statement “A woman is infertile because of an untreated STI” ask yourselves “But why?” and write the reason you come up with on a cardboard circle. Stick the cardboard circle next to the statement on the big piece of paper. Keep asking “But why?” until the line of argument is exhausted. Each reason has to flow directly from the one before, be written on a circle of the same colour as the first one, and be stuck directly next to the previous reason’s circle. Then begin again at the original statement and explore another reason why the woman did not get her STI treated using circles of a different colour. Each circle should contain a single specific issue. Do not use general terms such as “culture” as a reason; articulate which aspect of culture is causing the problem.

The figure below illustrates a series of reasons why for a different problem.





Task 2: Breaking the chain

After this has been done, analyse the chain of events for each reason to identify every point at which the chain can be broken by an appropriate intervention. Develop an action that can be carried out by the health care delivery system to deal with or overcome this problem. Write these up on a flip chart or an overhead transparency. Be as detailed and creative as possible.

One line of argument and possible actions are presented in the table below, as an illustration of what you should do.

Developing possible actions that health services can take

Problem identified	Possible action by health services system
Clinic will not see adolescents	Run workshops with health workers, e.g. <i>Health workers for change</i> , which get health workers to look at their own behaviour and challenge victim blaming. Institute spot checks to make sure health workers behave in a professional manner.
No clinic nearby	Build new clinics so that people have access. Make contraceptives available in schools and through community based distribution systems.



Task 3: Gender and rights

Look at the possible actions you have listed, and ask the following questions:

- Do the interventions address gender issues? Has this been done from the users' as well as the providers' perspective?
- Do the interventions attempt to challenge existing gender relations?
- Have the potentially different impacts of this intervention on women and men been considered?
- Have you ensured that any part of the intervention will not contribute to worsening the gender position of women (in relation to men)?
- Could the interventions potentially violate any rights? Have you thought through the specific circumstances in which this could happen? For example, screening all women who attend antenatal clinics for STIs.
- Do the interventions attempt to promote rights? Which rights do they promote?

Prepare a brief presentation of about 10 minutes for the big group.



Handout

2 Women and sexually transmitted infections

It is estimated that 340 million new cases of curable sexually transmitted infections occurred worldwide in 1999, of which 182 millions were among women aged 15–49 years. [1] Case numbers are distributed as follows, with many women having more than one disease:

syphilis	10.63 million
gonorrhoea	33.65 million
chlamydia	50.03 million
trichomoniasis	85.78 million

Biologically, women are more susceptible to most sexually transmitted infections than men. This is because of the shape of the vagina and a greater mucosal surface exposed to a greater quantity of pathogens during sexual intercourse since the quantity of seminal fluid is far greater than the vaginal fluid involved. Younger women are more susceptible because the cervix is still immature and they have a lower production of vaginal mucus, which means they have less of a barrier to infective agents. [2]

Poverty and lack of education and income earning opportunities often force women into commercial sex, which significantly increases their risk of infection. However, for the majority of women, high risk activity can simply mean being married. Social norms which accept extra-marital and pre-marital sexual relationships in men as normal, and women's lack of power to negotiate condom use and safe sex practices with their partners, are factors that make it difficult for women to protect themselves from sexually transmitted infections. [3]

The fact that it is the norm for young women to have sex with or marry older men also increases the risk of infection, because age and/or delayed marriage in men is associated with a higher likelihood of premarital sex with more than one partner, including with commercial sex workers, and hence a greater likelihood of infection. Violence involving sexual assault also carries the risk of sexually transmitted or HIV infection, in addition to its other problems. [3]

Not only are women at greater risk of infection, but also sexually transmitted infections in women are not easily identified or cured for a number of reasons. Over 50 per cent of sexually transmitted diseases in women are asymptomatic. Diagnosis is difficult and often requires running costly tests in sophisticated laboratories. Women's access to services is frequently poor, because management of sexually transmitted diseases is rarely provided as part of an integrated approach to women's health needs. [4] Even where facilities are available, the stigma associated with sexually transmitted infection is a major barrier to women seeking care.

This leads to complications that cause considerable morbidity and mortality and seriously impair the health of women, especially in developing countries for reasons mentioned above. For example, sexually transmitted infections cause pregnancy-related complications, sepsis, spontaneous abortions, premature births, stillbirths and congenital infections. Thirty-five per cent of cases of postpartum morbidity are attributable to sexually transmitted infections. Almost two-thirds of cases of infertility among women are attributable to sexually transmitted diseases. It is estimated that of all gynaecological admissions, 17–40 per cent are due to pelvic inflammatory diseases, mostly arising from sexually transmitted diseases. [4]

References

1. World Health Organization. *Global prevalence and incidence of selected curable sexually transmitted infections*. Geneva, WHO, 2001.
2. Howson CP, Harrison PF, Hotra D, Law M, eds. *In her lifetime. Female morbidity and mortality in Sub-Saharan Africa*. Washington D.C., National Academy Press, 1996.
3. World Health Organization. *Women of South-East Asia. A health profile*. New Delhi, WHO South-East Asia Regional Office, 2000.
4. United Nations Population Fund. *The state of world population 1997. The right to choose: reproductive rights and reproductive health*. New York, UNFPA, 1997.

SESSION

4

Prevalence data and costing considerations in service planning: Case: cervical cancer

What participants should get out of the session

Participants will:

- be acquainted with the principles of screening and their application to service development
- understand the relationship between disease prevalence and the cost of screening services
- see the linkages between the availability of resources and epidemiological information about a disease and decisions related to policy and services.



2 hours

Prior preparation

- Fill two opaque bags with marbles of two different colours. See Activity 2- Cervical cancer screening simulation, Step 1 on p.427 for detailed instructions

Materials

- Handout: "Cervical cancer screening simulation"
- overhead: "Criteria for choice of disease for screening", on p.426
- at least 315 marbles of one colour, and 85 marbles of a second colour, all of the same size
- two opaque bags (which you cannot see through) or pouches
- flip chart: "How to play the game", on p.427
- overhead with chart, on p.427
- overhead: data on age specific prevalence of cervical cancer, drawn from the cancer registry of a country from which the course has participants (example "Age specific prevalence of cervical cancer, South Africa (1994)", on p.429)
- overhead: "Reduction in the cumulative incidence of invasive cervical cancer over the age range 35–64 years, with different frequencies of screening", on p.429

Readings for the facilitator

1. Eddy D. Screening for cervical cancer. *Annals of Internal Medicine*, 1990, 113:214–225.
2. Fonn S. *Screening for cervical cancer: a unified national strategy*. Johannesburg, Women's Health Project, University of the Witwatersrand, 1993.
3. Miller AB. *Cervical cancer screening programmes – managerial guidelines*. Geneva, World Health Organization, 1992.
4. Miller AB et al. Report on consensus conference on cervical cancer screening and management. *International Journal of Cancer*, 2000, **86(3)**:440–447.
5. Sackett D. Laboratory screening: a critique. Federation Proceedings. *Clinical Laboratory Developments*, 1972, **34**:2157-61.
6. Stuart S et al. Demystifying and fighting cervical cancer. *Women's Health Journal*, 1992, **3**:29–52.

Readings for participants

Readings 4 and 6.

How to run the session

This session is a simulation exercise preceded and followed by an input. You will need to spend some time before the session putting together the materials. The simulation exercise takes place in the big group, with the facilitator taking participants through it step by step.



Activity 1: Input on screening

What to cover in your input

Screening is the presumptive identification, by simple tests, of unrecognized disorders in asymptomatic individuals. It is usually an expensive undertaking and it will only be affordable if good coverage is achieved. Explain that the activity in this session will help them see, through a simulation exercise, how the prevalence of cervical cancer influences the unit cost of a cervical cancer screening programme. Make a connection with inputs provided in the module on evidence where necessary.

Put up the table below as an **overhead**, and go over the points. Ensure everyone understands this.



Criteria for choice of disease for screening

Criterion	Reason
Common disease	Economically viable
Serious consequences if not treated	Reason for intervention
Long asymptomatic period	Time to treat
Facilities for diagnosis	Confirm screening result
Available effective treatment	Ethics
Disease of concern to the community	Consumer demand
Acceptable test	Increase utilization
Cost considerations	Ensure implementation

Source: Sackett DL. Laboratory screening: a critique. *Federation Proceedings, Clinical Laboratory Developments* 1972, **34**:2157–61.

Treatment

You should note that treatment for preinvasive disease in cervical cancer can be done using various options: surgery (cone biopsy); laser therapy; lletz - large loop excision of transformation zone using a diathermy; cryotherapy. Each of these methods attempt to remove the transformation zone of the cervix do not involve removing the uterus. Women require frequent follow up to ensure that their treatment worked and that their cervix remains normal.

Treatment for invasive disease requires that the woman is investigated and properly staged. In the early stages - stage 1 cancer and sometimes stage 2 - the usual treatment is a radical hysterectomy where the uterus and ovaries are removed. If the cancer has regressed further than this, and has spread into other organs, the treatment usually includes radiotherapy without removing the uterus.

In any form of cancer, palliative treatment should be offered, aimed at decreasing symptoms. Surgery to repair fistulae are often required in cervical disease. Treatment may include surgery and/or radiotherapy and/or chemotherapy. The most important component of palliative care is pain management, including giving morphine as required.



Activity 2: Cervical cancer screening simulation

Step 1: Preparation Prepare two bags of marbles. If marbles are not available or too expensive you can also fold up marked pieces of paper, or use coloured beans that are all of the same size. You will need:

- two kinds of marbles, many of one colour (X) and fewer of another colour (Y)
- two bags that one cannot see through.

In each bag put 200 marbles. In one of the bags put 25 marbles of colour Y and 175 of colour X. In the other bag, put 60 marbles of colour Y and 140 of colour X.

X denotes healthy (screen negative) people in the population, and Y denotes unhealthy (screen positive) people.

Prepare a flip chart with the following information:

How to play the game

- Cost of screening \$10
- Cost of treatment \$30

The aim of game is to find as many cases of disease as possible.

The winning group is the one that spends the least money.



Prepare an **overhead** with the following chart:

	Cases found		Cost of screening		Cost of screening and treatment		Cost per case detected		Cost per case detected and treated	
	Group 1	Group 2	Group 1	Group 2	Group 1	Group 2	Group 1	Group 2	Group 1	Group 2
Round 1										
Round 2										
Round 3										
Round 4										



Step 2: The screening

This step follows straight after Activity 1.

Divide the group into two. If you want to have even smaller groups have two (or more) groups with the 25/175 split and two (or more) groups with the 60/140 split. You will have to adapt the table accordingly.

Give each member of the group the handout “Screening simulation” with instructions for group work.

Explain to the groups that they are about to simulate screening a population, by drawing marbles out of the bag without looking into the bag. Each group draws out 100 marbles. They count the number of marbles of colour Y, and the number of marbles of colour X out of the 100 they have drawn. This represents the number of women with and without the disease, respectively. They then fill in the table in the handout.

They must repeat this process four times. At the end of each round the groups remove all the diseased cases (marbles of colour Y). These people now enter a treatment track and are no longer eligible for screening. All the negative cases (marbles of colour X), however, are returned to the bag as they may develop the disease between rounds and so are still eligible for screening.

To simulate people becoming positive between each round of screening, put three of the diseased cases (Y coloured marbles) back in the bag.



Put up the **overhead** of the table as groups start counting. Fill it in after each round, getting the groups to do the calculations. Use a pen of one colour for one group and a pen of another colour for the other group so that the contrast is clear. Do this until the participants have been through four rounds.



Step 3: Discussion

After the four rounds of counting are over and the table on the overhead has been completed, discuss with participants the differences and similarities that can be observed between the two groups, and between each round of screening.

What to cover in the discussion

- The first round of screening detects the greatest number of cases for both groups.
- The number of cases detected decreases with each round of screening, for both groups.
- If coverage were 100 per cent (i.e. they went through all the marbles in the bag and not just 100 each time) they would find all the cases on the first screen.
- Screening costs are constant but as less cases are picked up the cost per screening process (screening and treatment) increases.
- One group has a lower pick-up rate than the other. This is because of the lower prevalence rate of disease in this group.
- The lower the prevalence rate, the higher the costs of screening and treatment per case identified.



40 mins

Activity 3: Cervical cancer



20 mins

Step 1: Input

What to cover in the input

This is an input session on how the natural history of cervical cancer impacts on screening decisions. You may choose to talk briefly about what the various stages of cervical cancer are, from the early stage, CIN I (cervical intra-epithelial neoplasm), to micro invasive disease. (Use Reading 1 for basic information on cervical cancer.)



Overhead Prepare and present data on the age specific prevalence of cervical cancer, drawn from the cancer registry of a country from which the course has participants, like in the example below.

Age specific prevalence of cervical cancer, South Africa (1994)

Age group	Cases of cancer of the cervix	Total number of women	Women per case
0-19	13	6,886,182	529,706
20-24	77	1,818,478	23,617
25-29	116	1,619,920	13,965
30-34	236	1,508,410	6392
35-39	332	1,257,010	3786
40-44	339	1,035,646	2596
45-49	370	840,174	2271
50-54	375	703,047	1875
55-59	288	572,805	1989
60-64	350	456,593	1305
65+	614	1,081,752	1762

Source: Cancer Registry, South Africa, 1994



Overhead Present also the following evidence on the reduction in the cumulative incidence of invasive cervical cancer over the age range 35-64 years, with different frequencies of screening.

Reduction in the cumulative incidence of invasive cervical cancer over the age range 35-64 years, with different frequencies of screening

Frequency of screening	Percentage reduction in cumulative incidence	No. of tests per woman during the 35-64 year span
1 year	93	30
2 years	93	15
3 years	91	10
5 years	84	6
10 years	64	3

Source: Miller AB. *Cervical cancer screening programmes – managerial guidelines*. Geneva, World Health Organization, 1992.

Explain how the above data can be used for making policy decisions on the age group to be covered by a cervical cancer screening programme and the frequency of screening. For example, from the table above we know that if we started screening all women from age 45 onwards, we would need to screen between 2271 and 1762 women to identify one woman with the disease, assuming 100 per cent coverage. We can make calculations for different levels of coverage, and cost the intervention. Depending on the resources available, screening may be done once in 5 years or once in 10 years, or even once in a woman's life-time, but making efforts to cover every single woman aged 45 or older.



Step 2: Brain-storming interventions

In this last part of the session, brain-storm with participants the health systems interventions which would be required in order for a cervical cancer screening programme to be effective. Add in the points below as necessary.

Interventions needed for a cervical cancer screening programme include:

- educating service providers about cervical cancer and the logic of a programme (who to screen, how often and why)
- ensuring equipment and supplies are available, sterile and in working order
- setting up referral systems for treatment
- setting up a health information system to monitor coverage, follow-up of patients and patient referral
- some form of quality control
- recruiting enough women service providers (in some cultural settings this is a must)
- training service providers in technical skills
- training service providers in counselling skills
- ensuring privacy for patients
- education programmes to ensure the target population comes for screening (it is worth making the point that men too may need to be educated)
- carrying out screening exercises during a time/season convenient for poor women.

You may want to refer back to Session 2 and the health care delivery system wheel and highlight how many of the points made here were covered there.

Session developed by Sharon Fonn



Handout

1

Cervical cancer screening-simulation

You have been given a bag with marbles. You are going to simulate screening a population, by drawing marbles out of the bag without looking into the bag as you do it.

There are four rounds of “screening” (drawing marbles). In each round, your group has to draw out 100 marbles. Put aside marbles of colour Y as and when you find them, and keep marbles of colour X separate from these. When your group has finished drawing 100 marbles, count the number of marbles of colour Y; they represent the number of women with the disease. Fill in the table below as follows:

In the first column, **Cases found**, write the number of marbles of colour Y (say this is 12).

In the second column, **Cost of screening**, write \$1000, because you have screened 100 women at a cost of \$10 each (100 x \$10).

In the third column, **Cost of screening and treatment**, enter the figure you get when adding 1000 and (no. of cases detected x \$30). If the number of cases detected was 12, the number to write in this column would be $1000 + (30 \times 12) = 1000 + 360 = 1360$.

In the fourth column, **Cost per case detected**, write the answer you get when you divide 1000 (from column 2) by the number in column 1. In the example we have taken, this is $1000/12 = \$83.33$.

In the fifth column, **Cost per case detected and treated**, write the answer you get when you divide the figure in column 3 by the figure in column 1. In the example above, this is $1360/12 = 113.33$.

The facilitator will ask you to share your findings after each round.

Repeat this process four times. At the end of each round, remove all the diseased cases (marbles of colour Y). These people now enter a treatment track and are no longer eligible for screening. All the negative cases (marbles of colour X), however, are returned to the bag as they may develop the disease between rounds and so are still eligible for screening. To simulate people becoming positive between each round of screening, three of the diseased cases (Y coloured marbles) will be returned to the bag by the facilitator.

	Cases found	Cost of screening	Cost of screening and treatment	Cost per case detected	Cost per case detected and treated
Round 1					
Round 2					
Round 3					
Round 4					

SESSION 5 *Health workers for change: a health systems management tool*

What participants should get out of the session

Participants will:

- experienced a demonstration of a health services management tool
- explored the interpersonal (provider-client) aspect of quality of care within a health care delivery system framework and from a gender perspective.



1 hour and 45 minutes

Materials

- Each participant should be given a copy of the manual: Fonn S, Xaba M. *Health workers for change*. Johannesburg and Geneva, Women's Health Project and World Health Organization, 1995. It is available from WHO in Geneva.
or
- Handout: "*Health workers for change*. Workshops on obstacles to providing quality of care"

Readings for the facilitator

1. Fonn S, Xaba M. *Health workers for change*. Johannesburg and Geneva, Women's Health Project and World Health Organization, 1995.
2. Washington OO et al. The impact of health workers for change in seven settings: a useful management and health system development tool. *Health Policy and Planning*, 2001, supplement to **16**.
3. Vlassoff C and Fonn S. Health workers for change as a health systems management and development tool: conclusions and recommendations. *Health Policy and Planning*, 2001, supplement to **16**.

How to run the session

The session consists of two activities. The first demonstrates the health services management tool *Health workers for change* by running one workshop from it. The second is an input on the use of *Health workers for change* as a management tool. You will need at least one co-facilitator for the first activity, because the workshop is run for two groups at the same time.



45 mins

Activity 1: The demonstration

You will need an additional room for this session, so that you can run the workshop from the *Health workers for change* (HWFC) manual for two groups at the same time.

Divide participants into two groups. Ideally each group should have at least 10 members. Each group will work through an HWFC workshop. If you have access to *Health workers for change*, read the manual and choose one of the exercises that you think suits your local circumstance and then develop that workshop.

If you do not have access to the manual, you may use the workshop that we have reproduced in the handout.

You will note that the HWFC workshop guide (or the handout) explains how the workshop should be run and how to facilitate the discussion. You can follow this, and also make the links to the health care delivery system wheel introduced in Session 2. You and your co-facilitator should run the same workshop. Close the workshops after 45 minutes and bring everyone together for the input.



30 mins

Activity 2: Input on *Health workers for change*

In the big group provide an input on the *Health workers for change* workshops as a change management strategy to influence provider-client relationships. Use the summary below and the readings to prepare your input.

What to cover in your input

A response to one of the consequences of health sector reform

Health sector reform, underway in many developing countries, has resulted in cuts in health expenditure. At the same time, these reforms are supposed to address problems of poor quality of services and in improving access for poor people.

Health care provider morale is likely to be low in poorly resourced settings with low salaries, inadequate supplies and equipment, and so on. Yet reform requires personnel at all levels to embrace and implement new systems.

The *Health workers for change* manual, a health services management tool to improve quality of care, was developed with this situation in mind.

Addressing the interpersonal aspect of quality of care

Health workers for change (HWFC) began as an initiative to understand, from the health care provider's point of view, why provider-client relations are so often negative. The aim was to develop an intervention which improved the environment in which health care is delivered.

The HWFC intervention to address the interpersonal aspect of quality of care was developed through a series of research studies. These included studies with health care providers in rural South Africa, an acceptability study in four African countries, and an impact assessment study in seven primary health care sites in Africa and Argentina.

An opportunity to reflect on behaviour and attitudes

HWFC consists of six workshops. The methodology aims at "problem posing", presenting back to health workers their own conditions and asking them to reflect on these. Each activity leads into a discussion about provider-patient relations.

HWFC relies on participatory interactive learning methods to allow providers to reflect on their behaviour in a non-threatening space. It helps providers separate behaviour from intent, offering them an opportunity to think about behavioural and attitudinal change.

A social determinants perspective promotes changes in behaviour

The workshop methods also locate both the service user and provider within their respective social contexts. An attempt is also made to help service providers understand the various social, cultural and economic determinants of health. Such a framework is largely neglected in the training of health workers and in the way that services are offered. With a social determinants perspective on health problems, health workers are able to understand patient behaviour as a response to social circumstances rather than as ignorance or a refusal to comply with health workers' prescriptions. Providers become aware of their victim blaming behaviour, and methods such as role plays allow providers to develop empathy with patients. This promotes behavioural change.

The gender relations dimension

The HWFC workshops specifically address gender relations. This adds to providers' understanding of factors affecting health and health seeking behaviour in women and men. Awareness of issues such as control over decision making or resources, or even the right to have control over one's own body (for example, requiring permission to access services or access to money to utilize transport, or permission to use contraceptive technology), add an often previously unexplored dimension to the limitations many women face in relation to their health.

Ideas for action

The workshops culminate in the development of a prioritized list of practical actions that health workers themselves can initiate at the clinic level. This describes for district health managers what is required to build a district health system, and to earn the respect and trust of employees.

Real life results

Research on the impact of implementing HWFC in seven primary health care sites showed that:

- In five of the seven sites there was a decrease in the total time patients spent at the clinic.
- In four of the seven sites provider-client interactions improved. This was shown through more respectful interactions, better explanations of health conditions or drug regimens, prompt attention, greater availability of drugs, increased privacy, and not having to pay bribes.
- Facility level improvements included better team work, implementing changes identified during HWFC workshops, instituting clinic meetings to manage clinic activities, and staff taking the initiative to solve problems.
- At the system level some positive change was noted, including increased supervisory visits, greater involvement of facility level staff in budgeting, and improvements in facility functioning (improved drug ordering and management of facility controlled funds).

HWFC is a tested method of addressing the interpersonal aspect of quality of care. It illustrates that good management involves creating an environment in which staff are valued and feel they have a voice in decisions. If they are treated with respect they are much more likely to treat their clients with respect. Participatory management engenders responsiveness and communication, which are essential to good quality health care services.

Session developed by Sharon Fonn



Handout

1 Health workers for change. Workshops on obstacles to providing quality of care

Source: Fonn S, Xaba M. *Health workers for change*. Johannesburg and Geneva, Women's Health Project and World Health Organization, 1995:47-55.

Overcoming obstacles at work

Objective

To investigate the factors health workers identify in their work situations that affect their relationships with women clients.

Background

Health workers work within a health system and often have little decision-making power or control over their daily activities. Management in many systems is often slow or poor, and this causes understandable frustrations for health workers. Also, not receiving drugs or salaries are real problems.

In this workshop, we aim to discover, from the point of view of health workers, what problems they have at work and what things at work give them job satisfaction. We also want to define factors that are beyond their control, and those that are within their control to change. If we want health workers to treat patients with respect, then health workers need respect too.

Respect is something you have to get in order to have it for others. That is why we have said that this workshop series is best used in a situation where change is possible within the health service itself. However, there are things that can be done to make health workers more satisfied with their jobs even when there are no major changes in the health service.

Things needed	Timetable	
Pieces of paper, 10x10dm, 5 per participant and labelled 1 to 5	Explaining the exercise	10 minutes
1 pen per person	Working in small groups	20 minutes
5 sheets of newsprint and a felt-tipped pen	Totalling up	15 minutes
Something to stick paper on the walls	Discussing the results of the exercise	15 minutes
A small box, jar or hat		

Method

- Summary
- Introducing the objective
- Dividing into small groups
- Getting back into a large group to do group count using "Jinja paper technique"
- Running a group discussion

1. Introduce the session by saying:

“We are trying in this session to find out what problems health workers have at work. Often researchers ask patients what problems they have, but very seldom do they ask health workers. We would like to know what problems you have at work, and also how you think these problems affect your interactions with women patients.”

2. Divide into small groups.

We think it works well to divide into groups by category of health worker, as people in a similar position have similar problems. However, you can also divide the group randomly in groups of three to four people. Ask the groups to discuss the things at work that help or get in the way of their doing a good job. Walk around and assist the groups to generate this list. They do not have to write everything down. The purpose of the small group exercise is simply to get everyone thinking.

3. Get everyone back into a big group. Give each person five pieces of paper. One piece is labelled “1”, another “2” and so on up to “5”.



Ask everyone to write down five problems, one on each piece of paper. They should write their biggest problem on the paper labelled “5”. The second biggest problem goes on the paper labelled “4”, and so on. They should write their least important problem on the paper labelled “1”. They should not put their names on any of the pieces of paper.



Collect all the pieces. Put them into a jar or a hat or a box, and pull out one at a time. Ask for volunteers to keep the score of each category of problems. One by one call out each problem and say the number that has been given to the problem. The score keeper writes down the number value of the problem. So if "salaries" is one of the problems, one score keeper is given salaries as their category and writes down "salaries" on the top of the page, and "5" or "3" or whatever value the problem has. The score keeper repeats these steps each time "salaries" is called out. Another score keeper will keep track of the scores for all problems categorised under "equipment", another for "staff relations" and so on. Try to group problems appropriately. For example, "gloves" and "drugs" and "blankets" would all be grouped under "equipment".



After you have read out all the slips of paper, ask the people keeping score to total up the score for their subject. They should call out the scores to you, and you then write them in order of importance on a piece of newsprint.



Variation

To help those who cannot write, you will need to go to each individual and write the problems they name on the appropriate piece of paper. You need to be sure that the person can speak privately to you, so leave the room with the person if you have to. Remember that as the facilitator you must not show any value judgement in response to what people tell you. Simply show a neutral facial expression and write what they say!

4. Ask the group if they agree generally with the order in which the problems appear.

Again, this is not a detailed discussion but a place to start -the stimulus for a discussion. Going from the most important point to the least important point, ask the group to describe ways in which these problems affect their relationships with the women patients they see.

We developed and tested this idea as a group when we were together in Jinja, Uganda, as we were preparing to run the multicountry study in Africa. So we have called it the “Jinja paper technique”.

Summarize by going through what you have covered during the workshop, describe to the group the major points that came out of the session and make sure the group agrees with your summary.

Wrap up by linking this workshop to the next by referring to the **Workshop process diagram** and making the connections between the workshops clear.

Write up

Present the list that you developed with the group and give the cumulative scoring for each problem so that the ranking of each problem is clear. If, during the workshop you combined a few issues together under a general heading, then explain in the report what constituted that problem. For example you may have put: shortage of drugs, poor maintenance of equipment, broken scale under a heading 'inadequate resources'. You need to explain this in your report so that it is clear to a reader what resources are inadequate; otherwise they are unable to know how to respond to rectify the situation.

Experiences during prior workshops

This combination comes from all the countries we worked in:

- low salaries
- inadequate equipment and supplies
- heavy workload
- poor infrastructure
- bad relationship among staff in clinic
- no telephone

In the discussions about how these problems can affect the health worker-client relationship, these are some of the things we learned:

“When I am cross with the in-charge for telling me what to do all the time, then I don't take the patient a bedpan so I can get back at the in-charge.”

“If my salary is late, then it is my problem. When I get to work, it becomes the patient's problem. She must give me a little extra to see her. Sometimes I will not give enough drugs. I know she will not die, but she will also not get better properly, and must come again and pay again.”

One of the researchers using this method said,

“Somehow, by doing this, people opened up. They told me such amazing things, it is much better than other methods I have used to elicit information. ”

Solutions

Objective

To draw together what has been learned at the previous workshops, and to conclude by planning things that can be done at this health facility to improve quality of care.

Background

The point of this workshop series is to sensitize health workers to women's health needs, and to find out from health workers how they themselves

view their work. If the workshops have been successful there will be at least some changes, however small, that the health workers will want to make to improve things. The changes may be things health workers want for themselves, which will affect the way they relate to clients, or the changes may affect clients directly. We want to try and firm up these ideas in this workshop. Of course, some things are beyond the health workers' control, but other things are not. We will address them both. The motivation behind this workshop is to end with the health workers feeling that they have some definite course of action open to them. That given the will, they can change things themselves - that they have the power to do something.

Things needed	Timetable	
Materials for team-building game	Team-building game	30 minutes
Prepared summary list for all other workshops (see instructions in 'Method' below)	Summarizing findings from previous workshops	10 minutes
Sheets of newsprint	Break into groups to discuss solutions	45 minutes
Felt-tip pen	Joint discussion of solutions	15 minutes
Something to stick paper on the wall		

Method

Summary

- Playing a team-building game
- Going through the list you have prepared
- Running a group discussion to generate a list of possible things to do

To prepare for this workshop, you need to go through all the previous workshops and write down all the factors from each workshop that the health workers have identified as influencing, in any way, their interactions with clients. So from one workshop you could put "doing this job to support my family", plus all the other things that came up. From another workshop you could put "interpersonal conflict between staff", and so on. You will eventually have a full list of factors that have come up.

1. Begin with a team-building game (see Addendum).
2. Take your prepared list with you, but keep it as a prompt only for yourself. You then remind the group of the topic of each workshop (use the **Workshop process diagram**) and ask them to generate the list as they remember it. You can add from your prepared list anything that was not remembered by the group. When the group does not remember a point, you can say, "I went through my notes, and other things that came up were... Can I add these to our list?" Once you have compiled the list of factors, group them into common themes. You may put all work-related inefficiencies together and make another group of issues related to communication with clients. This will depend on what has come out of the previous workshops.

Variation

If you are running out of time you can take the list you have prepared and tell the participants “I went through all our previous workshops and have listed the issues that have come up, can I list them and you can add any I have forgotten? ” Then list the issues, you can write them onto the workshop’s process diagram with lines linking them to the workshops that they came from, as illustrated below.



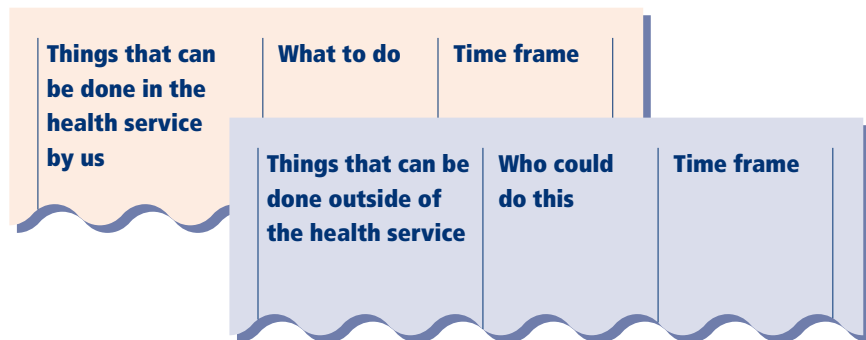
3. Divide the group into smaller groups and give each group a few of the issues. Ask them to discuss what interventions could be undertaken to rectify these issues. You can give each group some newsprint to write their ideas on. It is useful to have two sheets (see below). One with a heading “things that can be done at our health service level by us” and “things that can be done outside of this health service level.” Ask the groups to put time frames to the interventions that they would like to implement.

Summarize by going through what you have covered during the workshop, describe to the group the major points that came out of the session and make sure the group agrees with your summary. Go over the **Workshop process diagram** again and show the links between all the workshops with this last workshop. Discuss with the group how they will take this whole process forward and tell them what you are going to do. For example you may write a report or present your findings to the health service managers.

Thank everyone for their participation.

Write up

Here you need to list all the actions that the participants identified. Remember to include who they think it is should take action. Again, if you used the newsprint during the workshop, what is on it will form the basis of your report. In this workshop you have tried to get the participants to make real plans for change, so if they have made a time scale in which to take these actions, include this in your report.



Experiences during prior workshops

“On structural problems like drugs and supplies, accommodation, transport, water, electricity and refresher courses, health workers recommended that the government review the situation with the aim of improving the whole network of the health care system. Without those problems being addressed adequately and collectively, the plight of patients will worsen, and health workers' role as care providers will remain ineffective.”

“Health workers expressed that attitudinal change in themselves could happen if steps were taken to address their problems at work and alleviate their plight.”

“In spite of all the problems, health workers pointed out these problems are not devoid of solution. They suggested that for instance, in their training, the curriculum could be adjusted.”

Things that can be done in the health service	What to do
Staff shortage	Petition for more posts to be created. Help find people to fill the vacancies that do exist.
Poor support from management at hospital level	Develop a method of complaining and how to follow up when complaints are not dealt with. (In Uganda, one suggestion was to discuss the problem with the community clinic committee and get them to take it up.)
Conflict between staff at the clinic	Hold monthly meetings to discuss problems. Ask an NGO to run a conflict resolution workshop with us.
Patients don't seem to follow our advice	Ask for communication skills workshop.
Infertility, teenage sexuality, violence against women	Do in-service training on counselling skills.

SESSION

6

Service evaluation as a health management tool

What participants should get out of the session

Participants will:

- understand how the records of clinic organization and time use (staff and patients) can be used as a management tool to promote the provision of integrated services
- be exposed to experiments which have succeeded in improving access and quality of services within existing budgets
- appreciate the value of participatory research methods and management styles.



2 hours 45 minutes

Materials

- Handout 1: "The study design"
- Handout 2: "Pre-intervention data"
- Handout 3: "Actions"
- Handout 4: "Post-intervention data"

How to run the session

This session is drawn from a health system intervention conducted in South Africa (Tint KS, Fonn S, Ketlhpile M. *Time flow and work load study. Northern Province. Johannesburg, Women's Health Project, University of the Witwatersrand, 1999* (unpublished document)) and uses real data from one of the clinics. The activity consists of reading and discussions in small groups with inputs from the facilitator throughout. This happens in four steps. In each step the small groups read information from one handout, and then the facilitator engages them in a discussion. After the groups have read and discussed four handouts in this way, there is a concluding whole group discussion.

Activity: The case study



20 mins

Step 1: The study design

Divide the group into small groups of about five people. Introduce the activity and mention that the data in the handouts comes from a real study conducted by the Women's Health Project and is not hypothetical.

Give each participant a copy of Handout 1: "The study design". They have about 10 minutes to read it and discuss the questions.

Follow this up with a discussion in the big group based on the questions. (Participants stay seated in their small groups.)

What to cover in the discussion

Ask participants what they understand by the term "participatory", and what makes the intervention described in Handout 1 participatory.

They may identify the following features of a participatory intervention:

- health workers were involved in identifying the problem
- fully informed consent
- health workers were shown the results and asked to give feedback about whether the observations were accurate
- health workers participated in proposing solutions and interventions
- staff were involved in data collection and analysis. In other words (in the terminology of the Policy Module), they were involved in problem identification and in solution development.

In one instance, participants brought up the issue that clients were not involved, and remarked that the process may therefore not be considered to be fully participatory.

What are the strengths and the weaknesses of participatory interventions?

Strengths

- the commitment of health workers and their participation in making change happen may be counted upon
- there will be ownership of the results; the intervention is more likely to be sustained
- it will contribute to team-building.

Weaknesses

Participatory interventions take a great deal of time and effort.



30 mins

Step 2: Pre-intervention data

After this discussion, distribute Handout 2: "Pre-intervention data". Participants take about 15 minutes to read it and discuss the questions. As before, participants stay seated in their groups when they share answers to the questions in the big group, in response to specific questions from you.

What to cover in the discussion

Start with the frustration and resentment patients would feel because of the long waiting time, the unnecessary number of "provider stations", the short consulting times and the lack of privacy.

Then centre the discussion around the way staff time is spent on numerous unspecified tasks, while the number of patients seen per provider is quite low. This is likely to make providers feel that their time is being used inefficiently. They may feel stressed because of the long queues. Also, some staff members have less work, while others have too much to do. There may be many disgruntled staff members.

Close the discussion with suggestions for some interventions that the clinic staff may want to implement:

- Integrate services: could one staff member provide more than one service at the same provider station?
- Let one or two staff members go because of the low patient/staff ratio.
- Try to reduce time spent on unspecified activities.
- Do more community outreach work.



Step 3: Actions Distribute Handout 3 on the actions that clinic staff took. Groups read and discuss it in about 15 minutes. There is no big group discussion on this reading.



Step 4: Post-intervention data Distribute Handout 4 with post-intervention data and discussion questions. Groups take 20 minutes to read, and to discuss the questions. After this, groups stay seated as before. They share answers to the discussion questions in the big group, in response to specific questions from you.

What to cover in the discussion

General improvements

The first couple of discussion questions are straightforward. Things have improved, and indicators such as waiting time, utilization and direct-care time are some indicators which show this.

But what about women?

A gender critique of the interventions is more challenging. To begin with, data on utilization, direct-care time, waiting time in minutes, etc. have not been presented by sex, making it difficult to assess the overall gender impact of the interventions.

However, in so far as services were integrated, women are likely to have benefited. The provision of delivery services seems to have increased access to care for many women.

Perhaps the most obvious gender issue is time. In many countries women's time is seen as infinitely expandable, women have time to attend health services for their children even when these services are inefficient and involve long waiting times. Increasing service efficiency will benefit women (who disproportionately bear the burden of household reproductive work, caring for children, etc).

Meeting women's practical needs

Frequently within this module we have made the point that because women attend health services when they are healthy – for pregnancy and delivery related services, and for contraception - and because they are expected to be carers for the family, they suffer the consequences of

poorly functioning health care services more than men do. This is a gendered issue in society, as it relates to women's expected roles. Improving health care service functioning is a necessity for society as a whole. The benefits, however, will go some way towards meeting women's needs. This approach tries to recognize inequality in society. While it does not challenge gender norms it does take them into account. It thus meets women's practical needs.

Main points for closing this session

Ownership encourages action

Clinic staff were involved in the data analysis themselves. This gave them ownership of the findings and they are more likely to take action as a result. This is one of the driving principles of participatory methods.

Hard facts

Discussions in the clinic on organization were based on data and not on individual perceptions or feelings. Objective evidence was put forward. The data were not linked to any individual. People had to back up their opinions with data.

Data were presented dispassionately with no victim blaming. This is a way of being respectful and people are more open to listening.

In situations where gender differences persist in the work loads of male and female staff, this is a way of raising awareness on this issue in a non-threatening manner.

Finding solutions builds skills and confidence

Staff were left to develop their own solutions. This builds problem solving skills and gives people an outlet for some creativity. It can lead to a more fulfilling job. This method builds capacity. People are left with skills to apply to other problems.

Staff often gain confidence. If they are supported and allowed to innovate they can apply some of the skills learnt through this exercise to other areas of their work.

An alternative to top-down methods

For a manager or a planner, this kind of method – using data for decision making, letting people analyse their own situation and develop their own solutions – is a good option. It is a viable alternative to top-down methods of working.

Raising awareness of the impact on women

This method can be used to raise awareness on how women are disproportionately affected by inefficiencies in the delivery of health care services.

Session developed by Khin San Tint and Sharon Fonn



Handout

1

The study design

This case study presents the strategies used for facilitating the process of providing comprehensive reproductive health services integrated into primary health care services in South Africa.

Integrated services

The term “integrated services” refers to a situation where a multi-purpose provider can provide a range of services to a user during one visit. Thus a person could come and get a contraceptive method, ask a question about some other symptom, like coughing at night, and have a child immunized in one visit. Integrated services are thought to increase service access to women and vulnerable groups as all health needs can be met in a single visit. It also provides an opportunity for offering an additional service to an individual. For example a woman who has brought her child for immunization, once in a consulting room with a provider can also be asked if she has any personal health problems, needs contraception, is having any symptoms of disease ranging from TB to reproductive tract infections, as appropriate. This cuts down on missed opportunities for care.

Health providers believe that integrated services require additional staff

The Department of Health in South Africa is developing district based comprehensive primary care services. Thus the policy environment is conducive to this kind of intervention. However in most clinics it is not the current reality. There are many reasons why health providers believe that more staff members have to be recruited to implement integrated services. Their notion of integration is providing all basic services such as family planning, antenatal care, child health services, treatment for minor ailments and chronic diseases, no matter how these services are organized and when they are provided.

The intervention

1. Clinic staff and patients were fully informed of the proposed data collection and agreement was given to proceed.
2. Data was collected on how long patients spent waiting for and receiving care and the primary reason for their visit.
3. Staff were observed and how they spent their time was noted and classified as:
 - direct care (face-to-face with patients)
 - indirect care (performing tasks that are required in order to deliver services, e.g. ordering drugs, filling in clinic statistics, etc.)
 - break time (official breaks, e.g. lunch, tea)

- unspecified activities (not doing any productive work during working hours, e.g. talking to friends, sitting around, etc).
4. It was noted how the clinic was organized, what rooms were used for what, what equipment and facilities were available, how patients moved from one space to another, if patients knew where to go to get what they needed, and so on.
 5. All data was analysed on site and the method of analysis and results were discussed with staff.
 6. Staff looked at the data and gave input on whether it was accurate or not and reasons for why things operated as they did.
 7. Staff were reminded that services were supposed to render comprehensive integrated care, meaning all services must be available every day, provided by one provider in one room. A lot of discussion and clarification on the meaning of “integrated” took place as well as on the reason it was being promoted as a good system of providing care.
 8. Using the data collected, staff identified what worked well and what improvements could be made.
 9. Staff identified interventions that they wanted to implement and listed what was required in order for this to occur.
 10. It was agreed that staff would try to implement some changes with management support.
 11. The research team left and it was agreed that they would return in six to eight months to repeat data collection to see if there were any changes.

Questions

- This intervention is described as being participatory. What elements make it participatory?
- What do you think are the strengths and weaknesses of participatory interventions?



Handout

2

Pre-intervention data

Here are some of the data from the pre-intervention study.

Clinic organization

- The clinics still rendered vertical services; specific services were available at different times of the day, rendered by different staff in different rooms, although they were all under one roof.
- More than 90 per cent of the patients received a single service only.
- This indicated that the meaning of integrated services was not understood.

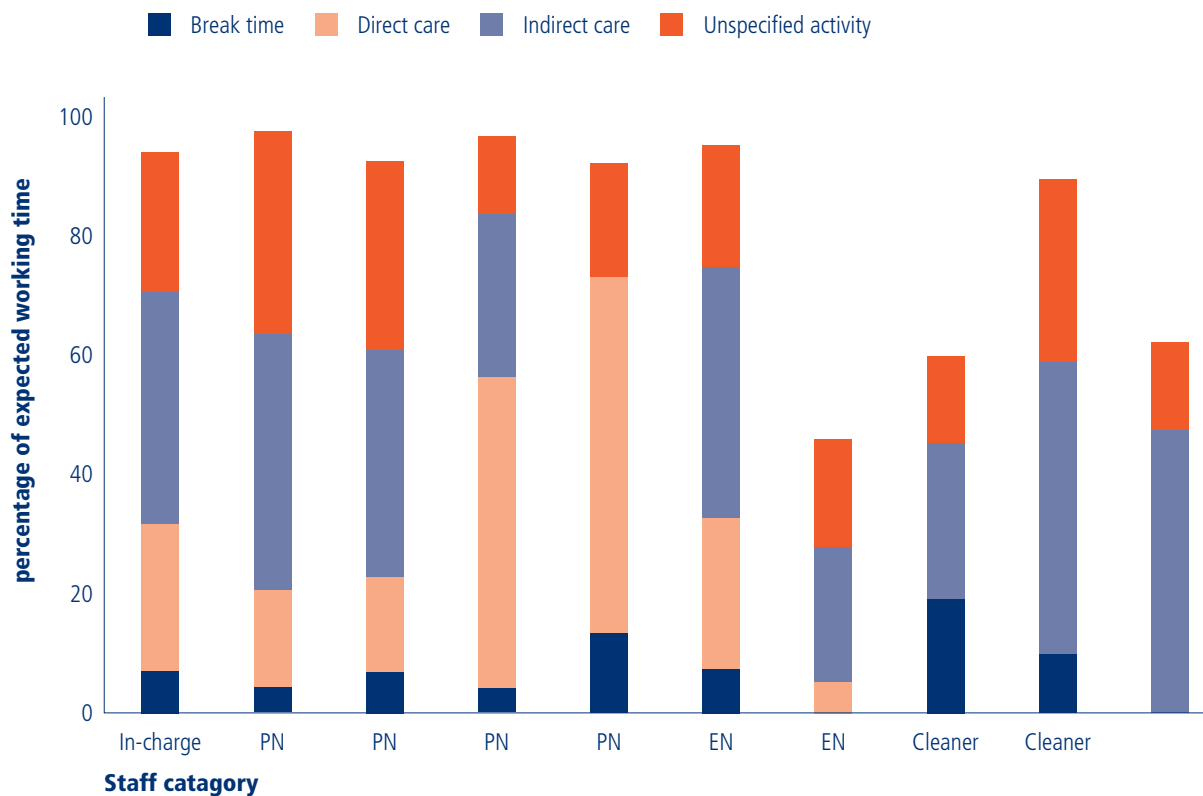
Examples of the impact of this type of organization

- A mother with a child coming to a clinic to get family planning for herself and immunization for her child spent the whole day in the clinic to get both services. She waited in the child health queue in the morning to get her child seen to. Then she waited until the afternoon family planning queuing began to get her own needs met.
- In the afternoon family planning sessions, young girls were all packed in one room and one provider injected one girl after another with Depo Provera while they were standing in a circle. There was no privacy, no discussion of problems and no choices of contraceptives were offered.
- Antenatal care was run by an appointments system on a specific day of the a week. A woman coming for antenatal care was palpated in one room, her vital signs checked in another, and she received her tetanus toxoid injection in another, being seen by many different providers in this process.

How clinic staff spent their time

The following table shows how staff spent their time. In-charge is the professional nurse in charge of the clinic. PN stands for professional nurse; this is a person trained in doing general care, diagnosis and treatment, antenatal delivery and post care. EN stands for enrolled nurse. This person has less training but can weigh children, often takes the vital signs (temperature and blood pressure, etc.), can immunize children, dress wounds, etc. Under supervision they can do additional tasks.

Individual staff time by activity in Western region (before intervention)



Additional information on staff time and work load

- Total daily attendance for 13 August 1998 was 155 patients
- The average daily attendance is 73 patients (based on previous three months' data)
- The number of staff is 19 (9 PN, 5 EN, 2 cleaners, 3 security guards)
- The ratio of staff to patients is, on average, 7 nurses for a total of 73 patients, which comes to 1:11 (the norm for the country is 1:30).
- The actual working time of all staff in the clinic as a percentage of the expected working hours is 80%
- The proportion of productive time of all staff is 48.1%
- The proportion of unproductive time of all staff is 51.9%
- The proportion of staff time used for direct patient care is 18.9%
- The proportion of staff time used for indirect patient care is 29.2%
- The proportion of staff time used for unspecified activities is 51.9%

Data on patient time

Cases found	Average waiting time in minutes	Average time for receiving care in minutes
family planning	20	3
immunization of child	38	4
dressing	20	7
antenatal care	74	10
minor ailments	35	5

Questions

- If you were a patient coming to this clinic, how do you think you would feel (use the data to back up what you are saying) and what would you want to change?
- If you were a nurse working at this clinic, what would you be thinking (use the data to back up what you are saying) and what would you want to change?
- List interventions that the clinic staff may want to implement.
- In your situation, are there male and female health care providers? If so, is work distributed among them equally? If not, can you describe who does which work and discuss why you think this is the case?



Handout

3 Actions

This handout describes how clinic staff responded to the results of the pre-intervention study. In discussion with all the staff, these are some of the issues that were clarified.

Patient time

Staff agreed that patients seemed to spend a very long time waiting. They said that long waiting times arose chiefly because all patients arrive early in the morning. By noon almost 70 per cent of the daily patients had received care and left. This has a two-fold effect. The clinic is overcrowded, uncomfortable in itself and the large volume of patients make staff feel stressed. However a breakdown of how staff spend their time – how much time they have free during a total day – suggests that staff are under stress rather than overworked. Staff said they contributed to this by waiting until all patients had arrived so that there could be a communal prayer before the clinic work began.

Staff time

Staff agreed that they spent a lot of time on indirect care: there were at least three different register books to fill in for each patient and this takes up a lot of time. For a number of months prior to the pre-intervention study there was no water in the clinic. As a result maternal delivery services and thus night duty were stopped. The duty roster had changed and everyone worked day shifts.

While staff said they provided integrated services they agreed that in fact they did not. They gave many reasons for this including:

- they had not used some skills for a long time – while they were trained to do everything they were used to providing only one service and they lacked confidence and skills in the others
- there were not enough blood pressure machines to have one in each consultation room so they only had one consultation room open
- they did not have enough cooler boxes to keep immunization vials in each room.

Some of the decisions that staff took

- Ask management to restore the water supply with immediate effect.
- Organize training for providing integrated services. Ways of doing on-the-job training were discussed. Clinic staff will use their different training backgrounds and share their multidisciplinary knowledge among themselves.
- The clinic will reorganize and reallocate staff for providing integrated services.

- Clinic staff will open more cubicles or rooms (two rooms for the time being) for all kinds of services. They can also be for a combination of services according to the demands of the community.
- Reorganize the clinic record keeping system.
- Revitalise the clinic committee.
- The clinic nurse in-charge will develop a mechanism for the screening of emergency patients to attend to first. This will be part of one of the on-the-job training initiatives, which will include training of the EN to identify the critical signs and to know when to inform the senior staff for immediate action.
- It was agreed that praying was a personal thing and that people could do it as they liked; it did not have to be a communal activity.
- A first come, first served system was started so that everyone knew who would go next except for very ill patients who would be seen first.
- A fast queue system was introduced and an EN would hand out pre-packed repeat medicines (e.g. for TB, hypertension, etc.) to people who did not want to see a nurse but came only for medicines.

Questions

- Are any of the actions on this list similar to ones that your group came up with?
- What do you imagine the costs of these interventions were? Affordable, or too expensive?
- Do you think any of these interventions will benefit women and men who use the clinic? Will it benefit women and men differently?



Handout

4

Post-intervention data

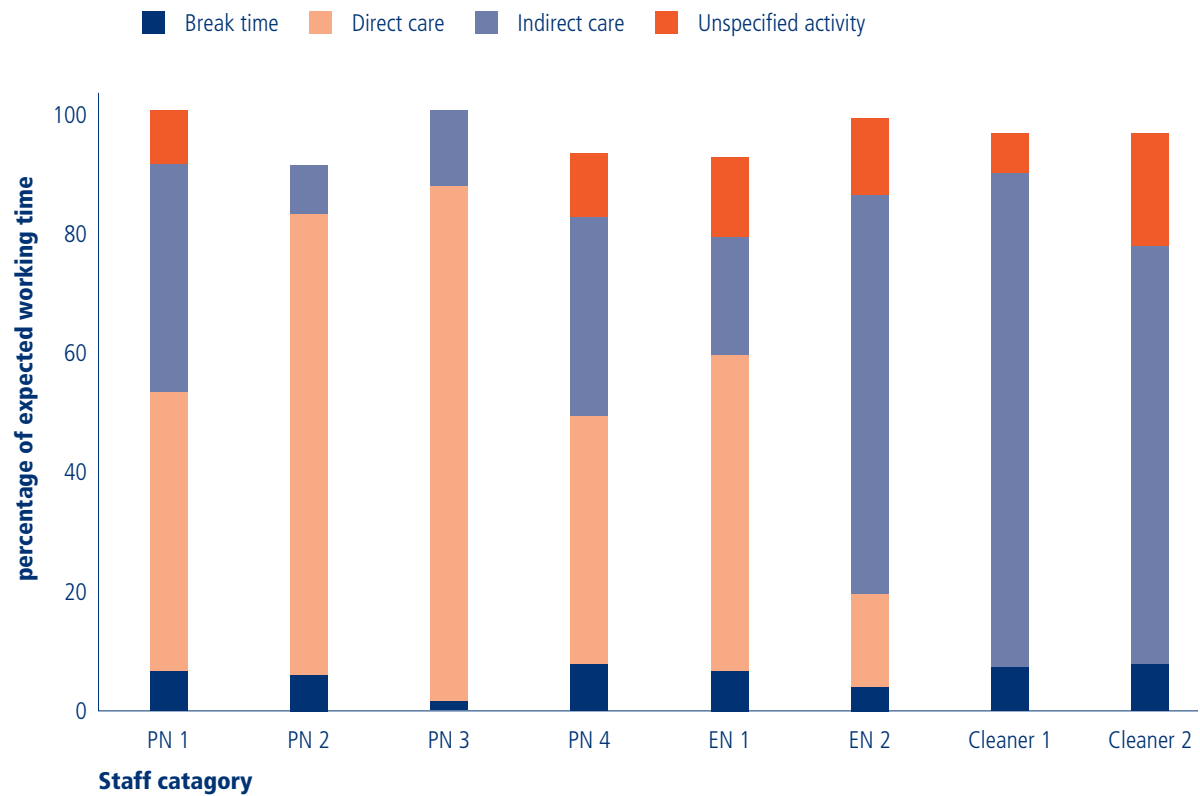
The post-intervention study revealed that:

- The clinic provided integrated services.
- The total attendance had increased to 200, indicating improved clinic utilization.
- The staff efficiency improved according to the following observations: increased proportion of staff time for direct patient care and decreased proportion of staff time for unspecified activities; the average number of patients attended per day by each staff member increased from 18 to 23.
- The average patient waiting time decreased generally for all services.
- The average patient time for receiving care from a clinic nurse increased.
- The clinic organization had changed with the opening of three consultation rooms for examinations, consultations and prescribing medicine.
- The clinic provided a 24 hour service and maternity services. The average number of deliveries per month was 35.
- The clinic was cleaned and staff looked confident and the clinic functioned smoothly. The overall impression was that this was normal and routine.
- The clinic had developed effective and practical systems for functioning well. There was a system for providing a child immunization service every day; a first come, first served queue system was introduced. Other actions included: the integration of chronic patient services; a system of recording the daily workload; and staff meetings for decision making.

Data on patient time

Service	Average waiting time in minutes	Average time for receiving care in minutes
immunization	14	4
antenatal	7	10
minor ailments	24	9
chronic	12	6
TB/DOTS	14	20
dressing	1	3
family planning	11	4
more than one service	14	4

Individual staff time by activity at clinic in the Western region (after intervention)



Questions

- Look at this data and decide if things have improved or not.
- List the indicators that make you think things have improved.
- Critique the actions taken and the data in the handout from a gender perspective. Do you think any of these interventions will benefit women and men who use the clinic? Will it benefit women and men differently?

SESSION

7

Application exercise: developing an intervention to improve quality of care

What participants should get out of the session

Participants will:

Participants will have applied the tools and concepts learned in this module to develop solutions to a health problem in their own work environments.



2 hours and 30 minutes

Materials

- Handout: “Application exercise in developing an intervention to improve quality of care”

Prior preparation

Before the session begins, give participants instructions as described in Activity 1, Step 1 below.

How to run the session

In this session, participants complete an assignment outside class hours. When they submit their work, you (and perhaps your co-facilitator) will need about a day or an afternoon and an evening to mark the assignments and write comments for feedback. You return the assignments and give feedback on the following day.

Activity 1: The assignment

2 hours and time outside class hours



Step 1: Preparation

After the end of Session 6, schedule 10–15 minutes for giving participants instructions for doing their application exercises and distribute the handout.

Give participants some examples of topics they may choose for this individual assignment, and emphasize that they have to

choose something they have encountered in their work and would like to see changed. Encourage them to choose real rather than hypothetical problems.

Examples of quality of care problems chosen for the application exercise

- Long waiting time for ambulance from hospital for referring complicated deliveries; reason was poor interpersonal relationship between clinic and hospital staff.
- Poor quality of care in maternity unit; high rate of infection in C-sections.
- Under-utilization of clinic services in five health centres; community members complain that there have been times when pregnant women were attended in delivery by relatives and not health centre staff.
- Lack of collaboration among NGOs, donors and different sectors within health department, resulting in the absence of a national reproductive health policy.
- Poor coverage of youth in an NGO's Newsletter readership
- Delay in the distribution of an NGO's IEC materials, resulting in accumulation of stock and material becoming dated before distribution.



Step 2: Beginning the assignment

Schedule 1 hour and 45 minutes of class time for participants to begin the exercise. This is usually scheduled for the last few hours of a working day, so that participants have the evening to complete the task. They have to submit the assignment the next morning.

Step 3: Assessment

Read all the assignments carefully and rank these as 'average', 'above average' and 'good'. In courses that are formally graded (See Introduction p.1), you may have to mark the assignments. Enlist the help of a colleague or co-facilitator who has taught in this module, so that grading is completed within a day.

Criteria for assessment

An intervention planned by a participant is considered to be good when all of the following criteria are met:

- data/indicators which described poor quality were explicitly linked to the intervention
- expected changes in indicators which would describe an improvement in quality were listed
- a system to monitor these particular indicators was described
- the gender and rights implications of the intervention were discussed in detail, and appropriately.

The intervention plan is considered average if it reflects that the person knows what she or he is doing, but has written up their ideas vaguely, with too many generalizations. The actions to improve service quality were not clearly spelt out, there was not enough detail, or it was not specific enough.

If the intervention plan gives sufficient information on the links between the problem and the actions to address these problems, but has not presented outcome indicators and systems for ongoing monitoring, then it gets a higher than average assessment.

As you go through the assignments, make notes for feedback, with special reference to common errors and misconceptions, and the extent to which a gender and rights framework has been applied. Set aside assignments which are especially well done in one or more aspects to share with the class.



Activity 2: Feedback

What to cover in the discussion

Some examples of the feedback you might give

- Use assignments which satisfied all the criteria of a good assignment as illustrations.
- Discuss assignments which had potential but did not satisfy all the criteria and show how they could have been developed further.
- When the problem was not appropriately chosen, or indicators were not valid – they did not measure what they were supposed to measure – discuss this in detail.

In one assignment, "the number of transfers to hospital was too high" was chosen as a measure of poor quality. In the discussion it was pointed out that the initial description of the problem "too many transfers" was not appropriate. Providers in more distant services, where fewer options for dealing with emergencies exist (in this case, being able to do a caesarean section), had to cope with a highly stressful situation. The purpose of referral in these circumstances was to avoid complications, and some degree of over-referral was to be expected and is acceptable. The problem needed to be redefined: it was not the number of referrals, but their potential inappropriateness. Being clear about what the problem is makes it easier to develop an appropriate intervention.

- Discuss the gender and rights dimensions of some of the interventions to reinforce this once again. We want to internalize it so that it gets routinely applied.

Criticize the work not the person

When giving feedback, do not be critical of the person but only of their work. Always give examples of what could have been done differently rather than just a critique. The manner in which feedback is given should build confidence and contribute to capacity-building; it should not be disempowering.

Revisit the objective

Conclude the session by going over the objectives in the Module brief. Make it clear to the participants that mainstreaming gender in health programming is what this module has been about. Gender mainstreaming is not a separate process. It has to be built into the process of identifying problems and solutions and implementing these solutions on a day-to-day basis. It is a world view, an approach that should inform every aspect of a health care delivery system on an ongoing basis.

Session developed by Sharon Fonn



Handout

1 Application exercise in developing an intervention to improve quality of care

You need to plan an intervention to improve the quality of care of a particular health care service that is delivered in your setting.

1. Choose an area in your day-to-day work where you think quality is an issue.
2. Explain why you think that quality is a problem in this specific area. For example: what data do you have that allows you to come to this conclusion? Or, if you have no data, on what basis have you decided, or what indicators are you using, to decide that quality is a problem?
3. Plan and describe an intervention to improve the situation. Outline SMART (Specific, Measurable, Achievable, Replicable and Time-bound) objectives for the intervention package and specific actions that will help meet these objectives. Explain in detail what will be done, by whom, with whom, over what period of time.
4. Give one outcome indicator and one process indicator to monitor the intervention.
5. What systems will you put in place to ensure that improved quality will be maintained?
6. Discuss how you have addressed the underlying gender issues in developing the intervention, and what the potential gender and rights implications/ impact of your intervention may be.

Your assignment should be no more than 5–6 typed pages (1.5 line spacing) long. There is no minimum length, except that all the above questions have to be addressed.

Example of a SMART objective and related actions and indicators

A SMART objective for a contraceptive services programme is:

- to increase by 50 per cent, by the end of one year, the proportion of male condom users served by the clinic.

A set of actions specifically to help meet these objectives, depending on what the underlying causes for low condom use are, would be:

- campaigns and training workshops to influence attitudes to condom use and to demonstrate correct use, starting with young adolescents
- improving the quality of condoms available

- setting up condom distribution points that would ensure easy access and privacy.

An outcome indicator to assess the objective is:

- number of condom users among male users of the clinic above age 15 years / total number of male users of the clinic of age 15 and above.

This indicator has to be measured at the beginning and end of one year, to assess if the increase over this period is 50 per cent or more.

A process indicator to assess the objective could be:

- number of trainees covered by workshops during the year, who have a positive attitude to condom use and know how to use them correctly.