NATIONAL OPEN UNIVERSITY OF NIGERIA

FACULTY OF HEALTH SCIENCES

DEPARTMENT OF PUBLIC HEALTH

COURSE CODE: PHS 812

COURSE TITLE: GLOBAL HEALTH

COURSE GUIDE

PHS 812
GLOBAL HEALTH

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INTRODUCTION

This course, *PHS 812 Global Health*, is a two-credit unit course. There is a recent quest for knowledge on global health challenges among which are many emerging and re-emerging communicable diseases; not to mention the alarming increase in the mortality arising from non-communicable diseases such as cancer, stroke, motor accidents and injuries. All these necessitate the expansion of knowledge in Global Health; a course that will address the factors contributing to the health of individuals and communities. Global health was described by Koplan et al. (2009) as "an area for training, study, research, and practice that places a priority on improving health and achieving equity and equality in health for all people worldwide". Global health emphasizes "transnational health issues, determinants, and solutions; it involves many disciplines within and beyond the health sciences and promotes interdisciplinary collaboration, and is a synthesis of population-based prevention with individual-level clinical care" Koplan et al. (2009). This description emphasizes the multidisciplinary nature of the course. The course will combine different teaching methods: lectures, self-study, assessment and a practicum. This course guide, therefore, tells you what to expect from studying this course material.

WHAT YOU WILL LEARN IN THIS COURSE

The Global health course will expose you to an overview of various issues, such as:

- globalization and health
- global burden of disease
- challenges in healthcare delivery
- social determinants of health
- healthcare financing
- leadership and management in global health
- global health and diseases including gender issues, and
- monitoring and evaluation of health services.

COURSE AIM

The aim of this course is to provide a good understanding of global health for sound management and administration of healthcare services.

COURSE OBJECTIVES

After going through this course, you should be able to:

- define and describe the concept of global health

- describe the social determinants of health
- describe the challenges of healthcare financing across countries
- explain the concept of financial management
- describe the effect of politics and policies on global health
- use case studies to describe the effect of climate change on the spread of diseases
- describe how to address global health disparities
- describe health-related targets and sustainable development
- illustrate the concepts of health services monitoring and evaluation

WORKING THROUGH THIS COURSE

In preparing this course, several thematic concepts were considered to ensure that students with basic knowledge of global health are able to understand the contents. Nevertheless, the listed textbooks and references will provide additional learning support to the students.

COURSE MATERIALS

This course comprises five modules subdivided into study units. Each of the units was arranged into:

i. A course guide

ii. Study units

STUDY MODULES

- globalization and health
- global burden of disease
- challenges in healthcare delivery
- social determinants of health
- healthcare financing
- leadership and management in global health
- global health and diseases including gender issues, and
- monitoring and evaluation of health services.

Five study modules are broken down into 23 Units. The Units comprised of in each of the study modules are listed below:

Module 5 Health Services Monitoring and Evaluation

Unit 1: Introduction to quality management for monitoring and evaluation

Unit 2: Programme monitoring and evaluation methods

Unit 3: Health systems strengthening

Unit 4: Global health in Nigeria; practicum

Module 1

In Unit 1, you will learn about the fundamentals of global health. The unit also discusses the health indicators and explains the burden of disease. In Unit 2, you will be taken through the social determinants of health. In Unit 3, you will be introduced to global healthcare delivery. In Unit 4, you will learn about the essential skills needed in global health, while, in Unit 5, you will learn about the major interdisciplinary topics in global health.

Module 2

In Unit 1, you will be introduced to health economics, its economic evaluation and types of economic evaluation. In Unit 2, you will learn about financial management and control. Unit 3 introduces you to the financing and delivery of healthcare services in developing countries. In Unit 4, you will learn about economic demography and global health, while, in Unit 5, you will learn about the importance of health policy and economics.

Module 3

In Unit 1, you will be taken through the various health services administration. In Unit 2, you will be introduced to a global perspective of the health sector reform. Unit 3 introduces you to leadership and management in global health. In Unit 4, you will learn about the importance of global health politics and policy, while, in Unit 5, you will learn about the political economy of global health.

Module 4

In Unit 1, you will be taken through case studies in tropical diseases, beginning with learning about what tropical diseases are while in Unit 2, you will be introduced to gender and health, in the context of global health and diseases. In Unit 3, you will learn about climate change, social justice, and health, while, in Unit 4, you will learn how to address global health disparities.

Module 5

In Unit 1, you will be taken through basic concepts in M&E as well as quality management for M&E. In Unit 2, you will be introduced to thematic monitoring and evaluation methods. In unit 3, you will be introduced to the challenges of health systems and how they can be strengthened. Finally, in Unit 4, you will be introduced to the practicum in Global Health in Nigeria and how it will be graded.

TEXTBOOKS AND REFERENCES

The following are a list of textbooks, journals and website addresses that can be consulted for further reading:

Birn, Anne-Emanuelle, Pilley, Yogan, and Holtz, Timothy H. (2017). *Textbook of Global Health*, Fourth Edition, Oxford University Press, New York ISBN: 9780199392285, 712pp

Cornelis van Mosseveld, Patricia Hernández-Pe˜na, Daniel Arán, Veneta Cherilova, Awad Mataria (2016). How to ensure quality of health accounts. *Journal of Health Policy* 120 (2016) 544–551

Jacobsen, Kathryn H. (2018). *Introduction to Global Health*, Third Edition; Jones & Bartlett Learning, ISBN-13: 9781284123890, 450pp. http://www.jblearning.com/catalog/9781284123890/

Koplan, J. P., Bond, T. C., Merson, M. H., Reddy, K. S., Rodriguez, M. H., Sewankambo, N. K., & Wasserheit, J. N. (2009). Towards a common definition of global health. *The Lancet*, *373*(9679): 1993-1995. DOI: 10.1016/S0140-6736 (09) 60332-9

http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(09)60332-9/fulltext

Kristen Jogerst, Brian Callender, Virginia Adams, Jessica Evert, Elise Fields, Thomas Hall, Jody Olsen, Virginia Rowthorn, Sharon Rudy, Jiabin Shen, Lisa Simon, Herica Torres, Anvar Velji, and Lynda L. Wilson (2015). Identifying Interprofessional Global Health Competencies for 21st-Century Health Professionals. *Annals of Global Health*, 81(2): 239 -247.

The United Nations 2030 Agenda: 17 Sustainable Development Goals to Transform Our World. http://afa.at/globalview/2015-2.pdf

World health statistics 2017: *Monitoring Health for the Sustainable Development Goals*. Geneva: World Health Organization; 2017. License: CC BY-NC-SA 3.0 IGO.

WHO (2007). Everybody business: strengthening health systems to improve health outcomes: WHO's framework for action. http://www.who.int/healthsystems/strategy/everybodys_business.pdf (Accessed Dec. 2017)

ASSESSMENT

There are two components of the assessment for this course. They are the tutor-marked assignment and the final examination.

TUTOR-MARKED ASSIGNMENT

The Tutor-Marked Assignment (TMA) is the continuous assessment component of the course. It accounts for 30 per cent of the total score. The TMAs will be given to you by your facilitator, and you will return it after you have done the assignment.

FINAL EXAMINATION AND GRADING

The examination concludes the assessment for the course. It constitutes 70 per cent of the whole course. You will be informed of the time of the examination.

SUMMARY

This course intends to provide you with knowledge about the factors contributing to the health of individuals and communities. It is our hope that the materials will be of immense benefit to you all.

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MAIN COURSE

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MODULE 1: CONCEPTS IN GLOBALIZATION AND HEALTH

UNIT 1 FUNDAMENTALS OF GLOBAL HEALTH

CONTENTS

1.0 INTRODUCTION

Globalization has aided improved healthcare in the 21st Century, but it has also ushered in new challenges, and new ways economically disadvantaged people can be exploited. Globalization is instrumental in shaping legal rules, ethical rules, policies and guidelines which affect health. Furthermore, research has linked globalization to disease proliferation, with an emphasis on global health governance being instrumental in promoting the best global practice in public health. In this unit, you will learn about the relationship between globalization and health as well as health indicators and the burden of disease. Also, at the end of this unit, you should have a good understanding of the concept of mixed-method approaches to the conduct of research and ethics governing the conduct of research in global health.

2.0 OBJECTIVES

At the end of this unit, you will be able to:

- Explain the effects of globalization on health governance
- Define health governance and global health governance
- Discuss the importance of health indicators, list their groups with examples
- Define mixed-method approaches and discuss design methods it utilizes
- Discuss elements of ethics as it relates to global health research

3.0 MAIN CONTENT

3.1 Global Health Governance

The interrelationships among globalization, disease and global health governance cannot be overemphasized. In order to provide a clear understanding of the concept of global health governance, the term "health governance" has to be appropriately defined. Health governance refers to strategies through which the health of a population is promoted and protected, and it can exist at the local, national, regional, international or global levels. Globalization has four major effects on health governance:

1. Increased globalization has brought about, or aggravated, transborder human health risks, the origin and impact of which transcend national borders
2. A unique effect of globalization on health governance is the steady increase in the number, and influence of, non-state actors
3. Globalization, in its current form, more often than not, worsens existing environmental, political and socio-economic problems.
4. Globalization is partly responsible for the decrease in the ability of national governments to deal with challenges related to global health

According to literature, *Global Health Governance* (GHG) can be defined as strategies through which local, national and international public and private entities strive to manage,

regulate and mitigate disease on a global scale. In this regard, the need for global health governance arises due to the fact that health determinants are increasingly being destabilized by globalizing forces, not within the scope of the health sector. Some of these forces include climate or environmental change, criminal activities and conflict, as well as investment and trade. Therefore, to ensure human health is given a higher priority in public health policies, GHG has increasingly garnered popularity as a vital concept in international debates. According to research, there is a relationship between global health and the global system of disease; one which has not been adequately addressed. By and large, the global system of disease is often characterized by health indicators and disease burden.

3.2 Health Indicators and Burden of Disease

In general, health indicators can be defined as directly or indirectly measurable health phenomena related to individuals or members of a defined population at the local, sub-regional, regional, continental or global scale, which can be used to report and expantiate upon the quality and quantity of their health over time. According to literature, global health indicators which measure health phenomena, directly and indirectly, can also be referred to as proximal and distal indicators, respectively. The World Health Organization (WHO) grouped health indicators into four major groups, each of which belongs to the communicable or non-communicable diseases subdomain. The four health indicators groups are those relating to; health status, risk factors, service coverage and health systems. Figure 1.1 to 1.4 provide more subdomains information of these groups.

Figure 1.1: Health status indicators (World Health Organization, 2015)

Figure 1.2: Risk factors indicators (World Health Organization, 2015)

Figure 1.3: Service coverage indicators (World Health Organization, 2015)

Figure 1.4: Health systems indicators (World Health Organization, 2015)

In a research to determine the deadliest infectious disease over the last 25 years, it was discovered that as of 2015, lower respiratory infection (pneumonia) was the most fatal disease, causing over 700 thousand child deaths in 2015. It was further reported that diarrheal diseases, malaria, HIV/AIDS and measles, were the four other leading cause of child deaths in that same year. However, while it is important to note that the deaths caused by these diseases are on a steady decline, Deloitte reported that by 2020, the three leading causes of death (cardiovascular diseases, cancer and respiratory diseases) will account for about 50 percent of the global healthcare expenditure, with an aging population which is projected to see an eight percent increase. They further stated that an estimate of 36.9 million people is currently affected by HIV/AIDS, and about 70 percent of them reside in Sub-Sahara Africa.

Apart from health indicators, health can also be measured in terms of the incidence, prevalence, occurrence, disease burden. The proportion of the population that has a disease at a point in time (prevalence) and the rate of occurrence of new disease during a period of time (incidence) are closely related. The ubiquitous way through which the burden of disease can be measured is by estimating the years 'lost' as a result of poor health. This loss is referred to as "Disability Adjusted Life Years (DALYs)", and is the addition of years of "potential life lost as a result of premature mortality and the years of productive life lost due to disability". Therefore, methods of global health research leading to accurate estimations of DALYs is important, as DALYs are really useful in determining life expectancy. This is due to the fact that it considers the global distribution of diseases and associated harm estimates. Ideally, one DALY can be equated to one year of 'healthy' life lost to one or more diseases.

3.3 Mixed-Method Approaches in Global Health Research

In the past, public health has followed a predominantly quantitative, epidemiological approach to mapping out health problems and determining their impact with regards to geographical location, time and characteristics of the individual, in addition to determining

the root causes of these health problems, perhaps through the problem tree analysis, as one of the analytical tools. However, since the 20th Century, the qualitative approach has been adopted in order to better understand the social phenomenon that predicts human behaviour. In this regard, the qualitative approach seeks to cultivate a more in-depth understanding of the root causes of human behaviour or decision making through research structured around in-depth interviews, key informant interviews, focus group discussions, case studies, unstructured interviews and ethnographic observation of behaviour patterns and possible modifiers. Nowadays, the quantitative approach which is based on deductive logic is usually combined with the qualitative approach which is based on inductive logic, to reach realistic conclusions; since reality cannot be fully expressed by a single approach. The mixed-method approach to global health research, therefore, refers to a holistic approach, or a mash-up between qualitative and quantitative methods, which draws on the strengths of both approaches in order to provide answers to complex research questions. Mixed-methods utilize various study designs, based on the type of research questions, and this can be:

- An exploratory, or explanatory sequential mixed-method research. Here, results achieved by the use of one tool, from either the quantitative or qualitative approach, are used as input to further explore the determinants or explain the root causes of findings or observations made in the study population.
- A convergent or concurrent mixed-method research. Here, from the onset of the research, quantitative and qualitative approaches are selected to propose an answer to the posed research question
- Embedded mixed-method research. Here, quantitative and qualitative approaches are nested one in the other, in order to provide new research insights
- A multi-phase mixed-method research. Here, one quantitative, qualitative or mixed-method research is conducted independently and is designed in such a way that each independent research approach is a build-up on a previous approach, in order to design and test a health prevention measure

When it comes to research, however, it is important to be able to distinguish what is right from what is wrong, and this is where ethics comes in.

3.4 Ethics in Global Health Research

Ethics, in general, seeks to determine why an action is right or wrong while ethics in global health research seeks to apply ethical principles to health and its related disciplines. Research ethics govern the standards of conduct for scientific researchers. It is important to adhere to ethical principles in order to protect the dignity, rights and welfare of research participants. As such, all research involving human beings should be reviewed by an ethics committee to ensure that the appropriate ethical standards are being upheld. Discussion of the ethical principles of beneficence, justice and autonomy are central to ethical review.

There are various theories of ethics which help to tackle the problem of delineating right from wrong, and these theories can further be divided into consequentialist and non-consequentialist theories. Consequentialism dictates that only the result of any action can determine if it is right or wrong. Two prominent examples of the consequentialist theory are utilitarianism and egoism.

- Utilitarianism is a concept in which an action is deemed right if the greatest number of people reap the highest benefit from its outcome.
- Egoism is on the other side of the utilitarianism spectrum and is individual-centric in that it deems an action to be right if it results in the greatest good for the most important person

On the other hand, non-consequentialism puts forward the idea that the consequences of a decision are not the most important, in reality. One of the most important non-consequentialist theories is Kantian ethics which deems that even though the consequences

of an action may be good, the action itself might be wrong. Kantian ethics proposes that individuals be “treated as ends, and not means to an end”.

4.0 Conclusion

In this unit, it has been explained that globalization affects health governance through increased transborder health risks, a steady increase in the number and influence of non-state actors, worsening of existing environmental, political and socio-economic problems as well as being partly responsible for national governments inability to appropriately deal with those challenges related to global health.

Furthermore, we learnt that global health governance is a set of defined strategies through which local, national and international public and private entities strive to manage, regulate and mitigate disease on a global scale. Also, we learnt that health indicators can be grouped into; health status, risk factors, service coverage and health systems domains.

In addition, we learnt that mixed-method approaches to global health research is a mash-up between qualitative and quantitative methods to global health research, and draws on the strength of both approaches in order to provide answers to complex research questions. We learnt that mixed-methods utilize design methods based on sequential, convergent or concurrent, embedded and multi-phase mixed-method research.

Lastly, we learnt about ethics and delineating right from wrong using the consequentialist and non-consequentialist theories of ethics. Here, we talked about utilitarianism, egoism and Kantian ethics.

5.0 Summary

In this unit, we learnt that:

- globalization affects health governance by increasing transborder health risks, number and influence of non-state actors, worsening existing problems and being partly responsible for the government's inability to deal with global health challenges
- global health governance is a set of defined strategies through which local, national and international public and private entities strive to manage, regulate and mitigate disease on a global scale
- mixed-method approaches to global health research is a mash-up between quantitative and qualitative approaches to global health research
- Consequentialist and non-consequentialist theories of ethics are used to delineate right from wrong

6.0 Tutor-Marked Assignment

1. Give a concise definition of health governance and global health governance
2. List and discuss the various ways through which globalization affect health governance.
3. Define health indicators, list the groups they can be divided into and give two main examples from each group
4. Define mixed-method approaches to global health research and discuss all the design methods it uses
5. How would you define ethics in global health research? Please give the theories of ethics and consider one example under each category.

7.0 References/Further reading

Definition of Wellness (2017), "Health Indicator", available at http://definitionofwellness.com/wellness-dictionary/health-indicator/.

Deloitte (2017), *Global health care sector outlook*.

Dodgson, R., Lee, K., Drager, N. and Organization, W.H. (2002), "Global health governance. A conceptual review".

Harris, D.M. (2011), Ethics in health services and policy: A global approach, J-B public health/health services text, Vol. 43, Jossey-Bass, San Francisco.

Kaur, M. (2016), "Application of Mixed Method Approach in Public Health Research", *Indian journal of community medicine official publication of Indian Association of Preventive & Social Medicine*, Vol. 41 No. 2, pp. 93–97.

Kay, A. and Williams, O.D. (2009), *Global health governance: Crisis, institutions and political economy*, *International political economy series*, Palgrave Macmillan, Basingstoke.

Labonté, R. (2015), "Globalization and Health", in Wright, J.D. (Ed.), *International encyclopedia of the social & behavioral sciences*, 2. ed., Elsevier, Amsterdam, pp. 198–205.

Larson, C. and Mercer, A. (2004), "Global health indicators. An overview", *CMAJ Canadian Medical Association journal = journal de l'Association medicale canadienne*, Vol. 171 No. 10, pp. 1199–1200.

Ortiz-Ospina, E. and Roser, M. (2017), "Global Health", available at: https://ourworldindata.org/health-meta/.

World Health Organization (2015), *Global Reference List of 100 Core Health Indicators*.

UNIT 2 SOCIAL DETERMINANTS OF HEALTH

CONTENTS

1.0 INTRODUCTION

In the last unit, we learnt about health governance and global health governance; and discussed how globalization affects health governance. In addition, mixed-method approaches can be used in global health research, while ethics govern the delineation of right and wrong from the protection of the public health perspective. In this unit, we shall examine the social determinants of health. Also, we will learn how the social determinants of health are grouped and what determinants are considered in each group.

2.0 OBJECTIVES

At the end of this unit, you will be able to:

- define social determinants of health
- list the five social determinants of health groups and their sub-divisions

3.0 MAIN CONTENT

3.1 Framework of Social Determinants of Health

Almost everyone is impacted by the social determinants of health, and as such, this makes them very important. Social determinants of health are the “conditions in the environments

in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks". Furthermore, using a "place-based" framework, Social Determinants of Health (SDOH) can be divided into five major parts, and these are presented in Figure 5. Sub-divisions of these five parts are presented in Table 1.

Figure 1.5: Social determinants of health (Healthy People, 2017)

Table 1.1: Social determinants of health and their sub-divisions (Healthy People, 2017; Heiman and Artiga, 2015)

S/N	Social determinants of health (SDOH)	Sub-division
1	Economic stability	• Employment • Income • Debt • Support • Poverty
2	Education	• Early childhood education and development • Enrolment in higher education • Vocational training • Language and literacy
3	Social and community context	• Civic participation • Discrimination • Engagement in the community • Social connection
4	Neighbourhood and built environment	• Access to foods that support healthy eating patterns • Safety • Environmental conditions • Quality of housing • Transportation
5	Health and healthcare	• Access to healthcare • Access to primary care • Health literacy • Quality of healthcare

Health impact assessments are increasingly being carried out to address the social determinants of health as well as strategies which seek to close health gaps and provide health services to more people.

4.0 Conclusion

Health is greatly affected by the existing conditions of an area, and these conditions, referred to as social determinants of health (SDOH), contribute to the quality-of-life outcomes, functioning and overall health of people in an area. The SDOH can be divided into five broad groups, consisting of; economic stability, education, social and community context, neighbourhood and built environment as well as health and healthcare. In addition, careful assessment of SDOH is used to close health gaps and provide health services to more people. Considering all these, the importance of social determinants to the overall health cannot be overstated.

5.0 Tutor-Marked Assignment

1. Define the social determinants of health.
2. List the major divisions of social determinants of health and give two examples from each group.

6.0 References/Further reading

Healthy People (2017), "Social Determinants of Health", available at: https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health (accessed 30 November 2017).

Heiman, H.J. and Artiga, S. (2015), "Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity", available at: https://www.kff.org/disparities-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/ (accessed 30 November 2017).

UNIT 3 INTRODUCTION TO GLOBAL HEALTHCARE DELIVERY

CONTENTS

1.0 INTRODUCTION

In the last unit, we defined the social determinants of health and looked at its major subdivisions. In this unit, you will be introduced to global healthcare delivery. As we will see, global healthcare delivery is the backbone of healthcare delivery services to resource deficit areas around the world. Also, we will learn about strategies through which global healthcare delivery problems can be alleviated.

2.0 OBJECTIVES

At the end of this unit, you will be able to:

- define global healthcare and global healthcare delivery
- list top issues in healthcare
- discuss implementation bottleneck as it relates to healthcare delivery
- discuss the strategies for tackling problems posed by improper implementation

3.0 MAIN CONTENT

3.1 Global Health and Healthcare Delivery

First and foremost, to have a good grasp of the importance of global healthcare delivery, it is important to understand what global healthcare means. According to literature, global healthcare is the subvention or supply of health services to resource-deficit areas worldwide, which are provided with no or inadequate health services. In their report on the global healthcare sector outlook, Deloitte projected that the global healthcare expenditure ouldreach 8.7 trillion U.S. dollars by 2020. Besides, the percentage of Gross Domestic Product (GDP) spent on healthcare was projected to increase to 10.5 percent in 2020, a 0.1 percent increase from 2015. Hence, low-income and emerging countries are expected to drive this growth. Some of the top issues in healthcare are healthcare delivery, operations, cost, innovation and regulatory compliance.

Global healthcare delivery can be defined as the conveyance of health services to people with diseases for which a proven treatment is available. In addition, it refers to the conscious effort to provide high-quality health services to areas previously considered too remote or poor to utilize them. Health policies, equity and justice also play a large role in expanding the reach of health services.

Research suggests that one of the greatest problems being experienced by the global health community is an “implementation bottleneck”. An implementation bottleneck means there exists a lack of appropriate delivery or implementation methods for the healthcare resources injected into global health. In essence, availability of interventional health services is not the primary constraint, but the delivery of these services to areas where they are needed the most; mostly in developing countries. One of the evident reasons for this breakdown in health services provision when it comes to delivery is the lack of appropriate infrastructure in areas where global healthcare services are most needed. Three strategies have been identified as having the potential to alleviate the problem posed by the implementation bottleneck and these are:

- Implementation research. This refers to studying successful implementation models using the methods of global health research and building new healthcare delivery system around them
- The synergy between health systems and Global Health Initiatives (GHIs). This entails the close monitoring of GHIs and existing health systems to ensure health services delivery is cost-effective and efficient
- Learning from successful business models. By doing this, those in charge of global health delivery programming can understudy management strategies used by companies in the private sector to successfully implement their delivery

4.0 Conclusion

Lack of adequate infrastructure for appropriate implementation of healthcare delivery, in areas where health services are needed the most, is a problem that still has to be tackled in low-income and emerging countries of the world today. By and large, to address the implementation bottlenecks, it is paramount to understudy successful healthcare delivery systems and implement these in context-specific remote areas lacking appropriate healthcare.

5.0 Summary

In this unit, we learnt that:

- global healthcare delivery systems are important
- global healthcare delivery is the conveyance of health services to people battling with diseases for which a proven treatment is available
- problems related to global healthcare delivery can be alleviated by using implementation research, understudying the synergy between health systems and global health initiatives in addition to learning from successful business models

6.0 Tutor-Marked Assignment

1. Define global healthcare
2. Define global healthcare delivery
3. What do we mean by “implementation bottleneck”
4. What is the greatest challenge faced by healthcare delivery in low-income and emerging countries and contexts
5. Discuss strategies through which problems posed by the implementation bottleneck can be solved

7.0 References/Further reading

Deloitte (2017), *Global healthcare sector outlook.*

Kim, J.Y., Farmer, P. and Porter, M.E. (2013), “Redefining global health-care delivery”, *The Lancet*, Vol. 382 No. 9897, pp. 1060–1069.

Unite for Sight (2015), “The Science of Global Health Delivery”, available at: http://www.uniteforsight.org/global-health-university/global-health-delivery (accessed 30 November 2017).

UNIT 4 ESSENTIAL SKILLS IN GLOBAL HEALTH

CONTENTS

1.0 INTRODUCTION

In the last unit, we learnt about the global healthcare delivery and implementation strategies which can be used to tackle problems being faced by the global healthcare delivery systems. In this unit, we will learn about the core skills and competencies required by healthcare professionals. By and large, it is important to have the right skills in order to be able to adequately deliver health services.

2.0 OBJECTIVES

At the end of this unit, you will be able to:

- discuss what essential skills connotes in global health
- determine which skills areas are a must-have for health services professionals

3.0 MAIN CONTENT

3.1 Core Competencies of Global Health

The essential skills in global health are a set of primary skills which professionals should possess before indulging in the “practice, education and research of public health”.

Furthermore, these essential skills serve as a framework to improve health practitioners professionally and better serve their communities. In essence, these core competencies or essential skills are needed by health professionals for the adequate and appropriate delivery of healthcare services. The core competencies are divided into eight skill areas which address different sections of global health. These eight essential skill areas are:

1. analytical skills
2. programme planning or policy development skills
3. management and financial planning skills
4. systematic thinking and leadership skills
5. public health sciences skills
6. cultural awareness or competency skills
7. communication skills
8. community health, oriented skills

4.0 Conclusion

Delivery of health services should be carried out by professionals who have the skills required to successfully administer health care. A healthcare professional is required to be able to analyze a situation to determine the best course of action, in addition to being able to communicate the requirements of standard healthcare procedures to the affected parties. In all, there are eight major skill areas which are a must-have for healthcare professionals looking to deliver health services.

5.0 Tutor-Marked Assignment

1. What do “essential skills” mean in the context of global health?
2. List the skill areas which are a must-have for healthcare professionals

6.0 References/Further reading

Council on Linkages (2014), “Core Competencies for Public Health Professionals”, available at http://www.phf.org/resourcestools/Documents/Core_Competencies_for_Public_Health_Professionals_2014June.pdf (accessed 28 November 2017).

UNIT 5 INTERDISCIPLINARY TOPICS IN GLOBAL HEALTH

CONTENTS

1.0 INTRODUCTION

In the last unit, we learnt about the essential skills that healthcare professionals must have as part of the requirements to deliver health services. In this unit, we will look at interdisciplinary topics which fall under the global health umbrella. Although there are many interdisciplinary topics under global health, only the relationship between health, climate change and sustainable development will be discussed in this unit.

2.0 OBJECTIVES

At the end of this unit, you will be able to:

- Understand what is climate change and its impact on global health
- Understand the relationship between the social determinants of health and climate change
- Understand sustainable development in the context of global health, and list the Sustainable Development Goals which are trying to solve the global health crisis

3.0 MAIN CONTENT

3.1 Global Health and Climate Change

According to the literature, the climate controls the ever-changing ecosystem as well as the likelihood of disease outbreaks. The relationship between climate change and global health is of paramount importance, even more so with global warming and the steady environmental degradation being experienced around the world today. The tropical regions of developing countries feel the most impact of climate change. According to the World Health Organization, the global climate is being affected by human activities which release carbon dioxide and other greenhouse gases into the atmosphere. The effect of this can be seen in increased natural disasters and changes in precipitation patterns, which have also been neither spatially nor temporally uniform. But how does climate change relate to global health? The effects of climate change tend to be drastically negative, and this, in turn, affects the social determinants of health. Some of these effects could include, but are not limited to:

- Excessive heat-related illnesses
- Air-, vector- and waterborne diseases
- Exposure to environmental toxins
- Amplification of cardiovascular and respiratory diseases
- Melting of the air glaziers and associated ecological transformations
- Increase in natural disasters and inconsistent rainfall patterns

Children and elderly people are the most vulnerable to health risks associated with climate change. Also, people in developing areas as well as areas with inadequate health infrastructures are prone to the consequences of climate change and ill-equipped to either adapt or cope with its outcomes.

3.2 Global Health and Sustainable Development

According to literature, sustainable development can be defined as any development activity which provides for the needs of the present generation without jeopardizing the ability of future generations to also develop and provide for themselves. The race is on to build better health systems in order to be able to achieve the Sustainable Development Goals (SDGs) as laid out in the 2030 Agenda for Sustainable Development launched at the end of 2015. SDG 3 has 13 specific health targets and aims to "Ensure healthy lives and promote well-being for people of all ages". In addition to this, Table 2 presents other SDGs with health-related targets.

Table 1.2: Sustainable Development Goals and their health-related targets

SDG No	Goal
SDG 2	"End hunger, achieve food security and improved nutrition and promote sustainable agriculture"
SDG 6	"Ensure availability and sustainable management of water and sanitation for all"
SDG 7	"Ensure access to affordable, reliable, sustainable and modern energy for all"
SDG 8	"Promote sustained, inclusive and sustainable economic growth, full and productive employment and decent work for all"
SDG 11	"Make cities and human settlements inclusive, safe, resilient and sustainable"
SDG 12	"Ensure sustainable consumption and production patterns"
SDG 13	"Take urgent action to combat climate change and its impacts"

Source: World Health Organization (2017b)

As the impact of climate change and environmental degradation becomes more profound, governments are scrambling to sustainably take precedence in striving to achieve economic development. Sustainable development and global health can be ensured if environmental and health conditions in developed and developing countries are made top priorities.

Besides, special attention should be paid to the aforementioned SDGs and efforts should be intensified in order to achieve them on a global scale.

4.0 Conclusion

Climate change and sustainability are two topics of great importance in the world today, given the drastic degeneration of the environment. An increase in the emission of greenhouse and other ozone layer depleting gases due to increased globalization and industrialization, and unchecked waste emission, is leading to an increase in global warming. Consequentially, the social determinants of health are affected negatively, leading to an increase in diseases and natural disasters. In all of this, children and the elderly remains the most vulnerable to health risks associated with climate change.

This is where sustainability comes in. Sustainable development seeks out ways to provide for present needs in a sustainable way, which does not affect the ability for future needs to be met. A number of Sustainable Development Goals (SDGs) have been set out to achieve this. Furthermore, among the SDGs, careful and successful implementation of SDG 3, which aims to "Ensure healthy lives and promote well-being for all at all ages", promises to have an overall positive effect on global health.

5.0 Summary

In this unit, we learnt that:

- Climate change causes an increase in natural disasters, changes in precipitation or rainfall patterns, affects the social determinants of health and causes a proliferation of diseases
- Children and the elderly are the most affected by climate change
- Sustainable development seeks to ensure the future generation can provide for themselves by providing for the needs of the present generation in a sustainable way

- SDG 3 has 13 specific health targets which seek to "Ensure healthy lives and promote well-being for all at all ages"

6.0 Tutor-Marked Assignment

1. What are the negative effects of climate change on the social determinants of health?
2. What is the major cause of climate change and how does this come about?
3. Which groups of people are the most affected by climate change?
4. What do we mean by sustainable development?
5. Which of the Sustainable Development Goals specifically targets health?
6. List the goals of four other SDGs which have health-related targets

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MODULE 2 GLOBAL HEALTH ECONOMICS

UNIT 1 INTRODUCTION TO HEALTH ECONOMICS

CONTENTS

1.0 INTRODUCTION

Economists are concerned with the allocation of scarce resources between competing demands. They are concerned with making the best choices and in particular, making the best use of existing resources and growth in the volume of available resources. The discipline of health economics emerged, as a result of economists' involvement in solving healthcare challenges. Some of these challenges being tackled in health economics include

improvement of patient survival, quality of life and fairness in access to services, among other concerns.

2.0 OBJECTIVES

At the end of this Unit, you will be able to:

- understand the scope of health economics
- explain the concept of economic evaluation in health economics

3.0 MAIN CONTENT

3.1 Definition and Scope of Health Economics

Health economics is the study of how scarce resources are allocated among alternative uses for the care of sickness and the promotion, maintenance and improvement of health, including the study of how health care and health-related services, their costs and benefits, and health itself are distributed among individuals and groups in the society. It can broadly, be defined as the application of the theories, concepts and techniques of economics to the health sector.

It is concerned with matters involving the allocation of resources between various health promoting activities, the quantity of resources used in health services delivery; the organization and funding of health service delivery institutions, the efficiency with which resources are allocated and used for health purposes, and the effects of preventive, curative and rehabilitative health services on individuals and the society.

As presented in Figure 2.1, the scope of health economics can be divided into eight distinct topics:

1. What influences health? (other than healthcare)

2. What is health, and what is its value?
3. The demand for healthcare
4. The supply of healthcare
5. Micro-economic evaluation at treatment level
6. Market equilibrium
7. Evaluation at the whole system level
8. Planning, budgeting, and monitoring mechanisms.

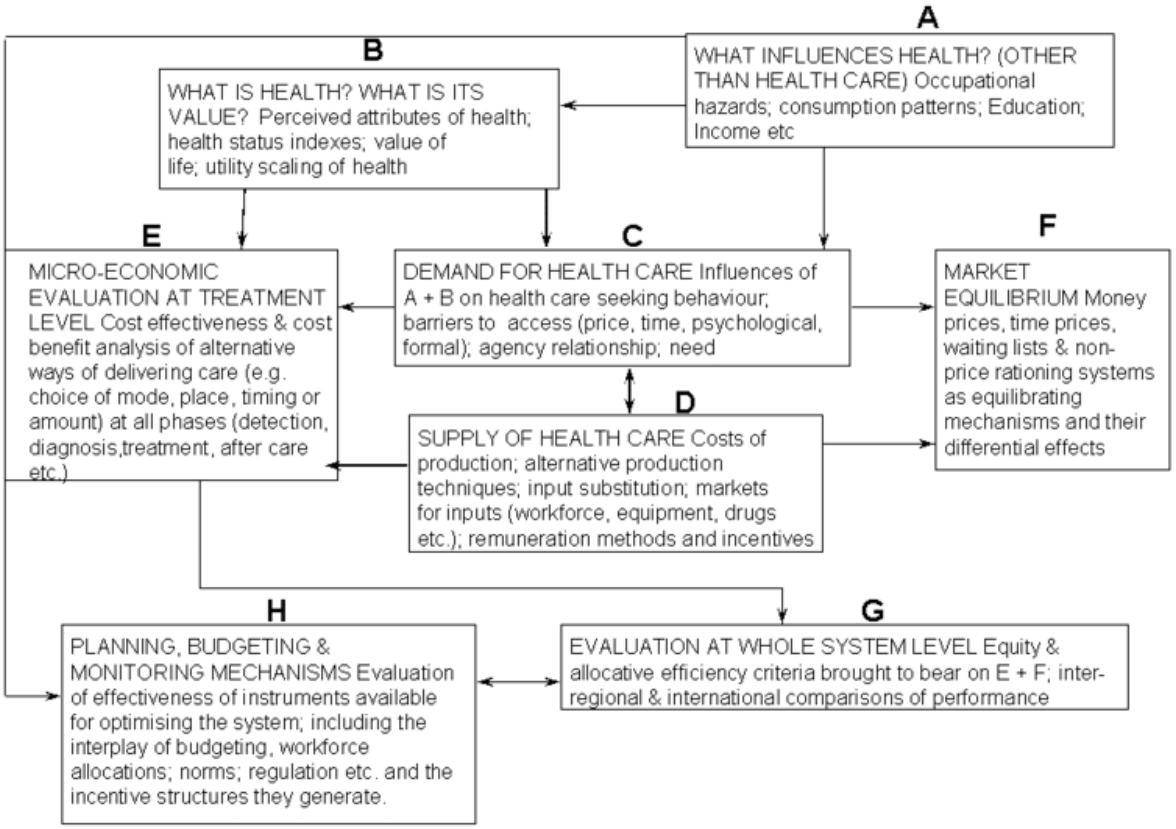

Fig 2.1: The framework of health economics

Source: LSHTM, 1998

Although all of these eight elements offer useful insights into the delivery of healthcare, it is an economic evaluation that provides the bulk of health economists' work and is of most relevance to healthcare administrators and practitioners.

3.2 Concept of Economic Evaluation in Health Economics

The concept of economic evaluation emphasizes efficiency in health care choices. It relates the benefits of alternative interventions to the resources incurred in their production. There are three principles that are pertinent in health economic analysis. They are;

Opportunity cost: Health economists stress the importance of value. When budgets are finite, resources invested in one area will be at the expense of a loss of opportunity in another and resources should be valued in terms of this lost opportunity (the opportunity cost).

Perspective: The viewpoint of the analysis of an economic problem is important. This will dictate which costs and benefits are important. The perspective of the patient, health authority and society may differ. Different perspectives will give different answers when deciding between treatment options and decision-makers must be clear on the preferred viewpoints.

Marginal analysis: The relationship between resources invested in an intervention and the accrued benefits is usually not directly proportional. In healthcare decision-making, it is important to consider how increments in benefit change with increment in resource allocation. This is known as a marginal analysis.

3.3 Types of Economic Evaluation in Health Economics

Cost minimization analysis: In a cost-minimization analysis, the consequences of two or more interventions being compared are equivalent. The analysis, therefore, focuses on costs alone, and the cheapest option is chosen.

Cost-effectiveness analysis: Cost-effectiveness analysis is the most common type of analysis and is used to compare drugs or programmes which have a common health outcome (for example, reduction in blood pressure, life-years saved). Results are usually presented in the form of a ratio (for example, costs per life-year gained).

Cost-utility analysis: A cost-utility analysis can be used to assess costs and benefits of interventions where there is no single outcome of interest and is useful comparing different programmes across different treatment areas. The most frequently used measure is the Quality Adjusted Life Year (QALY). Benefits are measured based on the impact on length and quality of life to produce an overall index of health gain. A healthy state is valued between 0 (worst health) and 1 (best health) combined with the length of time in that state.

Cost-benefit analysis: In a Cost-benefit Analysis, attempts are made to value all the costs and consequences of intervention in monetary terms. If the costs are less than the benefits, then the intervention is acceptable.

4.0 CONCLUSION

Health economics aims at allocating scarce resources in healthcare. This can be carried out effectively by using the tools of economic evaluation so that the best results are achieved and health sector goals are achieved with minimal investments.

5.0 SUMMARY

In this unit, we have learnt that:

- Health economics is the study of how scarce resources are allocated among alternative uses for the care of sickness and the promotion, maintenance and improvement of health. It alsoincludes the study of how health care and health-related services, their costs and benefits, and health itself are distributed among individuals and groups in society.
- The scope of health economics can be divided into eight distinct component topics
- The concept of economic evaluation emphasizes efficiency in health care choices.
- There are three principles that are germane in health economic analysis, namely; opportunity cost, perspective and marginal analysis.

6.0 TUTOR-MARKED ASSIGNMENT

1. Define health economics
2. Enumerate the health economics component topics
3. Explain the three principles of health economic analysis
4. List and discuss the economic evaluation methods

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UNIT 2 FINANCIAL MANAGEMENT AND CONTROL

CONTENTS

1.0 INTRODUCTION

Every organization makes use of funds for their activities. How money is handled will determine whether an organization will be able to carry out its functions and activities as well as achieve its set goals. Therefore, sound financial management and controls are required, and this can only be achieved if sound financial management principles and techniques are applied.

2.0 OBJECTIVES

At the end of this Unit, you will be able to:

- understand Financial Management and Control Frameworks
- explain the pillars of Financial Management and Control

3.0 MAIN CONTENT

3.1 Concept of Financial Management and Control

Financial management refers to the efficient and effective management of money (funds) in a way that enables an organization to accomplish it set objectives. It is the specialized function directly associated with the top management. Financial management and control are the basis of programme management and its framework should be the major source of guidance for planners, administrators, managers and their financial advisers in the efficient, effective and appropriate use of allocated resources.

According to planning technocrats, the purpose of a governmental or departmental/agency's financial management and control framework is: "to facilitates and define the boundary lines for the planning, use and accounting of resources." These "boundary lines' establishes a financial management and control framework through the resource management cycle (from planning to external reporting) within the rules, values, and performance expectations of the organization's stakeholders.

The resource management cycle has the following components;

- **Resource Planning:** This involves estimating financial consequences and risk of strategic objectives and alternatives.
- **Resource Acquisition:** Forecasting and acquiring resources in order to carry out business processes.
- **Resource Allocation:** Allocating the resources and setting budgets for activities in the business process.
- **Managing:** Using the acquired resources to carry out activities and deliver services to clients.
- **Monitoring/Controlling:** Ensuring efficient, effective and appropriate use of resources in light of the latest information (reallocating where needed).
- **External Reporting:** Providing accurate, relevant and timely information on the use of resources to stakeholders.

A successful financial management and control framework is present when an organization has the capacity to; adequately navigate through the resource management cycle, establish boundary lines that clearly delineate the limits within which all decisions and transactions must be made towards establishing and exercising clear accountabilities for managing resources and staying within the boundary lines as well as demonstrating integrity through shared organizational values and beliefs.

3.2 The Pillars of a Financial Management and Control Framework

Financial Management and Control are premised on four important pillars, which can be summarized as follows:

1. Performance Information (Linking financial and non-financial information)
2. Risk Management
3. Control Systems
4. Ethics, ethical practices and values

3.2.1 Performance Information (Linking financial and non-financial information)

This pillar is designed to associate resources with results. This objective can be difficult to achieve if there's poor management of the factors that cause costs (i.e. activities that consume resources). When the factors that cause costs are understood and managed, it is much easier to achieve sound resource management. Factors that cause the costs of activities (resources consumed) may include many things, such as the volume of client demand; service standards (e.g., accuracy and timeliness); the type of clients and the complexity of the governing rules and systems. This is the non-financial information that needs to be connected with the financial information in order to map resources with results.

A good cost management structure within the financial management and control framework will provide clear cost policies and principles, costing methodologies, and an activity dictionary that reveals the work inputs to achieve results. It will also have a costing module in its financial management and control system to link expenditures to activities, and the resulting activity costs to be assigned to performance targets and other cost objects, such as clients and services.

A good cost management framework not only enables the linking of resources to results for accountability purposes, but also provides better information for planning, alternative service delivery analysis, pricing of services, and other critical decisions. This technique, however, seems difficult to practice in public sector management. This can be associated with the fact that an expenditure culture is embedded in the system.

3.2.2 Risk Management

This second pillar is clearly related to financial management and control, particularly to control. This is because control is a function of risk. Controls are instituted solely to guard against undesirable and unpredictable events. Certain policies are established to debar the likelihood of private workers, and civil servants from engaging in wrong financial acts, such as misappropriating or overspending funds. Financial management controls are costly with far-reaching effects, and this is why they should be subjected to risk management techniques before implementation.

Financial management and control also use risk management to help in the analysis of decisions such as how to minimize the risk of adverse financial consequences. Furthermore, risk management exists also to alleviate the risk of opportunities being missed. This involves anticipating new technologies or new legislative provisions to ensure organizational readiness to take advantage of opportunities as soon as they are available or take effect.

3.2.3 Control Systems

Financial management control systems reflect mandatory controls such as those required for expenditures and revenues under certain policies and those arising from risk management techniques where at the discretion of the management. Decisions are made on what areas of management and accountability need protective or facilitative control measures. Protective controls serve to protect public funds from being spent recklessly and irresponsibly and public assets from loss, theft, and damage. Facilitative controls are controls that enable the achievement of programme objectives. For better understanding, protective controls are input-oriented while facilitative controls are output-oriented.

Protective control systems are epitomized by financial, appropriation and commitment accounting systems as well as inventory and asset systems. Due to their costly nature, these systems should be efficient. Facilitative control systems are epitomized by financial planning and forecasting systems and integrated financial and non-financial performance systems. They alert administrators of the need to revise plans and take actions to correct identified problems or to take advantage of newly identified opportunities.

3.2.4 Ethics, ethical practices, and values

Ethics for public service delivery usually means doing what is right rather than what is expedient or personally beneficial. Majority of civil servants instinctively do the right thing. However, in some circumstances, the right course of action for certain transactions or dealings might not be in accordance with the natural instinct of an average financial expert, so ethical principles have to be communicated to ensure that the right actions are taken. This pillar is probably the most important from the perspective of control because a lack of ethics and values can seriously weaken most control frameworks, whereas strong shared values and ethics make controls not only stronger but unnecessary in many cases; thus, creating the opportunity to reduce costs and increase innovation.

4.0 CONCLUSION

Good financial management aids in the efficient and effective management of funds and enables an organization to prudently accomplish set objectives. These have been shown to involve linking financial and non-financial data, risk management, instituting control systems and communicating ethical values and principles to financial and non-financial experts in ensuring, in particular, the integrity of healthcare service delivery.

5.0 SUMMARY

In this unit, we have learnt that:

- Financial management refers to the efficient and effective management of money (funds) in a way that enables an organization to accomplish it set objectives.
- Financial management and control is the basis of government management and its framework should be the major source of guidance for administrators, managers and their financial advisers in the efficient, effective and proper use of public resources.
- Financial management and control sits on four pillars; Performance Information, Risk Management, Control Systems and Ethics, ethical practices and values.
- A good cost management framework not only enables the linking of resources to results for accountability purposes, but also provides better information for planning, alternative service delivery analysis, pricing of services, and other critical decisions.
- Financial management and control also use risk management to help in the analysis of decisions such as how to minimize the risk of adverse financial consequences.
- Protective controls serve to protect public funds from being spent recklessly and irresponsibly and public assets from loss, theft and damage. Facilitative controls are controls that enable the achievement of programme objectives.
- Ethics for public servants usually means doing what is right rather than what is expedient or personally beneficial.

6.0 TUTOR-MARKED ASSIGNMENT

1. Explain the resource management cycle
2. Mention the pillars of financial management and control
3. Explain the importance of financial management and control in global health service delivery

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UNIT 3 FINANCING AND DELIVERY OF HEALTHCARE IN DEVELOPING COUNTRIES

CONTENTS

1.0 INTRODUCTION

It has been popularly said that "Health is wealth". The productivity of a population will be sub-optimal if it is unhealthy. The health sector in any country has been recognized as the engine room for growth and development because health is the basis for job productivity, the capacity to learn in school, and the capability to grow intellectually, physically and emotionally. Access to healthcare services on a sustainable basis in any country is an important obligation of government and the fundamental right of the citizens, through direct participation in the health delivery system and good legislature on health.

2.0 OBJECTIVES

At the end of this Unit, you will be able to:

- understand healthcare financing

- understand the relationship between financing and healthcare delivery
- explain the financial constraints of healthcare delivery in developing countries

3.0 MAIN CONTENT

3.1 Healthcare Financing

Healthcare financing can be defined as the mobilization of funds for healthcare service delivery. Healthcare financing involves acquiring and using funds and resources to carry out activities developed by the government to sustain the health of her population. These activities include the provision of medical and related services aimed at maintaining sound health through disease prevention and control and clinical (curative) treatments.

Concisely, the concept of healthcare financing deals with the quantity and quality of resources that the country spends on healthcare for her population. The amount of these resources is proportional to the country's total national income. The proportion of resources allocated for healthcare in a country can be said to be indicative of the value placed on healthcare in relation to other competitive demand categories of goods and services.

In some quarters, it has been inferred that the characteristics of healthcare financing can be used to describe the structure and the behaviour of different stakeholders and the quality of health outcomes. The relationship between healthcare financing and the provisioning of health services can thus be referred to as complex, intertwined and inseparable.

3.2 Sources of Healthcare Financing

Healthcare can be funded either publicly or privately such as through taxation or insurance, (also known as single-payer systems), or voluntary private health insurance respectively. Some common sources of funding for healthcare financing include the following;

Out-of-pocket payments: Out-of-pocket payments (OOPs) are defined as direct payments made by individuals to health care providers at the time of service use. This excludes any prepayment for health services, for example, in the form of taxes or specific insurance premiums or contributions. Out-of-pocket payments are part of the health financing landscape in all countries relying on user fees and co-payments to mobilize revenue, rationalize the use of health services, contain health system costs or improve health system efficiency and service quality. This is the most common method of healthcare financing in developing countries.

Tax-based revenue: The health financing system, where government revenues are drawn from tax deductions across all levels and sectors as the primary source of funding for healthcare expenditure is referred to as tax-based systems. The burden of healthcare funding is mainly shared over a larger population than in other systems.

Donor funding: Governments of many developing countries usually cannot bear the burden of healthcare financing for their populations alone due to declining economies. As such, donor countries such as the United States of America through the United States Agency for International Development (USAID) and international organizations such as World Health Organization (WHO) and United Nations Children's Emergency Fund (UNICEF) among others give financial assistance to developing countries to support their socio-economic growth and health development usually in the form of loans and/or aid grants. The donor countries gives about 0.7% of their gross national product as Official Development Assistance (ODA) to developing countries.

Social health insurance: Social Health Insurance (SHI) is a form of financing and managing health care based on risk pooling. SHI pools both the health risks of the people on the one hand, and the contributions of individuals, households, enterprises, and the government on the other. Thus, it protects people against financial and health burden and is a relatively fair method of financing health care.

Community-based health insurance: The community-based health insurance is a scheme which has a prepayment mechanism with pooling of health risks and of funds taking place at the level of the community or a group of people who share common characteristics (such as geographical or occupational). It is designed to provide financial protection from the cost of seeking health care. It has three main components; prepayment for health services by community members, community control, and voluntary membership

Private health insurance: The private health insurance is directly and voluntarily funded by prepayment by the insured members. Private health insurance has historically been characterized as voluntary, for-profit commercial healthcare coverage. Private health insurance is playing an increasing role in both high- and low-income countries; however, the distinctions between private and public health insurance are poorly understood by researchers and policy-makers.

3.3 Financial Constraints of Healthcare Delivery in Developing Countries

Healthcare financing in the developing world is greatly dependent on out-of-pocket or user-charge payments. Regrettably, there's limited access to money in households for out-of-pocket financing in many poor countries due to economic challenges and this becomes a binding constraint on health care use. Risk pooling and cross-subsidization, possible with pre-payments systems, break the dependency of health care utilization on current income.

Financing healthcare through out-of-pocket payments makes healthcare delivery prices a significant determinant of demand. These prices are usually substantial, and there is strong empirical support for the suggestion that the poor are more price-sensitive than the rich. These expensive user charges tend to skew healthcare access towards the rich than the poor unless effective mechanisms are implemented to shield the poor from these charges. Furthermore, informal charges are sometimes introduced in many public health care systems, and they also increase healthcare costs substantially.

Besides charges paid to the healthcare service providers, travel costs, waiting time and predetermined earnings are important costs of accessing healthcare in the developing world. In rural areas, the distances to healthcare facilities and the poor condition of roads, mean that time, effort and cost needed to arrive at the point of healthcare delivery can be substantial. There is evidence supporting the expected negative impact of these constraints on health care utilization in developing countries.

4.0 CONCLUSION

In this unit, we have looked at what healthcare financing entails, the importance and relationship between funds and healthcare service delivery, the common models of healthcare financing and financial constraints to healthcare service delivery in developing countries. Developing countries have dwindling economies which affect the allocation of resources to healthcare, thus making out-of-pocket payments the main source of healthcare financing individuals and households. Increased healthcare costs coupled with low wages have reduced access to healthcare in developing countries.

5.0 SUMMARY

In this unit, we have learnt that:

- Healthcare financing can be defined as the mobilization of funds for healthcare service delivery.
- Healthcare can be funded either publicly or privately.
- Some common sources of funding for healthcare financing include Out-of-Pocket payments, Private health Insurance, Community-based Insurance etc.
- Healthcare financing in the developing world is greatly dependent on out-of-pocket or user-charge payments.

6.0 TUTOR-MARKED ASSIGNMENT

1. What is healthcare financing?

2. Mention five sources of healthcare financing

3. Explain the financial constraints of healthcare delivery in developing countries

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UNIT 4 ECONOMIC DEMOGRAPHY AND GLOBAL HEALTH

CONTENTS

1.0 INTRODUCTION

Studies have shown that high levels of population health are associated with higher national income. This is expected as higher population incomes promote better health through improved nutrition, improved access to safe water and sanitation, and increased ability to purchase more and better-quality health care. The dynamics of this relationship will be further studied in this unit.

2.0 OBJECTIVES

At the end of this Unit, you will be able to:

- define important terms
- understand the relationship between demography and health
- understand the relationship between economics and health

3.0 MAIN CONTENT

3.1 Definition of Terms

Demography is the study of vital statistics in human populations, including size, growth, density, skewness and distribution.

Demographic economics: it is the application of economic analysis to demography. It is also known as population economics.

Global health: it is the health of populations in the global perspective. It has been defined as the area of study, research and practice that places a priority on improving health and achieving equity in health for all people worldwide. The focus is often placed on problems that exceed national borders or have a global political and economic impact. Thus, global health is about worldwide health improvement, reduction of disparities and protection against global threats that disregard national borders. Measures of global health include Disability-adjusted life years, Quality-adjusted life years and mortality rate.

Disability-Adjusted Life Years (DALYs): The DALYs is a summary measure that combines the impact of illness, disability, and mortality by measuring the time lived with disability and the time lost due to premature mortality. One DALY can be thought of as one lost year of "healthy" life. The DALYs for a disease is the sum of the years of life lost due to premature mortality and the years lost due to disability for incident cases of the health condition.

Quality-Adjusted Life Years (QALYs): QALYs combined the expected survival with expected quality of life into a single number: if an additional year of a healthy life is worth a value of one (year), then a year of less healthy life is worth less than one (year). QALY calculations are based on measurements of the value that individuals place on expected years of survival.

3.2 Health and Demography

An upgrade in health status and reduced mortality rates can consequently lower fertility and mortality rates. Population growth is the difference between birth and mortality rates (excluding migration) and the global population explosion in the last century can be attributed to improvements in health and dropping mortality rates. In developing countries, progress in health, especially maternal and child health interventions tend to reduce infant and child mortality rates, resulting initially to a surge in the number of children. Reduced infant mortality, increased numbers of surviving children and rising wages for women can also reduce desired fertility leading to smaller cohorts of children in future generations. Improved access to family planning can also help couples match more closely their fertility desires and realizations. However, recent health interventions have been targeted at the elderly, reducing old-age mortality and increasing the lifespan.

Theoretically, a sudden increase in the population reduces income per capita by putting pressure on scarce resources and by reducing the capital-labour ratio. These theories imply that population declines stimulate economic growth in per capita terms. However, these theories seem not to apply to modern populations where only slight associations can be inferred between overall population growth and economic growth. This was evident in the last century in which population explosion and substantial rises in income levels were observed.

High birth and low death rates both generate population growth, but seem to have quite different effects on economic growth. This may be because, while both forces increase population numbers, they affect the age structure quite differently. The effect of changing age structure due to increased birth rate (baby boom) has significant effects as these children (baby boomers) grow up and enter the workforce and then as they later retire. As long as the baby boomers are of working age, economic growth may be spurred by a surplus known as “demographic dividend” provided that the baby boom generation can be

productively employed. The demographic dividend increases the potential labour supply but its effect on economic growth depends on the policy environment.

3.3 Economic Growth and Health

Increased income levels result in increased health expenditure, as it is a function of income. On average, it has been proved that increased health expenditure leads to improvements in health. Moreover, wealthier persons are more likely to spend a more substantial proportion of their disposable income on better quality nutrition, hence, positively impacting their health status. In theory, health is a determinant of human capital and labour productivity. Therefore, health expenditures as investments in health should result in higher income levels.

The effect of health on individual productivity implies a relationship between population health and total output. In 2003, Shastry and Weil standardized a production function model of total output using microeconomic estimates of the return to health. They assumed a stable relationship between average height (income levels) and adult survival rates so that when adult survival rates improve, it can be inferred that there will be a rise in population heights.

4.0 CONCLUSION

Demographics have a direct effect on the economic status of populations as a large working population ensures productivity and increased income. This, in turn, improves the health of populations through improved healthcare provision and access.

5.0 SUMMARY

In this unit, we have learnt that:

- Demography is the study of human populations, including size, growth, density, distribution, and vital statistics.
- Demographic economics is the application of economic analysis to demography. It is also known as population economics.
- Global health is the health of populations in a global perspective.
- The DALYs is a summary measure that combines the impact of illness, disability, and mortality by measuring the time lived with disability and the time lost due to premature mortality.
- QALYs combine expected survival with the expected quality of life into a single number
- a sudden increase in the population reduces income per capita by putting pressure on scarce resources and by reducing the capital-labour ratio.
- The effect of health on individual productivity implies a relationship between population health and total output.

6.0 TUTOR-MARKED ASSIGNMENT

1. Define demographic economics and global health

2. Explain economic growth and health

3. Explain the meaning of the two terms; DALYs and QALYs

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UNIT 5 HEALTH POLICY AND ECONOMICS

CONTENTS

1.0 INTRODUCTION

Most political discourses surround personal healthcare policies, especially those that seek to reform healthcare delivery, and they are usually approached from an economic perspective. This often includes how to maximize the efficiency of healthcare delivery and minimize costs. To achieve this, enabling environment should be created through government statements, initiate sound policies and implement them through appropriate legislations that allow for effective healthcare delivery.

2.0 OBJECTIVES

At the end of this Unit, you will be able to:

- understand the concept of health policy
- identify health policies in Nigeria

3.0 MAIN CONTENT

3.1 Concept of Health Policy

According to the World Health Organization, health policy can be defined as the "decisions, plans, and actions that are undertaken to achieve specific healthcare goals within a society. The World Health Organization, states that health policy can achieve the following aims; define a vision for the future, outline priorities and the expected roles of different groups and build consensus and informs people.

Health policies are used to focus on the financing of healthcare services in order to spread the economic risks and burdens of ill health. Health policy may involve issues regarding financing and delivery of healthcare, access to care, quality of care and health equity. There are many categories of health policies such as; global health policy, public health policy, mental health policy, health care services policy, insurance policy, personal healthcare policy and pharmaceutical policy, among others.

Health policy and its implementation is complex. Health policy should be understood as more than a national law that supports a programme or intervention. Operational policies are the rules, regulations, guidelines and administrative norms that governments use to translate national laws and policies into programmes and services. The policy process encompasses decisions made at a national or decentralized level (including funding decisions) that affect whether and how services are delivered. Thus, attention must be paid to policies at multiple levels of the health system and over time to ensure sustainable scale-up. A supportive policy environment will facilitate the scale-up of health interventions.

3.2 Relationship between Health Policy and Economics

The interaction between health and the economy provides direction for investments in health and the design of health financing policies. Just as growth, income, investment and employment are a function of the performance and quality of the economic system, its regulatory frameworks, trade policies, social capital and labour markets; so, health

conditions (mortality, morbidity, disability) depend not just on standards of living, but on the actual performance of health systems themselves.

Health performance and economic performance are interlinked. Wealthier countries have healthier populations. It is common knowledge that poverty directly impacts life expectancy. National income has a direct effect on the development of health systems, through insurance coverage and public spending. The relationship between health policy and economics can be shown in efficient fiscal systems practised in some countries which have led to increases in taxes on certain health-threatening substances such as tobacco. These tax increases could be used to reinforce other public health policies like rule-based restrictions on smoking in public places.

Policymakers often run into a dilemma in trying to strike a balance between increasing funding for healthcare and cutting funding from other important areas of the economy. The challenge is to harmonize health and economic policies to improve health outcomes, as well as to minimize any negative impacts of compromises made while promoting support where necessary.

3.3 Health Policies in Nigeria

The following are some of the existing health policies in Nigeria;

National Health Policy (2005): It encourages the participation of communities and households in community-based financing programmes for primary healthcare services as well as public-private partnerships and collaborations for the growth and development of healthcare financing alternatives across all operational levels.

National Health Financing Policy (2006): It was designed to advance equity and access to quality and affordable health care and to ensure a high level of efficiency and accountability in the system through developing a fair and sustainable financing system.

National Strategic Health Development Plan (2010): The aim of the policy is to ensure that adequate and sustainable funds are available and allocated for accessible, affordable, efficient, and equitable health care provision and consumption at local, state and federal levels.

4.0 CONCLUSION

Health policies provide direction and focus for healthcare delivery. It can be an important tool for governments in backing and ensuring financial investments in healthcare and enforcing public health initiatives. However, oftentimes policymakers have to make decisions on providing the necessary resources for healthcare while trying to minimize impacts on other areas of the economy.

5.0 SUMMARY

In this unit, we have learnt that:

- Health policies are the "decisions, plans, and actions that are undertaken to achieve specific healthcare goals within a society.
- Health policy may involve issues regarding financing and delivery of healthcare, access to care, quality of care and health equity.
- Health policies are used to focus on the financing of healthcare services in order to spread the economic risks and burdens of ill health.
- The interaction between health and the economy provides direction for investments in health and the design of health financing policies
- Health performance and economic performance are interlinked.
- Existing health policies in Nigeria include; National Health Policy, National Health Financing Policy and National Strategic Health Development Plan.

6.0 TUTOR-MARKED ASSIGNMENT

1. What is health policy?

2. Summarize the relationship between health policy and economics

3. List the health policies in Nigeria

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MODULE 3 LEADERSHIP AND POLITICAL ECONOMY OF HEALTH SECTOR REFORM

UNIT 1 Health Services Administration/Delivery

CONTENTS

1.0 INTRODUCTION

Good service delivery is a vital element of any health system. Service delivery is a fundamental input to population health status, along with other factors, including social determinants of health. The precise organization and content of health services will differ from one country to another. The need for improvement in the delivery of health services can be pictured as the gap between what available funds and technologies could achieve and what they do achieve in specific countries, districts, and communities.

2.0 OBJECTIVES

At the end of this unit, you will able to:

- understand the concept of health service administration/delivery
- challenges of Healthcare delivery in Nigeria

3.0 MAIN CONTENT

3.1 Definition and Concept

The Healthcare industry is one of the largest industries in the service sector, the provision of healthcare services is a critical aspect of service delivery for any nation's economy to survive and for people therein to prosper.

Health service delivery systems that are safe, accessible, high quality, people-centred, and integrated are critical for moving towards universal health coverage. Service delivery systems are responsible for providing health services for patients, persons, families, communities, and populations in general, and not only care for patients. While patient-centred care is commonly understood as focusing on the individual seeking care (the patient), people-centred care encompasses these clinical encounters and also includes attention to the health of people in their communities and their crucial role in shaping health policy and health services.

People-centred and integrated health services are critical for reaching universal health coverage. People-centred care is care that is focused and organized around the health needs and expectations of people and communities, rather than on diseases. Whereas patient-centred care is commonly understood as focusing on the individual seeking care (the patient), people-centred care encompasses these clinical encounters and also includes attention to the health of people in their communities and their crucial role in shaping health policy and health services.

Integrated health services encompass the management and delivery of quality and safe health services so that people receive a continuum of health promotion, disease prevention,

diagnosis, treatment, disease management, rehabilitation and palliative care services, through the different levels and sites of care within the health system, and according to their needs throughout the life course. The WHO is supporting countries in implementing people-centred and integrated health services by way of developing policy options, reform strategies, evidence-based guidelines and best practices that can be tailored to various country settings.

Service delivery systems should also consider the whole spectrum of care from promotion and prevention to diagnostics, rehabilitation and palliative care, as well as all levels of care including self-care, home care, community care, primary care, long-term care, hospital care, to provide integrated health services throughout the life course. World Health Organization is supporting countries in moving towards universal health coverage through improving the efficiency and effectiveness of their health service delivery systems.

Good service delivery is a vital element of any health system. Service delivery is a fundamental input to population health status, along with other factors, including social determinants of health. The precise organization and content of health services will differ from one country to another. The need for improvement in the delivery of health services can be pictured as the gap between what available funds and technologies could achieve and what they do achieve in specific countries, districts, and communities. Low-performance levels for health care–delivery systems as a whole means that performance indicator averages are below what could be attained and is being attained by other, comparable systems. In many low- and middle-income countries, the overall level of health service–delivery performance is not what it could be.

The delivery of services is the immediate output of all the inputs into the delivery system. The organisation of this delivery determines, to a large extent if the inputs lead to the desired output: access to quality care. Delivery of health services is produced at the interface with the population. The most atomized product of this is the interaction between a single health provider and patient. However, from the perspective of a (national or local) HS perspective, it comprises the total of services in a specified area. The word ‘health

service' can refer both to the organisation that supplies care and to the specific product which is delivered.

When we talk about health services, we mean all services that have as a primary purpose the improvement of health. The term includes general health care and services that are aimed at specific health problems; disease control interventions and services responsive to the suffering of individuals; preventive and curative services; personal health services and population-based activities. There are many other terms with a different focus, for instance, on the level of care or the package of services. Examples of other terms are 'health care', 'primary health care', 'essential services' or 'priority interventions' services. We will use 'service' as a generic term, which can refer to all of the above. Health services are thus very diverse in nature. Besides, these services are delivered to the population via multiple modes and channels. Health services include all services dealing with the diagnosis and treatment of a disease condition, or the promotion, maintenance and health restoration.

Some concepts that have frequently been used to measure health services remain extremely relevant and are part of the key characteristics. For example, access, availability, utilization, and coverage have often been used interchangeably to reveal whether people are receiving the services they need. Access is a broad term with varied dimensions: the comprehensive measurement of access requires a systematic assessment of the physical, economic, and socio-psychological aspects of people's ability to make use of health services. Availability is an aspect of comprehensiveness and refers to the physical presence or delivery of services that meet a minimum standard. Utilization is often defined as the quantity of health care services used. Coverage of interventions is defined as the proportion of people who receive a specific intervention or service among those who need it.

A routine facility reporting system often referred to as a Health Management Information System (HMIS), is generally used to monitor and compare service delivery. Service data are generated at the facility level and include key outputs from routine reporting on the services and care offered and the treatments administered. Reporting may include supervisory or clinic-reported data on medicine stock-outs in a defined reference period

(e.g. during the last month), functioning of outreach services and availability of health workers. Because the data are routinely collected (often monthly or quarterly), it provides information on a continuous basis for time and seasonal trend analyses.

Strengthening service delivery is crucial to the achievement of the health-related Millennium Development Goals (MDGs), which include the delivery of interventions to reduce child mortality, maternal mortality and the burden of HIV/AIDS, tuberculosis, and malaria. Service provision or delivery is an immediate output of the inputs into the health system, such as the health workforce, the logistics of procurement, supplies, and financing. Increased inputs should lead to improved service delivery and enhanced access to services. Ensuring the availability of health services that meet a minimum quality standard and securing access to them are key functions of a health system.

Sufficient funding and efficient technology are necessary conditions for achieving health gains, but experience in many countries confirms that they are not sufficient. Effective and efficient service delivery is the point at which the potential of the health system to improve lives meets the opportunity to realize health gains. Health service–delivery performance means to access and use by those in need; adequate quality of care to produce health benefits; efficient use of scarce resources; and organizations that can learn, adapt, and improve for the future. All too often, potential benefits are not realized because service delivery underperforms.

The World Health Organization judges the performance of a health system against four goals; health, responsiveness, fair financing and financial risk protection. Responsiveness has however remained a key issue of concern among the four goals. It is defined as the degree to which a health system is able to meet the expectations of patients and their families in areas not directly related to healthcare delivery. These areas include:

- The ability of healthcare workers to show respect for the patients irrespective of their status, background or colour.

- Patients are getting prompt attention (i.e. immediate attention during emergencies and reasonable waiting times for non-emergencies).
- Access to amenities of adequate quality and to hospitals/clinics that are clean, spacious and serve quality food.
- Autonomy of people to take part in making choices about their health.
- The ability of patients to choose either a provider or the flexibility to pick which individual or organization that should deliver their care.

Deliberate efforts have been made by the Federal Government of Nigeria to initiate and sustain health sector reforms over the past years. The reform of this sector is predicated upon the fact that it is characterized by poor quality and inefficiencies in the provision of public sector health services, resulting in poor health outcomes and poor performances in the basic health indicators.

3.2 Healthcare Delivery in Nigeria

The tertiary level of healthcare in Nigeria is the domain of the Federal Government, secondary or intermediate care level is being administered by the state governments and the primary health care, that is the lowest governmental level of health care under the jurisdiction of the local government areas.

The tertiary level that the responsibility rests with the Federal Ministry of Health headed by the Minister of Health is the highest level of healthcare and it provides a mutually supportive referral system to the secondary care level. It provides specialist and rehabilitative, while the secondary level provides mutually supportive referral system to the primary health care level that provides at least the essential elements of primary health care that are delivered at the first point of contact between individuals and the health care system. Health service delivery structures are also largely tiered, and federal and state

parastatal and agencies have been created to implement programmes and manage services across different levels.

The primary health care system is a grass-roots approach meant to address the main health problems in the community, by providing preventive, curative and rehabilitative services (Olise, 2012). As defined in the Alma Ata declaration, primary health care is the "essential care based on practical, scientifically sound and socially acceptable methods and technology, made universally accessible to individuals and families in the community through their full participation, and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination" (WHO, 2012). In Nigeria, primary healthcare was adopted in the National Health Policy of 1988 (FMOH, 2004) as the cornerstone of the Nigerian health system as part of efforts to improve equity in access and utilization of basic health services (Aigbiremolen *et al.,* 2014). Since then, primary health care in Nigeria has evolved through various stages of development. In 2005, primary health care facilities were found to make up over 85% of health care facilities in Nigeria (FMOH, 2010).

The general understanding is that while policy development remains the responsibility of the Federal Government for those health issues that have national impact and cross-border implications, State Governments may choose to respond to these national directions in the context of local priorities they have established. They also develop their policy documents to which state budgets respond. Responsibility for service delivery is also shared among the three tiers of government.

Again, the general understanding is that the Federal Government is responsible for tertiary care and training of selected health professionals, state governments for secondary care and supervisory oversight of local government health units which are, in turn, responsible for the provision of primary care service delivery activities and its integration community-based outreach and support activities. While the organization of the health sector seems well-coordinated, the practical workings of the systems are not as seamless as depicted.

There is often a duplication and confusion of roles and responsibilities among the different tiers of government - the weakness in coordinating and tracking performance and benchmarking.

The tiered health service delivery system in Nigeria has, over the years, been plagued by sundry factors including inadequate funding and management, disconnect between health policy initiatives, reforms, and programmes of different regimes and weak institutional and human capacity building.

3.3 Major Challenges of Healthcare Delivery in Nigeria

With a teeming population of over 180 million people, Nigeria has continued to grapple with the challenge of creating an efficient healthcare delivery system. Healthcare services in Nigeria have been and are still very poor. With the poor quality of governance in Nigeria, the delivery of services in the public health sector has notably continually been constrained. Arguably, some incremental efforts have been made in terms of policy formulation and programme execution; such efforts have not significantly translated into concrete improvement and enhancement of public service delivery in the health sector.

Two plausible explanations for the poor performance are the decline in governance and near absence of quality culture. There is, therefore, a growing recognition and acceptance by governments that they do not need to dominate the provision of services. They only need, as a matter of exigency, to provide the enabling environment and play their roles in an increasingly complex governance environment. As a consequence, the current focus on governance as the totality of institutional structures within a political community as distinct from government that is the state's instrument for formulating and implementing public health sector policy and regulations helped to strengthen the case for institutional capacity and diversity for the efficient and effective delivery of public services in the developing world like Nigeria.

The absence of an adequate and effective management regime in the Nigeria health care delivery system contributes to the weakness in health management capacities at all levels of public and private health institutions. Such a weakness creates a high propensity for error in the implementation of health care policies. Feedback from healthcare receivers has shown that many healthcare workers have come short of the various indicators of responsiveness. Nigeria falls short of several indicators of frequent occurrences of disrespect towards patients during treatments and unduly long waiting times for non-emergency treatment among others. The lack of basic hospital amenities, the prevalence of small clinic spaces and non-compliance with the required basic water supply within 500m, basic sanitation conveniences, hand-hygiene and hand-washing standards continue to contribute to the declining quality of healthcare in Nigeria.

A world health report which specifically focused on the overall performance of health systems around the world ranked Nigeria 177 out of a total of 191 countries, on its degree of responsiveness to healthcare needs. The 2011 world health statistics show that Nigeria had only four doctors and 16 nurses per 10,000 people. This means that one doctor attends to 2500 patients and one nurse to 155 patients. The major challenges faced by the Nigerian health sector include inadequate facilities, inadequate training for doctors, inadequate funds, incessant strikes by healthcare workers, the erratic electricity supply, flooding the market by fake and adulterated drugs, and emigration of experienced health professionals and less than five percent of the national budget focused on health. All of these realities and more are caused by poor institutional arrangements, defective functional relationships, and management mechanism as a result of the absence of formal planning, clear objectives or a realistic appraisal of available resources in many aspects of healthcare delivery in the country.

One of the limitations to the full achievement of a universal healthcare delivery system is the limited coverage of Nigerians under Social Health Insurance. The National Health Insurance Scheme (NHIS) in Nigeria was established under Act 35 of the 1999 Constitution

by the Federal Government of Nigeria to improve the health of all Nigerians at an affordable cost through various prepayment systems. Through this scheme, universal coverage for all Nigerians is targeted at an affordable cost.

By its structure, it aims to provide social health insurance in Nigeria on a contributory basis where health care services of contributors and their dependents are made from a common pool of fixed, regular amounts made by the contributors. However, the coverage of the National Health Insurance Scheme is still below 5%. Some of the reasons for this can be attributed to ignorance, weak governance, funding etc. Most people covered that make up this 5 percent are workers in paid employment where a direct deduction from their wages (their contribution) is made into the pool. The larger uncovered population is mostly the unemployed who live in rural areas. There are people in paid employment who are yet to key into this plan for lack of proper machinery that seeks to enforce the provisions of the act setting up the scheme.

4.0 CONCLUSION

Health services are the most visible functions of any health system, both to users and the general public. Effective health service delivery in any country is engendering an acceptable programme that will assist the country to provide health care to populations having insufficient or no access to health services.

5.0 SUMMARY

In this unit, we have learned that:

- Health service delivery systems that are safe, accessible, high quality, people-centred, and integrated are critical for moving towards universal health coverage.
- The organizational structure of the Nigerian healthcare system suffers from a lack of specificity and ambiguities in the definition of roles and responsibilities of the three tiers of the system.

6.0 TUTOR-MARKED ASSIGNMENT

1. Explain the role of health service delivery systems in the attainment of universal health coverage.
2. Discuss the possible ways of solving the myriad of challenges facing the Nigerian healthcare system.

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UNIT 2 HEALTH SECTOR REFORM: A WORLDWIDE PERSPECTIVE

CONTENTS

1.0 INTRODUCTION

Health is wealth, and according to the WHO constitution adopted in 1948, health is defined as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. It is an essential carrier for economic growth and development. Good health is a critical input into poverty reduction, economic development at the scale of whole societies. In every country, the health sector is vital to both social and economic development. Health is central to sustainable development and wellbeing. High quality and affordable healthcare delivery, both at primary and tertiary levels, is a necessary condition for the development of human capital.

2.0 OBJECTIVES

At the end of this unit, you will able to:

- understand what is health sector reform
- understand the issues affecting health sector reform

3.0 MAIN CONTENT

3.1 Definition

Health sector reform implies more than just an improvement in health or health care. Health Sector Reform (HSR) is a sustained process of fundamental change in policies, regulation, financing, provision of health services, re-organization, management and institutional arrangements, which is led by government and designed to improve the performance of the health system for the better health status of the population. Health sector reform is aimed at improving the functioning and performance of the health sector and, ultimately, the health status of the population. It deals with equity, efficiency, quality, financing, and sustainability in the provision of health care, and also in defining the priorities, refining the policies and reforming the institutions through which policies are implemented.

Health sector reform is not only a health-related but also a development issue as health care systems account for nine percent of global production and a significant portion of global empowerment. Health sector reform implementation varies across different countries and regions of the world, indeed states within a country. This is because of differences in values, goals and priorities.

3.2 Principles of health reform processes

The three main principles of health reform processes are equity, efficiency and quality.

Equity

Equity refers to fairness. Equity in health is a major topic of discussion and literature. There are two types of equity namely; vertical equity and horizontal equity. The equitable distribution of health care among people of different levels of income is usually called *vertical equity* (care should be available as a function of need, not income), while distribution among people with the same health condition or need is called *horizontal equity* (equal need should entail equal treatment). The underlying assumptions are that

unequal health outcomes are unjust, that health services should be provided (or guaranteed) socially, and that the distribution of costs and benefits should somehow be related to health and wealth status.

Efficiency

Efficiency is a standard declared objective of reform in the public sector most especially in the health sector. Many reform processes are led by the economic national authorities, and are focused on public budget reduction, on changing the relative weight of fixed and variable government expenditure, and on producing better services with the same (or fewer) resources.

Quality

Technical quality refers to the impact of the health services on the health conditions of a particular population. Technical quality is an important dimension of the providers' performance. Sociocultural quality measures the degree of acceptability of services and responsiveness to users' expectations.

3.3 Health Sector Reform in Nigeria

The Federal Ministry of Health has the responsibility to develop policies, strategies, guidelines, plans, and programmes that provide direction for the national healthcare delivery system. The Federal Ministry of Health is the main provider of tertiary healthcare services and various other health intervention programmes aimed at promoting, protecting and preventing ill health of Nigerians. In Nigeria, the health sector reform was initiated and adopted in 2004 by the Obasanjo administration as a result of the prevailing poor health status of the population.

The strategic focus of the 2004 HSR in Nigeria was as follows:

1. Improve the performance of the stewardship role of government

2. Strengthen the national health system and improve its management

3. Improve availability of health resources and their management

4. Improve the access (including physical and financial) to quality health services

5. Reduce the disease burden attributable to priority health problems

6. Promote effective public-private partnership in health

7. Increase consumers' awareness of their health rights and health obligations

Health reform actions by the Nigeria Government

The following health reform actions were undertaken by the Nigeria government

- **National Strategic Health Development Plan (NSHDP):**

This plan was developed by Jonathan's administration in line with its Transformation Agenda for the period 2010 to 2015 through a participatory approach. The major objective of the program is to transform the health sector to enable it to better implement and institute results-oriented programmes within the context of the millennium development goals (MDGs) and national targets as enshrined in the National Vision 20:2020, and a new national health plan.

The plan seeks to:

1. Reduce the morbidity and mortality rates due to communicable diseases to the barest minimum
2. Reverse the increasing prevalence of non-communicable diseases
3. Meet global targets on the elimination and eradication of diseases
4. Significantly increase the life expectancy and quality of life of Nigerians

- **The Anti-Tobacco Bill of 2011:**

The bill is a comprehensive law to regulate the manufacturing, advertising, distributing, and consuming of tobacco products in the country by domesticating the WHO's Framework Convention on Tobacco Control (FCTC). The bill aims to protect children from being exposed to tobacco smoke as well as prohibiting every form of advertisement of tobacco products which may encourage children to smoke including the sale of tobacco too, and by, minors.

- **The NAFDAC Act (Amendment) Bill 2013:**

This is a bill that seeks to empower the agency to effectively carry out its functions. The principal objective is to reduce the incidence and proliferation of drugs offences.

- **The National Health Insurance Scheme Act (Amendment) Bill:**

This bill is to ensure more effective implementation of health insurance policy that enhances greater access to healthcare services by all Nigerians, as well as promote and effectively regulate health insurance schemes in Nigeria.

- **Save One Million Lives Initiative (SOML):**

The SOML Initiative was launched in October 2012 to provide quality health care services for the underserved through a public/private partnership. This approach does not only focus on providing inputs but also focus on delivery and impact. The SOML Initiative also demonstrates Nigeria’s commitment to the UN Commission on Life-Saving Commodities for Women’s and Children’s Health goal to save the lives of 6 million women and children globally by 2015.

- **SURE-P Maternal and Child Health Programme:**

The programme recruits and deploys nurses, midwives, and community health extension workers to designated healthcare facilities across the country to reduce maternal, newborn,

and child morbidity through expanded access to an integrated package of quality maternal and child health services in underserved and hard to reach communities across Nigeria.

- **Midwives Service Scheme (MSS):**

This programme aims at reducing maternal mortality by providing access to qualified and adequate birth attendants to the underserved, especially in the rural areas.

- **Community-Based Social Health Insurance:**

This scheme seeks to raise the coverage of health insurance by reaching out to the rural communities as well as the underserved. Under this scheme, rural communities pay only ₦150 monthly as a premium to benefit from the National Health Insurance Scheme.

- **Quality Improvement and Clinical Governance Programme:**

This programme aims at improving the quality of care in primary, referral, and tertiary facilities. The quality improvement and clinical governance agenda assess quality improvement through three prime lenses: patient safety, clinical outcomes, and patient experience.

Other Policy Actions include:

- Establishment of the Centre for Disease Control
- Introduction of new vaccines
- Modernization of the Federal Teaching Hospitals
- Private Sector Involvement in the Health Sector
- Nutrition

3.4 Primary Healthcare Under One Roof in Nigeria

Primary health care under one roof (PHCUOR), also called Integrated PHC Governance is a PHC reform promoted by the Government of Nigeria. It was introduced in 2005, aimed

at integrating PHC structures and programmes in states by the Primary Health Care Development Agency or Board (SPHCDA/B) within the framework of a decentralized health system. The PHCUOR policy is premised on the principle of "Three Ones"- i.e., one management, one plan and one monitoring & evaluation system. The PHCUOR was adopted by the National Council of Health in Nigeria, progress with implementation has been slow with States making varying degrees of progress on each domain, with Jigawa recording the highest proportion in compliance implementation (80%), while states, such as Ebonyi and Akwa Ibom recorded 0% (NPHCDA, 2015).

The PHCUOR guidelines outlines specific steps and approaches involved in establishing a functional SPHCDA/B and consists of nine specific domains

- Governance
- Legislation
- Minimum Service Package
- Repositioning
- Systems Development
- Operational Guidelines
- Human Resources
- Funding Sources
- Structure and Office Setup

The 2015 PHCUOR scorecard 3 assessment showed that 28 States in Nigeria now have State Primary Health Care Development Agencies with 26 of them having a legal establishment basis. However, majority of the States' establishment laws, and the bills in process do not conform with the national guidelines. Also, most States with SPHCDAs or equivalent structures, struggles with institutional repositioning and human resource management as staff are managed and paid by their parent MDAs. In addition, most States

with SPHCDAs are yet to establish the Local Government Health Authorities (LGHAs), which are expected to be the implementing arm of the SPHCDAs, while only 8 States have collapsed the LGA health departments into LGHAs. The implementation of PHCUOR requires huge financial resources, but with improved services focussed to the primary beneficiaries in resident domains.

3.5 Issues in Health Sector Reform

- **Institutional corruption:**

Corruption in the health sector is a major challenge worldwide. Institutional corruption is the deliberate effort of some individuals to make an institution ineffective by working at cross purposes to its goals thereby eroding public trust in the institution. Institutional corruption places an enormous burden on poor people who are mostly unable to pay for healthcare services.

In every health institution, improving the health of the nation should be of great importance to the workers and this can be achieved by ensuring that initiatives aimed at reforming the health sector are supported without prejudice, personal glorification, and deceit. These improvements would increase public trust in the health sector, ensure the effective use of financial resources for health, and produce increased investment in the health of the people. Lack of development of previous governments' policies by new administrations also affects the process of HSR in the country. The culture of continuity should be imbibed by government administrations. Improvements in the health of individuals in a nation should be made a national priority and treated with the utmost importance among decision makers.

Health care financing reforms

The most marked reform in the health sector involves, securing sustainable financing for health care. In most countries, the focus is on the contents of reforms rather than on the

processes and these always caused failure or delay in implementation. A worldwide study, with external assistance to the health sector from 1972 to 1990 revealed that smaller and poorer countries received more funds from external assistance in health sector per capita than larger and richer countries.

The fundamental principle of financing reforms is that health care funds are raised by the people according to their ability to pay, and not according to health need. It is also equally important that funds are spent according to health priority need, and not according to the ability to pay.

Resource generation

The quality, quantity, and balance of human resources for health are the main concerns in the health care delivery system. In most countries, there are still shortages of health personnel, despite all attempts to expand training institutions and their production capacities. This scarcity of workers is one of the reasons for high maternal mortality and low accessibility of essential obstetric care during pregnancy and childbirth. Lack of balance in the deployment of workers between the rural and urban areas is also an issue in health sector reform.

Reform in the provision of healthcare

Most countries in the world, developed different sets of health care packages to ensure good health delivery system and these include mother-baby package, baby-friendly hospitals, health-promoting hospitals, Integrated Management of Childhood Illnesses (IMCI), Safe Motherhood Initiative (SMI), EPI-plus, and recently, Making Pregnancy Safer with support and guidance. These essential health packages aimed at improving healthcare and increasing efficiency by making the best use of contact between health workers and concentrating on the needs of the individual rather than focusing on the single disease.

4.0 CONCLUSION

Health is an essential carrier for economic growth and development. High quality and affordable healthcare delivery, both at primary and tertiary levels, is a necessary condition for the development of human capital. Health sector reform is a sustained process of fundamental change in policies, regulation, financing, provision of health services, re-organization, management and institutional arrangements, which is led by government and designed to improve the performance of the health system for the better health status of the population.

5.0 SUMMARY

In this unit, we have learned that:

- The principles of health sector reform
- The multi-dimensional issues in the health sector reform

6.0 TUTOR-MARKED ASSIGNMENT

1. What is health sector reform?
2. Discuss the issues in the health sector reform
3. Discuss the health reform actions in Nigeria

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UNIT 3 LEADERSHIP AND MANAGEMENT IN GLOBAL HEALTH

CONTENTS

1.0 INTRODUCTION

Strong leadership and management competencies have long been identified as key elements for encouraging health systems that are responsive to population needs. National level management and leadership typically include setting policy and overseeing strategic direction, managing resource allocation, and monitoring policy targets and outcomes. At the end of this unit, you will be aware of the importance of good leadership and management in global health as well as global health governance.

2.0 OBJECTIVES

At the end of this unit, you will able to:

- understand the concept of leadership and management in health
- understand the role of governance in global health

3.0 MAIN CONTENT

3.1 Definition and Concept

Many definitions of ‘leadership’ exist in the literature. In organisational psychology, it is mostly defined as a group phenomenon (including the interaction between two or more people) and an intentional social exertion of influence, which aims at attaining objectives

by communication processes. While leadership and management are theoretically distinct, in practice, they overlap. Management is a set of task-oriented processes of planning, budgeting, organizing, staffing, controlling and problem-solving. Conversely, leadership is viewed as a process of enabling others to work in a specific context. It involves the creation of a vision and strategic direction for the organization, the communication of that vision to staff and stakeholders, and inspiring, motivating and aligning actors and the organization to the achievement of the vision.

Indeed, leadership has been cited as one of the key ingredients for healthcare reform in low-income settings. Leadership, communication, and vision are valuable attributes for health professionals who ascend to positions in which they design, implement and scale-up health programmes and policies. However, the competencies that support these attributes are rarely taught in standard medical or nursing curricula. The majority of health leaders and managers in developing countries are trained health professionals (doctors, nurses, clinical/medical officers and pharmacists) who rarely have any training or experience prior to being offered a managerial position. New managers are often promoted on account of clinical expertise: they may be ill-prepared for their new responsibilities and may be expected to gain managerial capacities by learning on the job or through brief training courses.

At the operational level, hospital, district and primary health care facility managers are responsible for converting inputs and resources such as finance, staff, supplies, equipment, and infrastructure into effective services that produce health results and are responsive to population needs. As decision space is transferred to these operational levels, the perceived need for leadership and management capacities has become more urgent.

Given the need to implement health policies in resource-poor and challenging contexts, health leaders and managers require both managerial and leadership competencies. A conceptualization of “managers who lead” provides a holistic approach to running health

care programmes, organizations, or facilities, where strong leadership and managerial practices strengthen organizational capacity and result in higher-quality services and sustained improvements in health. Management and leadership are an important part of the same job and are both necessary for success in simple and complex organizations.

The importance of management and leadership is also apparent in relation to the need to scale up HIV/AIDS, child health, maternal health, tuberculosis and malaria services in order to meet the health-related Sustainable Development Goals (SDGs). Despite increases in development assistance for health, many low and middle-income countries may miss these targets, and weaknesses in a general managerial capacity at all levels of the health system have been cited as one of the contributory factors in failing to scale up effective health services.

The 2014–15 Ebola outbreak in West Africa has demonstrated again the urgent need for strong leadership and coordination when responding to global health emergencies. The outbreak started in Guinea during December 2013, but cases soon began to spread to neighbouring countries Liberia and Sierra Leone. Despite 25 previous outbreaks of Ebola being successfully contained, this time, the disease spread from rural to urban locations and crossed borders, becoming a global threat – an unprecedented situation. All actors in the Ebola crisis appreciate that this has been a challenging response. Many agencies have struggled to identify and establish their role in the process, and therefore meet the needs of the people within this new landscape of a widespread, infectious, deadly disease in developing countries. We must learn lessons from this unprecedented outbreak, which will require a critical perspective.

3.2 Global Health Governance

In today's world of changing health risks and opportunities, the capacity to influence health determinants, status and outcomes cannot be assured through national actions alone because of the intensification of cross-border and transborder flows of people, goods and

services, and ideas. The need for more effective collective action by governments, business and civil society to better manage these risks and opportunities is leading us to reassess the rules and institutions that govern health policy and practice at the subnational, national, regional and global levels.

In broad terms, governance can be defined as the actions and means adopted by a society to promote collective action and deliver collective solutions in pursuit of common goals. This a broad term that is encompassing of the many ways in which human beings, as individuals and groups, organize themselves to achieve agreed objectives. Such organization requires agreement on a range of matters including membership within the co-operative relationship, obligations, and responsibilities of members, the making of decisions, means of communication, resource mobilization and distribution, dispute settlement, and formal or informal rules and procedures concerning all of these. Defined in this way, governance pertains to highly varied sorts of collective behaviour ranging from local community groups to transnational corporations, from labour unions to the United Nations Security Council. Governance thus relates to both the public and private sphere of human activity, and sometimes a hybrid or combination of the two. The ability of a society to promote collective action and deliver solutions to agreed goals is a central aspect of governance.

Health governance concerns the actions and means adopted by a society to organize itself in the promotion and protection of the health of its population. The rules defining such organization, and its functioning, can again be formal (e.g. Public Health Act, International Health Regulations) or informal (e.g. Hippocratic oath) to prescribe and proscribe behaviour. The governance mechanism, in turn, can be situated at the local/subnational (e.g. district health authority), national (e.g. Ministry of Health), regional (e.g. Pan American Health Organization), international (e.g. World Health Organization) and at the global level. Furthermore, health governance can be public (e.g. National Health Service),

private (e.g. International Federation of Pharmaceutical Manufacturers Association), or a combination of the two (e.g. Malaria for Medicines Venture).

"Global health governance" refers to the use of formal and informal institutions, rules, and processes by states, intergovernmental organizations, and non-state actors to deal with challenges to health that require cross-border collective action to address effectively. To improve social determinants of health requires policies that penetrate political, economic, and social contexts, often down to the local, neighbourhood and household levels. There is an acute need to broaden the public health agenda to take account of these globalizing forces and to ensure that the protection and promotion of human health are placed higher on other policy agendas. There is a widespread belief that the current system of international health governance (IHG) does not sufficiently meet these needs and, indeed, has a number of limitations and gaps. In light of these perceived shortcomings, the concept of Global Health Governance (GHG) has become a subject of interest and debate in the field of international health.

4.0 CONCLUSION

Leadership is more than a micro-organisational phenomenon. It goes beyond direct relationships between leaders and subordinates; rather, it takes place at all levels of an organisation. It can occur in indirect as well as direct forms. It includes the efforts of the management to reach both short-term and long-term objectives. Health governance deals with the actions and means embraced by a society to organize itself in the promotion and protection of the health of its population.

5.0 SUMMARY

In this unit, we have learned that:

- Good leadership and management competencies have long been identified as critical elements for encouraging health systems that are responsive to population needs.

- Leadership is one of the key ingredients for healthcare reform in low-income settings.
- Health governance **entails the** actions and activities used by a society to organize itself in the promotion and protection of the health of its population.

6.0 TUTOR-MARKED ASSIGNMENT

1. Explain the roles of leaders and managers in health promotion and protection.
2. What is the role of good leadership and management in the reduction of global child and maternal mortality?

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UNIT 4 GLOBAL HEALTH POLITICS AND POLICY

CONTENTS

1.0 INTRODUCTION

The human race is presented with new and demanding problems such as global poverty, lack of global development, climate change, human and national security, nuclear proliferation, transborder infectious diseases, globalization of disease risk factors, and global economic crisis. Traditional multifaceted policy models such as the global health policy are strained to sufficiently tackle these global problems.

Generally, there is a growing interest in global health governance and global health in the last decade; this is as a result of an increased interconnection between globalization and public health. Closer attention is being paid to global health policy and its important place in global politics with a plethora of social science publications being generated since the turn of the millennium.

2.0 OBJECTIVES

At the end of this unit, you will able to:

- understand what is global health policy
- describe health policy triangle
- understand politics in global health policies

3.0 MAIN CONTENT

3.1 What is Global Health Policy?

Global health refers to issues that directly or indirectly impact on the health of populations and can transcend national boundaries. Solutions to global health issues often require global cooperation and policy actions that are beyond the capacity of individual countries. Global *health* policy was also defined as "the statement of goals, objectives, and means that create the framework for global health activities" Global health policy incorporates both policy *content*, the substance of policy comprising rules and guidelines, and policy processes, the purposeful, deliberate actions, methods, and strategies that influence the shape and impact of policy development and implementation.

Global health policy and its implementation are formed by a complex and dynamic set of individuals, groups, and organizations that form global, interrelated networks of actors. These networks have an impact on the health of populations. Understanding such policy processes is a prerequisite for achieving global population health goals, such as universal health coverage, and for tackling the social and economic determinants of health, where causes and actions go beyond country borders.

Actors are considered important to the analysis of how policies are made and implemented. Global and country policy actors include individuals and institutions, such as civil society organizations, research institutions, the private sector and philanthropic organizations, governments and programme managers, health workers, and community-based organizations. Policy analysis in global health can help explain how power and the interests and values of different global actors play an important role in shaping policies. Power and politics, which are implicit in all fields of knowledge and activity, are made explicit and thereby more transparent through policy analysis.

Health policy analysis is a growing field, occupied by policy practitioners, including policy-makers and technical analysts, and by academic researchers and students. Practitioners are primarily interested in using policy analysis prospectively to help shape

future policies (analysis for policy), and in bringing evidence from the clinical sciences, epidemiology, and economics to inform the content of health policies.

3.2 Health Policy Triangle

Health policy triangle provides a useful framework to identify key issues in health policy and how they impact on the health systems, policies, and health of populations. The framework can be used to move beyond a study of the *content* of policies to understand how political, historical, and cultural *contexts* influence the direction and feasibility of policy-making.

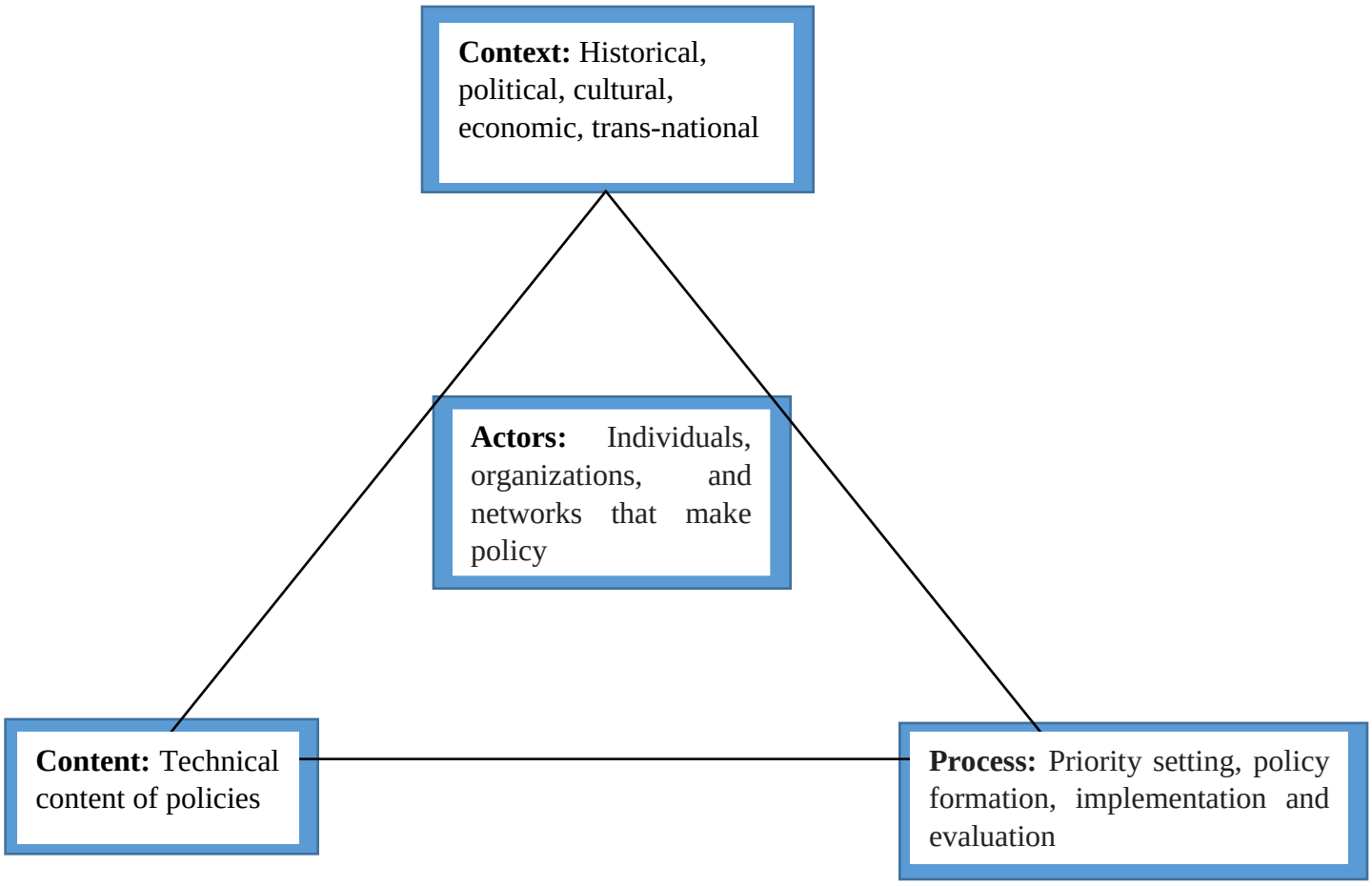

Figure 3.1: Health policy triangle

Walt and Gilson, 1994

The triangle emphasizes the importance of identifying the *actors* or stakeholders and the *processes* that lead to (or obstruct) health policy development and implementation. It is a flexible framework that can complement different policy theories to help explain which issues get on the policy agenda, and how these are formulated and implemented. The health policy triangle can be used to illustrate some important contextual factors, actors, and processes influencing the content of global health policy.

It is widely accepted that human beings require adequate health in order to maintain a minimally decent life. It is also widely accepted that states and their citizens have duties of justice to maintain health systems for the delivery of basic national health and the health needs of its population. Nevertheless, at the global level, there is far less certainty about what moral duties exist regarding the satisfaction of adequate health for those beyond borders. Although there is almost unified agreement that there are vast inequalities in global health and that more concerted efforts are needed to rectify these inequalities, there is also widespread disagreement about how to deliver these systems globally and the ethical principles that should underwrite such a system.

3.3 Global Health and Politics

The global health agenda has been dominating the current global health policy debate. It has compelled countries to embrace strategies for tackling health inequalities in a wide range of public health issues, such as communicable and non-communicable diseases, essential medicines shortfalls, access to healthcare delivery services, and health systems strengthening. In recent decades, the politics of global health has been narrowly debated. On the contrary, global health governance has been the milestone in politics and political processes to influence the shaping of population health goals worldwide.

Despite that several authors have developed theoretical frameworks for global health governance, politics have been conceived as one driver rather than the core of a shared

governance covenant worldwide. Nevertheless, and notwithstanding that current theoretical effort has focused on seeking renewal in global health as a conceptual framework, politics remain hindered by financing and policy initiatives. Thus, identifying an ideology behind global health is also a global quest by itself.

Global politics has posed the social determinants of health as a cross-cutting paradigm to understand population health. Nevertheless, as a social determinant of health, politics has led to a misguided debate on what are global health's ideological roots. Also, it has contributed to a misleading global health advocacy debate that can be driven based on the perceptions of two conflicting policy trends: one philanthropic-based and the other state-based. Consequently, there has not been political will for a thorough and comprehensive political debate from different world's stakeholders for addressing gaps in the economic model.

Global health will remain lacking in politics, while its challenges and principles undermine the economic model as the political driver worldwide. Moreover, moving toward politics-based global health would nudge High-Income Countries (HICs) to embrace a different path for development where Low- and Middle-Income Countries (LMICs) would not be part of their enrichment policies.

For policy diffusion of ideas, a lack of global health politics implies the capture of the global policy agenda by HICs while LMICs development continues tied to the global extracted economic model. Therefore, sharing global solutions shaped from LMICs' backgrounds would still be seen as a threat by HICs.

4.0 CONCLUSION

The design of these policies tends to have two key considerations involved in their formulation and which ultimately guide the practice of how issues are governed: an ethical/moral dimension regarding the decision of "who gets what and why" and more practical dimensions involving questions regarding "how, when, and where."

5.0 TUTOR- MARKED ASSIGNMENT

1. What is global health policy?

2. Described the health policy triangle

6.0 SUMMARY

Global health refers to issues that directly or indirectly impact on the health of populations and can transcend national boundaries. Global health policy entails a statement of goals, objectives, and means that create the framework for global health activities.

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UNIT 5 THE POLITICAL ECONOMY OF GLOBAL HEALTH

CONTENTS

1.0 INTRODUCTION

This course takes a social scientific approach to understand global health from a political economy perspective. This course will examine the conditions which shape population health and health service development within the wider macroeconomic and political context. Students will learn to critically analyse the social, economic and political forces that converge to create inequities in health both across and between countries.

2.0 OBJECTIVES

At the end of this unit, you will able to:

- analyse global health issues from a critical political economy perspective
- discuss the political economy analysis of human resources

3.0 MAIN CONTENT

3.1 Definition and Concept

'Political economy' originally developed in the 18th century as a form of moral philosophy that examined the conditions that influenced the economic actions of states. It is today an interdisciplinary field with diverse academic influences, ranging from Marxist analysis,

public choice theorists, and social scientists concerned with development. Most recently, it is also being mainstreamed into development agencies, as demonstrated by the range of guidance documents produced on how to undertake an applied political economy analysis for furthering organizational objectives (DFID, Worldbank).

The political economy provides concepts and methods for analyzing and influencing difficult challenges to health reform, including collective action problems, corruption, distributional issues, and patronage. It helps explain and manage different forms of power and the networks through which they flow, including the production of knowledge and the creation of legitimacy. Political economy analysis can help with understanding and change the structure and allocation of power, for instance, through assessments of governance, accountability, participation, and voice.

The political economy of health refers to a body of analysis and a perspective on health policy which seeks to understand the conditions which shape population health and health service development within the wider macroeconomic and political context. However, the relationships between economic development and health development are complex and can be analysed in terms of a range of different linkages:

- economic growth leads to increased resources for health
- health improvement contributes to economic growth
- people's health is exchanged for economic growth (mining 'accidents', unhealthy environments) and the 'disease burden' associated with these is the price of economic growth; raising questions

The dynamics of the global economy shape in various ways the health chances of people all over the world. Creating environments which can deliver ‘health for all’ requires knowingly and deliberately reshaping the global economy. Stories about the global economy play a powerful role in the political debate including the debate over health care and policy debates which shape the social determinants of health.

The field of political economy of global health seeks to explain and influence the broader forces that affect the distribution of health and resources for health within and across populations globally. Studying the prioritization, design, adoption, and implementation of health policies through a political economy lens allows us to draw inferences about the motivations, incentives, policies, and dynamics that can lead to improvements in population health. Political economy differs from more traditional perspectives in that it seeks to better understand and analyze the contestation of interests, and engages core concepts such as power, incentives, interest groups, ideas, and institutions. Weak institutions contribute to profound problems of implementation, and thus improving the performance of institutions is essential to improving health. Political economy can analyze the incentives that affect institutions and identify ways to make them more responsive to the health needs and desires of citizens.

To promote more political economy approaches among researchers and practitioners, the meeting participants made the following recommendations: First, we recommend the application of political economy concepts and methods in the design, adoption, and implementation of health policies. For instance, we recommend more political economy analysis to better understand and support the processes by which countries are making progress toward Universal Health Coverage (UHC). Examining issues such as UHC using a political economy approach offers a fuller understanding of policy processes and outcomes, in particular explaining why some countries are making progress toward UHC while others are not.

3.2 Political economy analysis of Human resources

The genesis of the human resources for health (HRH) crisis in African countries is complex and context-specific, even if common factors are applicable across the region. Underinvestment in the social sector, which accelerated in the 1980s and 1990s as part of the International Monetary Fund (IMF) and World Bank structural adjustment programmes, undermined the health sector. The health worker situation in developing

countries has deteriorated to crisis levels due to a variety of factors, including political instability and weak health systems, characterized by poor working conditions, while further exacerbated by the migration of health workers to industrialized countries.

The rationale for a political economy analysis of HRH stems from a recognition that the solution to the shortage of health workers across Africa involves more than a technical response. The problem consists in how policy is made, how leaders are accountable, how WHO and foreign donors encourage (or distort) health policy, and how development objectives are prioritized in these countries. Fundamentally, this is a political process, which presents constraints and opportunities for potentially effective technical solutions to be adopted and implemented.

The lack of health workers in low-income countries has been recognized as a development challenge since the 1970s, beginning with the Alma Ata Declaration or Health for All campaign in 1978 and later nested in broader discussions of structural adjustment in the 1980s and 1990s. HRH rose to the top of the global health agenda through the publication of the Joint Learning Initiative's report in 2004 and the World Health Report in 2006, which described the extent of the shortage of health workers in a number of countries.

Donor agencies responded by targeting increased production of health workers as a key development objective. In 1978, the WHO set a target of one physician per 5000 people in the Alma Ata Declaration/Health for All. In 2006, WHO adopted a threshold of 2.28 skilled health workers per 1000 people; if a country falls below that prescribed threshold, WHO refers to it as an HRH crisis country. According to WHO, there are 57 HRH crisis countries as of 2011 and 37 in Sub-Saharan Africa. One of the major obstacles to HRH crisis countries to raise their health worker density is the weak capacity of the government to plan and coordinate effectively.

As HRH was emerging as a global issue in the first decade of the 2000s, nearly every HRH crisis country in Africa wrote a strategic HRH plan to address its own health worker shortage. Many national HRH plans suffered from similar problems: over-ambitious

targets, disruptions (or even abandonment) due to leadership changes, little political support, and weak resource mobilization.

Despite a global recognition of the gravity and urgency of health worker shortage in Africa, little progress has been achieved to improve health worker coverage in many of the African HRH crisis countries generally. Powerful political and institutional incentives push stakeholders at the domestic and international levels not to invest in HRH. The status quo of institutional arrangements needs to be changed for new policy choices to reach the top of the agenda, and ideas have the power to be the earthquake to disrupt the previous rules of the game. Good governance and some degree of bureaucratic capacity alone do not ensure a successful HRH plan.

4.0 CONCLUSION

The political economy analysis in global health seeks to explain and change the structural inequalities and related processes that characterize certain forms of globalization. The field recognizes the role of social movements engaged with understanding and shaping public health and builds on past efforts by the classical pioneers of political economy who sought to improve the lives of those marginalized by structural forces in the industrial revolution.

5.0 SUMMARY

In this unit, we have learned that:

- A political economy approach offers a better understanding of policy processes and outcomes, in particular explaining why some countries are making progress toward universal health coverage while others are not.
- Political will, in the form of a long-term commitment to HRH, is essential to mobilize internal and external resources.

6.0 TUTOR-MARKED ASSIGNMENT

1. Explain the concept of political economy in global health
2. Discuss the role of health workers in the attainment of Sustainable Development Goals (SDGs).

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MODULE 4 GLOBAL HEALTH AND DISEASES

Unit 1 Case studies in tropical diseases

CONTENTS

1.0 INTRODUCTION

Tropical diseases include all diseases that occur mainly in the tropics. It often refers to infectious diseases that thrive in hot, humid conditions, such as malaria, leishmaniasis, schistosomiasis, onchocerciasis, lymphatic filariasis, Chagas disease, African trypanosomiasis, and dengue. In recent times, tropical regions of the world were more severely affected by infectious diseases in comparison to the temperate world. The main reasons why infectious diseases thrive in the such areas is due to both environmental and biological factors that support high levels of biodiversity of pathogens, vectors and hosts, but also in social factors that undermine efforts to control these diseases.

2.0 OBJECTIVES

At the end of this unit, you will able to:

- understand what are tropical and neglected tropical diseases
- understand the distribution and epidemiology of some tropical diseases

3.0 MAIN CONTENT

3.1 Definition

Tropical diseases are infectious diseases that increase in hot and humid weather conditions. Some of these diseases are caused by protozoa, such as malaria, leishmaniasis, Chagas' disease and sleeping sickness. Others are caused by worms, including schistosomiasis, onchocerciasis and lymphatic filariasis. One is viral, dengue fever. The eight WHO tropical diseases are transmitted to humans by various means, but always include a vector that is generally a hematophagous insect. Schistosomiasis has no vector, but rather intermediary hosts – snails – that release in water the infectious forms for humans.

The designation "tropical diseases" was not invented by the WHO and has been part of the medical vocabulary since the 19th century. It arose at no particular date and was gradually consolidated, as microorganisms came to be acknowledged as the causal factors of diseases and had their transmission mechanisms elucidated. The colonial expansion of England, France and other minor partners, including the United States, into the Caribbean and the Pacific, unfolded a new world full of exploitable riches, but also of unknown or unwanted diseases. Since most of the new colonies were located in the tropics, these curious and exotic diseases were said to be "tropical" From the start, however, many scientists, especially those from the tropics, disputed the "tropical diseases" designation, because it implicitly denoted some sort of biogeographic curse or fate.

3.2 Neglected Tropical Diseases

Neglected Tropical Diseases (NTDs) – is a diverse group of communicable diseases that prevail in tropical and subtropical conditions in 149 countries – affect more than one billion people and cost developing economies billions of dollars every year. NTDs are called neglected because they have been largely wiped out in the developed world and persist only in the poorest, most marginalized communities and conflict zones. They thrive in places with unsafe water, poor sanitation, and limited access to basic health care. Populations living in poverty, without adequate sanitation and in close contact with infectious vectors and domestic animals and livestock are those worst affected.

Parasitic and bacterial diseases, known to be neglected, are among some of the most common infections that affect an estimated 2.7 billion people who live on less than US$ 2 per day. The disparity between the haves and the have-nots has continued, and global climate change – besides unleashing natural calamities – is also creating conditions for diseases to thrive and for vectors to re-emerge in regions where they were previously thought to have been eliminated. The resurgence of dengue fever over the past few years is a testimony to this phenomenon.

Neglected tropical diseases kill an estimated 534 000 people worldwide every year. Their impact on worker productivity adds up to billions of dollars lost annually and maintains low-income countries in poverty. A WHO report on Social Determinants of Health found that those living in poverty, even those inhabiting large affluent cities, remain the most vulnerable and die younger. How much more severe must be the plight of millions, who live in deprived rural communities where basic facilities are non-existent.

Many NTDs disproportionately affect women and children. Those living in remote areas are most vulnerable to infections, and their biological and sociocultural consequences. Deliberate global health responses are needed to promote interventions in the biological and social contexts in which these diseases persist. Additional efforts are required to collect epidemiological data that show the differential impact of these diseases according to a

patient's sex and age in order to better inform policies, and guide targeted interventions for sustainable control.

Enormous progress has been made towards the control and elimination of several NTDs. Never before have so many of these diseases been targeted for action with time-limited goals, typically through the creation of public-private partnerships. This mobilization has changed the health landscape dramatically. Provision of drugs free of charge is a striking feature of such partnerships, with the release of additional resources for country-level activities to make treatment more accessible to patients.

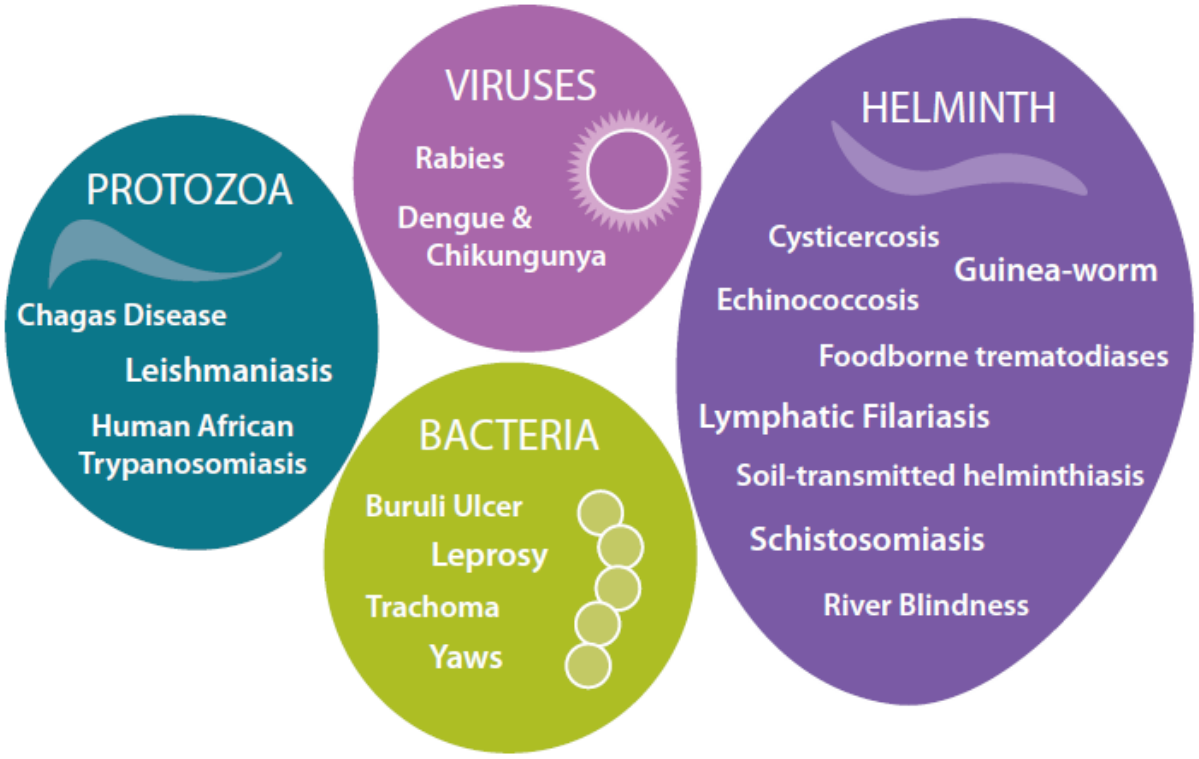

Figure 4.1: The 17 priority NTDs.
Source: Cotton (2015

3.3 Case studies of Tropical Diseases

Malaria

Malaria is caused by Plasmodium parasites. The parasites are spread to people through the bites of infected female *Anopheles* mosquitoes, called "malaria vectors." There are five parasite species that cause malaria in humans, and two of these species – *Plasmodium. falciparum* and *P. vivax*– pose the greatest threat. *P. falciparum* is the most prevalent malaria parasite on the African continent. It is responsible for most malaria-related deaths globally while *P. vivax* is the dominant malaria parasite in most countries outside of sub-Saharan Africa.

According to the World Malaria Report, released in November 2017, there were 216 million cases of malaria in 2016, up from 211 million cases in 2015. The estimated number of malaria deaths stood at 445 000 in 2016, a similar number to the previous year (446 000). In 2016, nearly half of the world's population was at risk of malaria. Most malaria cases and deaths occur in sub-Saharan Africa. However, the WHO regions of South-East Asia, Eastern Mediterranean, Western Pacific, and the Americas are also at risk. In 2016, 91 countries and areas had ongoing malaria transmission.
The WHO African Region continues to carry a disproportionately high share of the global malaria burden. In 2016, the region was home to 90% of malaria cases and 91% of malaria deaths. Some 15 countries – all in sub-Saharan Africa, except India – accounted for 80% of the global malaria burden. In areas with high transmission of malaria, children under 5 are particularly susceptible to infection, illness and death; more than two thirds (70%) of all malaria deaths occur in this age group. The number of under-5 malaria deaths has declined from 440 000 in 2010 to 285 000 in 2016. However, malaria remains a major killer of children under five years old, taking the life of a child every two minutes.

In most cases, malaria is transmitted through the bites of female *Anopheles* mosquitoes. There are more than 400 different species of *Anopheles* mosquito; around 30 are malaria

vectors of major importance. All of the important vector species bite between dusk and dawn. The intensity of transmission depends on factors related to the parasite, the vector, the human host, and the environment. *Anopheles* mosquitoes lay their eggs in water, which hatch into larvae, eventually emerging as adult mosquitoes. The female mosquitoes seek a blood meal to nurture their eggs. Each species of *Anopheles* mosquito has its preferred aquatic habitat; for example, some prefer small, shallow collections of freshwater, such as puddles and hoof prints, which are abundant during the rainy season in tropical countries.

Transmission is more intense in places where the mosquito lifespan is longer (so that the parasite has time to complete its development inside the mosquito) and where it prefers to bite humans rather than other animals. The long lifespan and strong human-biting habit of the African vector species is the main reason why nearly 90% of the world's malaria cases are in Africa. The transmission also depends on climatic conditions that may affect the number and survival of mosquitoes, such as rainfall patterns, temperature and humidity. In many places, transmission is seasonal, with the peak during and just after the rainy season. Malaria epidemics can occur when climate and other conditions suddenly favour transmission in areas where people have little or no immunity to malaria.

Vector control is the main way to prevent and reduce malaria transmission. If coverage of vector control interventions within a specific area is high enough, then a measure of protection will be conferred across the community. The WHO recommends protection for all people at risk of malaria with effective malaria vector control. Two forms of vector control – insecticide-treated mosquito nets and indoor residual spraying – are effective in a wide range of circumstances.

Long-Lasting Insecticidal Nets (LLINs) are the preferred form of Insecticide-Treated Mosquito Nets (ITNs) for public health programmes. In most settings, WHO recommends LLIN coverage for all people at risk of malaria. The most cost-effective

way to achieve this is by providing LLINs free, to ensure equal access for all. In parallel, effective behaviour change communication strategies are required to ensure that all people at risk of malaria sleep under a LLIN every night, and that the net is properly maintained.

Indoor Residual Spraying (IRS) with insecticides is a powerful way to rapidly reduce malaria transmission. Its potential is realized when at least 80% of houses in targeted areas are sprayed. Indoor spraying is effective for 3–6 months, depending on the insecticide formulation used and the type of surface on which it is sprayed. In some settings, multiple spray rounds are needed to protect the population for the entire malaria season.

Antimalarial medicines can also be used to prevent malaria. For travellers, malaria can be prevented through chemoprophylaxis, which suppresses the blood stage of malaria infections, thereby preventing malaria disease. For pregnant women living in moderate-to-high transmission areas, WHO recommends intermittent preventive treatment with sulfadoxine-pyrimethamine, at each scheduled antenatal visit after the first trimester. Similarly, for infants living in high-transmission areas of Africa, three (3) doses of intermittent preventive treatment with sulfadoxine-pyrimethamine are recommended, delivered alongside routine vaccinations. In 2012, WHO recommended Seasonal Malaria Chemoprevention as an additional malaria prevention strategy for areas of the Sahel sub-region of Africa. The strategy involves the administration of monthly courses of amodiaquine plus sulfadoxine-pyrimethamine to all children under five years of age during the high transmission season.

Early diagnosis and treatment of malaria reduces disease and prevents deaths. It also contributes to reducing malaria transmission. The best available treatment, particularly for *P. falciparum* malaria, is Artemisinin-based Combination Therapy (ACT). The WHO recommends that all cases of suspected malaria be confirmed using parasite-based

diagnostic testing (either microscopy or rapid diagnostic test) before administering treatment.

Schistosomiasis

Schistosomiasis is an acute and chronic parasitic disease caused by blood flukes (trematode worms) of the genus *Schistosoma*. Estimates show that at least 206.5 million people required preventive treatment in 2016. Preventive treatment, which should be repeated over a number of years, will reduce and prevent morbidity. Schistosomiasis transmission has been reported from 78 countries. However, preventive chemotherapy for schistosomiasis, where people and communities are targeted for large-scale treatment, is only required in 52 endemic countries with the moderate-to-high transmission.

People become infected when larval forms of the parasite – released by freshwater snails – penetrate the skin during contact with infested water. Transmission occurs when people suffering from schistosomiasis contaminate freshwater sources with their excreta containing parasite eggs, which hatch in water. In the body, the larvae develop into adult schistosomes. Adult worms live in the blood vessels where the females release eggs. Some of the eggs are passed out of the body in the faeces or urine to continue the parasite's lifecycle. Others become trapped in body tissues, causing immune reactions and progressive damage to organs.

Schistosomiasis is prevalent in tropical and subtropical areas, especially in poor communities without access to safe drinking water and adequate sanitation. It is estimated that at least 92% of those requiring treatment for schistosomiasis live in Africa. There are two major forms of schistosomiasis – intestinal and urogenital – caused by five main species of blood fluke. Schistosomiasis mostly affects poor and rural communities, mainly agricultural and fishing populations. Women doing domestic

chores in infested water, such as washing clothes, are also at risk. Inadequate hygiene and contact with infected water make children especially vulnerable to infection.

Migration to urban areas and population movements are introducing the disease to new areas. Increasing population size and the corresponding needs for power and water often result in development schemes, and environmental modifications facilitate transmission. With the rise in eco-tourism and travel “off the beaten track”, increasing numbers of tourists are contracting schistosomiasis. At times, tourists present severe acute infection and unusual problems, including paralysis.

Symptoms of schistosomiasis are caused by the body’s reaction to the worms' eggs. Intestinal schistosomiasis can result in abdominal pain, diarrhoea, and blood in the stool. Liver enlargement is common in advanced cases and is frequently associated with an accumulation of fluid in the peritoneal cavity and hypertension of the abdominal blood vessels. In such cases, there may also be enlargement of the spleen.

Schistosomiasis is diagnosed through the detection of parasite eggs in stool or urine specimens. Antibodies and/or antigens detected in blood or urine samples are also indications of infection. For urogenital schistosomiasis, a filtration technique using nylon, paper or polycarbonate filters is the standard diagnostic technique. Children with *S. haematobium* almost always have microscopic blood in their urine which can be detected by chemical reagent strips.

The eggs of intestinal schistosomiasis can be detected in faecal specimens through a technique using methylene blue-stained cellophane soaked in glycerine or glass slides, known as the Kato-Katz technique. For people living in non-endemic or low-transmission areas, serological and immunological tests may be useful in showing

exposure to infection and the need for a thorough examination, treatment and follow-up.

The control of schistosomiasis is based on the large-scale treatment of at-risk population groups, access to safe water, improved sanitation, hygiene education, and snail control. The WHO strategy for schistosomiasis control focuses on reducing disease through periodic, targeted treatment with praziquantel through the large-scale treatment (preventive chemotherapy) of affected populations. It involves regular treatment of all at-risk groups. In a few countries, where there is low transmission, the interruption of the transmission of the disease should be aimed for.

Groups of people targeted for treatment are:

- School-aged children in endemic areas.
- Adults considered to be at risk in endemic areas, and people with occupations involving contact with infested water, such as fishermen, farmers, irrigation workers, and women whose domestic tasks bring them in contact with infested water.
- Entire communities living in highly endemic areas.

Schistosomiasis control has been successfully implemented over the past 40 years in several countries, including Brazil, Cambodia, China, Egypt, Mauritius, Islamic Republic of Iran, Oman, Jordan and Saudi Arabia. There is evidence that schistosomiasis transmission was interrupted in Morocco. In Burkina Faso, Niger, Ghana, Sierra Leone, Rwanda and Yemen, it has been possible to scale up schistosomiasis treatment to the national level and have an impact on the disease in a few years. An assessment of the status of transmission is being made in several countries.

Soil-Transmitted Helminths

Soil-transmitted helminth infections are caused by different species of parasitic worms. They are transmitted by eggs present in human faeces, which contaminate the soil in areas where sanitation is poor. Approximately 1.5 billion people are infected with soil-transmitted helminths worldwide. Infected children are nutritionally and physically impaired.

Soil-transmitted helminth infections are among the most common infections worldwide and affect the poorest and most deprived communities. They are transmitted by eggs present in human faeces which in turn contaminate soil in areas where sanitation is poor. The main species that infect people are the roundworm (*Ascaris lumbricoides*), the whipworm (*Trichuris trichiura*) and hookworms (*Necator americanus* and *Ancylostoma duodenale*).

More than 1.5 billion people, or 24% of the world's population, are infected with soil-transmitted helminth infections worldwide. Infections are widely distributed in tropical and subtropical areas, with the greatest numbers occurring in sub-Saharan Africa, the Americas, China and East Asia. Over 267 million preschool-age children and over 568 million school-age children live in areas where these parasites are intensively transmitted and need treatment and preventive interventions.

Soil-transmitted helminths are transmitted by eggs that are passed in the faeces of infected people. Adult worms live in the intestine where they produce thousands of eggs each day. In areas that lack adequate sanitation, these eggs contaminate the soil. This can happen in several ways:

- eggs that are attached to vegetables are ingested when the vegetables are not carefully cooked, washed or peeled;
- eggs are ingested from contaminated water sources;

- eggs are ingested by children who play in the contaminated soil and then put their hands in their mouths without washing them.

In addition, hookworm eggs hatch in the soil, releasing larvae that mature into a form that can actively penetrate the skin. People become infected with hookworm primarily by walking barefooted on contaminated soil. There is no direct person-to-person transmission, or infection from fresh faeces because eggs passed in faeces need about 3 weeks to mature in the soil before they become infective. Since these worms do not multiply in the human host, re-infection occurs only as a result of contact with infective stages in the environment.

Soil-transmitted helminths impair the nutritional status of the people they infect in multiple ways.

- The worms feed on host tissues, including blood, which leads to a loss of iron and protein.
- Hookworms in addition cause chronic intestinal blood loss that can result in anaemia.
- The worms increase malabsorption of nutrients. In addition, roundworm may possibly compete for vitamin A in the intestine.
- Some soil-transmitted helminths also cause loss of appetite and, therefore, a reduction of nutritional intake and physical fitness. In particular, *T. trichiura* can cause diarrhoea and dysentery.

Morbidity is related to the number of worms harboured. People with infections of light intensity (few worms) usually do not suffer from the infection. Heavier infections can cause a range of symptoms, including intestinal manifestations (diarrhoea and abdominal pain), malnutrition, general malaise and weakness, and impaired growth and

physical development. Infections of very high intensity can cause an intestinal obstruction that should be treated surgically.

In 2001, delegates at the World Health Assembly unanimously endorsed a resolution (WHA54.19) urging endemic countries to start seriously tackling worms, specifically schistosomiasis and soil-transmitted helminths.

The strategy for control of soil-transmitted helminth infections is to control morbidity through the periodic treatment of at-risk people living in endemic areas. People at risk are:

- Pre-school children
- school-age children
- women of childbearing age (including pregnant women in the second and third trimesters and breastfeeding women)
- adults in certain high-risk occupations such as tea-pickers or miners.

The WHO recommends periodic medicinal treatment (deworming) without a previous individual diagnosis to all at-risk people living in endemic areas. Treatment should be given once a year when the baseline prevalence of soil-transmitted helminth infections in the community is over 20 percent, and twice a year when the prevalence of soil-transmitted helminth infections in the community is over 50 percent. This intervention reduces morbidity by reducing the worm burden.

In addition, health and hygiene education reduce transmission and reinfection by encouraging healthy behaviours; and provision of adequate sanitation is also necessary but not always possible in resource-poor settings. Periodical treatment aims to reduce and maintain the intensity of infection and to protect infected at-risk populations from morbidity.

Deworming can be easily integrated with child health days or supplementation programmes for preschool children or integrated with school health programmes. In 2016, over 385 million school-aged children were treated with anthelminthic medicines in endemic countries, corresponding to 68 percent of all children at risk.

The global target is to eliminate morbidity due to soil-transmitted helminthiases in children by 2020. This will be obtained by regularly treating at least 75 percent of the children in endemic areas (an estimated 836 million in 2016).

4.0 CONCLUSION

Tropical diseases are diseases that occur mainly in the tropics. The infectious diseases that thrive in hot, humid conditions and disproportionately afflict the "poor and outcast populations" of the world. The NTDs are a group of 17 lesser-known chronic infections which predominantly affect poor and disenfranchised communities. They are mostly chronic infections that are often disfiguring and stigmatising and result in reduced economic productivity. There are a number of NTDs that cause significant global morbidity in children, including the three major soil-transmitted helminths (STH) infections (ascariasis, trichuriasis and hookworm infection), schistosomiasis and trachoma. These NTDs are currently being targeted for global control and elimination through mass drug administration campaigns. They represent the most common NTDs and share significant geographical overlap.

5.0 SUMMARY

In this unit, we have learnt that:

- Many Tropical diseases disproportionately affect women and children.
- Those living in remote areas are most vulnerable to infections, and their biological and sociocultural consequences.
- NTDs also provides an excellent example of the complex inter-relationships between the different Sustainable Development Goals.

6.0 TUTOR-MARKED ASSIGNMENT

1. What are tropical and neglected tropical diseases?
2. Discuss the epidemiology of two Tropical diseases
3. Discuss the role of vaccine in malaria prevention.

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UNIT 2 GENDER AND HEALTH

CONTENTS

1.0 INTRODUCTION

Men and women are comparable in many ways. Nevertheless, there are important biological and behavioural differences between them. These differences, as well as the gender norms prevalent in any society, determine the health status of the people living in it. A gender approach to health considers the critical roles that social and cultural factors and powers relations between women and men play in promoting and protecting health. Gender issues in health determine access to health care, use of the health care system and the behavioural attitudes of medical personnel. At the end of this unit, you will be aware of the role of gender in health outcomes.

2.0 OBJECTIVES

At the end of this unit, you will able to:

- Understand the concept of gender and sex
- Understand the role of gender in disease causation
- Know what gender inequality means

3.0 MAIN CONTENT

3.1 Definition and Concept

Gender refers to "the array of socially constructed roles and relationships, personality traits, attitudes, behaviours, values, relative power and influence that society ascribes to the two sexes on a differential basis. Gender is relational—gender roles and characteristics do not exist in isolation, but are defined in relation to one another and through the relationships between women and men, girls and boys" (Health Canada, 2000; Vlassoff, 2007). Gender is related to how we are perceived and expected to think and act like women and men because of the way society is organised, not because of our biological differences. However, sex is the genetic/physiological or biological characteristics of a person which indicates whether one is female or male. Sex refers to biological differences, whereas gender refers to social differences (Vlassoff, 2007).

Gender norms, roles and relations can influence health outcomes and affect the attainment of mental, physical and social health and well-being. Gender has been shown to influence how health policies are conceived and implemented, how biomedical and contraceptive technologies are developed, and how the health system responds to male and female clients (Vlassoff, 2002). By capturing the different experiences of men and women, gender can be understood as dynamic and layered with a range of multiple, intersecting social determinants that impact on health. The gender differences in the consequences of tropical diseases include how illness is experienced, treatment-seeking behaviour, nature of treatment, and care and support received from the family and care providers.

3.2 Gender and Health

Patterns of health and illness in women and men show marked differences. Most obviously, women as a group tend to have longer expectancy than men in the same socio-economic circumstances as themselves. Yet despite their longevity women in most communities experience more illness and distress than men (US National Institutes of Health, 1992). The details of this excess in female morbidity and the factors that fuels it varies in different social groups, but the broad picture is one where women's lives seem to be less healthy than those of men (Macintyre, 1996).

Concerning public health and gender issues, this mostly affects maternal and child health issues where delays could occur due to delay in decision making. Also, it would certainly affect other health outcomes too. Improving female literacy would be one of the greatest investments a country could do to overcome this barrier.

We have seen that being 'male' or being 'female' has a major effect on an individual's health and well-being. The combination of their biological sex and the gendered nature of their cultural, economic and social lives will put individuals at risk of developing some health problems while protecting them from others.

Furthermore, the subsequent effect of these problems on the individuals concerned will also be influenced by both their gender roles and their sex. The 'natural' course of a disease may be different in women and men; women and men themselves often respond differently to illness, while the wider society may respond differently to sick males and sick females. Women and may also respond differently to treatment, have different access to health care and be treated differently by health providers others.

Biological factors vary between the sexes and influence susceptibility and immunity to tropical diseases. Gender roles and relations influence the degree of exposure to the relevant vectors and also to access and control of the resources needed to protect women and men from being infected.

Even when tropical diseases are shared by both sexes, they may have different manifestations or natural histories in women and men or differ in the severity of their consequences. For example, malaria is shared by women and men, with a tendency to be slightly higher in males (Howson et al., 1996). However, biologically, women's immunity is compromised during pregnancy, making them more likely to become infected and implying differential severity of the consequences. Malaria during pregnancy is an important cause of maternal mortality, spontaneous abortions and stillbirths. Particularly during pregnancy, malaria contributes significantly to the development of chronic anaemia. Women engage in far more health-promoting behaviours than men and have healthier

lifestyle patterns (Lonnquist et al., 1992). Being a woman may be the strongest predictor of preventive and health-promoting behaviour.

On the other hand, some disease conditions are more prevalent in men. For instance, men in the United States, on average, die nearly seven year younger than women and have higher death rates for all 15 leading causes of death. Men's age-adjusted death rate for heart disease, for example, is two times higher than women's, and men's cancer death rate is 112 times higher. The incidence of 7 out of 10 of the most common infectious diseases is higher among men than women. Men are also more likely than women to suffer severe chronic conditions and fatal diseases and to suffer them at an earlier age. Nearly three out of four persons who die from heart attacks before age 65 are men.

Furthermore, Income, education, age, ethnicity, sexual orientation and place of residence are all important determinants of health. When they intersect with gender inequality, they can compound the experience of discrimination, health risks, and lack of access to resources needed for health attainment.

3.3 Gender Inequality

Gender inequality is the notion that women and men are not equal. Gender inequality refers to unequal treatment or perceptions of individuals wholly or partly due to their gender. It arises from differences in gender roles. It stems from distinctions, whether empirically grounded or socially constructed.

Promoting gender equality and empowering women is one of the Sustainable Development Goals (SDGs). The SDGs explicitly recognize that gender equality and women’s empowerment are not only human rights, but also play an influential role in promoting the development and reducing poverty. When women have the same opportunities, access to resources, and life choices as men, the benefits and opportunities extend far beyond women themselves Gender in Nigeria. Allowing girls access to educational opportunities is one of the proven ways of bridging the gender gap and improving health care. By empowering

women and young girls through educational opportunities, they are able to become well-versed in the safest health practices, learning the best ways to deal with common issues in their communities. According to a 2011 report from the World Health Organization, denying primary education to young girls has been shown to negatively impact fertility rates, birth spacing, health literacy and healthy behaviours. Similar reports have found that educating women in Africa and Latin America lowers their risk of HIV infection.

Nigeria has a National Gender Policy that focuses on women empowerment while also making a commitment to eliminate discriminatory practices that are harmful to women. However, significant gender gaps in education, economic empowerment and political participation remain in Nigeria. While progress towards parity in primary school education has been made, there remains a significant wage and labour force participation gender gap. Discriminatory laws and practices, violence against women and gender stereotypes hinder greater progress towards gender equality. Nigeria has a particularly high maternal mortality rate and women access to quality health care is limited, particularly in rural areas.

Nigeria has one of the highest rates of maternal mortality in the world. One Nigerian woman dies in childbirth every ten minutes. Spending and implementation have not matched policies. Nigeria spends only 6.5 percent of its budget on health care. Poor access to safe childbirth services and lack of adequate and affordable emergency obstetric care are the main reasons for high mortality. Only 36 percent of women deliver in a health facility or in the presence of a qualified birth attendant.

4.0 CONCLUSION

Women and men are different as regards their biology, the roles and responsibilities that society assigns to them and their position in the community. These factors have a great influence on causes, consequences and management of diseases and ill-health and the

efficacy of health promotion policies and programmes. This is confirmed by evidence on male-female differences in cause-specific mortality and morbidity.

Gender inequality limits access to quality health services and contributes to avoidable morbidity and mortality rates in women and men throughout the life-course. Developing gender-responsive health programmes which are appropriately implemented is beneficial for men, women, boys and girls. Addressing gender inequality improves access to and benefits from health services.

5.0 SUMMARY

In this unit, we have learnt that:

- men and women are different in their biological makeup.
- these differences contribute to differential health risks among men and women.
- taking actions to discourage gender inequality in health is one of the most direct and potent ways to reduce health inequities.

6.0 TUTOR-MARKED ASSIGNMENT

1. Distinguish between gender and sex
2. Explain the roles of gender in disease causation.
3. Discuss the concept of gender inequality.
4. Discuss the possible ways by which the government and all stakeholders can ensure gender equity in the distribution of resources in the health system.

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UNIT 3 CLIMATE CHANGE, SOCIAL JUSTICE, AND HEALTH

CONTENTS

1.0 INTRODUCTION

Climate change refers to long-term statistical shifts of the weather, including changes in the average weather condition or the distribution of weather conditions around the average (i.e. extreme weather events). Despite many discussions on the causes of climate change, there is a general recognition of an on-going global climate change and the non-minor role of human activities during this process. Climate changes include alternations in one or more climate variables including temperature, precipitation, wind, and sunshine. These changes may impact the survival, reproduction, or distribution of disease pathogens and hosts, as well as the availability and means of their transmission environment. The health effects of such impacts tend to reveal as shifts in the geographic and seasonal patterns of human infectious diseases, and as changes in their outbreak frequency and severity. Climate change should be viewed fundamentally as an issue of global justice. Understanding the complex interplay of climatic and socioeconomic trends is imperative to protect human health and lessen the burden of diseases. At the end of this unit, you will be aware of the link between climate change, social justice and health.

2.0 OBJECTIVES

At the end of this unit, you will able to:

- understand the concept of climate change and global warming
- understand the link between climate change, social justice and health

3.0 MAIN CONTENT

3.1 Definition and Concept

Climate change is a global problem with grave implications: environmental, social, economic, political, and for the distribution of goods. It represents one of the principal challenges facing humanity in our day. Climate change is a current global concern and, despite continuing controversy about its cause and the magnitude of its effects, it seems likely that climate change will affect the incidence and prevalence of both indigenous and imported infections in Europe. Climate restricts the range of infectious diseases, whereas weather affects the timing and intensity of outbreaks. Climate change scenarios predict a change distribution of infectious diseases with warming and changes in outbreaks associated with weather extremes, such as flooding and droughts. Adverse health consequences caused by climate change include heat-related disorders, vector-borne diseases, waterborne and foodborne diseases, respiratory and allergic disorders, malnutrition, violence, and mental health problems. Its worst impact will probably be felt by developing countries in the coming decades.

3.2 Climate change and Health

A range of infectious diseases can be influenced by climatic conditions. The diseases that are most sensitive to influence, by ambient climate conditions are those spread not by person-to-person pathways but directly from the source: the water- and foodborne diseases as well as vector-borne diseases (which involve insects or rodents within the pathogen's life cycle). The ranges of several key diseases or their vectors are already changing in altitude due to warming. In addition, more intense and costly weather events create

conditions conducive to outbreaks of infectious diseases, such as heavy rains leave insect breeding sites, drive rodents from burrows, and contaminate clean water systems.

The largest health impacts of climate change worldwide seem to occur from vector-borne infectious diseases. The incidence of mosquito-borne diseases, including malaria, dengue, and viral encephalitides, are among those diseases most sensitive to climate. Climate change would directly affect disease transmission by shifting the vector's geographic range and increasing reproductive and biting rates and by shortening the pathogen incubation period. Climate-related increases in sea surface temperature and sea level can lead to a higher incidence of waterborne infectious and toxin-related illnesses, such as cholera and shellfish poisoning.

Water- and foodborne diseases are likely to become a greater public health problem as climate change accelerates, due to elevated temperatures, increases in extreme rainfall and flooding frequency, and an anticipated deterioration in water quality following wider drought events. There is strong evidence that links the incidence of waterborne outbreaks from pathogens such as *Cryptosporidium, Escherichia coli* 0157: H7,60 and *Campylobacter jejuni* following heavy rainfall events. Storm events of more than 3 inches of rainfall within 24 hours can overwhelm combined sewer systems and lead to an overflow that contaminates recreational and drinking water sources. Climate change is anticipated to increase the frequency of these events. Overall, there is growing evidence that climate-driven changes in air and water temperatures, rainfall, humidity, and coastal salinity can contribute to the risk for waterborne diseases in both marine and freshwater ecosystems. A recent meta-analysis of 87 waterborne outbreaks occurring globally from 1910 to 2010 showed an association with heavy rainfall and flooding, with Vibrio and *Leptospira* spp., being the most often cited etiologic agents.

There are many ways in which climate change disproportionately affects women. In low-income countries, women generally assume primary responsibility for gathering water,

food, and fuel for their households. Climate change-induced droughts to make this work much more difficult because water becomes less accessible, agricultural production decreases, and wood used for fuel needs to be obtained from increasingly distant places. As women face greater challenges in gathering water, they may develop increased risks of injury and rape.

Women have higher rates of death than men from extreme weather events, such as hurricanes and other storms. Pregnant women are especially susceptible to vector-borne diseases, such as malaria and waterborne disease. Because of longstanding bias and discrimination, in many countries, women have fewer resources to deal with damage and loss from extreme weather events.

Like women, children are especially susceptible to vector-borne diseases, such as malaria, and waterborne disease. Climate change adversely affects children in many ways. According to the World Health Organization (WHO), 88 percent of the burden of disease that can be attributed to climate change affects children younger than five years of age. Shortages of water and food lead to increased occurrence of childhood malnutrition and make it less likely that children will receive an adequate education. Besides, children are more vulnerable than adults to extreme weather events and other disasters because they have less physical strength and during the disasters, they may be separated from their parents.

Extreme high air temperatures raise levels of ozone and other pollutants and contribute directly to deaths from cardiovascular and respiratory disease, as can pollen or other aeroallergens that worsen in heat, particularly among elderly people.

3.3 Climate change and Social justice

The environmental and health consequences of climate change, which disproportionately affect low-income countries and poor people in high-income countries, have profound effects on human rights and social justice. These consequences threaten rights embodied in the Universal Declaration of Human Rights, such as the right to security and the right to a standard of living adequate for health and well-being, including food, clothing, housing, medical care, and necessary social services. They threaten civil and political rights, such as "the inherent right to life" and rights related to culture, religion, and language, as embodied in the International Covenant on Civil and Political Rights. They threaten economic, social, and cultural rights, as enshrined in the International Covenant on Economic, Social, and Cultural Rights, including the following:

The rights of self-determination.

- The rights to freely determine one's political status and freely pursue one's economic, social, and cultural development.
- The right "to the enjoyment of the highest attainable standard of physical and mental health".
- The right to education.

Climate change threatens the rights of women, as embodied in the Convention on the Elimination of all Forms of Discrimination against Women, especially women living in rural areas of developing countries, who are particularly vulnerable to the consequences of climate change. National governments have a duty to ensure that all of these human rights are promoted and protected.

These environmental and health consequences threaten civil and political rights and economic, social, and cultural rights, including rights to life, access to safe food and water, health, security, shelter, and culture. On a national or local level, those people who are most vulnerable to the adverse environmental and health consequences of climate change

include poor people, members of minority groups, women, children, older people, people with chronic diseases and disabilities, those residing in areas with a high prevalence of climate-related diseases, and workers exposed to extreme heat or increased weather variability.

People in developing countries are more than 20 times as likely to be affected by climate-related disasters as those in the developed world4. Small island states, coastal regions, megacities, mountainous and Polar Regions are also particularly vulnerable.

4.0 CONCLUSION

The global climate crisis threatens most people and their human rights. The adverse consequences of climate change will worsen. Addressing climate change is a health and human rights priority, and action cannot be delayed. Adaptation and mitigation measures to address climate change needed to protect human society must also be planned to protect human rights, promote social justice, and to avoid creating new problems or exacerbating existing problems for vulnerable populations.

5.0 SUMMARY

In this unit, we have learnt that:

- climate change health risks are occurring today and pose serious and widespread challenges for global health
- climate change has profound effects on human rights and social justice.

6.0 TUTOR-MARKED ASSIGNMENT

1. What is climate change?

2. Discuss the role of climate change in the increased prevalence of two vector-borne diseases.

3. Discuss the role of climate change in social justice.

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UNIT 4 ADDRESSING GLOBAL HEALTH DISPARITIES

CONTENTS

1.0 INTRODUCTION

Health and healthcare disparities refer to differences in health and healthcare among population groups. Disparities occur across many dimensions, including race/ethnicity, socioeconomic status, age, location, gender, disability status, and sexual orientation. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health on the basis of their racial or ethnic group, religion, socioeconomic status, gender, age, mental health, cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion. At the end of this unit, you will be aware of what health disparity means and the global efforts put in place to address it.

2.0 OBJECTIVES

At the end of this unit, you will able to:

- understand the concept of disparity in health
- understand the various measures and strategies put in place to combat disparity in health

3.0 MAIN CONTENT

3.1 Definition and Concept

Health disparity is defined as differences in health outcome between population groups due to differences in "social, demographic, environmental and geographic attributes". Further, health disparity is described as the differences in the health outcomes of population groups based on race, sex, education, social status, and geographic location. It is also referred to as inequalities in health outcomes among population groups attributable to "social, economic, and, or environmental disadvantage" based on race, religion, gender, sexual orientation, geographical location, or socioeconomic status.

The terms "health disparities" and "health inequalities" (often used interchangeably), while hardly household terms among the general public, have by now become familiar to many health practitioners, program managers, and policy-makers as well as researchers in the United States and other countries; "health equity" is a term rarely encountered in the United States but more familiar to public health professionals elsewhere. There is little consensus about what these terms mean, however, and the resulting lack of clarity is not merely of academic concern. How one defines "health disparities" or "health equity" can have important policy implications with practical consequences. It can determine not only which measurements are monitored by national, state/provincial, and local governments and international agencies, but also which activities will receive support from resources allocated to address health disparities/inequalities and health equity.

Disparities have been documented for many decades and, despite overall improvements in population health over time, many disparities have persisted and, in some cases, widened. Moreover, the recent economic downturn has likely contributed to a further widening of disparities. According to the WHO, "the social determinants of health are mostly responsible for health inequities—the unfair and avoidable differences in health status seen within and between countries". The social determinants of health as well as race and ethnicity, sex, sexual orientation, age, and disability all influence health. Identification and

awareness of the differences among populations regarding health outcomes and health determinants are essential steps towards reducing disparities in communities at greatest risk.

Health disparities do not refer generically to all health differences, or even to all health differences warranting focused attention. They are a specific subset of health differences of particular relevance to social justice because they may arise from intentional or unintentional discrimination or marginalization and, in any case, are likely to reinforce social disadvantage and vulnerability. Disparities in health and its determinants are the metric for assessing health equity, the principle underlying a commitment to reducing disparities in health and its determinants; health equity is social justice in health.

Every person should be able to achieve his/her optimal health status, without distinction based on race or ethnic group, skin colour, religion, language, or nationality; socioeconomic resources or position; gender, sexual orientation, or gender identity; age; physical, mental, or emotional disability or illness; geography; political or other affiliation; or other characteristics that have been linked historically to discrimination or marginalization (exclusion from social, economic, or political opportunities).

3.2 Addressing Disparities in Health

Reducing disparities in health will give everyone a chance to live a healthy life and improve the quality of life of all. The challenges of knowing what to do - what actions to take - are significant. For example, many health care providers are unaware of the fact that disparities exist, or of their magnitude. Reducing health disparities is a major goal of public health. Despite the persistence of disparities, progress is being made.

The different global strategy for the elimination of health disparities includes:

1. Ensure a strategic focus on communities at greatest risk.
2. Reduce disparities in access to quality health care.
3. Increase the capacity of the prevention workforce to identify and address disparities.

4. Support research to identify effective strategies to eliminate health disparities.
5. Standardize and collect data to better identify and address disparities.

In ensuring that all Nigerians have access to affordable and quality healthcare, the National Health Insurance Scheme (NHIS) was established under Act 35 of 1999. The scheme is a social health insurance scheme aimed at providing universal coverage for all Nigerians. This model ensured the introduction of Health Maintenance Organisations (HMOs) as financial managers of the Scheme; it, however, did not take off until 2005. There are several different programmes under the scheme aimed broadly at the formal and informal sectors. However, present coverage under the scheme is very low at just 7.9 million. In Nigeria, the WHO reported that private spending on health as a percentage of total health expenditure was 63.3 percent. Of this 95.4 percent was from out-of-pocket payment, indicating that a majority of Nigerians especially the poor have to pay for their healthcare, as they have no insurance coverage and up to 70.2 percent were reported to be living on less than USD 1.00 per day.

Concerted efforts in recent times have been made to improve coverage under the scheme. At the onset, the act establishing the NHIS made it optional, since it was a contributory scheme, people simply opted out. Critics in the earlier years have linked the poor coverage of the scheme to this and have repeatedly called for an amendment to the act to make it mandatory. Also, the scheme started with an enrolment of federal government employees while State employees and the informal sector were practically left out. Nine years after the scheme was launched, it had only commenced in two States. Recently this was also corrected with a mandate for all States of the federation to commence their own mandatory schemes. To address the funding challenges a National Basic Health Care Provision Fund was established under the National Health Act. Half (50 %) of this fund is meant for the provision of a basic minimum package of care at primary and secondary levels of care for the citizens under the NHIS. Provision for the poor and vulnerable was also included;

however one must bear in mind that the NHIS is a contributory scheme and method of accessing the scheme are not spelt out for the unemployed and the poor.
The mission of the NHIS-is to undertake a government-led comprehensive Health sector Reform aimed at strengthening the National public and private Health System to enable it to deliver effective, efficient, qualitative and affordable health services.

The objectives of the scheme are to:

- ensure that every Nigerian has access to good health care services
- protect families from the financial hardship of huge medical bills
- limit the rise in the cost of healthcare services
- ensure equitable distribution of healthcare costs among different income groups
- ensure a high standard of healthcare delivery to Nigerians
- ensure efficiency in healthcare services
- improve and harness private sector participation in the provision of healthcare services
- ensure equitable distribution of health facilities within the federation
- ensure appropriate patronage of levels of healthcare
- ensure the availability of funds to the health sector for improved services.

4.0 CONCLUSION

Despite major advances in medicine and public health during the past few decades, disparities in health and health care persist. Disparities exist when differences in health outcomes or health determinants are observed between populations. Reducing health disparities is of public health significance. Despite the persistence of disparities, progress has been made in addressing the observed disparities.

5.0 SUMMARY

In this unit, we have learnt that:

- health disparities are preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health that are experienced by socially disadvantaged populations
- health disparities are inequities that are directly related to the historical and current unequal distribution of social, political, economic, and environmental resources
- strategies have been developed to reduce disparities in access to quality healthcare.

6.0 TUTOR-MARKED ASSIGNMENT

1. What is disparity in Healthcare?
2. Discuss the role of government and relevant stakeholders in addressing global health disparities
3. Discuss the roles of the National Health Insurance Scheme in addressing health disparity in Nigeria.

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MODULE 5: HEALTH SERVICES MONITORING AND EVALUATION

Unit 1: Introduction to quality management for monitoring and evaluation
Unit 2: Programme monitoring and evaluation methods
Unit 3: Health systems strengthening
Unit 4: Global health in Nigeria; practicum

UNIT 1 INTRODUCTION TO QUALITY MANAGEMENT FOR MONITORING AND EVALUATION

CONTENTS

1.0 INTRODUCTION

To understand the effects of health services, there is a need for monitoring and evaluation of outcomes and impacts. According to Keeble (2010), Monitoring and Evaluation (M&E) aim to, through studying results, determine how well the health services plans are being achieved at various levels. It also seeks to determine if the health of the public is better as a result of health interventions through programme level indicators.

In the planning and execution of health action plans, evaluation of health services is important because it provides a breakdown of what worked, what did not work and the root causes, in the case of failure. This serves to help improve future strategy to ensure successful implementation of future health action plans and avoid the pitfalls of the previous programmes.

2.0 OBJECTIVES

At the end of this unit, you will be able to:

- understand the meaning of monitoring and evaluation (M&E)
- describe the importance and basics of M&E
- differentiate between monitoring and evaluation
- describe the framework for M &E of public health programmes
- describe the Quality management of M&E

3.0 MAIN CONTENT

3.1: Definition of Monitoring & Evaluation

Monitoring and Evaluation (M&E) involves the collection, storage, analysis and transformation of data into tactical information that can be used to make informed decisions for programme management and improvement (sustainability), policy formulation and advocacy. Monitoring and Evaluation show whether a service, or programme is accomplishing its goals, perhaps as conceived in its logical framework, or other frameworks, such as logic model. It identifies programme weaknesses and strengths, areas of the programme that need revision, and those that meet or exceed expectations. Important methods of improving the performance of those responsible for implementing health services are by monitoring of progress and evaluation of results (Salama, 2010)

Development projects and programmes put together to improve the health of communities cannot achieve their stated goals and objectives, except the planning stage is combined with effective/strong monitoring and evaluation phases/components. These components help in reducing the likelihood of having major cost overruns or time delays later. Good planning ensures that emphasis is placed on important results, while monitoring and evaluation aid learning from past successes and challenges to make an informed decision so that current and future initiatives are better able to improve people's lives and expand

their choice (UNDP, 2009). A well-planned M&E requires about 5-10 percent of a project budget

3.2: Basic concepts in Monitoring & Evaluation

3.2.1 What is Monitoring?

Monitoring of a programme or intervention project is an ongoing, continuous process which requires data collection at multiple points throughout the programme cycle to measure progress toward achieving programme objectives. Data collection from the beginning of a project provides the baseline information which answers questions such as: how well the programme has been implemented, variation from one community/household/site to the other, and if the intended people benefit from the programme. It also helps in deciding if intervention activities require an adjustment to achieve desired outcomes. It can, therefore, be referred to as "process evaluation". Monitoring helps stakeholders to make informed decisions regarding the effectiveness of programmes and the efficient use of resources (Frankel and Gage, 2007)

Monitoring can also be described as a:

- planning and management tool which provides the project management with regular and continuous feedback that can be used to make decisions, manage the project more successfully and plan for better project activities in the future.
- crucial part of the project management that will be carried out to observe the progress of the project implementation and to ensure that inputs, activities, outputs and external factors (such as the project assumptions) are proceeding according to the plan.
- tool to identify problems which may occur during project implementation so that corrective measure could be taken before the project is adversely affected (International Center, Chiang University (2002).

Figure 5.1 shows a graphic illustration of a programme monitoring over time. The indicator used for monitoring (shown on the “Y" axis) could be an element of the program that needs tracking, e.g. the cost of supplies, the number of times the staff provide certain information to clients, number of people adopting new facility or the percentage of clients/people who are pleased with the services they received.

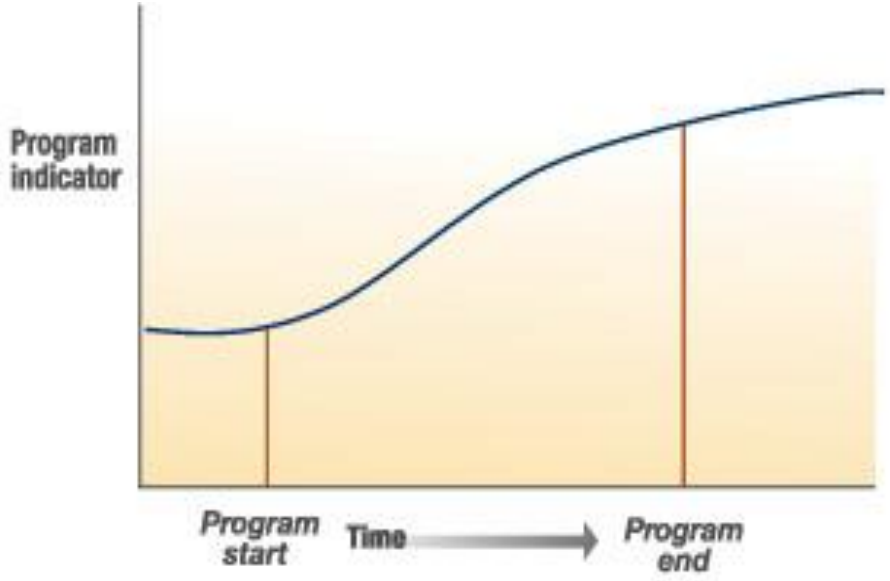

Figure 5.1: Possible graphic illustration of programme monitoring
Source: USAID & Knowledge for Health, Global Health e-learning website

3.2.2 What is Evaluation?

Evaluation “is a rigorous and independent assessment of either completed or ongoing activities to determine the extent to which they are achieving stated objectives and contributing to decision making”. Like monitoring, evaluations can apply to many issues such as an activity, project, programme, strategy, policy, topic, theme, sector or organization (UNDP, 2009).

Evaluation measures how well programme activities have met the expected objectives and, or the extent to which changes in outcomes can be attributed to the programme or intervention. The difference in the outcome of interest between having, or not having, the

programme/project or intervention is known as its "impact" and is commonly referred to as "impact evaluation." Figure 5.2 shows the graphic representation of evaluation over time

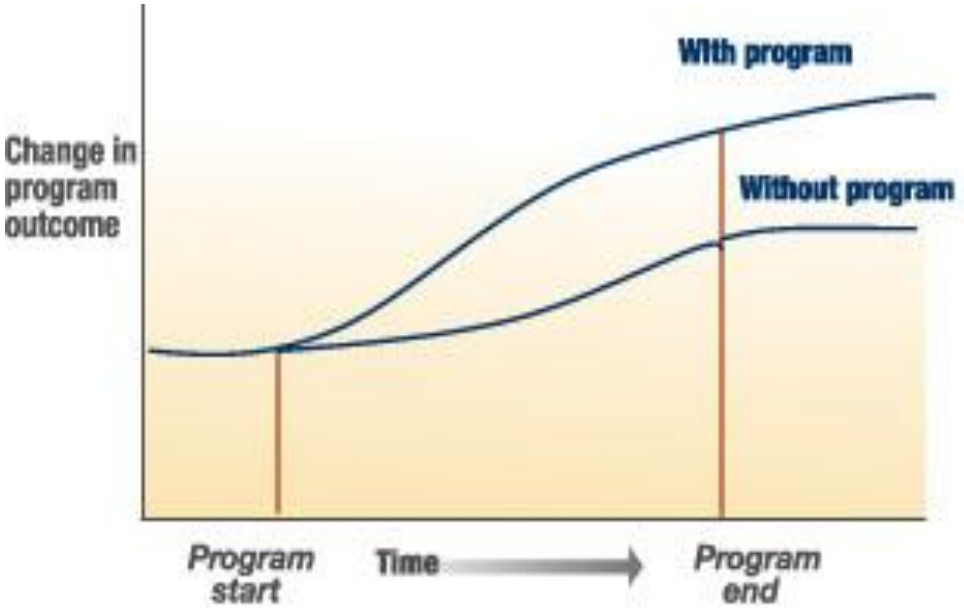

Figure 5.2: Graphic representation of program impact
Source: USAID & Knowledge for Health, Global Health e-learning website

3.2.3 Importance of M&E in Health Programmes

Monitoring and Evaluation helps stakeholders' to:

- make informed decisions regarding program operations and service delivery based on objective evidence;
- ensure the effective and efficient use of resources;
- assess the extent to which the program is having or has had the desired impact, in what areas it is effective, and where corrections need to be considered; and
- meet organizational reporting and other requirements and convince donors that their investments have been worthwhile, or that alternative approaches should be considered.

3.2.4 Differences between Monitoring and Evaluation

Table 5.1: Significant differences between M&E

	Monitoring	Evaluation
	Answers the question, what needs to happen now to reach the set goals?	Answers the question, have we achieved the set goals?
	Tracks what is been done (primarily inputs & outputs) to assess whether programmes are performing according to plan (goals and objectives)	Determines if the desired results (outcomes & impact) are achieved
	Assesses if things are being done right	Assesses if the right things are being done
	Ongoing from inception	Done independently to provide managers and staff with an objective assessment of whether or not they are on track
	Data collection at repeated intervals during programme implementation	Data collection can be intermittent, at the beginning of a programme (to provide a baseline) or at the end of significant milestones
	Monitoring data provides regular feedback that measures change over time in any of the programme components such as costs, personnel and programme implementation	Evaluation data can be used to assess the effectiveness, relevance and impact of achieving the programme's goals
	An unexpected change in monitoring data may trigger the need for a more formal evaluation of activities	Requires a comparison group to measure if the observed changes in outcomes can be attributed to the programme
	Progress indicators need to be closely monitored by a few people	Evaluation results need to be discussed, processed and interpreted by all stakeholders

3.2.5 The Monitoring and Evaluation Plan

A monitoring and evaluation (M&E) plan is a document that is usually developed at the programme inception, before any monitoring and helps to track and assess the results of the interventions throughout its life. The M&E plan consists typically of the same key elements but may have different specific targets for each programme results. The M&E plan consists of six major steps:

(i) Development of the programme goal and objectives;
(ii) Description of indicators (for tracking the progress and outcomes of the Programme or intervention);
(iii) Data collection methods and data sources;
(iv) Define M&E roles and responsibilities with regards to who will collect data for each indicator;
(v) Create analysis and reporting plan and
(vi) Plan for result dissemination.

Using these steps, the outline of the M&E plan is as shown below:

1. Introduction to the programme
    - Programme goals and objectives:
    - Logic model/Logical Framework/Theory of change
2. Indicators
    - Table with data sources, collection timing, and staff member responsible
3. Roles and Responsibilities
    - Description of each staff member's role in M&E data collection, analysis, and/or reporting
4. Reporting
    - Analysis plan
    - Reporting template table
5. Dissemination plan
    - Description of how and when M&E data will be disseminated internally and externally

In order to ensure effective M&E of the programme/intervention, it is pertinent that the M&E plan should be developed at the beginning when the interventions are being designed (HealthCOMpass, 2012).

3.2.6 The Monitoring and Evaluation Logic Models

Logic models provide a streamlined linear interpretation of a project's planned use of resources and its desired ends. They are tools that provide a diagrammatic representation of inputs/ processes, outputs, outcomes and impact of a programme. Logic models consist of five components:

1. **Inputs**: are resources, contributions, and investments that go into a programme;
2. **Processes**: are activities carried out to achieve the programme's objectives;
3. **Outputs**: are immediate deliverables (measurable products of a programme) such as services, events and products that reach the programme's primary audience;
4. **Outcomes**: are the short-term and intermediate results (benefits) or changes related to the programme's intervention that is experienced by the primary audience (clients, communities, or organization), e.g. change in behaviour or knowledge; or improvement in health
5. **Impacts**: are the long-term effects of a programme, such as improved health status (HealthCOMpass, 2015).

As shown in Fig 5.3, inputs (resources) used during processes (activities) produce immediate intermediate results (outputs) which ultimately leads to longer-term/broader results (outcomes) and impacts at population level. In a study focusing health services on population health goals using a logic model, McEwan and Bigelow (1997) asserted that the use of logic models facilitates overall governance of healthcare services by creating performance-monitoring frameworks for both short-term and long-term outcome objectives

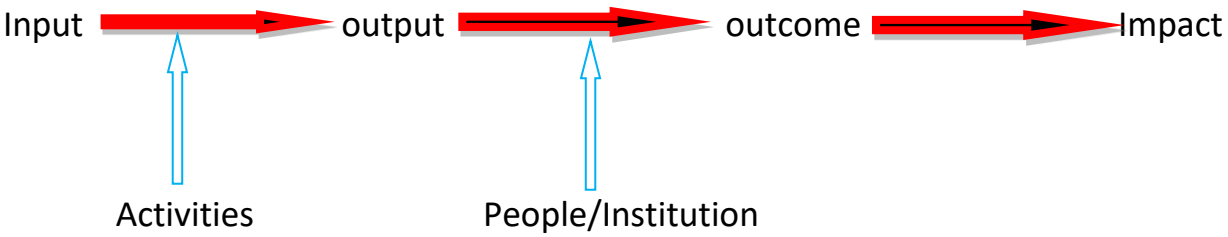

Figure 5.3: Schematic representation of a Logic Model

Figure 5.4 presents a Logic model for a project designed to improve health providers' knowledge, attitudes and practices (KAP); and to increase providers' awareness of violence against women as a public health problem and a violation of human rights.

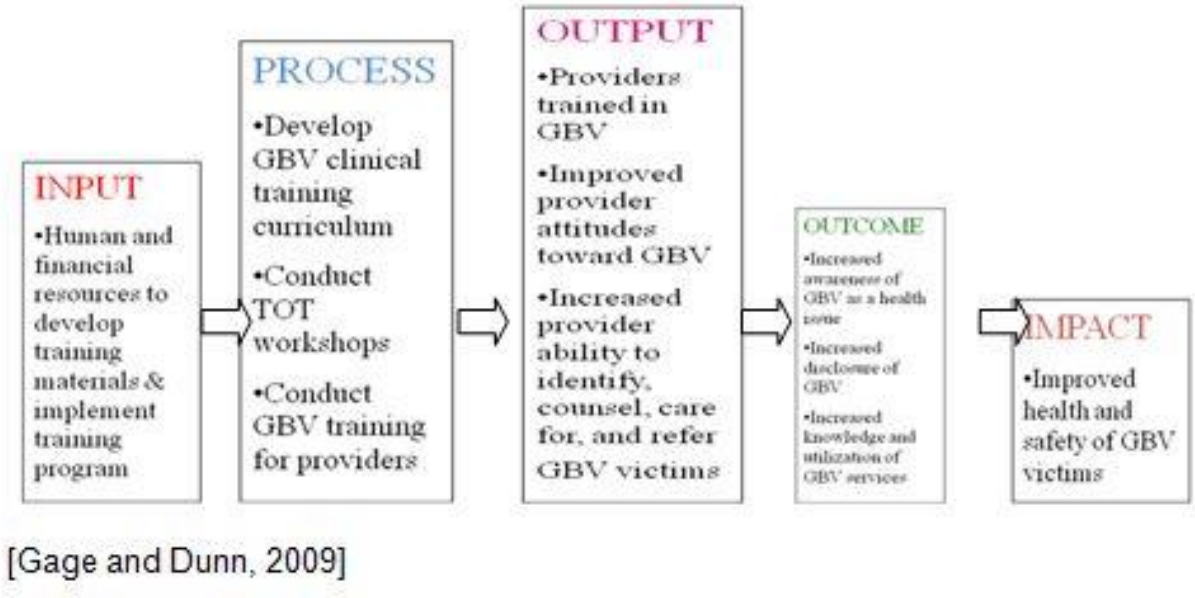

Figure 5.4: **Logical Framework for a Health Provider Training Programme**
Source: UN Women (2012).

INPUTS ⇨	ACTIVITIES ⇨	OUTPUTS ⇨	OUTCOME ⇨	IMPACT
• Human resources • Financial resources • IEC materials produced for the programme • Training guidelines	Distribution of IEC materials Training of laboratory staff and other key staff Organisation of community Health education campaigns on care and support for TB	IEC materials distributed among the stakeholders and community members Increased number of laboratory and other key staff trained Number of families/ communities sensitized on TB and care and support for infected people	Increased community members knowledge on TB transmission, treatment and support for TB clients Increased effectiveness and efficiency in TB detection/ management. Increased care and support for TB infected people	Reduced TB morbidity and mortality Reduced TB morbidity and mortality Reduced stigmatization for TB

Figure 5.5: Logic model on the reduction of TB morbidity and mortality in Lagos State

In addition, Karen Horsch's presentation on the use of the logic model in assessing improvement of the oral health of low-income children who received primary care in a community health service provided an excellent example of the use of logic models for programme planning and evaluation.

Use the link below to access the video on "Using Logic Models for Programme Planning and Evaluation" by Karen Horsch:
http://slideplayer.com/slide/4351582/#.WlGz_qHVVhc.gmail

3.3 Quality management for M&E

3.3.1 Introduction

The West Virginia Office of Technology (2012) described a quality management process as a method (or set of procedures) by which the quality of deliverables and processes is assured and controlled during the project. The process entails carrying out a variety of appraisal techniques and implementing a set of corrective actions to address any deficiencies and raise the quality levels within the project.

Accountability in programme reporting relies heavily on data quality. The M&E systems produce data which are used to assess and document the progress of health programmes. In many developing countries, such data have been found to be incomplete and inaccurate. It is therefore imperative that data collected during these processes are certified to be of high quality. This can be achieved by employing stringent and systematic data quality assurance procedures, which utilise Data Quality Management (DQM) Plan and Routine Data Quality Assessment (RDQA)

3.3.2 What Is Data Quality?

Data quality refers to the accuracy, value or worth of the information collected and emphasizes the high standards required of data capture, verification, and analysis, such that they would meet the requirements of an internal or external data quality audit.

3.3.3 Why is Data Quality Important?

Data quality is important because:

- Mistake should be prevented rather than detected
- Correcting data that has been wrongly recorded is difficult and expensive
- The quality of the data is largely determined by how well the interviews are conducted and forms are completed

- In the presence of errors, decisions based on the data is queried and may be invalidated

4.0 Conclusion

This unit covered the concepts of monitoring and evaluation as an important component of health projects. It helps stakeholders make informed decisions regarding programme operations and service delivery.

5.0 Summary

In this unit, we learnt that:

- M&E should be an integral part of any health project right from the planning stage
- Monitoring is “process evaluation, while evaluation is “impact evaluation”
- A logic model is an excellent tool for programme planning and evaluation
- There should be a clear understanding of the purpose and scope of M&E as this will help in deciding on the number of indicators to track and the budget levels
- Systematic data quality assurance procedures should be used to certify that data collected during M&E are of high quality
- Data quality should be considered as an important component of monitoring and evaluation

6.0 TUTOR-MARKED ASSIGNMENT

1. Why is M&E important?
2. What are the major differences between M&E?
3. What are M&E plans? What is there importance in health programmes?
4. List and describe the M&E components
5. Why is data quality important?

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UNIT 2: PROGRAMME MONITORING AND EVALUATION METHODS

CONTENTS

1.0 INTRODUCTION

There is presently an increasing interest among development partners and beneficiary communities to include M&E in their development projects from the planning stage. This is a sequel to the fact that M&E provides the opportunity of accessing the impact of activities and decide if a different programme implementation method will provide better output and outcomes. However, making a choice among different methods for a particular health project may not be that easy. This module will, therefore, provide an insight into the different types of methods to be used in data collection during M&E of development programmes and the circumstances under which each can be used

2.0 OBJECTIVES

At the end of this unit, you will be able to:

- List and describe different M&E tools, approaches and data collection methods
- State the purpose and use of each method
- State advantages and disadvantages of each method

- Describe the factors affecting the selection of M&E tools and subsequent data collection methods

3.0 MAIN CONTENT

3.1 M&E Tools, Approaches and data collection methods

It is important to ensure data collected during M&E will be used to check the progress of a project and make the necessary improvements as the project proceeds.

Nine M&E tools/approaches compiled by the World Bank Operations Evaluation Department include:

1. Performance Indicators.

Performance indicators measure inputs, processes, outputs, outcomes and impacts of a project. They are therefore very useful in setting targets for project implementation and measuring the resulting progress or achievement. However, SMART-G indicators that will give a good picture of overall project achievement can be developed only if the performance questions (e.g. question that will provide answer to the success or failure of a project); the changes intended (e.g. presence of something absent before or type of access to a service or product) and necessary information are first taken into consideration

Box 1: SMART INDICATORS

Specific: Is the indicator specific enough to measure progress towards the results?
Measurable: Is the indicator a reliable and clear measure of results?
Attainable: Are the results in which the indicator seeks to chart progress realistic?
Relevant: Is the indicator relevant to the intended outputs and outcomes?
Time-bound: Are data available at reasonable cost and effort?
Gender-sensitive: Programme and achievements are viewed through the gender lens to ensure inclusive participation of all stakeholders and beneficiaries and in results.

There are three types of indicators that can be related to each performance question

- Input: describe what goes into a project, e.g. number of hours of training or amount of money spent
- Output: describe project activities, e.g. a number of community workers trained etc.
- Impact indicators: measure the actual change in the target group or a situation

2. The logical framework (Log-Frame) approach.

This approach identifies objectives and expected causal links and risks along the results chain.

3. Theory-based evaluation

Provides a deeper understanding of the workings of a complex intervention. It helps planning and management by identifying critical success factors

4. Formal surveys.

These are used to collect standardised information from a representative sample of people or households. They are useful for understanding actual conditions and changes over time.

5. Rapid appraisal methods.

These are quick, cheap ways of providing decision-makers with views and feedback from beneficiaries and stakeholders. They include interviews, focus group discussions and field observations.

6. Participatory methods.

These allow stakeholders to be actively involved in decision-making. They generate a sense of ownership of M&E results and recommendations. The method helps in building local capacity.

7. Public expenditure tracking surveys.

These trace the flow of public funds and assess whether resources reach the intended recipients. They can help diagnose service-delivery problems and improve accountability.

8. Cost-benefit and cost-effectiveness analysis.

These tools assess whether the cost of an activity is justified by its impact. Cost-benefit measures inputs and outputs in monetary terms, whereas cost-effectiveness looks at outputs in non-monetary terms.

9. Impact evaluation.

This is the systematic identification of the effects of an intervention on households, institutions and the environment, using some of the above methods. It can be used to gauge the effectiveness of activities in reaching the poor.

Data Collection Methods for M&E projects

The wide variety of data collection methods can be grouped into two:

- Quantitative methods: produce data that are stated I represented as numbers)
- Qualitative methods: "gather information by asking people to explain what they observe, do, believe or feel" It reflects a change in attitude, quality, etc.) They are not easily represented in numerical form

The advantages, disadvantages and limitations of quantitative and qualitative data collection methods are shown in Table 5.2, while Table 5.3 lists the common qualitative and qualitative data collection methods for use in result chain,

Table 5.2: Advantages, Disadvantages and Limitations of Quantitative and Qualitative methods

Quantitative methods	Qualitative methods
Advantages • Provide robust, quantified findings • Information easier to analyse	**Advantages** • Useful to gain insights on what is happening • Easy to organise and cost-effective (small samples)
Limitations • Costly to organise (large samples) • Do not provide contextual information • Offer limited insights on what is happening	**Limitations** • Information collected cannot be generalised • Information harder to analyse

Source: Angela Orlando with critical inputs from Tawfiq El-Zabri and Ed Mallorie (2013)

Table 5.3: Common Qualitative and Qualitative Data Collection Methods for use in a Result chain

Results chain	Quantitative data used	Qualitative data used
Activity and output Tools are used to measure effectiveness of project strategies and are collected every month or at the end of each quarter.	• Activity and output tracking tools like data collection forms and matrices • Diaries and farm record books and self-help group records • Micro-finance records • Staff records • Annual work plan and budget	• Brainstorming • Key informant interviews • Focus group discussions • Diagramming
Outcome (collected annually)	• Questionnaire survey (annual outcome survey / thematic outcome survey) • KAP surveys of training outcomes • GIS annual surveys	• Focus group discussions • Key informant interviews • Case studies • "H" diagramming and input-output diagramming
Impact (data collected three times during the life cycle of the project)	• Questionnaire surveys for baseline, mid-term and final evaluation (RIMS and RIMS+) • Statistics on production, etc.	• Diagramming • Focus group discussions • Key informant interviews • Most significant change • Case studies

Source:
Case Study of IFAD Projects in Asia
IFAD's results-based management framework and the logical framework approach

Apart from survey/questionnaire, other quantitative tools include:

- Registries
- Activity logs;
- Administrative records;
- Patient/client charts;
- Registration forms;
- Case studies;
- Attendance sheets

The qualitative methods include:

- Field observation visits
- Stakeholder meetings
- Interviews
- Group discussions, focus group discussions
- Case studies
- Stories of change
- Action research
- Citizen report cards
- Most significant change
- Diaries
- Participatory video
- Timelines
- Spider diagrams

Of all the quantitative methods, the use of questionnaire survey is the most common, while Focus Group Discussion and Key Informant Interviews are the most common qualitative methods. It is imperative to note that the questionnaire can use both open and close-ended questions to collect information such as the opinion of the respondent about useful project services

3. 3 Factors determining the choice of methods may include (World Bank, 2004)**:**

- the purpose for which M&E is intended,
- main stakeholders who have an interest in M&E findings,
- how quickly the information is needed
- cost

5.0 Conclusion

This unit has described the different tools/approaches for data collection. Emphasis was also placed on the different methods under the two major groups of data collection. However, it is imperative to note that it is always better to use mixed data collection methods that are participatory.

5.0 Summary

In this unit, we have learnt the:

- different types of M&E tools/approaches
- different data collection methods
- advantages, disadvantages and limitations of different data collection methods
- factors affecting the selection M&E tools and subsequent data collection methods

6.0 Tutor-Marked Assignment

1. Describe the tools/approaches for data collection
2. What are the differences between the qualitative and quantitative types of data collection?
3. What are the factors determining the choice of data collection methods?

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UNIT 3: HEALTH SYSTEMS STRENGTHENING

CONTENTS

1.0 INTRODUCTION

A thriving and strong health system ensures that people and institutions, both public and private, effectively undertake core functions to improve health care delivery and health outcomes. The module is designed to improve students' understanding of the processes involved in health systems strengthening as well as recognize the principal inputs in the whole process. The module offers the opportunity to acquire up-to-date knowledge about health systems and the right skills set for evidence-based planning, management, and financing for quality improvement. The outcome of this module will help the students to build on their own experiences and understanding of health systems strengthening to develop proposals about how these systems can be strengthened - and who might or might not benefit. These improvements can be targeted at any combination of the regional, national, district, and community level.

2.0 OBJECTIVES

At the end of this unit, you will be able to:

- Define and explain the meaning of Health System Strengthening (HSS)
- Describe the challenges of health systems globally, as well as at regional, national, district, and community levels
- List and describe the six building blocks of HSS

3.0 MAIN CONTENTS

3.1 What is Health System Strengthening?

A "health system" is described as all the organizations, institutions, resources, and people whose primary purpose is to improve health. The health system, therefore, delivers preventive, promotive, curative and rehabilitative interventions through a combination of public health actions and the pyramid of healthcare facilities that provide personal health care - by both State and non-State actors" (WHO, 2010).

Health System Strengthening is described as:

(i) the process of identifying and implementing the changes in policy and practice in a country's health system, so that the country can respond better to its health and health system challenges;

(ii) any array of initiatives and strategies that improves one or more of the functions of the health system and that leads to better health through improvements in access, coverage, quality, or efficiency

In many developing countries, health outcomes are at an unacceptably low, while inequities in health status is a global problem. The Sustainable Development Goal (SDG) Target 3.8, which seeks to achieve universal health coverage (UHC) focuses on ensuring that health services at the reach of everyone without any hindrance. According to WHO (2017), 'the health-related targets of the SDGs cannot be achieved without making substantial progress

on UHC' UHC has been found to be inextricably linked with health system strengthening which will provide an impetus for delivering effective and affordable services to prevent ill health and to provide health promotion, prevention, treatment, rehabilitation and palliation services"

3.2 What are the challenges of health systems?

All health economies around the globe seem to be facing similar challenges some of which can be attributed to new inventions in consumer technology. Global challenges that may likely affect the effectiveness of health care systems in the nearest future include:

- rising costs,
- changing demographics,
- filling resource gap,
- easy access,
- focus on quality and healthcare becoming customer driver

Note: Check full details in:
CGI, (2014). Healthcare Challenges and Trends: The Patient at the Heart of Care. White Paper, 6pp.
https://www.cgi.com/sites/default/files/white-papers/cgi-health-challenges-white-paper.pdf

The situation is worse in many developing countries where the health systems are characterized by inadequate health resources and associated brain drain, lack of access to basic health care especially in the rural areas and among internally displaced people (IDPs) among others In Nigeria, the Health system is plagued by inadequate funding (<5% of total budgetary expenditure as against minimum of 15% recommended WHO) and inequitable distribution of health care resources between urban and rural areas among others

Note: For more information, check:

1) WHO (2017). Malaria campaign saving young lives in Nigeria: Interview with Dr Pedro Alonso, Director of the WHO Global Malaria Programme http://www.who.int/malaria/news/2017/emergency-borno-state/en/
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3.3 WHO building blocks for health system strengthening

Health system building blocks are described as the analytical framework used by WHO to describe health systems, disaggregating them into 6 core components. A health system will be deemed to have performed efficiently if there are sustained health outcomes through continuous improvement of the six inter-related HSS functions. Figure 5.5 shows the WHO health systems framework detailing the six building blocks of a health system, aims and desirable attributes.

1. Service delivery: An excellent service delivery is not only a vital element of a health system but also a fundamental input to population health status. Strengthening of service delivery is crucial to achieving the health-related SDGs (see Fig 5.6).
2. Health workforce: this refers to a group of people responsible for providing health services with the intent to improve the health of the populace. This group of people includes clinical, managerial and support staff. Experience has shown that there is always a shortage of health workers in many rural areas of developing nations.
3. Health information systems (HIS): a sound and reliable HIS is the bedrock of a sustainable health system. It provides information that enables decision-makers at all levels of the health system to identify problems and needs, makes evidence-based decisions on health policy and allocates scarce resources in the most desirable way. The health information system has four key functions:
    - data generation,

- compilation,
- analysis and synthesis, and
- communication and use.

4. Access to essential medicines: It is imperative that a functional health system should provide adequate access to essential medical products, vaccines and technologies of assured quality, safety, and efficacy at any point in time in order to satisfy the priority health care needs of the population.
5. Health system financing (HSF): In many countries of the world, provision of access to health financing arrangements which ensure that people have access to adequate health care is the cornerstone of modern health financing system (WHO, 2000). The main aim of HSF is to make funds for health systems available in a way that will ensure that all groups of people have access to needed services without any financial hardship. However, in many developing countries (e.g. Nigeria), out-of-pocket payments constitute the greatest percentage of health financing.
6. Leadership/ governance: According to WHO (2010). "leadership and governance in building a health system involve ensuring that strategic policy frameworks exist and are combined with effective oversight, coalition-building, regulation, attention to system design and accountability between various stakeholders in health, including individuals, households, communities, firms, governments, non-governmental organizations, private firms and other entities that have the responsibility to finance, monitor, deliver and use health services"

In other to monitor these building blocks effectively a set of indicators have been recommended for each block.

Note: For complete details on building blocks, indicators, data collection methods and sources, see WHO (2010) at
http://www.who.int/healthinfo/systems/WHO_MBHSS_2010_full_web.pdf

Figure 5.6 shows the relationship between HSS, UHC and SDGs

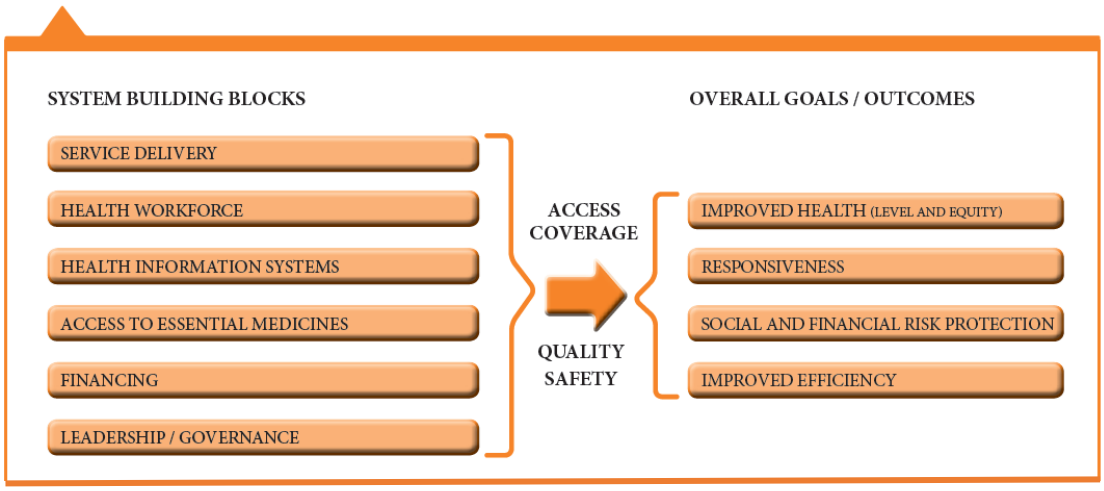

Figure 5.5: WHO health Systems Framework: The Six Building Blocks of a health System, aims and desirable attributes
Source: WHO (2010)

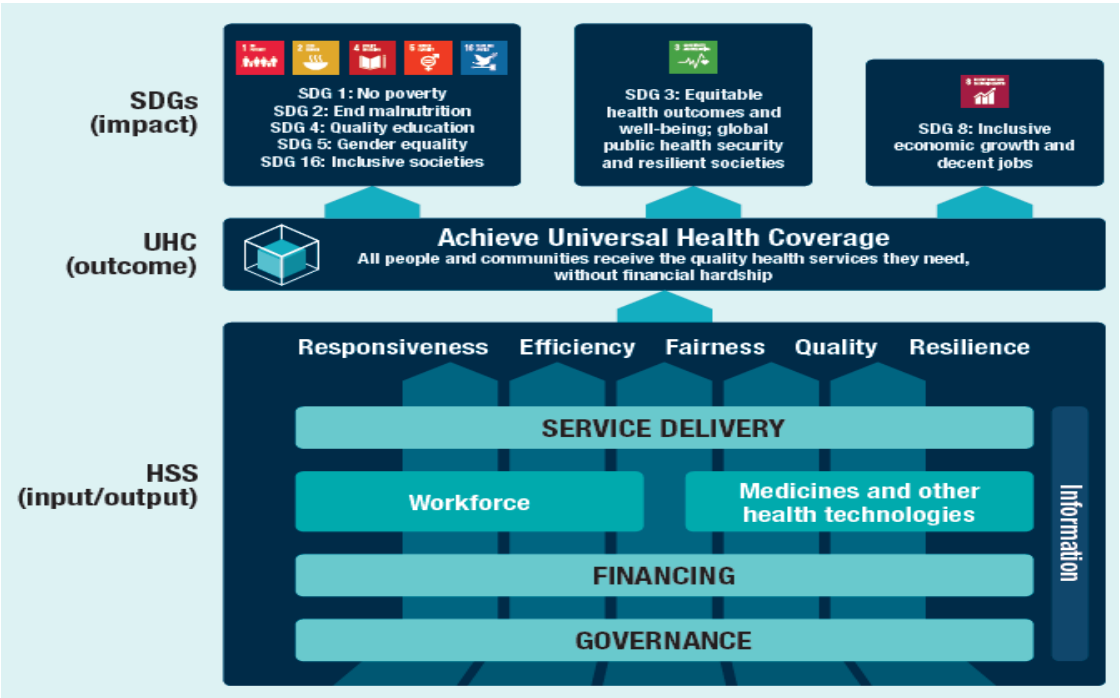

Figure 5.6: Relationship between HSS, UHC and SDGs

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UNIT 4: GLOBAL HEALTH IN NIGERIA: PRACTICUM

The Global Health Practicum is an integrated aspect of the Global Health- PHS 812 course. It is designed to bridge the theory and practice in a variety of health-related settings. The Practicum will be a unique opportunity for students to learn how to apply global health concepts, methods, and theory in health-related occupations in Nigeria. It will also enable them to develop the attributes needed for career development.

The practicum will be for four weeks during which the student will investigate a selected global health issue based on knowledge of the PHS 812 course. Students will use the prescribed logbook and will be supervised and evaluated. Students will be mentored and supported by qualified supervisors in the placement workplace as well as the course coordinator/lecturer. Upon completion of the practicum, students will submit their report (Logbook) and present their findings (this will also be graded). The student's application/agreement form is attached as Appendix1

APPENDIX 1

Practicum Approval – Sign off by Global Health Programme Coordinator

Student Name (please print, surname first)	
	Fore name(s) Last name
Student Number	
E-mail Address	
Telephone No.	

The student has fulfilled the academic requirements for **PHS 812: Global Health**

Programme Coordinator's Comments:

Name: ---

Signature: --- Date: ---