# Assessment of Private Health Facilities' Engagement in Provision of Maternal and Child Health Care Services

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# Contents



Acronyms

# Introduction

Based on United Nations (UN) estimates, Afghanistan has witnessed more than a 70% reduction in maternal deaths between 1990 and 2015. Child mortality has decreased by 50% and neonatal mortality (within the first 28 days of life) has declined by 32%. Pentavalent 3 vaccine coverage is 60%, measles coverage is 58% and exclusive breastfeeding of infants under 6 months of age is 55.5% (WHO, 2016)

Despite these achievements, Afghan mothers' and children's mortality remains among the highest in the region. Several factors affect the health system's capacity to reduce the risks that pregnant women face – access to and use of maternal and reproductive health services is still limited and the quality of services is low because of service delivery capacity, particularly, in difficult-to-reach rural areas (UNICEF, 2016). Community based health care interventions contribute to improved knowledge, attitude and behavior regarding maternal and child health care practices and lead to improved reproductive health outcomes (Hamdard, 2016).

Care International has implemented Opportunity for Mother and Infant Development (OMID) project in Afghanistan. OMID is a community based maternal and child health project. OMID is holistic health care delivery approach targeting districts 01 and 02. Care International plans to scale up this approach to district 06 as well.

The project life spans from April 2015 to March 2018. The project is funded by GlaxoSmithKline (GSK), a UK based private pharmaceutical company. CARE-UK is providing technical support to the project implementation team in Afghanistan. The main purpose of the project is to contribute to the reduction of maternal and infant mortality and morbidity through community based interventions. The project is facilitated and delivered by Community Health Workers (CHWs) and Community Midwives (CMs) (CARE, 2015).

CARE Afghanistan has also implemented successful models of economic empowerment for women called Village Saving and Loan Associations (VSLAs) and Community Based Saving Groups (CBSGs) in urban Kabul. A VSLA is a group of poor women who save together, then take small loans from mentioned group savings to run small businesses. The small businesses serve as a source of their income for these women.

Based on above experience, CARE-Afghanistan intends to conduct a research on engagement of the private sector in maternal health services. The specific research objectives comprise:

1. Mapping private health facilities in districts 02 and 06 which can be engaged in delivery of community based maternal health services

2. Mapping out availability of maternal and child health care services in studied private health care facilities.
3. Identifying the required amount to be paid for provision of maternal and child health mentioned health care services
4. Identifying whether the private health facilities are ready to build capacity of CHW through training and mentoring processes.
5. Measuring satisfaction level of women of reproductive age on access, and quality of mentioned services
6. Specifying the willingness of VSLA members to pay fees for the above-mentioned services
7. Measure the capacity level of the VSLA members who are supposed to be trained as CHWs

# Methods

The research team generated a list of existing private health facilities including outpatient and hospitals in district 02 and 06 of Kabul city. The research team mapped seven hospitals and six outpatient clinics. Three hospitals and one outpatient clinic declined to participate in this study. The team applied an observation checklist in each health facility to examine the availability of maternal and child health services, estimate the cost of selected MNCH services, and determine the level reduction in cost which mentioned facilities would consider for referred patients by CHWs.

In all mapped private health facilities, 164 clients were interviewed to measure satisfaction level of women of reproductive age on availability, quality, and behavior of health facility staff.

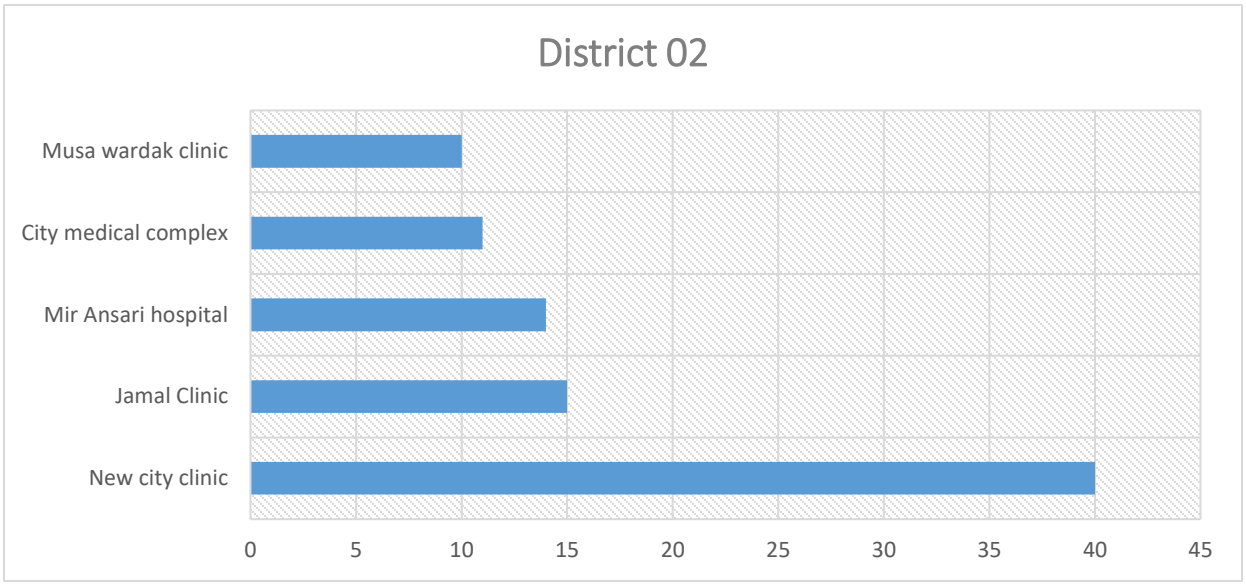
Furthermore, a representative sample of 158 VSLA members of children bearing age were interviewed on the willingness to pay for maternal and childhood services in private health care facilities through a safety net network.

Finally, the research team also conducted capacity needs assessment of nine VSLA members who met the CHWs established criteria. The purpose of capacity need assessment was to provide information for project technical team to develop a relevant and comprehensive CHW training curriculum.

# Findings

## Facility outputs

Measuring a facility's patient volume and the number of services delivered, which are known as outputs, is critical to understanding how private facilities respond to health service needs and their capacity to receive referrals from community.  Figures-1 and 2 illustrate the average outpatient volume across private health facilities in both 02 and 06 districts.



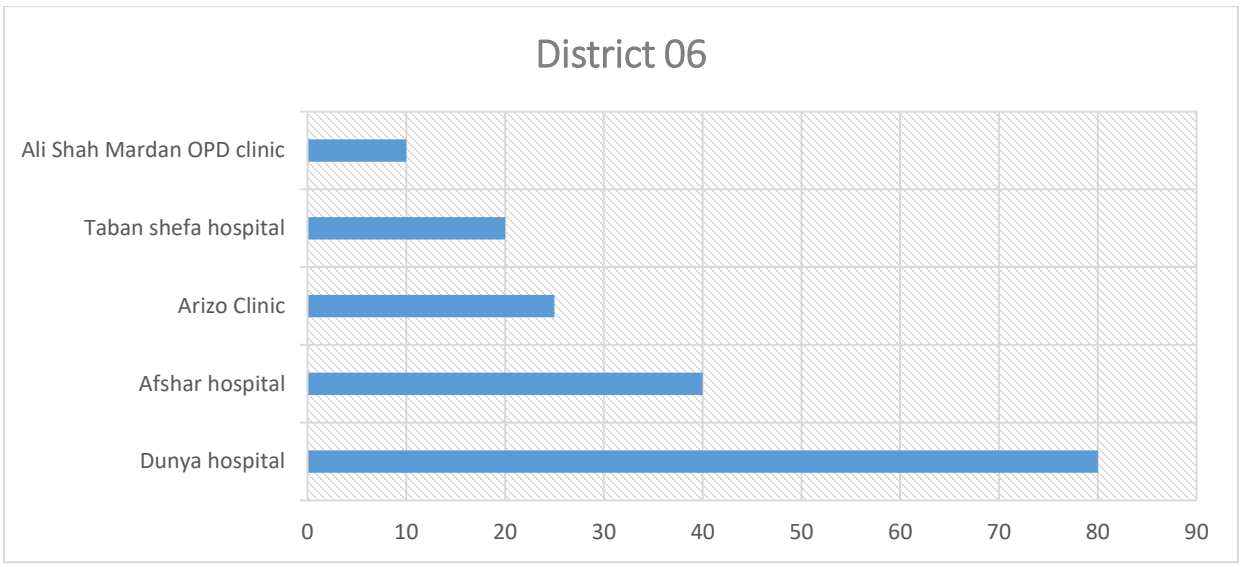
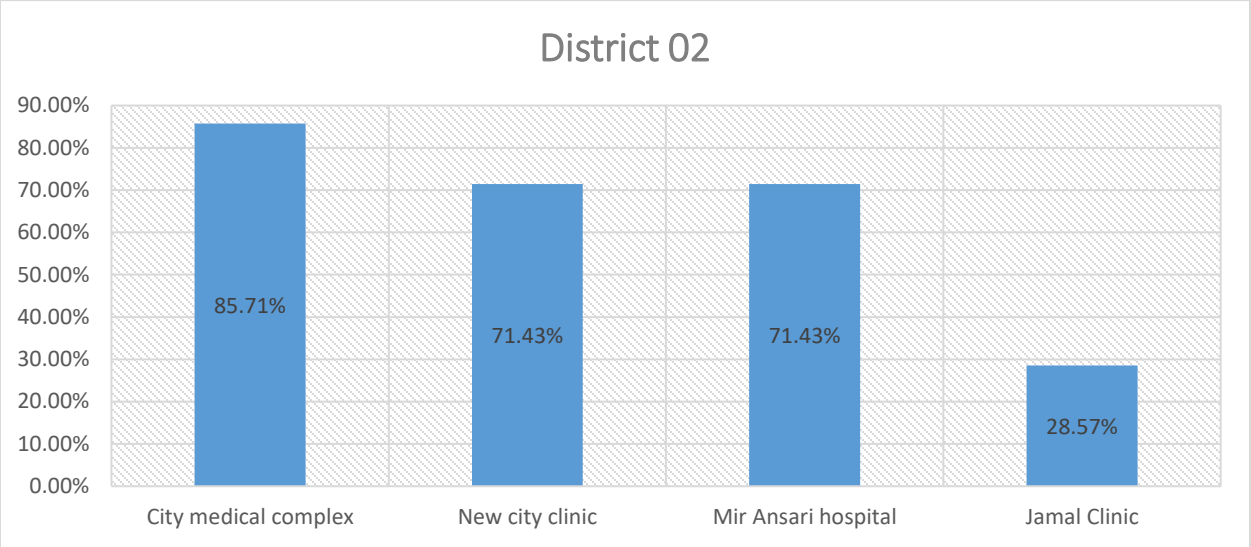
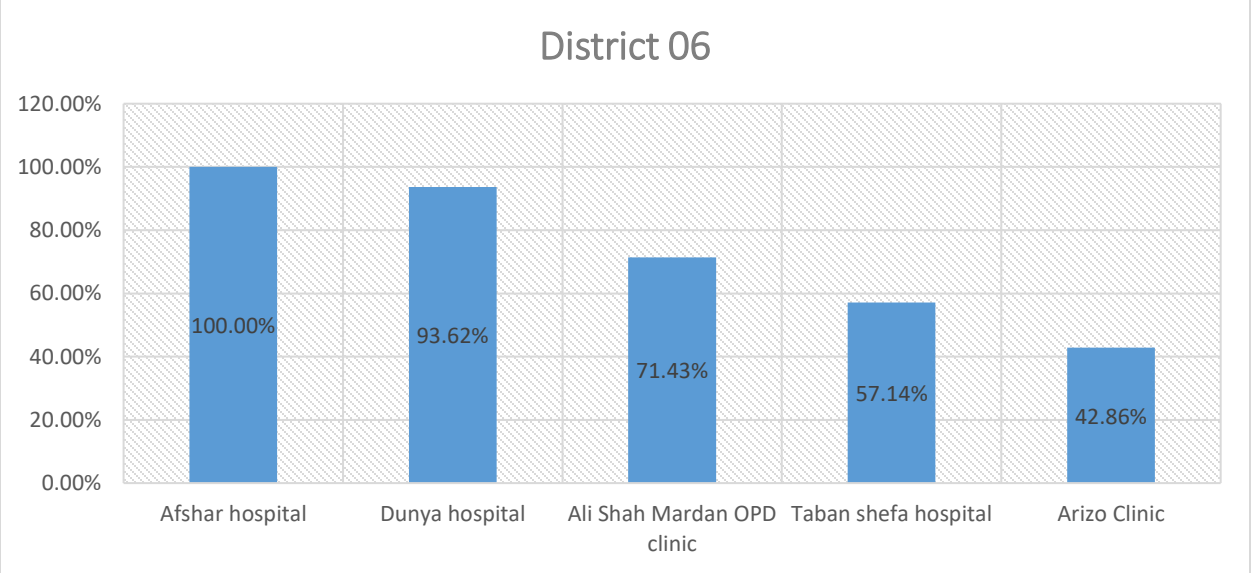




*Figure 1 and  2 Patient load per facility in both districts*

## Availability of MNCH services

Maternal health care services include Antenatal Care Visits (ANCs), referrals, mothers' vaccination, assisted delivery, C-section, and Post Natal Care (PNC).
The availability of key maternal health care services in different health facilities of district 02 and 06 is dissimilar. One private health facility provides 100 % of key component of maternal health care services, but some of them provide as little as 28.57 %. Figures-3 and 4 highlight the percentage of maternal health care services by private health facilities in both districts.




*Figures 3,4. Percentage of maternal health care services in different facilities*

Table-1 highlights the availability of key maternal health services in private health facilities in both districts.

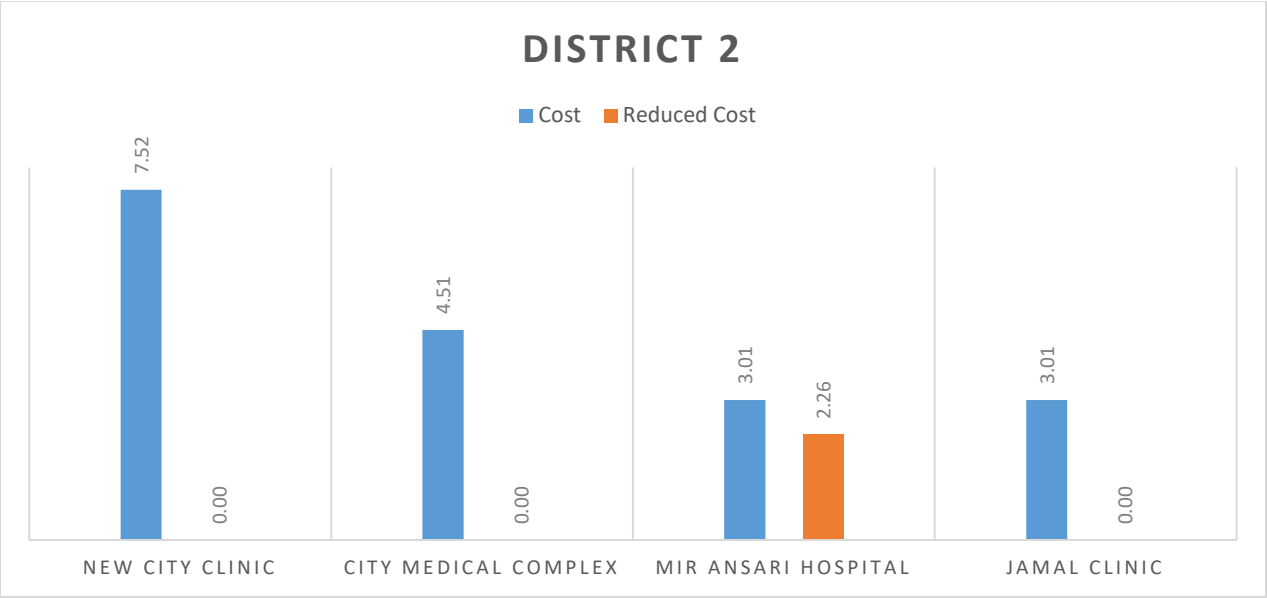
| Private Facilities | 4 Time ANC | Referral by ambulance | Mothers' vaccination | Assisted delivery | C-section | PNC |
|---|---|---|---|---|---|---|
| District 02 | | | | | | |
| New city clinic | | | | | | |
| City medical complex | | | | | | |
| Mir Ansari hospital | | | | | | |
| Jamal Clinic | | | | | | |
| District 06 | | | | | | |
| Ali Shah Mardan OPD clinic | | | | | | |
| Taban Shefa hospital | | | | | | |
| Dunya hospital | | | | | | |
| Arizo Clinic | | | | | | |
| Afshar hospital | | | | | | |

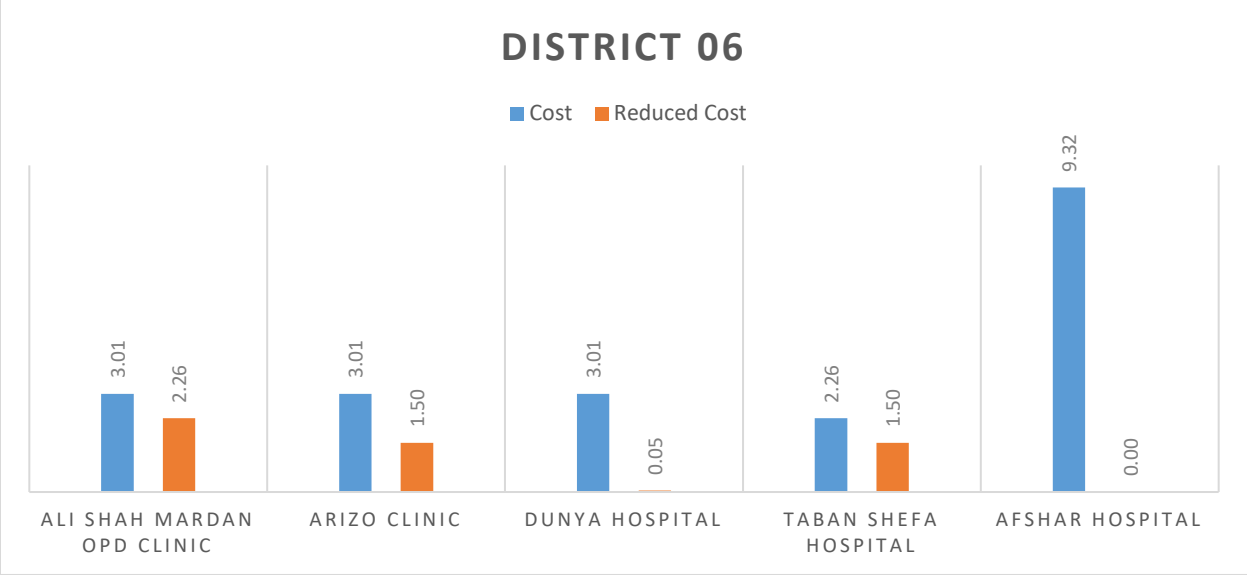
*red color indicates lack of services.

## The cost of selected MNCH services

### The cost of ANC

The costs of routine health services—antenatal care—are presented first. The costs are higher in hospitals than out patients' health facilities. The cost of the ANC services range from $2.26 to $9.32. The average unit cost for ANCs in the all facilities is approximately $4.62. Four out of nine health facilities are willing to reduce ANC cost for referred patients by CHWs. The reduction in cost ranged $1.56 to $2.26. Figures-4 and 5 show the cost of antenatal care in different private health facilities in both districts.

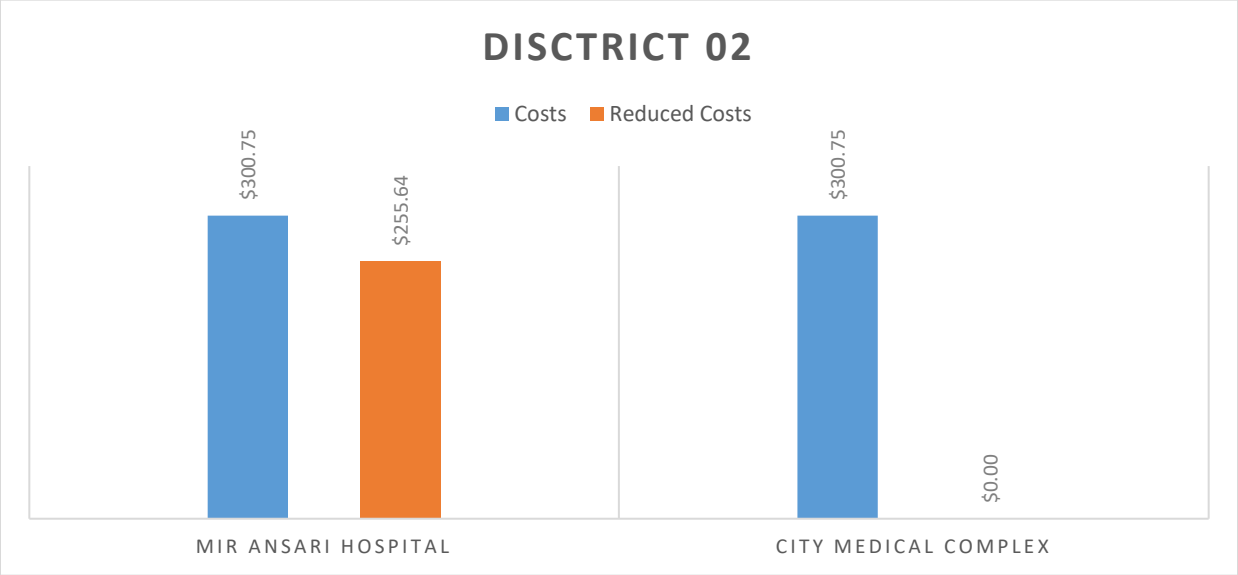


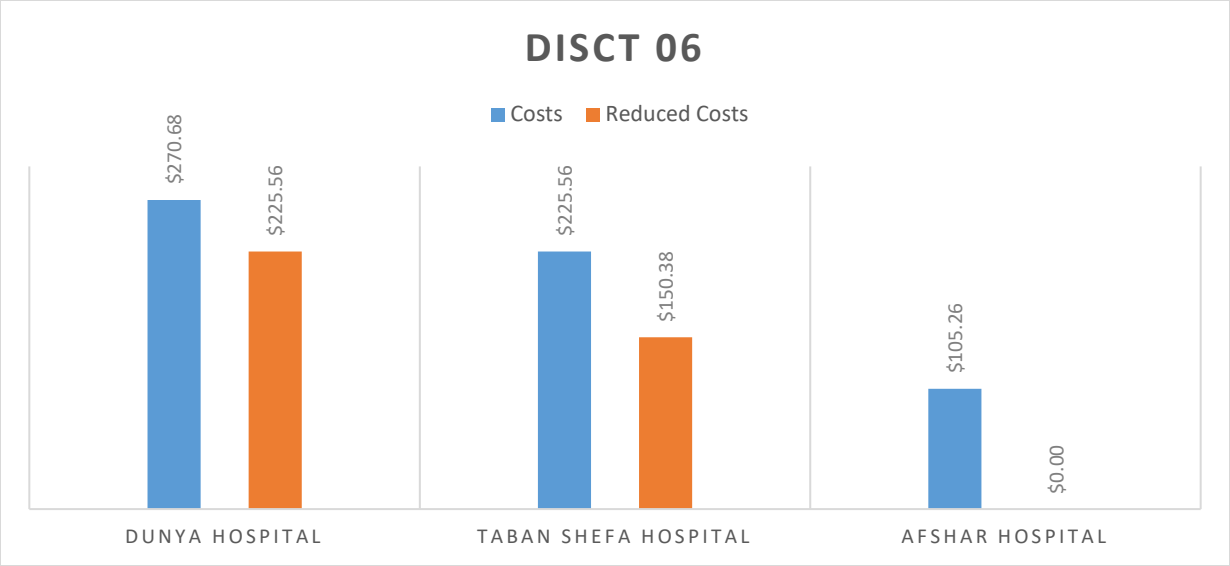



*Figures 4 and 5. The cost of ANC*

## The cost of assisted delivery services

Six out of nine studied private health facilities provided assisted delivery services. The total cost per assisted delivery ranged from $15.4 to $120.30. In the case of assisted delivery, the difference between the lowest and highest cost is much wider. The difference could be due to the difference in infrastructure and profile of each facility. Three out of six health facilities are willing to reduce cost for referred patients by community health workers. The reduction in cost ranged $45 to $75. Figures-6 and 7 shows the cost of assisted delivery care in studied private health facilities in both districts.






*Zero indicates the intention of health facility not to reduce the costs.*

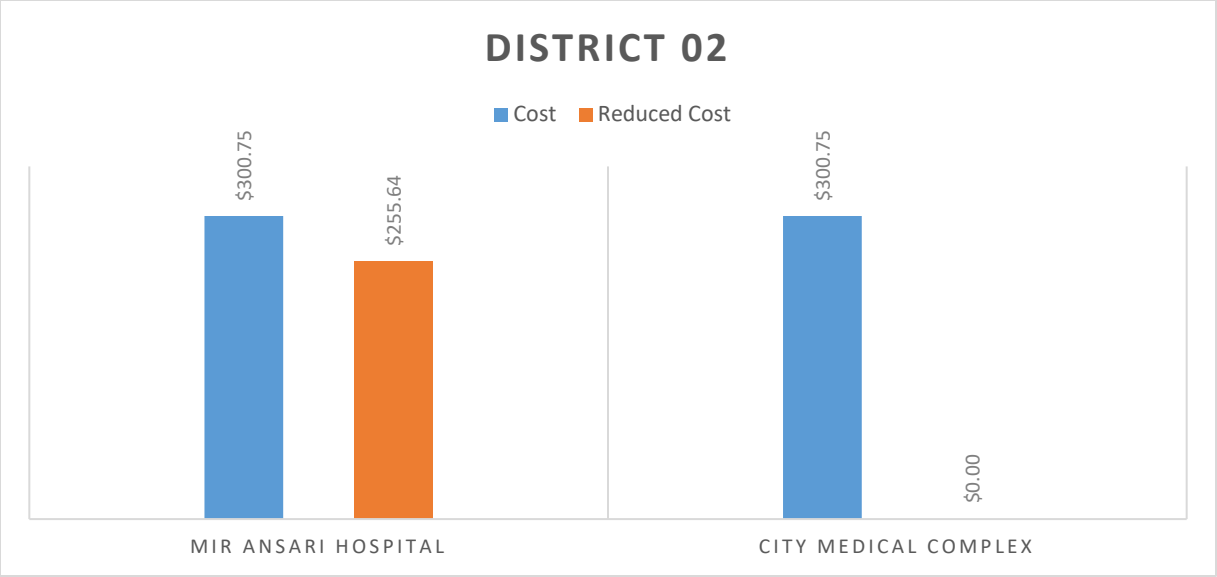
*Figures 6 and 72 Cost of assisted delivery*

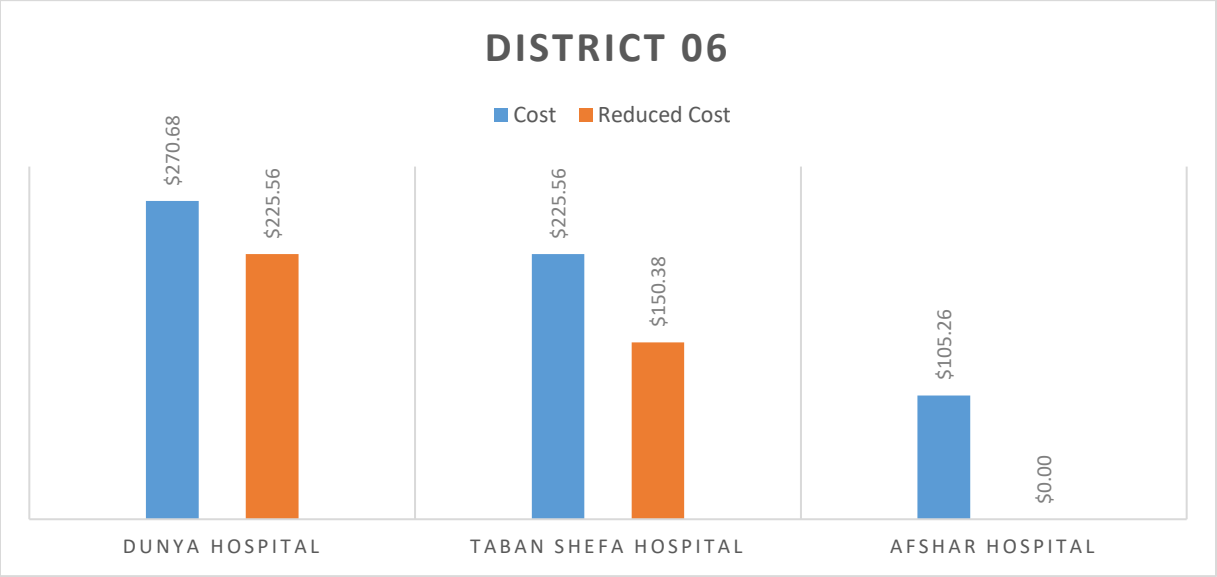
## The cost of treating obstetric complications through C- Section

C-section is indicated when mothers have had obstetrical complications. The indication for C-section includes previous C-section, dystocia, or difficult labor. Three following conditions commonly cause difficult labor: abnormalities in the mother's birth canal; abnormalities in the position of the fetus; or abnormalities in the labor, including weak or infrequent contractions.

Another major cause which requires C-section is fetal distress, a condition where the fetus is not getting enough oxygen. Fetal brain damage can result from oxygen deprivation. Cesarean section is a surgical procedure in which incisions are made through a woman's abdomen and uterus to deliver her baby.

The cost of cesarean section treatment at private hospitals in district 02 and 06 ranges from $105.26 to $300.75 respectively. 03 out of 05 hospitals are willing to reduce costs for referred patients by community health workers. The reduction in costs ranges from $45 to $75. Figure-8 and 9 show the cost of C-Section in private health facilities in both 02 districts.



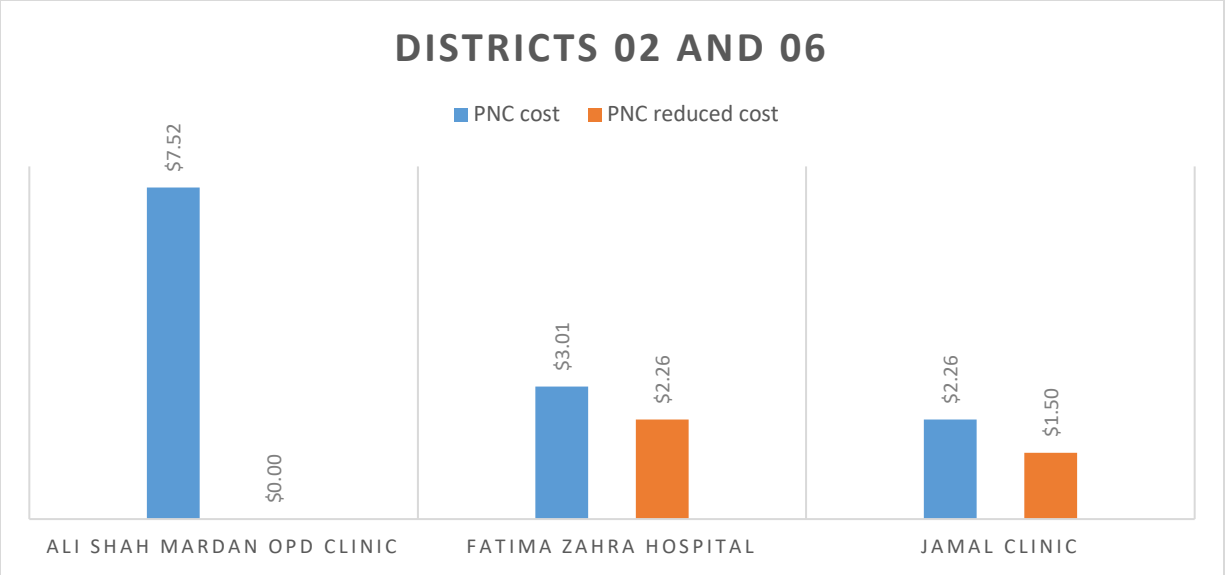




*Zero indicates the intention of health facility not to reduce the costs.*

*Figures 8 and 9 Cost of C-section*

## The cost of Post-Natal Care (PNC)

Five out of nine studied private health facilities provide PNC services. The cost records for PNCs are only obtained from 04 out 05 studies facilities. The cost per PNC in studies private facilities range from $2.26 to $7.52. Three out of five private health facilities are willing to reduce ANC cost for referred patients by community health workers. The reduction in cost ranged $1.50 to $3.01. Figure-10 shows the cost of PNCs in studied private health facilities in both districts.




*Zero indicates the intention of health facility not to reduce the costs.

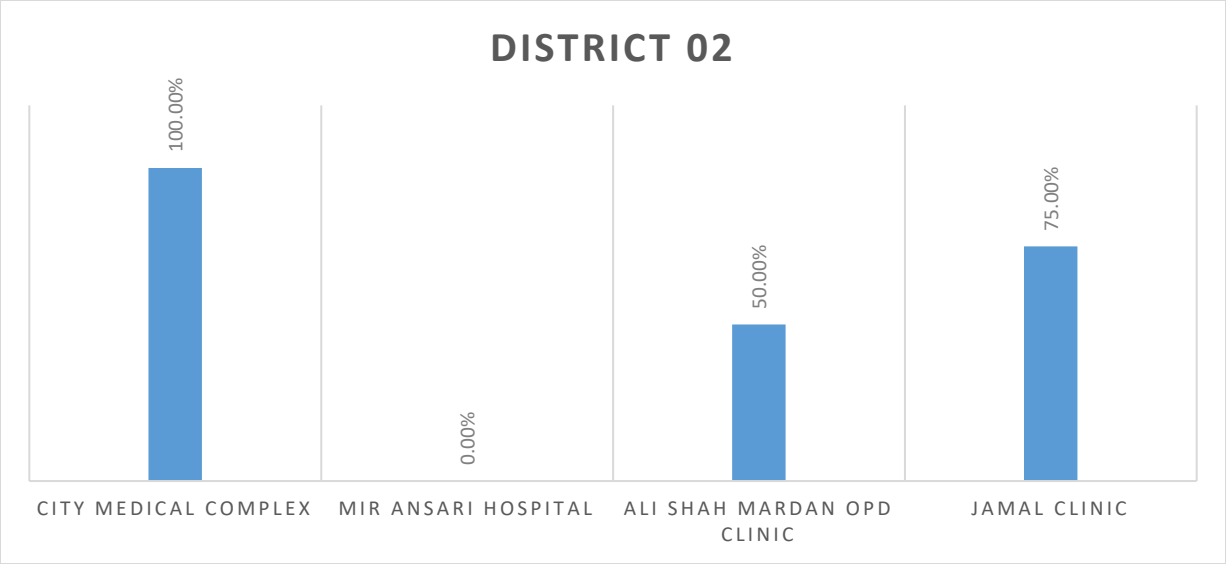
*Figure 10 Cost of PNC*

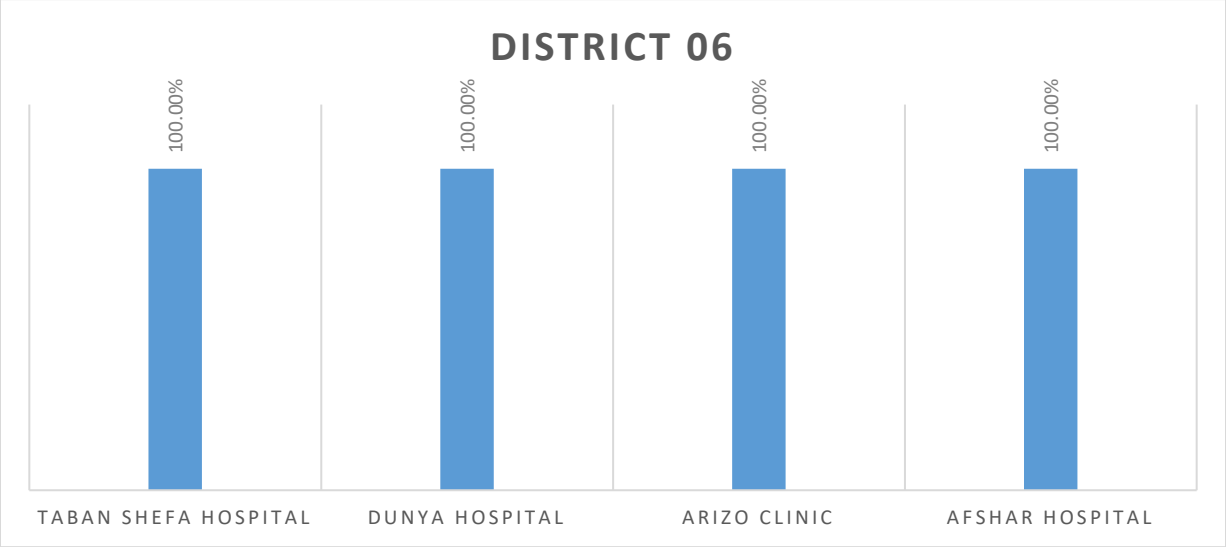
## Availability of family planning services

Family planning is the practice of controlling the number of children in a family and the intervals between their births, particularly by means of artificial contraception.

Family planning services should be available to men as well as women and should include counseling, information, education, and method delivery and follow-up (UNFPA, 2010). The basic package of family planning methods available include modern methods (e.g., hormonal contraceptives, IUDs, condoms, and counseling and, in addition to referrals for methods requiring higher levels of care, such as implants and sterilization.

Six out nine private health facilities in both districts had 100 % of all family planning methods. Comparatively, two private of OPD facilities had 0% to 45 % of family planning services. Figures 11 and 12 shows the availability of family planning services in both districts.




*Figures 11 and 12 Availability of family planning*

Table-2- highlights the availability of different family planning services in different studies private health facilities.

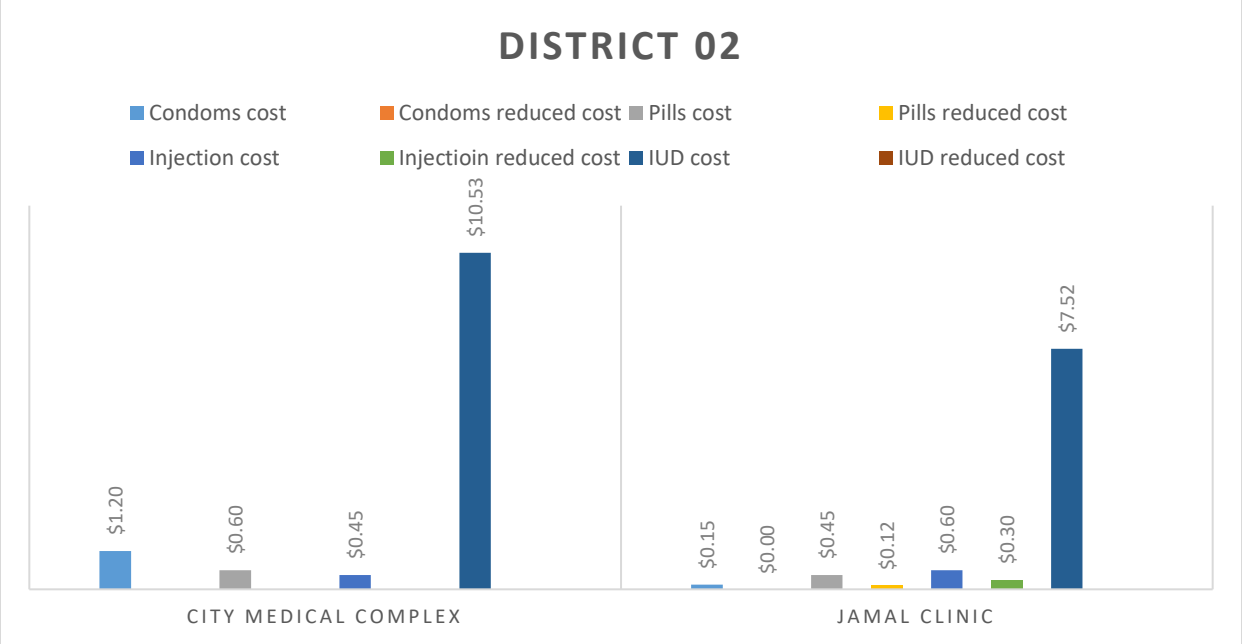
| Health Facilities | Condoms | Family planning pills | Injections for family planning | IUD |
|---|---|---|---|---|
| District 02 | | | | |
| City medical complex | | | | |
| Mir Ansari hospital | | | | |
| Ali Shah Mardan OPD clinic | | | | |
| Jamal Clinic | | | | |
| District 06 | | | | |

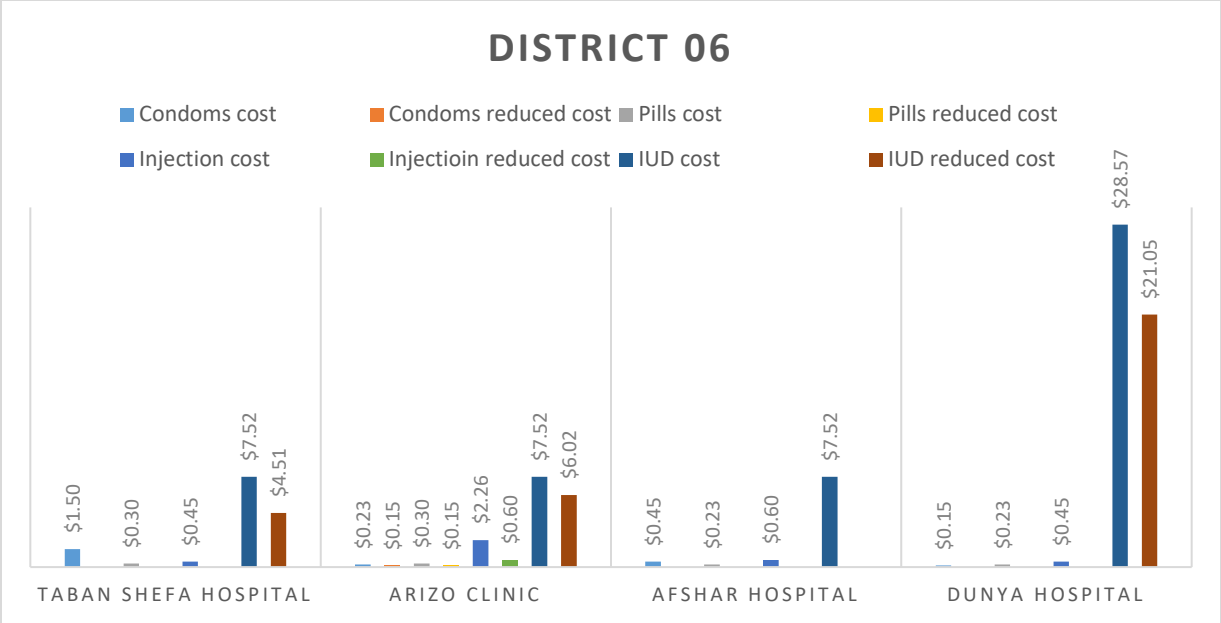
| | | | | |
|---|---|---|---|---|
| Taban Shefa hospital | | | | |
| Dunya hospital | | | | |
| Arizo Clinic | | | | |
| Afshar hospital | | | | |

*red color indicates lack of services in a health facility.*

## The cost of family planning services

Six out of eight studied private health facilities provide family planning services. The cost for condoms ranges from $0.15 to $1.20. The cost for pills ranges from $0.23 to $0.60. The cost for injections ranges from $0.45 to $2.26. The cost for IUDs ranges from $4.51 to $10.63. Three out six private health facilities which provide family planning services indicated willingness to reduced cost for referred patients by community health workers. The reductions in cost varied by type of service and facilities. Figure- 12 and 13 show the cost and indicated reduction in cost of different family planning services in studied private health facilities in both districts.

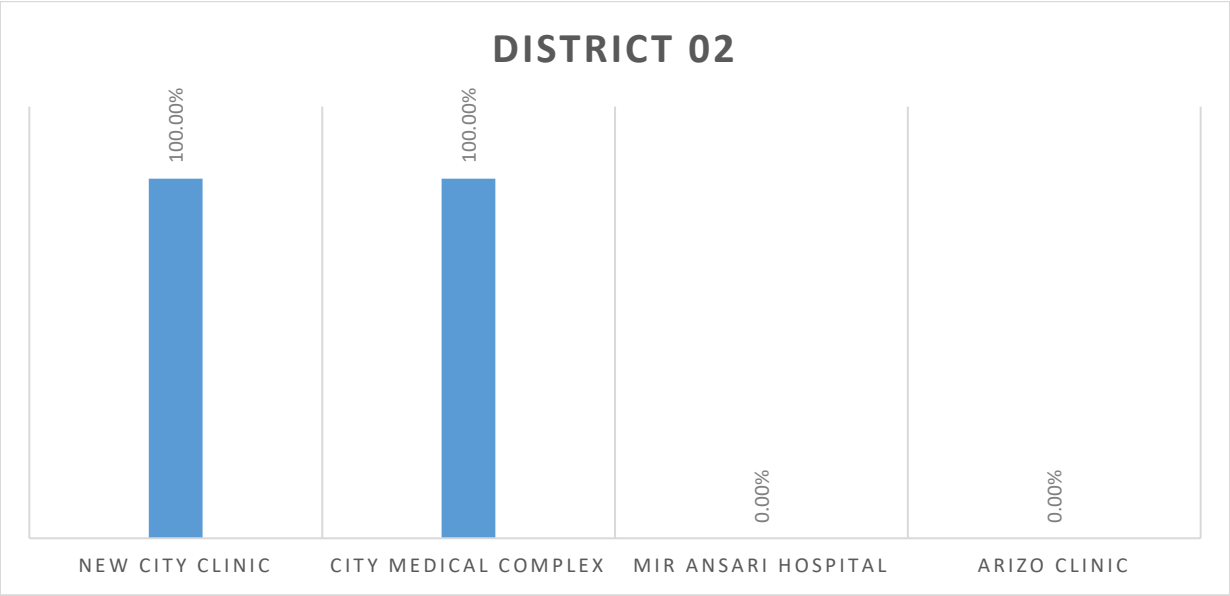


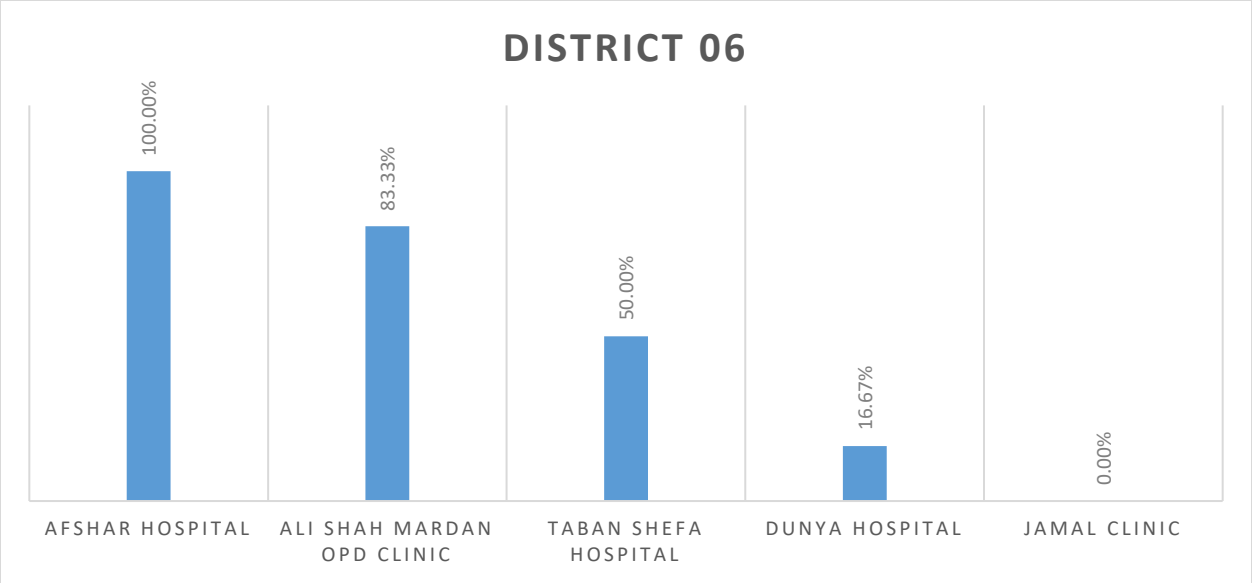



*Figures 12 and 13. Family planning services and reduction in cost*

## Availability of child health services in mapped private health care facilities

The children health services intend to give every child the best possible start in life. Key children health care services include routine childhood vaccination, child resuscitation, Integrated Management of Childhood Illness (IMCI), growth monitoring, micronutrient distribution, infant and young child feeding counselling. Three out of nine private health facilities had all key components of children health care services. Three others had 16% to 83 % of children health care services. Three of them had no children health care services. Figures 14 and 15 show the availability of child health care services in health facilities in both districts.






*Figures 14 and 15 children health care services*

Table-3-highlight the availability of key children health care services. The red color indicates nonexistence of mentioned services

| Health Facilities | Routine childhood vaccination | Child resuscitation | IMCI | Growth monitoring | Micronutrients distribution | Infant and young child feeding counselling |
|---|---|---|---|---|---|---|
| District 02 | | | | | | |
| New city clinic | | | | | | |
| City medical complex | | | | | | |
| Mir Ansari hospital | | | | | | |
| Jamal Clinic | | | | | | |
| District 06 | | | | | | |
| Taban Shefa hospital | | | | | | |
| Dunya hospital | | | | | | |
| Arizo Clinic | | | | | | |
| Afshar hospital | | | | | | |
| A.S. Mardan OPD | | | | | | |

The records pertaining cost of childhood diseases were not available in studied health facilities.

## The support of private health facilities to community health workers

The sustainable community health interventions are necessary for sustained health gains in community. Linking community health network with a network of local private health facilities can improve the referral systems and patients' outcome. Many of mapped facilities demonstrated willingness to support community health network through training, mentoring and provision of CHWs kits. Table-4 provides facility specific demonstrated support.

| Facility Name | Location | Support for CHC* | Support CHWs | CHWs training | CHWs kit |
|---|---|---|---|---|---|
| **New city clinic** | Second | Yes | Yes | Yes | Yes |
| **City medical complex** | Second | Yes | Yes | Yes | No |
| **Mir Ansari hospital** | Second | Yes | Yes | Yes | No |
| **Jamal Clinic** | Second | Yes | Yes | No | No |
| **Ali Shah Mardan OPD clinic** | Sixth | Yes | Yes | Yes | Yes |
| **Taban Shefa hospital** | Sixth | Yes | Yes | Yes | Yes |
| **Dunya hospital** | Sixth | Yes | Yes | Yes | Yes |
| **Arizo Clinic** | Sixth | Yes | Yes | Yes | No |
| **Afshar hospital** | Sixth | Yes | Yes | Yes | No |

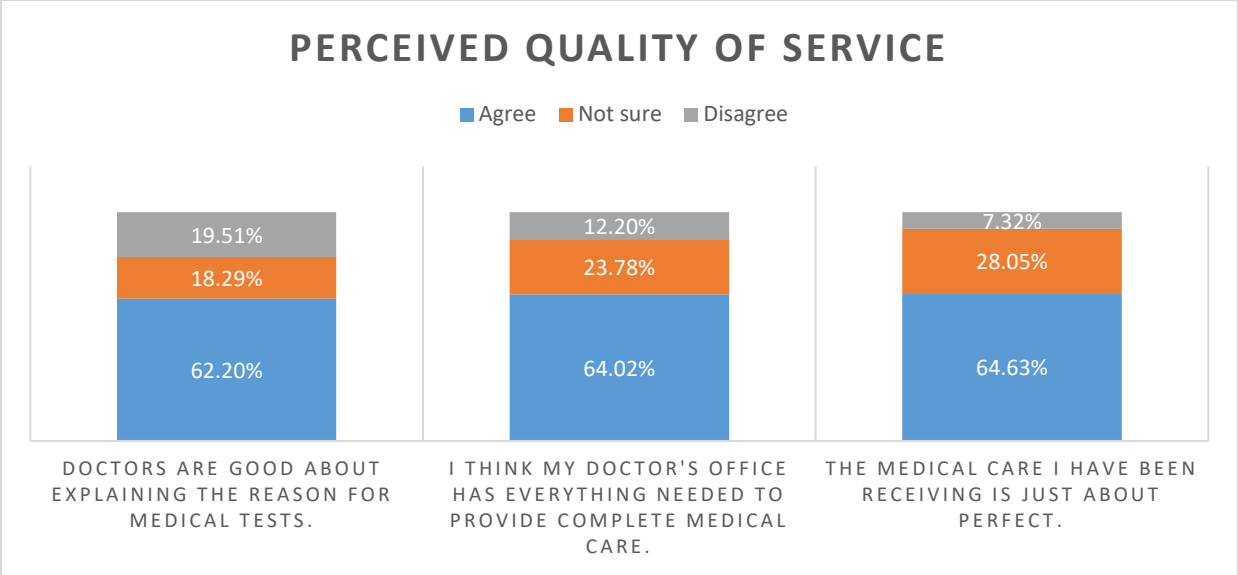
*Community Health Councils

## Patient satisfaction with MNCH services in private health facilities

### Perceived general quality of care

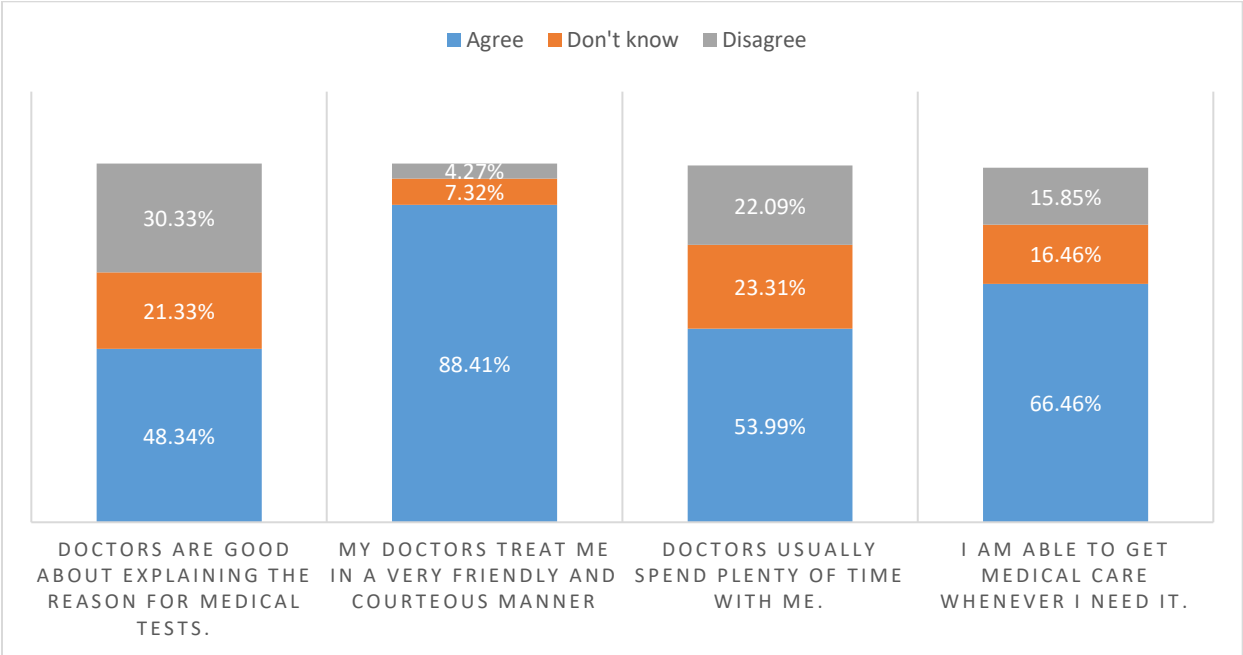
For nearly 25 years, the World Health Organization (WHO) has identified meeting individuals' universally legitimate expectations as a key health system objective. Patient satisfaction and ratings have been given increasing importance for measuring the quality of health services and are routinely used in developed countries for continuous quality improvement and value-based incentive payments (Dansereau, 2015). In addition to the intrinsic importance of meeting reasonable expectations, patient satisfaction and perceptions are associated with healthcare utilization. 164 patients from 09 mapped private health facilities were interviewed to examine their perception on the quality of maternal and children health care services they received in mentioned facilities.

62.20 % of respondents agree that health providers are good at explaining the reasons for medical test, 64.2 % believe that health facility has everything needed to provide complete care. 64.03 % perceive the health care as perfect. But 28.05 % of respondents are certain if there is perfect health care in visited health facilities.




## Private health facility staff behavior

The behavior of staff is an important factor for clients and patients' choice on the type of health facilities to receive health care services. Additionally, by analyzing health facilities staff behaviors, health providers can improve on their service delivery, advance clients' satisfaction and ensure a healthier population. The overall satisfaction of patients with health facility staff behavior ranges from 48 to 88.42 %. They are less satisfied as doctors as explaining them the reasons of medical test and spending little with them while examining them.



## Willingness to pay

Investing in health is fundamental to any poverty reduction strategy as healthy individuals are key to the economic productivity of any community. Both high and low-income countries finance health care using a mixture of five possible sources: taxes, social insurance contributions, private insurance premiums, community financing and direct out-of-pocket payments through, for instance, user fees and patients' direct payment to private providers.

Increasingly, governments in low-income countries and other purchasers of health-care services are experimenting with combinations of demand and supply side financing mechanisms such as the use of Output-Based Aid (OBA) voucher subsidies. While supply-side investments aim at supporting the health system issues through initiatives such as capital investments, demand side financing structures target the health system user, driving them to utilize health facility based services. Such mechanisms include health voucher programmes which place purchasing power directly in the hands of potential health-care users, giving them choice of health-care service providers and services. The strategies, mostly targeting the poor, have been used to improve uptake of health-care services in developing countries. One of the strategy is the safety where community members provide premium in to a pull funds and they receive subsidize care in health facilities when needed. We asked 158 women of reproductive age to examine their wiliness participating a community safe net program. More than 89 % of respondents were willing to participate in community health insurance program. 9 % don't want to participate and 2 % have no idea.  Figure below provide a comparison of different options.

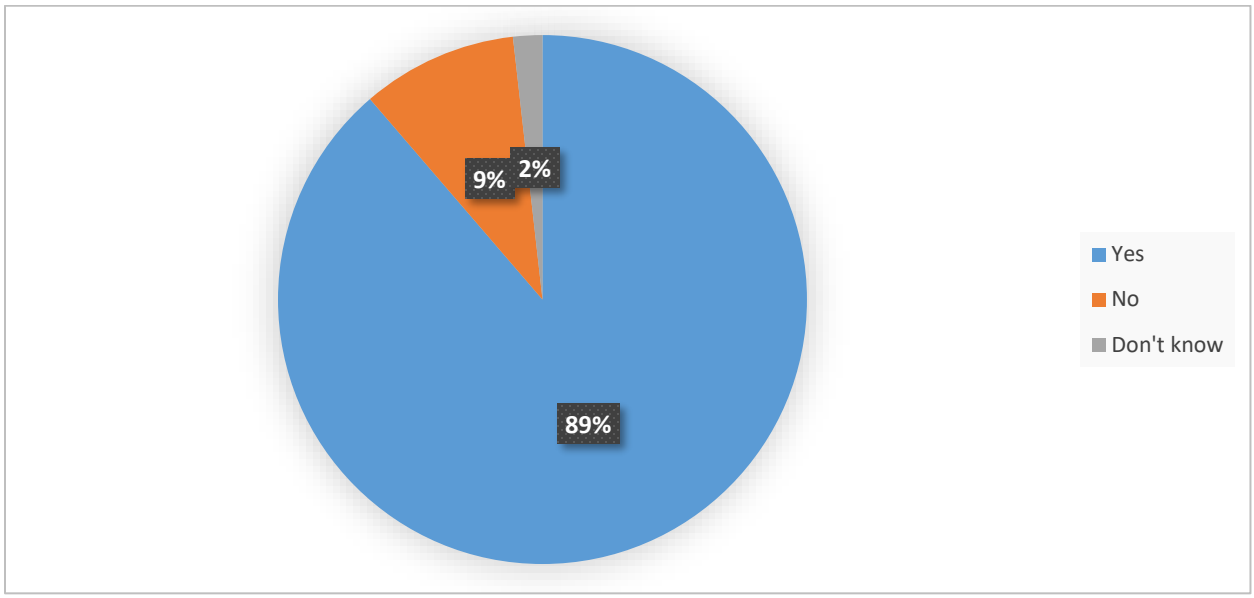



*Figure 3 Willingness to participate in safety net programs*

We also asked the respondents who had willingness to participate in safety net the factors for their willingness. The major factors include free access to care, followed by, facing health problems, helping others, peace of mind in time of illness.

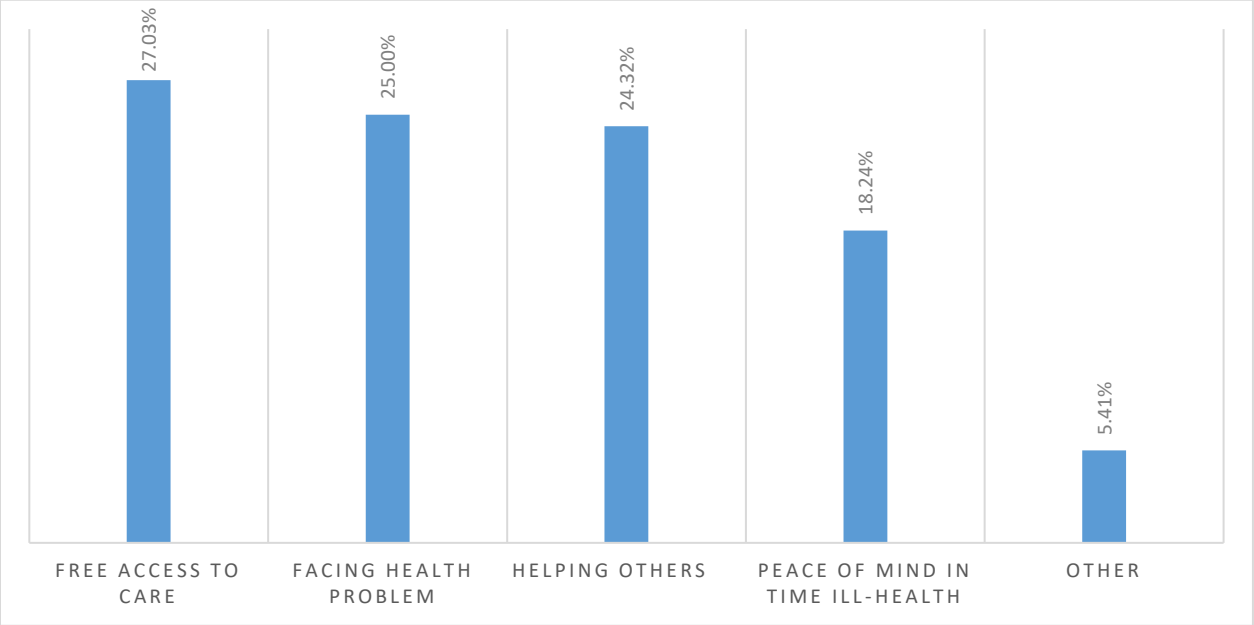



*Figure 4 The factors for willingness to participate in safety nets*

## Preference on the frequency of premium payment

The time and interval of premium is essential for the design of any community safety net program. The highest proportion of respondents 53.24% selected bi annual flat rate payments, while 21.23 %, 13.01%, 10.01 % preferred monthly, annually, and quarterly payments respectively.

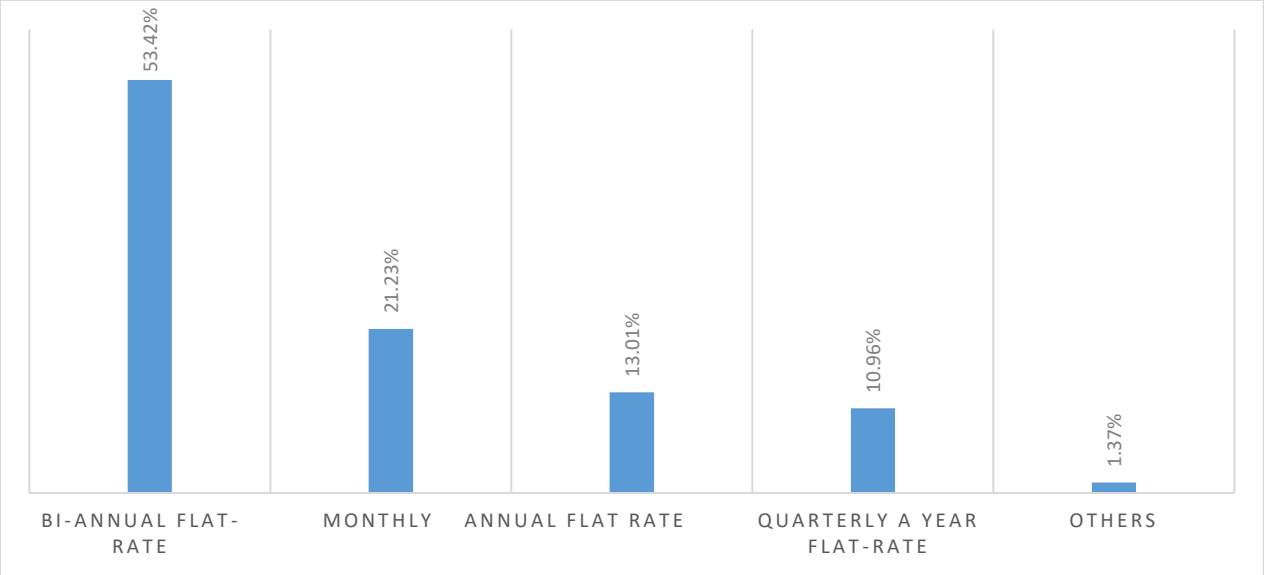



*Figure 5 Frequency and timing of payment*

## Preference on the amount of payment

The respondents were also asked about a set amount to pay as premium as per frequency they already identified to community safety net. 60 % of respondents selected to pay $ 1.5 and 17 % preferred a payment of $3.

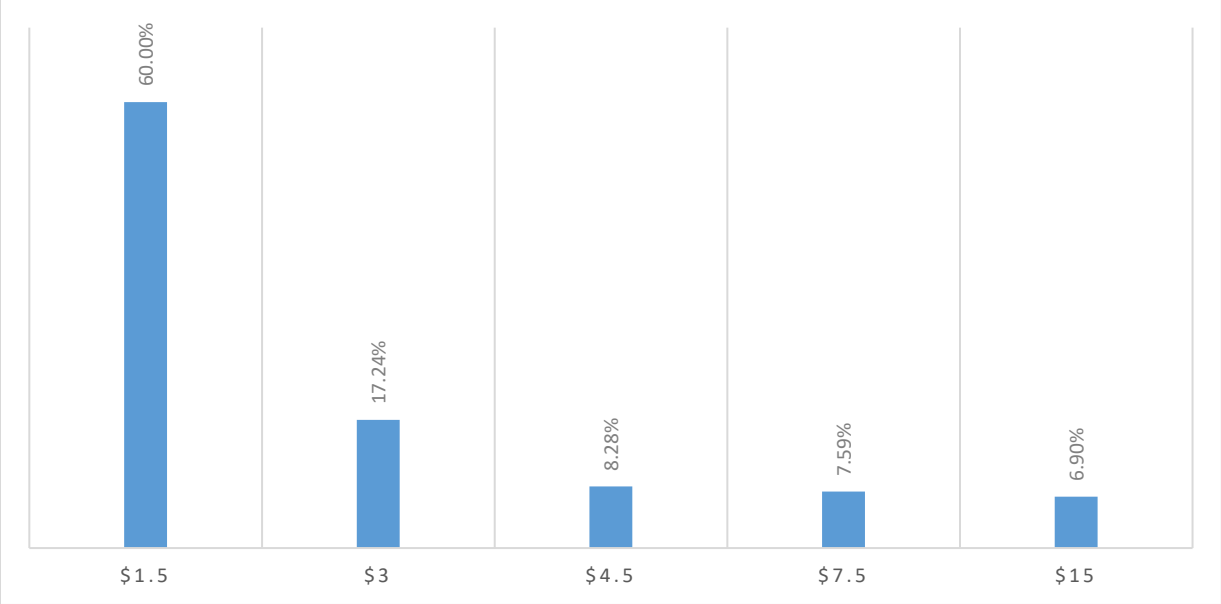



*Figure 6 Amount of premiums*

The Millennium Development Goals (MDGs) 4 and 5 - to reduce child and maternal mortality and achieve universal access to reproductive health - is failing too many people in too many

places in communities, particularly, due higher costs. The quantity and quality of spending on maternal, newborn and child health have a great impact on maternal and child health – and governments and communities have the power to fix the problem. Unless significant additional resources are mobilized for maternal, newborn and child health services (UN,2015). The respondents were asked if they are willing that a significant portion of pooled fund would be allocated to maternal and child health. 90 % of respondents agree that significant amount of any designed safely net pooled fund is allocated to maternal and child health services purchase.

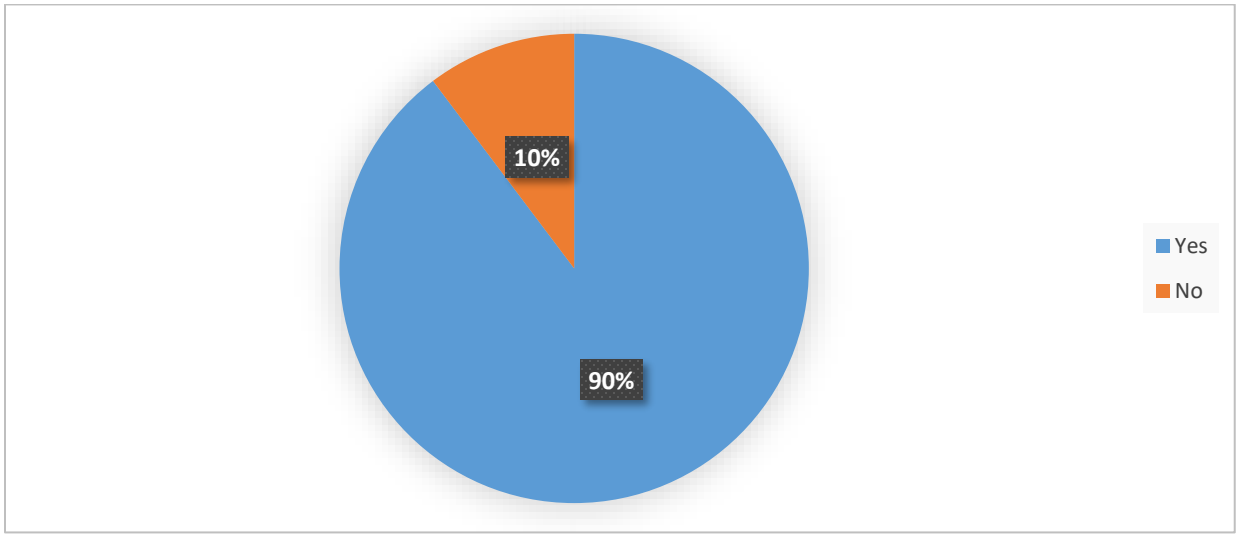



*Figure 7 Allocation of pooled funds to MNCH*

## Support community health workers' capacity building cost from pooled funds

There is ample evidence from research and implementation to show that community health workers, when appropriately trained, supplied, supported, and supervised, can identify, and correctly treat refer most maternal child health conditions likely ANC, PNC, referring complicated deliveries, pneumonia, diarrhea, and malaria. Therefore, it is important to have sustainable resources for the training, support and supervision of community of health workers. 68 % of respondents agreed that some part of safety net pooled funds can be utilized for capacity building of CHWs.

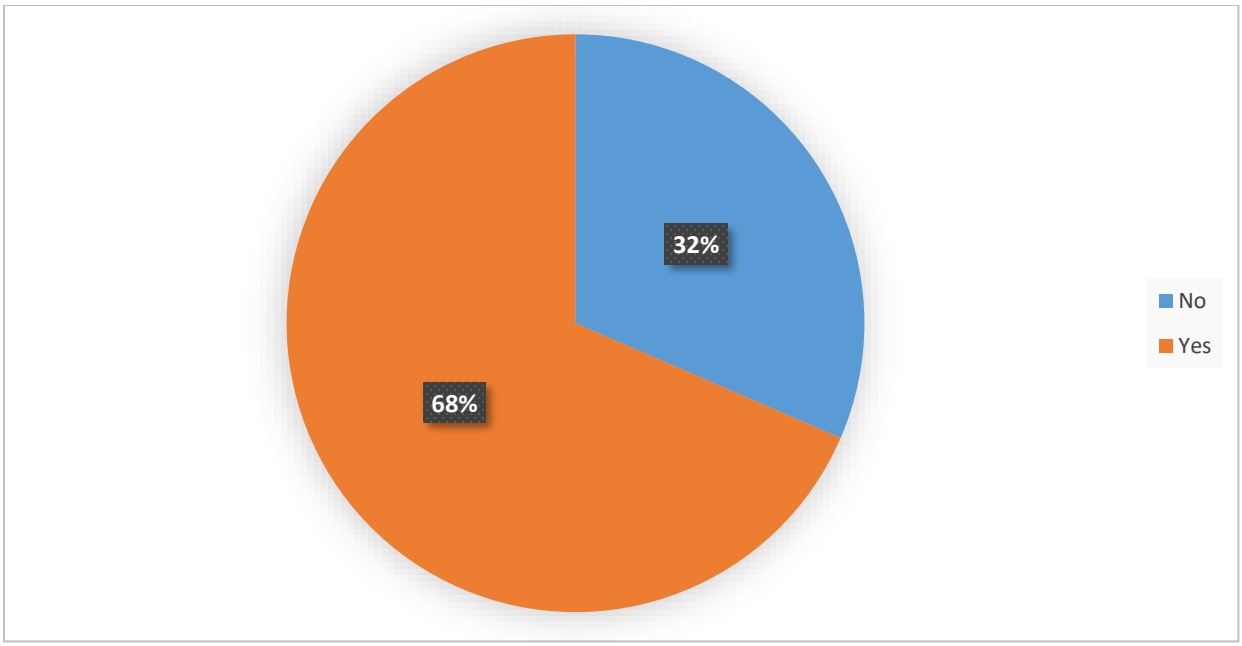



*Figure 8 Pooled funds allocation for CHWs training*

## Capacity needs assessment of community health workers

An important concept of Primary Health Care (PHC) is community health workers who act as a bridge between the health care delivery system and the community. CHWs enable health programmes to achieve three interconnected goals: building a relationship between the health care provider and persons in the community; improving appropriate health care utilization; and educating people to reduce health risks in their lives.

Appropriate knowledge and skills about leadership and interpersonal communication expertise, in addition to basic public health skills are a key to the work of CHWs. The CHWs can empower the community to identify its needs and can assist in planning a strategy to achieve the desired results. To accomplish this successfully, CHWs should be culturally sensitive, with an ability to build a strong community rapport. The result of CHWs capacity assessment indicated that 62 % respondents needed the skills to develop community capacity in community assessment and planning, 50 % in community mobilization, 37 % in helping community to identify problems. But lesser extent they needed skills to provide education and to monitor team activities.

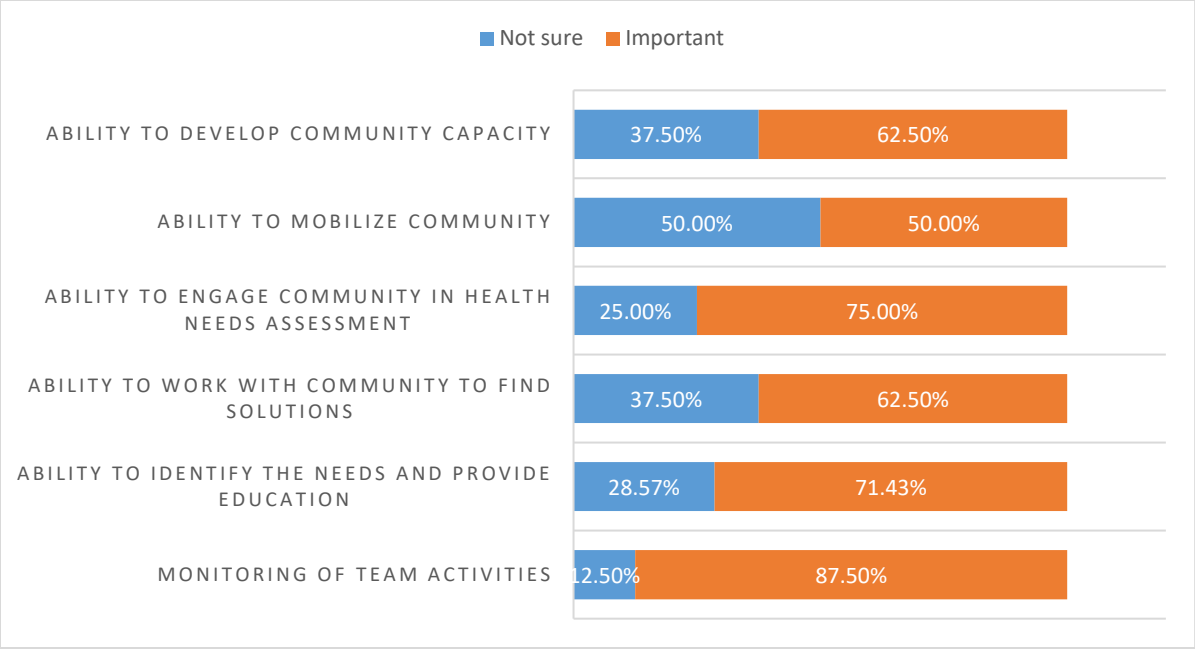
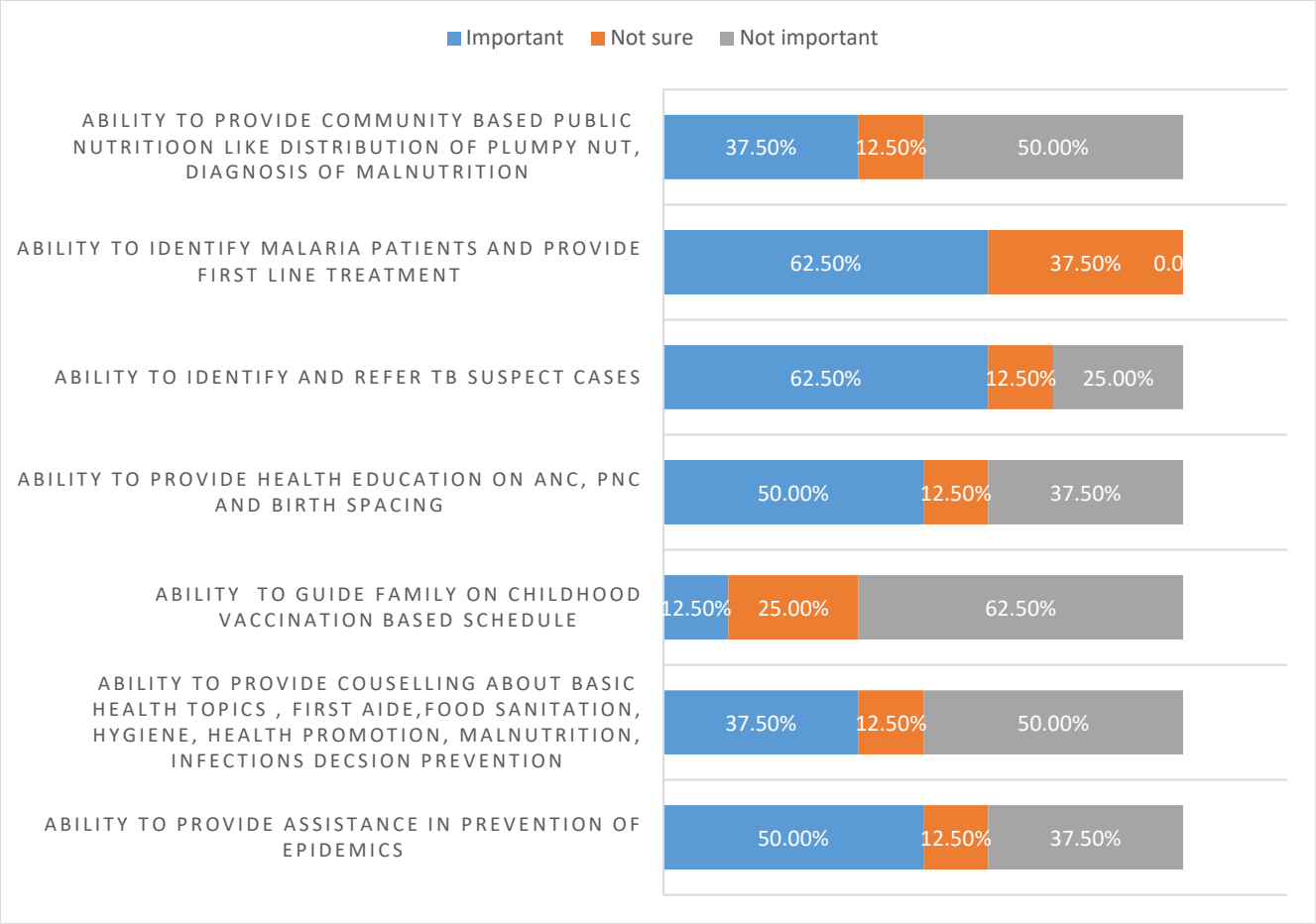



*Figure 9 Training needs*

Members of the community health workers' workforce always need new opportunities to work within the health care system. These opportunities come with questions and challenges about the roles CHWs can play and their specific capacity building and training needs. 62.50 % of to be CHWs needed trainings on identification and referrals of TB cases health education on ANC, 50 % on PNC and birth spacing, 37.50 on prevention of epidemics.




## Recommendations

1. The partnership of community and private health facilities should be based on contract and mutual memo of understanding. In the contract the role of both parties should be clear. The private health facilities would clearly confirm the support they indicated during this study period in the contract. CHWs should have a clear list of services availability and their cost in different studies facilities.
2. The community intended to participate in community safety nets to have free access to health care services when needed. We propose three basic tasks on the design of community health insurance and safety nets, a committee of community leaders, Care Afghanistan and government should design and monitor the safety net activities. Related to the design of community health insurance and safety nets, the committees should first help reduce the problem of adverse selection, by introducing simple rules. It could recommend to start up a safety net only when a minimum percentage of the target population could be enrolled. Waiting periods could also be recommended, to refrain people from signing up with a scheme only when they are ill. We strongly recommend not to enroll on individual basis but rather on a family basis. Apart from the percentage enrolment, the size of safety net is an equally important concern. Excessively small

schemes, for instance with only a few hundred members, do not constitute a solid risk pool capable of insuring its members adequately. Larger risk pools could thus be advised, for instance via the establishment of a federation or networks of communities. Thirdly, other concerns could also be addressed by committee, including membership, timing of collection, pooling and the role of the community in decision-making. However, community preferred a bi annual flat rate payment.

3. It is important to invest in training of current and new CHWs. Beside basic public health skills, they need to competent in leadership, communication, cultural diversity, problem identification and facilitation skills to develop new solutions for health-related matters. However, private health facilities have demonstrated interest to support CHWs but Government of Afghanistan has a mandate to e to train to CHWs, continuous link with Community based Health Care Unit (CBHC) unit of Ministry of Public will contribute to sustainability of CHWs work. Strengthening the capacity of CHWs through proper training and incentives will equip them with the proper tools and dissuade their turn over.

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