



Contents lists available at ScienceDirect

Social Science & Medicine

journal homepage: www.elsevier.com/locate/socscimed

Challenging logics of complex intervention trials: Community perspectives of a health care improvement intervention in rural Uganda



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ARTICLE INFO

Article history:

Available online 20 February 2015

Keywords:

Health care interventions
Community perceptions
Treatment seeking
Malaria
Randomized controlled trials
Uganda

ABSTRACT

Health systems in many African countries are failing to provide populations with access to good quality health care. Morbidity and mortality from curable diseases such as malaria remain high. The PRIME trial in Tororo, rural Uganda, designed and tested an intervention to improve care at health centres, with the aim of reducing ill-health due to malaria in surrounding communities. This paper presents the impact and context of this trial from the perspective of community members in the study area.

Fieldwork was carried out for a year from the start of the intervention in June 2011, and involved informal observation and discussions as well as 13 focus group discussions with community members, 10 in-depth interviews with local stakeholders, and 162 context descriptions recorded through quarterly interviews with community members, health workers and district officials.

Community members observed a small improvement in quality of care at most, but not all, intervention health centres. However, this was diluted by other shortfalls in health services beyond the scope of the intervention. Patients continued to seek care at health centres they considered inadequate as well as positioning themselves and their children to access care through other sources such as research and nongovernmental organization (NGO) projects.

These findings point to challenges of designing and delivering interventions within a paradigm that requires factorial (reduced to predictable factors) problem definition with easily actionable and evaluable solutions by small-scale projects. Such requirements mean that interventions often work on the periphery of a health system rather than tackling the murky political and economic realities that shape access to care but are harder to change or evaluate with randomized controlled trials. Highly projectified settings further reduce the ability to genuinely 'control' for different health care access scenarios. We argue for a raised consciousness of how evaluation paradigms impact on intervention choices.

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1. Introduction

The quest for evidence-based public health policy has led to a

new breed of research in which the randomized-controlled study design – the 'gold standard' for clinical trials – is applied to large-scale trials of clusters assigned to receive health-related interventions. In such trials, citizens of involved communities are transformed into subjects of evaluation, with aspects of their daily lives labelled as 'behaviours', and their health as 'outcomes'. This new approach to public health research has emerged under the rubric of 'complex interventions', in recognition of the relative complexity of changing the behaviour of social groups and organizations (Clark, 2013; Shiell et al., 2008). Evaluations focus on pre-specified outcomes, often measured at the individual level and

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then aggregated at the cluster or community level, and compared between ‘intervention’ and ‘control’ groups (MRC, 2008). Increasing interest has been placed on understanding an intervention’s implementation and mechanisms of effect in order to interpret outcomes (Oakley et al., 2006). Researchers may employ logic models to map interventions through to their intended effects in order to pre-define variables upon which to collect data (Harris, 2010). The importance of understanding ‘context’ when evaluating the impact of complex interventions has begun to be incorporated into health evaluations from other areas of social policy (Pawson and Tilley, 1997). However, still the focus of evaluations of complex interventions in public health is often trained on the intervention, its pre-defined outcomes and its predicted pathway of change.

Anthropologists take a different view to understanding the impact of interventions, drawn from a holistic approach that takes as its starting point the everyday lives of people who may be conceived by various programmes as participants, recipients, and implementers. This diverges from the dominant ‘complex interventions’ perspective of evaluation in two key ways. First, anthropologists have highlighted the way public health research employs a ‘factorial’ model of disease to social and cultural phenomena (Parker and Harper, 2006). In this approach social and cultural aspects of health are often formulated and reduced into discrete and quantifiable ‘factors’ or ‘beliefs’ held by the study population or community and are consequently considered alongside a range of other factors influencing susceptibility to disease at individual or population level. These so-called ‘beliefs’ are often separated from, and assessed in contrast to, ideas of medical science, leading researchers to investigate barriers (to be overcome) or gaps (to be filled) for effective provision of health care services (Yoder, 1997). Anthropologists critique this approach mainly because it creates splits between phenomena that may be more harmful than they are helpful (Parker and Harper, 2006). This approach, often taken in conceptualizing ‘complex interventions’, assumes local contexts to be stable and composed of uniform social realities that can be characterized by categorical variables (Bell and Aggleton, 2012; Chambers, 1998). An anthropological approach, by contrast, characterizes local contexts as diverse and dynamic, requiring researchers to be sensitive to these complexities. In locations with a long history of interventions, the trials themselves, with their varying origins, interests (both local and external), trajectories, target populations and durations often add to this diversity and influence their implementation and outcome (Whyte et al., 2013). The factorial model of disease problems and solutions aligns with a tendency in development to render technical matters that are often political (Murray Li, 2007), and anthropologists have drawn attention to what is obscured by the increasing depoliticization of disease control (Parker and Allen, 2014). For example, malaria has historically been cast as a technical challenge, overshadowing evidence of the political economy of the disease (Eckl, 2014; Packard, 2007). Second, anthropologists often highlight unintended consequences of interventions. The evaluation agenda in many public health interventions is often tightly focused on assessing whether specific interventions produce specific pre-defined effects. The holistic and bottom-up approach of anthropology attempts to situate the interests, realities and priorities in people’s lives (which may differ from but still drive the intervention) in historic, economic and political context, which may include specific interventions as well as combinations of programmes, policies and social movements (Kleinman, 2010; Mosse, 2004).

This paper brings an anthropological perspective to the field of complex intervention trials with an analysis of the impact on community members of a complex intervention trial (‘PRIME’) implemented at public health centres to improve health service provision, particularly for malaria, in Tororo district, Uganda. The

paper provides voices of ‘the field’, extending the notions of ‘context’ and ‘contamination’ evoked in traditional explanations of trial outcomes, by bringing to life the dynamic terrain of opportunities, negotiations and resistances emerging over time and which shape responses to intervention activities.

2. Study setting

The PRIME trial was conducted in Tororo district of eastern Uganda by the Infectious Diseases Research Collaboration (IDRC) which was already carrying out other malaria research in the study area, including surveillance of malaria morbidity and mortality and trials of antimalarial drug efficacy and safety (Jagannathan et al., 2012; Nankabirwa et al., 2010; Pullan et al., 2010). The study was conducted in 7 sub-counties of Tororo district; there were 22 lower-level government-run public health centres within the study area, including 17 level II health centres (HC IIs), which are typically staffed by one or two health workers, and 5 level III health centres (HC IIIs), which are staffed by 3–10 health workers, and may incorporate laboratory, in-patient and maternity services. In 2009–2010, when the formative research was conducted, staff shortages were encountered in almost all health centres, shortages in all drugs (including first-line antimalarials) and equipment were common, and many health centres lacked running water and electricity (Jitta et al., 2003).

Tororo district is a poor rural area with limited infrastructure. In 2009–2010, we found that few households had electricity, 25% reported having no toilet facilities, and 25% of household heads had no formal schooling (Staedke, 2010).

2.1. Malaria case management in Uganda – a historical perspective

Malaria treatment and diagnosis in Uganda has evolved through different strategies and policy shifts adopted by the national government and implemented by district authorities and ‘partners’ (Talisuna et al., 2014). Between the 1970s and 1990s Uganda was characterised by civil strife which left its health system in a state of disrepair. There was neither a malaria control policy nor strategic plan, and uncomplicated malaria was treated with chloroquine (CQ). With political and economic stabilisation, the Uganda government in conjunction with other global actors restarted the malaria control programmes. Due to widespread resistance to CQ, the Ugandan Ministry of Health selected the combination of CQ plus sulfadoxine-pyrimethamine (SP) as first-line treatment for uncomplicated malaria and introduced a programme for home-based management of fever, targeting children under five in attempt to ensure prompt and effective treatment of malaria. With studies indicating that CQ + SP was ineffective (see for example Yeka et al. 2005), it was replaced in 2004 with artemisinin-based combination therapies (ACTs) including artemether-lumefantrine (AL) as first-line treatment, and artesunate-amodiaquine (AS + AQ) as an alternative. In 2010, the World Health Organization (WHO) recommended that suspected malaria cases be confirmed by a parasitological test when possible (World Health Organisation, 2010). In response, the government of Uganda planned to provide microscopic services in all health facilities at level III and above, and rapid diagnostic tests (RDTs) for malaria at all level II health facilities (Talisuna et al., 2014).

Uganda emerged from years of political strife and economic collapse at a time of increased global attention and availability of funding for malaria control from global actors such as the World Bank, WHO and UNICEF and a host of other international nongovernmental organizations. Uganda’s public sector however lacked the capacity to absorb and implement all the funding as planned. A partnership approach was taken for joint missions by the

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