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## EVIDENCE FOR ACTION

## Establishing a baseline to measure change in political will and the use of data for decision-making in maternal and newborn health in six African countries

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## ABSTRACT

The Evidence for Action (E4A) program assumes that both resource allocation and quality of care can improve via a strategy that combines evidence and advocacy to stimulate accountability. The present paper explains the methods used to collect baseline monitoring data using two tools developed to inform program design in six focus countries. The first tool is designed to understand the extent to which decision-makers have access to the data they need, when they need it, and in meaningful formats, and then to use the data to prioritize, plan, and allocate resources. The second tool seeks the views of people working in the area of maternal and newborn health (MNH) about political will, including: quality of care, the political and financial priority accorded to MNH, and the extent to which MNH decision-makers are accountable to service users. Findings indicate significant potential to improve access to and use of data for decision-making, particularly at subnational levels. Respondents across all six program countries reported lack of access by ordinary citizens to information on the health and MNH budget, and data on MNH outcomes. In all six countries there was a perceived inequity in the distribution of resources and a perception that politicians do not fully understand the priorities of their constituents.

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## 1. Introduction

Evidence for Action (E4A) is a program funded by the UK Department for International Development (DFID) that seeks to improve maternal and newborn health (MNH) in six African countries: Ethiopia, Ghana, Malawi, Nigeria, Sierra Leone, and Tanzania. The present paper explores learning from across the program and presents the methodology and some findings from early data collection to inform country intervention plans, as well as serve as a baseline for monitoring progress.

The E4A program is based on the assumption that a level of political will is necessary to stimulate those with power to act [1]. By political will, we mean that sufficient numbers of those in positions of power at national and subnational levels are committed to making improvements to MNH. Advocacy efforts should therefore focus on stimulating and building this political will. If this assumption holds true, then

evidence in the hands of decision-makers at the right time and in the right format will result in action only if the political will exists. Similarly, the improved use of MNH data for decision-making is an important step between evidence building, advocacy measures and accountability mechanisms, and the improved use of resources.

At the start of the E4A program, MNH data existed, but were inaccessible to many decision-makers, underexploited, or simply out-of-date. Stakeholders interviewed during the design phase highlighted issues around political will, but no concrete picture emerged of whether and how data were used for decision-making, and whether there was a strong political will to make improvements. There were no studies or assessments that captured information about data use and political will that were comparable across all six countries or over time.

The questions for E4A therefore were: how could political will be measured; to what extent did decision-makers have access to and use data; and how could change over time in these two key outcomes be measured? To help answer them and determine the baseline situation for the program, we designed two tools: the Politics, Power, and Perceptions (PPP) tool and the Data for Decision-Making (DDM) tool. The present paper describes the development of these tools, their implementation, and some of the baseline results.

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## 2. Methods

### 2.1. The tools

Both tools are questionnaires. The PPP tool assesses the level of political will to improve MNH outcomes. The DDM tool assesses the extent to which key stakeholders make use of MNH data. Both tools were developed specifically for E4A, building on previous work. The DDM tool applied in Ethiopia varied slightly as the country's priorities and activities were different from the other five E4A countries.

There is a small but growing body of literature on how political will influences policy-making [2–4]. Embedded in an analysis of agenda setting [4] as well as policy networks and communities [5] that influence the policy environment, the PPP tool sets a baseline to measure change in context, processes, players (stakeholders), and power over time, and considers how these factors interact to shape policymaking. Several necessary aspects of political will must be in place if mortality reduction is to be achieved [6,7]. These include: effective teamwork among civil society advocates; an environment in which prioritizing MNH leads to political gain; influential “champions;” accurate national and subnational evidence; influence of national government over regional government; and resource allocation (donor and internal). Taking all these into account, the PPP tool collects data relating to three main streams: (1) social and political perceptions on MNH care; (2) political priority given to MNH care; and (3) accountability and governance structures supporting MNH care.

The DDM tool was adapted from elements of MEASURE Evaluation's PRISM tool [8], to make it both specific to the use of MNH data and sensitive enough that progress toward E4A targets is detectable. PRISM's measurement tools focus on three key factors for the success of a Health Management Information System (HMIS). These include: behavioral determinants such as knowledge, skills, attitudes, values, and motivation of the people who collect and use data; technical determinants such as data collection processes, systems, forms, and methods; and organizational/environmental determinants including information culture, structure, resources, roles and responsibilities of the health system, and key contributors at each level.

The DDM tool focuses mainly on the use of rather than the generation of data. As well as measuring the extent to which data are used, the tool also captures information about why data are not being fully utilized (e.g. is there a problem with availability, accessibility, quality?).

### 2.2. Sample selection

In each country, independent consultants were contracted to select and interview a purposive sample of 40–60 key informants for each tool, to gather views from an appropriate spread of national level, district level, and facility level informants. At national and district level (here district refers to the subnational level that was appropriate for each country), the pool of eligible informants was relatively small and the aim was to interview as many as possible. At facility level, the sampling was done by listing all possible health facilities in the E4A focal areas, then selecting a subsample based on how practical it was to visit them within the allotted time. At each sampled facility, contractors were instructed to interview 1–3 eligible informants according to the informants' availability on the day of the visit. PPP informants were opinion leaders (such as government ministers, representatives of health professional organizations, budget holders, district medical officers, civil society organization leaders, and senior clinicians) who were well-informed about MNH issues. DDM informants were people who had responsibility for generating, analyzing, or using MNH data (such as government ministers, national statisticians, monitoring and evaluation officers, senior clinicians, and health facility managers).

### 2.3. Data collection

Baseline data collection took place in 2012–2013, and data will be collected twice more over the lifetime of the E4A program: once at mid-point (2014) and once at end-point (2016). The same individuals will be interviewed wherever possible to maximize comparability between the baseline results and the 2014/2016 results. It will thus be possible to use the time trend analysis to help estimate the extent to which political will and the use of data for decision-making change over the lifetime of the program. However, it will not be possible to make a causal link between E4A activities and any observed change. A separate evaluation study will attempt to assess E4A's contribution to any observed change.

The use of face-to-face interviews allowed for a detailed set of questions (average interview duration was 20 minutes for PPP and 30 minutes for DDM) and for interviewers to request documentary evidence to back up the responses given by DDM informants, which acted as an important quality control mechanism. However, the use of a structured questionnaire meant informants' answers could not be explored in more detail to gain more qualitative insight.

The obvious benefits of using independent consultants were data integrity and easier access to key informants, but it also had some drawbacks as it limited the control over the way in which the interviews were done. It would have helped if the consultants were accompanied for the first few interviews to check that the instructions were being followed correctly. In future, some post-hoc quality control checks (e.g. by telephoning respondents to check answers were recorded accurately and their view about the interviewer) could be appropriate.

### 2.4. Limitations of the study design

Purposive sampling was used as it is important to collect the baseline data before implementation of the program, and time was critical. As national, district, and facility level informants had to be included, designing a representative sample would have been extremely difficult and open to question. The limited number of interviews done in each country owing to budgetary constraints would also make the representativeness of any sample questionable. However, a purposive sample makes it more difficult to track change over time during the 2014 and 2016 repeat surveys. To mitigate against this problem, the aim is to interview exactly the same informants in 2014 and 2016. Although it is possible that taking part in the interview itself brings about change, this approach will make the 2014 and 2016 results more comparable with the 2012 results than if we had taken a fresh purposive sample. We do not expect all the 2012 respondents to be available for re-interview, therefore it will be necessary to analyze the impact of including new respondents in the sample in future years.

The requirement for independence from E4A country teams led to a lack of ownership of the data among them. To ensure that the results truly represented the baseline situation, DFID required the two tools to be designed and administered during the inception phase of the program before most of the country teams had been recruited. The country teams therefore had no input into the study design and consequently much time and effort was required to explain the value of the data to them, and to encourage them to use the data to help plan their strategy.

Applying for ethical approval in each country well in advance of the start of data collection was important, as securing necessary approvals can take time. There was also a tension between the donor requirement to keep the process independent of the E4A country team and the requirement of the research ethics committee to name a local Principal Investigator to ensure shared responsibility for managing the process. In addition, where translation into local language was required, some challenges emerged as the questionnaires included some technical language.

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