



HEALTH PARTNERSHIP POPULATION STUDY:

Inclusion of the most vulnerable and
disadvantaged populations in
the Health Partnership Scheme

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1. Executive Summary

Background

The Health Partnership Scheme (HPS), funded by the Department for International Development (DFID) and managed by the Tropical Health and Education Trust (THET), supports the development of health services in low and middle-income countries (LMICs) by funding and supporting partnerships between UK and overseas institutions to improve health outcomes through skills transfer, capacity building and health system strengthening. Following an evaluation of the HPS in 2016, conducted by Triple Line and Health Partners International (the HPS Evaluator) on behalf of DFID, where a review of project proposals identified a lack of context analysis on social inclusion, THET commissioned an analysis of the current approaches to social inclusion with the HPS and to gain a better understanding of how disadvantaged populations might be prevented from benefitting equally to the health services provided. The definition of “disadvantaged populations” for the purposes of this study were based on DFID’s identification of the most excluded: the poor, women and girls, people with disabilities, and those discriminated against because of their ethnic group, religion, sexual orientation or gender identity. The objectives of this study were to:

- Design and undertake an analysis of the populations who use the health services and facilities that health partnerships work to strengthen, in terms of rural / urban, gender, ethnicity, disability and sexual orientation, for a sample of health partnerships, and the extent to which the health partnership scheme reaches disadvantaged populations;
- Outline recommendations for future health partnerships to support health systems and services for disadvantaged populations through their approaches to partnership management, area of work, project design and implementation, and monitoring, evaluation and learning.

Methods

A mixed methods approach was used, including a review of THET documentation; a quantitative online survey; and qualitative key informant interviews with two health partnerships during a visit to their project sites. A total of 41 respondents participated in the survey (a 16% response rate) and 17 key informant interviews were conducted. Data was collected on a) the definition of disadvantaged populations; b) accessibility of services for disadvantaged populations; c) monitoring service user data; d) challenges and opportunities of focusing on disadvantaged populations; and e) recommendations for future inclusion of disadvantaged populations. Data was collected in April and May 2017.

Key findings

Although not a focus of grant streams to date, several health partnerships report reaching disadvantaged populations under the current HPS. Health partnerships visited had designed their projects with poor and rural populations in mind, targeting health workers in rural, hard to reach areas, removing some of the accessibility barriers for local populations (distance and cost for transport). Doctors represent a significant proportion of those who have volunteered from the UK, and who have been trained to date overseas, but an important number of mid-level health workers have also been trained, as well as community health workers.

Most respondents agreed with the proposed definition of “disadvantaged populations” but there was more emphasis on poor and/or rural populations, women and girls, and people living with a disability being considered as “disadvantaged”. Some factors given include the physical remoteness from health services (rural), the inability to pay for health services (poor), and their limited decision-making power in the household (women). These groups were also cited as those most frequently targeted by health

partnership interventions. Despite making health services available in more rural locations, the surrounding populations still faced major barriers to accessing them, especially financially, as patients reportedly have to pay out-of-pocket for services.

Many health partnerships are collecting routine, and non-routine, service user profile data- especially on gender and location where the service user lives (rural/urban)- but standard metrics for tracking this service user data are not currently in place. When asked if they believed that collecting service user profile data would be feasible and/or useful, 58% of survey respondents said yes.

Many believed disadvantaged populations could be included into the future health partnerships and this would have a positive health impact on these populations, as well as improving links between hospitals and the communities. There were concerns about the additional time and resources required to focus on disadvantaged populations, and the stigma attached to certain characteristics such as disclosure of sexual orientation or mental health conditions. To reach disadvantaged populations, health partnerships recommended including a community sensitisation component in future projects, ensure local ownership of projects, collaborating with other actors, and building the capacity of health workers in rural areas.

Discussion

Based on the sample of health partnerships reviewed, this analysis has revealed that although it has not been a strategic priority to date, some disadvantaged populations are already being reached through the THET-funded health partnerships. The cadres of health workers trained under the current health partnerships serve as an indication for where services are being provided and which populations are benefitting. As a relatively high ratio of doctors have been direct beneficiaries overseas, given the (smaller) proportion of the health workforce who are doctors in LMICs, the health partnerships to date could be interpreted as being “doctor-heavy”. However, this may be due to the nature of the partnerships, the specialisms in question, and the availability and autonomy of health workers to participate in health partnerships. Nevertheless, many mid-level health workers have also been trained and encouragingly also community health workers (although a small proportion compared to their number and reach in LMICs), indicative perhaps of some health partnerships working at a community-level as a means to reach more disadvantaged populations. Integrating health workers from rural areas – as well as task-sharing to lower cadres of health workers – provided examples of inclusive strategies used by both projects visited to improve access to specialist services in District-level facilities and hence increase the likelihood of reaching more rural and poor populations.

Approximately half of respondents reported specifically targeting women and girls, poor, and rural populations, but limited information was available on why these groups were targeted and how, and why LGBTI, ethnic and religious groups were not so frequently considered disadvantaged, and were specifically targeted to a lesser extent.

Making a service available is critical, but making it accessible is essential too. Concerted efforts had been made in selecting and training health workers to make services available to poor and rural populations. But, in the absence of a health financing mechanism to subsidise or remove user fees, despite the availability of skilled personnel and equipment to provide a service, economically disadvantaged populations face major financial barriers to access the health services. The role of the health partnerships in surmounting barriers to services needs to be considered or whether partnering with others could be an effective and efficient means to do so.

Many health partnerships are collecting routine, and non-routine, service-user profile data but this data is not based on standard definitions, nor systematically tracked or reported. THET-funded health partnerships are potentially underestimating their reach to disadvantaged populations, but good quality data is not readily available to prove otherwise.

If health partnerships are to include a focus on disadvantaged populations in the future, significant considerations are required in how they are designed, where they are implemented, who they involve, and how their impact is measured.

Recommendations

The findings from this study suggest consideration of the following recommendations:

- i. **Prioritisation of disadvantaged populations in future grant streams:** Helping health partnerships identify the most disadvantaged populations is the first step. A focus on disadvantaged populations could be included in specific grant streams or integrated across all future grant stream. Consideration of different priority populations, countries/regions, health specialisms, health cadres, or task sharing innovations are encouraged.
- ii. **Consider disadvantaged populations in all aspects of the health partnership grant cycle:** Disadvantaged populations should be considered in all stages of the grant cycle; from the Theory of Change through to the grant application and management tools and impact assessments.
- iii. **Make health services both available and accessible to disadvantaged populations, e.g. by engaging with other partners:** Partnering with a range of actors such as community based organisations or peer networks, can enhance effectively targeting disadvantaged communities through health partnerships. Partnering with institutions to leverage health financing mechanisms can help overcome the financial barriers for disadvantaged populations by providing access to subsidised or free services.
- iv. **Conduct a follow-up mapping exercise of the current health partnerships to identify best practice and learn from any successful models:** A mapping exercise of the current health partnerships could lead to communities of practice between common groups about reaching disadvantaged groups, working groups, cross-learning and ultimately improved interventions.
- v. **Define a basket of indicators to measure the extent to which disadvantaged populations are being reached through health partnerships:** Introduce routine indicators to report on regularly, but also consider context-appropriate indicators that may not be standard metrics. Indicators would need to be developed with existing health partnerships to ensure that they are relevant and feasible.
- vii. **Help the focus on disadvantaged populations for health workers by supporting analyses and tracking:** Reduce the burden on health workers and identify external agencies to support health partnerships to access data on disadvantaged populations.
- viii. **Identify any potential areas of discrimination through a series of values clarification workshops:** At a head office and health partnership level, organise workshops to explore the values, attitudes and actions regarding the inclusion of disadvantaged populations.

2. Background

2.1 Context

THET (Tropical Health & Education Trust) is an international development organisation with over 25 years of experience in strengthening health services through forging partnerships with healthcare experts to develop targeted training programmes in low and middle income countries (LMICs). THET's strategic plan 2016-2021 outlines THET's global vision of achieving "A world where everyone has access to healthcare" by "working in partnership to support health workers across the world."

The Health Partnership Scheme (HPS), a six-year £30 million programme funded by the Department for International Development (DFID) and managed by the THET, supports the development of health services in LMICs. The HPS is one of the mechanisms by which THET supports health partnerships - a model for improving health care through ongoing collaboration, skills transfer, and capacity building, between UK NHS trusts, professional associations, universities and their counterparts in LMICs. THET has contributed to strengthening health systems in 32 countries worldwide by training and building the capacity of health workers and facilities through 139 partnerships under the current HPS.

A [2016 evaluation of the HPS](#), conducted by Triple Line and Health Partners International (the HPS Evaluator) on behalf of DFID, reported that "very few of the context assessments in project proposals had adequate analysis of the context in relation to gender inequality and **social exclusion**. Projects reviewed for the country case studies tended to have limited understanding or analysis of how gender inequality and social exclusion can affect efforts to enhance human resource capacity and skills or improve people's access to and use of services".

With a view to strengthening the understanding of social exclusion in the HPS, this report has been commissioned by THET following the recommendations from the HPS synthesis report. It analyses the current approaches to social inclusion within the HPS and reviews how disadvantaged populations may, or may not, be benefitting equally from the health services provided. This report provides recommendations on how disadvantaged populations can be better reached in future health partnership through strengthening both THET and HPS systems at all stages of the grant cycle.

More specifically, the aims of this study are to (see Annex 1 for the full terms of reference):

- Design and undertake an analysis of the populations who use the health services and facilities that a sample of health partnerships work to strengthen, in terms of potential forms of disadvantage or marginalisation – e.g. rural / urban, gender, ethnicity, disability and sexual orientation- and the extent to which the health partnership scheme reaches these populations;
- Outline recommendations for future health partnerships to support health systems and services for disadvantaged populations through their approaches to partnership management, area of work, project design and implementation, and monitoring, evaluation and learning.

To answer each objective, specific questions guided the analysis, looking at how disadvantaged populations are considered at different stages of the grant cycle:

a. How are disadvantaged populations considered in the design of health partnerships?

- i. *Grant overview guidelines*: do different grant streams have a focus on disadvantaged populations?
- ii. *Application guidelines*: Are there any requirements to include a context assessment about social inclusion? Is an analysis of equity as part of the value for money approach required?

- b. How are disadvantaged populations considered in the implementation strategies of health partnerships?**
- i. *Management and training*: which type of institutions are partnering for this health partnership (primary/secondary/tertiary)? Which cadre of health worker is involved? What type of training is planned e.g. is there cascade training in place to reach other cadre health workers in communities outside of their own?
 - ii. *Service delivery*: Where, and how, will the trained health workers provide services? Which populations do they reach? Are there any barriers (e.g. financial, socio-cultural, access) for disadvantaged populations?
- c. How are disadvantaged populations considered in the monitoring and evaluation strategies of health partnerships?**
- i. *Monitoring*: Which indicators do health partnerships report against? What routine and non-routine data is being collected on the profile of their service users? Can service user data be easily identified and attributed to the health partnership project?
 - ii. *Evaluation*: are disadvantaged populations being considered in health partnership evaluations?
- d. How could future health partnerships support health systems and services for disadvantaged populations?**
- i. *Lessons learned*: What lessons have been learned by the current health partnerships regarding the social inclusion of disadvantaged populations?
 - ii. *Reflections and recommendations*: What challenges and opportunities do health partners envisage with a greater focus on disadvantaged groups? What recommendations can current health partnerships provide to improve access for disadvantaged populations to health services in the future?

2.2 Defining disadvantage and marginalisation

In signing up to the Global Goals, DFID committed to ‘leaving no one behind’. DFID’s policy ensures that the poorest and most vulnerable populations have been prioritised; this includes the world’s most disadvantaged people¹. Before analysing the populations, who use the health services and facilities that health partnerships work to strengthen, the description of a “disadvantaged population” must be unpacked.

Disadvantage and marginalisation are rooted in social, political and economic structures. The solutions to disadvantage and marginalisation therefore require action well beyond the scope of health workers. However, disease and its management can play a critical role in marginalising or disadvantaging individuals, or compounding existing disadvantage. Health partnerships can therefore play an important role in addressing marginalisation and disadvantage by considering how they can avoid replicating structural disadvantage through the design of health partnerships, that are contributing to health system strengthening in different ways. Health partnerships can also play a role in strengthening health systems that respond *equitably* to the specific health situation of disadvantaged and marginalised people whose location, behaviours, and spending power often differs markedly from their fellow citizens.

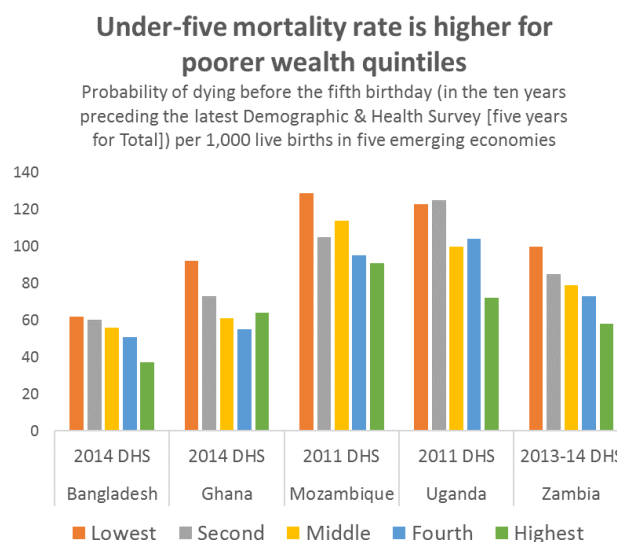
Disadvantage and marginalisation vary greatly from context-to-context and so require a context-specific approach to prioritising and addressing their different forms. Broad categories have been considered for this analysis, including disadvantage based on DFID’s identification of the most excluded:

- Economic poverty
- Disability
- Women and girls
- Ethnicity and Religion
- Sexual Orientation and Gender Identity

A brief definition of each group will be considered for this analysis, supported by a brief justification for each group’s health needs that lead to their relative disadvantage to healthcare access.

Economic poverty: The definition of poverty has been the subject of research and debate for centuries, but today UN agencies and many bilateral donors, including DFID, recognise that poverty comprises multiple dimensions including economic poverty. The Sustainable Development Goals recognise a figure of \$1.25 per day for living in extreme povertyⁱⁱ, whilst the World Bank also uses a figure of \$1.90ⁱⁱⁱ. However, given the different costs of goods and services across the world, most countries have developed their own national poverty lines. Many health or demographic statistics are analysed by wealth quintiles which provide useful information about the relationship between economic inequalities and health inequalities. As illustrated in Figure 1, this type of analysis often reveals marked differences in health status and behaviour between wealth quintiles.

Figure 1: under-five mortality rates by health quintile, in a selection of LMICs



Source: data extracted from a selection of country-level Demographic and Health Surveys (DHS) using www.statcompiler.com/en

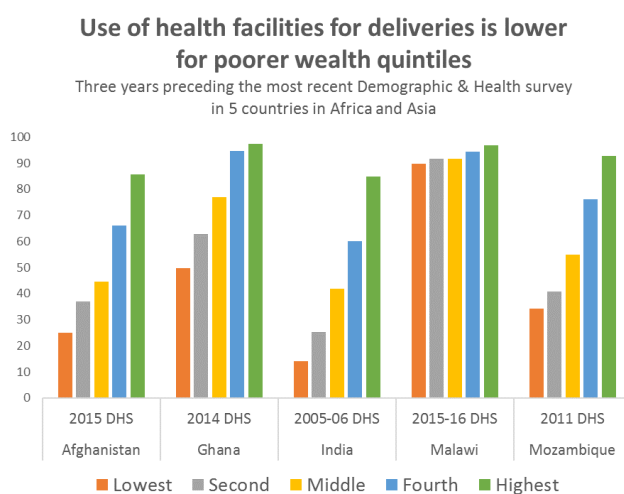
Economic poverty is manifested in geography. In LMICs, rural areas are often characterised by low incomes and weaker integration into the cash economy associated with poor infrastructure and livelihoods often based heavily on subsistence agriculture. This limits poorer, rural populations’ ability to respond to risks such as famine, epidemics, conflict or environmental change, compounding their distinct healthcare needs. More than 80% of the world’s poor live in rural areas^{iv}, where healthcare services are more scarce. For example, less than 38% of nurses and 25% of physicians work in rural parts of sub-Saharan Africa, where approximately 50% of the population live^v. In response, urban areas throughout emerging economies are characterised by slums initially populated by migrants from rural areas living in temporary, substandard and precarious housing often underserved by health facilities and other infrastructure^{vi}.

Disability: DFID’s disability framework highlights the need to provide accurate data on disability to strengthen development initiatives, including health interventions. The term ‘disability’ itself incorporates a wide range of physical, cognitive and learning and mental conditions which require each different support and have differential impacts on people’s lives. As per the UN Convention for the Rights of People with Disabilities (CRPD), people with disabilities in this report are defined as those who have “*long-term physical, mental, intellectual or sensory impairments, which, in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others*”^{vii}. Metrics and tools for measuring disability and generating consensus around common definitions can be accessed through the [Washington Group](#) which was established to provide standardised means of measurement of disability across countries^{viii}.

Globally, one billion people have a disability, 80% of whom live in developing countries^{ix}, largely due to the high disease burden and weaker health systems. People living with a disability are less likely to be employed and in education, experiencing higher poverty levels, exacerbating their financial barriers to healthcare and other basic services^x. They are more likely to experience violence than those without a disability, and often face significant stigmas that further their disadvantage or marginalisation^x. These stigmatising attitudes may be shared by health workers and health planners themselves, compounding access to quality care within the health system.

Women and girls: Gender plays a significant role in differentiating the life-chances and health of women and girls worldwide. Gender-based discrimination, undercuts women’s right to access healthcare, rendering women more susceptible to sickness and less likely to obtain care, for reasons ranging from affordability to social conventions keeping them at home^{xi}. Girls face disproportionate risks to their health compared to boys; from female genital mutilation, early marriage and pregnancy, to abuse and maltreatment^{xii}. Women and girls are faced with a greater burden of disease related to their gender, compounded by their reduced access to education, income and employment, all which can have an impact on a woman’s ability to preserve her wellbeing. Universal access to sexual and reproductive health services is essential for advancing women’s health. The OECD recommends investments in sexual and reproductive health (including rights), including investments in family planning, alongside addressing violence against women including care for victims of sexual violence^{xiii}. Many studies have shown that preserving maternal health, will also reduce the risk of child mortality^{xiv xv}. Figure 2 shows how the use of health facilities by women for deliveries varies between the wealth quintiles.

Figure 2: use of health facilities for deliveries by health quintile, in a selection of LMICs



Source: data extracted from a selection of country-level Demographic and Health Surveys (DHS) using www.statcompiler.com/en

The economic and social impact of investing in women and girls is potentially enormous. The Copenhagen Consensus Centre recently compared a range of different development investment options, concluding that investing in family planning was the third most cost-effective potential investment in international development after reducing world trade restrictions and freeing regional trade in the Asia Pacific region^{xvi}.

THET has commissioned a separate report specifically on a gender analysis of the HPS.

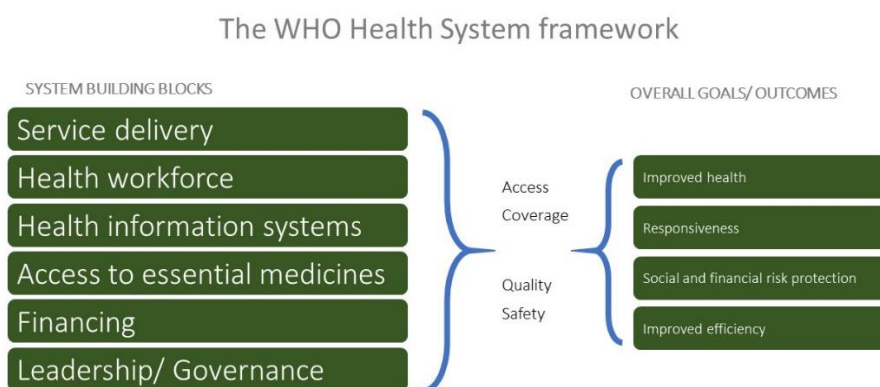
Ethnicity and religion: Ethnicity, religion and Caste are important determinant of health in many parts of the world. For example, in Nepal, a country heavily stratified by ethnicity, religion and caste, provides a striking example of these inequalities. Muslim women report much higher rates of unmet need for family planning than other ethnic groups, with over 39 per cent of women reporting an unmet need^{xvii}. Lower caste (or Dalit) women report higher levels of unmet need for family planning (31.3 per cent) than other caste groups. Caste-based discrimination by health workers leads to the withholding of services to Dalit women, long-waiting times and poor quality of care. Dalits also face discriminatory practices by other community members whereby higher castes discourage Dalits from accessing services. This deeply ingrained social exclusion leads many Dalits to distort their health-seeking behaviours.

Sexual Orientation and Gender Identity (SOGI): There is increasing recognition of the role that stigma plays in the health outcomes of lesbian, gay, bisexual, transgender, and intersex (LGBTI) individuals and groups^{xviii}. Stigma and discrimination because of sexual orientation or gender identity is widespread in social norms across Africa and Asia, and is enshrined in punitive laws against same-sex relations and transgender status throughout both continents^{xix}. Stigma can have major consequences on the quality of care including the denial of key services, verbal and physical abuse, lack of confidentiality and even coercion into medical procedures^{xx}. Poor psychological health among young LGBTI individuals are often attributed to living a life full of stigma, victimisation and social exclusion^{xxi}.

2.3 Situating health systems in settings of marginalisation and disadvantage

Health Partnerships contribute to boosting health outcomes by supporting health system strengthening. This report draws on the WHO definition of the health system— consisting of “...all organisations, people and actions whose primary intent is to promote, restore or maintain health. This includes efforts to influence determinants of health as well as more direct health-improving activities”^{xxii}. This has led to the development of a widely-used and instructive conceptual framework of health system building blocks, namely – service delivery, health workforce, health information systems, access to essential medicines, financing and leadership/governance. The model – illustrated in Figure 3- suggests that investment in each building block will enhance health system outputs – access, coverage, quality and safety. Ultimately, this should lead to improved health, responsiveness, risk protection and efficiency from the health system. However, in the contexts of widespread disadvantage these investments should be tailored to the distinctive epidemiological, human resource contexts as well as the unique structures of service delivery and health financing.

Figure 3: the building blocks of the WHO health system framework ^{xxii}



Source: World Health Organisation

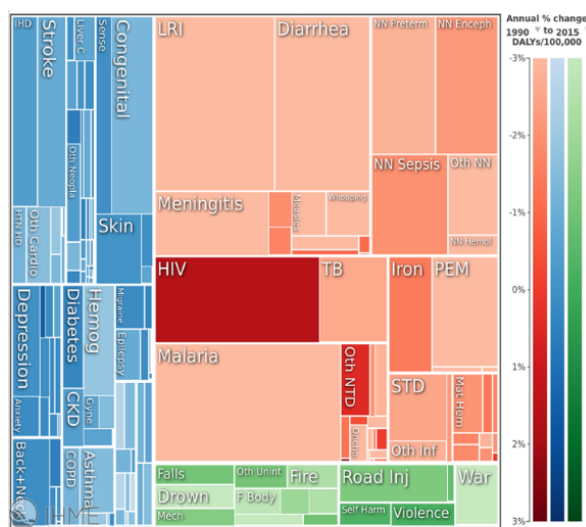
Four fundamental features of public health and health care provision in many low-income settings were incorporated into the conceptual framework from the start. They inform the development of the analysis and recommendations (in combination with the standard WHO health system framework) by:

1. **Recognising the distinctive disease priorities** of low-income settings;
2. Understanding the **composition of the health workforce** to reach disadvantaged populations;
3. **Recognising the role that non-state actors can play** in the delivery of health products and services to disadvantaged and marginalised people;
4. **Understanding the role of health financing** on access for disadvantaged populations.

Disease priorities

The health challenges of developing countries have major differences to those of the UK. For example, sub-Saharan Africa has only 3% of the global health workforce but accounts for almost half of all child deaths globally^{xxiii}. Over half of these deaths in African children under 5 years of age are caused by malaria, pneumonia and diarrhoea ^{xxiii}. In Figure 4, data from the Global Burden of Disease surveys have been used to visualise the relative health burden of different types of disease in low income countries^{xxiv}. In low income countries, although declining, communicable diseases account for the vast majority of death and disability (as estimated by health economists through disability-adjusted life years (DALYs)).

Figure 4: the burden of disease in low-income countries



Source: Institute for Health Metrics and Evaluation - Global Burden of Disease Viz Hub

Since the 1978 Declaration of Alma-Ata, Primary Health Care has been recognised as a priority approach to providing health care in low income and poorer settings. Inexpensive interventions such as provision and distribution of antibiotics, oral rehydration solution, insecticide-treated bed-nets and anti-malarials have been proven effective against the major childhood diseases, and it has been estimated that over half of all deaths could be prevented through these interventions^{xxiii}.

Composition of the health workforce

A core concern of the primary-health movement has been to try to overcome the vast human resource challenges of developing health systems. Task sharing, the process of enabling lay and mid-level, healthcare professionals – such as nurses, midwives, clinical officers and community health workers - to provide clinical tasks, has evolved over the past 30 years. This has seen the emergence of health systems staffed by unique cadres of health workers that either do not exist or are less common in more developed economies. For example, Clinical Officers – who undergo a shorter standard medical curriculum training than doctors – have emerged to play a major role in Malawi’s health system, far outnumbering the number of doctors trained and practicing^{xxv}. In Ethiopia, the National Health Extension Programme has trained more than 38,000 health extension workers who play an increasingly dominant role in the provision of primary care and preventative services throughout rural parts of the country^{xxvi xxvii}.

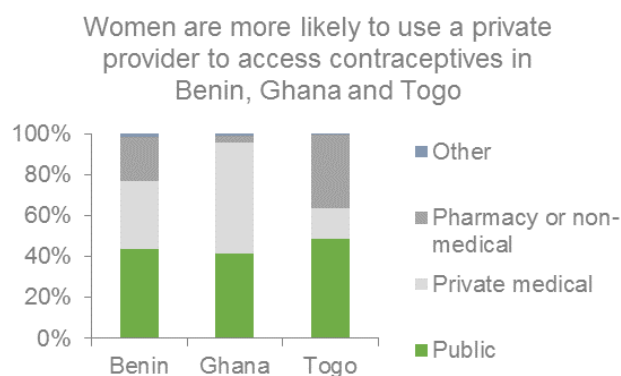
“The most pressing needs in developing countries are for balanced and integrated health systems with a particular emphasis on public health and primary care, not hospitals and tertiary care, although these have their place.”^{xxx}

More established cadres of health workers, such as nurses and midwives, are also being trained to play a greater role in the delivery of health services traditionally delivered exclusively by doctors or even specialists. The evidence-base is still being developed but in both low and high-income settings, research on task-sharing to nurses and midwives has demonstrated positive impact on the health outcomes of disadvantaged groups including strengthening policy and leadership^{xxviii}.

The Role of the Private Sector

Private health workers are the first source of care for many poor in sub-Saharan Africa and South Asia^{xxix}. The private sector includes all non-state actors in the health system – not just those operating with profit motivation. This includes non-governmental organisations (NGOs), community-based organisations (CBOs) and faith-based organisations (FBOs). Private health workers that are sought-out by disadvantaged and marginalised groups include a wide-range of front-line carers – such as unqualified drug-store owners, traditional healers and birth attendants, pharmacists, lab technicians - who offer advice and therapy, and issue commodities. In Benin, Ghana and Togo for example, women are more likely to access contraception from a private health workers than from a public-sector source, as demonstrated in Figure 5.

Figure 5: source of contraceptives amongst women in Benin, Ghana and Togo



Source: statcompiler.com based on Demographic and Health Surveys

Health partnerships should be considered in the context of this mixed economy that underpins most health systems in the world, including in LMICs. The report on Global Health Partnerships highlights the importance of not ignoring the role the non-state sector plays in health systems in LMICs^{xxx}:

“In many developing countries, the independent sector in all its manifestations – NGOs, faith-based organisations, small and large businesses, traditional healers – is the biggest health service provider. Whereas many countries are developing national or local government-run services, there is enormous scope to use the existing independent services to better effect through setting up systems for regulation and quality control.”

Health financing

The distinct health needs of the (very) poor, and their inability to pay out-of-pocket fees for services, has driven the international agenda on health financing mechanisms over the last two decades. A range of health financing mechanisms can co-exist in a given country. The principle mechanisms can include:

- User fees (patients pay out-of-pocket for health services)
- Social insurance financing (individuals contribute to a health fund, which in turn cover health costs)
- Community-based health insurance (similar to social insurance but based on average risk of community member and managed by a private not-for-profit company)
- Private insurance (individuals contribute to a private health fund, which in turn covers their health costs)
- Tax-based financing (income, corporate, import taxes etc. used to cover health costs)
- Voucher programmes (vouchers at little or no cost to the service user, typically managed by an NGO)

Health financing may be beyond the immediate control of health partnerships, which focus on strengthening human resources. However, the impact of health partnerships may be affected by the disadvantaged populations’ access to health financing mechanisms to overcome the costs to healthcare. User fees and health insurance schemes are the most-used health financing mechanisms used by disadvantaged groups but are not equitable for the poorest groups^{xxxii}. In the absence of appropriate government financing of health services or health fees, partnership models may try to integrate with other sources of finance (such as donors, integration of projects into other (funded) areas of health, or large scale research programmes) to avoid imposing user fees on the poorest^{xxxii}. More recent innovations with voucher programmes have proved to be successful in increasing access for poorest to health services, such as delivery care and family planning^{xxxiii} but require specific infrastructure and financial controls to target those most in need, ensure a quality service is accessible, and manage the risk of fraudulent activity^{xxxiv}.

3. Methods

A mixed methods approach was implemented, including:

- a review of THET documentation;
- a quantitative online survey;
- qualitative key informant interviews.

3.1 Secondary data review

The review of THET documentation sought to understand how disadvantaged populations have been considered in the HPS to date. The documents reviewed included initial background information on THET (including overview of THET programming, THET's strategic plan, principles of partnership, key performance indicators, position papers), documentation on the HPS (background information, case studies, evaluations), information about the HPS grant process (from grant guidelines to M&E plans), and some HPS data (including data on the health workers who conducted and received training). A full list of documents reviewed can be found in Annex 2.

3.2 Primary data collection

Online survey

An online questionnaire was sent to all project leads in the UK and overseas in April 2017. A total of 112 leads in the UK and 137 leads overseas were invited to participate in the survey. All survey responses were anonymous.

The questionnaires consisted of ten, primarily closed, questions around the following topics:

- The definition of disadvantaged populations
- Accessibility of their services to disadvantaged populations
- Monitoring service user data
- Challenges of focusing on disadvantaged populations
- Opportunities of focusing on disadvantaged populations
- Recommendations or lessons learned

Key informant interviews

Two current health partnership projects were selected as a sample from the current HPS, to explore in-depth the experience of reaching disadvantaged populations, through key informant interviews (KIIs). A shortlist of countries and health partnerships was provided by THET for consideration. The shortlisted projects were ongoing partnerships, had not been the subject of previous evaluations, or had not received project visits so as to limit the disruption to their activities. From this list, two health partnerships in the same country were selected based on the following criteria:

- One represented an urban, tertiary hospital and the other a more rural intervention in an isolated region, allowing for contrasting project settings;
- The services provided through these projects (burns care and imaging services) are generally needed by all types of populations;
- The health partnerships involved institutions that provide health services directly to patients;
- Visiting a burns centre provided an opportunity to analyse the frequency of poor patients, as the literature from reveals that burns patients are predominantly from poor households in LMICs, whilst the diagnostics project was based in a rural, remote part of the country where the population is predominantly poor;

- A National Health Insurance Scheme helped explore how the health partnership is interacting with a health financing mechanism intended to improve access to health services for the poor;
- Feasibility of visiting two health partnerships in the same country.

The UK project leads of the two partnerships (who were the focal points for THET to communicate with about the projects) were contacted to ascertain their willingness to participate. Following their agreement, their overseas partners were contacted to arrange a visit.

Whilst the core objectives of the interviews were aligned with the survey topics, there were some differences in the interview guide questions according to the different roles of interviewees (e.g. whether a UK coordinator, an overseas volunteer, or a NGO partner). A copy of the interview guides can be found in Annex 3.

4. Data Analysis

Secondary data: any key findings related to disadvantaged populations from THET documents reviewed were highlighted and extracted. Key findings from the analysis of the different grant stream overview documents have been collated in Annex 4.

Online Survey: Descriptive analysis of the survey results was conducted, and open text questions were coded by key themes and added to the data analysis framework of the study findings.

Key informant interviews: a selection of interview data was transcribed and key quotes identified. Manual thematic analysis of the data was conducted and codes were entered into a data analysis framework to draw out key themes.

5. Ethical considerations

Several measures were taken to ensure the data collection was done in an ethical manner:

- **Informed consent:** Interviewees were requested to give explicit consent to participate in the interviews. Signed consent was obtained prior to any interview. The risks and benefits of participating in the study were a key part of the informed consent form, and informants were explained that there were no direct risks or benefits to participating in the study. In the case of any photography of informants, a photography consent form was completed to permit use of the photograph in media applications.
- **Sensitivity and respect:** Given the nature of the questions being asked, a respectful and sensitive approach was used when conducting interviews. In the case of interviewing a service user, a health worker who had already participated in an interview, approached the service and privately asked if they would like to participate in a short interview. Upon agreement, they were they approached and some brief questions asked. Photographs of the service users were not taken as this was not deemed sensitive or appropriate due to the nature of injury and the age of the service users.
- **Data protection:** Information provided in the interviews and survey was confidential and informants' identity protected. If any direct quotes were included in the report, the informants were referred to as e.g. "nurse, overseas partner", or "UK partner". The names and codes of the projects visited have also been protected in the external report. Recordings were made of interviews (except for those with service users where notes were taken) and stored on a password-protected computer. Hard copies of the informed consent forms and interview notes are stored in a folder and will be kept safely for a period of 5 years. Scanned copies of the informed consent forms are saved on a password-protected computer.
- **Data management:** Data will be kept stored safely, with no one else having access to it beyond the consultant who conducted the study and the research team at THET, should it be required. Recordings were made of interviews and stored on a password-protected computer.

6. Results

6.1 Secondary data review

A review of the secondary data revealed a great diversity of health partnerships are currently being funded, spanning a wide range of countries, health areas, health cadres, and interventions. Health partnerships can be funded through different projects, including multi-country partnerships, paired institutional partnerships, long-term volunteering, start-up grants, and extension grants. The review offered insights into the extent to which disadvantaged populations are included in the health partnerships. Below is a summary of the findings, with a focus on the design, implementation, and evaluation stages of the health partnerships.

6.1.1 How are disadvantaged populations considered in the design of health partnerships?

At an organisational-level, the 2016-2021 Strategic Plan outlines THET's vision to have a world where everyone has access to healthcare, and its mission of working in partnership to support health workers across the world. This is supported by its 2017 impact and enabling goals to reach their strategic priorities, with recognition of the need to address social inclusion and gender equality moving forward. The HPS is funded by DFID and managed by THET, to improve health outcomes for people in LMICs through skills transfer, capacity building and health system strengthening. To date, the measures of success and impact of the HPS have been centred around: 1) the health workers trained (number trained, improvement in skills over time); 2) the implementation of improved policies and curricula; 3) the use of improved equipment, information and communication technology, and health information management systems; and 4) the UK volunteers self-reporting or demonstrating improved clinical and leadership skills.

A review of the grant stream overviews, highlighted how health outcomes amongst disadvantaged populations have been prioritised from the outset in some grant applicant guidelines:

- **Poor and rural populations:** Two of the grant streams focused on poor populations: 1) the large Paired Institutional Partnerships (LPIP) “encouraged projects to reach under-served and rural areas”; and 2) multi-country partnerships (MCPs) stated that one of the four core objectives of this grant scheme was to improve health outcomes for people living in poverty.
- **Value for Money:** All grant stream application guidelines requested that the applicants' projects demonstrate value for money (VfM). This would therefore require a component on “equity” and addressing the greatest needs (for health). Guidance on the definition of VfM was not identified in the grant application guidelines.
- **Priority countries:** All grant stream application guidelines include a list of DFID and devolved administration priority countries which include some of the poorest countries in the world (Afghanistan; Bangladesh; Burma; Cambodia; DR Congo; Ethiopia; Ghana; India; Kenya; Kyrgyzstan; Lesotho; Liberia; Malawi, Mozambique; Nepal; Nigeria; Occupied Palestinian Territories; Pakistan; Rwanda; Sierra Leone; Somalia (including Somaliland); South Africa; South Sudan; Tajikistan; Tanzania; Uganda; Yemen; Zambia; and Zimbabwe).

Other areas of interest from the grant stream overviews, which could affect the inclusion or exclusion of disadvantaged populations in the design of health partnerships, are highlighted below:

- **NGOs as a partner:** NGOs are generally not eligible to apply (unless they manage a not-for-profit clinic or hospital), with the exception of MCPs where locally registered NGOs can apply. NGOs can play many roles in supporting health systems to target disadvantaged populations in LMICs including health financing mechanisms for disadvantaged groups, or targeted strategies for working with underserved populations.

- **Private for-profit health institutions as partners:** are not eligible to apply with the exception of in the MCP stream and if they can demonstrate that majority of their health services are offered free of charge to the poor. Private institutions often play a major role in health systems, including provision of services for disadvantaged populations (see the *Role of the Private Sector* in section 2.3 above).

THET has also requested that applicants to its other grant streams include a specific analysis of beneficiaries proposed through a partnership, although in a non-directive fashion. Whilst an explicit focus on disadvantaged populations is not apparent in the medium PIP and the medical equipment grants, the grant applications forms for the [medium PIP](#), [large PIP](#), and the [medical equipment](#) grants, do include a specific section that requires information about who the direct (e.g. health workers) and indirect (e.g. patients) beneficiary populations will be, and “*how the different needs of men, women and other groups (e.g. religions, ethnicities, age groups, abilities) will be addressed. These groupings are indicative and may not be directly relevant to your project. However, you should be able to demonstrate that there has been consideration of these matters*”.

6.1.2 How are disadvantaged populations considered in the implementation strategies of health partnerships?

Information was only collected on the health workforce trained or participating in health partnerships. Key information on the role of health partnerships in strengthening the health system building blocks that contribute to the capacity of a health system to benefit disadvantaged populations- including the pro-poor financing of health services, delivery channels, leadership and governance- was not routinely considered in the health partnership documentation.

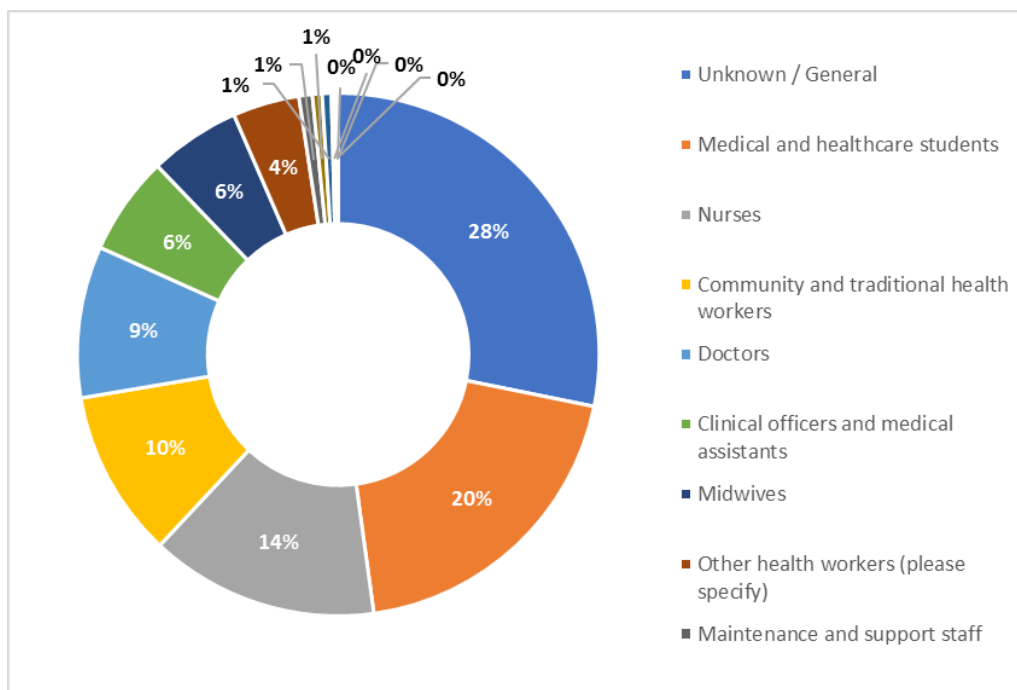
Cadre of health workers¹

THET tracks the number of health workers supported through health partnerships. Over 71,700 health workers have been trained to date. The largest defined group of beneficiaries are medical and nursing students (20%), followed by nurses (14%) and community and traditional health workers (10%). Doctors and Clinical Officers/Medical assistants account for 15% combined. To a much lesser extent, maintenance and support staff, health management and support workers, laboratory health workers, pharmaceutical workers, environmental and public health workers and dentists have benefitted. A full breakdown of health workers trained is provided in Figure 6.

Overall, more female health workers have been trained than male – driven by the high number of female-dominated professions of nursing and midwifery. The table does not include data on where health workers are based (type of health centre or hospital – primary, secondary, tertiary), if they work in a public or private institution, or if their health centre or hospital is based in a rural or urban area.

¹ Note: in both tables related to the health cadre who have conducted trainings or been trained, there is a health cadre entitled “Other” under which a significant number of health workers have been categorised. The composition of these health workers is unknown.

Figure 6: number of overseas staff trained in current health partnerships, by cadre (up to March 2017) (n=71,748)



From a UK perspective, data regarding which cadre of health professionals have volunteered their time to the health partnership has also been collected. Doctors (14%) are by far the most frequently cited cadre to have volunteered their time, with a significantly lower volume of nurses (4%). A disaggregation of each cadre by gender is available, highlighting an almost even number of male and female doctors (although a significantly higher number of days were spent overseas by female doctors), and more female nurses than male.

6.1.3 How are disadvantaged populations considered in the monitoring and evaluation of health partnerships?

To assess which service users were reached as a result of the health partnerships, a review of the project indicators and data, where available, was conducted. From a selection of health partnership reports that were reviewed, it became apparent that indicators related to the profile of service users who ultimately benefited from the health partnerships were not systematically included. The [2015 HPS Annual Review](#) recommended that “DFID and THET agree best method to collect information on the populations served through the partnerships.”

In late 2015, THET began collecting population-related data that was available across health partnerships. The quality of the data reportedly varied greatly in quality and source, and at the point of collecting this information, some projects had already finished. Where data collection has begun, health partnerships have a large proportional reach amongst disadvantaged populations. For example, 20% of all projects collect data on reaching the poorest 40%, and of these projects, they report that 55% of service users reached through these projects are in fact amongst the poorest 40%. Below is a summary of service user profile data that was available at the time of writing (data is up to March 2017):

- Out of 139 projects, the following projects are collecting data on disadvantaged populations:
 - 20% on serving the poorest 40%
 - 18% on people with disabilities
 - 21% on female populations

- 24% on populations from rural areas
- 6% on ethnic minority groups
- Of those collecting data on these disadvantaged groups, they reported the following proportion of the total service users as follows:
 - 55% of their service users are amongst the poorest 40%
 - 25% of their service users are living with a disability
 - 62% of their service users are female
 - 59% of their service users are from rural areas
 - 22% of their service users are from ethnic minorities

The definitions used by health partnerships to define these indicators (e.g. how to assess a patient is from the poorest 40%) were not acquired for this analysis. However, standard metrics for tracking this service user data are not currently in place. The data presented above does not include figures from any of LPIP or MCP projects – who had a focus on poor and rural populations in the grant overviews - as these projects did not report collecting data of this nature.

6.1.4 Were disadvantaged populations considered in health partnership evaluations?

[A value for money review](#) (including two case studies) was conducted, as well as an [evaluation of the HPS in 2016](#). Each report considered the social inclusion of disadvantaged populations in their review – the value for money review analysed equity, and the evaluation provided a review of social inclusion and gender analysis. Many of the health partnerships reviewed in the evaluation were concentrated in facilities in urban areas and in tertiary or secondary hospitals. However, these were reportedly serving lower-income populations and those referred from rural areas. Examples from the evaluation and the value for money report highlighted how projects are reaching disadvantaged groups in different ways, including:

- Waiving fees for vulnerable, low-income groups in Nigeria;
- Training nursing students from remote and rural parts of Uganda and providing family planning outreach services to remote and underserved communities;
- Demonstrating equity at a participant and beneficiary level in Uganda (from a mix of rural and urban hospitals to the gender balance at a senior management level).

6.2 Primary data results

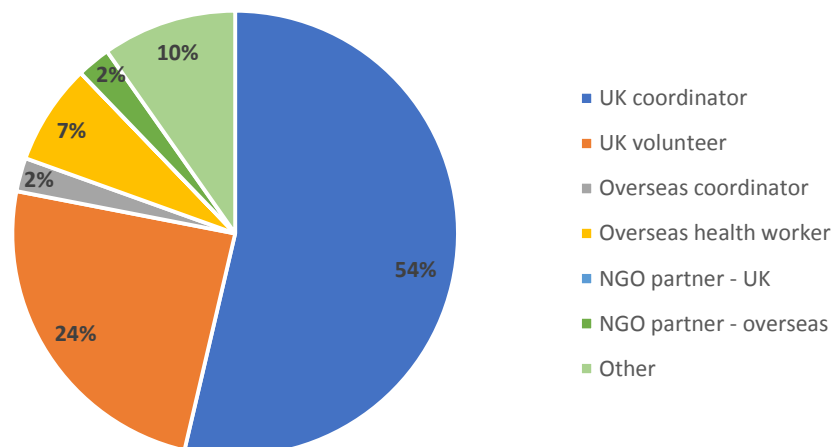
A total of 17 key informant interviews were conducted in April and May 2017. This included interviews with:

- 2 UK coordinators
- 1 UK volunteer
- 1 UK NGO representative
- 2 overseas coordinators
- 11 direct beneficiaries who were trained through the health partnership and/or benefitted from the intervention. This included 5 health workers from the burns centre project (2 nurses, 1 physiotherapist, 1 doctor and 1 pharmacist), and 6 from the imaging project (2 assistant practitioners, 2 physician assistants, 1 accident and emergency nurse, and 1 chief physician)
- 2 mothers of service users at the burns centre

Interviews with UK partners were conducted via Skype prior to conducting the country visit, with the exception of the UK NGO representative where the interview was conducted during the country visit. Interviews in the burns and imaging project were conducted face-to-face.

A total of 41 people responded to the online survey, out of 249 who were invited to participate (137 from overseas and 112 from the UK); a 16% response rate. As depicted in Figure 7, there was a higher response rate from the UK: 78% of respondents were UK coordinators or volunteers, and only 11% were based overseas. Full survey results can be found in Annex 4. The number of survey respondents was too small (especially from overseas) to identify any commonalities or divergences in responses between the UK, overseas partners, and/or NGOs.

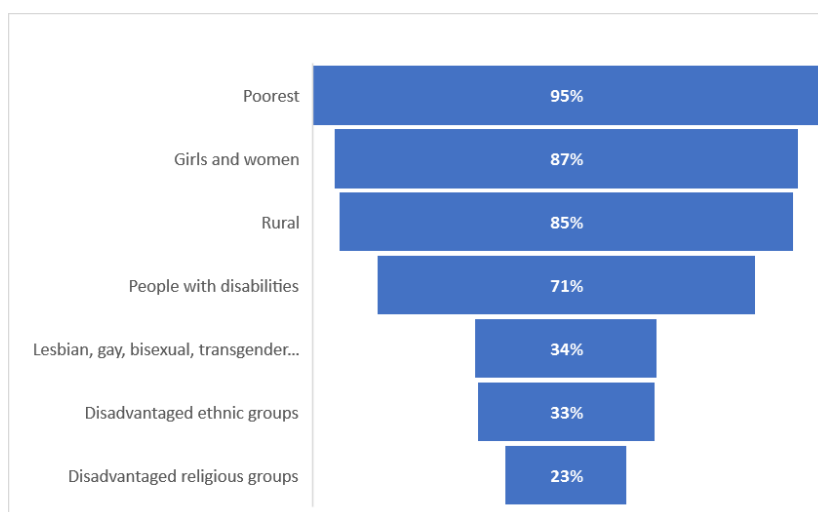
Figure 7: survey respondents by role that best describes them, (n=41)



The definition of disadvantaged populations

The survey asked personnel involved in health partnerships how they defined disadvantaged populations in programming. Survey results revealed that poor, women and girls, rural populations, and people with disabilities were the groups most frequently considered as disadvantaged in the context of their health partnership (by 95%, 87%, 85% and 71% of survey respondents respectively), as shown in Figure 8.

Figure 8: % of survey respondents who consider each group as disadvantaged in their context (n=41)



Many informants agreed that they would consider all groups as disadvantaged, but confirmed that poor and rural populations are at a particular disadvantage due to (physical) inaccessibility to health services and inability to pay for them.

"[rural people] they don't have easy access. Most of the infrastructure is not there. We have very poor road networks. The rural communities within the Districts are far apart. They are very distant from the nearest hospital."
(Physician Assistant, Overseas)

Some informants considered women as disadvantaged due to their financial dependence on their husbands or their lack of decision-making power within the household. People with disabilities were reported to have financial barriers to healthcare, often unemployed and dependent on their families to support them financially.

A third of survey respondents believed that LGBTI and certain ethnic groups were disadvantaged populations in their project context, but two-thirds did not consider them disadvantaged or did not know. Interview informants reported no discrimination towards patients based on their ethnic group. They also reported no discrimination against LGBTI individuals, thus not categorising them as "disadvantaged", but they also revealed that sexual orientation is not talked about openly in their conservative and religious context. Religious beliefs were not frequently associated with being disadvantaged, 23% of survey respondents and no interview informants reported any discrimination on religious grounds.

Other groups that were not included on the list provided in the survey and interviews but were considered as disadvantaged by a small number of respondents were: children (including children with disabilities), the aged, refugees and widows. These were mainly cited in relation to their increased risk to certain health outcomes (such as burns for children), their lack of financial means to access healthcare (widows and the aged), and difficulty to travel to a health centre (the aged).

Consideration of disadvantaged populations in the health partnership project

Design stage

Both projects that were visited demonstrated a strong understanding of the inequitable access of their health service to disadvantaged populations, especially those living in rural areas and poor. Expanding access of their health services to these populations was integral to their projects from the design stage. For one project, the intervention region selected was predominantly rural and one of the poorest in the country.

“Trying to make sure that people didn’t have to travel miles to get an x-ray...that was the ultimate aim of the process...making it more local”
(UK volunteer)

“The intention from day 1 has been to support the vulnerable and the poor”
(Overseas coordinator)

For the other project, there was less of a direct link in terms of the immediate population profile in their locality (in a tertiary hospital in the capital city), but the project coordinators were aware that poor people were at higher risk of burns and so their project would ultimately benefit this group. The tertiary hospital is also one of the two referral hospitals for burns in the country, and so serve patients from all over the country.

“The poor are always with us. Most people who get burned are from disadvantaged groups. Burns is one of the neglected [diseases]”
(Overseas coordinator)

Implementation stage (cadre of health worker)

The initial focus of the burns care project was on training burns care nurses from the tertiary hospital in question to respond to the severe shortage of trained burns nurses and to reduce pressure on the referral hospital. As the project evolved, and word of mouth spread, nurses from all over the country participated in training courses – from a range of District hospitals and smaller clinics. In total, 97 female and 37 male health workers were trained through this project. This project not only enhanced the role of nurses in burns care but also trained nurses across the country to provide burns care in District-level facilities. The project developed burns care guidelines for dissemination at a national level, enabling all healthcare facilities, in all Regions, to better manage burns cases.

“We are trying to reduce the number of complications. Many of the patients who end up here, are patients who were badly managed in peripheral hospitals. One of the things that...this project was going to do, was if the patient gets burned and gets good initial first aid, good basic management, many would not get to the point where they need to be referred to our facility...at a District level we can get support to them”
(Overseas Coordinator)

To respond to a major human resource gap in the region, the imaging project targeted a new cadre of health worker. Assistant Practitioners were identified and trained to provide a range of basic x-ray services. Their approach responded to an unmet need for imaging services, in a region where only 2 radiologists served a population of over 1 million inhabitants. In response, this project sought a long-term approach by identifying lay people who were from and/or committed to the region to be trained as Assistant Practitioners. Eight Assistant Practitioners were trained, 7 male and 1 female, with several providing x-ray services for the first time in District-level hospitals.

“We decided to be pragmatic and develop a team of staff who can provide a basic service. It was either that, or no service at all. We felt that with support, we could provide a good quality service using people who were not professionally qualified”
(UK Coordinator)

Both projects developed innovative examples of task sharing to increase the volume of trained burns care and diagnostic staff in operation; the burns project is task sharing more burns care tasks to nurses, which is currently not part of the national nurse-training curriculum. The imaging project innovated to provide x-ray services to a new cadre of lay health worker, who do not hold previous healthcare qualifications.

Case study

In a hot, dusty, arid part of the country - where the majority of the population is rural and over half of the population lives in poverty- Stephen* provides x-ray imaging for the first time in his District Hospital. At 13km from the nearest municipal town and over 800km from the capital city, inhabitants surrounding the hospital no longer have to travel long distances to access imaging services.

A couple of years ago, Stephen was working as a pharmacy assistant when he

was invited to train as a radiographic assistant (Assistant Practitioner). With a population of over 1 million inhabitants, the region had only 2 radiographers providing imaging services. The region is considered an unattractive place to work due to the harsh climate, the heavy workload (due to shortage of health workers) and lack of career development opportunities. To fill the necessary gap for imaging services, and to relieve the pressure on the few resources that did exist, a health partnership between a UK Hospital, a local NGO and the Ministry of Health was awarded a grant from THET to identify and train assistant practitioners in imaging services. Without prior qualifications related to imaging, but with a strong commitment to professional development and to improving health in the region in which he was born, Stephen successfully completed the training course. He is one of the first of a new cadre of health worker in the country that has been trained to provide imaging services, unique to this project and potentially a blueprint to be replicated nationwide and in other resource-poor settings.

Stephen works alone in the imaging department; he is always on call. Days are usually filled providing x-rays to service users. On days where an x-ray machine has broken down in the next-nearest hospital, he can see as many as 30-40 service users. The service users are typically young men who have had motorbike accidents, and chest and TB cases (more men than women), and who come from distant villages, referred to his Hospital from smaller health centres. He works closely with his colleagues in the District hospital, especially those who request and interpret x-rays, such as Samuel*- the only A&E nurse at the hospital- who relies on x-ray services to determine the severity of injuries.

Although imaging services are *available*, they are not always *accessible*. The service currently costs service users the equivalent of £5 GBP – a fee which is an unobtainable amount of money for many and a major barrier for the poor. The hospital administration can waive fees on a case by case basis, but financial barriers to imaging services remain a key issue for the local population seeking healthcare – particularly discriminating against the poorest-and a daily frustration for Stephen and Samuel.

Stephen and Samuel would like to see the government provide free healthcare to those who cannot afford it, as well as scaling up the number of skilled health workers to respond to the unmet need for imaging services in other parts of their region. Stephen hopes that his role will soon be officially recognised by the Ministry of Health and be included on the government payroll. This would be a major step in task-sharing imaging services to people like Stephen, and could serve as an example to scale up across the country where human resources are scarce, and the needs are high.

** names have been changed to protect identities*



*“Here is a District. It’s not like towns.
The rural villages are around...there
they don’t have money”*

*“There is a policy
document...that states that
race, religion and socio-cultural
background shouldn’t be a
reason why you don’t provide
emergency services to people.
But it boils down to what you
have in your pocket”*

6.2.1 Implementation stage (targeted strategies)

The survey asked if specific disadvantaged populations were intended to be reached through the health partnership projects. Figure 9 shows which groups were reported as specifically targeted.

Figure 9: proportion of health partnerships who report targeting disadvantaged populations (n=39)

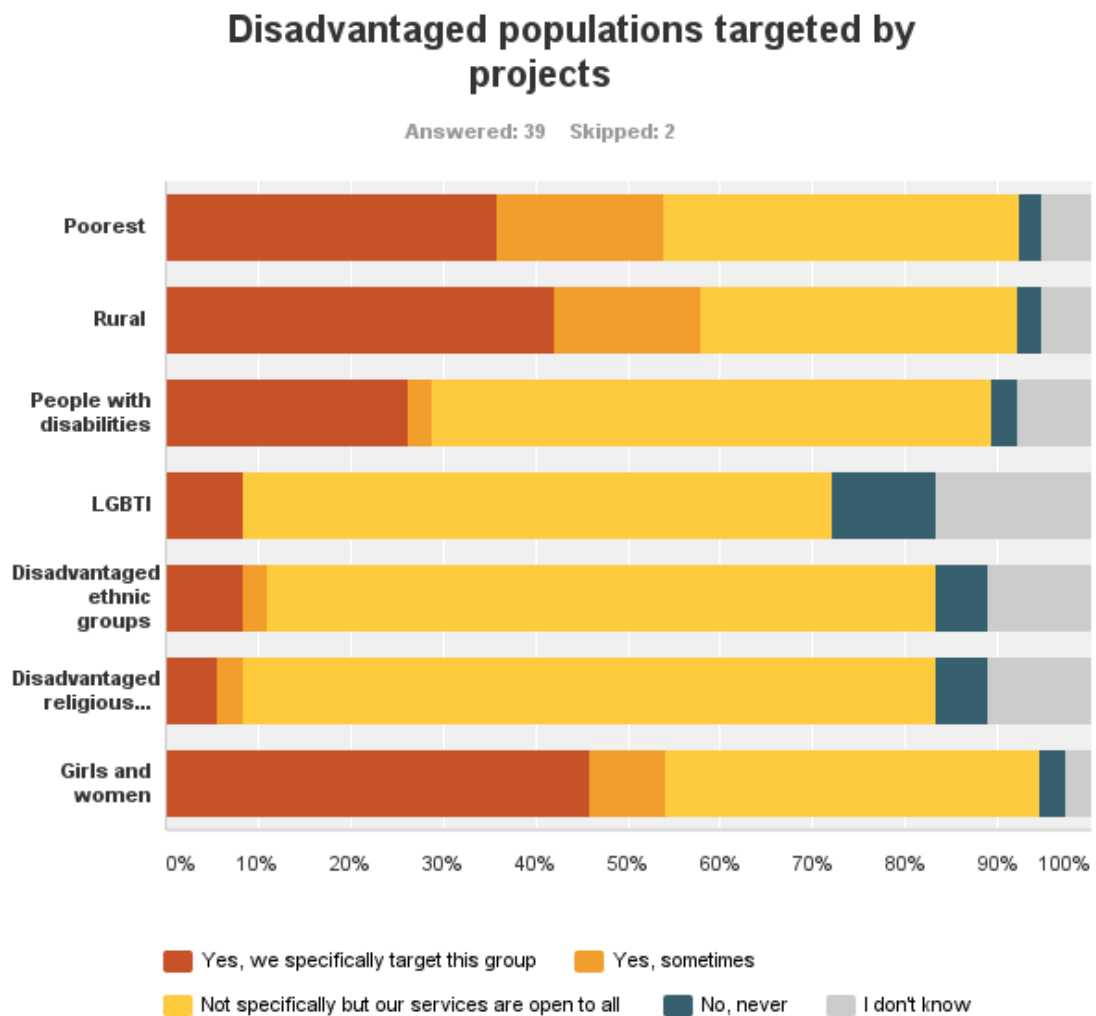


Figure 9 shows that the highest proportion of partnership projects reported targeting mostly women and girls, rural populations, the poorest and people with disabilities from the list of disadvantaged populations provided. In the comments section (open), survey respondents shared their experiences of their projects, with some specialising in women and/or children’s health, or working with rural health facilities to increase access in these disadvantaged areas. However, the majority of respondents say that they although their projects were not specifically targeted at disadvantaged populations, their services are open to all who need them. This was especially the case for people from disadvantaged religious or ethnic groups, LGBTI, and people with disabilities- direct targeting of these groups was reportedly low but most respondents confirmed that their services were open to these populations.

6.2.2 Implementation stage (service availability for the poor)

Both projects that were visited demonstrated that they are reaching poor, rural communities, through different strategies described below. Poor and rural have been combined into one sub-category as

there was significant overlap, and limited distinction, between the two factors identified during interviews. Discrimination because of ethnic group, religion or sexual orientation have also been grouped, as responses were unanimous.

Making services available to poor and rural populations by building capacity in District-level facilities

Both projects visited are building the capacity of health workers to provide services in poor, rural areas and improving access to burns care and imaging services. As described above, both projects have trained health workers (nurses and assistant practitioners) to provide services outside of the urban hubs and bring services down to District-level hospitals. This increases access for poor and rural people in several ways:

- a. The availability of services at a District level **reduces the time and cost associated with travelling** to the secondary or tertiary hospitals in urban hubs. Prior to the projects, people in need of burns and imaging services would be referred to secondary or tertiary hospitals to access them. Whilst some time and cost for travel may still be required to reach a District-level hospital, it has been reduced for many;
- b. The proximity of health services at a District level can not only lead to better health outcomes for service users, but it **can reduce the risk of complications** if an injury is left untreated (and potentially resulting in diagnosis and treatment being more costly);
- c. Having skilled health workers based at a community level also improves access to **follow-up care** for service users if needed (reducing the risk of complications – see above).

Making services available to the poor by providing a service that responds to disproportionately common health risk faced by the poor

The burns centre sees individuals who are reportedly predominantly poor. Informants explained that scalds from boiling water are the most common form of burns and these occur mainly in children and women from poor households who do not have access to modern cooking methods. By increasing the number of skilled health workers to provide burns treatment, poor people are benefitting as a result.

*“Children are more vulnerable than adults.... their mothers are poor...80% cannot afford [the treatment]”
(Nurse, Overseas)*

Making services available to poor and rural populations by providing outreach services for free

Although not THET-funded, health workers have been using their skills acquired from the THET-funded trainings during outreach visits to provide free services for poor, rural areas. Funding for outreach is secured through partnerships with the private sector (e.g. corporate organisations or NGOs). For example, the burns care team had just returned from an outreach visit to a rural part of the country to provide surgery for children with cleft lips or palate, where a NGO had invited them to provide the clinical intervention. On other occasions, they may do a more general surgical outreach visit, based on their own needs assessment (e.g. noticing a high volume of service users at their centre coming from a certain Region) or following an invitation by an organisation or company working in a specific Region. Outreach visits will usually last one week and the team work tirelessly to see all the people who need their services. One informant expressed the value of these outreach visits to reaching disadvantaged

groups- especially the poor and women as they usually do not have the financial means of their own to pay for healthcare. Whilst not directly burns-related outreach visits, the staff use their acquired skills on surgical outreach visits, as well as cascading their knowledge to health workers at the host rural facilities to manage surgical cases, including burns.

6.2.3 Implementation stage (service availability for people with disabilities)

There were mixed responses from interviews regarding the levels of access for people living with disabilities. Overall, informants reported that they see few service users with a disability, with the exception of one radiographer who said he saw many people living with disabilities. Resources in hospitals were not adapted to facilitate access for people with a (physical) disability. One Assistant Practitioner reported that she can adapt x-ray machine positions to respond to the needs related to disability, whilst UK volunteers recognised the limitations to providing a quality service for people with disabilities.

“Their resources are so poor in the hospitals, there isn’t basic provision made for anybody...let alone for people with disabilities”
(UK coordinator)

“A lot of physical barriers for people with physical disabilities. Either getting them to the hospital or moving them around the x-ray room...one of the things that the radiographers from the UK found most frustrating was the lack of aids and difficulties of manual handling...in transferring people in a safe and comfortable way”
(UK volunteer)

During most interviews, informants focussed on people with physical disabilities when asked about disability, and did not refer to other forms of disability – with the exception of two who referred to mental health cases. Some informants commented that people with disabilities are often unemployed and do not have the financial means to pay for accessing health services.

One other finding linked to disability was the risk that untreated burns can lead to contractures which can, in turn, lead to a disability. Prevention of disabilities was therefore a key component of the work of the burns care project.

6.2.4 Implementation stage (service availability for women and girls)

All health workers interviewed reported providing services to women and girls. Children and women represented a greater number of service users at the burns centre. Young girls were reported to have equal risks of sustaining burns than young boys, although this was unsubstantiated by further evidence. The imaging project reported cutting across all the disadvantaged groups, but did see fewer women and girls (compared to adult males) as many cases they deal with were road accidents (motorbikes accidents amongst young adult males) and chest x-rays for heart and respiratory conditions, to which older adult males are reportedly at higher risk to due to alcohol and tobacco consumption.

“Due to socio-cultural practices, it limits most of our women from accessing the healthcare...in some communities, every decision in the house has to be made by the husband. If the woman is sick, their husband has to give the go ahead”
(Nurse, Overseas)

The imaging project included a component on ultrasound training, increasing access to ante-natal scans for pregnant women. Two informants said the women do not control the household income and they must ask permissions from their husbands to pay for health services, whilst two others said women sometimes work and earn, and control, their own income.

6.2.5 Implementation stage (service availability for all ethnic and religious groups, and LGBTI individuals)

All informants reported that they had never witnessed a service user being discriminated against because of their ethnic group, religion or sexual orientation. Sexual orientation however was reported to be a topic that is not openly discussed and a service users would not share this information with health workers, it simply “doesn’t come up”. Being LGBTI however is considered to “not exist” in the traditional context, so there is no active discrimination for something that is not discussed or considered to exist.

6.2.6 Implementation stage (barriers to access)

Above, there are many examples of how this sample of health partnership projects are making burns care and imaging services more *available* to different disadvantaged populations – in particular poor and rural populations. However, in practice, the informants explained that there were significant contextual barriers to healthcare that are impeding the desired *access* that was intended:

Financial barriers

Informants reported that financial barriers were the major barrier for disadvantaged populations to access their health services. A National Health Insurance Scheme (NHIS) exists in theory, but no longer in practice. The scheme should cover the basic costs for service users to access health services, but due to funding issues at a government-level, hospitals have not been reimbursed for the provision of health services to service users by the government for over a year. The hospitals visited explained that this has left them in an impossible situation as they cannot afford to provide services now without charging service users as they need a flow of funds to cover basic running costs, consumables etc. Poor people are reportedly struggling to pay these out-of-pocket fees for services, with service users numbers affected in some cases. In some cases, fees are waived but this is at the discretion of the hospital administrators. In other cases, hospital staff look for sponsorship for a service users or use some of their own funds.

“You can get 10 people lined up for x-ray or ultrasound...just because of finances, only two will agree to do it. Some go, and come back at a different time. Some will never come back...”
(Assistant Practitioner, Overseas)

“Before, with NHIS they would do everything for free for them [pregnant women]. They used to come...20-30 people...now they have started charging, we are scanning only 5 people”
(Assistant Practitioner, Overseas)

“it’s not at all uncommon that a parent will refuse a child to have a skin grafting operation, because they can’t afford. Or a person will be unable to have appropriate treatment...because they can’t afford it. It’s a very unfair health service system which is strongly biased against poor people”
(UK Coordinator)

Interruption of service provision due to equipment failure

Break-down of equipment and lengthy delays in it being fixed, interrupted the continuous provision of quality imaging services. Several x-ray machines under the imaging project have experienced difficulties, leading to an interruption of services at several facilities, resulting in individuals unable to access x-ray services and being referred to the next closest facility. This can have major implications for health seeking behaviour, especially for the poor and people living with disabilities who struggle to find the financial and/or physical means to travel a further distance. Without a local maintenance solution to fixing the equipment, an engineer from the UK had to ultimately visit the sites to carry out repairs.

Socio-cultural barriers

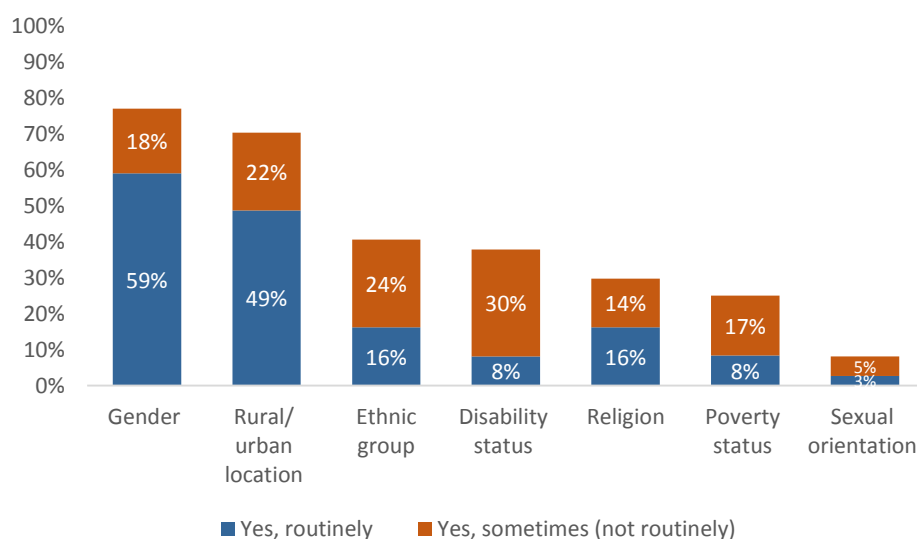
Gender-based barriers were alluded to by two informants, with women reported to not control household income and/or decision making power regarding their health. 87% of survey respondents considered women and girls a disadvantaged group. Why they believed they were disadvantaged was not provided but we can assume their gender is an identifying factor. There were no fee-waiving mechanisms or subsidies reported for this group.

LGBTI individuals were considered by 34% of survey respondents as disadvantaged. Informants reported no experiences of discrimination against people because of their sexual orientation (or gender identity), but that this was not openly spoke about in their culture.

6.2.7 Monitoring stage: tracking the ultimate beneficiaries (service users)

Survey results show that 59% *routinely* collect data on the gender of their service users, 49% on whether they are rural, 22% on religion and ethnic group, and under 10% on their poverty status (8%), disability status (8%) and sexual orientation (3%), as demonstrated in Figure 10. Others reported collecting profile information, but not routinely.

Figure 10: % of survey respondents who routinely or sometimes collect service user data, by profile characteristic (n=39)



Survey respondents highlighted that they collected data on the trainings conducted and the participants, and were not tracking the service users who ultimately benefitted from the health workers being trained (these indicators were not part of the project indicators). Service user data that is

collected is largely in patient registers, some have electronic management information systems, and others are available in District-level health reports or gathered through patient exit interviews.

In the interviews, overseas partners reported that they collect some routine data on each service users which could be used to track the profile of the service users. They all reported collecting data on gender and whether a service user was a NHIS holder or a private (fee-paying) (as a proxy for being poor); some reported documenting the village from where the service user comes from (which could also be a proxy for being poor if the village is rural). One informant explained that they take a narrative “social history” of each service users which outlines their financial situation, including their occupation and insurance cover. Religion and ethnicity are in some cases asked for individual-level patient records, but information regarding the sexual orientation of a service user is never reportedly collected. The nature of data collected is aligned with standard ministry of health data requirements. Service user data has not been included in either of the projects’ THET reports to date as was not a requirement.

“No doubt [health partnership name] is doing that [reaching disadvantaged populations]. Can I tell you the numbers? Not necessarily...”
(NGO partner)

When asked if they believed that collecting service user profile data would be feasible and/or useful, 58% of survey respondents said yes, 22% said no, and 19% said they did not know.

6.2.8 Monitoring stage: attribution of service user data to the THET-funded health partnership

In some cases, informants said attribution of service users to the project in question could be easily identified. For example, if a service was not previously available, such as x-ray services in a particular District, but now is as a result of the health partnership, then all service user data can be attributed to the project. In other cases, some services already existed prior to the project but skills have been enhanced as a result of the health partnership.

What are the lessons learned about inclusion of disadvantaged populations in health partnerships?

Informants were asked to share any lessons learned from their projects regarding the inclusion of disadvantaged populations. Some of their lessons are shared below:

- ✓ When working with health workers in the public sector, deployment of trained health workers to rural hospitals can take a lot of time and it can be harder than anticipated working with the Ministry of Health to make this happen. Important to plan carefully from an early stage;
- ✓ To enable health workers from remote regions to participate in trainings in an urban hub, covering their transport and accommodation costs can be an important factor to enable this to happen (as they would otherwise not be able to afford to participate);
- ✓ The service is the machine; without a machine, there is no service. Ensure to consider the maintenance of equipment in the project if the equipment is an essential part of the service;
- ✓ Select the appropriate health workers: in regions that face an issue with staff retention, identify and recruit staff who are likely to stay in the region to ensure continuity of the services.

6.2.9 Opportunities and challenges to focus on disadvantaged populations

Survey respondents shared what potential challenges and opportunities they envisaged if future health partnerships had a focus on disadvantaged populations. A summary is presented below in the Figures 11 and 12:

Figure 11: Potential challenges identified



Figure 12: potential opportunities identified



WordItOut

WordItOut

Many survey respondents believed disadvantaged populations could be included into the future health partnerships and this would have a positive health impact on these populations, as well as improving links between hospitals and the communities. There were particular concerns about the additional time and resources required to focus on disadvantaged populations – not only regarding providing services for them but also to collect data regarding service user profiles. Caution with data collection was urged, especially regarding characteristics that can be stigmatised such as sexual orientation or mental health conditions.

“Health partnerships are about strengthening health services in situations where virtually everyone is needy/poor. Given the already huge difficulties in providing health services in these under-resourced settings, I don't think it is valuable to add 'tiers of priority' to different types of disadvantage. The only thing I would have thought might be valuable would be to do a pilot in a country that is near the top of the LMIC table and where it might be possible to identify tiers of priority. It is far too complicated/time-consuming/ambitious/expensive to try and do it in a country where a) everyone is poor and b) there are virtually no decent health services.”
 (Survey respondent)

“A focus on inclusion of poorer individuals by way of providing transport and finances for medication would enable access to services by families who typically default on attendance and medication due to poverty. Focus on inclusion of rural populations would allow interventions (for example psychoeducation) to reach people in distant communities that may not have the resources to travel to health centres”
 (Survey respondent)

“It will target services and focus on addressing the specific needs of this populations”
 (Survey respondent)

Survey respondents and interview informants were asked what recommendations they would make for improving inclusion of disadvantaged populations. A summary of some of the recurring recommendations from the survey and interviews are listed below:

- **Include a community sensitisation component:** working more with community health workers and groups is encouraged as a means to reach populations;
- **Ensure local ownership:** local health workers to design project plans based on local needs and cultural appropriateness;
- **Foster coordination with others:** collaborate with other actors e.g. state services and private sector;
- **Build the capacity of health workers in rural areas:** increase the number of health workers trained based in rural areas and develop trainer of trainers to cascade skills further.

7. Limitations

There were some methodological limitations to the analysis. The survey provided an opportunity for a wider scope of people involved in health partnerships to share information and ideas regarding disadvantaged populations. The survey respondents were predominantly UK-based, so the survey results include less contribution from overseas partners. The analysis could not draw conclusions on the inclusion of disadvantaged populations in all of current health partnerships as only two projects were visited and the survey had a low response rate. Analysis findings were therefore drawn from a sample of sources, as well as the secondary data, and represent an insight into some health partnerships but are not representative of them all. There are many different groups that can be considered as “disadvantaged”, but the interviews and analysis were limited in depth regarding the health needs of these populations, if they are being reached, and any potential barriers to access. For example, whilst informants reported seeing fewer service users who were living with a disability or were women, it was not known whether the absence of members of these groups was a reasonable representation based on their number and prevalence of disease or injury within this group, or because there were barriers which impeded them coming to health facilities. In the absence of standard definitions for disadvantaged populations, the extent to which socially excluded groups are represented in the health workforce was not considered in detail in this study, but is recommended for inclusion in future studies, through a sensitively constructed approach. Due to time and logistics, meeting with groups who represent a disadvantaged population was unfortunately not possible. A limited number of service users were interviewed, due to the sensitivity of some of the injuries or a lack of service users during the timing of the site visit.

8. Discussion

This study has revealed that although not a strategic priority to date, some disadvantaged populations are already being reached through the THET-funded health partnerships, in particular those that reportedly benefit women and girls, poor, rural populations and people with disabilities. How health partnerships are measuring disadvantage though, may vary greatly. The analysis uncovered some of the efforts underway to reach disadvantaged populations, but also some of the major barriers to making services truly accessible to disadvantaged populations and demonstrating the impact.

Disadvantaged populations have not so far been an explicit priority for the health partnership scheme; the tools that guide the design stage of grant streams did not include requirements to include disadvantaged populations as project beneficiaries. The exceptions are two grant streams alluding to poor and rural populations, but projects funded under these streams are not collecting data on service user profiles, so their impact on these populations is not easily assessed. The health partnerships visited during this study provided insights into the various efforts made, from the design stage onwards throughout the grant cycle, to reach disadvantaged populations, yet the documentation does not tell the same story. If both the health partnerships in this study uncovered efforts to extend services to disadvantaged populations, one must assume there are examples of other health partnerships investing in similar initiatives.

The cadres of health workers targeted in the health partnerships to date reveal that a range of professions have been involved both in the UK and overseas. In the UK, doctors have been the most frequent cadre of volunteers and overseas, a relatively high ratio of doctors have been direct beneficiaries. Given the (smaller) proportion of the health workforce who are doctors in LMICs, the focus of the health partnerships to date could be interpreted as being “doctor-heavy”. This however, may also be due to the nature of the partnerships, the specialisms in question, and the availability and autonomy of health workers to participate in health partnerships. Nevertheless, many mid-level health workers have also been trained and encouragingly also community health workers (although a small proportion compared to their number and reach in LMICs), indicative perhaps of some health partnerships working at a community-level as a means to reach more disadvantaged populations.

The cadres of health workers selected, and the facilities in which they work, are important determinants of the populations that will be reached. Primary healthcare has been recognised as a priority in poorer settings^{xxiii} but, broadly speaking, does not appear to have been a priority for the health partnerships in terms of the health cadres involved. Unfortunately, the type of facility in which health workers are providing services was not easily identifiable but could also serve as a proxy indicator for the populations they are reaching. Integrating health workers from rural areas – as well as task-sharing to lower cadres of health workers – was an example of an inclusive strategy used by both projects visited to improve access to specialist services in District-level facilities and hence increase the likelihood of reaching more rural and poor populations. In one project, task-sharing to a new cadre presents an exciting opportunity to scale up and reach more disadvantaged regions where health resources are scarce, and could follow in the footsteps of other success models, such as task-sharing to health extension workers in Ethiopia^{xxvii}. The cadres of health workers and the types of facilities in which they work are key features to focus on in future health partnerships, to try and ensure that they are the best fit to reach the intended populations.

Approximately half of respondents reported specifically targeting women and girls, poor, and rural populations. What remains to be understood is how they define these categories, why these populations were targeted more than others, as well as what respondents mean by “specifically targeting” – which could range from having a service available to this population or to having conducted

a needs assessment and tailored a strategy to reach them. A key first step must be to define 'disadvantage', as at present there are no standard metrics across all health partnerships for defining, and determining, e.g. poorest 40% or a person with a disability. How health partnerships internally record a given indicator could potentially differ greatly from one project to another. What is also interesting is why LGBTI individuals, and members of certain ethnic and religious groups were considered to a lesser extent as disadvantaged; it may be that these groups are genuinely not discriminated against in that country and therefore not considered at a disadvantage, or that their needs and barriers to healthcare are not understood and therefore they are not considered as disadvantaged. It is important that the needs of these populations be understood and not excluded from future health partnerships, as they could have major barriers to healthcare in settings where they face discrimination. In the case of sexual orientation and gender identity, there remains a risk that the subject is so taboo that it is considered even by health workers to not exist, increasing the potential risk of discrimination. Determining the most disadvantaged populations may not easily be in the remit of the health workers, who are already overstretched in doing their day job.

Making a service available is critical, but making it accessible is essential too. The two projects visited had aimed to make services available to disadvantaged groups, especially poor and rural populations, by building the capacity of health workers in rural areas. Unfortunately, this alone has proved to be insufficient. Financial barriers were the major barrier to access; unless health services are subsidised or free, then most financially disadvantaged groups cannot afford them, and will remain out of their reach in the absence of a supportive health financing mechanism. Other barriers such as equipment maintenance and socio-cultural barriers are also important factors that all health partnerships must consider when designing a project and identifying its target populations. The role of the health partnerships in facilitating this, needs to be considered and whether alone they can surmount such barriers or whether partnering with others could be an effective and efficient means to do so.

Many health partnerships are collecting routine, and non-routine, service-user profile data but this data is not based on standard definitions, nor systematically tracked or reported. THET-funded health partnerships are potentially underestimating their reach to disadvantaged populations, but good quality data is not readily available to prove otherwise. Some data is already collected, but other profile data such as poverty status is more complex to define and determine. Proxy indicators can be used but determining the poor, and the poorest of the poor, is a multifaceted procedure. A preliminary need is to consider whether identifying the poorest (or other disadvantaged populations) is in the remit of the health workers involved, or if they can work with others to help identify those most in need. Encouragingly, over half of survey respondents thought it would be feasible and useful to collect data on disadvantaged populations, but many expressed concern over adding additional data requests to the heavy workload of health workers.

If health partnerships are to include a focus on disadvantaged populations, significant considerations are required in how they are designed, where they are implemented, who they involve, and how their impact is measured. At a strategic level, the focus of health partnership impact would extend to the outcome-level health indicators based on the targeted populations who benefit from the services. The role and direction of health partnerships in strengthening health systems will need to be re-visited and consideration given to the balance between building the skills of the workforce in a specific service and taking a programme-wide approach that encompasses other components such as community sensitisation possibly in collaboration with more actors, as outlined in the 2016 Evaluation.

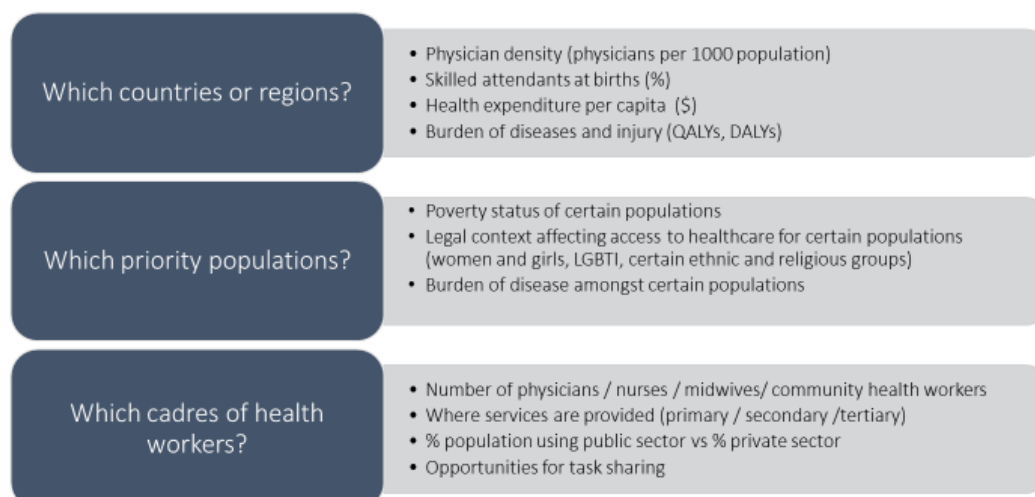
9. Recommendations

To have the intended impact on disadvantaged populations in future health partnerships, a clear vision is needed, supported by a range of tools that can guide health partnerships in successfully designing and implementing their projects for those populations. The findings from this study suggest consideration of the following recommendations:

vi. **Prioritisation of disadvantaged populations in future grant streams**

Helping health partnerships identify the most disadvantaged populations is the first step. The process of identification could take many forms, and could be done in collaboration with others who work already with these populations, who can easily provide information and guidance. The situation and needs of the disadvantaged populations will vary depending on the country context, so at a health partnership level, a country-level needs assessment would also be required (see point vii below). THET could integrate disadvantaged populations into their grant funding streams in different ways. For example, there could be specific grants for different priority populations, countries/regions, health specialisms, health cadres, or task sharing innovations. An alternative, or complementary, approach could be to mainstream disadvantaged populations as beneficiaries across all future grants. Figure 13 below outlines some of the potential questions that can guide the identification process of these priority areas. They are a collection of some of the indicators (and not an exhaustive list) used by organisations such as the World Bank, the World Health Organisations and UN Agencies, and serve merely as an example of questions and indicators that could contribute to the identification process.

Figure 13: possible indicators to guide priority setting at country/region, population, and health-cadre level

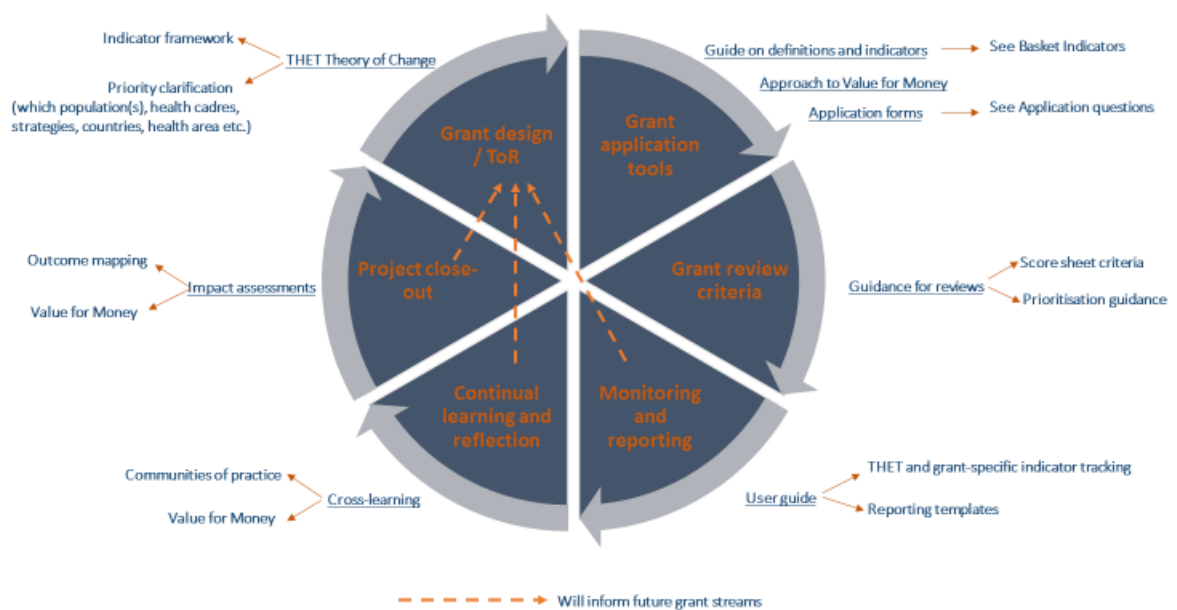


vii. **Consider disadvantaged populations in all aspects of the health partnership grant cycle**

Once disadvantaged populations have been defined, identified and prioritised, they should be considered in each stage of the grant cycle, as demonstrated in Figure 14 below. Starting with a Theory of Change, grant application guides, grant selection criteria, and grant monitoring and reporting tools, would all include clear requirements about the inclusion of disadvantaged

populations. As the projects evolve, cross-learning between health partnerships would be encouraged and facilitated to increase the impact of the interventions for disadvantaged populations, whilst impact assessments would include a review of the extent of their social inclusion. Lessons learned about reaching disadvantaged populations through monitoring, continual learning and reflection and impact assessments will all feed into strengthening the design of future grants.

Figure 14: Guidance on how to include a focus on disadvantaged populations at different stages of the grant cycle



viii. **Make health services both available and accessible to disadvantaged populations, e.g. by engaging with other partners**

A range of actors such as community based organisations (CBOs), peer networks, public and/or private sector, can enhance access to services for disadvantaged populations through engaging in advocacy with health system leaders, innovating with delivery channels or leveraging various financing mechanisms. To enable this, grant guidelines would need to be relaxed to allow the inclusion of a wider range of actors as partners. Below are two ways that partnerships could enhance targeted interventions for disadvantaged populations and overcome financial barriers to healthcare:

- o To overcome challenges related to **targeting** disadvantaged populations, and ensuring **socio-cultural** barriers do not impede access, health partnerships might be encouraged to partner with local organisations or agents already embedded in the communities. To identify and target the populations most in need, CBOs or peer networks could be an entry point; they would be well placed to help the identification process, and to support the provision of health information, advice, and referral information, as well as communicating the needs and sensitivities of these populations to the health workers. Where appropriate, these agents could provide some basic healthcare too (see task sharing in point i.). This partnership would be a more effective approach as it would reduce the additional efforts required of health workers to accurately identify disadvantaged populations; the partners

might also be more appropriate gatekeepers as they are already known and trusted within their communities.

- To overcome challenges related to the services being **financially** inaccessible to disadvantaged populations, health partnerships might be encouraged to partner with institutions to leverage health financing mechanisms. For the most financially disadvantaged, this could include access to mechanisms such as voucher schemes, community-based insurance schemes or creating a referral pathway to a e.g. private or NGO health centre which waives fees for disadvantaged populations. A sustainable, long-term vision to health financing is to be encouraged, which may have to encompass an advocacy component to work with local governments to address health inequalities.

ix. **Conduct a follow-up mapping exercise of the current health partnerships to identify best practice and learn from any successful models**

From this exercise, communities of practice between common groups about reaching disadvantaged groups could be created, leading to working groups, cross-learning and ultimately improved interventions. This mapping assessment could identify the following information regarding current health partnerships:

- Which diseases / area of health
- Where they are working (country, urban / rural,)
- Which cadre they work with
- Who they partner with (CBOs, NGOs, public/private/corporate institutions etc.)
- Health financing mechanisms in place
- Which data are they collecting and how

x. **Define a basket of indicators to measure the extent to which disadvantaged populations are being reached through health partnerships**

Once disadvantaged populations have been identified, prioritised, and integrated into project designs and plans, the extent to which they are reached needs to be systematically captured. Introduce routine indicators to report on regularly, allowing comparison of trends across health partnerships. In Figure 15 below is a basket of initial suggestions of indicators that might help guide discussions on indicators for reaching disadvantaged populations, including a means of verification for how this data can be collected. However, indicators would need to be developed with existing health partnerships to ensure that they are relevant and feasible. Measuring poverty can be more complex; consideration might be given to collecting some routine proxy indicators (such as rural location), and non-routine data collection (such as exit interviews) which could provide more rigorous measures of poverty status of service users. Consideration should also be given to context-appropriate indicators that may be beneficial to a health partnership but not considered a standard metric.

Figure 15: Guidance for a proposed basket of indicators on disadvantaged populations

Disadvantaged population	Possible indicators	Means of verification
Poor	<ul style="list-style-type: none"> ▪ Number and/or % service users living on <\$1.25 or \$1.90 a day ▪ Number and/or % service users who live in rural areas (proxy indicator) ▪ Number and/or service users paying for services (proxy indicator) ▪ Number and/or service users with health insurance (possible proxy indicator) 	<ul style="list-style-type: none"> ▪ Annual patient exit interviews² ▪ Routine ▪ Routine ▪ Routine
Women and girls	<ul style="list-style-type: none"> ▪ Number and/or % of women service users ▪ Number and/or % of girls (disaggregated by age groups) ▪ Number and/or % of female health staff trained 	<ul style="list-style-type: none"> ▪ Routine ▪ Routine ▪ Routine
People with disabilities	<ul style="list-style-type: none"> ▪ Number and/or % service users with a physical impairment ▪ Number and/or % service users with a hearing impairment ▪ Number and/or % service users with a visual impairment ▪ Number and/or % service users with a mental health condition 	<ul style="list-style-type: none"> ▪ Routine ▪ Routine ▪ Routine ▪ Routine
Sexual orientation and gender identity	<ul style="list-style-type: none"> ▪ Number and/or % service users who are lesbian ▪ Number and/or % service users who are gay ▪ Number and/or % service users who are bisexual ▪ Number and/or % service users who are transgender ▪ Number and/or % service users who are intersex 	<ul style="list-style-type: none"> ▪ Routine or exit interview ▪ Routine or exit interview ▪ Routine or exit interview ▪ Routine or exit interview ▪ Routine or exit interview
Ethnic group	<ul style="list-style-type: none"> ▪ Number and/or % service users from [ethnic group to be determined locally] 	<ul style="list-style-type: none"> ▪ Routine
Religion	<ul style="list-style-type: none"> ▪ Number and/or % service users by [religious group to be determined locally] 	<ul style="list-style-type: none"> ▪ Routine

These indicators could be developed in collaboration with health partnerships and/or adapted depending on the local context and cultural appropriateness. All the suggested indicators in Figure 15 are related to *service users*. In relation to health workers, expanding the profile data collected to include information on the health facilities they work in (primary/secondary/tertiary), where they are situated (urban/rural), and profile data such as disability status, religion, ethnic group, sexual orientation and gender identification, would allow insights into the extent that disadvantaged populations are represented in the workforce.

ix. **Help the focus on disadvantaged populations for health workers by supporting analyses and tracking.**

The inclusion of disadvantaged populations will require additional efforts to identify and accurately target them and to track their service usage, but this should not be allowed to become burdensome. It should be possible to invite ideas to support them without significantly increasing the workload of healthcare workers who are already overstretched. For example, an external agency could be employed to help identify and define disadvantaged populations, e.g. through a series of country-level analyses of their health needs, and who they work with (as potential health

² Exit interviews would require the use of a pre-determined poverty index with context-specific questions to determine if a patient can be determined as poor.

partnership partners). These analyses could be made available at the grant call for proposals stage. Or, to assess the “typical” profile of service users, an external agency could design and conduct patient exit interviews.

- x. **Identify any potential areas of discrimination through a series of values clarification workshops.** Values clarification workshops allow individuals to explore their values, attitudes and actions regarding certain topics. In this case, it could be used to look at the inclusion of disadvantaged populations, allowing values to be analysed and consideration for how it can affect the prioritisation, design and implementation of health partnerships. The workshops could be organised by a neutral, external party and held at a head office level, as well as at a health partnership level.

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