Author's response to reviews

Title: Can international health programmes be sustained after the end of international funding? The case of eye care interventions in Ghana

Authors:

Karl Blanchet (karl.blanchet@lshtm.ac.uk)
Philip James (P.James@salford.ac.uk)

Version: 5 Date: 20 September 2013

Author's response to reviews: see over
We thank both reviewers for their valuable comments. We have addressed the issues raised by both reviewers as described below:

Reviewer’s report 1:
- Major Compulsory Revisions
  1. The authors describe that the study took place more than 4 years ago. It is important that the authors discuss this and possible implications.

In fact, data collection ended in 2009 and the analysis of data was conducted in 2010. I added a few more details in the Methods section.

2. The authors embed qualitative research in the results section but provide little detail on how this was collected other than mentioning discussion with key informants. It would be helpful if the authors could provide more methodological detail around the qualitative research.

Thank you for your comment. I added several paragraphs to explain how data collection took place:

Page 10: “All reports (statistics, activities, evaluations, and budgets) produced during the ten years of the eye-care programme were collected. During the course of the study, additional documents (e.g., health facility statistics, reports from regional authorities, minutes of management committee meetings, mission reports from the Swiss Red Cross, national policies) were collected and analysed. Documentary research was used for data triangulation and theory triangulation (Denzin 1978), and also helped raise new research questions and identify new informants.”

Page 12: “In-depth interviews were conducted by the first author to understand the reasons for continuation or interruption of activities. 51 interviews were carried out in 2009 with officers at the Ministry of Health, regional and district health authorities, district hospital managers and health staff, Swiss Red Cross officers and community members. All the ophthalmic nurses in health facilities, the regional ophthalmologist and the regional health officer in charge in 2006 of eye care service delivery were still in place at the time of the study in 2008 and 2009.”

3. The authors should discuss the validity of the proposed approach and suggest the need for it to be applied in other settings and interventions

This is a very point. I added on page 25 in the Discussion section the following paragraph: “One limitation of the approach is that it does not capture the dynamics of health systems. The assessment at one point in time should be repeated over time to measure how the continuation of activities evolve and how the perception by health professionals in relation to attributes of innovations changes with the changing policy and finance environment. However, the utilisation of indicators validated by key informants was considered by the authors as appropriate way of describing the characteristics of innovations. Applications could be numerous in the field of international health to manage and predict in plan-tenation and scaling up of innovations (e.g., m-health, new drugs).”

- Minor Essential Revisions
  1. The authors should consider reducing some of the tables— in particular Tables 7–12 could be deleted
I understand the point made but could not find any other way of visually presenting the data. I maintained the tables.

Discretionary Revisions
1. Recommend that the authors consider replacing the term “developing countries” with the more acceptable term “low- or middle-income countries (LMICs)”

The term “developing country” has been replaced by low and middle-income country.

Reviewer’s report 2

The paper aims to answer an important question of sustainability of health programs after donor contribution. However, there is a major flaw in the logic in the paper. Namely, financing aspects are largely ignored. Routine consultation can be financed as part of routine work (indeed does not require specific financing), but others do need some financing. Who pays the cost of surgery? Is it a hospital or patient? Unless financing element is clearly addressed as part of the analysis (e.g., analysis includes adjustment for costs of activities and financial situations after the donor departure, and not just a few words to mention this), the analysis and argument has a major flaw or is very weak at best. This is especially important as the paper deals with the issues of sustainability and low resource setting.

Thank you very much for your comment. I have inserted details on financial sustainability in relation with the mandate of hospitals – data which had been collected and reported.

Page 8: “In terms of financing, all the direct costs of the activities were funded by the Swiss Red Cross (i.e., medical consumables for surgeries, fuel and per diem for the outreach activities including school health screening). Eye care staff were all employed and paid by their hospital. From a patient perspective, user fees were only paid for facility-based activities (consultations and cataract surgeries). All outreach activities (outreach consultations and school health screening) were delivered free of charge for the patient.”

Page 23: “The mandate of district hospitals was to deliver facility-based services and serve the population living in their catchment area (i.e., the district). Every facility-based activity, such as consultations and cataract surgeries, was considered by hospital managers as fully controllable with the mandate of a Ghanaian district hospital. These two activities were fully in compliance with the mandate of district hospitals and no modification was required from the district hospitals to adjust their structure to deliver these activities. As such, facility-based consultations and cataract surgeries were perceived by hospital managers to be highly controllable innovations. The costs of these activities were included in the budget of the district hospital and were even refunded by National Health Insurance Scheme put in place by the Ministry of Health.

Hospital managers acknowledged that confusion existed over who should be responsible for the management and financing of outreach and school health activities. One hospital manager explained, “Outreach activities should have been carried out by the district authorities not by the hospitals. They are the ones in charge of all the health interventions that take place outside the walls of this hospital. However, they never took the initiative and our staff had to conduct the outreach consultations.” As another hospital manager described it, “Outreach activities and school health activities had never been seen as a problem as long as the costs of these activities were fully covered by the international organization. As soon as the international organization ceased its financial support, it became unclear for the health actors who should continue these
activities, the hospital or the district authorities.” The lack of clarity regarding the outreach activities and school health activities created conflicts between two distinct entities: the district health management teams (DHMTs) and the district hospital. In the Ghanaian health system, district hospitals are not accountable to the DHMTs. DHMTs are in charge of all the activities conducted at the primary health care level of the health system. Outreach consultations and school health activities were perceived as inconsistent with the mandate of the district hospitals. They also required slight adaptations from district hospital teams as described by one ophthalmic nurse: “outreach activities and school screening introduced new ways of working at the hospital. We had to contact headmasters or local authorities to offer our services. We then organised trips in collaboration with these people. This was very unusual for us. We were used to wait for the patient to come to the hospital. Now we had to do the inverse.” Outreach and school activities were described as almost inconsistent with the mandate of hospitals and required adjustments from hospitals.

The theory and methods to answer this question are well described. However, results/finding section is mixed with methods (e.g., scoring system) and interpretations.

We provided more details on the qualitative methodology to describe how the results were generated from mixed methods.

Limitation of the study is not clear. For example, continuation may depend on availability of one individual at a region/district. Have the authors confirmed that all individuals were still working at these hospitals at the time of study?

We confirm that all individuals were still working at these hospitals at the time of the study. I have inserted the text following sentence on page 12:

“Al l the ophthalmic nurses in health facilities, the regional ophthalmologist and the regional Health Officers in charge in 2006 of eye care service delivery were still in place at the time of the study in 2008 and 2009.”

We have also inserted a paragraph on the limitations of the study:

Page 11: “Limitations

One issue concerned the level of accuracy of medical records. As observed by the first author during data collection, medical records collected in district hospitals were not always coherent or complete. This was obvious when figures were missing or when the writing style in the books changed. However, the level of detail required by the investigator only concerned the volume of activities. No data was collected about type of diseases, limiting errors of misclassification.

The other challenge met by the investigator was that medical records were not always conserved or maintained in good condition: they were recorded in books and kept on shelves, and a few old books were missing and could not be found at the hospital. In addition, some activities were not correctly reported; for example, at the start of the programme in 1996, ophthalmic nurses did not differentiate between facility-based consultations and outreach consultations. Record keeping dramatically improved from the year 2000, when the Swiss Red Cross put a lot of effort into reporting and requested that nurses systematically record patients in their books categorised by activity.”
The investigator was assisted by the ophthalmic nurse in charge of the eye clinic to fill in missing information when a figure was not clearly written or when records were absent. All ophthalmic nurses responded positively to the requests of the investigator and provided support by researching medical records in archives or asking the administrator of the hospital to provide the correct figures when available.

Data on hospital admissions was triangulated in order to verify the veracity of the following three sources: i) daily records completed by the ophthalmic nurse following each consultation; ii) quarterly records completed by the ophthalmic nurse but submitted to the Swiss Red Cross every three months; iii) annual records derived from annual hospital reports. The investigator compared the two sources of information. When there was a difference between the two sources of data, the figures were not considered valid and were not reported.”