

Round table discussions

Between April and November 2002, **Healthlink Worldwide** and **GIC Ltd** held the first two of a series of round table discussions in London as part of the **Disability and Healthcare Technology Knowledge and Research (KaR) programme**. The aim of these discussions was to:

- raise the profile of the programme, particularly among those working in disability
- share learning from individual KaR projects and related activities with a wider audience
- discuss important issues in the fields of disability and healthcare technology.

At each discussion one or more organisations gave presentations about work they were doing. Participants then discussed issues raised by these presentations, and broader issues related to the day's theme.

1 Disability and education

The first round table discussion, *Disability and education*, was held on 10 April 2002. It was chaired by **David Clarke**, of the **Education Department** of the UK **Department for International Development (DFID)**. As a part of his introduction, Clarke said that although up to 10% of children might have a special need or impairment, UNESCO estimates that only 1-2% of these have access to primary education.

Beverly Ashton of **Action on Disability and Development (ADD)** reported that over the past year, ADD has been asking disabled people in the South to identify what would make the biggest difference in their lives. The most common response was that education is the top priority. Ashton reported that disabled people in the South are often denied access to education for three main reasons:

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1. Institutional discrimination. As schools in the South are oversubscribed, one way of reducing numbers is to exclude disabled people. This is often reflected in government statistics, which do not always include figures for disabled children. Other factors that adversely affect disabled children include:

- large class sizes, which reduce opportunities for special help
- inadequate teacher training
- lack of future prospects for disabled children
- financial barriers such as the cost of uniforms.

2. Environmental factors, such as the distance between school and home, which can make attending school difficult for less-mobile children.

Once at school, other factors may affect children with specific impairments. For example, the lack of special writing aids means that blind children find it harder to learn.

3. Attitudinal problems such as fear and low expectations, which are found among parents, teachers and children. For example, many parents and children fear bullying, and teachers are sometimes concerned that disabled children may be noisy and disruptive.

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Given the compound nature of this discrimination, Ashton said it was necessary to work with a variety of groups to break down barriers. She identified disabled people's organisations (DPOs) as key players, and said that DPOs could do things like pay for disabled children to attend school, run literacy classes, visit head teachers and parents, and run classes for excluded children and adults.

International non-governmental organisations (NGOs) are also playing a role, providing Braille guides, hearing aids, special schools and early stimulation for pre-school children. However, these initiatives are only scratching the surface of the problem. Many disabled children do not go to school, so end up as disadvantaged adults.

In commenting on this presentation, Clarke said he had been working on education policy with the **World Bank**, **UNICEF** and **UNESCO**, amongst others. He concluded that disability is often pushed to one side in favour of other pressing issues, citing the recent process of developing *Poverty Reduction Strategy Papers* (PRSPs) as an example. Of eight completed PRSPs, only two had anything relating to disability and education.

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Another question raised the issue of whether DPOs should focus more on campaigning for system change rather than supporting individual disabled people. Ashton explained that this was indeed the main focus of ADD's work.

She pointed out that the action needed was not difficult, but in most cases, it was not happening.

David Constantine and **Chris Rushman** of **Motivation**, an organisation working to improve the quality of life of wheelchair users, gave the second presentation. Motivation employs wheelchair users as trainers to teach hospital staff in countries in Asia, Eastern Europe, Latin America and Africa.

Following many requests for such training, Motivation conducted a needs assessment in 1997 in Tanzania, Uganda and Zimbabwe. This led to the establishment of an orthopaedic training centre in Moshi, **Tanzania**.

Motivation then established a **wheelchair technologists' training course**

with support from the **European Union, States of Jersey** and the **KaR programme**. All the students enrolled on the first course were disabled people. *For further information about this project, see the project report **D8**.*

Through the experience of setting up this course, Motivation learned a number of lessons, including the importance of developing course literature (manuals, lesson plans, handouts and teaching notes), curriculum development and a clear course structure.

The course has had a number of significant results, including the development of a competent local team and the graduation of all first-year students. The programme now has permanent facilities and a second year of training has started.

During discussions that followed these presentations several suggestions were made about how DFID could play a greater role. These included:

- using the international profile of the Secretary of State for International Development, Clare Short, to press for educational statistics to include all children
- requiring all DFID-funded NGO programmes to include disabled people
- supporting an international workshop for special-education teacher training.

One problem which emerged in this discussion was that it was not always clear which DFID budget such initiatives would come from.

Clarke acknowledged that disabled people had low visibility within DFID, as did women and people from ethnic minorities. He acknowledged that there was sometimes a gap between rhetoric and practice, and that there are difficulties and delays in implementing government policy on these issues.

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He acknowledged that DFID is moving away from support to projects because that leads to fragmented efforts and increased transaction costs. DFID's main focus is now on the 'macro' level through 'general budget

support'. This means a stronger role for government and has significant implications, as it means that projects will find it more difficult to get funding unless embedded in government structures.

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2 Better healthcare for the poor: does the management of healthcare technology matter?

The second round table, *Better healthcare for the poor: does the management of healthcare technology matter?* was held on 27 June. It was jointly chaired by **Roger Drew, Director of the KaR programme**, and **Andrei Issakov, Co-ordinator of Health Facilities and Service Outcomes in the Department of Service Provision at the World Health Organization (WHO)**. The day's presentations and discussions focused on the relationship between the management of healthcare technology and improving healthcare for poor people. The morning was given over to four short presentations, and a discussion about the work of a KaR-funded project, the **Essential Healthcare Technology Package (EHTP)**.

For information about EHTP, see the project report **HCT1**.

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First, **Yunkap Kwankam**, a scientist working on health facilities and service outcomes within the **Department of Service Provision at WHO**, made a presentation which examined the relationship between management of healthcare technology and efforts to improve the health of the poor. He began by saying that in many developing countries

appropriate medical equipment is simply not available. This might be due to a number of reasons, including lack of facilities and resources, poor budgeting and planning, or a failure by manufacturers to provide a steady supply of a particular product. Sometimes medical equipment is present, but is broken and not useable. Again, this may be due to a number of reasons including lack of preventive and corrective maintenance, inadequate utilities and a difficult environment, including heat, humidity and dust. In other situations, equipment is available and is in full working order, but is not being used, for a variety of reasons, including lack of skilled personnel, appropriate utilities (such as electricity) or various consumables, such as medicines etc. In order for medical technology to be used properly, all the required resources, including facilities, human resources, medical devices and pharmaceuticals, need to be available at the same time.

Kwankam examined the relationship between management of health care technology and efforts to improve the health of the poor.

Kwankam concluded by questioning the current emphasis on targeting health services at the poor, arguing that the poor were best served by a functioning

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general health system, which was responsive to expectations of the whole population it served and was fairly financed.

Second, **Hanief Kader, Deputy Director for Health Technology** in the **Department of Health in South Africa**, presented experience of

managing healthcare technology in South Africa. He explained about the current state of healthcare provision in the country, including the ways in which the public and private sectors differ, the increasing demands on the system (particularly because of HIV/AIDS), the declining resources available to the health sector and the fact that resources remain disproportionately concentrated at secondary and tertiary levels. This is the background to problems with medical equipment. A recent survey showed that up to 25% of all medical equipment in hospitals in South Africa was non-functional.

Current problems include:

- equipment maintenance currently attracts less than 1% of the health budget
- problems with procurement and acquisition
- a severe skills shortage, for example, there are only three clinical engineers in the public sector in South Africa
- failure to enforce regulations
- infrequent evaluations
- inefficient and poorly managed systems.

Kader concluded by advocating a re-structured approach to health, with an emphasis on integrated planning, sustainability and affordability. Plans for healthcare technology need to be integrated into health system plans, rather than being separate from them. This would apply to capital projects and to donor funds and would require considerable new legislation.

Michael Dobson, Senior Clinical Lecturer at the **University of Oxford** and **WHO Liaison Officer for the World Federation of Societies of**

Anaesthesiologists, gave the third presentation. He started by pointing out that much of the current approach to transfer of health technology is based on people in the

North thinking they know what is needed, what the target is, having an effective delivery system and believing that their project will make a big impact. Additionally, technology standards are often set internationally but are inappropriate for many environments. An example of this is the emphasis on using electronic media, including the Internet, to reach developing countries. Although access to the Internet improved markedly in Africa from 1993 to 1997, many people were still only able to gain, at best, very limited access.

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As a response to this problem, Dobson argued for locally managed systems. He referred to the KaR-funded **Teaching-aids At Low Cost** project using a CD-ROM to supply information on anaesthetics to doctors in district hospitals in Zimbabwe. He explained how the system had been developed with local advice, which led to using 'old' technology, a user-friendly CD-ROM. *For further information, see the project report **HCT 7**.*

Paul de Leeuw, Director of International Healthcare Projects at Phillips Medical Systems in the Netherlands, gave the fourth presentation. He said that commercial suppliers of medical equipment in Africa often focus on meeting the needs of tertiary hospitals rather than district hospitals. Reasons for this include:

- resources for district hospitals are often decentralised and fragmented
- supplying tertiary hospitals is seen as being more prestigious
- maintenance of equipment is better funded and more efficient in tertiary hospitals
- tertiary hospitals attract more highly skilled staff who expect access to up-to-date medical equipment.

Also, tertiary institutions are located in capital and other major cities. This makes it easier for commercial suppliers to access them and service their needs.

The needs of district hospitals in poor areas are dramatically different from the needs of hospitals in the North or in richer urban areas in the South. However, medical equipment is often designed by engineers who are not aware of the these needs. Equipment that is appropriate to district hospitals needs to:

- be designed to be used by relatively unskilled staff
- function well in the given environment
- take into account the reliability of power and water supplies
- be easy to maintain using existing skills and resources.

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He concluded that the main problem with medical technology in Africa is not the lack of equipment but that more than half of it is inappropriate for the setting. He laid the blame on "highly ineffective procurement procedures", unco-ordinated donor efforts and lack of real feedback to manufacturers. He urged WHO to play a much stronger role in this process, including assessing health technology needs and making recommendations, mobilising the private

sector, and promoting sustainable approaches with governments and funding agencies. This would encourage the private sector to take responsibility for sustainable results, and invest in and supply appropriate technologies.

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The discussion that followed was led by two invited participants from the South. **Palitha Abeykoon, advisor to the Minister of Health in Sri Lanka**, said that within the health sector in Sri Lanka, technology management is focused on safety and effectiveness, but there is a lack of expertise within the country. Also, there is high demand for 'high-tech gadgets' as these are equated with better health and are often demanded by northern-trained doctors. Much equipment is inappropriate because it is not thoroughly assessed before being acquired. He gave four examples of technologies that he believed had been properly assessed before being acquired. These are hepatitis B vaccination, antiretroviral agents, telemedicine and an injection strategy. All of these were well funded, supported by outside agencies and consistent with government priorities. He concluded that Sri Lanka would benefit from studies on the role of healthcare technology in determining quality of care, the role of technology assessment in health policy development, the way the private sector manages technology, and how an information dissemination service could support evidence-based decision-making.

Enrico Nunziata, advisor to the Ministry of Health in Mozambique, said that a key problem in Mozambique is the lack of skilled personnel. He reported that there are very few qualified engineers in the public sector, as most engineers migrate to the private sector where they are better paid. The Ministry of Health is now committed to forming an equipment commission and to including a focus on skills and personnel in a huge healthcare technology planning exercise.

Several broad conclusions arose from the day's discussions. The importance of integrating health technology planning into health system planning was stressed, as was the need for considering appropriate facilities, personnel and drugs – not just medical equipment alone. It was also felt that there was a need for a comprehensive study of the way in which appropriate management of healthcare technology contributes to positive health outcomes.

Reports of other KaR round table meetings will be featured in future issues of the programme newsletter, *Disability and Healthcare Technology*, and at **www.kar-dht.org**