

# WORLD HEALTH & POPULATION

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Population Consultation: A Powerful Means to Ensure that Health Strategies are Oriented Towards Universal Health Coverage\*

Citizen Involvement in Tunisia\*

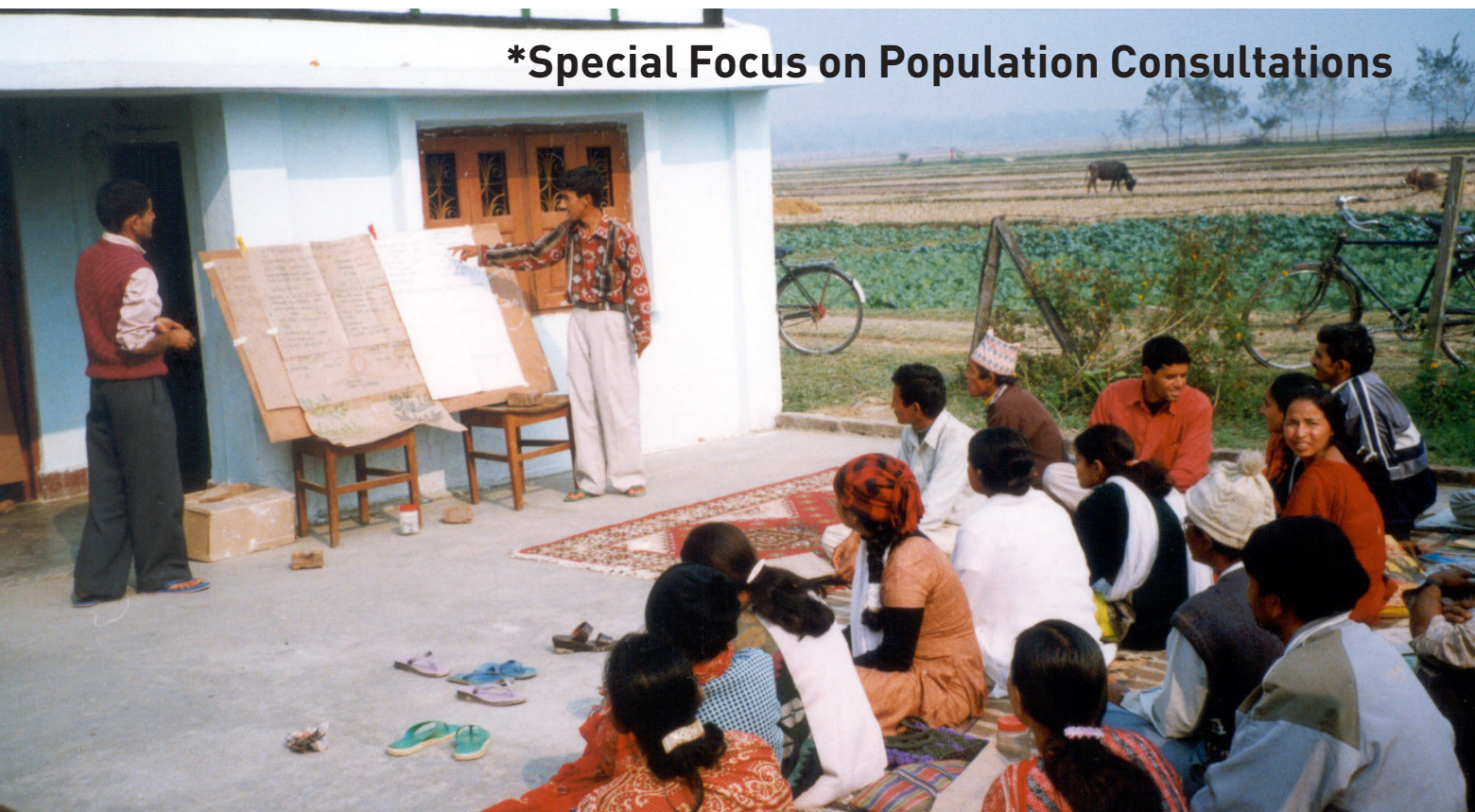
Population Consultations: The Experience in Guinea\*

Population Engagement and Consultation at the Local Level: Thailand Experience\*

Making Public Consultations in Health Work, A Contextual Approach\*

Poverty in Ukraine: Development, Validity and Reliability of a New Measure of Financial Strain for Young Adults

**\*Special Focus on Population Consultations**





**FROM THE EDITORS**

**3**

**PERSPECTIVE**

**5**

**Population Consultation: A Powerful Means to Ensure that Health Strategies are Oriented Towards Universal Health Coverage**

**Katja Rohrer, Dheepa Rajan and Gerard Schmets**

**COMMENTARIES**

**16**

**Citizen Involvement in Tunisia**

**Benoit Mathivet**

**19**

**Population Consultations: The Experience in Guinea**

**Mohammed Lamine Yansané**

**22**

**Population Engagement and Consultation at the Local Level: Thailand Experience**

**Weerasak Putthasri, Nanoot Mathurapote and Orapan Srisookwattana**

**27**

**Making Public Consultations in Health Work, A Contextual Approach**

**Shomikho Raha and Helene Grandvoinet**

**RESEARCH PAPER**



**32**

**Poverty in Ukraine: Development, Validity and Reliability of a New Measure of Financial Strain for Young Adults**

**Iryna Balabukha, Ambika Krishnakumar and Lutcmie Narine**





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**Barbara Marshall**  
E-mail: [bmarshall@longwoods.com](mailto:bmarshall@longwoods.com)

## DESIGN AND PRODUCTION

**Anthony F. Bickenson**  
E-mail: [abickenson@longwoods.com](mailto:abickenson@longwoods.com)

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COVER IMAGE: Agricultural extension meeting  
in Eastern Terai region of Nepal, 2002. Photo by  
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## From the Editors

In this issue of *World Health & Population*, we are pleased to introduce a special focus on population consultation as a means of ensuring that health reforms move towards Universal Health Coverage (UHC). As Rohrer, Rajan and Schmets (2017 p. 6) explain in their introductory paper, “despite ... increasing recognition that the ‘population’ is the key factor of successful health planning and high-quality service delivery,” it has received limited attention or research interest.

Using illustrations from World Health Organization locations internationally, the authors argue that population consultations can be used successfully to assess a population’s needs and expectations – especially in low-resourced jurisdictions:

“Giving the voice to the population is a means to strengthen accountability, to reinforce the commitment of policy makers, decision-makers and influencers (media, political parties, academics, etc.) to the health policy objectives of UHC, and, in the special case of donor-dependent countries, to sensitize donors’ engagement and alignment with national health strategies.”

Next in the issue, we turn to a series of “on-the-ground” perspectives from three jurisdictions that have employed population consultation as a tool for health planning – Tunisia, Guinea and Thailand.

Describing work-to-date in Tunisia, Mathivet (2017) explains that population consultation is being implemented in a multi-phase approach with Phase I

– regional consultation with thousands of participants – beginning in 2013. From that, a common vision for healthcare emerged. However, Phase II – development of health policy options to address each new priority – is proving to be more complicated than expected. One of the biggest challenges is to reach agreement on the actual wording of complex policy options so that the population can review and express their opinions. Another challenge during this process is managing the public’s expectations as well as shifting political climates.

In Guinea, population consultations were used to develop consensus on the current health system, and to develop a new vision and priorities for 2015–2024. As Yansané (2017) identifies, the process successfully uncovered areas of dysfunction as well as challenges and barriers within the existing health system, and opportunities to mitigate them. Another positive outcome from the population consultation was an increased sense of ownership of the health system by all stakeholders.

In Thailand, the 2007 National Health Act laid out guidelines for a participatory public policy process that included: health assembly, health impact assessments and creation of health system statutes (charters). Putthasri, Mathurapote and Srisookwattana (2017) explain that public consultation is required as part of the process of developing the local statute. Since 2009, more than 500 sub-districts or Tambons across Thailand have created their own local health system charter covering areas as diverse as: social determinants of health, risks and diseases, lifestyle, health services and health funding as well as



mental and social health, as they apply in the local context. Public engagement is critical to understanding the local context and creating the local health statute, and ensures accountability on the part of policy makers.

The special focus concludes with a thoughtful commentary from Raha and Grandvoinet (2017), who agree that public consultations are a fundamental part of public health policy design and implementation. However, they caution against the assumption that population consultations are actually inclusive of the whole population, that policy makers will be influenced by the results or that consulting the public will lead to Universal Health Coverage. They suggested that to be successful, public consultations must focus on specifically stipulated objectives, and include a process for ensuring the results are implemented.

The research paper in this issue takes readers to another part of the world – Ukraine. Balabukha, Krishnakumar and Narine (2017) describe work they did

in developing a valid, reliable measure of financial strain among young adults attending post-secondary institutions. The intent was to develop an alternative approach to current objective measure of poverty and economic hardship that does not typically include consideration that many young people are actually living at home with parents where basic needs – housing, food and clothing – are being met. Financial strain has been positively correlated with declining physical and mental health, poor personal relationships and negative outlooks towards the future. The authors demonstrated that their new measure can be used to predict emotional distress and potential violence against romantic partners among college-attending young adults who are experiencing financial hardship.

As always, we look forward to your comments and insights on this collection of ideas and insights.

– The Editors

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# Population Consultation: A Powerful Means to Ensure that Health Strategies are Oriented Towards Universal Health Coverage

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Katja Rohrer, MA  
Independent Consultant  
Berlin, Germany

Dheepa Rajan, MD, PhD  
Technical Officer, Health Systems  
Department of Health Systems Governance and Financing  
World Health Organization  
Geneva, Switzerland

Gerard Schmets, MAE  
Coordinator, Health Systems Governance, Policy, and Aid Effectiveness  
Department of Health Systems Governance and Financing  
World Health Organization  
Geneva, Switzerland



Correspondence may be directed to:  
Dheepa Rajan  
E-mail: [rajand@who.int](mailto:rajand@who.int)



### Abstract

*Background:* We seek to highlight why population consultations need to be promoted more strongly as a powerful means to move health reforms towards Universal Health Coverage (UHC). However, despite this increasing recognition that the “population” is the key factor of successful health planning and high-quality service delivery, there has been very little systematic reflection and only limited (international) attention brought to the idea of specifically consulting the population to improve the quality and soundness of health policies and strategies and to strengthen the national health planning process and implementation. So far, research has done little to assess the significance of population consultations for the health sector and its importance for strategic planning and implementation processes; in addition, there has been insufficient evaluation of population consultations in the health sector or health-related areas.

*Discussion:* We drew on ongoing programmatic work of World Health Organization (WHO) offices worldwide, as most population consultations are not well-documented. In addition, we analyzed any existing documentation available on population consultations in health. We then elaborate on the potential benefits of bringing the population’s voice into national health planning. We briefly mention the key methods used for population consultations, and we put forward recent country examples showing that population consultation is an effective way of assessing the population’s needs and expectations, and should be more widely used in strategizing health. Giving the voice to the population is a means to strengthen accountability, to reinforce the commitment of policy makers, decision-makers and influencers (media, political parties, academics, etc.) to the health policy objectives of UHC, and, in the specific case of donor-dependent countries, to sensitize donors’ engagement and alignment with national health strategies.

*Conclusions:* The consequence of the current low international interest for population consultations probably has the most negative effect on resource-poor countries, as this analytical oversight comes with a high price. However, a population consultation has the potential to give more benefit and added value to contexts where resources are scarce and where planning processes pose a high extra burden, and should thus be promoted among international donor agencies.

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### Background

Governments and institutions worldwide are progressively increasing the involvement of the population in decision-making processes, aiming at strengthening transparency, legitimacy and the quality of health planning decisions (Catt et al. 2003). Giving

voice to citizens in decision-making and policy-making processes (spaces formerly exclusively reserved to appointed or elected representatives) is now seen as a critical element of good governance (Department of Economic and Social Affairs 2008). The last session of the 2015 United Nations General



Assembly adopted the sustainable development goals, promoting “responsive, inclusive, participatory and representative decision-making at all levels” (United Nations Department of Economic and Social Affairs 2015).

Specifically for the health sector, the importance of people’s involvement in defining their needs, expectations and opinions to feed into national planning processes is increasingly being recognized (Cornwall and Shankland 2008). The 1978 Alma Ata declaration on Primary Health Care laid the foundation for this, explicitly highlighting the right of people to participate in health planning and implementation (Declaration of Alma-Ata et al. 1978); this right was further reaffirmed through the World Health Organization (WHO)’s World Health Report 2008, where stronger participation of patients in health policy design processes was emphasized (WHO 2008). Subsequently, the WHO explicitly made the case for “social participation” (WHO 2015a) in connection with the debate around social determinants of health (WHO Commission on Social Determinants of Health 2008). Furthermore, when dealing with health services organization, the international focus has shifted to putting people at the centre, i.e., people-centred health services (WHO 2015b). From a legal perspective, participation and consultation are cross-cutting principles embodied in international human rights treaties and are part of the human rights-based approach to health (Potts 2010; UN 2012).

However, despite this increasing recognition that the “population” is the key factor of successful health planning and high-quality service delivery, there has been very little systematic reflection and only limited (international) debate and attention brought to the idea of specifically consulting the population for improving the quality and soundness of health policies and strategies and for strengthening the national health planning process and implementation. So far,

research has done little to assess the significance of a population consultation for the health sector and its importance for strategic planning and implementation processes, and there has been insufficient evaluation of population consultation in the health sector or health-related areas.

In this paper, we debate and elaborate on *why* population consultation needs to be promoted more strongly by introducing it as a powerful means to move health reforms towards Universal Health Coverage (UHC). We examine the potential *benefits* of bringing the population’s voice into national health planning and briefly elaborate on the key *methods* used. We put forward recent *country examples*, with the aim of enriching the current international debate around participatory and inclusive health planning by making the case that more attention given to population consultation in the health sector can contribute to bringing a country closer to UHC.

## Discussion

### What is a population consultation?

Based on a OECD definition, a population consultation is: “... a two-way flow of information, which may occur at any stage of [the health planning process], from problem identification to evaluation of existing regulation. It may be a one-stage process or ... a continuing dialogue. Consultation is increasingly concerned with the objective of gathering information to facilitate the drafting of higher quality regulation” (Cohen and Arato 1994; Rodrigo and Amo 2006).

The objectives of a population consultation on health-related matters are to capture a population’s demands, opinions and expectations; improve national health strategizing and planning; and increase the health system’s responsiveness (Provincial Health Assembly in Trang Province Thailand 2014). Examples presented in this paper show that a population consultation is a unique feature in the planning process: it provides a

key information source for policy makers; it increases the population's ownership; it strengthens accountability and transparency (OECD 2015); and it reinforces monitoring and evaluation mechanisms (Jadoo et al. 2014). Thus, a population consultation complements a situation analysis, a health needs assessment and/or a health sector review, but it should not be confused with any of those. A population consultation goes beyond facts and figures and incorporates qualitative and non-expert information, such as current opinions and future expectations, on health-related matters.

### **Understanding the political context of a population consultation**

The country examples presented in this paper show that the democratic and social set-up of countries making use of population consultations varies greatly. The interest in a population consultation is thus not necessarily tied to the type of governance or the source of legitimacy of the government. With this in mind, we highlight that the term “population” is not to be confounded with “civil society,” which is directly linked to the types and qualities of democratic social interactions (Cohen and Arato 1994; Rodrigo and Amo 2006).

That being said, even though democracy is not a direct prerequisite for population consultations, in reality, democratic countries tend to better enable successful population consultations by inherently placing greater value on the factors which provide a fertile ground for them, such as the following:

- an interest in continuous dialogue between the government, decision-makers, other stakeholders' representatives and the population;
- accountability and transparency;
- population ownership;
- involvement of a multiplicity of stakeholders in policy making; and

- independent media coverage informing and questioning the issues and the outcome of the consultation.

### **Population consultation is a crucial tool on the path towards UHC**

An increasing number of countries have adopted UHC as a national health sector goal (WHO 2017). However, the suggested UHC reforms usually face the huge challenge of attempting to reconcile scarce resources with the need to provide a comprehensive package of high-quality health services to the whole population. More effective health planning is thus critical, given such limited resources, to ensure that UHC is the ‘final destination’ of the health sector (Kutzin 2013). We expand in more detail below on how a consultation of the population can support UHC-oriented health planning.

One of the key features of a UHC-oriented health system is the ability to ensure good health for marginalized and vulnerable communities (Brearly et al. 2013). A population consultation is an extremely powerful means to increasing the ability of a country to assess and respond to inequities in access to healthcare as described with country examples below.

Even though health financing reforms are definitely critical to UHC, the “other” side of the UHC coin, often ignored due to its complexity, is health service delivery reforms. We argue with concrete examples that a population consultation can improve health services and service provision methods, which better enable a country to march forward towards UHC.

A population consultation can thus help policy- and decision-makers in the following different ways:

1. Increasing the effectiveness of national health planning, given limited resources, by:
  - *Capturing needs, demands and expectations:* Governments and ministries of health usually have high technical expertise and information and evidence on normative needs.

They may, however, have limited knowledge of the expectations and demand of the population they serve. A population consultation allows for a much more comprehensive situation assessment that reflects also the demand for services and, consequently, better health planning, which is closer to people's expectations.

In Guinea, for example, the "*Etats Généraux de la Santé*" (EGS) (2014) (pre-Ebola), provided timely and necessary complementary information to the technical analysis of the health system by thematic groups, coordinated by the MoH. The EGS in Guinea brought together approximately 250 participants coming from all sections of society. The EGS did not intend to duplicate or "validate" the technical analysis, but to go beyond and complement it by bringing in other points of view and a more system-wide perspective. The EGS enabled a wide range of external stakeholders to contribute to the debate in a political and personal way, rather than in a technical way. In addition, the EGS provided a forum whereby the population could express their expectations of the health sector and produce useful recommendations to be included in the National Health Development Plan.

- *Going beyond the health sector:* Many health sector challenges might not lie uniquely within the sphere of the health sector. A well-organized consultation provides a more holistic view of the social and economic burden the population is facing, thus encouraging the MoH to build bridges to other sectors – thereby improving the effectiveness and quality of health planning.

The recently published report "Nothing about us without us: Citizens' voices for women's, children's and adolescent's health" on 19 countries' citizens' hearings recounted how citizens called for more comprehensive linkages between health and other sectors such as education, nutrition, water and sanitation (WASH), and agriculture (White Ribbon Alliance Uganda 2015).

- *Strengthening planning capacity:* In countries with strong resource limitations, health planning capacities tend to be weak; in this case, a consultation improves the planning process and potentially makes the outcome of a situation assessment sounder.

In Haiti, for example, a consultative workshop (which was also termed an "*états généraux de la santé*" – EGS) was undertaken in 2012 to prepare for a new overarching National Health Plan post-earthquake, which would serve as a reference document for the health sector (Rapport des Etats Généraux de la Santé 2012). The EGS was preceded by intense organized debate and deliberation within the 10 administrative (geographic) departments of the country. These departmental discussions were more technical in nature and were conducted mainly by external health and/or policy experts, acknowledging that MoH only may not have all the solutions to the nation's health problems. Suggestions and proposals from the EGS helped steer the development of a new National Health Policy and a National Strategic Health Plan 2012–2022.

- *Enlarging the information base for decision-making:* Direct responses from the population on the current health situation or on proposed decisions and reforms expand the information base for health policy making, thereby strengthening the ability of policy makers to make informed decisions, and consequently, use available resources more effectively.

The 1999 "*états généraux de la santé*" in France allowed policy makers to focus on new and emerging issues, such as a patient's right to health and youth health, which may not have gotten the same level of attention otherwise (Brücker and Caniard 1999).

- *Improving monitoring and evaluation:* A population consultation provides essential information on the population's opinions and expectations, which strengthen the monitoring and evaluation processes by directly linking policy decisions to the assessment of health system performance for the population.

For example, Turkey's health sector reform ("*Health Transformation Programme*" – HTP) was assessed in 2013 via a survey of almost 500 households spread across seven regions (Jadoo et al. 2014). Respondents were questioned on their views regarding the Turkish health system before and after the HTP reform. Over 75% of the respondents preferred the current health system and were more satisfied with health services now compared to that previously. The Turkish Statistics Institute's (TURKSTAT) Life Satisfaction Survey reported 39.5% overall population satisfaction with health services in 2003, just before the launch of the HTP. In 2010, that number had dramatically increased to 73% (Turkish Statistics Institution Data base 2013). Both surveys helped lend legitimacy to the HTP and gave backing to continue with the reform.

- *Improving accountability:* Accountability and transparency can be increased through the direct interaction and elevation of the population as a participating stakeholder.

In Tunisia, the “dialogue societal” has pushed the government to take into account the results of the population consultation in their high-level National Health Conference in 2014, independent of government and regime changes (WHO Tunisia Country Office 2017).

2. To increase the ability to assess and respond to inequities in access to healthcare by:
  - *Ensuring inclusiveness:* A population consultation is an instrument that addresses the full social and political spectrum of a country. This opportunity of including the voice of marginalized population groups will have benefits for equitable health planning.

In the dialogue societal programme in Tunisia, vulnerable and marginalized population groups were targeted for focus group discussions, as they did not turn up in large numbers during the regional “Citizens’ Meetings on Health.” This enabled a heightened awareness and improved buy-in from these groups for the process of health sector reform currently on-going (WHO Tunisia Country Office). The following population groups were targeted:

- patients living in remote areas;
- patients living in poor urban zones;
- single mothers;
- families living in impoverished regions;
- isolated senior citizens; and
- families living in polluted industrial areas.

- *Highlighting sub-national or social differences and the need for tailored and diversified approaches:* A consultation enables decision-makers to better tailor policies and reforms to the needs of different sub-sections of the population and thereby improve equity among different parts of the population.

In Thailand, National Health Assembly (NHA) resolutions helped raise the visibility of equity-related issues. For example, NHA resolutions have covered the following equity-focused topics: stateless people’s access to basic public healthcare; disabled people’s fair access to health services; well-being of informal workers; occupational health and safety of workers in industrial and service sectors; and southern regional development initiatives that may be unresponsive to the eco-culture and people’s need (NHA Resolutions available at <http://en.nationalhealth.or.th/>). The National Health Commission acknowledges that it is too soon to measure the achievement of NHA in improving equity; however, actions such as a Cabinet resolution in 2010 announcing that basic public healthcare, including health promotion, treatment, rehabilitation and prevention, will cover stateless people and demonstrate that the inequity problems that were raised at the NHA are being addressed. In addition, the National Disabled Commission was created in 2012 in line with the NHA 2010 resolution on the disabled. The NHA thus plays a crucial role in bringing issues of inequity to the attention of the public and decision-makers, to better tailor policies and reforms to disadvantaged and marginalized sub-sections of the population (National Health Commission Office of Thailand 2017; Department of Foreign Affairs and Trade 2013).

- *Empowering the population in making their voice heard:* A well-organized population consultation, with methods and tools adapted to the needs and living conditions of all sections of society, can enable the consulted population to feel more comfortable in voicing their needs and expectations more confidently and freely.

Community consultations undertaken in eight Victorian local governments (Australia) in 2008 aimed at capturing the needs and views of their citizens to be included in local policy making. The consultations tried specifically to address marginalized population groups to achieve more inclusive and representative consultation results, in addition to the general public, which is easily accessible through mainstream media and usually considered as active citizens. Results showed that consulting marginalized population groups and tailoring consultation methods to their specific needs and circumstances increased the likelihood of their participation and increased the inclusiveness of the consultations (Brackertz and Meredyth 2008).

- *Identifying specific needs of marginalized groups:* The consultation process could be a first step in improving the sustainable involvement of marginalized and hard-to-reach population groups in policy making processes. It

enables policy makers to design specific tailored policies better accepted by the full population and potentially improve the equity orientation of health systems performance.

The NHAs in Thailand mentioned above, for example, have succeeded in involving those who are often marginalized in policy making, with subsequent improved buy-in by these very groups (Rasanathan et al. 2012).

### 3. To improve services and service provision methods by:

- *Gauging the quality of services as perceived by the population:* A population consultation can give deep insights into the perceived quality and acceptance of the services provided.

In 2012, the European Commission (EC) set up an independent and multidisciplinary "Expert Panel on Effective Ways of Investing in Health" (EXPH) to advise the EC on health system issues. Many of the EXPH expert opinions are deemed "preliminary" in nature, as they are then subject to public consultations before becoming "final." The EXPH started its work in July 2013 and has since provided the EC with their expert opinion on a variety of topics. In 2015, the EXPH launched a public consultation on their preliminary expert opinion on "Access to health services in the European Union." European Union citizens and stakeholders were requested to submit their comments, suggestions, views and contributions regarding specific aspects of the EXPH report.

Following this public consultation, a final opinion is to be prepared by the EXPH. All comments and suggestion received through the consultation are made publicly accessible. The EXPH will comment on each submission and provide feedback and information if the submission was taken into consideration. If a submission was not taken into consideration, the EXPH will elaborate on the rationale. This process shows the careful handling of public opinion on access to health services and is exemplary in the way insights from the public on health services can be used to advise decision-making institutions like the EC (Directorate General for Health and Food Safety 2016).

- *Guiding policy makers in designing strategies to improve health service delivery:* Policy makers can obtain a more comprehensive picture of service quality by looking at quantitative and qualitative data. Epidemiological data, when complemented by qualitative parameters

elicited from a population consultation, can help better comprehend the links between service quality and health status, with more leads for service improvement strategies.

In Uganda, a citizen petition led to a parliamentary health committee visit to the concerned district with the aim of listening more closely to citizen concerns on healthcare. The citizen feedback prompted the parliamentary health committee to actually visit the district health facilities, to see for themselves the state of the local health system. What they saw corroborated with the citizens' assessment on healthcare quality and has led to tailored measures, which have significantly improved health service delivery in the district (White Ribbon Alliance Uganda 2015).

## Overview of methodologies and approaches

Each methodological approach to a population consultation requires country-specific preparation that may involve evidence- and information-gathering, targeted dialogue with special population groups or a variety of other activities. The most common approaches to a population consultation include the following:

### 1. Face-to-face dialogue with large population sample(s)

The essence of this approach is a large-scale, organized series of public debates. Its main characteristic is that it captures the population's opinions and expectations through structured face-to-face debates between the organizers and the population and among citizens themselves. Its purpose is to inform the priority-setting process and/or the decision-making process. Its strength comes from the level of evidence-based technical preparation of the topics to be discussed: from a simple, short and easy-to-understand way of presenting the topics to an excellent structuring of the debates so as to lead to a clear formulation of opinions and expectations.

### 2. Consultative methods with invited participants from different population groups

The two predominant types of consultative methods are the consultative meeting and the focus group.

- *Consultative meetings* bring together stakeholders who are informed about, have a view on and/or are experienced in a particular area, for the purpose of voicing their opinions and assessments for a particular objective. These meetings are smaller in number than the larger face-to-face consultations mentioned above. Usually, the participants are carefully selected from different population groups to ensure adequate representativity – for example, professional associations, patient groups, district health authorities and others are typical participants of these types of gatherings. Technical experts from government, development partners and civil society are usually present as well and may provide specific technical inputs on an issue.
- *Focus group interviews* are usually done with small, relatively *homogeneous* groups (6–12) of people with similar backgrounds and experience. The homogeneity and the much smaller size of the groups are the main differences from consultative workshops. The group interviews provide a platform to discuss a specific topic freely and interactively, with the help of a moderator. The moderator uses general guidelines and protocol such as introducing the subject, keeping the discussion flowing while using subtle probing techniques and preventing a few participants from dominating the discussions. Focus group discussions allow a more in-depth exploration of stakeholder opinions, similar or divergent points of view and judgments, as well as information on behaviours, understanding and perceptions of an initiative. They are also extremely useful for gathering information on tangible and intangible changes resulting from an initiative.

3. Survey types and survey tools with invited/selected population groups and one-on-one individual survey types and tools  
Like the face-to-face dialogue with large population samples and consultative workshops, the purpose of a survey is to capture the opinion of the population and its expectations. However, the methodology is different and leads to different results: in surveys, debates do not take place; randomly selected citizens answer questionnaires prepared by technical experts and statisticians, or answer interviews guided by professional interviewers. A multiplicity of methods exists to survey the population, with specific advantages and challenges. As these methods are extensively documented elsewhere, this paper will refrain from entering into those details (Table 1; available at: <http://www.longwoods.com/content/25157>).

## Conclusion

### Bridging the knowledge gap: Where should research focus?

Despite the growing call for more population involvement in planning, the actual use of a consultation and its benefits for sustainable health planning needs to be further analyzed and evaluated. It is of note that much of the information we were able to access on the population consultation mentioned in this paper was via people directly involved with the process. The following documentation and academic analyses would greatly assist countries to bridge the knowledge gap:

- A sound collection of lessons learned in various contexts to feed national planning and nurture international discussions.
- An in-depth analysis on the benefits and potentials of a population consultation for strategizing in the health sector.
- An analytical framework aimed at generating generalizable conclusions,



based on a good documentation and analysis of experiences.

- Increased analytical engagement in research related to priority setting and evaluation methods that explicitly include interaction with the population.

The consequence of the current low international interest for population consultations has probably the most negative effect on resource-poor countries, as this analytical oversight comes with a high price. A population consultation has the potential to give more benefit and added value to contexts where resources are scarce and where planning processes pose a high extra burden, and should thus be promoted among international donor agencies.

#### **How can stakeholders give population consultation a more prominent and sustainable role in health policy making?**

This paper has shown that a population consultation is a means to support reforms oriented towards UHC by increasing the effectiveness of national health planning, given limited resources; by increasing the ability of a country to assess and respond to inequities in access to healthcare; and by highlighting ways to improve health services quality, coverage and access. The health ministries and their national and international partners, including academics, should follow up on this and take a closer look at the use of population consultations for national health planning.

National engagement from health ministries is needed

Ministries of Health should be courageous enough to undertake population consultations on a regular basis and, if necessary, seek international support or capacity-building. Initiatives from sub-national level or from non-governmental organizations to bring a population consultation onto the

table should be taken seriously by the central government.

It must be acknowledged that a population consultation does come with costs. First and foremost, domestic resources must be mobilized or earmarked for this sort of exercise. In low-income countries with high donor engagement, the international community and donors must be called upon to include population consultation in their funding areas. Donor countries and agencies that are supporting the planning process should put a strong emphasis on the benefits of population consultation processes.

Increased international support is needed. Support for a population consultation from international actors is essential. Even though donor policies are less politically driven than those during the 1980s and 1990s, there is still a tendency to decide on funding priorities outside the country context. Global Health Initiatives, often influencing countries' priorities through funding prospects (World Health Organization 2014), would do well in supporting population consultation.

A special role for international institutions, especially WHO, would be to include the topic of population consultation stronger in debates, workshops and capacity-building mechanisms around health planning and governance and promulgate its proliferation.

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#### **Author's contributions**

K.R. and D.R. conceptualized and wrote the manuscript. G.S. provided critical input of the manuscript's intellectual content. All authors approved the final version of the manuscript.

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Tribute to Dr. Heather K. Spence Laschinger	13
Engaging Nursing Voice and Presence During the Federal Election Campaign 2015	19
Implementing a Just Culture: Perceptions of Nurse Managers of Required Knowledge, Skills and Attitudes	35
Optimizing Registered Nurse Roles in the Delivery of Cancer Survivorship Care within Primary Care Settings	46
Organizational Commitment and Nurses Characteristics as Predictors of Job Involvement	59

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# Citizen Involvement in Tunisia

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Benoit Mathivet, MSc  
Health Policy Adviser  
World Health Organization  
Tunis, Tunisia



Correspondence may be directed to:  
Benoit Mathivet, World Health Organization, Rue du Développement  
Cité El Kadhra, Tunis, Tunisia  
E-mail: mathivetb@who.int



## Abstract

Tunisia embarked on a process of population consultation in 2013, the first phase of which is often presented as an example, including in the paper in this issue by Rohrer, Rajan and Schmets (2017). The present commentary aims to provide an update on the development and challenges encountered in recent years and also explore their causes and possible ways to move ahead.

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Tunisia embarked on a process of population consultation in 2013 – the “*dialogue societal en santé*” – with the explicit goal to promote the involvement of citizens as a key instrument for the development of the national health policy.

This was foreseen, from the start, as a long-term cycle, consisting of three complementary phases (which could later on be repeated), all expected to rely on a high level of citizens’ participation:

- the first phase is dedicated to the establishment of a common vision

and key priorities for health policy based on a mutually agreed upon analysis of the current situation;

- the second phase is dedicated to the operationalization based on the participatory, consensual selection of the best options to move ahead with the reforms; and
- the third phase consists of monitoring and reporting of achievements and challenges in the implementation and in the consensual determination of corrective measures.

The first phase started in 2013 and relied on the intense regional consultation of thousands of citizens and health professionals to considerably enrich the situation analysis, which would have otherwise, as often, solely consisted of experts' work on existing literature and official data. Even better, each regional assembly elected its representatives, responsible for collectively validating the situation analysis and establishing a common vision and key priorities, to be then compiled as the premises of a strategic vision for the long-term development of the health sector. This process culminated in September 2014, with a time of high-level political appropriation, during a National Conference, which presented the White Book for better health in Tunisia – the “*Livre Blanc*” and endorsed a declaration on the “Realization of the right to health in Tunisia.”

Phase I was rich, innovative and rightfully promoted as an example of what could be done to better involve citizens in health policy. But where did it go from that point?

Since 2014, the launch of the second phase suffered numerous delays, reasons for which can be found in not only the specific Tunisian political context but also in the inherent nature of phase II.

Starting with the latter, phase II, dedicated to the selection of options of health policy for each of the priorities identified in phase I, is immensely more technical than phase I. To lead to a properly informed, collective and consensual selection of options, time is required first to formulate these options, and then to word them concretely enough – they are often very complex – so that everyone can express their opinion. The timing and nature of population consultation is therefore very different. In phase I, the situation analysis involved everyone massively from the start. In phase II, facilitators of the process have to manage citizens' expectations (high since phase I), keep them informed of the progress of the technical work on options being developed, identify

everyone's skills to be able to involve them at crucial times, etc. Determining this *modus operandi* certainly took time in Tunisia, and it is actually still in the process, as the main objective is to go on with a genuinely sincere citizens' participation.

The political situation, characterized with frequent changes in the composition of the government and of the ministerial teams, including at the ministry of health, also played a role. In periods of profound political and socio-economic changes such as the one currently experienced in Tunisia, those in charge are often asked to deliver drastic improvements in a short period of time, and social services including health, often crystalize the dissatisfaction of the population, practitioners and the government alike. In such times, citizens' participation may be (wrongly) perceived as a threat, providing a stage for political destabilization and generating even more delays, and the temptation is high for a government, of course, to take into account existing priorities, but to move ahead in the determination of a way forward without further consultation.

### **What To Do To Move Ahead Then?**

First and foremost, advocacy work is currently conducted to convince the decision-makers that the time initially dedicated to dialogue is never wasted and that it may actually later spare a lot of the headache of a conflict emerging during implementation. In fact, dialogue may even speed things up during the development of reforms by creating an appeased atmosphere. This is a lesson of phase I: regional meetings gathered people who were initially conflicting with each other and they reached consensus in record time. First, progresses are currently happening in this direction in Tunisia, with the forthcoming approval of a roadmap for phase II of the “*Dialogue societal*.”

Secondly, and however pleasant it is to be perceived as an example, it is certainly time for

Tunisia to look around at other international experiences in terms of citizen participation and the article by Rohrer, Rajan and Schmets (2017). is certainly inspirational. The case of National Health Assemblies in Thailand brings, for instance, a lot of good ideas on how to address the challenges just described.

To conclude, population consultation is still alive and kicking in Tunisia, benefiting from a renewed political interest and looking for innovative ideas to move ahead.

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# Population Consultations: The Experience in Guinea

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Mohammed Lamine Yansané  
Senior Advisor  
Ministry of Health  
Guinea



Correspondence may be directed to:  
Mohammed Lamine Yansané  
E-mail: [yansanelamine@yahoo.fr](mailto:yansanelamine@yahoo.fr)



## Abstract

Dr. Yansané is the senior policy advisor to the Minister of Health in Guinea and the former Head of the Minister's Office and former Secretary General, Health. He has been instrumental in advocating for and co-organizing the *États Généraux de la Santé* in Guinea in 2014. His perspective is clearly one of a policy and decision-maker who has a particular interest in bringing population views, needs and expertise into the policy-making process in the hope that it will lead to improved buy-in of the policy and better implementation. Dr. Yansané was requested to provide input on the utility value of population consultations in his country and the added value from his perspective of more international debate on deliberative democracy in the health sector.

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## 1. Tell us How the National Health Consultations in Guinea have Particularly Benefited the National Health Planning Process

The National Health Development Plan (PNDS)'s term was coming to an end at the time so the Ministry of Health (MoH) and

all the technical and financial partners embarked on a review of the National Health Policy in view of drafting a new PNDS covering the period 2015–2024, using the health policy dialogue approach.

In this context, the authorities decided to organize the National Health Consultations.

The National Health Consultations were not meant to be technical but rather popular and participatory with broad consultation of the population. They were based on the following two major principles: ensuring consensus and ownership of the sectoral vision and future sectoral policy and identifying the absolute priorities for the new PNDS in a systemic vision.

The National Health Consultations were held from Monday 23 to Thursday 26 June 2014 at the Novotel Conakry.

The purpose of organizing the National Health Consultations was to arrive at a shared diagnosis of the health system in Guinea and reach a consensus or achieve an appropriation by the stakeholders of the new health policy vision and the actionable priorities of the National Health Development Plan for the period 2015–2024.

The National Health Consultations were attended by approximately 300 participants from all walks of life, including representatives of associations of health system beneficiaries, mayors of urban and rural communes, national institutions, government, former ministers and general secretaries of health, trade unions, the MoH and other ministries, technical and financial partners, health centre management committees, non-governmental organizations, societies and associations of health professionals and beneficiaries of the health service.

The method of work of the National Health Consultations consisted in the preparation of basic documents, which were developed at a series of workshops attended by officials from the MoH and other ministerial departments and development partners.

The actual work of the National Health Consultations consisted in the organization of (1) plenary sessions: presentations by national and international experts followed by discussions and clarifications; (2) group work covering three themes, namely, health status, healthcare provision and technology and health resources; (3) daily evaluation

meetings of the organizers, moderators, chairpersons and rapporteurs of the different working committees; (4) communication activities to gather opinions of users and communities before and during the National Health Consultations through spots, reports, interactive programmes, provision of a toll-free number and a front-line SMS system.

The results of the reflections and analysis of each working group were referred back to the plenary. The debates and consensus on the main issues and the outcome of the pooling of grassroots opinions served as a basis for adding detail and emphasis to the analysis of the sectoral situation and for priority-setting. The findings and recommendations of the National Health Consultations served as a basis for drawing up the new health policy and preparing the Health Development Plan for the next 10 years.

In conclusion, the National Health Consultations provided a salutary opportunity to identify the dysfunctions, challenges and obstacles faced by the Guinean health system and to identify opportunities to mitigate these as much as possible. The focus of this important forum enabled all the participants to reach consensus on a vision and necessary recommendations for the development of a national health policy and a national plan for health development.

The presence of the Head of State, His Excellency the President of the Republic, at the opening ceremony, and that of the Head of the Government, the Prime Minister, at the closing ceremony, is eloquent testimony to the government's commitment to organizing this event.

## **2. Why do you Think it is Important and Necessary to have more evidence regarding Consultations with the Population on the Health Sector, at the International Level?**

Comparing the process of developing the current PNDS with the previous one, we can see that the public has been consulted

through a political dialogue on the whole process, from the evaluation of the current PNDS to the setting of priorities. As a result, ownership of the measures to be implemented can be fostered through better use of services and proactive participation in implementation.

Consulting the population through the National Health Consultations has enabled all social stakeholders to highlight health issues. As a result, it has been possible to understand the reasons for the poor performance of the system, many of which lie outside the control of the MoH. To provide solutions, an integrated approach was favoured. Some benefits of this consultation included the following:

- An increase in the proportion of the national budget spent on health from 2.5% in 2014 to 8.4% in 2017.
- The recruitment of almost 4,000 new health workers to plug the enormous human resources gap noted during the consultations.
- Establishment of multi-sectoral consultation bodies at all levels of the health system, namely, the Health Sector Coordinating Committee, the Regional Health Sector Coordination Committee, the Prefecture Health Sector Coordination Committee and the Prefecture Committee for the Coordination of the Health Sector. These bodies are responsible, *inter alia*, for validating and evaluating annual work plans.

### **3. Specifically, how Would More Factual Data Regarding Consultations with the Population at the International Level be Beneficial to Guinea?**

Guinea has begun a process of policy dialogue to develop strategic documents through consultation with the population at all stages of the development of the PNDS. It

is useful to have more evidence from other experiences to help better implement and monitor the new plan so that the role of the population is not limited to priority-setting.

The public consultation process should continue through a better functioning of the coordination and consultation bodies that have been set up, to ensure public accountability on the progress made and to flag any obstacles to the implementation of the PNDS.

Today, there are major challenges in moving towards universal health coverage in terms of availability of and access to health services in Guinea, despite the ongoing reforms. Some countries that have initiated a public consultation process have developed new strategies to identify solutions to these problems. We believe that by drawing inspiration from some of these experiences and from the dynamics created through the National Health Consultations in Guinea, the country can move quickly towards universal health coverage.

Popular participation should be pursued within the framework of the decentralization of health management through effective participation of communes, especially in managing basic human resources and overseeing the management of other resources.

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# Population Engagement and Consultation at the Local Level: Thailand Experience

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Weerasak Putthasri, DDS, DSc  
Deputy Secretary General  
National Health Commission Office  
Nonthaburi, Thailand

Nanoot Mathurapote, MA  
Head of Global Collaboration Unit  
National Health Commission Office  
Nonthaburi, Thailand

Orapan Srisookwattana, BSc, MA  
Deputy Secretary General  
National Health Commission Office  
Nonthaburi, Thailand



Correspondence may be directed to:  
Nanoot Mathurapote, National Health Commission Office, Nonthaburi, Thailand  
E-mail: [nanoot@nationalhealth.or.th](mailto:nanoot@nationalhealth.or.th); tel.: +66-2-832-1924.



## Abstract

The World Health Organization handbook on Strategizing National Health in the 21<sup>st</sup> Century has emphasized the importance of the process of population consultation on needs and expectations. According to Thailand National Health Act 2007, three innovative social tools for participatory healthy public policy process were proposed, i.e., health assembly, health impact assessment and health system statute (charter). In practice, population consultation process is required in the process of the tools

implementation. Therefore, this paper aims to illustrate how local health statute implementation supports population participation and consultation at the local level.

The first local health statute owned by Cha-lae sub-district in Songkla Province had been introduced in 2009. So far, there are above 500 sub-districts or “Tambon” having their own health system statutes. Tambon Administrative Organization (TAO), health and non-health sectors, community leaders and civil society seemed to be key actors or a mechanism for the local health statute. This demonstrated three crucial elements or sectors for policy development, i.e., policy maker, evidence support and society. Contents of the local health statute are wide ranged, including social determinants, risks and diseases, life style, health services, health fund, to mental and social health in regard to the local problem and context. Therefore, it needs the process of discussion and consultation to seek their common interest and expectation.

Local health statute in Thailand is an example of engagement and consultation of the population for health policy. This confirmed the process of population consultation on their needs and expectation that can be implemented both at national and local levels. This is also the strategy to improve the accountability of policy makers for health impacts at all levels of policy making. The challenges of local health statute include the mechanism to maintain and ensure the engagement and ownership for sustainable implementation. Lastly, the local government’s continued commitment toward providing funding support through the implementation process and the self-assessment framework of implementation is needed.

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The World Health Organization handbook on Strategizing National Health in the 21<sup>st</sup> Century emphasized the importance of population consultation on needs and expectations (Rohrer and Rajan 2016). Methods and approaches are documented and recommended taking the national context into account. Although the legal status of any country, territory or city or the area of its authority are considered, the case study of its implementation at the local level is limited.

According to Thailand National Health Act 2007 (National Health Commission Office 2007), three innovative social tools for participatory public policy process were proposed, i.e., health assembly, health impact assessment (HIA) and health system statute (charter). Obviously, the National Health Assembly (NHA) is both a platform and a process to seek participation of government

sector, academia and people sector in the policy process from agenda setting, resolution drafting, stakeholder and public consultation, resolution adoption and implementation to monitoring and evaluation. In practice, population consultation is also required in the process of health impact assessment and national health system statute.

There are many sub-districts or “Tambon” that have their own health system statutes. The preamble part of the first National Health System Statute 2009 (National Health Commission Office 2009) mentions that the local partner networks can prepare their own statutes on a health system for their locality, provided that such statutes are not in conflict or incongruent with the Statute on National Health System. Therefore, this circumstance would be an example of how a mechanism is implemented at the local level for population participation and consultation.

### Local Health System Statute

Tambon (sub-district) is a local administrative unit in Thailand, smaller than district and province respectively. It is the third level of the administrative division. Each Tambon consists of 8–10 villages, with the local government unit named Tambon administrative organization (TAO). The TAO council comprises two representatives from each village of the Tambon and one a directly elected president. In 2016, ~500 (out of 7,000) Tambons voluntarily declared their own health statutes.

The first local health statute was introduced in Tambon Cha-lae, province of Songkhla, in 2009. The TAO, health and non-health sectors (e.g., teacher, social developer), community leaders and civil society seemed to be key actors or mechanisms for local health statute. This showed three crucial elements or sectors for policy development, i.e., policy maker,

evidence support and society. In Thailand, religion and belief are also accounted for as determinants of health. Therefore, religious leaders, especially Buddhist monks are sometimes involved in drafting health statute and implementation direction (Tambon Mae-thod, province of Lampang). To ensure its effective movement and sustainability, some health statutes can be integrated into the local strategic plan and budget (Tambon Dongmunlek, province of Petchaboon). The contents of the local health statute are wide ranged, including social determinants (economy, forest, natural resources), risks and diseases (food, tobacco, consumer protection, safe sex, non-communicable diseases), life style (observe the Buddhism precepts, alcohol-free, gambling-free, non-violence in local festival and ceremony), health services, health fund, mental and social health (Table 1).

**Table 1. Example of local health statute: Key actors, characteristics and content**

Year	Tambon, province	Key actor	Characteristics of statute	Content/area interest
2009	Cha-lae, Songkhla	TAO and civil society	<ul style="list-style-type: none"> <li>• First Thailand local health statute</li> <li>• Informal, focusing on coordination</li> <li>• TAO council involved in health statute committee</li> </ul>	Sufficient economy, food safety, safe sex, non-communicable diseases, participatory local fund
2009	Sung-men (District), Phrae	District Health Office	<ul style="list-style-type: none"> <li>• First district-level health statute</li> <li>• Health sector from district hospital, district health office, and all of the Tambon health promotion hospitals actively involved</li> <li>• MOU signing with a district office</li> </ul>	Local health centre, community broadcasting, traditional health care, consumer protection, food safety, participatory health fund
2010	Mae-thod, Lampang	TAO and civil society	<ul style="list-style-type: none"> <li>• Buddhist belief adhered to local health aspect</li> <li>• A monk is chair of committee</li> <li>• Concept of health impact assessment concept is integrated</li> </ul>	Forest and natural conservation, environment, land and mining
2010	Dongmunlek, Petchaboon	TAO	<ul style="list-style-type: none"> <li>• Extensive research on population opinion</li> <li>• Using Tambon strategic plan and budget to implement health statute</li> </ul>	Traditional medicines, participatory healthcare, fund for health welfare, local fund
2011	Rimping, Lampoon	TAO	<ul style="list-style-type: none"> <li>• Integrated concept of HiAP</li> <li>• Organized formal forum for consultation</li> </ul>	HiAP, women's health, breastfeeding, food safety, tobacco
2011	Preu, Amnatcharoen	TAO	<ul style="list-style-type: none"> <li>• Local scholars (knowledgeable person) as initiators and key actors for movement and implementation</li> </ul>	Healthy local festival (alcohol-free event), integrated volunteer and traditional health care, consumer protection, food safety, healthy workplace and home, mental health

HiAP = Health in All Policies; MOU = memorandum of understanding; TAO = Tambon Administrative Organization.



From local experience, there are five steps or processes for developing local health statute. The critical first step is searching for local leaders or change agents to facilitate and organize the consultation process. Tambon establishes the local committee which is to take care of this role. Second, they then retrieve and analyze local health problems and related information including processes of sharing concerns and learning among all stakeholders. Third, change agents or local committees organize face-to-face public deliberative platforms for seeking the opinion of the population. Fourth, local committees' drafting visions, directions and interventions for consultative discussion are documented. At this stage, organizing a local health assembly is an option. Finally, all stakeholders meet and seek a consensus and a common ground for actions. Normally, monitoring plans and updating those statutes are also mentioned. All five steps explained above include considering and undertaking a population consultation.

Consultation for a local health statute is a key success for their engagement. The health statute indicates sharing information or concerns and drawing collective vision of their local health. All activities will be aligned towards health-desirable visions. The process of extensive consultation is crucial for actively seeking the opinions of interest groups, stakeholders and local people. For pooling or consolidating all local resources, e.g., human resources, funding is usually discussed for effective implementation. Importantly, this local public policy using participatory approach and process also promotes the spirit of democracy at the local level.

### Discussion

The local health statute in Thailand is an example of engagement and consultation of the population for health policy. This confirmed that the process of population

consultation regarding their needs and expectations can be implemented both at national and local levels. Methods in health statute engagement used both face-to-face dialogue and invited multisectoral stakeholders for a series of consultation meetings. Evidence and information were retrieved from health facilities and academic institutions and by conducting an opinion survey at the local level. This approach can capture wide-ranging contents to promote the Sustainable Development Goals (SDGs) and Universal Health Coverage (UHC).

Local- and national-level engagement is accountable towards population needs, concerns and expectations. However, the citizen dialogue at the local level can beneficially address the challenges to ensure representativity and resource-intensive need of national-level consultation. Such direct involvement leads later to ownership and active engagement of that plan implementation. The methodological design used in local consultation can also be tailored towards the specific characteristics of population and context. There are key success factors from the Thailand experience including 1) having role models and change agents; 2) exposure to a clear learning process; 3) having a wide consultation platform and a scaling-up plan; 4) using effective communication and social media; and 5) providing a clear written plan and steps of implementation.

Furthermore, this participatory local policy formulation and implementation supports the concept of Health in All Policies (HiAP), "approach to public policies across sectors that systematically takes into account of the health and health systems implications of decisions, seeks synergies and avoids harmful health impacts, in order to improve population health and health equity" (Leppo et al. 2013). An HiAP approach in local health statute here emphasizes the concerns and consequences of public policies of all health determinants. In this case study, supporting

contexts are governance structures at the local level and conducting intersectoral communication and implementation. This is also the strategy for improving the accountability of policy makers for health impacts at all levels of policy making.

The population consultation obviously included raising social awareness for its own policy. The Tambon health statute could be a social innovative tool for sustainable development. This concept is possibly adopted by other counties. Challenges of the local health statute include mechanism to maintain and ensure engagement and ownership for sustainable implementation. Lastly, is the need for the local government's continued commitment to provide funding support through the implementation process and the self-assessment framework of implementation.

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*Edited by Dr. Jennifer Zelmer, University of Victoria*

# Making Public Consultations in Health Work, A Contextual Approach

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Shomikho Raha  
Senior Public Sector Specialist  
World Bank\*  
Washington, DC

Helene Grandvoinet  
Lead Governance Specialist  
World Bank\*  
Washington, DC



Correspondence may be directed to:  
Helene Grandvoinet; E-mail: [hgrandvoinet@worldbank.org](mailto:hgrandvoinet@worldbank.org)  
Shomikho Raha; E-mail: [sraha@worldbank.org](mailto:sraha@worldbank.org)



## Abstract

Public health consultations are a fundamental part of public health policy design and implementation. However, one cannot assume that these consultations will automatically be inclusive, that their inputs will indeed influence policy makers, and that this will lead to progress towards UHC. Assessing how public consultations can be more inclusive and influential for stronger results needs to be part of the consultation design. This commentary offers some suggestions on how to do so.

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\*Any views expressed in this commentary are the views of the authors and do not represent the views of the World Bank group.

The milestone Alma-Ata Declaration of 1978 with its pledge of “Health for All” noted that “people have a right and duty to participate individually and collectively in the planning and implementation of their health care.”<sup>1</sup> Nearly 40 years later, the lead paper titled “Population consultation on needs and expectations” in the WHO-published handbook for strategizing national health in the 21<sup>st</sup> century reminds us of the importance of this, and it focuses on the ways populations can be consulted both in planning and implementation for Universal Health Care (UHC).

The lead paper presents an overview of different population consultation methods (Rohrer et al. 2017), with some brief snapshots of a wide range of recently conducted consultations for health planning and implementation. Evidence of the effect of consultations on the decision-making process or the implementation stage is anecdotal. However, the variety of examples shows that, in many different contexts, consultations did succeed in raising awareness of issues that were not central to the discussion before, and engaged a broad range of stakeholders, including vulnerable groups, in health discussions.

Rohrer, Rajan and Schmets (2017) note that consultations can be relevant at different points in policy development or a program cycle, whether it is to improve planning, mid-term course correction or impact evaluations. Various purposes can be prioritized, such as getting vital information from excluded and vulnerable social groups at the planning stage or focusing on using citizen feedback for monitoring, evaluating and making public health programs accountable.

The Tunisia case is particularly interesting, with the Societal Dialogue launched in 2012 as a combined effort by the government, international partners and different

sections of the media (TV, regional radio, print media) to mobilize people to participate in the first-ever citizens’ meetings on health.

This lead paper (Rohrer et al. 2017) is a useful introduction to the consultation process in health for those in the ministries of health or in NGOs who are interested in learning what such processes entail and what they can bring.

What it lacks is a frame for assessing under which circumstances consultations will be the most effective in bringing in a broad range of perspectives and influencing public health programs towards universal health coverage.

To do so, we need to challenge a few assumptions that are implicit in the paper. In fact, although many examples provided in Rohrer et al. (2017) are fascinating and even convincing, they do not go beyond anecdotal evidence in showing that (1) consultations succeed in reaching out to a broad range of stakeholders, representing various views and groups; (2) stakeholders’ inputs were taken into account by policy makers and the inputs did influence policy and/or implementation beyond a statement of intent; (3) this led to progress towards UHC; and (4) the population was aware of this and satisfied with the process.

Political economy considerations of stakeholder management can often be a motivational driver of consultative processes in practice, aimed at building a support base for a particular reform measure. Although it is important that the consultation be seen as unbiased, if it is to be effective and credible, it is equally often the reality that there are existing (or perceived) biases and incentives driving consultations. The lead paper takes an apolitical stand in giving the guidance to make explicit from the beginning that stakeholders should not attempt to influence the process of the consultation. In reality, stakeholders are

bound to be driven by their interests, incentives and preferences.<sup>2</sup>

In a 2015 publication, we unpack the drivers of citizen action and state action relevant for effective social accountability, highlighting also the important role of information, civic mobilization and the nature of the citizen–state interface (Grandvoinet et al. 2015). Figure 1 has some relevance to further understand when and why population consultations have shown results for public health in specific cases, and why often not as well, and we will use some of its findings to discuss three key questions below.

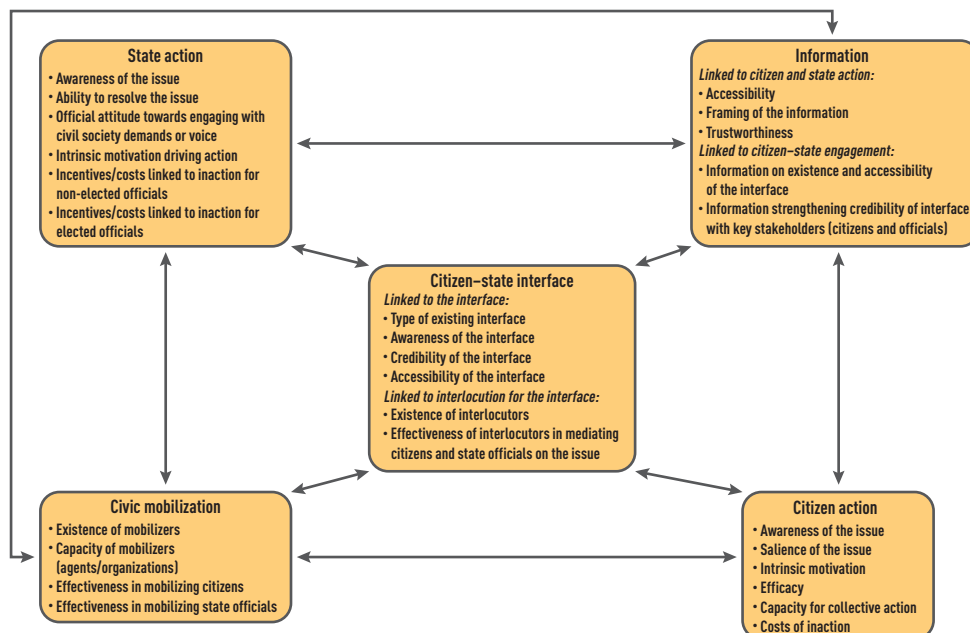
**What Will Make the State Engage in Consultations and use their Conclusions?**

First, we need to acknowledge and address government apprehensions that consultations become more a forum for criticisms of well-known failures of health systems, rather than the normative ideal that the lead paper highlights. In this case, the state might just choose not to engage in any form of consultations.

Second, assuming consultations do take place, the quality of the consultation will matter, and this is closely linked with the attitudes of officials towards a consultative process and the shifts in mindsets of officials required for a productive engagement. How can beliefs and incentives be changed such that an engagement is not perceived as an imbalanced one between the powerful state officials or the educated elite on the one hand, and a vulnerable “hard-to-reach” population on the other?

Third, a consultative process requires a wider enabling ecosystem to ensure that citizens’ inputs are taken into account and that there is feedback to citizens as to how their inputs were taken into account (and if not, why) following consultative processes. Experience suggests this is where implementation has been the weakest. Rohrer et al. (2017) indicate that such follow-up is important; what is as relevant is to discuss the various reasons *why* such follow-up does not happen. More guidance is needed on mitigating against such risks, by unpacking the reasons that explain lack of responsiveness from the state (whether it is linked to a choice of priorities, capacity, incentives, etc.).

**Figure 1. Unpacking the drivers of citizen action and state action for effective social accountability**



Fourth, the nature of the interface for the consultations can be critical in determining the credibility of the consultative process, including the role of interlocutors. In an interesting case of discussions that the China, Hong Kong SAR initiated on a Health Protection Scheme, the lead paper further observes that a public consultation can end up going in unexpected directions. Although the need for consultations is evident again in this case, we need to still better understand why governments or other initiators of consultations (including NGOs and donors) can be more open to such *unexpected directions* that consultations can foster.

#### **What will Motivate Citizen Action, and in this Case, What Will Make Citizens Participate in Consultations?**

If the main motivating aim of a population consultation is to draw upon the population's expectations and demands, we need to be sure our assumptions that (1) citizens care; (2) citizens are informed; and (3) citizens can inform the specific areas of health service planning, beyond known generalities all hold in the particular country/local context and on the focal issue. Processes beyond a consultation are needed, aimed at information and civic mobilization, to raise awareness and salience of health-related issues among citizens, build citizen trust and their efficacy to effect policy or a program. It is important that we build our knowledge base of why consultations have failed or succeeded, not because of the consultation method alone (i.e., focus group or survey), but because of these additional activities to stimulate meaningful citizen action.

We know that accessibility of information is crucial (and accessibility needs to cater to different audiences), as well as its frame and trustworthiness of the provider of the information. This will mean different things for information inciting people to participate in consultations or for information provided

during such consultations. One interesting avenue for research is how to embed the use of new information and communication technology (ICT) in such consultations to broaden their reach and make them more agile.

We also know that two critical factors will matter for citizens to engage with the state: (1) the nature of the interface (and whether the consultation platform is perceived as credible and accessible), and (2) the existence and quality of interlocutors that mediate the consultation.

Finally, yet importantly, most consultations will involve some form of mediation by civil society organizations. Understanding their interests and viewpoints on some of the issues up for debate will be important, as well as their weight in the dialogue, to ensure that consultations are not captured by a narrow group of organizations with very specific interests that could be at odds with public interest.

Assumptions that those participating do not genuinely represent or appreciate the collective interest of the population may remain relevant, if a population consultation is not universal in coverage or adequately targeted to cover the heterogeneity of ethnicities, religion, gender, income and age. Rohrer et al. (2017) are correct to prioritize consultations with the excluded and marginalized; it is worth noting that it is precisely such consultations that might require additional efforts and costs.

#### **Will Consultations always Lead to Better UHC?**

Rohrer et al. (2017) seem to assume that asking a broad range of stakeholders their viewpoint on universal health coverage would bring more weight to this effort. This may not automatically be the case, for the following reasons.

At the planning stage, much will depend on the view over UHC in the consulted population. Although one might assume a



universal desire to get access to quality healthcare, discussions might become more heated if issues such as financing of such healthcare come into play, or financing of particular needs that may be at odds with specific beliefs (support to the fact-based evidence of the benefits of family planning might be opposed, for instance, on religious grounds).

In the implementation stage, although identifying gaps and inefficiencies is a crucial first step, it stops short of solving them. When ignorance of such gaps and inefficiencies is the main impediment to progress, consultations may have a direct beneficial impact on UHC. In cases where inefficiencies are also linked to capacity, incentives or beliefs, the link will be much less straightforward.

**Conclusion**

The population needs to have a say in health. Consultations can be a supportive element for this, but these need to focus, in each particular case, on specific objectives and how to support a constructive process that will lead to meaningful progress for UHC.

A follow-up to the WHO Handbook lead paper could take up more examples of population consultations in health, looking at the practical challenges of citizen commitment and awareness to engage, and the types

of costs and incentives on the part of the initiators of the consultation, to discuss how to best use this instrument to support UHC. Although the lead paper concludes that consultation “will always have positive effects on the interaction between policy makers and the population,” we are likely to find in practice that there are cases where such consultations can raise expectations of the participating population that are not fulfilled, or be perceived as not inclusive by sections of society, creating more harm than good. How to avoid such occurrences is part of the goal.

**Notes**

1. Declaration of Alma-Ata, 1978; <[http://www.who.int/publications/almaata\\_declaration\\_en.pdf?ua=1](http://www.who.int/publications/almaata_declaration_en.pdf?ua=1)>.
2. The importance of interests, preferences and incentives is discussed most recently in the World Development Report 2017: Governance and the Law. Washington, DC: World Bank.

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# Poverty in Ukraine: Development, Validity and Reliability of a New Measure of Financial Strain for Young Adults

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Iryna Balabukha, PhD  
PhD Graduate, Department of Human Development and Family Science  
Syracuse University  
Syracuse, NY

Ambika Krishnakumar, PhD  
Associate Professor, Department of Human Development and Family Science  
Syracuse University  
Syracuse, NY

Lutchmie Narine, PhD  
Associate Professor, Department of Public Health, Food Studies and Nutrition  
Syracuse University  
Syracuse, NY



Correspondence may be directed to:  
Iryna Balabukha  
E-mail: [erin.balabukha@gmail.com](mailto:erin.balabukha@gmail.com)



## Abstract

The purpose of this paper was to develop a valid and reliable measure of financial strain for use with college-attending young adults in Ukraine. The newly developed measure represents an alternative approach to currently used objective measures of poverty and economic hardship. Objective measures are not adequate or applicable for use with Ukrainian young adults who are mainly dependent on

their families for economic support. Financial strain was conceptualized as the financial adjustments that young adults have to make to meet their basic housing, food and clothing needs. Items were generated to capture the construct of financial strain, and content validity of the scale was assessed. Exploratory factor analysis strongly supported the unidimensional nature of the scale. In addition, findings from simultaneous multiple-group confirmatory factor analyses indicated configural, metric and factor invariance of the measure across the southern and central regions of Ukraine. The new measure of financial strain was positively correlated with emotional distress and violence against romantic partners, indicating good predictive validity. The scale also showed good internal consistency. We suggest that the new measure is appropriate to use with young adults in other Eastern European countries in transition.

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### Introduction

Poverty is a major threat to environmental health and well-being of individuals worldwide, a situation that has been further exacerbated by the world financial crisis of 2008 (World Health Organization 2010). Although economic recovery has been sluggish in many parts of the world, the fiscal crisis engulfing many “transition economies” like Ukraine has been severe (World Bank 2010). Before the financial crisis in 2008, Ukraine’s economic growth was slow, a result of limited political changes and slow economic reforms, but in recent years, heightened unemployment, falling incomes and price inflation have further worsened the quality of life for many Ukrainians (World Bank 2010). Most studies in Ukraine have examined poverty on the basis of absolute (what households should be able to count on to meet their basic food and non-food needs) or relative (based in relation to the overall distribution of income or consumption in a country) indicators (Grushetsky and Kharchenko 2009). In addition, traditional economic measures such as the lack of material resources or limitations in disposable income do not fully capture the meaning of poverty and economic hardship for Ukrainian families. Within the Ukrainian context, the psychological or subjective component of poverty which emphasizes the daily life challenges and financial

adjustments that families have to make on a daily basis to meet household needs has been understudied. Hence, in this paper, we focus on the subjective aspect of poverty, which is conceptualized as the financial adjustments that individuals living in poverty have to make on a frequent basis for their survival to meet their basic housing, food and clothing needs. We term this construct as financial strain, which we consider more appropriate to assess the experiences of poverty for individuals and families in transition economies. In this paper, we focused on the experiences of financial strain among young adults transitioning into adulthood in Ukraine. Traditional measures (e.g., objective assessments of income, employment status, etc.) are not applicable for young adults who mostly depend on financial support from their families. Increased financial strain is associated with declining physical and mental health among young adults, presents challenges for their personal relationships and is associated with young adults having a negative outlook about their future (Creed and Klisch 2005). Hence, our goal in this paper is fourfold: (1) to examine the current status of studies of poverty in Ukraine; (2) to develop a contextually appropriate measure of financial strain for young adults; (3) to determine the construct validity of the newly developed measure using measurement invariance techniques across the southern

and central regions of Ukraine; and (4) to determine the internal consistency of the new financial strain measure.

### **Economic context and studies of poverty in Ukraine**

Poverty and economic stagnation of the Ukrainian economy existed before its separation from the Soviet Union in 1991. Although socialist economies were centrally regulated, with its citizens experiencing full employment, job security, subsidized housing, controlled pricing, free access to social resources and no officially reported rates of poverty, this period was also marked by slow economic growth and widespread shortages of goods and services (Bruck et al. 2008). In the 25 years post independence, Ukraine has transitioned from a socialist to a market economy, but a range of poor internal economic policies including inadequate economic liberalization and privatization of industries, government restrictions around trade and pricing, fiscal and monetary irresponsibility among other factors has led to economic stagnation and a steep economic downturn over the past decade (Matuszak and Sarna 2013). These macroeconomic factors have resulted in income inequality, declining wages, rampant inflation, declines in social benefits and low purchasing power of citizens, which, in turn, have affected the health and well-being of families and households (World Bank 1996).

Unlike in the Soviet Union, the current Ukrainian Government no longer provides the Ukrainian population with free housing and extensive social support; advanced education does not guarantee well-paid and high-status jobs. Hence, traditional pathways to financial independence are not the norm. Nowadays, many young adults in Ukraine feel lost in their transition to adulthood because of the changing social, economic and cultural traditions. They also cannot rely on the advice and life experiences of older generations who are often not equipped to

deal with the multitude of social, economic and cultural changes taking place in the new democratic and free market systems. In other words, many emerging adults do not have a clear “road map” that would guide their life and career choices.

According to a report by the United Nations in Ukraine (2009), “widespread poverty is one of the most acute socio-economic problems for the country. The extent of poverty, its depth, and a critical income polarization between social groups are a major cause for concern” (p. 1). In recent years, there has been a further significant deterioration of the country’s economy, which has resulted in people experiencing difficulties to meet the economic needs of their families and themselves. Political instability, military conflict in the Donbas region and the consequent currency devaluation have driven up consumer prices. In April 2015, consumer prices were 60.9% higher than the year before (State Statistics Service of Ukraine [SSU] 2015). Yet, household incomes remained low; in 2015, an average monthly wage was UAH 3,728<sup>1</sup> compared with UAH 3,480<sup>2</sup> in 2014 (SSU 2015). The latest report by the SSU (2015) indicated that 9.7% of Ukrainians were unemployed with the highest unemployment rates among young adults. In the 2012–2013 academic year, tuition fees for university education ranged between US\$500 and \$2,000 a year. At the same time, the average monthly wage of Ukrainian adults was around \$384 in 2013 (UAH 3073; in 2013, 1 Ukrainian Hryvnia equaled 0.072 US dollar). While the Ukrainian Government provides some tuition and housing subsidies, it is not nearly enough to cover the costs of university education. Most full-time students depend on their parents for financial support. The need for this support in turn results in financial strain for most families.

Studies examining poverty and economic hardship have used what we refer to in this paper as an economic approach characterized

by regional and national assessments of per capita income, household dependency ratios (dependent family members to the earning/productive members and expressed as a percentage), unemployment, numbers of pensioners, education status and so on. Research on poverty in Ukraine has been conducted and analyzed by government statistical agencies or private research institutes, such as the State Statistics Service of Ukraine, Kiev International Institute of Sociology and the Institute for Demography and Social Studies of the National Academy of Sciences of Ukraine (Grushetsky and Kharchenko 2009). There have been a series of nationwide surveys, such as Ukraine-96, the Ukrainian Longitudinal Monitoring Survey (Lehmann and Terrell 2006) and Life in Transition Survey (Habibov 2010), which have provided rich information on the macroeconomic characteristics of poverty. These surveys have assessed the absolute and relative poverty of the Ukrainian population. The absolute poverty rate in Ukraine was assessed at \$4.30 per day by the United Nations and reflected the inability of a person to pay for a minimum consumption basket; relative poverty was indicated when individuals' per capita expenditures were <75% of the median expenditure level, which, in 2014, was set at UAH 1,227 by the Ukrainian Government (Ministry of Social Policies of Ukraine 2015; Paniotto and Kharchenko 2008; National Academy of Sciences of Ukraine (NASU) 2008). In all these large-scale surveys, the construct of poverty was assessed as a dichotomy with a focus on the number (and percentage) of individuals who were below the specific poverty level.

There are regional variations in poverty levels across Ukraine (Cherenko 2008). Although there are limited data on the regional distribution of poverty, numerous Ukrainian Government reports on regional economic development provide some evidence of the economic development in different administrative regions. The State

Statistics Services of Ukraine provides publicly available data using the following indicators: gross domestic product (GDP) per capita, individual income and unemployment rate. Thus, for example, comparison of two regions in Ukraine – Cherkasy and Odessa – based on the reports by SSU, suggests that the GDP per capita of the Cherkasy region was lower than that of the Odessa region by 9.3%, the average monthly wage was lower by 9.0% and the unemployment rate was higher by 3.8% (SSU 2015).

### **Challenges to assessing poverty in Ukraine**

Participant responses to income-related questions in Ukraine often do not accurately reflect actual earnings (Grushetsky and Kharchenko 2009). According to Grushetsky and Kharchenko (2009), household budget surveys in Ukraine have indicated significant differences between household income and expenditures. One of the reasons for this has been that income is consistently underreported in most surveys. In the Ukrainian Longitudinal Monitoring Survey, household expenditures exceeded income by nearly 150% (Grushetsky and Kharchenko 2009). Grushetsky and Kharchenko (2009) suggest that incomes were minimized by many respondents, as they were involved in informal employment and doubted the confidentiality of the surveys. Another factor for underreporting may be lack of time or the inability of the respondents to account for all their supplementary earnings at the time of the interview (Grushetsky and Kharchenko 2009).

Research on poverty in the US and other developed countries suggests that poverty is strongly associated with one's educational level and employment status (Edin and Kissane 2010). However, the relationship between education/employment and household income is significantly affected by cultural, historic and economic factors, which are unique for Ukraine and other post-Soviet countries. The report by the

Institute of Demography and Social Studies suggests that “poverty and the poor in post-socialist countries differ markedly in comparison with other parts of the world, in particular because a significant portion of the post-socialist poor are quite highly educated” (NASU 2008: 8). Indeed, wages are low not only among unskilled workers but also among highly educated professionals. For example, in the healthcare and social services sector, which primarily consists of doctors, nurses and social workers, the average salary in January–November 2015 was UAH 2,722 (\$108) per month; in the educational sector, the average salary was equal to UAH 3,038 (\$122) per month (SSU 2015). Research by Bruck et al. (2008) suggests that the impact of education on the financial well-being of Ukrainians increased in recent years, with an additional year of schooling contributing to a 4.1% increase of the mean consumption level. Thus, although advanced education may help Ukrainians succeed and obtain a well-paid job, it does not protect against poverty as well as it does in the developed countries.

Examining informal economy and workplace crime in Ukraine, Rodgers, Williams and Round (2008) found that 30% of the respondents received their wages or some part of it as cash in an “envelope,” allowing employers to reduce their payroll tax obligations. The researchers suggested that “due to the historical antecedents of the Soviet workplace and the sheer scale of workplace crime in Ukraine, such activities are considered a ‘normal’ aspect of everyday life rather than criminal activities” (p. 667). In a study on the prevalence of off-the-books entrepreneurs in Ukraine, Williams (2009) found that only 10% of start-up enterprises operated on a wholly legitimate basis, whereas 51% were not registered and conducted all their trade in the informal economy. The former Prime Minister of Ukraine Mykola Azarov argued that in 2011, shadow trade accounted for 40% of the

domestic market (InterfaxNews 2011). According to Transparency International (2012), Ukraine was ranked 134 out of 178 countries on the Corruption Perceptions Index for 2010. Widespread corruption, money laundering activities and workplace crime indicate that individual financial well-being may depend not only on the employment status and hours worked but also on the workplace access to the semi-legal or illegal income.

In conclusion, current methods of assessing poverty and economic hardship using the economic approach have the following shortcomings: (1) they are dependent on information on earnings that are subject to distortion in transition countries such as Ukraine; (2) do not capture the unique conditions faced by subgroups in the population such as young adults; and (3) they do not capture economic situations at the household/individual level.

### **Subjective measures of financial strain**

One approach to measuring economic hardship that is more focused on the household/individual level of people’s lives and living conditions is as reflected by the extensive work of Conger et al. (2002). In their discussions about family economic hardship and family/youth outcomes, Conger et al. indicated that the association between family economic conditions (e.g., household income, unstable work, debt–asset ratios, employment status, etc.) and parental and family functioning was through family members’ experiences of economic pressure (similar in nature to the term financial strain used in this paper). Thus, subjective economic pressure is said to be a key variable in understanding family/youth outcomes more than objective indicators of family economic hardship. Conger et al. (2002) conceptualized economic pressure as a multidimensional construct including: (1) “unmet material needs,” (2) “can’t make ends meet” and (3)



“financial cutbacks.” The subscale, “unmet material needs” was assessed on a four-point response scale (1 = strongly agree; 4 = strongly disagree) about whether family members could afford to meet family needs for housing, clothing, food and medical care, etc. (e.g., My family has enough money to afford the kind of home we would like to have; We have enough money to afford the kind of clothing we should have; We have enough money to afford the kind of medical care we should have). The subscale “can’t make ends meet” was assessed by two items that included (1) whether family members had difficulty paying bills during the past 12 months on a five-point scale (1 = no difficulty at all; 5 = a great deal of difficulty) and (2) the amount of money left at the end of the month on a five-point scale (1 = more than enough money left over; 5 = not enough to make ends meet). The subscale “financial cutbacks” was measured using 14 items that asked participants about whether they had to make changes in their expenditures because of financial shortcomings on a “yes” or “no” format (e.g., postponed household purchases, changed food shopping or eating habits to save money).

The measures of economic pressure developed by Conger et al. and by other family researchers (e.g., Hilton and Devall 1997) examine subjective aspects of poverty; however, its use among young adult populations is limited, as it was developed for older adults who are married and/or have children. For example, detailed questions about monthly bills and debt may not be suitable for young adults, and especially for students, as family finances may still be handled by parents and thus young adults may not be aware of certain financial problems.

#### **Development of the measure of financial strain**

As indicated earlier, there are currently no measures available that assess financial strain among young adults in the Ukraine.

In the current study, financial strain was conceptualized as the financial adjustments that individuals living in poverty have to make on a frequent basis to meet their basic housing, food and clothing needs. Our conceptualization of financial strain is closely aligned with the conceptualization of “financial cutbacks” from the Conger et al. (2002) study with rural Iowa families (Iowa Youth and Families Project). In addition, we also examined items (e.g., Not enough money for food; Not enough money for clothing) that were used in the World Mental Health Survey (WMHS) (Bromet et al. 2005; Paniotto and Kharchenko 2008). We adapted the list of items from both surveys based on the socioeconomic information drawn from the Ukrainian literature (e.g., the item “Have to use second-hand garments or use hand-me-down garments, because new ones were too expensive to buy” was used instead of “Not enough money for clothing”). A list of 22 items was considered for content validity by a group of university experts and young adults in Ukraine. The final list of eight items (discussed below) was decided upon based on discussions between the first author, Ukrainian faculty experts in the US and young adults in Ukraine. Discussions between all involved indicated that this set of eight items reflected the financial situation of young adults in Ukraine. Although the items from the WMHS survey and the Conger et al measure of “financial cutbacks” were assessed on a yes/no format, based on focus group discussions, it was decided to assess the frequency of financial strain over a one-year period on a five-point response scale (0 = never; 4 = always). Because in our paper we aimed to develop an instrument that would measure the subjective experiences of financial strain among young adults rather than categorize people into two groups (poor vs. not poor), the use of a Likert scale was more appropriate for our research goals. Translation

procedures were based on the recommendations of Sousa and Rojjanasrirat (2011). The items in the newly developed financial strain measure were first translated from English to Ukrainian and to Russian. They were then back-translated to English by two Ukrainian residents who were fluent in Ukrainian, Russian and English. The translated and back-translated versions were compared to check for mismatches in content and meaning of the statements. When there were mismatches, the text was adjusted until there was agreement on the final version of the document. Finally, pilot testing of the pre-final version of the scale in Ukrainian and Russian languages was performed with a sample of Ukrainians who did not speak English.

### Outcomes of financial strain

A nationally representative study on the epidemiology of psychiatric disorders in Ukraine conducted within the World Mental Health research program by the World Health Organization suggests a strong link between mental health problems and financial strain (Bromet et al. 2005). The study demonstrated that inadequate financial status predicted mood disorders, which were observed in almost 10% of the surveyed men and 21% of surveyed women. The prevalence of psychiatric disorders, based on 12-month rates, was the second highest (with the US being the highest) for the 14 countries completing the survey. Kharchenko (2010) suggested that in Ukraine, financial strain resulted in social disadvantages and deprivation including the inability to access healthcare services, which, in turn, lead to emotional distress.

The study by Bromet et al. (2005) showed that inadequate financial status was also associated with alcohol disorders among Ukrainians. In addition, financial strain represents a significant vulnerability factor in intimate partner violence (IPV). Ehrensaft et al. (2003) reported that in the US, there was

about a 20% decline in the risk for partner violence for each one-standard-deviation increase in socioeconomic status of the survey participants.

### Analytic strategy

Construct validation of the newly developed measure of financial strain was undertaken using a series of psychometric procedures. First, we used exploratory factor analysis (EFA) techniques to ascertain the dimensionality of the underlying construct and the strength of factor loadings. Following this initial step, construct validation procedures included examining the nature of the association between items and the underlying construct across two regions in Ukraine – Cherkasy and Odessa – using simultaneous multiple-group confirmatory factor analyses (CFA). The CFA was conducted by examining measurement invariance of the measure across the two regions. Finally, the reliability and predictive validity of the measure were also examined.

### Sample and Procedure

Full-time students (undergraduate and graduate programs) were invited to take part in this study. It should be noted that 80% of secondary and high school graduates in Ukraine continue their education at higher education institutions (HEI) ('vywinavchalnizaklady') (Pochtovyuk 2013). In academic year 2011–2012, 76% of HEI students were enrolled in undergraduate and graduate programs, and the rest were enrolled in junior specialist programs (Educational, Audiovisual and Culture Executive Agency 2012). These figures suggest that undergraduate and graduate students represent the majority of the young adult population in Ukraine.

Students were recruited from 11 academic departments at three universities located in Odessa and Cherkasy (the universities and the departments were selected using convenience sampling). In total, 612 students participated

in the survey (from a sampling frame of 625 students; response rate of 98%). From this original sample, 14 participants were excluded from the analysis, because they had skipped over >10% of the survey or did not take the survey seriously (e.g., these individuals either endorsed the midpoint or the extreme ends on the Likert response scale for all the questions). The final sample consisted of 598 students (166 males), including Ukrainians (92.3%), Bulgarians (3.2%), Russians (1.8%) and members of other ethnicities. Participants ranged in age between 18 and 26 years ( $M = 19.45$ ;  $SD = 1.15$ ).

Data were collected in Spring and Summer 2013. Students completed the questionnaires during or after their classes. Respondents were given the option to choose whether they wanted to take the survey in Russian or Ukrainian. Participation in the survey was voluntary; students did not receive any course credits or financial rewards for participating in the study.

## Measures

### Financial strain

Financial strain was assessed using the eight items of financial strain developed for the current study. The full list of the items is presented in Appendix 1 (available at: <http://www.longwoods.com/content/25152>). The Russian and Ukrainian versions of the questionnaire are available upon request.

### Psychosocial outcomes

The following four aspects of psychosocial outcomes were assessed: emotional distress, positive affect, alcohol use and IPV.

Emotional distress was measured using 17 items on depression and anxiety symptoms (e.g., “uncontrollable crying,” “anxiety attacks”) from the Trauma Symptoms Checklist 40 (TSC-40; Briere 1996).

Responses were provided on a four-point scale (0 = never; 3 = often) ( $M = 0.84$ ;  $SD = 0.53$ ). Cronbach’s alpha was 0.87. To measure positive affect, the participants were

asked to report on a five-point scale (0 = none of the time; 4 = all of the time) how much time during the past 30 days they felt “cheerful,” “in good spirits,” “extremely happy,” “calm and peaceful,” “satisfied” and “full of life” ( $M = 2.66$ ;  $SD = 0.67$ ).

Cronbach’s alpha was 0.90. Alcohol use was measured using the Alcohol Use Disorders Identification Test (AUDIT; Saunders et al. 1993). The measure included 10 items (e.g., “How often do you have a drink containing alcohol?”). Responses to eight questions were rated on a five-point scale (1 = never; 5 = daily or almost daily) and the rest on a three-point scale (1 = no; 3 = yes, during the last year) ( $M = 0.40$ ;  $SD = 0.45$ ). Cronbach’s alpha was 0.81. Intimate partner violence was assessed using 20 items (e.g., “Slapped my partner”) of the Revised Conflict Tactics Scales (CTS2; Straus et al. 1996). Participants reported on how often they had engaged in violent acts over the past year on a seven-point scale (0 = never being violent; 6 = being violent more than 20 times) ( $M = 0.75$ ;  $SD = 0.79$ ). Cronbach’s alpha was 0.89.

## Results

Before beginning the analyses, we examined the percentage of missing data. Only 1% was missing and the data were determined to be missing at random. Hence, multiple imputations using the expectation maximization technique were conducted to replace the missing values (Little and Rubin 1987). We also examined skewness and kurtosis of the variables. All items met the assumptions for univariate normality with the exception of the violence and alcohol use scales. These two scales were log-transformed.

### Exploratory factor analysis

Using a randomly drawn sample of 249 (42%) from the sample of 598 participants, we ascertained the dimensionality and strength of factor loadings of the financial strain scale. The eight items of the scale were subjected to maximum likelihood (ML) method of

extraction. The intercorrelations among the eight items were  $>0.30$  (with the exception of two correlations). The Kaiser–Meyer–Olkin value was 0.87 (higher than the recommended value of 0.60). The Bartlett’s test of sphericity was also statistically significant. These findings pointed to the appropriateness of the data for factor analysis. ML analysis indicated the presence of one factor (eigenvalues exceeding 1) explaining 42.49% of the variance. Inspection of the scree plot also indicated the presence of a single factor of financial strain. In addition, all factor loadings loaded  $\geq 0.39$  and hence all items were retained for the CFA analysis.

#### Multiple-group confirmatory factor analyses – measurement invariance

Measurement invariance was assessed following guidelines suggested by Dimitrov (2010). The following four progressively restrictive models were tested (1) *configural invariance*, which was examined by specifying the financial strain items on to a single latent construct for each region (similar pattern of factor loadings); in this model, all parameters were allowed to vary freely across regions; (2) *metric invariance*, was examined by setting the factor loadings to be equal across the two regions, while allowing other parameters to vary freely across regions; this model examined whether the strength of the factor loadings was the same across the two regions (weak measurement invariance); (3) *scalar or intercept invariance* was examined by constraining the item intercepts and the factor loadings across the two regions; this model examined whether the strength of the factor loadings and item intercepts was similar across the two regions (strong measurement invariance); and (4) *factor invariance* that was examined by constraining the factor loadings and latent factors across the two regions.

Model fit for each of the models was assessed separately by using multiple fit indicators. In addition to the chi-square statistic ( $\chi^2$ ) and

the associated *p*-value, descriptive fit indexes such as the comparative fit index (CFI), Tucker–Lewis Index (TLI) and Root Mean Square Error of Approximation (RMSEA) were also used to evaluate each of the models. Nonsignificant chi-square, CFI values  $\geq 0.95$ , TLI  $\geq 0.95$  and RMSEA  $\leq 0.06$  (Hu and Bentler 1999) were considered criteria for good model fit. Values of at least 0.90 for CFI and TLI are considered acceptable (Bentler 1990) as are values  $<0.08$  for RMSEA (Hu and Bentler 1999). Information from the different model fit indices was jointly considered to examine the acceptability of the models (at least criteria for two out of three fit indices needed to be met). In addition to determining individual model fit, we also compared competing pairs of models using the chi-square difference test and changes in normed fit index or change in the incremental fit index. Change in CFI  $\leq 0.01$  was considered necessary to ascertain if the more restrictive model was superior to the less restrictive model (Cheung and Rensvold 2002).

Means, standard deviations, unstandardized and standardized factor loadings for items on financial strain are indicated in Table 1. In the preliminary run, findings indicated that the data were multivariate nonnormal and hence the bootstrap resampling procedure (to account for the underestimation of standard errors that occurs with skewed distributions) within AMOS (using 2,000 bootstrap samples) was used to estimate model test statistic *p*-values and parameter standard errors (Efron and Tibshirani 1993; Nevitt and Hancock 2001).

#### Configural invariance

The one-factor solution of financial strain items indicated acceptable model fit for both regions and supported configural invariance ( $\chi^2 = 170.163$ ;  $df = 40$ ; RMSEA = 0.07; CFI = 0.933; TLI = 0.907) (Table 2). Factor loadings for both regions were statistically significant ( $\geq 0.45$  for both groups).

**Table 1. Item means, SDs, and unstandardized and standardized factor loadings of the financial strain scale for Odessa and Cherkasy samples**

Financial strain items	Odessa			Cherkasy		
	Beta	$\beta$	Mean (SD)	Beta	$\beta$	Mean (SD)
EHQ3	1.319***	0.478	1.10 (1.16)	1.150***	0.453	1.24 (1.18)
EHQ4	1.904***	0.821	0.73 (0.97)	1.927***	0.778	0.98 (1.15)
EHQ5	1.727***	0.811	0.56 (0.89)	2.008***	0.855	0.85 (1.09)
EHQ6	1.995***	0.843	0.75 (0.99)	2.098***	0.894	0.99 (1.09)
EHQ7	1.964***	0.728	1.36 (1.13)	1.936***	0.720	1.41 (1.25)
EHQ8	0.911***	0.464	0.42 (0.823)	1.197***	0.568	0.65 (0.98)
EHQ1	1.000	0.492	0.59 (0.652)	1.000	0.446	0.99 (1.04)
EHQ2	0.711***	0.481	0.32 (0.62)	0.846***	0.489	0.54 (0.80)

$\beta$  = standardized beta; Beta = unstandardized Beta weight; SD = standard deviation.  
Note: Factor loading for EHQ1 was fixed at 1. \*\*\* $p < 0.001$ .

**Table 2. Fit statistics for the measurement invariance models for the financial strain scale for the Odessa and Cherkasy samples**

Invariance models	$\chi^2$	df	p	CFI	TLI	RMSEA	$\Delta$ df	$\Delta \chi^2$	$\Delta p$	$\Delta$ NFI	$\Delta$ CFI
Configural	170.163	40	<0.001	0.933	0.907	0.074					
Metric	178.177	47	<0.001	0.933	0.920	0.068	7	8.013	0.331	0.004	0.000
Scalar	222.807	55	<0.001	0.914	0.913	0.072	8	44.630	0.000	0.023	0.019
Factor	184.709	48	<0.001	0.930	0.918	0.069	1	6.532	0.011	0.003	0.010

$\chi^2$  = chi-square; CFI = comparative fit index; df = degrees of freedom; RMSEA = root mean square error of approximation; TLI = Tucker-Lewis index; NFI = normed fit index.

### Metric invariance

The strengths of the factor loadings were similar or equivalent across the two regions supporting the acceptability of the metric invariance model ( $\chi^2 = 178.177$ ;  $df = 47$ ; RMSEA = 0.068; CFI = 0.933; TLI = 0.92). Although the chi-square difference test was significant, findings indicated that the metric invariance model was a good fit to the data compared with the configural invariant model.

### Scalar invariance

The scalar invariance model was supported as indicated by the acceptability of the fit indices ( $\chi^2 = 222.807$ ;  $df = 55$ ; RMSEA = 0.072; CFI = 0.914; TLI = 0.913). When this model was compared with the

metric invariance model, results indicated that the chi-square difference test was significant and the change in CFI was  $\leq 0.019$ . The scalar invariance model was not a superior fit to the data compared with the metric invariance model.

### Factor variance invariance

The factor invariance model was supported as indicated by the acceptability of the fit indices ( $\chi^2 = 184.709$ ;  $df = 48$ ; RMSEA = 0.069; CFI = 0.930; TLI = 0.918). When this model was compared with the metric invariance model, results indicated that the chi-square difference test was significant and the change in CFI was  $\leq 0.01$ . The factor invariance model was a good fit to the data compared with the scalar invariant model.

In summary, the financial scale indicated configural, metric and factor variance invariance across regions. Model fit statistics were acceptable across all different models of invariance, although the change in chi-square value was significant when comparing different measurement invariance models; the change in CFI was  $\leq 0.01$  (exception of the scalar invariance and metric invariance model comparison). After examining the Lagrange multiplier tests, three item intercepts were freed to vary across regions (wear torn/damaged shoes [item 2], unable to buy dairy products [item 5] and unable to pay mortgage/house rent [item 8]). Doing so resulted in a change in CFI of  $\leq 0.01$ . Although these three items could be included with the other five invariant items (given that they indicated configural, metric and factor variance invariance), a more appropriate approach would be to exclude items 2, 5 and 8 from the measure of financial strain when comparing financial strain across regions.

#### Reliability and predictive validity

Reliability analysis indicated that the Cronbach alpha for the scale was 0.80. To assess the predictive validity, the associations between financial strain and outcomes were examined (Table 3). Significant positive correlations were observed between financial strain, emotional distress and IPV. Financial strain was negatively correlated with positive affect but not with alcohol use.

#### Financial strain and demographic characteristics

Financial strain was examined across several demographic characteristics. An independent-samples *t*-test showed significant gender differences (males:  $M = 0.89$ ;  $SD = 0.83$ ; females:  $M = 1.05$ ;  $SD = 0.80$ ;  $t(598) = -2.16$ ;  $p < 0.05$ ). The magnitude of the differences in the mean was very small ( $\eta^2 = 0.008$ ), indicating that only 0.8% of the variance in financial strain was explained by sex. Positive correlation was observed between financial strain and age ( $r = 0.16$ ;  $n = 598$ ;  $p = 0.01$ ). The level of financial strain varied depending on the city where the participants studied (Odessa:  $M = 0.9$ ;  $SD = 0.77$ ; Cherkasy:  $M = 1.12$ ;  $SD = 0.85$ ;  $t(598) = -3.24$ ,  $p = 0.001$ ); however, the geographic location explained only 1.7% of the variance in financial strain ( $\eta^2 = 0.017$ ).

#### Discussion

This study proposed a new measure of financial strain among young adults in Ukraine. The scale represents the first instrument that allows researchers to capture financial conditions specific to young Ukrainians. The new financial strain scale has several advantages over the existing measures used in Ukraine. First, unlike the objective indicators of poverty that provide aggregate data on economic hardship of Ukrainians (NASU 2008), the new scale allows researchers to examine poverty at the individual level.

**Table 3. Associations between financial strain and outcomes**

	Mean	SD	1.	2.	3.	4.
1. Financial strain	1.00	0.81				
2. Emotional distress	0.85	0.53	0.34**			
3. Positive affect	2.65	0.66	-0.31**	-0.50**		
4. Alcohol use	0.13	0.11	0.08	0.11**	-0.04	
5. Violence against romantic partner	0.21	0.16	0.14**	0.29**	-0.09*	0.31**

SD = standard deviation. \* $p < 0.05$ ; \*\* $p < 0.01$ .



Second, the scale assesses individual or family financial situations more accurately than traditional criteria such as household income, parental education and employment. Indeed, as discussed above, because of the widespread informal economy and wages paid in cash, income is often underreported and thus cannot be a reliable indicator of financial strain. Similarly, parental employment status may be classified incorrectly when the official employment status does not match with the actual employment (e.g., when a person who is registered by the government as unemployed works full-time). Because social and economic characteristics of Ukraine are similar to many other Eastern European countries in transition, we suggest that the new measure may be used in several other post-Soviet countries, such as Russia and Belarus.

EFA and CFA, as well as predictive validity and reliability analyses, were performed to examine the psychometric properties of the new scale. EFA suggested the unidimensional nature of the scale, with all items being positively correlated with each other. The CFA of the scale indicated configural, metric and factor invariance across the southern and central regions of Ukraine. The analysis also showed that the measurement properties of the scale would improve if items 2, 5 and 8 were removed from the scale. To examine predictive validity, we tested the associations between financial strain and psychosocial outcomes. As expected, we observed relationships between financial strain and such outcomes as emotional distress, positive affect and IPV. Financial strain did not correlate with alcohol use. Overall, the scale showed good predictive validity.

The financial strain scale has the following limitations, which should be addressed in future research. Our sample was limited to university students and did not include those who dropped out of college and whose education was limited to vocational training. In addition, our sample was limited to

southern and central Ukraine; psychometric properties of the scale across other regions in Ukraine should be examined in future studies. Psychometric characteristics of the scale should be tested cross-culturally to assess whether the scale is suitable for measuring financial strain among young adults in other Eastern European countries in transition.

In recent years, challenges of poverty and financial strain have become even more of a concern for Ukrainian families given the uncertainties of war and political and economic turmoil. In these situations, young adults in college may experience even greater financial strain than in earlier years because their families may have fewer economic resources to share with their young adult children. We consider that our newly developed measure of financial strain is appropriate for use with young adults in Ukraine and in other Eastern European countries. Use of this measure will help researchers better understand the nature and experiences of young adults' financial strain.

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### Notes

1. Equals US\$177 as of 2 June 2015, according to the exchange rate by the National Bank of Ukraine.
2. Equals US\$221 as of 31 December 2014, according to the exchange rate by the National Bank of Ukraine.

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