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BETTER HEALTH THROUGH SYSTEM STRENGTHENING OVERVIEW

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BETTER HEALTH THROUGH SYSTEM STRENGTHENING OVERVIEW

This Partners for Health Reform*plus* (PHR*plus*) End-of-Project Report presents the project's vast body of work in health system strengthening in terms of its contribution to USAID's Strategic Objectives for global health. The report explains how health system strengthening impacts priority services with an overview of health system strengthening (Book 1), numerous examples of our global- and country-level activities for each Strategic Objective (Books 2-4), and a compendium of health system tools that the project has developed (Book 5).

DISCLAIMER

The author's views expressed in this publication do not necessarily reflect the views of the United States Agency for International Development (USAID) or the United States Government.

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INTRODUCTION

This five-part report summarizes the results achieved by the United States Agency for International Development's (USAID's) global flagship health system strengthening (HSS) project, *Partners for Health Reformplus (PHRplus)*.

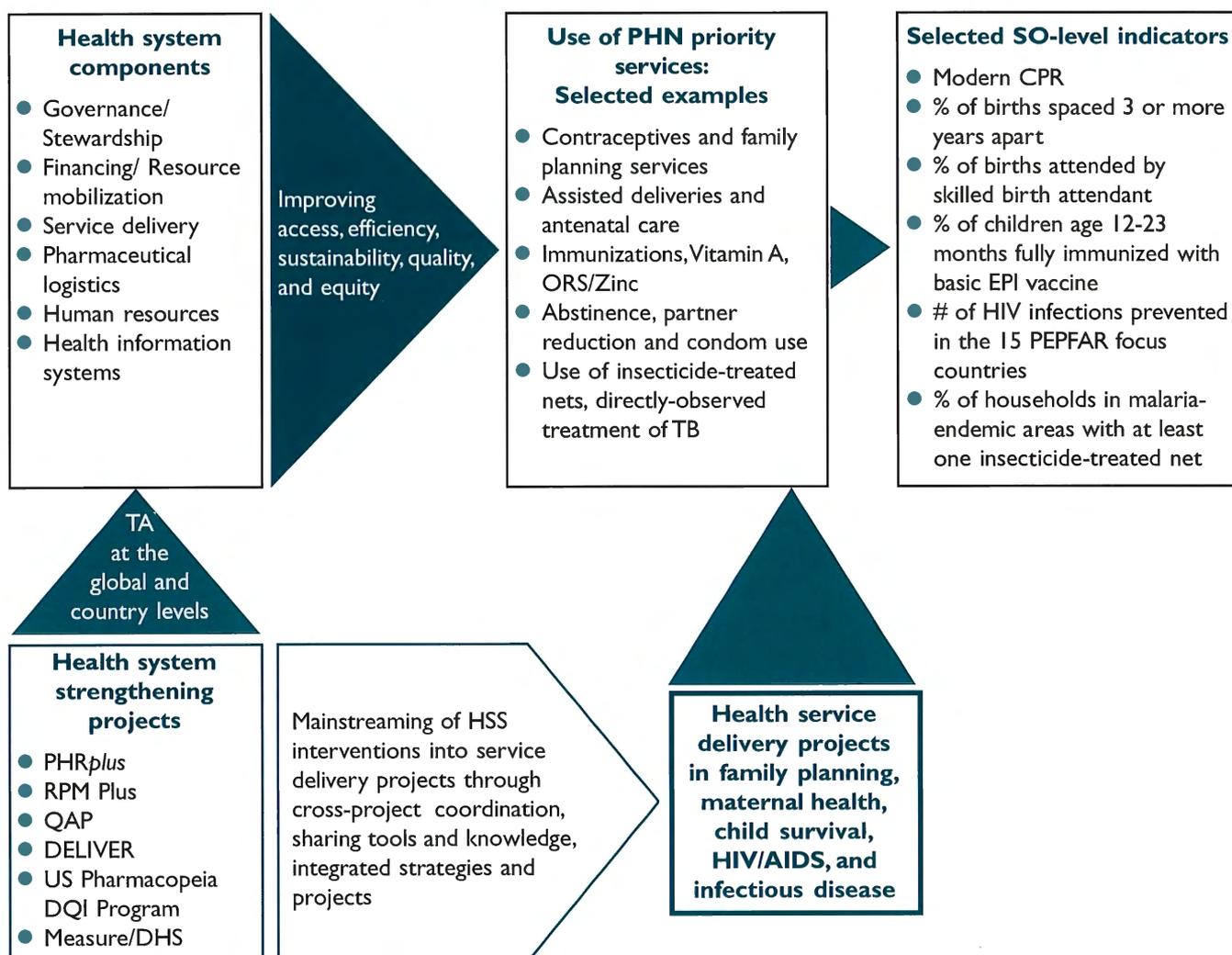
This overview places HSS in the context of USAID's focus on strategic objectives (SOs), defines HSS, shows how specific cross-cutting HSS efforts contribute to USAID's results framework, and lays out some of the future agenda for HSS. The four other books of the report focus on how *PHRplus* work has contributed to achievement in each of the five USAID SOs (grouping SOs 1, 2, and 3; then discussing SOs 4 and 5 separately), and a compilation of tools.

USAID has spent billions of dollars over the past few decades on projects that have enhanced the delivery and use of proven population, health, and nutrition (PHN) priority services. This spending has contributed to substantial reductions in morbidity and mortality and increases in life expectancy in many countries (though some of the gains have been eroded by HIV/AIDS). Despite these achievements, the burden of disease that the PHN priority services address remains unacceptably high in most developing countries. Many of the programs that focus on the delivery of services could accomplish more, but they run up against system-related obstacles.

USAID recognized the systems problems and began to address them with a series of global projects that started with the Health Financing and Sustainability project in 1989, followed by the Partnerships for Health Reform (1995-2001) project that focused on supporting health sector reforms through better informed and more participatory policy processes, more equitable and sustainable health financing systems, and improved health services. USAID's systems portfolio has expanded in scope and depth, but still represents a modest amount of spending relative to USAID's support for direct service delivery. The current portfolio of systems strengthening projects includes those that address drug supply, quality, workforce issues, and logistics. (Figure 1 shows how USAID's systems strengthening projects relate to projects that focus directly on the delivery of PHN priority services.) As noted above, USAID's "flagship" for overall HSS is *PHRplus*.

PHR_{plus} (October 1, 2000-September 30, 2006) has an overall ceiling or funding limit of \$98 million. USAID/Washington clients – Global Bureau SO teams, regional bureaus, and the Office of the Global AIDS Coordinator – have funded approximately \$22 million with the remaining \$76 million coming from USAID missions in more than 30 countries around the world. (As PHR_{plus} reached its funding limit in early 2006, it had to turn away several clients requesting additional assistance.) This demand for PHR_{plus}’ services indicates the increasing recognition by USAID’s various units of the importance of addressing systems issues as complements to service delivery efforts.

**FIGURE I
SCHEMATIC REPRESENTATION OF HOW USAID’S SYSTEM STRENGTHENING PROJECTS RELATE TO HEALTH SYSTEM COMPONENTS, SERVICE DELIVERY PROJECTS AND THE USE OF PHN PRIORITY SERVICES**



In responding to USAID requests, PHR \textit{plus} has effected results such as the following:

- ▲ Developed new tools that countries are using for policy making, and monitoring and evaluating reform (e.g., National Health Accounts [NHA] subanalyses)
- ▲ Provided technical assistance and developed implementation tools and approaches that are contributing to the sustainability of promising new initiatives (e.g., community-based health financing [CBHF] schemes)
- ▲ Assisted with implementation of complex reforms to help make them more effective in delivering on their promise (e.g., decentralization)
- ▲ Provided complementary analytical and technical support to disease-specific programs (e.g., human resource analyses, antiretroviral policy development, and cost estimates and methods to complement the President's Emergency Plan for AIDS Relief [the Emergency Plan, or PEPFAR])
- ▲ Contributed to the global agenda through tool development and facilitating field- and evidence-based discussion and debate (e.g., development of the Financial Sustainability Plan concept and tools through the Global Alliance on Vaccines and Immunization [GAVI] and collaborating with other partners on the Montreux Challenge and Health Systems Action Network [HSAN])

As noted earlier, the following parts of this overview look at the health systems agenda of the early 21st century, how PHR \textit{plus} worked to move this agenda forward and the results it achieved, and ideas about the future direction for HSS.

WHY IS HEALTH SYSTEM STRENGTHENING ESSENTIAL TO IMPROVING PRIORITY SERVICES?

Strong health systems are critical to achieving better health outcomes; priority services rely on health systems

Priority services, such as those that are the focus of the USAID Bureau for Global Health's SOs, aim to reduce infant and child mortality and morbidity, address reproductive and maternal health, and reduce the threat of infectious diseases. Much of the effort to fulfill the SOs is through program-specific strategies to improve the delivery of priority services.

Program-specific strategies are clearly necessary, but they often do not achieve their full potential due to health system constraints outside the scope of the program. Unaddressed, these system constraints may hamper a program reaching all socioeconomic groups, or hinder its interventions going from small scale to national scale. Failure to strengthen a health system also may limit program sustainability after the end of USAID support.

Evidence from recent studies of child survival programs shows that health system constraints (such as high staff turnover, low quality training of health workers, poor supervision, lack of continuous supplies for pharmaceuticals and vaccines) are major impediments to increasing coverage of child health services.¹ In another example, a family planning program may train volunteers in counseling, referral, and resupply of contraceptives. However, if the system for commodity supply is weak, poor service outcomes and dissatisfied clients may produce disappointing results. The investment in mobilizing and training family planning volunteers will not, on its own, necessarily result in a successful family planning program.

Two global initiatives that focus on specific diseases and interventions, the aforementioned GAVI, and the Global Fund to Fight AIDS, Tuberculosis (TB) and Malaria (Global Fund), recently began to offer specific support for HSS to complement support for service delivery. The United Nations (UN) Millennium Project's Task Force on Child and Maternal Health cites the health system as the major obstacle to achieving the Millennium Development Goals (MDGs).²

Health system issues constraints limit further improvement and expansion of priority health services

USAID's investment in HSS has resulted in the successful development and implementation of interventions – often multiple instances of implementation – to alleviate constraints, as Table I illustrates.

¹ Bryce, J., el Airfeen, S., Parioy, G., Lanata, C.F., Gwatkin, D., Habicht, J., and the Multi-Country Evaluation of IMCI Study Group. 2003. "Reducing child mortality: can public health deliver?" *The Lancet* 363:159-64.

² United Nations Millennium Project's Task Force on Child and Maternal Health. 2005. *Who's Got the Power?: Transforming Health Systems for Women and Children*. UN.

TABLE 1: CONSTRAINTS TO INCREASED UTILIZATION OF PRIORITY SERVICES AND EXAMPLES OF HSS INTERVENTIONS

Level	Constraint	Examples of HSS interventions to address constraints
Household / community	<p><i>Financial:</i> inability to pay at time of need, informal fees, lack of risk sharing</p> <p><i>Physical:</i> distance to facility</p> <p><i>Information:</i> lack of appropriate consumer information on value of service</p>	<p>Risk sharing/insurance</p> <p>Targeted subsidization of poor</p> <p>Behavior change communication</p>
Facility	<p><i>Staffing:</i> shortage and maldistribution of appropriately qualified staff, low health worker motivation</p> <p><i>Management:</i> weak technical guidance, program management, and supervision, unavailable and under-used information for decision-making</p> <p><i>Drugs and supplies:</i> inadequate drug and medical supplies</p>	<p>Investment in human resources</p> <p>Quality standards / accreditation</p> <p>Provider payment mechanisms linked to performance</p> <p>Resource reallocation</p> <p>Drug procurement and distribution systems</p> <p>Bottom-up health, surveillance, and management information systems</p>
Health system	<p><i>Resource allocation:</i> inequitable and inefficient distribution of health resources</p> <p><i>Planning and management:</i> weak and overly centralized systems for planning and management</p> <p><i>Procurement and distribution:</i> weak drug policies and supply systems</p> <p><i>Quality assurance:</i> weak quality standards, inadequate regulation of service delivery and pharmaceuticals</p> <p><i>Cooperation:</i> lack of intersectoral action and partnership</p> <p><i>Incentives:</i> weak incentives for providers to use inputs efficiently and respond to user needs and preferences</p>	<p>Decentralization</p> <p>Public-private partnerships</p> <p>Quality assurance and accreditation standards and strengthened regulation</p> <p>Vertical integration of common functions (e.g., supervision, human resources, targeting subsidies)</p> <p>Link financial and program data for planning and evaluation through mechanisms such as NHA</p> <p>Resource reallocation</p> <p>Priority setting through laws and regulations</p> <p>Performance-based management</p> <p>Monitor and evaluate system functions, as well as programs</p>

Source: Adapted from Hanson, K. et al. 2001. *Constraints to Scaling Up Health Interventions: A Conceptual Framework and Empirical Analysis*. Geneva: WHO Commission on Macroeconomics and Health.

WHAT IS A 'HEALTH SYSTEM'?

The World Health Organization's (WHO) *World Health Report 2000*³ defines a health system as “all the organizations, institutions and resources that are devoted to producing health actions.” A health system encompasses national health policies and programs, laws and regulations, organization and management structures, and financing arrangements, which in combination result in availability and quality of services aimed at improving health. A health system includes all levels within a country's health care system: central, regional, district, community, and household levels. It includes public and private participation in financing, risk sharing, and provision of services.

The *World Health Report 2000* also identifies four functions of the health system: (1) stewardship; (2) financing; (3) human and physical resources; and (4) organization and management of service delivery. These four functions are defined in Box 1.

BOX 1

WHO: FUNCTIONS OF THE HEALTH SYSTEM

Stewardship:

- The continuous process of developing, revising, and enacting policies and regulations
- Raising awareness and mobilizing communities, institutions, and individuals to promote effective health policies and practices
- Ensuring an environment in which the government, non-governmental organizations (NGOs), private enterprises, and individual health practitioners can operate effectively and efficiently

Financing:

- The collection, pooling, and allocation of sufficient resources to pay for health services and products

Resources:

- The recruitment, training, deployment, and retention of qualified human resources
- The procurement, allocation, and distribution of essential drugs and supplies
- Investment in and maintenance of physical health infrastructure (e.g., facilities, equipment)

Organization and management:

- Institutional arrangements for managing and delivering health services, including public and private sector roles, quality assurance, decentralization, and contracting.

WHAT IS 'HEALTH SYSTEM STRENGTHENING'?

The phrase 'health system strengthening' is used increasingly in policy discussions (Box 2). HSS comprises to an array of initiatives and strategies aimed at improving the functioning of a health system or any of its subsystems⁴ in terms of access, quality, equity, efficiency, and sustainability (see Figure 2). Health sector reform may require significant changes in national policies, programs, and practices; in health sector priorities, laws, regulations, organizational and management structure; and in financing arrangements.⁵

³ World Health Organization. 2000. *The World Health Report 2000, Health Systems: Improving Performance*. Geneva.

⁴ Eisele, T., Hotchkiss, D., Bennett, S., and Stillman, K. 2003. "Linking Health System Strengthening Interventions to the Strategic Objectives of USAID's Global Health Bureau, A Conceptual Framework." Unpublished draft. Bethesda, MD: Partners for Health Reformplus Project, Abt Associates Inc.

⁵ Knowles, J.C., Leighton, C., and Stinson, W.S. 1997. *Measuring Health Sector Reform for System Performance: A Handbook of Indicators*. Bethesda, MD: Partnerships for Health Reform Project, Abt Associates Inc.

BOX 2

INTERNATIONAL ATTENTION TO HEALTH ISSUES HAS PROMPTED GREATER ATTENTION TO HSS

The WHO World Health Report 2000, Health Systems: Improving Performance (WHO, 2000) focused on the performance of health systems as integral to addressing priority health issues.

- “Combating disease epidemics, striving to reduce infant mortality, and fighting for safer pregnancy are all WHO priorities. But the Organization will have very little impact in these and other battlegrounds unless it is equally concerned to strengthen the health systems through which the ammunition of life-saving and life-enhancing interventions are delivered to the front line.” (p. xii.)

The Millennium Development Goals were adopted by the global community at the Millennium Summit in September 2000. Half of the goals concern health directly or indirectly. In *Rising to the Challenges, the Millennium Development Goals for Health* (World Bank, 2004), the World Bank reviews progress toward achieving MDGs.

- “To accelerate progress toward the Millennium Development Goals, most countries need to significantly increase investments in the core public health functions, in addition to providing and financing health services.” (p. 139)

The WHO Commission on Macroeconomics and Health disseminated findings from research on key factors affecting health outcomes in developing countries at the end of 2001. The Commission’s *Improving Health Outcomes of the Poor, Report of Working Group 5* (WHO, 2002), identified overcoming health system constraints as essential to improving the health of the most vulnerable.

- “Most of the poorest billion people lack access to a health system that is adequate to the task... This state of affairs - the lack of an effective and capable health delivery system - limits all efforts to scale up the provision of effective interventions.” (p. 64)

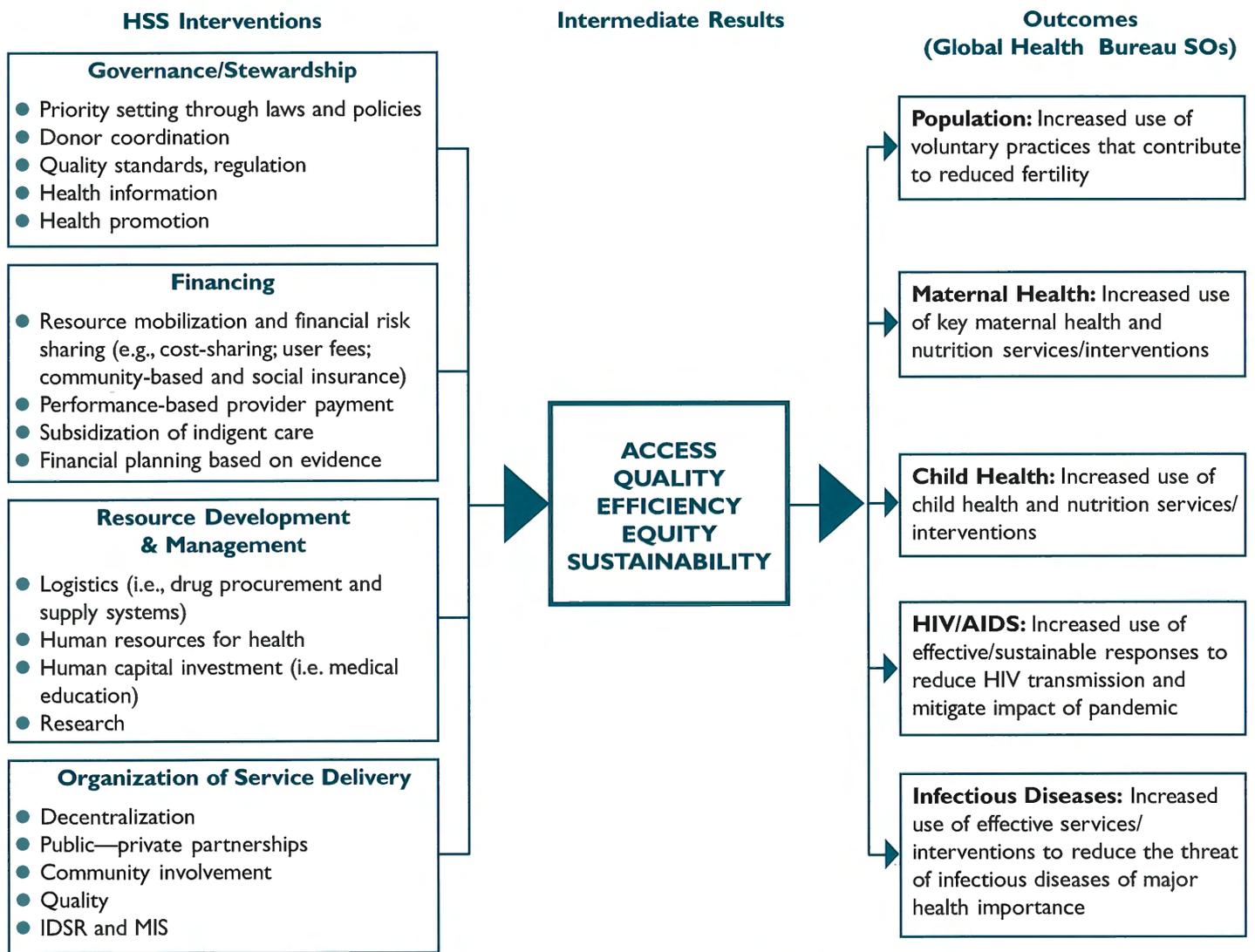
Human Resources for Health, Overcoming the Crisis (Joint Learning Initiative, 2004) analyzes research and presents findings on the importance of attention to human resource development in the context of supporting health systems in developing countries.

- “Strengthening, not fragmenting, health systems should be a principal objective of all programs, especially categorical programs focused on priority diseases.” (p. 138)

Funding partnerships move to strengthen health systems: The major global health initiatives have begun to recognize that attainment of their objectives would be limited without attention to systems.

- The Global Fund announced its commitment to supporting health system development through its 5th and 6th round awards.
- In 2005, the Global Fund awarded Rwanda a US\$14 million HSS grant to expand coverage of CBHF to include the poorest and most vulnerable populations.
- GAVI is launching a system strengthening initiative in 2006.
- An international meeting in Montreux brought together partners, including WHO, the World Bank, GAVI, and the Global Fund, in a “Challenge meeting: Making health systems work” in April 2005. The meeting resulted in forming of the HSAN (Health Systems Action Network).

FIGURE 2
HOW HSS INTERVENTIONS LINK TO HEALTH OUTCOMES



HOW DOES HSS IMPROVE PRIORITY SERVICES? THREE CROSS-CUTTING EXAMPLES

This section discusses three HSS initiatives that are cover cross-cutting, that is, they are not limited to a specific intervention but rather address health systems generally. They are illustrative of the kinds of initiatives that benefit the specific aims of USAID’s PHN priority services approach but also have broad impact on health services.

Many HSS efforts aim at *policy changes* or produce them as a by-product of a focused intervention. The first part of this section enumerates examples of policy changes that have resulted from PHR*plus*’ HSS work; it also discusses in some detail one of PHR*plus*’ policy-oriented activities, the applied research into the systemwide effects of the Global Fund. The second part looks at *CBHF initiatives* to increase access to health services generally by reducing the financial barriers to use of services at the time of need. In the third part discusses *NHA*, which produce an information base that assists with strategic decision-making and the monitoring and evaluation of policies.

IMPROVED HEALTH POLICIES

Government exercises the stewardship function through the development, implementation, and enforcement of policies that affect the other health system functions. WHO has recommended that one of the primary roles of a ministry of health is to develop health sector policy, with the aim of improving health system performance.⁶

Governments exercise a variety of policy “levers” that can affect health programs and health outcomes (see Table 2).

⁶ World Health Organization. 2000. *The World Health Report 2000, Health Systems: Improving Performance*. Geneva.

TABLE 2: GOVERNMENT POLICY AND HEALTH PROGRAMS

Governmental policy levers	Relevance to health programs
Size of the total government health budget	Sets the overall limit on what government can do.
Financing mechanism of the health care system	Determines what financial barriers may exist to access to care (e.g., fees, their level, and exemptions).
Allocation of the government health budget	Reflects how the government uses its tax resources, e.g., to hire, contract with, or subsidize providers, regulate the sector, provide information, and configure the sector: preventive vs. curative services, personnel vs. supplies, investment in human resources (training) vs. physical resources (hospital), etc. Affects which populations will benefit: rich vs. poor, urban vs. rural.
Regulation of civil society organizations	Can facilitate or constrain the functioning of private voluntary, nongovernmental, and community organizations and their capacity to influence and advocate for health services.
Political support to raise awareness for specific health messages/behaviors	Clear government support for specific health messages such as prevention of HIV, contraceptive use, or TB treatment can be powerful for stigmatized or controversial health initiatives
Adoption of specific health standards or guidelines	Can improve the quality of care, expand or constrain the number of providers, facilitate implementation of approaches like Integrated Management of Childhood Illness.
Regulation of pharmaceuticals	Can influence the ability to bring drugs and supplies into the country; can improve quality assurance practices for and rational use of drugs.

Source: Adapted from the PHRplus Technical Reference Materials: Health Systems Strengthening

HSS activities often help ministries of health to identify the need for policy reform, that is, either new policies or modified existing ones. Table 3 lists examples of how PHRplus' system strengthening work has impacted policy. The examples range from policies for disease-specific programs (e.g., malaria and HIV), to broader sector financing, and to health system-wide reform programs.

TABLE 3: THE POLICY IMPACT OF HSS: SELECTED EXAMPLES

Focus	Title	Country	Policy impact
Health care financing	NHA	Kenya, Rwanda	<p><i>Increases in health spending.</i></p> <p>Among the findings from NHA in Kenya was evidence that 51% of all expenditure in health care is out-of-pocket spending by households. As a result, the Ministry of Health received a 30% increase in its allocation from the Treasury in fiscal year 2005/2006.</p> <p>Among the NHA findings in Rwanda was that 50% of the health sector is financed by donors, 40% by private sources, and only 10% funded by the government. The Ministry of Health used these findings to argue successfully for a doubling of the health budget.</p>
Health care financing, HIV/AIDS	Antiretroviral therapy (ART) policy	Uganda	<p><i>ART Policy.</i> In 2004, with the assistance of PHRplus, Uganda adopted a national policy on ART that was the most comprehensive ART policy in Africa. The policy was a pre-condition for Uganda's successful application to the Global Fund for support for ART scale-up.</p>
CBHF	District-based approach	Ghana	<p><i>National Health Insurance Act.</i> The Ghana Parliament passed a National Health Insurance Act (HIA) to improve access and quality of basic health care services through the establishment of mandatory health financing schemes at the district level. PHRplus laid the groundwork for the HIA through its support to the development of community-based schemes. PHRplus also facilitated participation by community scheme representatives in the hearings and debate over the HIA, providing them a voice in policy decisions. After the passage of the HIA, PHRplus assisted the Ghana Health Service to conduct baseline household surveys as a part of the monitoring and evaluation of HIA's impact.</p>
		Senegal	<p><i>Strategic framework for CBHF.</i> With the growth of the CBHF movement in Senegal, the Ministry of Health with assistance from PHRplus developed a national strategic framework to work with the movement. The framework focuses the ministry on facilitation of the movement and information gathering and lesson sharing.</p>
HIV/AIDS ART program management	AIDSTreatCost (ATC) software	Uganda	<p><i>Financial sustainability of ART.</i> PHRplus conducted a comprehensive analysis of resource requirements for scaling up ART activities in Uganda with the PHRplus-developed ATC software, and worked with policymakers to begin to formulate approaches to long-term financing needs for sustaining scaled-up ART provision.</p>
Quality of care	Health facility accreditation	Egypt	<p><i>Facility accreditation.</i> PHRplus helped the Ministry of Health and Population, hospitals, and medical schools to develop accreditation standards and survey methods for hospitals and primary care facilities in Egypt. As a result, the government established a national health facility accreditation unit independent of the ministry.</p>

cont'd p. 12

TABLE 3: THE POLICY IMPACT OF HSS: SELECTED EXAMPLES (CONT'D)

Focus	Title	Country	Policy impact
Infectious disease surveillance	Public health policy, law	Georgia	<i>New public health law.</i> The Ministry of Labor, Health and Social Affairs in Georgia, with PHRplus assistance, developed and applied tools to strengthen surveillance of and response to vaccine-preventable diseases. In so doing, weaknesses in the underlying public health system were revealed. As a result, the government is drafting a new public health law to improve organization and management of public health services by defining core public health functions, making clear the roles and responsibilities of all stakeholders, again with PHRplus assistance.
Infectious disease surveillance	Malaria	Democratic Republic (DR) of Congo	<i>Malaria treatment policy change.</i> PHRplus worked with the Ministry of Health of DR Congo, the World Bank, and the Roll Back Malaria Partnership to estimate financial need to switch to Artemisinin-based combination therapy. The estimate was a key input into the decision by the World Bank to include a \$30 million malaria component into a health loan.
Primary health care strengthening	Market analysis	Egypt	<i>Market analysis study spurs multiple actions.</i> PHRplus assisted with a market analysis to identify strengths and weaknesses of the Suez governorate health sector. Analysis findings resulted in the Ministry of Health and Population revising exemption policies for poor and vulnerable to expand access; conducting information, education and communication campaigns; expanding coverage to secondary care; developing contracting mechanisms to include NGO and private facilities; and permitting free choice of ministry facility for families.
Policy change	GAVI immunization plan	Global	<i>Sustainable financing for the fight against multi-drug resistant TB.</i> The TB Green Light Committee obtained a preliminary commitment from the Global Fund to grant an exception to its policy and provide basic support to the committee for its work to ensure the quality of programs to address multi-drug resistant TB. This allows more countries to obtain discounted drugs and strengthen the battle against multi-drug resistance.
Health reform	Decentralization	Peru	<i>Information for priority setting.</i> Regional Health Analysis (a version of NHA) provided key information for the Participatory Health Planning Process and for the definition of financing and resource allocation policies and strategies in four regions.
Health reform	Pharmaceuticals	Jordan	<i>NHA results led to rational drug use strategy.</i> The results from a series of NHAs contributed to the Ministry of Health citing pharmaceutical reform and rationalization of drug purchasing and dispensation as a policy priority. With PHRplus assistance, the ministry is leading the development and implementation of a rational drug use strategy.

Another example of PHR \textit{plus} ' policy impact is the use of collaborative research results to influence the direction of the Global Fund. The Systemwide Effects of the Fund (SWEF) Network (a collaborative group of research organizations) aims to understand the effects of the Global Fund on the broader health systems of recipient countries. SWEF research funded by USAID, the European Commission, and other donors in countries in Africa, Asia, Eastern Europe, and Latin America focuses on four thematic areas: effects on the policy environment; the public-private mix; human resources; and pharmaceuticals and commodities. PHR \textit{plus} contributed to SWEF through the development of a conceptual framework, research protocol, research implementation in key countries, and analysis of preliminary findings of results.

SWEF RESEARCH FINDINGS AND THEIR IMPLICATIONS

Preliminary results from studies on the effects of the Global Fund in Benin, Ethiopia, and Malawi show that the Global Fund has indeed affected their health systems. In some cases, the Global Fund processes contributed to stronger health systems, while in other cases Global Fund-supported processes revealed long-standing system weaknesses.

- ▲ Examples of positive effects include the creation of new public-private partnerships, and training and infrastructure strengthening efforts that have potential positive spin-off effects to other areas of the health system.
- ▲ Examples of negative effects include a disconnect between the Global Fund processes and national policies on decentralization and cost recovery; human resource constraints; and the creation of parallel systems for procurement of drugs and commodities.⁷

IMPACT OF NEW FUNDS AND MECHANISMS ON PRIORITY HEALTH SERVICES

SWEF findings from Ethiopia and Malawi indicate that groups that work to expand reproductive health services have not participated extensively in the Global Fund planning processes, and Global Fund activities are not integrated into reproductive health, family planning, or other preventive care services. Global Fund activities are having an impact on health workers, increasing their responsibilities and shifting them from the public sector to nongovernmental and other organizations. In Ethiopia, SWEF also found shifts in resources from community reproductive health and family planning programs to activities related to the Global Fund's three focal diseases. As a result of these findings, SWEF recommended the integration of the focal disease services with reproductive health and family planning services, and greater involvement of reproductive health and family planning advocates in planning for Global Fund activities.⁸

⁷ Stillman, K. and Bennett, S. September 2005. *Systemwide Effects of the Global Fund: Interim Findings from Three Country Studies*. Bethesda, MD: The Partners for Health Reform \textit{plus} Project, Abt Associates Inc.

⁸ Schott, VV., Stillman, K., and Bennett, S. September 2005. *Effects of the Global Fund on Reproductive Health in Ethiopia and Malawi: Baseline Findings*. Bethesda, MD: The Partners for Health Reform \textit{plus} Project, Abt Associates Inc.

COMMUNITY-BASED HEALTH FINANCING SCHEMES AND THEIR IMPACT ON UTILIZATION AND FINANCING OF PRIORITY SERVICES

CBHF schemes (also known as mutual health organizations, or MHOs) exist in many different forms but share the goal of helping communities meet health financing needs through pooled revenue collection and resource allocation decisions made by the community. The schemes represent a type of insurance program, with members paying small premiums on a regular basis to offset the risk of needing to pay large health care fees upon falling sick. CBHF schemes are typically based on the concepts of mutual aid and social solidarity, and are always not-for-profit; in this sense, they are unlike many commercial insurance schemes.

There is growing evidence that CBHF schemes have a positive impact on access to and utilization of priority health services such as maternal and child health services and HIV/AIDS prevention and care:

- ▲ **Maternal health:** When CBHF schemes include maternal health services, they can reduce barriers to care and promote use of these services. Studies in Rwanda and Mali show that pregnant CBHF scheme members are more likely than pregnant non-members to seek care at a modern health care provider. For example, in the Bla District of Mali, 71 percent of pregnant scheme beneficiaries delivered with a skilled birth attendant (doctor, midwife, nurse) compared to 43 percent of non-beneficiaries ($p < 0.008$); 41 percent of pregnant women covered by CBHF sought prenatal care in the first trimester, making them 2.5 times more likely to do so than women without coverage.
- ▲ **Child health:** Most schemes incorporate maternal child health services in their benefits package and promote the use of prevention services. In Mali, 62 percent of insured children under age 5 slept under an insecticide-treated net; they were twice as likely to do so as uninsured children.

BOX 3 PHRplus CBHF PUBLICATIONS

- Guide to Designing and Managing Community-Based Health Financing Schemes
- *Stratégies innovatrices pour le développement des mutuelles de santé* (English forthcoming)
- 21 Questions on Community-Based Health Financing (also in French)
- Training of Trainers Manual for Mutual Health Organizations in Ghana
- Evaluating the Effects of the National Health Insurance Act in Ghana: Baseline Report
- Equity Initiative in Mali: Evaluation of the Impact of Mutual Health Organizations and Maternal Health IEC Interventions on Utilization of High Impact Services
- Determinants of Financial Stability of Mutual Health Organizations in the Thies Region of Senegal: Household Survey Component
- Effects of Mutual Health Organizations and IEC on Reducing Barriers to Access and Use of Maternal Health Services in Rural Mali
- Improving Quality of Care for Mutual Health Organization Members: An Introductory Manual for MHOs (also in French)

▲ **HIV/AIDS prevention and care:** Some CBHF schemes offer voluntary counseling and testing; some focus on promoting HIV/AIDS prevention through health education. The Global Fund recently awarded Rwanda a \$14 million grant to expand coverage of CBHF schemes to include the poorest and most vulnerable populations, groups that often include people living with HIV/AIDS (PLWHA).

While the above shows that CBHF schemes can impact the use of PHN priority services, some have questioned whether such schemes can ever reach a large portion of the population. Rwanda’s experience shows that substantial scale-up is possible; as of 2005, 45 percent of the Rwandan population had joined schemes (Box 4).

**BOX 4
MHO SCHEMES ARE CENTRAL TO
FACILITATING ACCESS TO HEALTH CARE FOR
THE POPULATION**

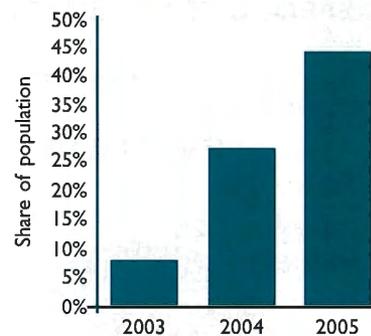


MHO Schemes:

- Have removed access barriers for members
- Are rolled out in the country and have seen huge increases in enrollment
- Are rolled out to the entire population, with government paying for the poorest 25%
- Build a culture in the population of investing in health
- Are supported by national solidarity mechanisms

Source: Government of Rwanda

**Evolution of MHO
Membership in Rwanda**



**NATIONAL HEALTH ACCOUNTS AND NHA
SUBANALYSES AND THEIR IMPACT ON PRIORITY
SERVICES**

NHA is an internationally accepted tool to summarize, describe, and analyze all sources and uses of health financing. NHA provides information on total health spending in a country (public, private, and donor expenditures), and tracks the flow of funds from one health care actor to another. NHA reveals who pays for health care and how much they spend on different types of services, how funds are distributed across different health services, and who benefits from health expenditures. The NHA tool is designed to inform the health policy process, allowing policymakers to make evidence-based decisions and avoid potentially adverse choices. As was noted in Table 3, NHA findings resulted in big increases in health funding in Kenya and Rwanda.

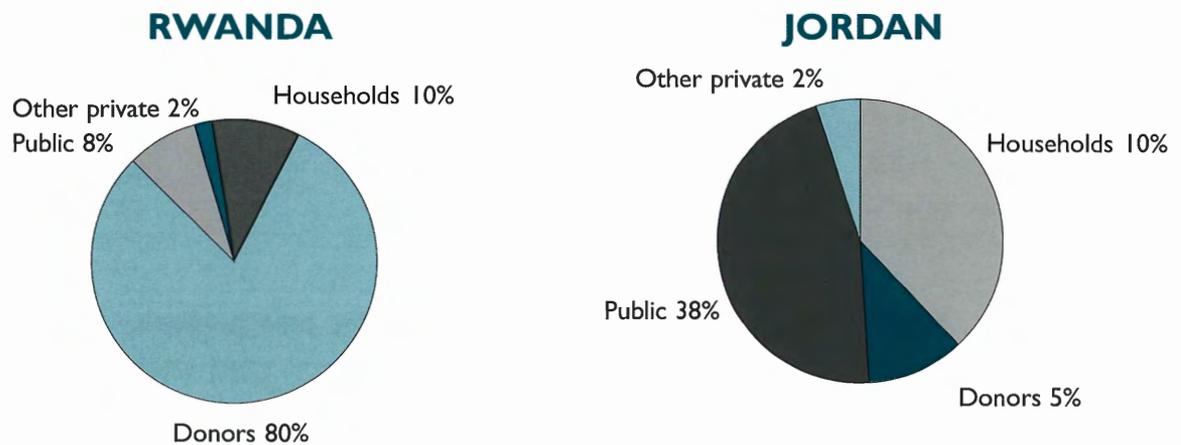
To focus more directly on analysis of priority services, PHR*plus* has enhanced the general NHA methodology by developing NHA subanalyses to understand resource flows for individual sectors or diseases. Again, Rwanda provides an example of NHA impact on policy: there, the malaria subanalysis estimates revealed that funding for that disease - the country's most significant cause of morbidity and mortality - was decreasing as other global priorities received more attention. Subanalysis findings spurred the Minister of Health to counteract this trend.

Other NHA subanalyses are the following:

▲ **Reproductive health subanalyses** have been implemented in Egypt, Jordan, and Rwanda. Estimates (some shown in Figure 3) show a dependence on donors to finance reproductive health in Rwanda; relatively low government contribution to reproductive health (in fact, in Jordan and Rwanda, households finance more than the government); low spending on maternal health care services; and a high level of household contributions, close to half of all curative reproductive health expenditures.

FIGURE 3
NHA REPRODUCTIVE HEALTH SUBANALYSIS FINDINGS

Where do reproductive health dollars come from?



Reproductive health services are being financed mostly by donors (Rwanda), households and governments (Jordan)

- ▲ **Child health subanalyses** provide policymakers with information by tracking expenditures on health services related to conditions that contribute to high morbidity and mortality in children and resources channeled to priority child health services; examine who is financing child health priority services; and monitor investment in child health against other priorities.
- ▲ **HIV/AIDS subanalyses** provide information on overall HIV/AIDS-related expenditure patterns, allow for improved resource planning, and permit tracking of service utilization and out-of-pocket health expenditures by PLWHA. For international donors, the subanalyses provide disaggregated data for assessment of performance by HIV service areas and ensure that donor assistance is tracked in a transparent manner so that the flow of funds contributes to those in need. Findings for Rwanda, Kenya, and Zambia reveal that out-of-pocket spending on health services by PLWHA is 2.6 to 6 times higher than the general population (Table 4).

TABLE 4: OUT-OF-POCKET (OOP) SPENDING ON HEALTH BY PLWHA AND THE GENERAL POPULATION

	Rwanda	Kenya	Zambia
HIV/AIDS OOP per PLWHA (PPP)	\$45.59	\$54.98	\$49.61
General health OOP per capita (PPP)	\$12.79	\$20.94	\$8.48
Magnitude of increase in OOP spending by PLWHA	3.6 fold	2.6 fold	5.9 fold

PPP= purchasing power parity

WHAT IS THE AGENDA FOR FUTURE HSS?

MAINSTREAMING HSS INTO USAID PRIORITY PROGRAMS

USAID's Bureau for Global Health aims to strengthen health service delivery projects. This goal is encapsulated in the bureau's Global Health Initiative for Mainstreaming Health System Strengthening, an effort to find cost-effective ways to put the knowledge, expertise, and tools created by its HSS projects at the service of USAID missions and service delivery projects, as well as their counterparts, so that they can address the health system constraints to increased use of priority services.

PHR*plus* has contributed to "mainstreaming" HSS into USAID programs by articulating the links between HSS and health outcomes, developing technical reference materials on HSS for the PVO Child Survival community, and creating a Health Systems Assessment Approach (see below).

At the direction of USAID's Global Bureau, PHR*plus* leads specific mainstreaming activities, working closely with other HIDN (USAID's Office for Health, Infectious Disease and Nutrition) implementing partners, Rational Pharmaceutical Management Plus (RPM Plus) and Quality Assurance/Workforce Development projects. The mainstreaming initiative has produced health systems tools summaries, one-page overviews on available tools for quick reference (as noted above, HSS tools are

described in a separate Section 5 of this report, and they can be downloaded from the project website: www.PHRplus.org); the conceptualization, development, and piloting of a Health Systems Assessment Approach (see Box 5) and integration of HSS content into the Child Survival and Health Grants Program Technical Reference Materials.

BOX 5 HEALTH SYSTEM ASSESSMENT APPROACH

Jointly developed by PHR*plus*, RPM Plus, and the Quality Assurance Project, this manual is a step-by-step guide for a rapid assessment of a country health system through six modules that cover specific system functions. It has been tested in Angola, Benin, and Pakistan.

EMPHASIZING ACCOUNTABILITY IN THE FUTURE AGENDA FOR HSS

The issue of accountability has emerged as an important new direction in improving health system performance. The concern with the issue reflects a consensus among development assistance agencies that accountability is essential to ensure effective delivery of basic social services, especially for the poor; increasing recognition that health system actors have significant power to affect people's lives and well-being; concern for proper use of funds flowing into countries for health care; and recognition that health reform efforts without an accountability framework can hamper health system performance.⁹

PHR*plus* began to address accountability issues in its systems work. In Albania, the project examined the practice of requiring informal payments to service providers. In DR Congo, it conducted case studies of the governance of semi-autonomous health zones and recommended a rethinking of the Charter of Mbanza-Ngungu that provides their framework. In Peru, it assisted with the implementation of citizen referendums to set health priorities to which regional authorities could be held. In Senegal and Benin, PHR*plus* helped national governments develop strategic frameworks for promoting CBHF that preserve the community accountability features of the schemes that appear to be key to their success.

⁹ Hotchkiss, D. and Brinkerhoff, D. 2006. *Improving Primary Health Care by Strengthening Accountability in the Health Sector. Insight for Implementers*. Bethesda, MD: The Partners for Health Reform*plus* Project, Abt Associates Inc.; Lewis, M. 2006. *Governance and Corruption in Public Health Care Systems*. Working Paper Number 78. Center for Global Development.

THE MOVE TOWARDS GREATER INTERNATIONAL COLLABORATION: THE HEALTH SYSTEMS ACTION NETWORK

As part of the increasing global focus on the importance of health systems, the development of a health systems action network was proposed at the “Montreux Challenge meeting: Making health systems work” in April 2005. Although the objectives that HSAN will pursue are still being elaborated, the consultative process on the design of the network that PHR*plus* facilitated indicated broad consensus on developing a global community of health systems thinkers and practitioners. Further work on developing the HSAN concept will be done by a group of developing country representatives at a meeting co-sponsored by USAID, Britain’s Department for International Development, and the Bill and Melinda Gates Foundation in Toronto in August 2006.

WWW.HSANET.ORG

The screenshot shows the website for the Health Systems Action Network (HSAN) in Microsoft Internet Explorer. The browser's address bar shows the URL <http://www.hsanet.org/>. The page has a dark header with the title "Health Systems Action Network" and a star logo. Below the header, there is a navigation menu on the left with items like "Home", "Consultative Meeting", "Consultative Report", "Health Systems: Speakout", "About HSAN", "Montreux Challenge: Making Health Systems Work", "Global Health Initiatives", "Reports and Resources", "Health Systems Calendar", "Links", and "Contact Us". The main content area features a "Welcome to the Health Systems Action Network (HSAN)!" message, a photograph of a healthcare worker, and a section titled "Health Systems and Health Systems Strengthening" which lists key functions: development of human and other key resources; service provision; financing; and stewardship (oversight and guidance).

ACRONYMS

ACT	Artemisinin Combination Therapy
AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Therapy
ATC	AIDSTreatCost
CBHF	Community-based Health Financing
CDC	U.S. Centers for Disease Control and Prevention
DR Congo	Democratic Republic of Congo
EPI	Expanded Program on Immunization
FSP	Financial Sustainability Plan
GAVI	Global Alliance on Vaccines and Immunization
HIA	Health Insurance Act
HIDN	Health, Infectious Disease and Nutrition
HIV	Human Immunodeficiency Virus
HSAN	Health Systems Action Network
HSS	Health System Strengthening
IDS	Infectious Disease Surveillance
IDSR	Integrated Disease Surveillance and Response
ITN	Insecticide-treated Net
MDGs	Millennium Development Goals
MHO	Mutual Health Organization
MIS	Management Information Systems
NGO	Nongovernmental Organization
NHA	National Health Accounts
NHS	National Health Service
PhilHealth	Philippines National Health Insurance
PEPFAR	President's Emergency Plan for AIDS Relief
PHN	Population, Health and Nutrition
PHR <i>plus</i>	Partners for Health Reform <i>plus</i>
PRSP	Poverty Reduction Strategy Paper

SO	Strategic Objective
SP	Sulfadoxine-Pyrimethamine
SPARHCS	Strategic Pathway to Achieve Reproductive Health Commodity Security
SWAp	Sectorwide Approach
SWEF	Systemwide Effects of the Global Fund
TB	Tuberculosis
THE	Total Health Expenditures
UN	United Nations
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
VPD	Vaccine-preventable Disease
WHO	World Health Organization

PHR*plus* PROJECT FACTS AT A GLANCE

MISSION

Partners for Health Reform*plus* has been USAID's flagship project for health policy and health system strengthening in developing and transitional countries from 2000 to 2006. Building on the predecessor Partnerships for Health Reform Project, PHR*plus* focuses on health policy, financing, and organization, with additional emphasis on community participation, infectious disease surveillance, and information systems that support the management and delivery of priority health services. PHR*plus* results include the following:

- ▲ Implementation of appropriate health system reform.
- ▲ Generation of new financing for health care, as well as more effective use of existing funds.
- ▲ Design and implementation of health information systems for disease surveillance.
- ▲ Delivery of quality services by health workers.
- ▲ Availability and appropriate use of health commodities.

COUNTRIES WHERE PHR*plus* HAS WORKED

LATIN AMERICAN & THE CARIBBEAN

LAC Regional
Bureau
El Salvador
Guatemala
Honduras
Mexico
Nicaragua
Peru

AFRICA

Africa Bureau
REDSO
Angola
Benin
DR Congo
Cote d'Ivoire
Eritrea
Ethiopia
Ghana
Kenya
Malawi
Mali
Mozambique
Nigeria
Rwanda
Senegal
Tanzania
Uganda
Zambia

EASTERN EUROPE

E&E Bureau
Albania
Georgia
Romania
Ukraine

ASIA/NEAR EAST

ANE Regional
Bureau
Cambodia
India
Jordan
Morocco
Philippines
Vietnam
Yemen

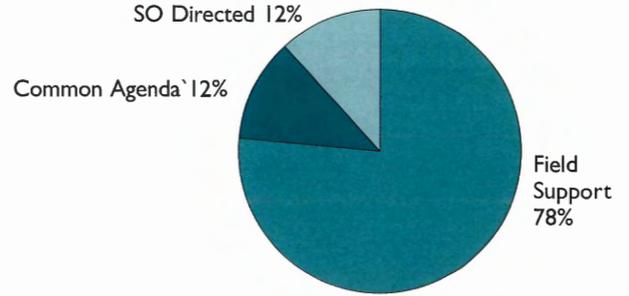
PHRplus STAFFING

- ▲ 10 site offices (Albania, Benin, Egypt, El Salvador, Eritrea, Ghana, Jordan, Peru, Senegal, and Yemen)
- ▲ More than 120 staff around the world
- ▲ 6-person Senior Management Team

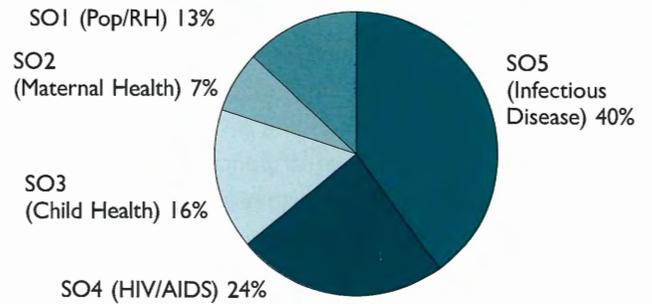
PHRplus THEMATIC AREAS

- ▲ Community-based health insurance
- ▲ National Health Accounts
- ▲ Global alliances
- ▲ Decentralization
- ▲ Infectious disease surveillance and response
- ▲ HIV/AIDS
- ▲ Applied research
- ▲ Mainstreaming
- ▲ Country field support

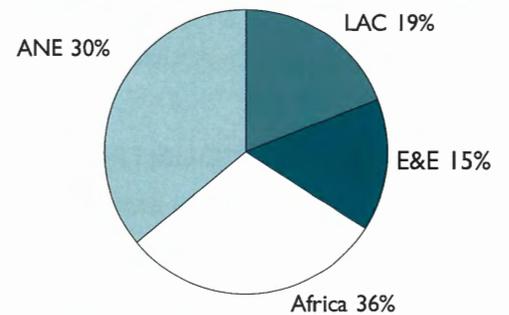
Distribution of Total Project Funds



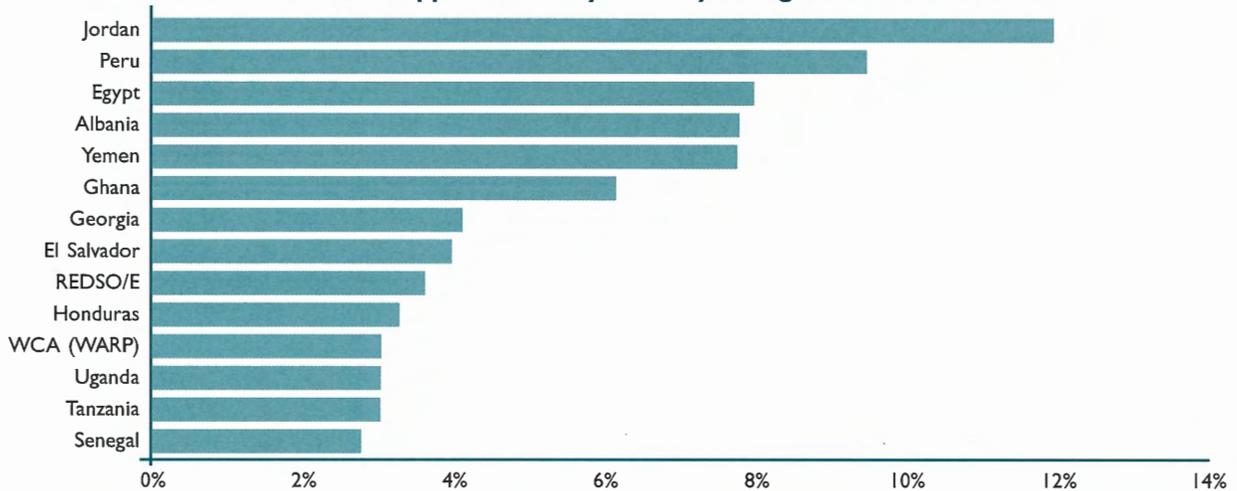
Distribution of SO Directed Funds

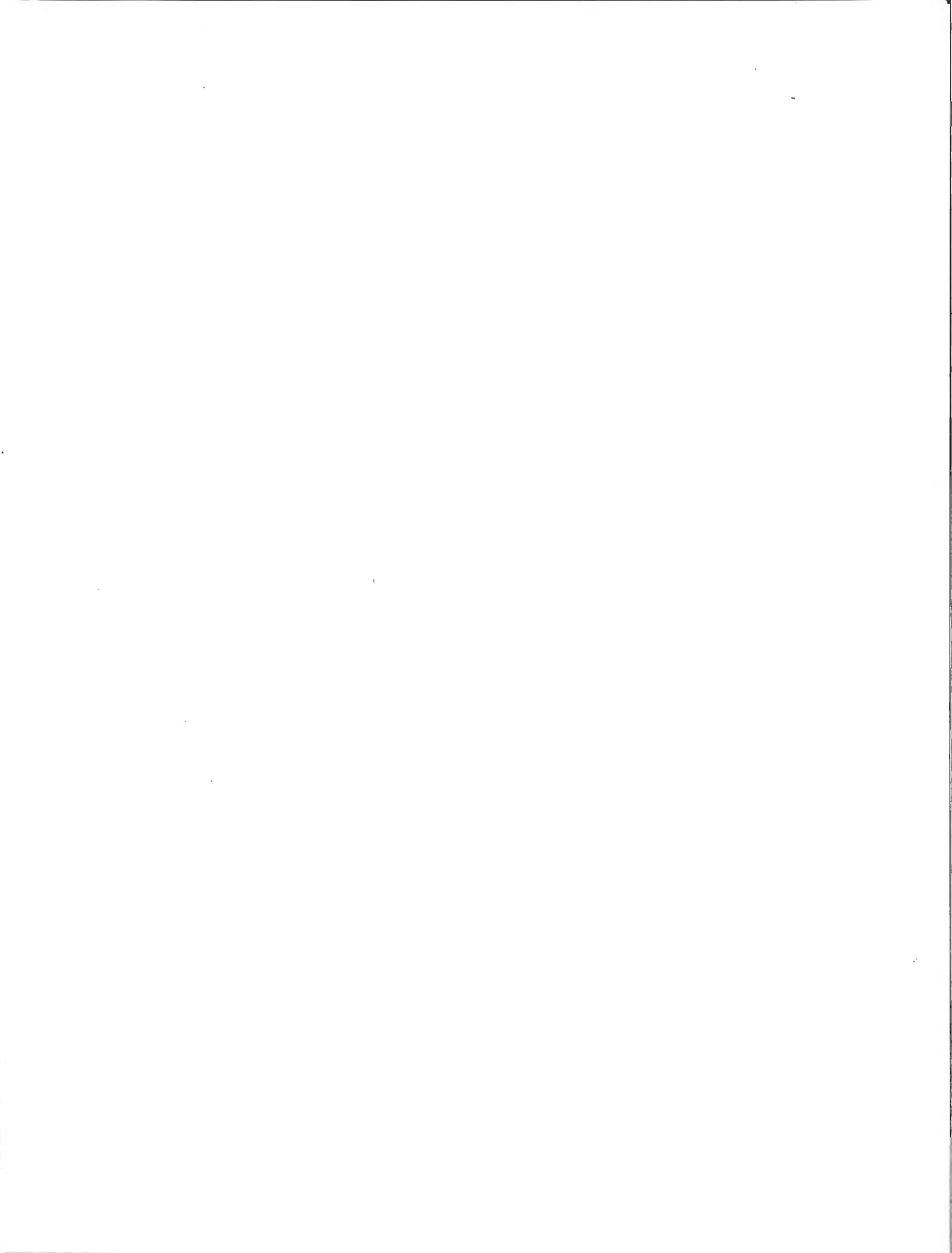


Distribution of Field Support Funds, by Region



Distribution of Field Support Funds by Country - Programs of \$2M or More





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