

PHR

Project

Final

Report

1995–2001

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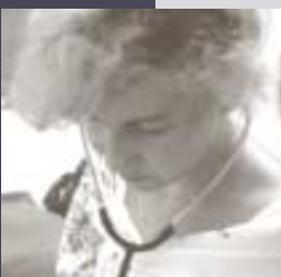
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PHR Mission

The Partnerships for Health Reform (PHR) Project seeks to improve people's health in low- and middle-income countries by supporting health sector reforms that ensure equitable access to efficient, sustainable, quality health care services. In partnership with local stakeholders, PHR promotes an integrated approach to health reform and builds capacity in the following key areas:

- ▲ Better informed and more participatory policy processes in health sector reform;
- ▲ More equitable and sustainable health financing systems;
- ▲ Improved incentives within health systems to encourage agents to use and deliver efficient and quality health services; and
- ▲ Enhanced organization and management of health care systems and institutions to support specific health sector reforms.

PHR advances knowledge and methodologies to develop, implement, and monitor health reforms and their impact, and promotes the exchange of information on critical health reform issues.

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Acronyms

AIDS	Acquired Immune Deficiency Syndrome	NGO	Non-Governmental Organization
ANMC	Alliance Nationale des Mutualités Chrétiennes de Belgique (National Alliance of Christian Mutuals of Belgium)	NHA	National Health Accounts
BASICS	Basic Support for Institutionalizing Child Survival	NIP	National Immunization Program
CA	Cooperating Agency	PAHO	Pan American Health Organization
CBHF	Community-Based Health Financing	PHN	Population, Health and Nutrition
CESAG	Centre d'Etudes Supérieures en Administration et Gestion (Center for Advanced Management Studies, WCA Region)	PHR	Partnerships for Health Reform
CH/N	Child Health and Nutrition	PSI	Population Services International
DHMT	District Health Management Team	QI	Quality Improvement
DIP	District Implementation Plan	RESSMA	Réseau de l'Economie et les Systèmes de Santé du Maghreb (Maghreb Economics and Health System Network)
FHF	Family Health Fund	RTK	Rapid Test Kit
GAVI	Global Alliance for Vaccines and Immunizations	SAR	Small Applied Research
HIO	Health Insurance Organization	SIDA	Swedish International Development Agency
HIV	Human Immunodeficiency Virus	SO	Strategic Objective
HPSS	Health Policy and Systems Strengthening	SPA	Sector Program Assistance
IEC	Information, Education, and Communication	UNICEF	United Nations Children's Fund
ILO	International Labor Organization	USAID	United States Agency for International Development
IMCI	Integrated Management of Childhood Illness	VCT	Voluntary Counseling and Testing
IPM	Instituts de Prévoyance Maladie	WHO	World Health Organization
IR	Intermediate Result	WHO/EMRO	World Health Organization/Eastern Mediterranean Regional Office
LAC	Latin America and the Caribbean	WSM	World Solidarity Movement
LAC HSR	Latin America and the Caribbean Health Sector Reform		
MAR	Major Applied Research		
MCH	Maternal and Child Health		
MCH/FP	Maternal and Child Health/Family Planning		
MH/N	Maternal Health and Nutrition		
MHO	Mutual Health Organization		
MOH	Ministry of Health		
MOHP	Ministry of Health and Population		



Introduction

The United States Agency for International Development (USAID) awarded the five-year contract for the Partnerships for Health Reform (PHR) Project to Abt Associates Inc. on September 29, 1995. Abt's project team, which includes Development Associates, Inc., Harvard School of Public Health, the International Affairs Center of Howard University, and University Research Co., LLC, began work in October 1995. This report covers the entire project period, including the six-month extension period, through March 31, 2001.

Summarizing the cumulative work of five and a half years is a challenging task. This document will not provide a comprehensive list of every PHR activity, but will focus on key results and contributions of the PHR project under three main rubrics: 1) results achieved as set out in the project's own Strategic Framework, 2) results contributing to the USAID Global Bureau/Population, Health and Nutrition (G/PHN) Center's Strategic Framework, and 3) a synthetic look at significant results in key countries and technical areas. For more details about activities, the reader may refer to PHR technical reports, tools, and other publications contained in a special CD-ROM available from the follow-on project, PHRplus, Resource Center. (Publications also may be downloaded from the PHR website, www.PHRproject.com.)

It should be noted that achievements in improving health systems performance rely on a complex interplay of factors, some of which are under project control and others that are influenced by the broader social, political, and economic environment. The design and implementation of health reform is a long-term process, and impacts of these changes on health care utilization are not always immediately evident. In addition, PHR has worked on certain activities, in some countries, for nearly five years, while other efforts, in the same or different countries, have only recently started. Thus, the discussion of contributions below will show a range of results that lie along the continuum of the health reform process: gathering information, working together to make decisions, designing interventions, implementing strategies, and monitoring and evaluating results.

Purpose and Scope of the PHR Project

The purpose of the PHR project is to support health sector reform and to advance knowledge about resolving health sector problems in Africa, Asia, Latin America and the Caribbean (LAC), the Middle East, and Eastern Europe.

The USAID Office of Health and Nutrition designed the PHR project to support reform with a capacity to address a wide range of health sector problems in a variety of country

situations worldwide. Under its contract, PHR has five main implementation modes - global assistance and special initiatives, applied research, information and dissemination services, training, and long- and short-term technical assistance - in three core areas:

▲ Health Policy and Management

- △ Formulation, regulation, implementation, and monitoring of health policies
- △ Institutional reform, decentralization, and results-oriented planning and management
- △ Human resource and infrastructure development; capacity building for policy and management processes

▲ Health Care Financing

- △ Design, implementation, and evaluation of cost-recovery, insurance, managed care, Ministry of Health (MOH) budgeting, and innovative means to generate resources
- △ Improved methods to allocate, manage, and monitor use of health resources in the public and private sectors and by households
- △ Enhancement of the cost-effectiveness of health and nutrition interventions; cost-estimating and expenditure tracking

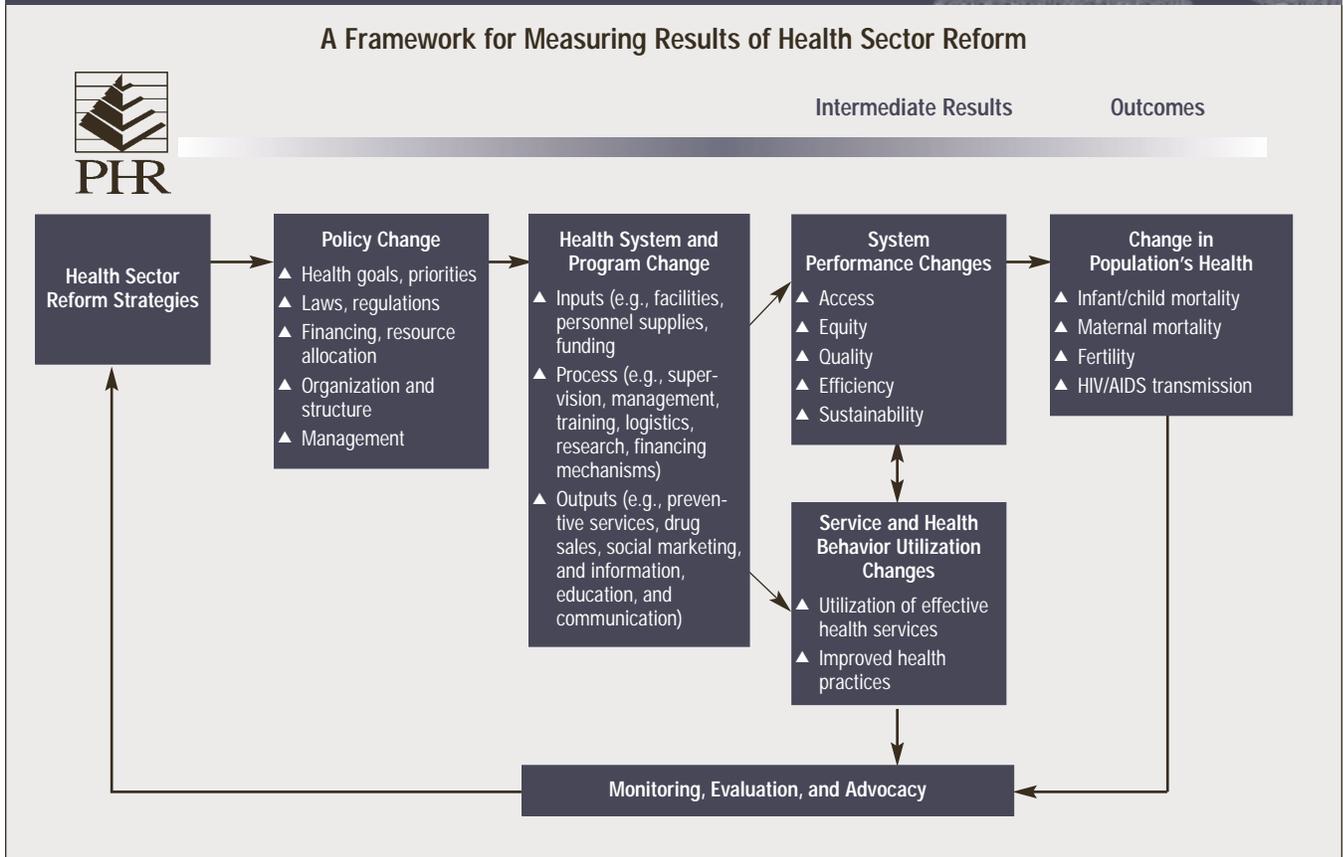
▲ Health Service Improvement

- △ Organization, supervision, and quality assurance of health and nutrition services
- △ Pharmaceutical policy and management, prescription practices, and drug logistics
- △ Private sector development, public-private linkages, and strengthening non-governmental organization (NGO) management

PHR Project Areas of Concentration

Although the health sector performance issues that PHR reform activities address are systemic and usually sector-wide, the project has not worked exclusively at the national or central level. In many instances, PHR's task has been to demonstrate an approach at the local level (e.g., in a decentralization initiative) that could be generalized nationally. Alternatively, PHR's role has been to assist in resolving a problem at one level of the health care system (e.g., primary care clinics; hospitals) that is creating a major and immediate constraint to achieving broader system goals and objectives (e.g., for institutional or financial sustainability

Figure 1: PHR Conceptual Framework



or increased access to cost-effective health services). Similarly, PHR often focused on these problems as they applied specifically to the five priority health services that the PHN Center has identified.

PHR focuses on the development and implementation of reforms that improve health system performance - that is, improvements in the access, equity, quality, efficiency, and sustainability of health systems. Improvements within these components can be considered essential for meeting the PHN Center's Strategic Support Objectives of improving use of priority interventions necessary for attaining USAID's Strategic Objectives (SOs) of improved health outcomes. Along with focusing on results of reform for improving system performance as a key underpinning to improving people's health, PHR has emphasized the development and use of indicators that measure these links and the progress of health sector reform efforts.

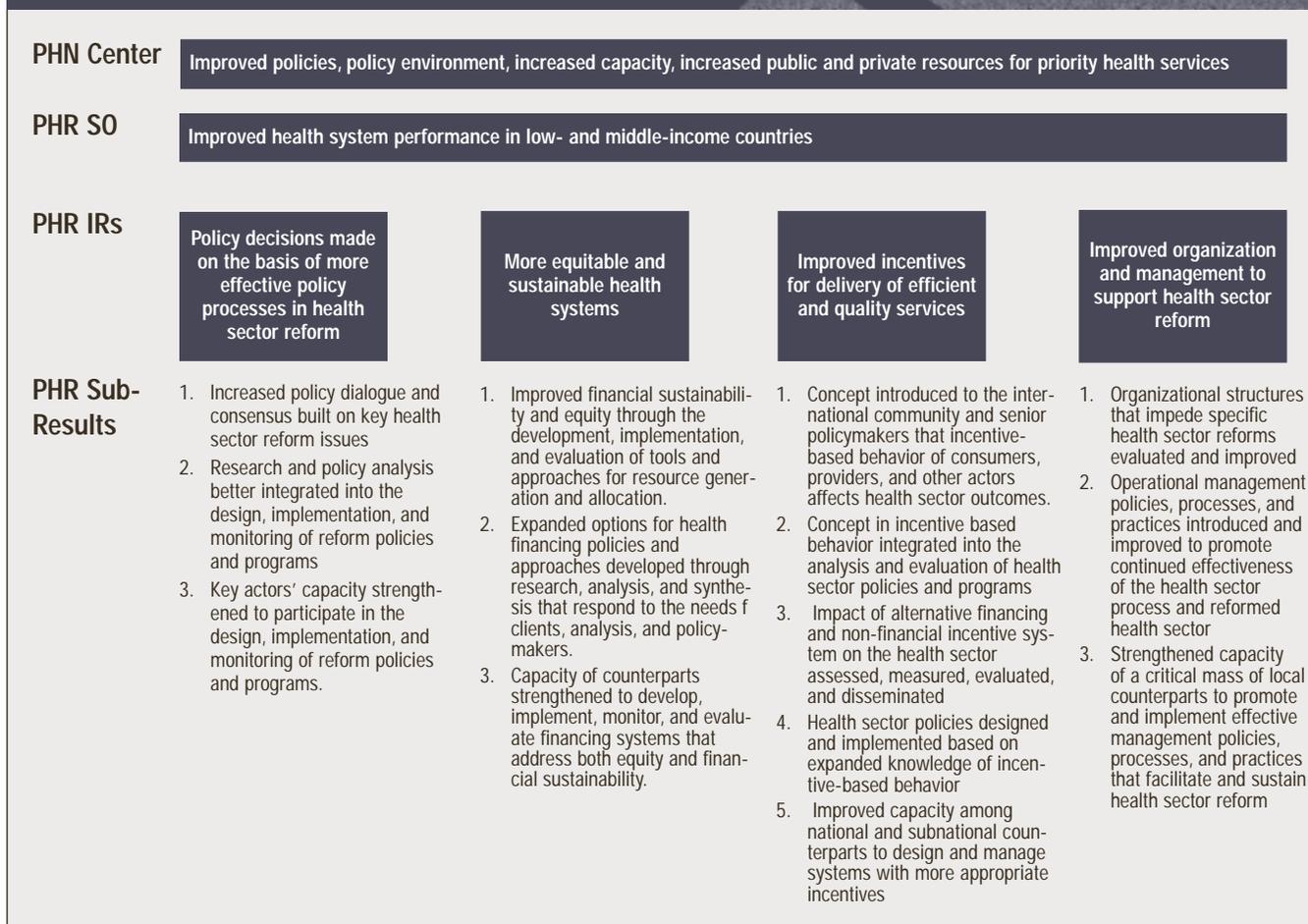
PHR's Strategic Framework

Early in the life of the project, PHR undertook a special initiative to develop indicators for measuring the impact of health sector reform, with an emphasis on key measures of systems performance in terms of equity, access, quality, efficiency, and sustainability. This effort culminated in a *Handbook of Indicators for Measuring the Results of Health Sector Reform for System Performance*, which

has guided the project's monitoring of results of its country technical assistance activities towards improving system performance. The handbook contains a conceptual framework (see Figure 1) that illustrates the main pathways from health sector reform to improved health of the population, including the feedback process by which reforms are periodically modified. In addition to showing how sector reform can have results for health status, the framework can also be used to trace "backwards" from poor health status indicators to obstacles in the health system that reform may need to address before people's health can be improved. It is designed to place the focus of improved system performance in perspective and to define an overall context to guide all of PHR's activities.

In this framework, health sector reform strategies lead to policy change on a variety of fronts (e.g., legal, financial, organizational). These policy changes, in turn, produce changes in practice related to the inputs (e.g., funding, personnel), processes (e.g., supervision, management), and outputs (e.g., health care services, medications, supplies) of health systems and programs. It is these changes in inputs, processes, and outputs that result in: (1) changed (improved) system performance (measured by indicators related to access, equity, and so forth) and (2) changed service utilization (measured by population behavioral change using indicators for service utilization, health seeking practice, lifestyle, and so forth).

Figure 2: PHR Strategic Framework: The IR Tree



Together these two sets of changes - in system performance and service utilization - are linked directly to the USAID PHN Center's SOs related to increased use of priority health services, and, ultimately, to changes in the population's health as measured by, for example, changes in mortality or fertility rates. While many other factors in the environment, economy, and society also affect people's health, Figure 1 is limited to illustrating key aspects of the role of the health system.

In Year III (FY98), the PHR project self-initiated the development of a strategic framework with one SO and four intermediate results (IRs) for the project. (The Description of Work in the project contract had outlined core health reform areas, but the contract had not specified any results framework for the project.) This strategic framework permitted tracking overall progress toward specific, project-wide SO and IRs that reflect PHR's role in technical assistance, applied research, special initiatives, training, and information and dissemination. The objectives of this new phase of PHR's strategy were to guide and monitor project activities in health sector reform and to provide a framework and indicators that reflect the project's contribution to USAID's and the PHN Center's strategic objectives for priority health services.

PHR's project-wide strategic objective is to achieve improved health system performance in low- and middle-income countries. PHR's four IRs reflect the major areas felt to be essential to this improved performance:

- ▲ Policy decisions made on the basis of more effective policy processes in health sector reform
- ▲ More equitable and sustainable health financing systems
- ▲ Improved incentives within health systems to encourage agents to use and deliver efficient and quality health services
- ▲ Improved organization and management of health care systems and institutions to support specific health sector reforms.

Figure 2 displays PHR's strategic objective and IRs, along with several sub-results for each category of IR. In 1999-2000, the Health Policy and Systems Strengthening division of the G/PHN Bureau developed its own strategic framework that builds on this one.



Results Related to PHR's SO and IRs

PHR's strategic objective, formulated as "improved health systems performance in low- and middle-income countries," focuses on better policy processes, more equitable and sustainable financing systems, improved incentives for delivery of quality and efficient services, and improved organization and management to support health sector reform.

The following sections outline "best" results that PHR has achieved in these result areas over the last five and a half years. It should be noted that health systems strengthening work often requires a long lag time to show results. Achievement of results is also highly dependent on the political and economic stability of the countries where PHR works. In many cases, the results of project efforts have not been fully realized due to political unrest, changes in government, and/or economic crises. However, PHR, through its focus on stakeholder participation and capacity building, has laid the groundwork for future results, if a longer timeframe is considered.

Policy Decisions Made on the Basis of Effective Policy Processes in Health Sector Reform

Experience has shown that reform efforts have often failed to achieve their anticipated results, and sometimes have had unintended consequences for priority health services. The design and implementation of reform is essentially a political process and often lacks accurate information upon which to inform these more "political" decisions. In this light, PHR highlighted a key intermediate result for improved health systems performance: policy decisions made on the basis of effective policy process in health sector reform. An improved policy process is based on the recognition of three key elements:

1. the political nature of policy decisions: increased dialogue and consensus on key reform issues;
2. the technical element: research and policy analysis better integrated into the design, implementation, and monitoring of reform; and
3. increased local capacity to participate in design, implementation, and monitoring of reform.

The following sections examine important issues regarding each element and significant contributions and results achieved under the PHR project.

IR1.1 Increased policy dialogue and consensus built on key health sector reform issues

Stakeholder¹ participation and communication in the policy process has been highlighted in the new Health Policy and Systems Strengthening (HPSS) Flagship project, thus demonstrating increased recognition of the importance of these features to the effectiveness of the process. PHR contributed to this effort in several ways: by developing methods to improve stakeholder participation, conducting research to better understand the policy process, and using the methods, concepts, and findings to achieve increased dialogue and consensus on reform issues.

Methods developed to improve stakeholder participation and dialogue: As a partner in the **Latin America and Caribbean Regional Health Sector Reform (LAC HSR) Initiative**, PHR developed a toolkit to help health sector reform teams better understand the nature of the political process and develop skills to actively manage that process.

The toolkit contains three key tools: stakeholder analysis guidelines (to identify interested parties and assess their support, underlying interests, and whether their interests should be taken into account); **advocacy** (to determine objectives, identify target audiences, determine strategy, and develop, target, and deliver the message); and **conflict negotiation guidelines** (to anticipate, contain, and resolve disputes that arise when parties with different interests need to work together towards a mutually agreeable solution). The toolkit also includes a section on strategic **management**, a method for achieving policy goals through an assessment of internal and external factors that define the appropriate strategy. Observable results were achieved by the Honduras Ministry of Health (MOH) when officials applied these new skills to: a) support the formulation of a National Drug Policy; b) facilitate evidenced-based decision making in the use of National Health Accounts (NHA); c) establish a Community Drug Fund; and d) promote internal advocacy (institutional capacity building) among senior- and middle-level decision makers in the MOH. PHR has produced two policy primers to aid policymakers' understanding of the issues in stakeholder participation and consensus building: LAC HSR Initiative's **Primer on Provider Payment Alternatives for Latin America: Concepts and Stakeholder Strategies** and **PHR Primer on Strategic Stakeholder Communication for Strengthening Health Systems**.

1. Stakeholders are individuals or organizations who have a vested interest in an action or policy being promoted.

Research to increase understanding of the political process: Delays and reversals in reform implementation have been shown to result from obstacles such as conflict over policy goals between different interest groups, lack of relevant information, and limits on the institutional capacity available to design and implement reforms. PHR's Major Applied Research (MAR) study on the **Dynamics of Policy Change** studied the critical factors facilitating and constraining the development and initial implementation of selected financing reforms in Zambia and South Africa. The study generated 10 principles that any country could use to strengthen processes of decision making (see page 30 for more details).

Results achieved in improvement of dialogue and consensus: Increasing communication and dialogue has been an integral part of many PHR country activities. Such increased stakeholder participation has taken many forms with a wide range of results. In **Senegal**, misunderstanding of roles of local governments and health districts under the newly decentralized system led to drastic reductions in resources available for health. PHR led a series of participatory stakeholder meetings on these problems in three regions, after which the MOH developed written regulations requiring local health committees to form district-level committees in partnership with MOH officials. They also initiated development of legislation for the national General Assembly that required local elected officials in a health district to form an association through which government block grants were distributed to more effectively finance district activities. This effort, in addition to a matching fund mechanism through USAID, led to increased resources available for health. In the participating districts, health care expenditures increased from \$2/capita to \$3.75/capita. In **Ecuador**, a combination of stakeholder analysis and political mapping, combined with capacity building in these methods, led to an increased number of groups involved in the reform design and the establishment of a new department in the MOH on negotiation and conflict resolution. In the **Dominican Republic**, PHR helped organize a seminar where representatives from all political parties participated in a Dialogue and Construction of

Health Reform Forum to ensure that the health reform issues stayed on the political agenda, regardless of who took power in the upcoming elections. In **Bolivia**, following the implementation of an evaluation of the government's maternal and child health insurance program, PHR trained several MOH counterparts and local consultants to facilitate consultative meetings in six different areas of the country. Findings of the evaluation and needed areas for improvement were presented and discussed with department and district-level stakeholders including health system managers, facility administrators, health providers and workers, elected officials and community representatives. The extra time and outreach invested in this stakeholder consultation built consensus about next steps, integrated local-level input into the planning of services and national insurance, and improved the ability of a public program to deliver essential services to the poor.

IR 1.2 Research and policy analysis better integrated into the design, implementation, and monitoring of reform policies and programs

Sound policy is founded on good information. PHR has contributed to better policy elaboration through the development of tools to help policymakers understand the current situation, what kind of options are available, and the possible advantages and disadvantages of these options. PHR country work has also provided good technical information that has sometimes resulted in the decision not to implement a planned (but unsound) policy.

Methods developed to integrate better information and policy analysis into reform design, implementation, and monitoring: Obtaining useful information in a format that facilitates analysis and interpretation is one key component of good policy design. PHR has worked to refine and disseminate a series of tools that provide information about financing health services. **National Health Accounts** is a methodology for measuring total national health expenditures in terms of where they come from, how they are organized among financing institutions in national health systems, and how they are used. More specific variations of the NHA methodologies have been developed for HIV/AIDS (in Rwanda) and for regional breakdowns for maternal and child health (MCH) care (in Morocco). **Immunization financing tools** provide a methodology for conducting in-depth analyses of immunization programs in terms of current financing mechanisms and potential program improvements. In addition, PHR, as part of its work in Egypt, has developed a series of **decision support tools**, such as the Inpatient Bed Policy Simulation model, which projects requirements and supply of hospital beds to create an appropriate balance between these two, and the Basic Benefits Simulation model, which enables forecasting of workforce, pharmaceuticals, and financing for various scenarios about covered benefits.

PHR has contributed to better policy elaboration through the development of tools to help policymakers understand the current situation, what kind of options are available, and the possible advantages and disadvantages of these options.

Research and studies to better understand the content of good policy at the global or local level: There is still much to be learned about which policy reforms work and which do not. PHR has conducted several MAR studies that have focused on important technical issues at a global level related to key policy issues - the policy process, equity, decentralization, public/private sector mix, health worker motivation, and alternative provider payment mechanisms. PHR also supported a Small Applied Research (SAR) program to advance knowledge about health sector reform at the individual country level. Sixteen grants were awarded in 12 countries (see box).

Results achieved in improving policy content: In many countries, PHR has been active long enough to see the influence of improved technical information resulting in better policy decisions. In Egypt, several PHR studies, together with insights gained by piloting a new model of service delivery and financing, have influenced several important decisions by the Ministry of Health and Population (MOHP) and other donors. The Health Workforce Rationalization Plan has convinced the European Commission to support training of additional family doctors. The PHR financing study has informed the World Bank decision to decrease the number of family health centers to be built, thus averting wasteful use of resources. MOHP policymakers have used the PHR bed needs model to explain and justify the need to reduce hospital construction in Egypt and have cut construction of new beds by 10 percent. This will enable the shift of MOHP funds to primary health care over the next five years. In **Jordan**, results from a survey of private insurance and a series of focus groups with the uninsured were critical in leading MOH decision makers to avoid a premature decision to adopt a voluntary health insurance program. The program would have required a higher level of management capacity than available at the time, and would have created adverse selection. In **Honduras**, the MOH, based on findings from a PHR study on community drug funds, changed the policy on what kinds of drugs should be stocked in these funds and what kind of support these funds should receive (including training in efficient management and pricing). The recently completed user fee study in Honduras, in addition to analysis of household survey data on income and expenditures, will form the basis for continued policy work under the HPSS project.

IR 1.3 Key actors' capacity strengthened to participate in the design, implementation, and monitoring of reform policies and programs

Capacity building in the policy process has been a key component of PHR's country and regional activities. In some cases, these have been formal training activities to impart knowledge and skills to participants. In others, it has been done one-on-one during the course of the work itself.

SAR Topics	
Country	Topic
Ghana	Contribution of private providers to public delivery
India	Competition, incentives of private hospital market
Peru	Targeting public health expenditures
South Africa	Design of low-cost health insurance package
Sri Lanka	Operating efficiency in public sector facilities
Tanzania	Growth of private sector and challenge to quality
Uganda	Impact of user fees in government health units
Bangladesh	Costing of IMCI (Integrated Management of Childhood Illness) module
Georgia	Policy, regulatory decisions for hospital financing
Jamaica	Protecting the poor under health insurance
Peru	Determinants of women's health service usage
Philippines	Local governments' health financing initiatives
South Africa	Cost-effectiveness analysis of AIDS patient care
Tanzania	Appropriate payment mechanisms for poor
Uganda	Priority services under decentralization
Zimbabwe	Regulation and incentives for private providers

Under the **LAC HSR Initiative**, PHR developed and conducted a training workshop on "Managing the Policy Process" in Honduras, Nicaragua, and Chile. Technical reform teams and decision makers from 13 countries in the region participated in this innovative and participatory learning vehicle. The LAC Policy Toolkit also has a stand-alone training manual that has been field-developed to allow for continued capacity building within the region. For example, feedback from the training on conflict resolution indicated that in Costa Rica the skills were used to help resolve a strike by the unions, and, in El Salvador, negotiation skills were used in developing new projects between the MOH and the NGOs. In **Malawi**, more than 100 district-level health managers have been trained in planning and budgeting for the new decentralized system. **Jordan's** leaders and opinion-makers from the MOH, Royal Medical Services, and academia participated in a study tour to the

United States on strengthening the demand for and use of research in policymaking. Post-tour briefings conducted under the leadership of Prince Firas Ra'ad and PHR resulted in Jordan's first Research/Policy Forum, "Strengthening Evidenced-Based Policymaking in Jordan." Recommendations emerging from the Forum - to strengthen the research/policy link - were submitted by the Royal Palace and the MOH to the Parliament. Participants in each of these events represented Jordan's health care leadership from the MOH, the Royal Medical Services, Jordan University, Jordan University of Science and Technology, and Applied Science University. More than 150 participants in 27 countries have been trained and supported in their implementation of the **National Health Accounts** methodology, including the establishment of three regional networks to continue support and capacity building. In the **Dominican Republic**, PHR has helped launch a new system for monitoring and evaluation of the health reform process, which will provide data on ongoing reforms and help inform future decisions on health systems changes.

More Equitable and Sustainable Health Financing Systems

One major focus of PHR activities has been health financing. Resource constraints and rising health care costs have led many countries to examine new ways to generate and allocate their resources. In many instances, governments are looking for solutions to either inadequate resources or increasingly costly services. PHR sought to maintain a focus on equity and sustainability in its examination of financing issues and to expand the options that were explored for financing health services.

Improved financial sustainability and equity through the development, implementation, and evaluation of tools and approaches for resource generation and allocation

Improving equity and sustainability of any financing system requires information about how well that system is working. PHR has developed a series of tools and approaches to examine these systems and better understand them. In many cases, the findings from application of these tools have led to policy changes that increased equity and/or sustainability.

Methods and tools to improve equity and sustainability: The **LAC HSR Initiative** has provided policymakers in the region with a comprehensive analysis of equity, as well as how inequities might be addressed. The **LAC equity primer** (*Guía básica de política: Toma de decisiones para la equidad en la reforma del sector salud*) lays out the various levels and stages at which equity decisions are made, while the **LAC targeting** (*Targeting Methodologies: Conceptual Approach and Analysis of Experiences*) analyzes actual LAC experiences and lessons learned in trying to target certain groups with the goal of

improving equity. The **immunization financing toolkits** are: 1) a financing assessment tool that helps policymakers develop the financial component of medium-term action plans for immunization programs, and 2) a resource document that compiles extensive information on immunization financing: articles and web resources pertaining to costing, financing, policy issues, and a contact list of key institutions and individuals working in immunization issues.

Increased knowledge about sustainability: The **immunization financing** studies carried out in Morocco, Côte d'Ivoire, Bangladesh, Colombia, and Ghana provided information to policymakers on the origins of the resources for immunizations and the disbursement of these resources. The studies also estimated the costs of including additional vaccines, such as Hepatitis B. Findings indicated that immunization is affordable at less than \$1/capita to fully immunize a child, but that there is significant donor dependence for specific recurrent immunization costs. These studies also identified areas for improved efficiency and provided a baseline for better forecasting of vaccine needs. Similar studies focusing on polio eradication efforts in Morocco, Côte d'Ivoire, and Bangladesh showed that government funding for routine immunizations increased during polio campaigns in these three countries. In addition, these studies indicated that the **polio eradication** campaigns do not lead to reductions in funding for routine immunization programs because the Polio Eradication Initiative (PEI) activities attract additional funding to the sector. The increase in funding appears to take place for two reasons: 1) many donors prefer to specialize in either polio eradication or routine immunization, and 2) some donors increase their overall level of funding so that they can support a high-profile activity such as polio eradication. A user fee study in **Honduras** showed that in the current system, revenues generated from institutional user fee collection were less than the costs of collection. The system continued to operate because individual facilities appreciated having these funds to spend at their discretion. The **MAR study on Expanded Coverage of Priority Services through the Private Sector** focused on creating a model through which government choices for expanding coverage of priority services can be analyzed. The model assesses how governments can best use a small amount of additional funding to expand priority services, examining options such as providing more consumer information, expanding the quantity of public services, or subsidizing private providers. The application of this model to data from Egypt suggests that where public services are underutilized and there are significant non-government alternatives, governments should consider allocating more resources at the margin to subsidize transportation, educate women, and finance non-public services rather than expanding the quantity of public services.

Increased knowledge about equity: The **Equity MAR** examined the effects of socio-economic status on morbidity, utilization, and expenditures in eight countries: Burkina Faso, South Africa, Zambia, Paraguay, Guatemala,

Thailand, Kazakhstan, and Kyrgyzstan. Key findings from this study include: 1) the private sector is a significant provider of care for the poor in several (three) countries studied; 2) rural populations use hospitals more often than urban populations in three countries; and 3) in some countries, the poor devote a larger percentage of their consumption spending to health than do the rich. These results indicated that equity considerations varied by country, highlighting the need to study equity locally to understand how best to address it. Such further investigations into equity for the purpose of designing appropriate interventions have taken place in **Mali**. Here, an extensive survey of households and providers generated information about the demand and supply for health services to determine what kinds of strategies would address the specific issues in two types of settings. Findings indicated that the poor spend significantly less on health, but the relative importance of income in patterns of care seeking is unclear. However, rural inhabitants are systematically less likely to use health care services than those living in urban areas. Local partners have examined these results for the development of strategies to increase utilization of priority services: intensify information, education, and communication (IEC) campaigns, promote mutual health organizations, and develop low-cost tools to improve the quality of care. PHR, under the **LAC HSR Initiative** has completed a primer on equity and a comparative analysis of social insurance in the LAC region. The latter assesses vertical and horizontal equity, as well as coverage and access.

Results achieved in resource generation and allocation:

In several countries, information about the effects of resource generation and allocation has led to implementation of new or modified policies. Based on policy analysis and dialogue by PHR and others, the MOH in **Morocco** increased its budget to fully fund contraceptives and vaccines. The Moroccan parliament approved this increase in national expenditures, as well as a tax waiver on contraceptive imports. The government of Morocco also doubled its budget for the national immunization program as a result of PHR's immunization financing study, after its dissemination and discussion among stakeholders. These budget increases for contraceptives and immunizations reduce dependence on USAID and other donors. In **Bolivia**, PHR's evaluation of the Maternal and Child Health Social Insurance program led to an increase in reimbursement rates (up to 30% for maternal health services) that are more in line with actual costs. Increasing reimbursement rates will facilitate sustainability of this program that has increased MCH service utilization among the poor. The application of tools developed under the immunization financing activity in **Côte d'Ivoire** and **Bangladesh** assisted these countries in applying to Global Alliance on Vaccines and Immunization (GAVI) for assistance in incorporating additional vaccines to their programs. In **Zambia**, introduction of PHR-designed systems for managing sales of insecticide treated nets for malaria prevention has resulted in improved collection rates (almost 100%) and cost-

Improving equity and sustainability of any financing system requires information about how well that system is working. PHR has developed a series of tools and approaches to examine these systems and better understand them. In many cases, the findings from application of these tools have led to policy changes that increased equity and/or sustainability.

recovery (54%) in districts in which the system is operating. The system of management and sales has expanded from six rural health facilities to a total of 64, and resulted in an increase in households with nets from 7% to 30-40%.

Results achieved in making financing systems more equitable: In **Rwanda**, the prepayment scheme introduced in three districts allows members to pay an annual premium that entitles them to a defined benefits package for a given period of time. This scheme has resulted in increased utilization of modern health facilities for all income groups, compared to non-members, with the biggest increases seen in the lowest income group. The Family Health Model, being tested in seven pilot facilities in Egypt, ensures more equitable delivery of services for all 120,000 enrolled members who are eligible for the whole range of services available under the basic benefit package: maternal and reproductive health services, child health services, and adolescent and adult health services (including prevention and treatment of both communicable and non-communicable/chronic diseases).

Expanded options for health financing policies and approaches developed through research, analysis, and synthesis that respond to the needs of clients, analysts, and policymakers

Conventional approaches to financing health services have not always succeeded in generating adequate resources or creating the kinds of coverage and utilization sought. PHR has studied various financing systems, and designed and implemented innovations that have increased knowledge and understanding of the options available.

Innovative financing methods studied: Since 1996, PHR has been studying the design, capacities, and performance of **mutual health organizations** (MHO) in West Africa and has provided technical assistance to foster their success. MHOs are organizations that aim to improve access to affordable, quality health care based on an ethic of mutual aid, the collective pooling of health risks, and member participation in fund management. The MHO movement has

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gained the attention of governments and other donors who now recognize the importance of community participation in the design and financing of health services. While traditional MHO benefits packages focused on hospital care, today MHOs are beginning to include preventive and basic health care. PHR conducted a survey of 50 MHOs in six countries, with in-depth evaluation of 22 MHOs. In Senegal, the MOH established a special committee to examine policy issues, to coordinate activities, and to support the development of viable MHOs in that country. Similar work is taking place in East Africa through the **Community-Based Health Financing (CBHF) Network**, an informal association of grassroots health care financing practitioners, policymakers, and technical experts. PHR, in collaboration with the network and USAID's Regional Economic Development Services Office (REDSO) in Nairobi, completed a comprehensive research and analysis of existing CBHF schemes in Kenya, Tanzania, and Uganda. This analysis resulted in the production of a comprehensive "how to" manual for emerging schemes and rural communities interested in building capacity in CBHF management and operations. The manual was distributed to NGOs, ministries of health and finance throughout Africa, and other key players in health sector reform in the United States and Europe. NGO-contracting case studies in the LAC region have demonstrated the viability and success of this form of public-NGO partnerships in increasing access and coverage of primary care services.

Results of implementation of innovative financing methods: In Rwanda, PHR worked with national and local counterparts to test an innovative prepayment scheme in three rural districts, which would expand access to health care among families who only have access to cash on a seasonal basis. Many people questioned the feasibility of such a scheme in such a poor area. Yet, at the end of the first year of the PHR-supported Prepayment Scheme Pilot more than 8% (88,000) of the target population was enrolled in 54 prepayment schemes. This has resulted in increases in utilization, including a 45% increase in health center deliveries and a 25% increase in prenatal services in the two

pilot districts with the highest enrollment rates. It has also stimulated better care-seeking behavior as well as increased equity, community participation, and financial sustainability. In **Egypt**, PHR developed, in conjunction with the Health Insurance Organization (HIO), a Family Health Fund which will have many innovative components: performance-based contracting, payments only to accredited facilities, periodic customer satisfaction input as a condition of contract, and capitation payment for a family health model of care. Currently, the performance-based contracting is in effect. The capitation payment system is still in development while cost analyses of pilot site services are providing critical information to develop capitation rate structures. In **Morocco**, officials have changed policies for their vaccine revolving fund to consider a wider range of funding options for childhood immunizations. The new funding options will mobilize more local resources and improve sustainability as donor funding dwindles. In **Ghana**, PHR has provided technical assistance to several mutual health organizations. As a result, the number of MHOs in Ghana has increased from four to 24, and membership has increased dramatically. In addition, the MOH has reoriented its health financing strategy from one of a national health insurance system to one of promotion and support to MHOs.

Results from innovative financing mechanisms for USAID: In **Zambia**, PHR worked with the USAID Mission to develop a Sector Program Assistance (SPA) agreement that ties USAID cash support to performance in three main areas: 1) government funding of essential health care package, 2) achievement of people-level impact with the essential package, and 3) financial reporting accountability and management. PHR assistance was instrumental in developing mutually acceptable objectives and performance measures. As a result of the SPA, USAID-Zambia is now participating in a debt-for-health swap that releases funds to a district-level common basket for health care under Zambia's donor-supported sector-wide approach. To date, \$2 million have been released to support district health services and the promotion of a new health care financing policy. In **Senegal**, previous data indicated that less than 5% of donor funds ever reached health facilities. PHR worked with USAID to develop an innovative mechanism to ensure that their resources reached the periphery. USAID provided matching funds to decentralized local government units now responsible for allocating resources to health and other sectors at the local level. In the first year, local funding for health increased 80%, and then an additional 20% on top of that by the third year. In addition, this USAID money is being used directly by health facilities to cover the costs of renovations, materials/equipment/drugs, logistics, and supervision.

Tools to expand options for health financing: PHR has developed a number of tools to help mutual health organizations strengthen their performance and sustainability. Several training of trainers manuals and management

information system tools were developed for specific MHOs receiving assistance, and a MHO managers handbook is currently being produced in French. Similarly, PHR has developed, based on lessons learned from a three-country study in East and Southern Africa, a **CBHF** toolkit and manual that describe the process of setting up and operating a CBHF scheme. The toolkit includes descriptions and analyses of several “off-the-shelf” software packages that could assist emerging schemes to improve management and operations. The toolkit complements the manual, which is designed to enable local schemes to build management systems and capacity.

Capacity of counterparts strengthened to develop, implement, monitor, and evaluate financing systems that address both equity and financial sustainability

PHR has built human resource capacity in two major ways to enhance financing system performance: capacity of those who are managing the systems and capacity of those who will be designing, implementing, and evaluating the systems.

Capacity building for specific financing schemes: PHR has conducted a series of workshops on **MHOs** and **CBHF schemes** to disseminate best practices and lessons learned. In 2000, more than 70 representatives of West African MHOs, government officials, and Cooperating Agencies (CAs) from Ghana, Côte d’Ivoire, Benin, Mali, and Senegal learned about and/or presented results from current MHO experiences in the region. A similar event in East Africa brought together 30 representatives from East African CBHF schemes, MOH officials, and NGO representatives from Kenya, Tanzania, Uganda, and Rwanda. In **Egypt**, PHR provided training for six HIO managers in performance-based contracting and management of health insurance to enable them to manage the new Family Health Fund’s (FHF’s) incentive-based payments and develop the capita-tion estimates. PHR systems and training have already been put into effect for the first performance-based incentive payments to providers in the pilot facilities that occurred in early 2001. In **Zambia**, PHR developed cost-sharing guidelines and conducted training of trainers for regional health officers to train district-level staff in these guidelines. In addition, this workshop launched a widespread capacity building effort and resulted in a decision to set up a coordinating committee to make needed amendments to the guidelines, manage the implementation process, and develop a plan and budget for strategies for dissemination of the guidelines. Also in Zambia, PHR trained local partners who are now implementing the sale and distribution system for insecticide treated nets and providing ongoing monitoring. The system has been so successful that it is being expanded to cover all of the initial three districts and two additional districts.

Capacity building in health financing: A key area where capacity is generally lacking, particularly in Africa, is health economics. PHR has worked with universities in **Senegal** (*Centre d’Etudes Supérieures en Administration et*

Gestion, CESAG) and **Rwanda** (National University of Butare) to develop graduate programs in health economics. In Senegal, five West African economists completed training at the CESAG regional center. PHR’s assistance included curriculum development; assessment of regional demand for program, organizational, budget and strategic planning; as well as faculty recruitment and development. As a result, CESAG was selected as regional training partner for World Bank Institute Flagship course on health financing and health sector reform. In **Morocco**, PHR also provided training in health economics and assisted the Maghreb Economics and Health System Network (**RESSMA**) to develop a regional website on health reform, economics, and policy issues to promote ongoing exchange and a mechanism for disseminating information on these subjects. PHR’s **Small Applied Research** program was designed as a means to increase capacity among developing country researchers, advance knowledge on health sector reform, and support reforms. A survey of grant recipients indicated that they experienced growth in their capacity to conduct policy-relevant, scientifically valid research, as well as a bolstering of their policy research networks and ability to generate new research funding.

Improved Incentives for Delivery of Efficient and Quality Services

Experience with a broad range of reforms to strengthen health systems has made it abundantly clear that understanding the underlying incentives in the present and proposed systems is key to achieving desired outcomes of the reforms. Incentives are the tangible or intangible rewards or consequences experienced by individuals, groups or organizations that are either inherent in the system or explicitly designed to induce certain behaviors.

Concept introduced to the international community and senior policymakers that incentive-based behavior of consumers, providers, and other actors affects health sector outcomes

The concept of incentive-based behavior is not new, but it has often been viewed narrowly in terms of financial incentives to reduce costs. Financial incentives are indeed one mechanism for generating motivation to carry out certain behaviors, but there are many more determinants to worker and organizational motivation. PHR explicitly developed an intermediate result in this area with the goal of not only studying and testing incentives, but also introducing the concepts to policymakers and advocating for more consideration of this concept in the design of reforms.

Conceptual work and tools on incentives: The **Health Worker Motivation MAR** started with an interdisciplinary workshop to review experiences of reform and health worker motivation, to present and refine a conceptual framework, and to develop a research agenda. The *PHR Primer*

on Health Worker Motivation and Health Sector Reform presents this multi-disciplinary conceptual framework for understanding the various factors influencing worker motivation and discusses how health sector reform can be designed to positively impact on motivation. PHR has developed and disseminated a number of other primers for policymakers on various aspects of incentives. The *PHR Primer on Alternative Provider Payment Mechanisms* discusses incentives created by these mechanisms and provides examples of the types of systems that have been used around the world. Through the **LAC HSR Initiative**, PHR produced an additional three primer series on provider payment reform: 1) *Provider Payment Alternatives for Latin America: Concepts and Stakeholder Strategies*, 2) *Guide to Prospective Capitation with Illustrations from Latin America*, and 3) *Prospective Case-based Payments for Hospitals: A Guide with Illustrations from Latin America*. These primers have been written for policymakers and technical reform teams who are seriously considering initiating such reform in their countries and disseminated to over 650 key actors in the LAC region.

Increased awareness generated about incentive-based behavior: PHR's conceptual framework on health worker motivation has been presented and discussed at the World Bank (during the Health Development week in 1999), at the Harvard School of Public Health in 1999, and at the 2000 APHA annual conference. The framework and subsequent study have been presented to key policymakers and hospital managers in **Jordan** and in the **Republic of Georgia**. Requests from the World Health Organization (WHO) to participate in a consultative meeting on health worker motivation (2000) and invitations to attend the University of Liverpool School of Tropical Medicine conference on quality assurance and human resource management (2001) provide evidence of PHR's leadership role on this topic. In **Peru**, extensive discussions about the role of incentives preceded the development of the case-based reimbursement system, and MOH personnel have demonstrated their command of these concepts in subsequent writings, presentations, and roundtable discussions.

Concept of incentive-based behavior integrated into the analysis and evaluation of health sector policies and programs

In the context of the **Health Worker Motivation MAR**, PHR commissioned four case studies on the impact of health sector reforms on health worker motivation. These case studies, from Chile, Senegal, Zimbabwe, and Kazakhstan, outlined how various components of reform and the process of reform affected worker satisfaction, commitment, and performance. These case studies showed the positive results from systems with balanced incentives (Kazakhstan) and the more negative results from reforms that were poorly communicated and unevenly implemented (Senegal and Zimbabwe).

Impact of alternative financial and non-financial incentive systems on the health sector assessed, measured, evaluated, and disseminated

In **Jordan** and the **Republic of Georgia**, PHR's applied research on Health Worker Motivation examined key factors affecting worker satisfaction, commitment, and behavior. Results were used in both countries to make changes at the hospital level and provide recommendations for higher-level changes. In Jordan, hospital managers at one study hospital have already implemented increased communication mechanisms, staff recognition, better staff orientation, and improved performance appraisal processes. Specific recommendations were also made for improvements in civil service regulations (technical staff recruitment and selection procedures) and MOH procedures (employee orientation, job descriptions, and minimum staffing needs). In the Republic of Georgia, PHR research on health worker motivation has already resulted in reforms in how physicians are paid at one of the study hospitals. In the **Provider Payments MAR**, PHR examined the effects of capitation payments on services delivered, spending, organizational management practices, and market structure. Capitation generally involves a flat monthly fee paid for each beneficiary covered, instead of payment based on services provided. Findings from a three-country study (Nicaragua, Argentina, and Thailand) indicate that capitation promoted an emphasis on primary health care services, reduced use of inpatient care, and helped contain overall health spending. The World Bank's program on provider payments has asked to use PHR's case studies to further develop its work.

Health sector policies designed and implemented based on expanded knowledge of incentive-based behavior

Reforms designed to reward efficiency and better management: In **Rwanda**, the community-management prepayment scheme, which enrolled 8% of the population in pilot districts, provides incentives through capitation payments (fixed monthly per capita amount for each member enrolled at the site) for health center staff to improve quality health service delivery and to focus on preventive interventions. The scheme also provides incentives to increase patient satisfaction, which will foster increased enrollment and, therefore, additional payments. The system has also removed one of the main disincentives (price for services) for patients to seek early treatment, because, once enrolled, they are eligible for a range of services with only a very minor co-payment. In comparison with scheme members, non-members spend four to 12 times more overall to remedy their illness. In **Peru**, PHR has worked with the MOH to develop a new case-based hospital payment mechanism, which is currently being tested in eight selected hospitals. The rationale for this reimbursement mechanism is to improve MCH care in Peru, focused on primary and secondary levels. Currently, hospitals consume the bulk of resources for health. The case-based reimbursement

system seeks to create a more balanced health system, using incentives (average cost reimbursements based on health resources grouping) rather than administrative control to reduce excess capacity. Such case-based reimbursement will be introduced into provider/purchaser contracts and can also be used for quality control and better clinical management.

Reforms designed to reward better quality and performance: PHR has worked with the MOH in **Egypt** to develop a primary health care facility accreditation program and a Family Health Fund to establish performance-based contracts with PHR pilot facilities. The accreditation program forms the basis for a facility's eligibility to contract with the Fund as well as for continuous quality improvement - two key components of the Egyptian reform agenda. The financing system includes two components: a capitation payment to the facility for each enrolled member plus a performance-based payment to providers. These incentive payments, which are being piloted, reward decreased patient waiting time and delivery of preventive and promotive care. Indicators being tested include number of visits, use of ancillary services, referral patterns, visit length, prescribing behavior, and patient satisfaction measures. In **Honduras**, PHR has provided technical assistance for the development of the MOH's regulatory function. PHR compiled an inventory of existing health legislation, assisted in the development of norms and standards, and supported the baseline survey in one region that has set the stage for licensing of facilities to be implemented.

Reforms designed to reward increased local resources for health services: In **Senegal**, PHR worked with USAID to develop a system of incentives (matching funds) available to local communities who develop health action plans and pledge their locally generated tax revenues to fund them. This incentive system resulted in nearly 100% increases in local funding in the first year; continued growth in the second and third years; better coordination between local government units, health facilities, and health districts; and increased mobilization of community-based organizations in preventive activities.

Improved capacity among national and sub-national counterparts to design and manage systems with more appropriate incentives

In all PHR countries where incentive schemes have been developed (**Egypt**, **Rwanda**, **Peru**, and **Senegal**), PHR has worked closely with counterparts to design and test the interventions. In many cases, specific training has been provided, such as 10 training workshops in Rwanda's three pilot districts to develop detailed modalities of the three different prepayment schemes, with strong community participation. In Jordan, as part of the Health Worker Motivation MAR activities, the **Jordan** PHR Scholars Program was created in which research capacity and experience in worker motivation was developed through seven PHR scholars representing three Jordanian universities and

their academic mentors. PHR Scholars attended research methodology classes; participated in the Health Worker Motivation MAR data collection, analysis, and interpretation for the Jordan study; and conducted individual small studies on complementary topics in motivation. Scholar study topics included: methods of performance assessment, employee development activities, job satisfaction among physicians, perceptions of leadership characteristics, the meaning of work, perceptions of organizational justice, and organizational socialization. In **Peru**, clinicians were actively involved in selecting the case-group mechanism to be used and in validating the chosen Health Resources Group system.

Improved Organization and Management to Support Health Sector Reform

Countries engaged in health reform often make significant changes in the way health services are organized and managed. At the same time, reform initiatives strengthen other, more traditional efforts to improve supervision, logistics, information systems, and district capacities to plan and implement new approaches. PHR has assisted countries in making structural and procedural changes, while enhancing local capacity to promote and implement effective organizational and management changes.

Organizational structures that impede specific health sector reforms evaluated and improved

In many instances, there are organizational structures that currently impede the desired health systems performance. Changes in organizational structures can facilitate access, better decision making, better communication, and better regulation. However, in some cases, little is truly known about how well newly devised structures will perform. PHR has thus been active in studying and testing new structures, as well as providing technical assistance to ensure sound design.

Information about new organizational structures: PHR's **Decentralization MAR** analyzed the allocation decisions, local process of decision making, and health system performance in Zambia's decentralized health care system. It was found that guidelines made at the central level on how resources should be allocated across different functions were not observed by districts and were only weakly enforced. Understanding of the roles, responsibilities, and selection criteria of decentralized authorities varied from district to district. The study recommended that much clearer guidelines on roles be developed. Overall, no clear evidence that decentralization had weakened the Zambian health system was found. Indeed, in the face of economic decline and the rise in HIV/AIDS, the system appeared to have maintained itself with stable utilization rates with the one exception of immunization rates. Through the **LAC HSR Initiative**, PHR designed and conducted a hospital

autonomy study tour to Colombia for **Latin America/Caribbean** policymakers, and developed a case study on hospital autonomy in **Colombia** to explore how these hospitals managed the transition from public hospitals to autonomous “social enterprises.” PHR recently assisted the Ministry of Health in **Benin** with their decentralization efforts by conducting a study investigating ways to make administrative decentralization consistent with reforms in the health sector.

Testing new organizational structures: PHR is currently assisting the Ministry of Health in **Jordan** to decentralize aspects of public hospital management. Working closely with a Hospital Decentralization Steering Committee of national-level stakeholders and hospital managers at two pilot hospitals, PHR has assisted the development of a list of key areas in which authority and responsibility for certain managerial functions could be decentralized to the hospitals within the mandates of current government regulations. Training was provided to hospital staff in accounting, finance, procurement, management, computer skills, and medical records so they will be able to take on these new responsibilities. In addition, boards of directors have been established at the pilot hospitals to oversee the implementation of the new responsibilities delegated to the hospitals. In **Malawi**, the MOH has approved a strategy of hospital reform developed with PHR assistance, beginning with the two largest referral hospitals. The approved hospital autonomy implementation plan is based on a phased approach, beginning with strengthening hospital systems and outpatient health centers, followed by strengthening hospitals’ operational capacity, and ultimately completing the transfer of operational autonomy to the hospitals.

Results related to new organizational structures: In **Morocco**, PHR assisted the MOH to draft legislation regulating paramedical functions related to delivery of maternal child health/family planning (MCH/FP) service delivery. This legislation outlines conditions in which nurses and midwives may practice privately, thereby expanding access to care, particularly for poorer and rural communities where few physicians choose to practice. In **Senegal**, PHR has worked to develop mechanisms for shared planning among un-synchronized local structures. The MOH decentralized to a health district strategy, which was followed shortly after by a larger decentralization of authority and financing for nine sectors, where local expenditures for health, among others, were given directly to local government units. PHR assistance documented few common boundaries among the health and local government administrative units. In **Honduras**, PHR has helped establish a regulatory body within the MOH. This body has started licensing MOH primary health facilities, and the private sector is also interested in participating. In **Egypt**, the MOH, after years of policies that restricted health information, has established a National Information Center for Health and Population and a Wide Area Network that provides decision makers with access to an Executive Information System with key health performance indicators.

Operational management policies, processes, and practices introduced and improved to promote continued effectiveness of the health reform process and the reformed health sector

Results related to organization of services and support:

In **Egypt**, PHR has assisted the MOH to achieve consensus on clinical practice guidelines for primary health care. Many of these guidelines existed within vertical programs, while others were developed for other services within the basic benefits package. These guidelines have formed the backbone of the accreditation survey instrument and training for family health practitioners. In **Jordan**, findings from the PHR-supported Patient Flow Analysis at the largest MOH referral hospital have led to reduced patient waiting time in three outpatient departments and to emergency room restructuring to reduce waiting time and ensure that true emergencies receive expedited treatment.

Results related to financial management of services:

In **Rwanda**, PHR developed, implemented, and trained staff on the correct use of accounting tools to gather and record monthly financial data in health centers, hospitals, and prepayment scheme bureaus in the pilot area to ensure accuracy and transparency of financial transactions in the facilities. In **Egypt**, PHR also worked with the Egypt Family Health Fund to establish performance-based contracts with the PHC pilot facilities. PHR developed and installed two information systems for transferring funds to providers, and trained FHF and pilot facility staff in their application. Business managers at pilot sites have been trained in cost accounting and analysis, which will allow the FHF to develop capitation rates and will help the pilot facilities better manage their resources under a capitation payment system. In **Zambia**, PHR has been collaborating with the Central Board of Health and the Department of Economics at the University of Zambia on evaluation and guideline development for district-level, cost-sharing mechanisms. As part of this work, PHR assisted with IEC campaigns for the community and pilots of alternative forms of cost sharing. In addition, PHR helped build political support for those issues in the guidelines that were felt to be contentious. In **Malawi**, PHR, in collaboration with the MOHP, assisted the Chikwawa District Health Office in strengthening its systems for financial management and accounting through computerization of ledger maintenance and accounting functions performed by district accounts staff. This change established a foundation for greater accountability and transparency in the management of government obligated funds. The District Health Office is now producing monthly income and expenditure returns, transactions statements, and budget reports with the Quicken software package.

Results related to other organizational processes:

In **Malawi**, five PHR-supported District Health Management Teams (DHMTs) have succeeded in developing and submitting draft implementation plans to the MOHP. These implementation plans inform resource allocation at district level and create more streamlined

systems for donor coordination, local government involvement, and community participation in the delivery of priority health care services under a decentralized system. PHR assisted the Malawi MOHP to develop a framework for district implementation planning and helped to pilot test the use of this methodology initially in 10 districts. In **Ecuador**, PHR has assisted with stakeholder analysis, political mapping, and strategic planning to support reform efforts (deconcentration and better resource allocation). For more than 15 **mutual health organizations** in West Africa, PHR has strengthened management through training. PHR training enabled fledgling organizations to establish benefits and rates that would ensure a viable pool of funds for its members, carry out financial management, and develop organizational structures (including writing a constitution, forming a general assembly, etc.).

Results related to information systems: In the **Dominican Republic**, PHR has completed, through a participatory process with all key actors in the health sector, the indicator matrix and database to monitor and evaluate the health sector reform process in the Dominican Republic. The Minister of Health, PAHO, the World Bank, and other key stakeholders have accepted the resulting matrix. This indicator matrix is currently being presented in Honduras as a model and will also be utilized by PAHO in other countries in the LAC region where it provides technical assistance in the monitoring and evaluation of health reform. In **Egypt**, information systems have been strengthened at both the national policy level and the Family Health Fund/participating facilities level. PHR developed and installed two information systems to measure performance that is used to determine incentive payments and trained FHF and pilot facility staff in their application. These systems have already started being used in making fair and rational incentive payments to facilities and staff, and will provide managers with information needed to improve provider performance. In **Peru**, in tandem with the development of a case-based reimbursement system, PHR has strengthened the clinical information systems in the eight pilot hospitals, by introducing the International Classification of Diseases, 10 Revision (ICD-10) coding procedures and improving coding of principal/secondary diagnoses and procedures, patient demographics, and discharge status. Hospital staff has been trained in the use of the new information systems and 75,000 cases that have been coded will be used to develop the rate structure for the reimbursement system.

Strengthened capacity of a critical mass of local counterparts to promote and implement effective management policies, processes, and practices that facilitate and sustain health sector reform

Effective implementation of any reform requires local capacity to carry out and sustain the new ways of doing things. As part of every organizational and management

reform effort, PHR has built capacity of local counterparts to analyze, facilitate, evaluate, and sustain reforms.

Results related to strengthened capacity to manage: In the **Dominican Republic**, PHR technical assistance strengthened the planning, human resource management, and monitoring and evaluation capacity of Dominican Provincial Health Directorates in four target provinces. A post-intervention assessment revealed that health teams were more results-oriented, held regular meetings for monitoring activities, had more participatory leadership, and were better able to work with the resources available to them. In **Malawi**, results of a recent follow-up assessment indicate that Phase One District Health Management Teams saw a direct relationship between their District Implementation Plans (DIPs) and program/project/donor-specific workplans. DHMTs recognize the DIP as a tool that will eventually replace the need for stand-alone donor/program workplans, since these activities are now fully integrated into the DIP. DHMTs are now positioned to effect greater leverage over the process of donor coordination and the use of participatory planning approaches among a wider number of stakeholders (including local government, NGOs, and traditional authorities, and Village Health Committees) to achieve stronger and more measurable health outcomes. In the **LAC HSR Initiative**, a survey of 47 participants from nine countries attending four LAC HSR regional events conducted by PHR (hospital reform, public-NGO partnerships, and NHA) revealed that 85% of participants are taking action based on what they learned in the workshops and study tours, from policy dialogue to design and implementation of reforms. In **Senegal**, PHR worked with mayors and elected rural leaders to develop and implement a health financing scheme that mobilizes local tax revenues to supplement national-level financing of health services. Rural leaders then committed local tax revenues to help finance and implement locally developed health action plans.

Increased capacity built in specific areas: In **Honduras**, PHR has developed the capacity of Ministry staff to establish more effective health laws, draft new legislation, and strengthen its regulatory function. Eight senior MOH personnel participated in an intensive one-week study tour to the United States to learn more about the methods and tools PHR has developed for the accreditation of health facilities. In **Egypt**, PHR assisted an accreditation team of 11 Egyptians to survey five health facilities in Alexandria to test an accreditation model that is being used to support contracting for services in both public and private facilities. This accreditation team has organized training of trainer activities to prepare other governorates to participate. In **Morocco** and **RESSMA**, training of provincial health managers from Morocco, Tunisia, and Algeria in health economics - costing and financing - has provided 100 people who are better able to execute new responsibilities under a decentralized system.



Results Related to G/PHN SOs

Improving health systems performance is in fact an intermediate result necessary for achieving increased utilization and coverage with priority health services. In many countries, PHR has had the opportunity to either work directly with the service delivery level or has been working long enough in a country that results have emerged in these areas. In other cases, studies conducted by PHR under its Special Initiatives have provided key information for the improvement of service delivery of priority areas. The following pages describe key results and contributions that PHR has made towards the Global PHN Bureau's strategic objectives and intermediate results. The discussion focuses on SOs 2-5, for which PHR received funding.² For each strategic objective, PHR results and contributions are listed on relevant intermediate results.

SO 2: Increased Use of Key Maternal Health and Nutrition (MH/N) Services

IR 2.1 Effective and appropriate MH/N interventions and approaches identified, developed, evaluated, and/or disseminated

Maternal health costing studies conducted in three African countries (Uganda, Ghana, and Malawi) provided key information for guiding improved service provision where little research has been done on costs. Funded as part of a global study of maternal care in collaboration with the MotherCare project, the studies highlighted variations in costs from country to country, but indicated that efficiencies could be improved if facilities: 1) encouraged utilization at lower levels of the system, 2) adjusted staffing levels to match client load, and 3) set user fees more in line with needs of ensuring adequate availability of necessary drugs and supplies. In addition, evidence from these three countries show that user payments alone may not be the main financial obstacle to use of maternal services: transportation and other costs are often equally or more important in determining a woman's access to care.

IR 2.2 Improved policy environment for MH/N programs

PHR has contributed to improvements in the policy environment for maternal health care. In Morocco, PHR assisted the MOH in developing legislative codes to allow paramedical personnel to provide certain MCH/FP services. The resulting proposed law, which expands access to care particularly for poorer and rural communities, has been presented to the Secretary General of Government for submission to Parliament. Also in Morocco, PHR supported the development of a National Health Accounts activity that generated

estimates of resources being spent in the delivery of maternal and child services at the national and provincial levels. In the process, provincial health planners were trained and are now better able to align resource allocation with policies for priority services. Similarly, in **Malawi**, NHA results indicated the dangers of hospital-level services draining resources from the lower-level health facilities during decentralization of budgets. To protect the resources for facilities that provide primary MCH care to the bulk of Malawi's population, the MOHP is splitting the budgets for district hospitals and for district-level primary care facilities and activities. In **Bolivia**, PHR's evaluation of the MCH social insurance program led to changes in reimbursement rates for key MCH services so that they more closely matched provider costs (e.g., reimbursements for maternal health services were increased by 30%), thereby ensuring maintenance of quality and sustainability for these services to the poor. The evaluation showed that utilization of covered services (including antenatal care and delivery, and key curative and preventive services for children under five) increased, most strongly among the poor and also for adolescents. In **Egypt**, the Family Health Fund pays performance-based incentives to providers for both increased productivity and quality, and will be making capitation payments for the care itself in the near future. In **Mali**, the equity initiative study, which surveyed households and providers about the demand and supply of care in rural and urban Mali, led to the development of IEC and MHO strategies to address, among others, the problem of weak use of postnatal care and facility-based delivery care.

IR 2.4 Increased access to and availability of quality MH/N programs and services

Results related to increased access: In **Rwanda**, at the end of the first year of the Prepayment Scheme Pilot, more than 8% of the target population was enrolled in 54 prepayment schemes. Consequently, in the two pilot districts with the highest enrollment rates, this has resulted in enrolled-member utilization increases of 45% for health center deliveries and 25% for prenatal services. Moreover, the prepayment schemes include coverage for cesarean sections at the local hospitals. In **Bolivia**, the newly revised MCH insurance package (described above) now also includes post-abortion

2. PHR's work in Morocco on tax waivers and funding for contraceptives has directly contributed to SO1's intermediate result 1.2 (improved policy environment and increased global resources for family planning programs) by ensuring the sustainability of contraceptive availability through national funding. In addition, country-level work in Egypt and Rwanda has increased access to family planning services through their basic benefits packages.

complications, based on costing data prepared by PHR. In **West Africa**, MHOs receiving technical support and/or training from PHR have strengthened their capability to negotiate for better quality services from participating providers. In **Egypt**, the family practice model being implemented in the seven pilot facilities – and soon to be replicated in other governorates – has increased access, continuity, and quality of care for the basic benefits package of key maternal, child, and adult health. Working with the MCH section of the MOH, PHR and the QI unit adapted standards into a standardized format for inclusion in the basic benefits package clinical guidelines and into the accreditation standards.

SO 3: Increased Use of Key Child Health and Nutrition (CH/N) Interventions

IR 3.1 New and improved cost-effective interventions developed and disseminated

Developing cost-effective interventions requires having accurate data on program costs. PHR has assisted the SO 3 in providing methods and costing data for several key childhood interventions: integrated management of childhood illness (IMCI), vitamin A, and polio eradication in particular. A **polio eradication cost-effectiveness analysis** conducted in Turkey and Cambodia examined various strategies for achieving polio eradication. Results indicated that, although total costs were higher (6%-40%), combining national immunization days and child-to-child campaigns with high investments in surveillance and strong management support is more cost-effective than funding separate immunization days and child-to-child campaigns with limited investment in surveillance and management. Collaborating with an inter-agency working group (WHO, World Bank, UNICEF, USAID, and BASICS), PHR developed an **integrated management of childhood illness** costing tool to enable users to plan and budget for the introduction, implementation, expansion, and sustainability of IMCI more easily. This costing tool, which consists of four Excel spreadsheet files, a user's guide, and data collection forms, can be used for financial planning, advocacy, management, and resource planning. PHR field-tested it in Nepal and found it to be a flexible and powerful tool for developing budget estimates, but also found that the quality of the results depends on the availability of a reliable health information system. PHR conducted a comprehensive cost analysis of Nepal's National **Vitamin A** Program. The study identified current costs and facilitated budget planning for the full-scale national implementation by developing and analyzing several different potential long-term program scenarios. In **Morocco**, immunization financing guidelines and tools were disseminated to regional health managers through training workshops. Discussions and exercises included looking at wastage of vaccines, providing greatest coverage in a more efficient way, and calculating the amount and costs of vaccines needed for a given year.

IR 3.2 Improved policies and increased global, national, and local resources for appropriate child health services

Related to work in **Morocco**, PHR's study on tax relief for key MCH/FP commodities in 22 countries provided key information about tax relief (waivers of import, value-added and/or sales tax) for vaccines, oral rehydration salts, and contraceptives. Where waivers exist, they lead to reduction of unnecessary and often substantial costs of taxes and other administrative costs associated with the purchase of imported essential MCH/FP commodities. In Morocco, based on the results of this study and advocacy efforts, the MOH proposed tax relief for contraceptives to the Ministry of Finance and Economics, which now has resulted in 50% reductions in import taxes for pills, IUDs, and injectable contraceptives. A PHR study of the effect of the **polio eradication campaign** in Morocco, Côte d'Ivoire, and Bangladesh showed that these campaigns resulted in increased government funding for routine immunizations, because polio eradication efforts appear to attract a different group of donors than those supporting routine immunization efforts. Another study examined trends for the last 10 years in donor funding for polio eradication and routine immunization. Although there were a few cases of reductions, overall, the polio eradication campaign did not have an overall negative effect. Immunization financing studies in four countries have provided key information for strengthening national immunization programs.

IR 3.4 Improved quality and availability of key CH/N interventions

Efforts in **Morocco, Egypt, Rwanda, and West African MHOs** have improved access to and quality of key child health services as part of the package of services provided under these efforts. In **Egypt**, the IMCI guidelines have now been fully incorporated into the accreditation standards used to accredit facilities and act as indicators for incentive payments.

SO 4: Increased Use of Improved, Effective, and Sustainable Responses to Reduce HIV Transmission and to Mitigate the Impact of the HIV/AIDS Pandemic

IR 4.3 Improved knowledge about, and capacity to address the key policy, cultural, financial and other contextual constraints to preventing and mitigating the impact of HIV/AIDS

In **Rwanda**, PHR collaborated with the MOH and WHO to adapt the NHA methodology to allow for analysis of HIV/AIDS specific expenditures. The findings revealed that HIV places an exceptional financial burden on households of persons living with AIDS and that treatment of HIV-related illnesses heavily taxes the health care system. Currently, about 7% of total expenditures on HIV go to

prevention of HIV/AIDS, while almost 80% pay for treatment of HIV-related illnesses. With donor and government spending going mostly towards prevention activities, 93% of health monies for treatment comes from out-of-pocket expenditures. The analysis also revealed accentuated inequities in the use of and expenditures on health services to treat HIV/AIDS. To respond to the need for greater equity in access to care, PHR supported the MOH in the development of prepayment schemes that enroll households with persons living with AIDS. As a result, about 10,000 persons with HIV were enrolled in the three pilot districts. In **South Africa**, PHR conducted a study of the economic impact of HIV/AIDS on the education and public service sectors. Findings indicate that HIV/AIDS will profoundly affect manpower available in each sector and the ability of these sectors to provide services in light of the demands caused by HIV/AIDS. These findings will be used to plan with sector managers at both national and provincial levels to develop and implement strategies for action, based on the “best” and “worst” case scenarios provided by the study. In **Senegal**, decentralization of health service planning and implementation to the district level posed an additional challenge to the treatment and prevention of HIV. The positive consequences of decentralization are that local decision making and implementation of HIV/AIDS activities is integrated into the health system, more resources are available for HIV/AIDS activities, and the public and private sectors plan jointly for HIV/AIDS services. However, some issues related to these political reforms still need to be addressed. National coordinating bodies do not coordinate well with key health committees, and the roles of the various committees are not clearly understood. NGOs and community groups play a crucial role in the delivery of HIV services, and in some cases are the exclusive service providers for the treatment of HIV-related illnesses. Decentralization in **Ethiopia** created a federal unit to coordinate health service provision and regional autonomous states to plan and implement services. In practice, however, these bodies do not function. Moreover, due to the lack of public service provision, HIV/AIDS is exclusively provided by NGOs, prevention activities are not standardized, and imbalances exist between needs and resources at the regional level. In **Cambodia**, PHR has adapted an Activity-Based Costing methodology for cost accounting designed to compare the costs of specific HIV/AIDS interventions, various components of a given intervention, and programs including multiple interventions. This methodology has laid the groundwork for much needed cost-effectiveness and cost-benefit analysis tools for HIV/AIDS interventions.

PHR provided financial support to Population Services International (PSI) in **Zimbabwe** to conduct two separate research and evaluation activities concerning quality improvement in HIV/AIDS service delivery. At several Voluntary Counseling and Testing (VCT) centers across the country, PSI completed a mystery client study to assess client satisfaction with daily operations and an evaluation

of the effectiveness of new Rapid Test Kits (RTK) in determining HIV/AIDS infection in blood specimens collected at counseling visits. The results of the mystery client study are available to assist VCT managers and staff to improve daily operations and interactions with clients, while the RTK evaluation results suggest that introduction and use of these kits will improve effectiveness of HIV/AIDS diagnosis and counseling at all VCT centers.

IR 4.4 Strengthened and expanded private sector organization responses in delivering HIV/AIDS information and services

PHR examined best practices from **Guatemala** and **Brazil** with HIV/AIDS service provision through contracting with NGOs. NGOs provide a range of services from education and prevention, to training, counseling, and advocacy. In Brazil, the MOH contracted with NGOs, while in Guatemala, donors contracted with the NGOs. These case studies revealed the following best practices: routine involvement of stakeholders, linking objectives to program design, highlighting key characteristics of successful contract administration, and combining assistance and accountability in financial monitoring.

SO 5: Increased Use of Proven Interventions to Reduce the Threat of Infectious Diseases of Major Public Health Importance

IR 5.2: Improved policies and increased global, national, and local resources for appropriate infectious disease interventions

In **Zambia**, PHR has assisted in strengthening the sustainability of malaria prevention through its work on systems for managing sales of insecticide treated nets. The management and sales systems have expanded to 64 rural health facilities and are showing improved collection rates (almost 100%) and about 54% cost-recovery rates. The percentage of households with nets has increased from 7% to 30-40%.

In support of the need for better surveillance information (see results of polio eradication cost-effectiveness study described above), PHR has developed an **infectious disease surveillance advocacy** tool. The advocacy presentation and user’s guide are designed to help persuade interested and influential parties to support improvements in their public health surveillance and action system. The user’s guide provides guidance on how to use advocacy to build ownership for improvements while assessing a surveillance and action system, and contains background information, speakers notes (talking points), and MS PowerPoint slides that can be used for actual presentations.



Significant Contributions and Achievements

The previous sections have outlined the various PHR contributions according to a series of specific result areas. This section will take a more synthetic approach to key country programs and technical areas, describing a sample of PHR focus activities.

Key Country Program Results/ Contributions to the Field of Health Sector Reform

PHR has worked in more than 40 countries over the life of the project and has had unique opportunities in several countries to test innovative approaches to long-standing reform issues. Egypt represents a country where PHR's efforts stretched over many different components of reform (financing, quality, information systems, and service delivery), offering the opportunity to develop and pilot a comprehensive package of reforms. In addition, PHR's efforts come at the end of a long run of projects and studies in the health sector, such that the Ministry of Health and Population (MOHP) was prepared to make the decisions and embark on implementation. Senegal, a country where PHR started with only a few small-scale activities, developed into an opportunity to assist the government of Senegal and MOH to come to grips with the results of two uncoordinated, ill-prepared national reform agenda and their consequences for health. Rwanda, emerging from a devastating civil war, was looking for ways to increase the utilization of health care services by its poor, rural populations. Morocco is an example of a country transitioning to "graduating" status as a country where USAID no longer needed to operate a mission. PHR, through a variety of policy activities, facilitated the government's efforts to reduce dependency on donor funding. PHR's contribution to the LAC HSR Initiative significantly expanded information and tools to LAC policymakers.

Egypt

Egypt's health sector reform is based on the following guiding principles: universality, quality, equity, efficiency, and sustainability. USAID assists the Egyptian reform effort through its Health Policy Support Program, which provides to the MOHP cash transfers that are released on attainment of mutually agreed-upon benchmarks. The benchmarks represent implementation of the government of Egypt's health sector reform agenda. USAID also funds technical assistance for attaining the benchmarks. PHR's work in Egypt

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corresponded to Phase 1 of Egypt's health reform implementation (1996-2001), the focus of which was three-fold: improving the regulatory capacity of the MOHP, developing an integrated primary care delivery model, and developing a social insurance mechanism to achieve universal coverage. The establishment of a pilot/demonstration project in Alexandria governorate represented the culmination of many years of preparatory studies and experiments with various aspects of the reform package as well as a test of the aforementioned principles of Egyptian health care reform. The demonstration project has increased the capacity of the MOHP, the governorate, and the provider community to implement the full reform and to create sustainable financing of integrated primary health care services.

Improving the regulatory capacity of the MOHP through quality improvement, strategic planning, and health information systems: Before the establishment of the Quality Improvement (QI) Directorate in the MOHP, the ministry's effort to ensure provision of high-quality health care were dispersed and uncoordinated. With support and assistance from PHR, the QI Directorate laid groundwork for a more comprehensive QI agenda. The QI Directorate, after obtaining approval for their use from Egyptian authorities and vertical program experts, published and disseminated a set of clinical practice guidelines for all components of the basic benefits package (covering maternal, child and adult health needs). Where vertical programs had already developed guidelines, these were adapted and integrated. These guidelines have been the basis for training of providers at the Alexandria pilot sites and for standards for facility accreditation. An accreditation process and tools have been developed, tested, and used to accredit all pilot primary care facilities and will be expanded to other governorates shortly.

Egypt has excess hospital beds and specialist physicians in urban areas and a shortage of primary health care physicians. PHR has supported the ability of the MOHP to make

strategic decisions by creating an executive information system to provide critical health system information to key MOHP decision makers through an electronic ministerial network linking 60 MOHP key executives and providing them with 15 health system indicators that are routinely updated. The MOHP is currently using its own resources to extend the network. In addition, PHR introduced a series of decision-support tools for health workforce planning, hospital bed needs planning, and capital equipment planning, and has worked with the MOHP to decrease excess MOHP capacity in hospital beds and health workforce.

Developing and implementing a new care delivery model that ensures access to a comprehensive set of quality maternal, child, and adult health services:

In contrast to the previous system of fragmented, specialty-oriented care, the Egyptian health care reform model is based on the concept of integrated primary care, with a defined basic benefits package of services delivered by (public or private) family practice teams to a roster of enrolled families. PHR, working with seven pilot health facilities, has trained providers in clinical guidelines and the family health model and trained managers in cost accounting, human resource management, continuous quality improvement, and patient management and records systems. In addition, the pilot sites have established a family-based medical record system, established computerized tracking of patient rosters and encounters, and renovated clinics. Currently, the Montazah District pilot project has rostered over 120,000 individuals to family practice teams and another 15 facilities in three pilot governorates will open soon. The model provides guidance on selection of providers, training, staffing and supervisory guidelines, and clinic information systems. The initial pilot sites have all gone through the accreditation process, have active quality improvement teams working, and collect client satisfaction data on a regular basis. With this new model, productivity of family health physicians has increased from approximately three encounters per physician per day to 16 per day.

Establishing a separation between financing and provision of care through the Family Health Fund:

The Health Insurance Office is the source of insurance for several groups of Egypt's population: those employed in the public sector and participating private sector companies, school-age children (7-18 years), newborns (0-11 months old), and retirees. This system left uninsured many groups who should be priority targets for primary health care services. In addition, under the HIO system, consumers cannot choose their providers, and the reimbursement system pays providers per visit, based on a seniority sliding scale. The Family Health Fund, which is currently being piloted by the HIO, has been developed to apply innovations in insurance to reinforce all the goals of reform: universality, quality, equity, efficiency, and sustainability. The FHF is to administer performance-based contracting with accredited family health units, through capitated payments for enrolled members and incentive payments for quality performance. The

FHF was established by Ministerial Decree, and director and staff have been appointed. PHR provided assistance with organizational development activities to create this new entity. The FHF performance standards, monitoring, and incentive payments have been designed and tested. Complementary information systems that capture and analyze the data needed to calculate measures of performance have been implemented at both FHF and the health facilities. The FHF made its first incentive payments, and providers have responded positively about their fairness. Cost data from the seven pilot sites are being collected and analyzed to develop the reimbursement structure for the capitation payments that the FHF will implement next.

Creating a demonstration site for the comprehensive package of reforms has provided a living laboratory to test key reform strategies. Through the demonstration, MOHP counterparts have learned to manage a complex reform and become advocates for change in health care delivery. Providers and families have had the opportunity to experience the new system. Through structured and informal mechanisms for feedback, they have shaped future reform strategies. And perhaps most importantly, policymakers have begun to use data and results from the demonstration to plan and regulate the system.

Senegal

The government of Senegal has implemented successive waves of decentralization since independence, including the creation of rural communes in 1972. In 1991 the Ministry of Health adopted the health district model; decentralized planning, managing and monitoring functions to the district; and increased community participation in financing and managing health services. Then, in a parallel but uncoordinated multi-sectoral reform implemented in 1997, the government devolved peripheral services in health, education, and seven other sectors to local government units. This reform did not take into account the realities of service delivery and support systems of the health districts: New local-government boundaries did not correspond to those of the health districts, and no hierarchy or functional relationship was developed to coordinate these local units. In addition, central public funding, once dedicated to local health services, was diverted to other uses. As a result, the MOH experienced problems in its financing and delivery of services and support in the health districts. In this context, PHR first assessed the "damage" caused by these waves of decentralization and worked with the various stakeholders to initiate dialogue and communication. Another preliminary step was to assist USAID to develop an innovative strategy for providing a greater percentage of its resources to the periphery and to provide incentives for decentralized local government units to invest their resources in health.

PHR started by observing and documenting the impact of the 1997 decentralization on local health systems. Emerging from field visits and interviews with various stakeholders

(in health and local government) was a situation in which few stakeholders had any real understanding of what was involved in the decentralization process, little communication was taking place between them, and few were following the laws and regulations set forth in the Decentralization decree. In addition, many negative effects on the health system were discovered: funding for health services was decreasing, and funds transfers were delayed. The local government units and the MOH were exhibiting little interest in peripheral service delivery. Even though the health sector contributed over half the *Fonds de Dotation*, at the local level, they were receiving only a small portion. This assessment presented to the MOH and USAID the first real evidence of the consequences of decentralization on peripheral health services.

In response to this situation, PHR spearheaded an effort to increase communication, initially facilitating face-to-face communication. Later, through a series of participatory stakeholder meetings in three regions, key local government and health stakeholders began to discuss the place for health in this new system of decentralized governance. PHR conducted sensitization and training on decentralization and health for both health district and local government unit staff, and advocated for the recognition of the district health system. The MOH has since developed written regulations requiring local health committees to form district-level committees in partnership with MOH officials, and initiated development of legislation for the national General Assembly that will require local elected officials in a health district to form an association through which government block grants can be distributed more effectively to finance district activities. These various activities of increasing communication and formal mechanisms set the “organizational” stage for the next phase of intervention - matching grants. The purpose of these matching grants was two-fold: to provide a mechanism for USAID to provide assistance and funding in health in a newly decentralized system and to provide incentives for local government units to increase the amount of resources they dedicate/allocate to health. PHR helped design a new mechanism for matching grants by which USAID would provide a certain percentage of matching funds to local governments who commit locally generated tax revenues to contribute to health activities partially funded by resources coming from the national level. To receive matching grants, community plans must be developed, and the communities make their proposal for activities to be funded. The community plans must be developed with input from key local stakeholders, including elected officials, health committee members, health personnel, and other community-based organizations. The community plans must be incorporated into an overall health district and regional health plans.

Prior to the matching mechanism, most local governments devoted no resources to health. In the first year, 1999, 24 communities in three districts participated (all eligible communities), pledging \$300,000 of local tax revenue for health

activities, and received \$200,000 in matching funds. By the following year, 75 communities in eight districts had participated. The level of local government contributions increased by 121% in 2001. The money provided by communities and the incentive matching grants was used to construct health huts (bringing services closer to the beneficiaries), increase supervisory visits, purchase drugs and equipment for health units and rural maternities, and train additional birth attendants.

As a result of this innovative funding mechanism, public funding increased for local health services. Health personnel reported increased motivation because they now had a clearer role in the local decision making process for health, that is, acting as technical advisors in community planning. Local elected officials also displayed increased motivation and enthusiasm for the joint planning process mandated by these incentive grants. Community-based organizations became mobilized to support preventive health services. Although it is too early to know the long-term effects of this innovative financing and incentive scheme, results from the first three years show increasing enthusiasm from the many stakeholders.

Rwanda

In 1998, two years after the re-introduction of user fees, consultation rates at public and church-owned health facilities in Rwanda had dropped to a worrisome low level (about 0.25 visits/capita/year). At the same time, Rwanda's health indicators scored lower than those of other sub-Saharan countries. This raised concerns about effects of user fees on equity in financial accessibility to care. The MOH recognized the need to launch alternative financing

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The LAC HSR Initiative activity differs from many of PHR's country activities, in that results are focused on providing tools, methodologies, and information to LAC country decision makers. PHR has contributed substantially to the LAC HSR Initiative in many areas, with a focus on National Health Accounts, developing a policy toolkit, analysis of financing mechanisms used in the Region, guides to increasing equity, and dissemination of other interventions.

methods to improve financial accessibility to care for that 70 percent of the population living in poverty. To do so, it decided to implement prepayment schemes, which it hoped would improve access to quality health care, increase community participation, and strengthen financial resources and management capacities at health centers and at the prepayment schemes themselves. However, before establishing schemes nationwide, the MOH decided to pilot-test schemes in three districts: Byumba, Kabgayi, and Kabutare. During the schemes' first year of operation, data was routinely collected at health care facilities and prepayment schemes, and patient exit surveys, household surveys, and focus groups were conducted in both the pilot districts and two control districts. An evaluation based on all these data would figure heavily in the MOH decision on whether to expand the prepayment schemes.

Designing the prepayment schemes: PHR assisted the MOH to establish a steering committee with representatives from both national and regional levels and stakeholders from the three pilot districts to create a strategic framework for the development and implementation of the prepayment process. PHR, in collaboration with the MOH and district health authorities, then organized 12 workshops for health centers and community representatives to train participants on insurance principles, financial management, and marketing strategies. In addition, these trainings were also used to define the schemes' modalities: benefit package, waiting period, co-payment, premium level, management structure, provider payments. Then, the basic design for the schemes was presented and discussed during a widespread community consultation process in which the MOH and local church groups conducted a series of "town meetings" where organizational issues were discussed. As a result, 54 prepayment schemes were created, each one attached to a health center.

How the prepayment schemes work: The prepayment scheme is based on three main pillars:

- ▲ **The benefits package:** All three districts chose the same benefits package for health center-level services; it included preventive and basic curative services, all drugs on the essential drug list, hospitalization at the health center, and ambulance transfer to the hospital. For hospital services with health center referral, all districts covered cesarean sections, overnight stays, and physician consultations, while one additionally covered non-surgical pediatric and malaria cases.
- ▲ **Revenue generation and management:** Members can subscribe as individuals, families or groups. Members pay an annual premium (about \$7.50/household) that entitles them to one year of services included under the benefits package (after a one-month waiting period). Payment of premiums is organized when the rural populations have cash. Members manage the prepayment funds. The prepayment schemes held regular discussions and elections in general assemblies with their members and held contractual arrangements with their partners.
- ▲ **Provider payments:** Providers and scheme managers pay health centers a monthly capitation rate for enrolled members. Hospitals are paid on a per episode basis for cesarean sections and on a fee-for-service rate for consultations and overnight stays.

Enrollment and participation: On July 1, 1999, members started to enroll in the prepayment scheme that partnered them with their preferred health center. By the end of the first year, the schemes had enrolled 88,303 members. Enrollment rates ranged from 6% to 11% of the population in the three districts. However, among the 54 schemes, this enrollment rate ranged from 1% to 55% of the population in the facility's catchment area. Administrative councils, which are elected by prepayment members, manage the prepayment schemes. These councils consist of a president, vice president, secretary and treasurer. Council members volunteer their free time to manage their local schemes. On average, the schemes organize three general assemblies with their members per year, revealing strong community involvement, and commitment to rebuilding social cohesion in a country that has been recently tormented by civil war.

Equity and coverage - achievements realized: Evaluation of provider and prepayment routine information has shown that members seek modern care five times more often than non-members do: consultation rates among members range from 1.2-1.6 per year. In comparison with non-members, income appears to have no effect on utilization of care among members. Members also have higher coverage of prenatal care and are more likely to deliver at a modern health facility than non-members. Although the annual premium represents a large burden for the poorest 25%

of the districts' populations, the poor constitute the majority of prepayment scheme members, and in one district, the church has subsidized premiums for the most vulnerable groups (orphans, widows, and HIV-positive individuals).

Based on the first-year results of the prepayment schemes' impact on health care in these three districts, the MOH has decided to scale the schemes up to a national level, in response to the demand from the population in other areas for prepayment.

Morocco

Morocco has made significant reductions in infant mortality and fertility, while making gains in contraceptive prevalence and immunization coverage. Yet important challenges remain: sustaining this performance as donors such as USAID and UNICEF phase out support, ensuring equity of these gains, and increasing capacity in the public and private sectors to resolve current and future programmatic issues in a sustainable manner. PHR's work in Morocco is characterized by its input into the policy process through information and advocacy. As a result, PHR has assisted the government of Morocco and the MOH in developing sustainable systems for the financing of the country's family planning program and its immunization program, as well as improving the policy and regulatory environment for family planning and MCH services.

The contraceptive phase-over: PHR developed and supported an advocacy strategy to assist the MOH to increase support across the government for family planning programs. This included conducting a study of tax waivers in 22 countries to examine whether they granted tax exemptions, waivers or reductions for the purchase of vaccines, oral rehydration salts, and contraceptives. As a result of these efforts, the MOH gained commitment from the government of Morocco to increase funding for contraceptives and to add a line item for reproductive health in the budget for its five-year plan. In addition, import taxes and customs duties have been reduced on several contraceptives.

Immunization financing: PHR, in collaboration with the MOH and WHO, conducted an in-depth study of the costs and financing of Morocco's national immunization program. The study found that over 32% of the budget was being spent on national immunization days, that World Bank funds covered 60% of expenditures, and that planned improvements would require a doubling of the national budget (introduction of the Hepatitis B vaccine, replacement of cold chain equipment, changes in the reporting and supervision systems). As a result of this study, PHR assisted the MOH to develop a strategic plan which led to a doubling of the budget for the immunization program.

Increased access to MCH services: Using a study tour to Chile and Tunisia to gain information on best practices and create advocates for members of the Department of Legal

Affairs in the MOH, a representative from the Midwives Association, and a member of Parliament, PHR supported the MOH in drafting legislation to authorize 15 types of private sector paramedical providers to expand the range of services they provide. This piece of legislation has been submitted for parliamentary review. Such legislation, counteracting severe restrictions on the ability of paramedical staff to practice without direct supervision of a physician, would increase access, particularly in rural areas where few physicians want to practice, to essential MCH services.

National Health Accounts: Morocco has developed a unique experience with National Health Accounts. National experts rather than consultants have been the lead implementers (from both the MOH and the Ministry of Finance), with assistance from PHR. NHA has also taken on a different twist in Morocco, where data are collected and analyzed at a provincial level, and the NHA team has disaggregated the data by specific priority services like family planning and maternal and child health.

LAC Initiative

The Latin America and Caribbean Regional Health Sector Reform (LAC HSR) Initiative is jointly funded and managed by USAID and the Pan American Health Organization, and implemented by PAHO, PHR, the Family Planning Management Development Project, and the Data for Decision Making project. The LAC HSR Initiative focuses on four strategic areas:

- ▲ Development, testing, and dissemination of methodologies and tools for the analysis, design, implementation, and monitoring of national health sector reforms
- ▲ Acquisition, processing, and dissemination of information on national health reform efforts, and making this information widely available
- ▲ Monitoring reform processes and outcomes as well as equity access to basic health services by developing and implementing tools and disseminating information obtained
- ▲ Helping countries share experiences and assistance through regional conferences and workshops, institutional linkages, a regional forum for researchers, and study tours.

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National Health Accounts: PHR, in collaboration with PAHO, supported the development of the first regional NHA network in Latin America. Eight countries participated in a series of three workshops; PHR provided technical assistance directly to four countries: Bolivia, Ecuador, Guatemala, and Mexico. Since then, Honduras has also conducted NHA activities with PHR assistance. Institutionalization of NHA is a critical focus now, and PHR has prepared a document on Lessons Learned in the Institutionalization of NHA in the LAC Region. PHR continued support in Ecuador, Honduras, and Guatemala using mission funds to facilitate the institutionalization of NHA and its use for health policy formulation.

The policy toolkit: One essential aspect to an effective policy process is having effective political and communication skills to be able to generate support for reforms. PHR developed the *Policy Toolkit for Strengthening Health Sector Reform*³ and its accompanying trainer's manual to help health reform professional in managing the policy process by providing skills in the areas of stakeholder analysis, advocacy, and conflict negotiation. Some results that have emerged from these trainings include a strike resolution in El Salvador and negotiations of the second phase of the *Programa Mejoramiento de Salud* in Guatemala.

Information and guidance about financing mechanisms in the region: Many countries in the LAC Region are faced with issues related to equitable financing of their health sectors. PHR has developed a series of analyses and primers to assist policymakers on these issues. PHR's *Comparative Analysis of Social Insurance Mechanisms in Latin America and the Caribbean* summarizes the various strategies used in the region, their respective coverage rates, mode of provision, coordination with public and private facilities, and subcontracting structures, within the context of each system's ability to achieve equity, coverage, and sustainability. PHR has also developed three primers related to provider payments: *Provider Payment Alternatives for Latin America: Concepts and Stakeholder Strategies*; *Guide to Prospective Capitation with Illustrations from Latin America*; and *Prospective Case-based Payment for Hospitals: A Guide with Illustrations from Latin America*. These primers are designed to equip health policymakers, regulators, payer agencies, and providers of services with the operational knowledge of two reimbursement systems, case-based payments and capitation, that have the highest potential for contributing to greater efficiency and sustainability in the health sector.

Guides to improving equity: PHR developed two tools to assist policymakers to analyze and adjust their policies that affect equity, including targeting. The equity primer (*Guía básica de política: Toma de decisiones para la equidad en*

la reforma del sector salud) helps policymakers identify the many levels and stages at which equity decisions are made and define and address equity within the context of their own reform processes. The *Targeting Methodologies: Conceptual Approach and Analysis of Experiences* provides lessons learned from current experiences with targeting, and key recommendations for developing and implementing targeting mechanisms.

Discussion and dissemination of innovations in the health sector: Hospital reform and the role of NGOs have emerged as new areas for strategy and policy activities. PHR has documented some of these as part of their work in the LAC HSR Initiative. PHR organized two regional meetings and produced two "State of the Practice" papers on new roles of NGOs in health sector reform: *Partnerships between the Public Sector and Non-governmental Organizations: Contracting for Primary Health Care Services and Partnerships between the Public Sector and Non-governmental Organizations: the NGO Role in Health Sector Reform*. Both papers were built upon information-sharing sessions organized at the regional meetings.

PHR organized two study tours to Colombia to promote South-to-South sharing on public hospital reform. Based on the enthusiastic response to PHR's Hospital Reform study tours to Colombia, PHR developed a case study on Colombia's hospital reform that describes and analyzes the transition process for Colombia's public hospitals into "social enterprises." The case study highlights the main changes the reforms required of the hospitals, how select hospitals chose to implement those changes, how these hospitals managed the transition process, and then draws conclusions about successful approaches to implementing hospital reform, with a focus on change management.

PHR's contributions to the LAC HSR Initiative have brought key information and tools to over 650 policymakers in the LAC Region.

Zambia

Following the election of a new democratic government in 1991 Zambia adopted a program of health sector reform that was perhaps the most radical program in sub-Saharan Africa. The main thrust of this program was a shift from a centralized and hierarchical health care system to a decentralized one which was more responsive to users and which gave greater initiative to health care workers on the ground. Despite some considerable achievements, the Zambian health reforms have continued to face problems, particularly regarding the financing of health care. The support that PHR provided to Zambia was primarily focussed upon strengthening financing policies and systems, and facilitating improved health care financing. PHR support to Zambia was most intense during the period 1997-1999 (although smaller-scale activities have continued since this period) and took a variety of forms.

3. The LAC HSR Initiative publications listed in this section are available in English and Spanish, except the equity primer, which is available from the LAC HSR Initiative only in Spanish. PHR published a similar primer, though its orientation is global, rather than LAC.

Contributions to the development of a health financing policy: PHR conducted in-depth analysis of the health and health-related data collected under the Living Conditions Monitoring Survey so as to provide the first accurate information in Zambia on household expenditures on health care, patterns of health care seeking behavior, and how demographic variables (such as income) affected these. An in-depth study of cost-sharing activities in five districts combining analysis of routine data on utilization and financing with focus group discussions was also undertaken. Both of these studies were presented at national workshops convened to help develop a comprehensive health financing policy and influenced the contents of the policy. Unfortunately the policy has never been finalized due to political changes in Zambia.

Strengthening cost-sharing activities: An ad hoc approach to the implementation of cost sharing in Zambia has caused substantial problems for the government: many citizens associate the reform program with cost sharing alone. PHR developed national cost-sharing guidelines aimed at strengthening and standardizing approaches to **cost sharing**, and conducted a workshop for national and regional officials to discuss these guidelines. PHR has also worked more intensively in selected sites to pilot a new financing scheme that allowed clients to pre-pay for health care services. Many of the tools used to help strengthen cost sharing in Zambia have been compiled in a toolkit. The bilateral project in Zambia, with support from PHR has followed up on many of these activities.

Financing of insecticide treated nets: As part of a broader initiative to reduce morbidity and mortality due to malaria in Eastern Zambia PHR provided assistance with the implementation of community-based distribution and financing systems for insecticide treated nets. PHR developed operations procedures for distribution, sales and financial management of nets, and trained staff in these procedures. PHR also provided follow-up monitoring and developed a database to track stocks, sales, and funds.

Sector Program Assistance: PHR provided assistance with the design and negotiation of SPA including facilitating consultative meetings on the SPA to build consensus with government of Zambia and donors, preparing an economic analysis and developing performance milestones in consultation with numerous stakeholders. SPA in Zambia has enabled USAID to contribute directly to district-level budgets which is extremely important given the decentralized system of health care in Zambia.

In addition to the technical assistance activities in Zambia, two of PHR's research studies (on decentralization and on the policy process of health financing reform) were conducted in Zambia. These studies have allowed PHR to further contribute to the development processes within Zambia, and also draw lessons from the innovative program of health sector reform in Zambia, which are relevant to other countries.

Key Contributions in Specific Areas of Health Sector Reform

National Health Accounts - a method for providing critical health financing and allocation information to policymakers

As health systems have grown and become more complex, planners and policymakers need better tools to analyze health financing issues. National Health Accounts provides an internationally appropriate tool for analyzing health expenditures in terms of *who* is spending *how much* for *what* health services. The NHA methodology measures and organizes expenditures as they flow from their sources through financial intermediaries to providers of health services, and, ultimately, across the various functions of the health system. At each level, the NHA methodology calls for a comprehensive view of the health sector, encompassing public and private-for-profit and not-for-profit entities that finance, manage, or use health funds to deliver services. The strength of NHA lies in its ability to deliver results that are of import to health sector policymakers and managers.

PHR has taken the lead to establish NHA in 27 countries in Latin America, Africa, and the Middle East. This effort has included development and refinement of NHA tools, provision of technical assistance and capacity building to countries embarking on NHA, creating regional networks, and leveraging support from other international donors.

NHA tool refinement: Prior to PHR, the NHA methodology had been applied in a handful of developing countries. Since 1996, PHR worked in collaboration with the WHO, World Bank, and OECD to improve the methodology, standardize it, and make it more policy-relevant. PHR, with its partners, has developed an NHA User's Guide. In addition to contributions to the methodological sections, PHR developed chapters entitled "Using NHA Results in Policy Analysis and Systems Reform" and "Institutionalizing NHA."

Local institutional capacity building: PHR has worked with 27 countries to develop the knowledge and skills necessary to undertake data collection, compilation, analysis, presentation, use of results for policy, and institutionalization. Capacity building has taken place through regional workshops and in-country technical assistance.

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Creating regional networks: There are significant challenges to be overcome in the creation of NHA. While individual countries can and have addressed many of these challenges on their own, substantial benefits can be gained from cross-country collaboration in the development and implementation of NHA. A regional network approach has been used in three different regions: Latin America and Caribbean, East and Southern Africa, and the Middle East and North Africa. The same three-workshop format has been used in all three regions to establish the networks. During the first workshop, countries were introduced to the NHA framework and methodology. The second workshop was used to discuss specific methodological issues arising during data collection. The third and final workshop created a forum for presentation and discussion of NHA and its policy relevance at the national and regional level.

- ▲ **Latin America and the Caribbean:** sponsored by USAID's Latin America Regional Bureau, PAHO, and PHR. The network includes eight countries: Bolivia, Dominican Republic, Ecuador, El Salvador, Guatemala, Mexico, Nicaragua, and Peru.
- ▲ **East and Southern Africa:** sponsored by USAID, the Centre for African Family Studies, the World Bank, the Swedish International Development Agency (SIDA), and PHR. The nine countries participating are: Ethiopia, Kenya, Malawi, Mozambique, Rwanda, South Africa, Tanzania, Uganda, Zambia, and Zimbabwe.
- ▲ **Middle East and Northern Africa:** sponsored by USAID, the World Bank, WHO/Eastern Mediterranean Regional Office, and PHR. The network includes: Djibouti, Egypt, Iran, Jordan, Lebanon, Morocco, Tunisia, and Yemen.

Leveraging support from other donors: Multi-donor coordination has been a cornerstone of PHR's work in National Health Accounts. Such coordination has included rotating the hosting of regional workshops, seeking agreement on technical approach and methodology, and standardizing terminology and reporting.

Making NHA policy-relevant: The value of NHA stems from the use of its results for policy purposes. NHA can guide good policy decisions as well as avert potentially bad ones. A few selected examples will be presented here. In Jordan, NHA results were used to estimate and evaluate financial effect of alternative proposals for universal health care coverage. Based on this analysis, none of the proposals for universal coverage was feasible and the policy was dropped. In Malawi, NHA results that indicated the poor were already paying substantial amounts out-of-pocket have triggered closer examination of alternative financing options, such as user fees and social insurance.

NHA results have been coupled with data from other sources to evaluate the level of equity in several countries. In Egypt, public sources fund 10.8% of health spending for the poorest compared to only 2% for the richest house-

holds. In contrast, in the Dominican Republic, subsidies finance a greater proportion of total spending (36% for the poorest quintile) but are far less progressive, with the richest quintile receiving a subsidy half as big as the poorest.

In Guatemala, NHA is being used to track progress toward targets established in the 1995 Peace Accords for increases in public spending on health. Funding for NHA is now a line item in the MOH budget and estimations are being done annually. In South Africa, the NHA team compared average cost per patient day with occupancy rates in public hospitals. Based on their findings, they estimated that savings of the magnitude of nearly 9% of total public health spending could be attained if institutions with higher-than-average cost per patient day were to reduce their spending to the mean level.

The NHA framework has been expanded in two countries to generate indicators that inform health policies aimed at reaching specific target populations. To better comprehend the scope of the AIDS epidemic and overall expenditures associated with it, the Rwanda NHA team, with assistance from PHR, developed a special study using the NHA methodology and framework. Results indicated that HIV/AIDS treatment and prevention absorbed 10% of all spending in the health sector, and is disproportionately financed by households (93.5%). These results led several prepayment schemes to include HIV/AIDS interventions in their benefit packages. In Morocco, where maternal mortality rates (228 per 100,000 live births) are high relative to the country's level of development, the Moroccan team tailored the NHA estimation to generate estimates of expenditures on maternal and child health services. These estimates show that, although the MOH devotes a significant portion of its budget to these services (16%), its overall contribution remains low. Donors play an important role, with the majority of their funding (62%) being spent on these priority services. As is the case with health care in general, out-of-pocket outlays finance the largest share of total expenditures on maternal and child health care.

The NHA initiatives supported by PHR have created solid capacity in 27 countries to develop and apply National Health Accounts. NHA data have been produced, allowing policymakers, in many cases for the first time, to accurately see how much is being spent on health, who pays, and for what. This accurate picture of financial flows in the health system is critical to guiding improvements and formulating rational policies.

Institutionalizing NHA: The power of NHA is in its ability to measure changes over time and provide input to a changing policy environment. PHR has facilitated the institutionalization of NHA in several countries. For example, in Morocco, four permanent staff (in the Health Economics Unit of the Planning Department of the MOH) have been designated to work part-time on the periodic production of NHA estimations. In Guatemala, NHA is a line item in the MOH budget and is done annually. NHA estimations have

been done annually since 1995 when PHR first started there. In Ecuador, although political circumstances dictated that NHA first be housed within an NGO, PHR has since been successful in moving NHA into the Planning Unit of the MOH where it will have greater policy penetration.

Mutual Health Organizations: strengthening community-based initiatives in health insurance

Community-based health insurance schemes, or Mutual health organizations (*mutuelles de santé*) as they are called in West Africa, are voluntary, non-profit insurance schemes for the informal sector, formed on the basis of mutual aid and the collective pooling of financial risk associated with health, in which members participate in management. These schemes have arisen as a spontaneous popular response to the growing recognition that individuals and communities often must share the responsibility with governments for ensuring financial coverage for health care. In many countries where user fees have been implemented, these community-based initiatives are designed to increase access to and utilization of basic health services through a new form of financing based on prepayment and risk sharing. They also contribute to democratic governance, as members of these voluntary schemes directly participate in their management and express their preferences for health care. They enhance resource mobilization in the health sector by garnering contributions from the rural poor, a population normally seasonally or temporarily excluded from services. Community-based health insurance may even positively affect the quality of health services available to members, as schemes learn how to assess provider quality and factor quality into contracting.

The depth, scope, and sustainability of MHO contributions, however, depend on schemes that are well-designed and well-managed. As the growth in community-based health insurance has been dynamic and rapid, much work needs to be done to ensure that its potential can be reached. PHR has been working with MHOs in West Africa since 1996 to assess the design, capacity, and performance of many of these schemes, and has provided technical assistance to foster their success and to maximize their contributions to the health sector.

In collaboration with the International Labor Organization (ILO), World Solidarity (WSM), and the National Alliance of Christian Mutuelles of Belgium (*Alliance Nationale des Mutualités Chrésiennes de Belgique*, ANMC), PHR's work started with a study of MHOs in West Africa whose purpose was to analyze the actual and potential contribution of MHOs to the financing, delivery, and access to health care in West and Central Africa. The study covered nine WCA countries, compiling data from an inventory of 50 MHOs in nine countries and more in-depth case studies of 22 selected MHOs in six countries. This regional study highlighted several key constraints to the efficiency, effectiveness, and sustainability of MHOs in West Africa: weak

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financial management (low dues collection and lack of synchronization between dues collection and income-earning periods), inadequate marketing, adverse selection, a general lack of negotiations with providers on quality issues, and low population coverage. Most of the schemes were less than three years old and covered less than 1,000 members.

Following this intensive study of current MHO operations, PHR set out to provide technical support to targeted schemes in Senegal, Ghana, and Côte d'Ivoire. In Côte d'Ivoire, PHR worked with the biggest MHO in Africa, MUGEF-CI, with almost 500,000 members. Starting with facilitating a meeting of the MHO and its partners, PHR recommended that the scheme start by fighting fraud. This scheme had estimated "free-rider" costs of cost to 50% of its income, meaning that individuals not contributing to the plan were using its benefits. Financial equilibrium of the scheme has since been restored when the elimination of fraudulent membership cards reduced the number of actual beneficiaries by almost 20%. In Ghana, where the MOH was promoting a national health insurance scheme, PHR focused on redesigning a pioneer MHO scheme, which has subsequently become a model for other MHOs in the country. In 1999, there were only four MHOs in Ghana and now there are 24. In the meantime, the pilot of the national health insurance scheme failed and the MOH has since adopted an MHO model. The pioneer MHO scheme now has mechanisms to fight adverse selection and has increased membership by, among other things, changing the registration period for new members to the main harvest season when rural populations have access to cash.

PHR carried out technical assistance to target MHOs in Senegal and added new programs of technical assistance to women's MHOs. Primary activities focused on training in administrative and financial management, organizing sensitization campaigns to help MHOs reach target populations and increase membership, designing and instituting

measures to improve dues collection among members, and helping MHOs put in place measures to control fraud and abuse. As a result of PHR technical assistance, some target MHOs have dramatically increased their membership (and Faggaru went from about 200 to 1,400 members, Fissel re-launched from 0 to 2,100, and Soppanté from 1,600 to 4,500.) PHR also worked closely with a local support unit (the GRAIM) in the Thiès region to increase their capacity to provide technical assistance to MHOs.

As a result of PHR technical assistance, the Ministry of Labor and Employment in Senegal has created the Technical Union of IPMs (*Institutions de prévoyance maladie*) to provide ongoing assistance and support to IPMs. In Senegal, approximately 140 IPMs cover in excess of 600,000 people. PHR staff were part of the seven-person steering committee established in January 2000 to determine the Union's missions, its roles and functions, its status and necessary means for sustainability, and legal and other reforms necessary to enhance the performance of the IPMs.

From 1997 to 2000, the number of community-based health insurance schemes in 11 countries in West and Central Africa rose from approximately 57 to more than 400.⁴ Given the paramount importance of good design and adequate training to build management capacity within these schemes, such explosive growth necessitates a concerted response. PHR has provided tools and training, including an MHO manager's guide, management information system tools, a video on MHO best practices, and training of trainers manuals for several countries. While these schemes cannot alone constitute a sector-wide financing policy, they can be an important element by covering otherwise hard-to-reach populations in the rural and informal sectors. Through such targeted assistance, community-based health insurance can play a vital role in improving the resources, reach, and sustainability of the health sector in developing countries.

Cutting edge research

"Successfully pursuing long-term reforms in democratizing environments involves not just knowing in which direction to move, but paying attention to how to get there."

Brinkerhoff, D. 1996. "Process perspectives on policy change: Highlighting implementation." *World Development* 24(9): 1395-1401.

PHR's Major Applied Research program sought to prepare and implement a research agenda that would advance the knowledge about health sector reform with value to a broad group of policymakers at the global level. Although all six MARs address key issues confronting those designing and implementing health reform, two of these stand out as really breaking new ground: PHR's MAR on the policy process in health financing reform and its MAR on health worker motivation. Unlike other MARs, which focused more on

4. Inventory carried out by partners in *La Concertation*: PHR, the ILO, WSM, and others.

the technical aspects of health reform, both these research studies sought to better understand "process" aspects of health reform - at a macro level, how do policy decisions get made, and at a micro level, what motivates people carry out their work well. Both these areas were little studied, yet their impact on implementation of reform is crucial.

Understanding how various factors influence the pattern, pace and impact of reforms is important in strengthening the reform efforts. The *Policy Process in Health Financing Reform* study analyzed reforms in South Africa and Zambia during the 1990s. The study synthesized the experiences of these two countries in reforms related to resource allocation mechanisms and resource mobilization. The study analyzed the inter-relationships between the actors involved in the process of reform, the context of reform, and policy design. It also reviewed strengths and weaknesses of the processes used to initiate, develop and implement reforms. The value of this study is manifested in the 10 principles (see box) emanating from the comparative analysis of these two countries' experience. These principles form a guide, applicable to other countries, whose application would strengthen decision making and enable change in health care financing policies to support improved delivery of health care.

The Impact of *Health Sector Reform on Health Worker Motivation* study explored how health reform can be best designed to stimulate health worker motivation, as one of several factors that influence worker performance and thus health systems performance. Very little research exists on motivation in developing and transition countries and questions have been raised about the cultural relevance of research from industrialized countries. Worker motivation

10 Principles

Financing Policy Change should:

1. be an integral part of health systems development
2. pay attention to the "art" of politics
3. be developed through a balanced mix of open and closed processes
4. develop wide-ranging strategies of information gathering
5. use strategies and tactics to strengthen policy development
6. balance strong political leadership with effective technical capacity to support change
7. specify clear roles for different groups of technicians and analysts in the process
8. take into account implementation needs
9. in its pattern of implementation, enable further change
10. include monitoring and evaluation as central components of implementation strategy

is influenced by a number of factors, and clear understanding of major determinants requires knowledge of the fields of psychology, organization development, human resource management, anthropology, and economics. As a result, this MAR started with a multi-disciplinary workshop to discuss a conceptual framework and four country case studies (Kazakhstan, Zimbabwe, Chile, and Senegal), that examined the impacts of reforms on health worker motivation. From the workshop an agenda for further work emerged: the second phase of study then focused on conducting fieldwork on major determinants and outcomes of health worker motivation in Jordan and the Republic of Georgia.

Findings from this study indicate that many of the factors found to be important for motivation in industrialized countries may be universal: sense of self efficacy, sense of control over work environment, attitudes to change, organizational pride, management support, resource availability, and jobs that allow for achievement, challenges, advancement, use of a variety of skills, and job security. Many of these are susceptible to management intervention, often at an operational level. In fact, in two of the four study hospitals, hospital management has already implemented some changes. These findings also indicate that financial incentives on their own are unlikely to be sufficient. Work by other international organizations, such as WHO and the Global Health Workforce Strategy group, indicate the need for additional information in this area. The results also indicate key areas for the design of reforms, ensuring that they foster staff development, organizational pride, open communication and management support, and good job design.

Immunization financing

In recent years, national governments and the international health community have become increasingly concerned with issues of financing national immunization programs. Despite tremendous gains achieved in immunization coverage in the 1980s in nearly all developing countries with the establishment of Expanded Programs on Immunization - now often called national immunization programs (NIPs) - coverage rates in the 1990s plateaued or even declined in a number of countries, especially in sub-Saharan Africa. Such declines can be attributed to a reduction of immunization funding by donors, declining national health budgets accompanied by deteriorating economic conditions, and increased attention to other health priorities, such as HIV/AIDS, which consume limited health funds. With support from the Child Survival Division of the USAID Office of Health, PHR assisted in the evaluation and development of financing strategies for sustaining and expanding national immunization programs.

Reviewing immunization financing experiences in developing countries: PHR conducted a review of existing information on immunization costs and financing in developing countries, based on a literature review and E-mail surveys conducted through UNICEF and PAHO country

offices. Summarized in the *Review of Financing of Immunization Programs in Developing and Transitional Countries* report, PHR outlined exiting information: the costs of immunization, financing of NIPs, the role of the private sector and NGOs in immunization delivery and financing, and country experiences with international mechanisms to facilitate vaccine procurement and financing (UNICEF's Vaccine Independence Initiative, PAHO's Revolving Fund and the European Union Initiative.)

PHR also conducted a series of country case studies in Morocco, Bangladesh, and Côte d'Ivoire. A study on the Colombian immunization program was also conducted, but focused mainly on the impact of decentralization on the program. These studies examine the effectiveness of various country-level financing strategies and how particular mixes of practices have worked in different settings and under different conditions. The studies also determine the additional costs of incorporating new vaccines and other innovations into NIPs and presented recommendations to the countries on how to improve the financing and sustainability of their immunization programs overall. PHR produced a synthesis paper on these four case studies, which draws broader lessons, and conducted two regional workshops (in Cameroon and India) on immunization financing with representatives from 30 countries. With findings and basic principles of costing and financing reviewed, participants were able to then examine their own country programs and prepare applications for funding from the Global Alliance on Vaccines and Immunization.

PHR has also recently completed an additional case study on Ghana that examines the role of financing within the context of the sector-wide approach and decentralization.

Financing assessment tool and resources for immunization services: PHR developed a financing assessment tool for immunization services designed to help NIP managers and other ministry of finance and health officials in developing countries to develop the financial component of medium-term action plans for immunization activities. The tool focuses on costing, financing, and planning issues, and is geared primarily towards country-level immunization managers and coordinating bodies. In addition, PHR compiled extensive information on immunization financing in one document, the *Immunization Financing Resources*. Intended for a wide audience of donor agencies, ministers of health and finance in developing countries, public health and research institutions, and universities, this document identifies over 250 articles and web resources pertaining to costing, financing, policy issues, and other related topics, and provides a contact list of key institutions and individuals working on immunization issues.

Technical support: In addition to the studies and tools discussed above, PHR has been instrumental in providing technical support for the implementation of GAVI strategic plans. PHR reviewed and provided technical assistance in the development of GAVI's global assessment tool,

particularly on costing, financing, and planning components that will be used to evaluate immunization programs and determine country needs. PHR has also assisted the GAVI Financing Task Force in the development of a fact sheet on user fees. This fact sheet will be used to inform policymakers on the benefits and drawbacks of implementing user fees in NIPs.

Other Innovations and Contributions

The above sections have highlighted some examples of where PHR has made substantial contributions to strengthening health systems performance in particular countries or globally in specific technical areas. PHR has also made smaller, but not necessarily less significant contributions to work in the field of health sector reform and health systems strengthening. The paragraphs below describe some of these other contributions.

Exploring emerging health sector reform-related issues

Over the life of a five-year project, the field of health sector reform has changed, as new strategies and issues arise. PHR has had the opportunity to contribute to several of these in small ways, as the extent of PHR's involvement has been somewhat dictated by the funding mechanisms available to support work in these areas. In some cases, these issues have been picked up by other projects to be further explored. Three such emerging areas stand out: NGO contracting, participation in policy, and health worker motivation.

- ▲ **NGO contracting:** Many governments have started to step back from their primary role as a service provider to become instead a payer and regulator, and to allow broader social participation in the reform process. As a result, the role of the NGO as an alternative provider and advocate with which governments can work has come to the forefront. Yet, documented MOH experiences with NGOs are rare. PHR, under funding from the LAC HSR Initiative, developed and conducted two regional meetings on the role of the NGO in health sector reform and contracting with NGOs for service delivery, and published two "State of the Practice" papers on this topic. Through another mechanism, PHR supported the development of case studies related to NGO contributions to service provision for HIV/AIDS. Although PHR would have liked to explore further the potential for NGOs in health sector reform, no further funding was available, and some of this work has been taken up by another contract (Commercial Marketing Strategies).
- ▲ **Stakeholder participation:** Although not explicit in PHR's technical areas of work, stakeholder participation has long been recognized as a key element in an effective policy process. Yet few tools were available to assist reform managers in identifying and advocating for reforms. With its MAR funding, PHR has done

seminal research in this area, examining the role of various stakeholders in the policy process and how stakeholders influence reform design and/or implementation. As part of its work in Ecuador, PHR developed and implemented tools to increase consideration of stakeholder opinions into reform designs, and promulgated the tools through LAC HSR Initiative's *Policy Toolkit for Strengthening Health Sector Reform*. PHR has prepared for policymakers two primers to serve as references on terminology, concepts and results: *PHR Primer on Strategic Stakeholder Communication for Strengthening Health Systems* and a LAC HSR Initiative primer on *Provider Payment Alternatives for Latin America: Concepts and Stakeholder Strategies*. Now, this key area of stakeholder participation has become an explicit component of the follow-on project (HPSS).

- ▲ **Health worker motivation:** Increasingly, as systems improvements are developed, tested and implemented, the role of individual staff in contributing to systems performance is coming to the fore. Although extensive research has been done in the United States and other industrialized countries on worker motivation, little data is available for developing and transition countries. Like many aspects of the management of human resources, worker motivation has seemed to be "too difficult" to tackle, and yet, without solid evidence about what motivates in these countries, how can reforms be designed to produce the balance of incentives and disincentives needed to create the systems performance desired? PHR approached this issue through a two-pronged approach: 1) a conceptual phase which included the development of a conceptual framework and several country case studies of the impacts of reform on health worker motivation, and 2) fieldwork in two countries to examine the major determinants and outcomes of health worker motivation. This work has laid the groundwork for further work in health worker motivation, creating a baseline upon which to measure effects in these two countries, providing initial evidence for the universality of some determinants and the cultural sensitivity of others, and creating a set of tools that could be adapted for other contexts.

Pilot testing as a means of building knowledge, demonstrating feasibility

Although PHR certainly is not the only project to use pilot testing, PHR's experiences in Egypt and Rwanda show the benefits of these approaches for testing the implementation of complex interventions. For example, in Egypt, PHR assisted the MOHP to pilot all three components of its reform package: integrated family practice model of primary care service delivery, financing of providers based on capitation and incentive payments, and new regulatory mechanisms to ensure quality of care (accreditation). Using these seven pilot facilities as living laboratories, the MOHP

was able to test its approaches, gain skilled practitioners, and develop advocates for these new approaches. In Rwanda, the MOH faced a key question of feasibility of prepayment schemes in the poor, rural sections of the country. PHR worked with the MOH to design a prepayment scheme, implement it and evaluate its impact in three districts. From this experience, policymakers learned that such schemes were attractive to Rwandans, and that participation appears to result in lower rates of self-medication, better access to care, and better utilization.

Leveraging funds and donor collaboration

As globalization hits the world economy, it has also become an increasing part of development work. PHR has been successful in leveraging USAID funds to obtain additional funding for key PHR activities such as NHA. Here, USAID funds would not have been sufficient to achieve the number of countries now being touched by NHA. PHR has been able to solicit assistance from other international donors, such as the World Bank and WHO, to pay for additional countries to attend regional NHA workshop, allowing for greater participation in these information sharing fora. In many of PHR's technical areas, staff has worked collaboratively with other USAID-funded projects or other international organizations to develop joint products and technical assistance.

- ▲ Integrated Management of Childhood Illness: WHO, BASICS, UNICEF
- ▲ Immunization Financing: WHO, World Bank, Gates Foundation, UNICEF
- ▲ National Health Accounts: World Bank, PAHO/WHO, SIDA
- ▲ Mutual Health Organizations: ILO, ANMC, WSM

Information Dissemination and Connectivity

During the project, PHR's technical work was supported by the Information and Dissemination (ID) team. The team prepared various summaries that highlighted the significance and results of PHR projects in Africa, Asia, LAC, and the Middle East in the form of Executive Summaries, Primers for Policymakers, and a magazine entitled the *Health Reform and Priority Services Journal*. The ID team also supported PHR researchers in making presentations at international conferences, including the American Public Health Association, the Global Health Council, the International Health Economics Association, SOTA meetings, and numerous PHR-sponsored brown-bag presentations and seminars; ID members worked with technical staff to sharpen their presentations to focus on the impacts and results that their work has had.

In addition to these writing, editing, and training services, the ID team took advantage of the Internet to amplify the impact of its work: PHR worked hard to balance the com-

plexity of its 275-page website with the need to maintain the site's "user-friendliness." In spring 1999, a new website was introduced, written in HTML 2 language that maintained a professional look that reinforces the quality and conveys the breadth and scope of PHR's publications, yet at the same time ensures the ease of connectivity by visitors who may have old web browsers and tenuous connectivity. To ensure that the website was effective, ID staff registered **www.PHRproject.com** meta-names with more than 10 top search engines. An electronic connectivity newsletter was sent out each month to draw attention to recent activities and publications, and the website was promoted at conferences, training sessions, workshops, and in each mailing. As a result, the PHR website logged more than 1.5 million "hits" and recorded a total of 20,000 document "downloads" by visitors from 134 countries.

The ID team provided a range of other services during the project's life.

- ▲ The **Resource Center** responded to more than 2,800 requests for information and disseminated more than 25,000 reports during the last three years of the project;
- ▲ **Editorial Services and Production** edited and produced more than 190 technical and special reports, and helped produce more than 471 administrative reports.
- ▲ **The Connectivity Unit**, which developed the project website, maintained it and constantly updated pages, uploaded documents, and addressed various technical problems that cropped up from time to time on this large (310 Megabyte) site. Documents were offered in MS Word, WordPerfect, Adobe PDF, and HTML (text) formats.

Result-based Training and Performance Improvement

All PHR training investments are designed to support broad-based health policy and systems reforms. Working hand-in-hand with counterparts and partner organizations, PHR has developed a wide range of innovative approaches to training. Primary learning modalities have included:

- ▲ On the-job training;
- ▲ Structured workshops, and study tours
- ▲ Sensitization and consensus-based learning forums; and,
- ▲ Use of electronic media (PHR-supported listservs and websites) to reinforce new knowledge, skills, and learning applications.

PHR field-based training materials, designed for use in low, medium, and high technology learning environments, have successfully built competencies in systems change, policy dialogue, advocacy, health care financing, and decentralization. PHR has also set the pace in the design and field testing of tools, modules, and teaching approaches that are replicable in a wide range of host-country settings.



Conclusions

There are immense challenges to describing and summarizing a five-and-a-half year project as vast in scope and geographic implementation as the Partnerships for Health Reform. For that reason, this report has not attempted to be comprehensive, but to highlight key accomplishments and contributions of this project to the health of the people in the countries where it has worked and to the field of health sector reform at a more global level. The report has summarized key results achieved, based on the project's own strategic framework and based on that of USAID's Global Bureau for Population, Health and Nutrition. It has also described results achieved in several key countries and technical areas.

As can be gleaned from these pages, PHR has accomplished many objectives. Nevertheless, it has not been able to bring to fruition all the work that it started. Health sector reform is a long-term process and PHR has come in at different phases in different countries. Many of the innovations designed under PHR funding are now being tested (e.g., the Family Health Fund in Egypt and case-based payments in Peru), and the ultimate results are not yet known. On many occasions, PHR jumped into uncharted waters to

look for new solutions, try out strategies, and learn from implementation (e.g., prepayment schemes in Rwanda or incentive grants in Senegal). In some cases, PHR has become heavily involved in reform in the very early stages of collecting evidence upon which to make policy (e.g., Jordan) or in building the constituencies for reform (e.g., Honduras and Dominican Republic). Health reform is also an inherently political process, and, in some cases, political instability has led to stagnation or even reversals of reform strategies (e.g., Ecuador and Dominican Republic). Yet PHR's contributions in these circumstances have had positive impact, as its interventions have built capacity, provided evidence that can serve future reform endeavors, and raised awareness of, and interest in, reforms.

In addition to countries where PHR had a large presence, the work on global issues or smaller in-country interventions may not have produced on-the-ground results, but the tools, research, and case studies are critical building blocks to those results, as they provide evidence and mechanisms upon which to develop solid policy that in turn will improve health systems performance and ultimately the health of the people.

Note

CD ROM: Final PHR Publications

PHR publications may also be downloaded from the PHR website: www.PHRproject.com. Publications of the Latin America and Caribbean Regional Health Sector Reform Initiative may be downloaded from the Initiative's website: www.americas.health-sector-reform.org.



Partnerships for Health Reform

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