National Health Fair Celebrates Health Reform Successes in El Salvador

Salvadoran President Francisco Flores opened the first Salvadoran Health Fair, held January 23–24, and presided over the swearing-in ceremony for the community health councils of all 28 of the country’s new Sistemas Básicos de Salud Integral. SIBASIs are government-funded health service networks that offer preventive, primary, and hospital level care. This ceremony provided official recognition for the role of civil society in the definition of health needs and services in El Salvador.

The National Health Fair was an opportunity for senior officials of the Ministry of Public Health and Social Assistance (MSPAS) to generate increased interest, knowledge, and involvement on the part of key actors in the health sector as well as the Salvadoran public at large, in the development of the local health infrastructure needed to deliver primary health care. MSPAS leaders organized the fair, the Technical Secretariat of the Presidency and the Inter-American Development Bank provided financial support, and PHRplus provided technical assistance in developing content and presentations.

Minister of Health José Francisco López Beltrán oversaw another important Health Fair event, the signing of management contracts between the central-level MSPAS and SIBASI directors. These contracts are necessary precursors for the decentralization of public health budgets for all preventive, primary, and most hospital care to the SIBASI level. They define the norms and standards, performance indicators, and responsibilities of the SIBASIs as the managers and providers of health services. The contracts also define the
stewardship and regulatory function of MSPAS in the decentralizing public health sector. During fiscal year 2003 the contracts are based on historical budgetary figures, but, by 2005, decentralized budgets are expected to be developed using performance-based contracts. The management contracts were developed by the MSPAS with the technical assistance of PHRplus.

In addition, PHRplus’ Carlos Castaño reviewed the MSPAS SIBASI manual for administration and finance and was able to identify opportunities for increased efficiency in operational procedures at both the SIBASI and central MSPAS level. Castaño developed an administrative survey that was conducted by MSPAS during February in all 28 SIBASIs, thus expanding the reach of PHRplus’ technical assistance to the entire SIBASI system. In March, Judith de López, Director of Administration and Finance for MSPAS, and Carlos Castaño presented the findings and recommendations of the survey to all international health sector donors in El Salvador. PHRplus will continue to work with MSPAS on efforts to support and develop the local health infrastructure for better delivery of basic health care services.

For further information, contact kathleen_novak@abtassoc.com ▲

Women’s Reproductive Health Awareness Campaign Launched in Albania

Based on a 2000 UNICEF survey, estimates of the number of abortions in Albania range from 49 per 100 live births in 1993 to 34 in 1999. The country’s Ministry of Health estimated a rate of 41.9 abortions per 100 live births in the same year. As staggering as these figures are, they may underestimate the true number because abortions performed in the growing private health sector are not well reported. This high rate of abortion stems from women’s lack of access to reproductive health (RH) and family planning (FP) information and products – in a recent PHRplus survey of three districts, only 4 percent of women of reproductive age reported using contraceptives.

In its effort to improve primary health care in Albania, beginning in pilot sites in the districts of Berat and Kucove, PHRplus found that, while midwives and other health care providers receive some RH/FP education, information is not passed on to women because health center providers are not trained or expected to act as client educators. RH/FP consultations and products have been available only in the two district polyclinics and the Berat Maternity Hospital, and few rural women could journey the several hours that it takes to reach the facilities.

In response, PHRplus has helped local primary health centers launch a Women’s Health Awareness Campaign throughout the districts of Berat and Kucove as part of the broader primary health care program. Initial campaign activities in December 2002 consisted of making reproductive health education materials available to women in their local primary health centers, where they already seek services such as curative care and immunizations, and improving referrals to OB/GYN specialists.

In addition, women’s groups were created at the two rural facilities that participate in the PHRplus primary care pilot. Each group comprises 10 to 20 women, who discuss reproductive health issues with a trained midwife. Their myriad questions and concerns reveal their desire and need for information.

Since February, a coalition of health directors, maternity and hospital directors, OB/GYN physicians, consultants from polyclinics, and
midwives have formed a Women’s Health Awareness Team in each district. Convinced that integrating RH/FP services into local health facilities is key to success, teams aim to expand the campaign to other locations.

Local health officials have been particularly supportive: PHRplus worked to structure the campaign with the directors of Public Health and of Primary Health Care in each district, and their offices coordinate the program. Directors of the Berat Maternity Hospital and the district polyclinics also were eager for the campaign to start. The director of the Maternity Hospital, which serves both districts, pointed out that, last year, his facility alone performed 850 abortions, compared to 1,340 total live births. He was adamant about the need for communities to be educated.

Albanian health officials soon should be able to better tailor their RH/FP efforts, based on findings from two household surveys – a national reproductive health survey of 6,000 women and 2,500 men, and a PHRplus survey of 2,000 urban and rural households in Berat, Kocove, and Fier. The latter looks at health problems; health care expenditures; use of preventive and curative care and contraceptives; and perceptions of service quality. Survey findings will be shared at a workshop in Albania planned for May 2003.

For further information, contact catherine_connor@abtassoc.com ▲

Health Policymakers in West and Central Africa Launch Regional NHA Network

Policymakers from 25 countries across West and Central Africa (WCA) created the WCA Regional Network for National Health Accounts (NHA) during the first NHA conference in that region. Held in Dakar, Senegal, on January 28-29, the meeting was the largest regional NHA gathering to date and marked a significant pooling of donor resources and efforts to support the network as a vehicle to improve health systems performance and efficiency in WCA.

The policymakers meeting responded to two key lessons learned from NHA experience in East and Southern Africa (ESA): the need to engage policymakers early in the NHA process and to promote the value of NHA as a tool in planning and policy formulation. To date, 10 ESA countries have completed a first round of comprehensive NHA estimates. However, it is only recently that the findings started to influence policy and countries started to focus on how to institutionalize NHA.

At the WCA meeting, Mr. E. Kabanda from the Ministry of Health in Rwanda referred to the importance of NHA and, in particular, the HIV/AIDS sub-analysis for his country. The sub-analysis revealed for the first time to the Rwandan Ministry of Finance, Ministry of Health, and others, the burden of out-of-pocket HIV/AIDS expenditures placed on poor households. The findings have led to increased allocation by the government for HIV/AIDS services. Rwanda is keen to undertake another round of NHA and HIV/AIDS studies. It encouraged other countries to follow suit and requested donors present to support these efforts.

The objectives of the Dakar meeting therefore were to introduce WCA policymakers to the concepts and principles of NHA as a tool for health care expenditure data collection and its relevance for policy formulation and to build support among the countries for further in-country implementation of NHA activities. The resulting WCA NHA network, through which countries can exchange information and support each other, will assist in national-level implementation and institutionalization of NHA.

The recommendations for follow-up from the meeting include further discussion with international partners and countries interested in NHA, and continuation of the regional network in the next few years. In addition, many countries stated they have been doing NHA or a form of NHA, and participants emphasized the need for technical assistance and capacity building for their NHA teams as they achieve consensus on the methodology and data collection activities. In response, a regional training workshop for WCA technical experts was proposed for July.
The WCA Regional NHA Network conference was organized by the PHRplus project, in collaboration with the World Health Organization/Geneva, WHO’s Africa regional office (WHO/AFRO), WHO/Senegal, the French Cooperation, and the Swedish International Development Cooperation Agency (SIDA).

For further information, contact janet_edmond@abtassoc.com ▲

Georgia Rolls Out Immunization MIS Reforms

As Georgia prepares nationwide rollout of a new immunization management information system (MIS) this year, results of a year-long pilot of MIS reform implemented in the Kacheti oblast were presented at a national conference held February 5-6 in Gudauri. The pilot is implemented by regional health authorities with assistance from PHRplus, and the Georgian NGO Curatio International Foundation (see Highlights, October 2002).

More than 60 participants from local, regional, and national health institutions (including government officials, immunization managers, and pediatricians), as well as USAID, UNICEF, and the EU, heard Dr. Mamuka Djibuti, program manager, summarize key findings from the pilot.

The new system has improved data quality. This will enable health workers to more accurately:

▲ determine target (child) population;
▲ project vaccine needs;
▲ compute immunization coverage; and
▲ evaluate program performance of individual facilities and districts.

The system also introduced a number of innovations that allow better immunization program management and more rational use of resources at all levels such as:

▲ identification of district-specific factors preventing children from being immunized;
▲ determination and monitoring of area-specific vaccine utilization/wastage patterns;
▲ monitoring of vaccine distribution from existing stores to the point of consumption; and
▲ up-to-date tracking of vaccine balances in all facilities.

“Accurate determination of the child population is the cornerstone for the immunization MIS and one of the most critical components of the program,” said Dr. Djibuti. He praised the pilot for finding 829 previously uncounted children, a number that increased estimates of Kacheti’s child population by 25 percent. Djibuti also emphasized that “routine analysis of data, detailed revision of the results, and feedback to the lower levels supports the system’s proper functioning.”

Previously, data passed upward through the system were often incomplete or inaccurate, leading to uninformed and inappropriate decision making. The information collected in Kacheti is used for management purposes. Its successful use is reflected in the reduction of contraindications administered, use of mobile immunization brigades in low-coverage areas, development of lists of non-immunized children for follow-up, investigation of reasons behind high vaccine wastage, and working with pediatricians to promote early initiation of vaccination.

Djibuti also mentioned issues that must be addressed, such as the need to maintain the high quality of data over the long term, increase utilization of the data for program management, and ensure sustainability of information system reforms.

The Georgia health authorities, including the Department of Public Health and the National Center for Disease Control, welcomed achievements of the pilot, which included strengthening local
Developing Strategies to Support Contraceptive Security

Identifying and prioritizing strategies to overcome barriers to achieving contraceptive security was the focus of a November 2002 meeting of USAID/Washington’s Contraceptive Security and Logistics (CSL) Division and its cooperating agencies (CAs). Contraceptive security exists when all persons are able to chose, obtain, and use quality reproductive health commodities.

The meeting looked at five barriers of particularly concern for poor and rural populations in developing countries:

- Inadequate market segmentation that deters the expansion of partially subsidized or unsubsidized services;
- Absence of third-party (employers, insurance, etc.) support for services;
- Inadequate support by host governments;
- Inadequate or unreliable donor support; and
- Ineffective public sector performance in providing services.

Each CA presented lessons learned in addressing the barriers from their particular areas of expertise. PHRplus suggested actions that USAID and others can take to promote contraceptive security in the context of health sector reform:

- Improve targeting of public health services to better reach the rural and poor;
- Include provision of family planning and reproductive health commodities in the benefits packages of insurance schemes;
- Integrate family planning into primary care services;
- Improve targeting of public health services to better reach the rural and poor;
- Include provision of family planning and reproductive health commodities in the benefits packages of insurance schemes;
- Integrate family planning into primary care services.

However, they expressed concerns about sustainability of the new system in the absence of continued assistance currently provided by PHRplus and recommended developing strategies to address this issue.

Participants also pointed out the challenge of motivating health care workers to produce quality MIS work when salaries are paid sporadically. Another challenge will be working out the practical and legal aspects of creating immunological commissions to help deal with the excessively administered contraindications.

Participants also reviewed the plan for nationwide rollout. A national working group will be formed to coordinate progress, provide recommendations on how to address the constraints encountered, and evaluate need for further revisions in the system. To facilitate rollout, rayon immunization managers, public health managers, and chief pediatricians from other regions will be trained in their respective regional capitals beginning in March, and then return to their rayons to train other health workers. Those who demonstrate superior MIS skills will help with monitoring, evaluation, on-the-job training, and technical assistance. Expert groups will be formed in each region to assess progress and exchange experiences. Telephone helplines at Curatio and the National Center for Disease Control will be established to answer questions from the field.

For further information, contact anton_luchitsky@abtassoc.com.
Support evidence-based decision making and priority setting; and
Implement demand-driven quality improvements.

Other participating CAs were those that, like PHRplus, have received Contraceptive Security Special Initiative funds: the POLICY Project, Population Reference Bureau, DELIVER, Commercial Market Strategies, and Johns Hopkins University Center for Communications Program.

Overall, the meeting (1) expanded CA consensus on the most important lessons already learned about barriers to contraceptive security, (2) identified practical actions and tools to address the barriers, and (3) prioritized remaining barriers for attention in the next round of efforts to learn how to strengthen contraceptive security. Ultimately, CA recommendations will be incorporated into a new strategy being developed by CSL in the near future.

As additional follow-up to the meeting, the CSL division and CAs are documenting the lessons learned and practical ways to implement the lessons in a tool that will be broadly disseminated by the division.

For further information, contact caroline_quijada@abtassoc.com

Jordanian MOH Formalizes Hospital Job Descriptions for More Efficient Management

In response to a program for major social sector transformation announced by King Abdullah in 2002, the Jordanian Ministry of Health (MOH) and PHRplus/Jordan are collaborating to develop job descriptions for all public hospital staff. The royal initiative strives in part to make government more transparent and efficient by improving management and accountability within the civil service. The MOH is one of the first government agencies to begin formalizing job descriptions as a foundation for clear, transparent systems for recruitment, supervision, and evaluation of its hospital employees.

Until recently, the MOH lacked written job descriptions for its roughly 14,000 health care personnel. The absence of such descriptions produces personnel management challenges for hospital directors: the civil service recruitment system cannot always provide them with appropriately qualified staff; they do not have a clear basis for routine supervision; and they lack a transparent system for job performance evaluation.

The momentum to begin work on job descriptions emerged from a quarterly Hospital Policy Forum meeting of Jordan’s 23 MOH hospital directors (see Highlights, September 2001) during which a PHRplus presentation on the strategy for and benefits of establishing job descriptions generated considerable interest among participants.

In a workshop following the Forum meeting, a PHRplus human resources consultant and supervisors from Al Karak hospital laid groundwork for the process. The consultant along with a PHRplus/Jordan staffperson, MOH counterparts Drs. Abdel Razzaq Shafei, Ayyoub As-Sayaideh, and Hani Brosk, hospital supervisors, and the hospital administrator interviewed nearly 300 employees. Interview findings helped the team to draft a description for each job category – responsibilities, daily tasks, qualifications, education, and experience. Employees reviewed the descriptions, and the descriptions then were modified as necessary. This collaborative approach built skills among the MOH staff that will enable them to continue to develop and update job descriptions.

Job descriptions for 400 hospital employees and the private contractors who provide kitchen, cleaning, and security services now exist. They are expected to contribute to improved hospital efficiency and accountability. PHRplus is helping the MOH use the descriptions as a tool to establish transparent performance criteria for annual employee reviews. Hospital directors can use the descriptions when recruiting new staff to identify the skills and qualifications needed by job
Streamlining the financing of primary care in Albania promises to contribute to improved delivery and quality of care.

Legislation Paves Way for Improving Financing of Primary Care in Albania

PHRplus assessments of health planning, budgeting, and financing in Albania have led to legislative action that supports unifying the flow of funds through the health sector. In November 2002, the Albanian Parliament passed a law giving the Health Insurance Institute (HII) the legal basis to become the single source of payment for health care. The legislation substantiated the Prime Minister’s announcement only one month earlier of the government’s policy goal to make the HII the sole source of payment for primary health care (PHC) by 2004, and for all health care by 2005. These events represent broad and high-level support for major health finance reform, a step that will help to improve service delivery.

They also represent another concrete achievement of the collaboration between PHRplus and the government of Albania, which focuses on improving PHC in the context of government-wide decentralization. The collaboration is working to resolve weaknesses in the financing and management of PHC that, while not caused by decentralization, are exacerbated by it. For example:

▲ In the past several years, the health sector has been allotted 6-7 percent of government spending, a share inadequate to cover overall needs. However, PHC receives a respectable 43 percent of the total health budget. This 43 percent needs to be used far more efficiently. For example, personnel costs consume more than 70 percent of PHC funding, often in underutilized health posts and centers, while basic supplies are lacking.

▲ PHC financing is fragmented: the Ministry of Health (MOH) pays salaries of non-physician health care workers, the HII pays physician salaries and drug reimbursements, and the Ministry of Local Government and Decentralization (MOLGD) pays for facility operational costs. No accurate quantification of the current flow of funds exists.

▲ Lack of coherence in decentralization directives hampers PHC financing. For example, local governments fund PHC operations from MOLGD block grants; yet, because accountability for actual spending is to the Ministry of Finance, the MOLGD does not realize that many strapped local governments have substantially reduced allocations for PHC operational costs. In addition, neither the MOLGD nor the local governments have the capacity to assess and plan local health care funding, yet they cannot tap the technical expertise of the MOH because lines of authority do not intersect.

The need to streamline the financing of primary care was a major topic at a PHRplus-sponsored meeting in June 2002 for a wide range of policymakers.
from national and regional/district level MOH offices, the HII, and the MOLGD. Since the workshop, there have been follow-up discussions and a technical brief written by PHRplus on PHC financing. The activities led to greater understanding of the issue and the decision to have PHC funding flow through the HII.

Unifying PHC funding does not, however, address all systemic weaknesses that have negatively impacted the delivery of effective, high quality primary health care in Albania; also needed are administrative and clinical improvements at the facility level. PHRplus is therefore assisting four PHC facilities in the Berat prefecture to make the improvements – for example, a new medical records system is already in place (see Highlights, October and May 2002).

For further information, contact catherine_connor@abtassoc.com ▲

Improving Maternal Health through Health Insurance – Rwanda and Bolivia

A forthcoming PHRplus publication will examine PHR’s work on two health care financing interventions, a prepayment scheme in Rwanda and social health insurance in Bolivia. The activities reveal that women are more likely to use maternal health services when they are covered by an insurance scheme.

Health insurance schemes have become a key strategy to reduce financial barriers women face in accessing maternal health services. Being insured allows a woman to use more medical care than she could afford when having to pay user fees.

In Rwanda, PHR provided technical and financial assistance to the Ministry of Health to develop and implement, in three districts, 54 member owned and managed prepayment schemes. These schemes cover essential maternal and child health (MCH) services, as well as Cesarean sections at the district hospital. Findings reveal that insured women are more likely to have one to three prenatal care visits and are twice as likely to deliver with professional assistance. In contrast, where user fees are charged, women are more likely to give birth alone or with family assistance. Evidence shows that women’s use of skilled birth attendants is integral to ensure that delivery-related complications are recognized, referred, and treated to prevent maternal and infant deaths.

In Bolivia, PHR evaluated the impact of the national insurance program for mothers and children by examining whether the lifting of user fees on a defined package of MCH services improved access to these services. PHR found an increase in the use of MCH services covered by this insurance program, including prenatal visits and deliveries in health facilities. The poor and adolescent girls, two groups previously underutilizing these services, were among those benefiting most from increased access to medical care.

As these two interventions demonstrate, health insurance schemes fill a key gap in improving equity in women’s utilization of maternal health services. However, to ensure financial sustainability of insurance schemes – and improvements in women’s health – schemes must be designed to include incentives that encourage appropriate insurer, patient, and provider incentives.

For further information, contact alison_comfort@abtassoc.com ▲
Strengthening Accountability to Improve Health Systems

Increasing accountability is a key element in a wide variety of reforms, from government-wide anticorruption campaigns, to national-level health system reform programs, district-supervised health service delivery, and community-based health funds. All health systems contain different types of accountability relationships, which function with varying degrees of success. Often it is the perception of failed or insufficient accountability that stimulates change. While this puts accountability at the forefront of health system improvements, simply improving accountability does not substitute for other reforms.

PHRplus has developed a conceptual framework and analytic tools that examine accountability from a systemic perspective and highlight the multiple levels of accountability and connections among health ministries, government audit and control bodies, legislatures, professional associations, hospitals, community groups, and so on. The accountability landscape is filled with a broad array of actors with multiple connections; these create layered webs of accountability with varying degrees of autonomy and sources of control/oversight.

A recently issued PHRplus report identifies three accountability-enhancing strategies:

▲ reducing abuse,
▲ improving performance/learning,

and

▲ assuring compliance with procedures/standards.

In practice, efforts to increase accountability are likely to include more than one strategy. Reducing abuse is a pillar supporting the other two; it focuses on containment of fraud, misuse, and corruption. Methods to encourage compliance with procedures/standards involve regulation, oversight, monitoring, and reporting requirements. Sources of sanctions for non-compliance include the country’s legal framework and judicial system, administrative rules and operating procedures, markets and quasi-markets, professional norms and ethics, licensing and accreditation, and sociocultural values. Strategies for improved performance/learning often include clarifying chains of accountability to determine more precisely who is responsible for what, shortening the chains to make feedback on performance more direct and timely, and/or making the chains more powerful to increase incentives for responsive performance.

Several case studies are planned to field test and fine tune the framework and the tools, and contribute to sharper observations regarding enhancing accountability in health sector operations and reform efforts.

Accountability and Health Systems: Overview, Framework, and Strategies is available at www.PHRplus.org or from the PHRplus Resource Center, PHR-InfoCenter@abtassoc.com.

For further information, contact derick_brinkerhoff@abtassoc.com

IDSＲ Implementation in Ghana Goes North

Following last year’s publication of Guidelines for Integrated Disease Surveillance and Response (IDSＲ) for Ghana, the Ministry of Health (MOH) and the MOH National Surveillance Unit as well as the Ghana Health Service are moving to introduce the new IDSＲ system to health workers and build the capacity of institutions to support its sustainable operation. The guidelines represent an essential roadmap to the operation and function...
With the finalization of the guidelines, PHRplus, in consultation with USAID/Ghana, the MOH, and the Ghana Health Service, has now begun to support introduction and operation of IDSR in Ghana’s three northernmost regions: Upper East, Upper West, and Northern regions. Regional medical directors have been brought on board to ensure their involvement in planning and rollout.

In consultation with the regional medical directors and National Surveillance Unit staff, eight of the 24 districts in the three regions are targeted for initial rollout. In February, PHRplus led a planning seminar to develop consensus on the nature and timing of collaboration. Meeting for three days in Wa, the capital city of Upper West region, seminar participants from all eight districts, from the three regional health offices, and from the National Surveillance Unit developed plans to roll out IDSR. The plans define PHRplus support for: 1) capacity building; 2) continuous assessment and problem solving; 3) sharing; and 4) strengthened supervision as key elements to the rollout.

The consensus is expected to strengthen surveillance by going beyond the mere delivery of new tools and methods in order to engage system users and stakeholders in identifying and addressing the myriad problems and issues that have limited past efforts to improve surveillance. The key message of information use—and not merely data collection and transmission—has been transmitted, and regions and districts are eager to collaborate to put strategy into practice.

For further information, contact jim_setzer@abtassoc.com ▲

Employee Profile: Elona Nasufaga

Elona Nasufaga joined PHRplus in March 2002 as an administrative assistant in the Tirana, Albania office. She has since taken on additional responsibilities in the finance and administration department, where her tasks include handling petty cash, consultant invoices, and timesheets.

Before coming to PHRplus, Elona worked as a peer educator with Population Services International-Tirana, leading seminars to educate young people and village women on the risks of HIV/AIDS and STDs. She also held short-term positions as a translator for several local and international agencies. Elona holds a degree in English from the University of Tirana and is currently taking an evening course in organizational management to better her management skills.

Elona makes a strong contribution to the Albania team and is described by her colleagues as bright and full of potential. She is said to represent “the new generation of Albanians, the post-communist educated youth of the transition period [who are] impatient with the slow pace of reform of the Albanian society.” Elona enjoys being part of a team working to improve the health sector in her country and appreciates the exposure the project gives her to people from other countries and cultures. ▲

New PHRplus Website Launched

PHRplus has launched its new website at www.PHRplus.org. The new site is significantly different in a number of ways: it is easier to navigate and to retrieve documents; it features new information about our work, goals, and partners; and it has a ‘Links’ page to take visitors directly to other web-based health resources. An important objective of the redesign is to provide easy access to users with limited computer hardware/software capacity.
The new ‘Focus Areas’ section at <www.PHRplus.org/focus_new.html> presents information about project work in health systems strengthening “themes” such as mutual health organizations and decentralization, as well as in areas such as HIV/AIDS and infectious disease surveillance. Much of our work completed in partnership with others is listed in the ‘Focus Areas’ section.

Visitors who register and log in have access to a project documents database which they can search by author, title, country, date, or keyword all PHRplus materials as well as reports from the predecessor Health Financing and Sustainability (1990-95) and the Partnerships for Health Reform (1995-2001) projects. The reports and materials searched are instantly available on-screen in Acrobat PDF format.

Another significant aspect of the new site is a sophisticated tracking system that enables the project to contact visitors who have downloaded materials to inquire about their usefulness.

For further information, please contact the webmaster ricky_merino@abtassoc.com

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**New Employees**

Over the past six months, PHRplus welcomed the following staff members:

- **Cheikh Mbengue**, Technical Officer (based in Senegal, directs Benin program)
- **Martine Cisse**, Assistant Accountant, Senegal
- **Isaac Gyamfi**, Operations Manager, Ghana
- **Gustavo Corrales**, Long-term Advisor, Honduras
- **Midori de Habich Rospigliosi**, Project Director, Peru
- **Ilirjan Hasani**, Finance and Administration Manager, Tirana, Albania
- **Sokol Kaso**, Office Manager, Berat, Albania
- **Klarita Lacka**, Implementation Officer, Berat, Albania
- **Catherine Chanfreau**, HIV/AIDS Technical Adviser, Bethesda
- **Beaura Mensah**, Information Dissemination Specialist, Bethesda
- **Christopher Tetteh**, Disease Surveillance Technical Officer, Bethesda
- **Tammy Stewart**, Task Manager, National Health Accounts, Bethesda

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**New PHRplus Publications (October 2002 – March 2003)**

- **Tools and Guidelines for Implementing New Payment Mechanisms for Ambulatory Care in the Ministry of Health Provider System of Peru (TE 016)** by Alfredo Sobrevilla, Luz Loo, Alexander Telyukov, and Miguel Garavito (*Also available in Spanish: Herramientas y pautas de implementación para los nuevos mecanismos de pago ambulatorio en el sector salud del Perú*)
- **Accountability and Health Systems: Overview, Framework, and Strategies (TE018)** by Derick Brinkerhoff
- **Piloting Health System Reforms: A Review of Experience (TE019)** by Sara Bennett and Mary Paterson
- **Costing of HIV/AIDS Treatment in Mexico (TE 020)** by Sergio Antonio Bautista, Tania Dmytraczenko, Gilbert Kombe, and Stefano Bertozzi

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**Working Papers**

- **Margaret Saunders**, part-time Technical Officer, Knowledge Building, Bethesda

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**For further information, please contact the webmaster ricky_merino@abtassoc.com**
Partners for Health Reformplus

Partners for Health Reformplus is USAID’s flagship project for health policy and health system strengthening in developing and transitional countries. The five-year project (2000-2005) builds on the predecessor Partnerships for Health Reform Project, continuing PHR’s focus on health policy, financing, and organization, with new emphasis on community participation, infectious disease surveillance, and information systems that support the management and delivery of appropriate health services.

PHRplus focuses on the following results:

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

Nancy Pielemeier, DrPH, Project Director
Cheri Rassas, Deputy for Operations
Steve Mason, Deputy for Finance
Sara Bennett, PhD, Research Advisor
Marty Makinen, PhD, Financing and Systems Reform Advisor
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A copy of Highlights is posted on our website, www.PHRplus.org

Ghana (WP001) by Sylvia Anie, George Kyeremeh, and Samuel George Anarwat
▲ Maternal Health Financing Profile: Tanzania (WP003) by Caroline Quijada and Alison Comfort

Workshop Reports
▲ Workshop Summary: PHRplus Community-Based Health Financing Coordination Meeting (WS 001) by Brant Silvers

Special Products

Insights for Implementers
▲ Nueva perspectiva para los ejecutores: Descentralización y reforma del sistema de salud (IN 001) by Derick Brinkerhoff and Charlotte Leighton (Also available in English)

NHA Global Policy Brief
▲ Using NHA to Inform the Policy Process (NHA 02)

Executive Summaries
▲ La necesidad de reformar el sistema de cobros a los usuarios en los establecimientos de salud de Honduras (ES 001sp) by John Fiedler, Javier Suazo, Maria Sandoval, and Francisco Vallejo (Available in Spanish only)

Resources and Tools
▲ A Glossary of Health Reform Terms for Translators (English, French, Spanish, and Russian) (GL 001) by Liz Nugent and Lena Kolyada
▲ Compendium of Publication Abstracts (AB 02/03)
▲ Publications List (with indices) (PL 02/03) ▲

PHRplus Community-Based Health Financing Coordination Meeting 2003

Tanzanian Team Visits PHRplus

Swai (USAID/ Dar es Salaam) visited Bethesda in March to work with the PHRplus Tanzania Infectious Disease Surveillance (IDS) team and the CHANGE project’s Rebecca Fields and Ann Jimerson. Work centered on further development of the strategic framework and action plan for USAID-supported efforts to strengthen IDS in Tanzania. Also participating, but not shown in the photo, were Peter Nsubuga, Kathy Cavallaro, and Helen Perry from the Centers for Disease Control and Prevention. ▲

From left to right: Peter Mmbuji, Lynne Franco, Stephanie Posner, Cara Vileno, Leonard Mboera, Rebecca Fields, Raphael Kalinga, Ann Jimerson, Patrick Swai, Chris Tetteh

Drs. Peter Mmbuji (National Institute for Medical Research, NIMR), Leonard Mboera (NIMR), Raphael Kalinga (MOH), and Patrick

A copy of Highlights is posted on our website, www.PHRplus.org