Economic factors have a major impact on women’s health care choices, particularly in poor and rural areas. The economic cost of wages lost during trips to health providers, as well as related transportation expenses and user fees, can deter women from using health services. Community-based health financing (CBHF) schemes have increasingly been shown to be one way of reducing economic barriers to care. Schemes vary significantly in purpose and design, but most share the goal of providing members with affordable access to health care by allowing them to pay a modest premium on a regular basis to access a defined package of health care services with select providers.

There is considerable variation in services included in the benefits packages of CBHF schemes. While services such as deliveries, and prenatal and postnatal care are commonly included, family planning often is not. PHRplus conducted a qualitative study in two regions of Senegal to examine factors that affect the inclusion or exclusion of family planning services in the benefits package of CBHF schemes and, more broadly, the role of CBHF in promoting reproductive health.

The study, which took place in April 2004, included a diverse sample of 13 mutual health organizations (MHO is the term used in the West Africa region to describe CBHF schemes) and associated health facilities in the regions of Thiès and Louga. All MHOs completed a short questionnaire containing questions about the MHO, including date of creation, intervention zone, target and beneficiary population, services covered, and services offered at the health facility associated with the MHO. Researchers led a total of 13 focus group discussions with 97 women beneficiaries from MHOs that offer and do not offer coverage of family planning services and commodities.
Four principal findings emerged:

▲ MHOs increase accessibility to health care services.

Participants noted that the MHO enables a reduction in fees for hospital visits and prescription medicines, and some specified that the MHO membership card facilitates their access to health services. Many participants noted that MHOs reinforce community solidarity, recognizing that even if they were not sick and did not use the benefits, their contributions helped others.

▲ Women play an important role in creating MHOs that offer family planning services.

MHOs that offer family planning services were most frequently initiated by a group of women. Some participants spoke emphatically of the dynamism and leadership of these women. MHOs that do not offer family planning services are usually initiated by a group of men or a mixed community group.

▲ Demand plays an important role in inclusion of family planning and reproductive health services in benefit packages.

Overall, participants emphasized three points: (1) the general assembly (the MHO governing body) plays an important role in the decision to include or exclude family planning benefits; (2) the decision to include family planning is influenced mainly by demand from members; and (3) the decision to exclude family planning from the benefits is affected mainly by the constraints of the MHO and the facilities as well as by low demand.

▲ MHO membership increases access to care.

Most participants felt that being a member of an MHO provides beneficiaries greater access to health care but doesn’t necessarily impact one’s use of services. MHO administrators felt that the lower cost of health services for MHO members made services more accessible and thus contributed to members’ health seeking behavior. Beneficiaries emphasized the need to take care of one’s health as the primary motivation to seek care, whereas administrators felt that the MHO as an organization inculcates an awareness of the importance of prevention among women members. Most participants in all categories felt that the frequency of use of health care services was influenced by factors such as quality of care, whether the facility makes the patient feel welcome, competence of health/MHO personnel, geographic accessibility of health post, and benefits offered by the MHO.

While the majority of MHO members are satisfied that the most essential health care services are included in their benefits, many of them recognize that MHOs are financially constrained in the choice of coverage, and would like to see more reproductive health and family planning benefits added.

The study also reinforces the fact that the decision to include and exclude services, including family planning services, is influenced in part by the demand expressed by members. When prompted, most participants felt that reproductive health services are important, but were aware that current information and promotion activities are virtually nonexistent due to low social demand, lack of funds, and inadequate training of MHO administrators.

Using the results of this study, PHRplus will develop recommendations for MHO administrators and technical assistance agencies for ways to maximize the role MHOs can play in increasing utilization of reproductive health and family planning services. A full report on the study is forthcoming.

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**New Development Assistance Mechanisms: Jeopardizing Contraceptive Security?**

Contraceptive security exists when people are able to choose, obtain, and use high quality contraceptives for family planning and prevention of HIV/AIDS and sexually transmitted infections. In many countries, people rely on free or subsidized contraceptive supplies made available by governments and international donor agencies. There is, however, a growing financing gap as current levels of government resources and donor support are increasingly inadequate to meet rising contraceptive demand.

Changes in the way donors are providing aid may further siphon off funding for reproductive health commodities. There is a trend to move away from targeted donor-funded projects towards pooled funding of a single policy and expenditure program defined under a sector-wide approach (SWAp).

Beyond SWAs, the emergence of global funds, such as the Global Fund to Fight AIDS, TB and Malaria and the Global Alliance for Vaccines and Immunizations, as well as new mechanisms such as poverty reduction strategies (PRSP) and the Millennium Challenge Account, are also affecting donor transfers to countries, which in turn may influence contraceptive security. The increased emphasis on poverty alleviation means governments must now focus on programs and activities that will achieve poverty reduction goals if they wish to access external funding.

Similarly, a global call for reducing disease...
burden may turn attention away from non-disease interventions such as family planning.

To assess the impact of SWAps and PRSPs on contraceptive security, PHRplus looked at the experiences of three countries – Ghana, Zambia, and Bangladesh – in designing and implementing these mechanisms. The study sought to determine: 1) whether contraceptive security issues such as the availability of commodities, strengthened logistics systems, and quality counseling services were explicitly addressed in government strategies; and if so, to what extent they were included, 2) whether donor funding levels changed due to new arrangements, and 3) what plans, if any, exist within the SWAp and/or PRSP to finance reproductive health commodities. Information was gathered through interviews with key country informants and a literature review.

The PHRplus study found that when family planning was discussed in PRSPs or SWAps, it was often referred to in general terms such as “the strengthening of family planning programs” or “increasing reproductive health/family planning education.” Explicit financial commitments to commodities were usually missing.

The picture is less clear as to whether the new funding mechanisms have changed or influenced the level of commodities provided by donors. Accurate estimates of global donor financing for reproductive health commodities are difficult to obtain. For some donors it is difficult to separate the amount spent on commodities versus overall reproductive health/family planning program support, particularly if the donors are participating in pooling of funds. Many bank loans are used to finance basic social service programs (such as integrated health and nutrition) with reproductive health/family planning components embedded within them making disaggregation of figures difficult.

The challenge, then, is to ensure that contraceptive security is perceived by governments and development partners as a national good; that it is fundamental to broaden development, poverty reduction, and health goals; that this commitment is expressed through explicit attention in SWAps and PRSPs; and that the commitment is matched by resource allocations, implementation, and monitoring.

Using the findings from the three country studies as well as the literature review, the following are recommendations that PHRplus has developed for all stakeholders – host country governments, donors, program implementers as well as communities – to maximize resources for contraceptives.

▲ Be knowledgeable and proactive about the changing funding environment to ensure visibility of commodities.

▲ Modify programs to reflect new objectives and be creative in demonstrating how reproductive health/family planning priorities and programs meet the funding flows and international demands.

▲ Map out how reproductive health/family planning programs and services help achieve internationally accepted goals and measures such as the Millennium Development Goals.

▲ Link planning and budgeting processes to broader national and international objectives.

▲ Improve tracking of donor as well as government expenditures on contraceptives.

▲ Encourage private sector participation in development of PRSP and SWAps.

The entire report can be downloaded from www.phrplus.org.

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Creating Ownership for Albanian Health Information System

Improving primary health care (PHC) relies in great part on the availability of complete, accurate, and timely data on types of services delivered, common conditions treated, and patient demographics. Although some data were being collected manually when PHRplus began work on PHC in Albania in 2002, the Albanian health system was not set up to analyze and use the information at the health center level.

The building of a new health information system (HIS) in Albania began by adapting tools developed by PHR in Egypt. These tools included a facility-based information system, requiring facility staff to fill out an encounter form for each visit. The forms were then scanned into a database and reports were generated for each pilot site. Equipment needs were minimal and included a computer network, scanner, and printer.

Nurse Adelina Mehilli at the 10 Korriku Health Center in Berat completes patient visit encounter form.
The system proved effective in the initial four pilot sites, producing routine reports that contributed to improved planning and monitoring.

As interest in expanding the system developed, refinements became necessary to increase chances for sustainability. The project invited all stakeholders to participate in reforming the system to be more effective in the Albanian context. Work to adapt the system to country-specific conditions suddenly made local ownership the system’s strongest point. Collaboration started in fall 2003 and resulted in the creation of a simple encounter form to be entered manually. Instead of networks and scanners, the system is based on individual machines and floppy disks.

After several months of dialogue and technical redesign, the new system was tested. Training began in April 2004. Four months of user experience indicates that:
- Costs for encounter forms have been cut in half
- Encounter forms are now completed in a third of the original time
- Data entry time has been cut by 40 percent
- Monthly reports are generated in less than five working days after month’s end

The system is now quickly spreading for use in clinics in the Berat region and is run completely by Albanians. The original pilot involved four health centers. In August 2004, 18 health centers provided complete data for analysis at the health center, district, and region levels. Local health authorities are providing resources to print encounter forms and are providing staff for data entry. The central government is currently evaluating the system for scale-up throughout the country.

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**Yemeni Midwives Create Professional Association**

Maternal/infant mortality and morbidity rates, as well as the population growth rate in Yemen are among the highest in the developing world. Various sources estimate 351-850 women die per 100,000 live births and approximately 84 percent of women give birth at home without a trained attendant. Less than half of the 65 district hospitals can perform Cesarean sections.

Strengthening the role of and increasing the number of practicing midwives in both rural and urban areas is essential to improving access to emergency obstetric care as well as to other basic reproductive and child health services, and to improving maternal and child health outcomes.

Until this year, Yemeni midwives had had no formal professional organization to advocate for the profession or assist with the resolution of critical issues such as scope of practice, training and education, and employment opportunities. The creation of an independent midwifery association in Yemen is an important step to strengthening the leadership role of midwives in service delivery and national policy dialogue on the well-being of mothers and children.

In June 2004, the Partners for Health Reformplus project and the RH/FP Directorate, the Department of Nursing and Midwifery, the Community Midwives Training Project, the Union of Practicing Health Professions, the Health Sector Reform Policy Unit, and donors. Participants also included midwives from Lebanon, Bahrain, Indonesia, and the United States, countries with a long history of midwifery associations. In addition, the general secretary of the International Confederation of Midwives attended and encouraged Yemeni midwives in this new venture. Experiences from each of the visiting countries enriched the discussion and helped to identify obstacles and lessons.

Following the national workshop, the midwives worked behind the scenes to prepare the association registration with the Ministry of Social Affairs. Despite opposition from physicians and nurses, the association held its first general assembly on September 2 with overwhelming support from more than 80 midwives who traveled at their own expense from all parts of the country. The formation of this association represents a major step in the history of Yemeni women by recognizing the role that midwives play in maternal, child, and family health and by giving them an active voice in improving training and services to promote better health.

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The formation of a midwifery association in Yemen is an important step in recognizing the role midwives play in improving maternal and child health outcomes.
### Scaling Up ART Provision in Uganda

An estimated one million people currently live with HIV/AIDS in Uganda. The Ugandan government has demonstrated commitment to combat the epidemic by launching a scale-up of anti-retroviral therapy (ART) service provision with the goal of increasing service delivery from the current 23,000 patients (nearly all in private sector treatment) to 150,000 (with most delivery by the public sector) by 2012.

**PHRplus** conducted a comprehensive analysis of resource requirements for scaling up ART activities in Uganda in April-May 2004. The cost projections built on a 2003 costing of the Uganda ARV program using the PHRplus-produced AIDSTREATCOST (ATC) software and input data from programs currently operating in Uganda. The projections include costs of highly active anti-retroviral therapy; voluntary counseling and testing; laboratory services for prevention of mother-to-child transmission; treatment of opportunistic infections and sexually transmitted infections; home-based care; prophylaxis for TB; information, education, and communication for ART; training facility-based staff; and capital improvements of facilities. In addition, the projection estimates the human resource requirements of the scale-up.

Projections show that the annual cost of the ART package will increase gradually from about US$ 90 million in 2005 to US$ 130 million in 2012. The ART package will require financial resources necessitating a considerable increase in health spending which could quickly exceed resources available now. For example, requirements for most categories of personnel – doctors, counselors, nurses, nutritionists, lab technicians, and pharmacists – will double to triple between 2005 and 2012.

At the time of the launch of the ART scale-up, Ugandan stakeholders met at a workshop facilitated by PHRplus to discuss issues related to the long-term sustainability of government-provided ART given the cost projections. Over 50 participants from the Ministry of Health, the Ugandan ARV policy financing sub-committee, the AIDS Support Organization, the Ugandan Joint Clinical Research Center, the Centers for Disease Control, DELIVER/JSI, the Global Fund for AIDS, Tuberculosis and Malaria, and other stakeholders debated the sustainability question.

The PHRplus team helped the participants begin to frame the issue of sustainability of scaling up the ART package by posing three questions:

1. How to prepare for the day when fewer external resources are available for ART?
2. How to ensure that resources go as far as possible to ensure that the goals of the ART are attained or approached?
3. If the demand for ART exceeds supply, how to prioritize delivery while remaining true to the principles of Uganda’s national ART policy of equitable and universal access?

Participants brainstormed a long list of options to address these issues and prioritized them for further analysis. A year-long series of policy discussions and technical assistance is scheduled for PHRplus and USAID to further work with policymakers to improve the sustainability prospects of ART provision. By taking these first steps toward addressing sustainability, Uganda is ahead of many in the developing world, although the road ahead is long. Challenges are considerable even with the ART program reaching only a minority of the currently HIV-positive Ugandans, much less when fully scaled up.

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### Employee Profile

Takondwa Mwase, recently appointed PHRplus National Health Accounts (NHA) Advisor, sees the greatest promise of NHA to be its potential to bring together many actors in a collaborative process that fosters good stewardship for improved health. “Tako,” originally from Malawi, will be based in his home country but will work worldwide to provide technical assistance and on-the-ground advising.

Tako’s interest in NHA originated from his master’s thesis on health financing and expenditures in Malawi, in which he analyzed efficiency and equity using the NHA framework. After serving as a health economist for the Ministry of Health in Malawi, he was the NHA fellow for Africa at World Health Organization (WHO) headquarters in Geneva. From there he was posted to the WHO Regional Office for Africa in Harare, Zimbabwe (and later in Brazzaville, Congo), where he was responsible for establishing a NHA and health financing unit and, subsequently, for providing technical and capacity building assistance in the WHO Africa region.

As interest in NHA increases worldwide, Tako feels his greatest challenge will be to meet the growing demand for technical assistance and advising on the NHA process and its policy impact. His greatest satisfaction in this work comes from witnessing policymakers and technicians deliberate together and start to “speak the language,” ultimately grasping the policy-changing potential of the NHA tool to better health systems.
Regional Health Accounts Facilitate Decentralization in Peru

In 2003, the Peruvian government issued a clear mandate to decentralize state functions and to begin the transfer of responsibilities and financial resources to regional governments. This process has led to the need for new tools to strengthen decentralized planning and decision-making. In this context, PHRplus is assisting the regional governments of La Libertad, Lambayeque, San Martin, and Ucayali in the implementation of Regional Health Accounts (RHA) based on the National Health Accounts framework. RHA is a set of standardized definitions, classifications, and accounting methods that provides financial information regarding availability of resources and allows identification of opportunities for reallocation to prioritized health interventions.

La Libertad and Lambayeque have successfully completed the first RHA in Peru. Annual per capita expenditure for health in both regions is around US $85, with high out-of-pocket household spending (from 40 to 60 percent of total resources) going mostly toward the purchase of pharmaceuticals. Results from Lambayeque indicate that public facilities that provide ambulatory services spend 64 percent of their resources on curative services and only 11 percent on preventive services. In the ambulatory facilities of Social Security services, as much as 23 percent of the budget goes to administrative expenses.

Regional health councils are starting to focus on issues raised by the findings including:

- Reducing dependency on direct household payments, i.e., increasing insurance coverage
- Improving inter-institutional coordination between the public and social security sectors
- Increasing efficiency of health service provision, e.g., making better use of hospital capacity

In a recent meeting of Ministry of Health (MOH) officials and regional presidents and health directors on national decentralization, representatives of La Libertad and Lambayeque emphasized the relevance of RHA. Nery Saldarriaga, vice-president of the Lambayeque regional government, said: “It has been surprising to learn from these Regional Health Accounts that public resources are mainly allocated to curative spending… It is important to continue with the RHA effort and institutionalize it as a financial management tool.”

Due to widespread interest in having access to this methodology, the MOH has committed itself to promote RHA throughout Peru. With PHRplus technical assistance, the MOH has formed a task force to develop operational guidelines for the use of RHA nationally.

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Ghana Health Insurance Act Mandates National CBHF

Considerable international attention has focused on the potential for community-based health financing (CBHF) schemes in developing countries to cover basic health care costs for members while avoiding the financial strain that is often associated with unexpected medical care. The Commission on Macroeconomics and Health, launched by WHO in 2000 to recommend a set of health measures to minimize poverty and maximize economic development in developing countries, reported that such schemes appeared the most promising domestic financing strategy in low-income countries. By providing technical assistance on the development and implementation of CBHF schemes in Senegal, Ghana, Mali, Tanzania, and Zambia, PHRplus has gained substantial insight into what makes such schemes successful.

In August 2003, the government of Ghana passed a Health Insurance Act to improve access and quality of basic health care services in Ghana through the establishment of mandatory community-based health financing schemes at the district level. While there are several independent community schemes in Ghana already, the attempt to establish national standards for locally operated insurance schemes is novel.

PHRplus has initiated a district-based approach to monitoring and evaluating the early effects of the Act in collaboration with the Ghana Health Service (GHS). The objectives of the evaluation are to:

1. Provide the GHS with timely information regarding the process of implementation of the Act at the district...
level and the early effects of implementation upon health care providers and district health authorities.

2. Pilot district-level monitoring systems for providers and district health authorities that could later be rolled out across the country.

Six districts were selected for intensive monitoring and evaluation based on whether or not they had a pre-existing CBHF scheme and on certain socioeconomic characteristics. As part of the baseline data collection, scheme development and implementation will be documented in each selected district. In addition, the existing health management information system will be enhanced by capturing information on service utilization, client insurance status, financial performance, and quality of care.

The monitoring effort focuses on questions such as: How does implementation of the Act affect service utilization by different population groups (members/non-members, socio-economic profile, formal/informal sector workers) and/or by type of scheme, service and level of care? In addition, how does implementation of the Act affect the financial situation of health care providers and how does it affect quality of care and access for the poor?

The above activities will be supplemented by additional data collection through client exit interviews, household surveys, and focus group discussions with health care providers and community members. The client exit surveys and the household surveys will collect information on health seeking behavior and health care utilization as well as on household characteristics. These surveys are aligned with PHRplus survey activities in Mali and Senegal, which share the common goal of measuring the impact of CBHF schemes on the demand for and utilization of basic health services. PHRplus is collaborating with both the Health Research and Monitoring and Evaluation Units of the GHS as well as with the District Health Authorities to implement this work. Fieldwork for baseline data collection began in September 2004 and is expected to be completed by December 2004.

Extracting lessons learned as this Act is implemented may enable PHRplus to help guide the government of Ghana in this ambitious endeavor. Findings from the Ghana initiative will also be of interest to policymakers in other countries, as Ghana is one of few countries where social health insurance explicitly builds on CBHF schemes.

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PHRplus Publications (April - September 2004)

Technical Reports
▲ The Pilot Process: Case Study on Piloting Complex Health Reforms in Kyrgyzstan (TE 036) by Mark McEuen
▲ Scaling Up Antiretroviral Treatment in the Public Sector in Nigeria: A Comprehensive Analysis of Resource Requirements (TE 037) by Gilbert Kombe, David Galaty, and Chizoba Nwagbara
▲ Primary Health Care Reform in Albania: Baseline Survey of Basic Health Service: Utilization, Expenditures, and Quality (TE 038)
▲ The Impact of PhilHealth Indigent Insurance on Utilization, Cost, and Finances in Health Facilities in the Philippines (TE 039) by Pia Schneider and Rachel Racelis
▲ Knowledge, Attitudes, and Practices Related to Maternal Health in Bla, Mali: Results of a Baseline Survey (TE 040) by Kimberly Smith, Tania Dmytraczenko, Beaura Mensah, and Ousmane Sidibé
▲ Ensuring Contraceptive Security within New Development Assistance Mechanisms (TE 042) by Caroline Quijada, Tania Dmytraczenko, and Beaura Mensah
▲ Costs and Utilization of Primary Health Care Services in Albania: A National Perspective on a Facility-level Analysis (TE 043) by Alan Fairbank
▲ Methodological Guidelines for Conducting a National Health Accounts Subanalysis for HIV/AIDS (TE 044) by Susna De, Tania Dmytraczenko, Catherine Chanfreau, Marie Tien, and Gilbert Kombe
▲ Estimating the Cost of Providing Home-based Care for HIV/AIDS in Rwanda (TE 045) by Rudolph Chandler, Caytie Decker, and Bernard Nziyiye
Workshop Reports

▲ Use of Information to Address TB/HIV in Cambodia: Workshop Proceedings from Banteay Meanchey, Battambang, Phnom Penh, and Sihanoukville (WS 003) by Jayaseeli Bonnet, So Phat, and Kunrath Seak

▲ Scale-up of TB/HIV Collaborative Activities in Cambodia (WS 004) by Jayaseeli Bonnet, So Phat, Kunrath Seak, and Caroline Quijada

Special Products

▲ The Role of Pilot Programs: Approaches to Health Systems Strengthening by Sara Bennett, Mark McEuen, Linda Moll, and Margaret Saunders

▲ 21 Questions on Community-based Health Financing (21 Questions sur le FCS: Les Mutuelles de Santé) by Sara Bennett, Allison Gamble Kelley, and Brant Silvers. Available in English and French

▲ Using the National Health Accounts Subanalysis to Track Resource Flows for HIV/AIDS (NHA Policy Brief) by Marie Tien and Roselyn Ramos

▲ Investments in Health Contribute to Economic Development by Margaret Saunders, Raj Gadhia, and Catherine Connor

▲ Diseño de un Seguro Obligatorio de Accidentes de Automóviles (Resumen Ejecutivo) by Ursula Giedion, Gloria Ubilla, Enrique Saint-Pierre, and Ricardo Bitrán. Available in Spanish only

▲ Sistemas de Referencia y Contrarreferencia en los Servicios de Salud (Resumen Ejecutivo) by Cecilia Má. Available in Spanish only

▲ Convenios de Gestión en el Sector Salud (Resumen Ejecutivo) by Rubí Valenzuela Magaña. Available in Spanish only

Tools

▲ Health Systems Strengthening and HIV/AIDS: Annotated Bibliography and Resources (TK 011) by Lena Kolyada

▲ Synthesis of Findings from NHA in Twenty-six Countries (TE 046) by A.K. Nandakumar, Manjiri Bhawalkar, Marie Tien, Roselyn Ramos, and Susna De

▲ Informal Payments in the Public Health Sector in Albania: A Qualitative Study (TE 047) by Taryn Vian, Kristina Gryboski, Zamira Sinoimeri, and Rachel Hall Clifford

▲ Costing Nevirapine Delivery to Infants: A Zambian Case Study (TE 048) by Sara Zellner and Stephen Musau

▲ Nigeria: Rapid Assessment of HIV/AIDS Care in the Public and Private Sectors (TE 049) Partners for Health Reform plus, DELIVER, and POLICY Project

▲ Instrumento estandarizado de identificación de beneficiarios para programas sociales en el Perú (TE 050) by Miguel Madueño, Javier Linares, and Alessandra Zurita. Available in Spanish only

▲ Out-of-Pocket Payments and Utilization of Health Care Services in Albania: Evidence from Three Districts (TE 051) by David Hotchkiss, Paul Hutchinson, Altin Malaj, and Andrés Berruti

▲ Monitoring and Evaluating Hospital Autonomization and Its Effects on Priority Health Services (TE 052) by Ramón Castaño, Ricardo Bitrán, and Ursula Giedion

▲ Contracting for Primary Health Services: Evidence on Its Effects and a Framework for Evaluation (TE 053) by Xingzhu Liu, David Hotchkiss, Sujata Bose, Ricardo Bitrán, and Ursula Giedion

▲ Monitoring and Evaluation of Decentralization Reforms in Developing Country Health Sectors (TE 054) by Paul Hutchinson and Anne LaFond

Partners for Health Reform plus

Partners for Health Reform plus 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

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