We are excited to share some of the many lessons we have learned through implementing the PHR Project over the past five years. These highlights selected from reports covering 20 quarters are just that: glances at the many issues and initiatives the PHR Project worked on in over 40 countries — from Egypt to Bolivia, from Honduras to Senegal, from Morocco to Georgia. They represent cumulative results, and much more in terms of real potential for the ultimate impact of this vast array of activities.

PHR focused on four “results areas” underpinning the attainment of USAID’s global strategic objectives for family planning, reproductive and maternal health, child survival, and prevention of infectious and sexually transmitted diseases:

- Policy decisions made on the basis of more effective policy processes
- More equitable and sustainable health financing systems
- Improved incentives within health systems to encourage the delivery and use of efficient, quality services
- Strengthened organization and management of systems to support specific health sector reforms

Some of the highlights illustrate how we have applied tools and methodologies of health reform to examine the interaction of changes in health systems with the delivery of priority services. Others demonstrate the potential of using regional networks to disseminate new ideas and approaches. There are highlights that show how applied research results can be quickly channeled into program improvement, how culturally appropriate interventions can be scaled up, and how the introduction of new concepts can be rapidly integrated into on-going reform efforts.

Special recognition for the successful conclusion of this flagship project is due to many partnerships: USAID COTRs past and present — Bob Emrey, Forest Duncan, Suzanne McQueen, Linda Lankenau, Katie McDonald, and Karen Cavanaugh, USAID Mission and Bureau staff, host-country collaborators and counterparts, and all staff and consultants of PHR, former and current, at the home and the field offices around the world. Thank you very much.

It is our hope that PHR results and lessons not only will sustain in the settings in which they were developed but also replicate elsewhere. We look forward to continuing work in this exciting field in the coming years with partners around the world.

Nancy Pielemeyer, Dr.PH
Focus on Special Initiatives

HIV/AIDS: Priorities and Challenges for the Health Sector

PHR presented key findings from studies focused on the organization, management, and financing of HIV/AIDS programs in July at the International AIDS Conference in Durban, South Africa. Presenters addressed how strengthening the health sector as a whole, through promoting efficient and cost-effective programming, can serve to enhance the sector’s ability to curb the HIV/AIDS epidemic.

As HIV/AIDS threatens to undermine the overall development of many countries, decision makers must be strategic in their resource allocation decisions. The challenge is how to make the best use of available resources to expand coverage, access, and quality of services while at the same time continue to combat pervasive diseases such as malaria, diarrhea, and respiratory infections.

PHR researchers are developing tools and conducting analyses on how resources for HIV/AIDS programs can be most effectively allocated. Dr. Alexander Telyukov presented a study that addresses a pressing need for a uniform and replicable methodology of HIV/AIDS program costing. The approach, known as activity-based costing (ABC), enables the separation of various programs into common structural units, each one defined by an activity and a process. The standardized activity-cost matrix is instrumental for comparing costs of different HIV/AIDS interventions. Furthermore, the proposed terminology of activities and costs will be used to design new and evaluate ongoing programs and technical and budget proposals. PHR worked with HIV/AIDS country program managers in Cambodia, which has the most serious HIV/AIDS epidemic in Asia, to design the activity-cost matrix.

PHR also presented on alternative ways that donors and governments can provide HIV/AIDS services including contracting out to NGOs to deliver an array of services including palliative care, voluntary testing and counseling, and to conduct educational campaigns. Contracting to NGOs can be an efficient and effective use of resources, allowing governments to shift their role from service provider to service manager. Likewise, NGOs are often able to deliver services at a lower cost and typically have better access to vulnerable populations.

Focus on Africa

Hospital Reform in Malawi

The concept of hospital autonomy originated in countries where central health authorities have primary responsibility for the provision of curative inpatient care in addition to planning and regulating health programs. As the cost of inpatient care rapidly increases, the role of governments in providing and managing these services comes under scrutiny.

In Malawi, the government decided to enact reforms to improve the efficiency of the two largest public-referral hospitals. PHR, at the request of the MOH and USAID/Malawi, assisted in assessing the present operational status of the two hospitals to devise a hospital autonomy implementation plan.

Malawi’s hospital autonomy strategy is based on a phased approach that ensures systematic implementation.

Phase I – Initiate strengthening of hospital systems and outpatient health centers.

- Reinforce the current capacity of the primary care system by implementing a specialist rotation system at outpatient and rural health centers versus at the central referral hospital. An inventory management system for drug supplies is also introduced.
- Introduce a referral system at the primary care outpatient clinics and at district and rural hospitals.
- Implement full user fees at the hospital-based outpatient clinics to discourage primary care patients from using tertiary hospitals for routine illness treatment.
- Implement in-depth assessment of personnel qualifications and determine training requirements.
Initiate administrative, financial, procurement, and personnel training.

Develop bylaws for hospital boards of directors detailing powers and responsibilities.

Appoint boards of directors.

Conduct needs assessment of administrative, financial, procurement, and human resource systems.

Initiate mobilization of political legislative support.

Compile a list of all laws and regulations that impact the transfer of operational autonomy to the hospitals.

Phase II – Strengthen the hospitals’ operational capacity.

Complete training of administrative, financial, and human resources personnel.

Implement detailed administrative, financial, purchasing, and human resource policies and procedures.

Initiate the transfer of authority and responsibilities to the hospitals in areas that do not conflict with existing laws.

Draft and present to relevant political stakeholders proposed changes in laws before full transfer of authority.

Phase III – Complete the transfer of operational autonomy to the hospitals.

Finalize implementation of hospital administrative, financial, procurement, and human resource systems.

Enact changes to laws that will formally create a legal entity for autonomous hospitals.

Design a monitoring and evaluating system that measures progress made and that examines the health outcome impact of the hospital reform process.

PHR is working on the design of the referral system and facilitating agreement with specialists on a rotation plan to provide specialist care at the district hospitals.

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**Focus on Special Initiatives**

NHA Regional Workshops Establish Foundation for Improving Health Systems in 27 Countries

How much does a country spend on health care? Who is paying and for what services? How much is allocated to priority health programs or populations? Who are the key players? The answers are revealed through National Health Accounts (NHA). NHA is a highly useful method for understanding the health care financing issues facing low- and middle-income countries. NHA is a tool for gathering both public and private national health expenditure data in a given period that helps lay the foundation for effective and equitable health sector policies and programs.

PHR has taken the lead to establish NHA in 27 countries using a multi-donor, regional network approach. Multi-donor coordination has entailed rotating the hosting of the regional workshops, seeking agreement on technical approach and methodology, and standardizing terminology and reporting. At the workshops, country representatives compare notes and share experiences. Participants not only learn from their colleagues, but form professional alliances that reinforce and enhance the utilization of NHA. The workshops also act as milestones and create a healthy competitive atmosphere to maintain momentum on the work. The regional approach fosters the development of a technical consensus on data sources, definitions, and categories for analysis, making cross-country comparisons of results possible.

The first effort began in 1997. In collaboration with the Pan American Health Organization, PHR completed the Latin American and Caribbean (LAC) NHA initiative in eight countries: Bolivia, Dominican Republic, Ecuador, El Salvador, Guatemala, Mexico, Nicaragua, and Peru. This was followed with regional initiatives in Africa and the Middle East, both of which held third and final regional NHA workshops this quarter.

The Middle East/North Africa Regional NHA Workshop culminated two years of successful collaboration among PHR (funded by USAID’s ANE Bureau),
the World Bank, and the WHO/Eastern Mediterranean Regional Office to develop NHA capacity in eight countries: Jordan, Morocco, Egypt, Lebanon, Tunisia, Djibouti, Iran, and Yemen. In most of the countries, high expenditures on pharmaceuticals emerged as a key policy issue.

Meanwhile in Africa, PHR convened NHA teams from eleven East and Southern African (ESA) countries in Cape Town, South Africa, April 9-14, for the final Africa regional workshop.

The Kenya NHA revealed the major role the private sector plays in financing health care services, contrary to what the MOH had previously believed. In Malawi, there was evidence for the first time that services provided at public hospitals cost more than those provided at NGO hospitals—a finding that may impact hospital sector reform efforts underway. Initial NHA findings in South Africa indicated that despite changes made following the first health expenditure review in 1994/95, the gap in the allocation of funds among primary and secondary services and provincial distribution of funds has not narrowed as envisioned.

The same successful three-workshop format was used in each region 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 that may have arisen during data collection. The third and final workshop was used as a forum for presentation and discussion of NHA and its policy relevance at the national and regional level. Participants discussed strategies for institutionalizing NHA and linking NHA data to key policy concerns.

Conclusions are remarkably similar between countries. For example, social relationships in the workplace and pride in working at a particular facility are important determinants of motivation in both Georgia and Jordan. Significant differences in determinants between different types of workers (managers, supervisors, workers, and different cadres of workers) are also apparent in both countries. However, in Jordan, many options emerge for improving motivation (such as improving equipment and the physical work environment, as well as increasing teamwork), whereas in Georgia, low health worker incomes present a fundamental obstacle to improved motivation.

**Focus on Applied Research**

**Health Worker Motivation: Influencing National and International Policy**

PHR has been conducting in-depth studies of health worker motivation (HWM) in the Republic of Georgia and the Kingdom of Jordan. The studies:

- analyze the determinants and consequences of HWM in selected hospitals;
- make recommendations for changes in hospital practices and workforce regulations; and
- contribute to the development of operational tools that could be used in other settings.

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Focus on Latin America and the Caribbean

Monitoring Health Reform in the Dominican Republic

Experts from major Dominican public and private health institutions approved a matrix of indicators to monitor health sector reforms. The matrix marks the first time that a LAC region country has attempted to design and field-test a detailed monitoring and evaluation system tailored to the country’s health sector reform process. Analysis of indicator data will allow health care policymakers to assess the progress, direction, and the outcome of health sector reform. After refinements from field testing, the process will be documented and the matrix will be disseminated in order for other countries, both within the LAC region and elsewhere, to use the model to design their own.

The March meeting, a national-level workshop convened by the Dominican Secretariat of Public Health and Social Assistance (SESPAS), culminated a 10-month effort by a work group of public and private institutions to develop the indicators. PHR and PAHO provided technical assistance at each step of the process.

Analysis of the indicator results will provide key input for policymakers regarding the changes taking place under health reform initiatives related to legal and normative reform issues; the development of the SESPAS’ role as the regulatory body of the health sector; decentralization; equity in access; strengthening human resources; financing, efficiency, and sustainability of service provision; community participation; quality; environmental health; and health promotion. PHR continues to work with local counterparts to draft a national health sector reform policy document to validate and ensure the sustainability of the health reform process.

Focus on Special Initiatives

National Immunization Program in Morocco Doubles Budget

Using empirical evidence from a PHR study entitled *Case Study on the Costs and Financing of Immunization Services in Morocco*, the Moroccan Ministry of Health (MOH) has succeeded in persuading the country’s Parliament and Ministry of Finance to double the government budget for next year’s National Immunization Program (NIP).

The study, prepared by PHR staff and consultants from the World Health Organization and Morocco, analyzes current program costs and expenditures. It proposes options for reducing costs, changing the mix of financing sources, and mobilizing additional resources in the future. The intragovernmental advocacy and policy dialogue engendered by the study are particularly important in the broader context of the decentralization currently taking place in Morocco. The process of decentralization has empowered regional health authorities by granting them increased financing and management responsibility. However, the additional responsibility must be accompanied with adequate training. The study identifies areas of the program that must be strengthened at the regional level. It is also key for the financial sustainability of the NIP in light of the end of the five-year World Bank loan program in 2001, which finances vaccines and supplies.

Response to the recommendations has been immediate, by both the government of Morocco and donors:
- USAID/Rabat will increase funding for the vaccine revolving fund and work closely with the MOH and UNICEF to assist in the introduction of the Hepatitis B vaccine.
- The National Committee on Vaccination Coordination was activated.
- A base for a five-year strategic plan is in place.
- Workshops are being organized to provide technical assistance to the MOH on planning, costing, and financing of vaccines.
- The MOH is preparing a regular evaluation process for the NIP.
- Better understanding of the contributions of the MOH and other partners has increased their dialogue and willingness to take action.
Focus on Latin America and the Caribbean

Strengthening Honduras’ Capacity to Regulate the Health Sector

The Honduran Ministry of Health (MOH) invited PHR to directly support its efforts to review and revise its regulatory codes as part of a broad plan to reform Honduran health services. PHR’s long-term advisor was asked by the Minister of Health to join the Ministry’s Regulation Working Group. The group works to establish health norms and laws more effectively, develop draft legislation, and strengthen capacity for regulatory oversight of the health sector.

In August, the MOH conducted a seminar focusing on health legislation. PHR presented the results of a technical review of the existing health legislation and regulatory codes. PHR’s consultant designed a computerized information system to organize this information for the Ministry and increase the awareness of policymakers of the existing legal environment.

Focus on Africa

Prepayment Programs in Rwanda: More than 12,000 Members in Two Months

People in Rwanda currently contribute to the financing of their health care costs through user fees. While this may appear to be a straightforward system—you pay for health care only if and when you need it—it has several drawbacks: Even low fees may prevent the poor from seeking care when they truly need it. This is especially a problem for certain socioeconomic groups, such as farmers who have “extra” cash only on a seasonal basis, or low-wage workers who are not paid when they are too sick to work. Also, only those who seek care contribute towards the cost of health care; this denies ongoing financial resources to a health care system or group.

Prepayment schemes address these problems. Under prepayment, individuals or households pay a premium into a health care fund on a regular basis, usually annually, semi-annually or even monthly. Payment of the premium entitles the individual or household to seek health care services in a defined benefits package, for a given period of time, without additional payment. Contributions from persons who do not fall ill help to cross-subsidize the care of those who do.

In the first half of 1999, the Rwanda Ministry of Health, in collaboration with PHR and community members from three districts, developed a prepayment scheme. Its objectives are to improve access to and quality of health care; engage community members in program administration; and strengthen management capability in health centers and districts. On July 1, prepayment pilot programs were introduced in the three districts, management committees were constituted, and contracts were signed with health care facilities. The programs were publicized on national radio theater broadcasts. By September 1, more than 12,000 Rwandans—1.3 percent of the population of the three districts—had enrolled in the programs.

While each district program has unique aspects, the three programs share certain features: All members join by paying an annual premium. Each district offers care at 15 to 20 health centers and one hospital. The benefits package includes preventive and basic curative care provided by nurses in health centers, essential drugs, hospitalization, and ambulance transfer to the district hospital. Members also are entitled to consultation by a physician, overnight stay in the hospital, and free caesarian-section.

One example of a satisfied patient is a woman who had a caesarian-section at the district hospital after being transferred by ambulance from a health center. In a radio interview, she said, “if I were not a member, I would not have had enough money to pay for my treatment.”

Two interesting findings became apparent from the start:
- Communities with prior mutuelle (non-profit community-based health care financing organizations) experience show highest membership numbers. This encourages the ministry of health and PHR to identify and collaborate with other mutuelles in Rwanda, and prepares them for nationwide expansion of the prepayment scheme
- Members of poorest communities were the first to sign up, indicating that prepayment programs do respond to the needs of the poorest; and

During a one-year test phase, the three pilot programs were evaluated through a household survey and patient exit interviews. Assessment criteria were the scheme’s sustainability, viability, equity, and efficiency. The evaluation findings yield recommendations for a nationwide health financing program.

Update from April 2000

Prepayment Schemes Mobilize Resources for Health Sector in Rwanda

At a three-day workshop on prepayment schemes (PPS) hosted by PHR in Kigali, the Minister of Health encouraged PPS representatives to provide information to other health regions and districts planning to launch similar schemes. More than 50 representatives from the MOH, churches, prepayment schemes, government authorities, and international
organizations participated in the
workshop.

Preliminary data from health centers
reveals the potential of prepayment
schemes to mobilize additional resources
for the health sector. Members’
anualized per capita contribution to
primary health care (US$ 0.92) is on
average more than twice as high as that of
non-members (US$ 0.40). During the
first six months of operation, prepayment
schemes have improved access to care
for members, who report on average 1.4
health center consultations per capita,
compared to the non-member
consultation rate, which remained at 0.3
per capita. Members also tend to receive
fewer drugs (US$ 0.87) per visit than
non-members (US$ 0.97). Survey data
will need to confirm the reasons for this
difference; however, health center
personnel point out repeatedly that PPS
members seek care at an earlier stage of
disease progression than non-members
and therefore require less treatment and
recover faster. The government official in
charge of social affairs in one pilot
district comments that the poorest areas
in the district have the largest PPS
membership pools.

Workshop participants made the
following recommendations to
strengthen prepayment scheme
implementation in the three districts:

- strengthen awareness and
  information campaigns in
  collaboration with all stakeholders;
- institutionalize a permanent secretary
  at the regional level in charge of
  implementation and follow-up of PPS;
- create on a prefecture level a PPS
  steering committee headed by the
  prefect;
- adjust members’ co-payment in
  selected health centers where services
  are over-used by members; and
- initiate legal process to acquire
  association status for PPS.

Teams of doctors and nurses trained in
family medicine are demonstrating an
integrated care model, the first of three
pilot test system elements that also
include new regulatory and financing
mechanisms. Doctor/nurse teams are
responsible for a roster of 3,000 patients
or roughly 600 families. In the past,
Egypt has made significant progress in
addressing specific health issues through
vertical programs. Yet, despite their
success, these programs have fragmented
the delivery system into many specialized
facilities and providers. As a result,
individuals must currently seek care from
many providers in different locations to
meet their healthcare needs.

For the first time, the rostering system
assigns every family a doctor and each
family member a medical record to ensure
continuity of care. The new care model is
designed to integrate specific health
services for child survival, family
planning, maternal and reproductive health,
to improve the sustainability of these
priority services currently delivered
through vertical programs. After one year
in operation, the pilot is expected to
produce preliminary indicators of health
outcomes, access to care, and costs.

“We’re moving health reform
activities out of the five-star hotels and
into the towns and villages” declared
Egypt’s Minister of Health and
Population, Dr. Ismail Sallam, at the
inaugural meeting of the Health Reform
Planning and Monitoring Committee.
PHR hosted a reception for the minister
and the 19 committee members, who are
undersecretaries of the Ministry of Health
and Population (MOHP) and leaders of
the Health Insurance Organization (HIO).
Representatives of USAID and the World
Bank, directors and staff of the main
MOHP departments, and others involved in the health reform, attended the reception to mark the inaugural meeting of those who are responsible for strategic planning and monitoring of the health reform program.

Dr. Wagida Anwar, director of the Technical Support Office, responsible for coordination of the reform program, highlighted preparatory reform activities at the central level and in three pilot governorates slated to test the new primary care system over the next five years.

...Update from July 2000

Improving Quality of Primary Care through Facility Accreditation

The Ministry of Health and Population (MOHP) in Egypt, with support from the PHR project, continues to make significant strides in implementing the primary care reform strategy in its pilot facilities. Over the past year, reform efforts focused on three main components: 1) implementing an integrated family practice care model, 2) developing a new social insurance financing mechanism through the establishment of a Family Health Fund, and 3) strengthening the role of the MOHP in regulation through a facility accreditation program.

Thus, for the first time in Egypt, a facility accreditation program has been designed and tested with the MOHP taking the lead in its development and implementation. The aim of the accreditation program under health sector reform is to improve quality of primary care and to use the accreditation status of a facility as the basis for contracting with the Family Health Fund. To this end, only facilities that meet optimal levels of quality and management performance will be allowed to contract with the Family Health Fund to deliver a basic benefits package of services. In its first phase, the program includes the public, private, and NGO facilities participating in the pilot reform program, and focuses only on health units and centers. The accreditation program prepares public facilities for their new role under the reform. It also offers a system for continuously improving the quality of care and provides means for educating and involving facilities in the quality improvement process.

Over the past year, PHR staff completed several important steps to design the program and prepare it for implementation, including: 1) legal analysis to ensure that the proposed program lies within the boundaries of Egypt’s health laws and legislation; 2) identification of key dimensions of quality that will set the focus of accreditation assessment; 3) development of accreditation standards, policies and procedures; 4) development and testing of the accreditation survey instrument; and 5) development and testing of a computerized database for analysis and reporting. Scores for each of the dimensions of quality are weighted to reflect the importance of each dimension relative to the total score. Consensus-building exercises conducted among MOHP officials at each step of the process ensured that the system was tailored to meet the needs of the health care system in Egypt.

Institutionalization of the accreditation program continues to be an important next step, with emphasis on building the local capacity for accreditation. Once fully implemented, the accreditation program will provide the reform in Egypt with a framework for continuous quality improvement and performance-based contracting, two key components of the Egyptian reform agenda.

...Update from October 2000

Prototype Information Systems for Health Financing and Social Insurance Put into Place in Egypt

Great advances have been made to enable the Family Health Fund (FHF) to establish performance-based contracts with the six pilot sites. Fund staff have developed position descriptions, a strategic and business plan, budgets, and a performance monitoring system. Most
recently, two key information systems were completed and are now linked to serve the needs of both the facilities and the Fund.

The first is a new clinical information system that is used by the family practice clinics to gather and process patient encounter and cost data. This Arabic language system was adapted from software produced by a previous USAID-funded project which developed information systems for Egypt’s health insurance organization.

The Oracle-platform software includes a component for beneficiary registration that establishes a unique patient identifier both to link families for treatment purposes, and to establish insurance eligibility by households. The system assists clinicians to record detailed medical histories, track treatment by prompting for delivery of essential services including immunizations or chronic disease management, and capture routine patient encounter data. Facility managers receive reports on primary care team efficiency, cost per patient per visit, and utilization of pharmaceuticals and laboratory and x-ray services.

A second new piece of software supports the FHF’s administration of performance-based contracts with the facilities. This MS-Access performance monitoring system accepts patient encounter data from facility-based clinical systems and enables Fund staff to prepare comparative reports on twelve indicators of cost, efficiency, and quality.

These two linked MIS systems will be used as a basis for performance incentive payments in the first stage of Egypt’s health financing reform. They are prototype systems that will provide experience in both insurance claims systems and clinical information systems. The National Technology Laboratory, financed by the World Bank, will then draw on these to design Egypt’s national health insurance information systems. The experience gained through these rapidly deployed prototype systems will improve the likelihood that larger systems will perform well and will meet user requirements.

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**Focus on Asia/Near East**

Managers Learn Skills to Facilitate Decentralization of Health Systems

The ministry is decentralizing. Top District officials are asking: how can we cope with our new resource allocation responsibilities? Which incentive systems will motivate physicians and other personnel to work more productively? How does the district set prices for services to improve cost recovery without hurting access to care by the poor? There will be a major cut in health funds in my district, what programs or services should I reduce? What type of analysis do I need, and how can I interpret the results to help me make decisions?

These and other equally difficult questions face mid-level health system managers in the Maghreb (western North Africa) where countries are decentralizing their health systems. In response, PHR delivered a two-week course in Morocco in April that trained 26 regional and provincial health system managers from Morocco, Tunisia, and Algeria in the use of economic and financial tools to deal with their increased level of responsibility under decentralization. The tools will allow these managers to develop and manage public sector health programs more efficiently, equitably, and in a sustainable manner.

The regional course was sponsored by USAID’s ANE Bureau in collaboration with WHO, the Rotary Club of Algeria, and RESSMA (Réseau économie et systèmes de santé au Maghreb). RESSMA is a regional network of professionals interested in health economics and health systems.

Upon its completion, participants rated the course practical and informative and directly applicable to their work. They predicted that the techniques learned would have a positive impact on their individual performance and more broadly on improving the management of health systems in the region.

PHR will follow up with participants in three months to find out how they are applying what they learned. This feedback will help tailor the curriculum content for future courses, which RESSMA plans to repeat on an annual basis.
**Focus on Applied Research**

**Improving the Process of Health Financing Reform**

For the past year and a half PHR has supported research in South Africa and Zambia that examines the process of health financing reform. Changes in health care financing mechanisms have been a central element of the reforms in sub-Saharan Africa, yet little is known about the factors that influence the potential of such reforms to achieve either their stated objectives or broader goals.

Key lessons regarding the policy process include:

▲ **Communicating complex policy designs.** Technical complexity of policies in South Africa often cause communication between technicians and policymakers to break down. Policies that cannot be expressed simply and clearly are difficult to sell and unappealing. Reform messages need to be adapted for different audiences and communication should focus on highlighting key aspects of reform.

▲ **Matching policymakers’ values.** Policies regarding free care and the initial process of resource reallocation benefited tremendously from high-level political support, as politicians saw how these reforms linked into higher-level political goals.

▲ **Building health economics capacity.** Technical weaknesses in financing policy design were evident. Demand for health economics analysis needs to be created and the supply of well-trained health economists ensured.

▲ **Building implementation capacity.** Adequate capacity was a critical constraint, not just in terms of skills, but in terms of systems and the joint functioning of organizations to produce effective implementation as well.

▲ **Implementing radical change.** During complex transition processes, policymakers need to focus on priority setting and capacity development.

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**Focus on Africa**

**PHR Mobilizes Taxes for Senegal Decentralization Efforts**

PHR brought together officials from the Ministries of Health and Interior, mayors, and elected rural leaders in Senegal to develop consensus on a third-party health finance scheme that mobilizes local tax revenues to supplement national level financing of health services. These “first of a kind” sessions, sponsored by USAID/Senegal, were aimed at implementing the financing scheme developed by PHR to help the Government of Senegal decentralize numerous government functions including health.

Once PHR gained consensus on the health activities, it worked with AVSC International to engage ministry, district, and rural community representatives to develop mechanisms to distribute USAID’s share of the financing.

The results were positive. Rural leaders have committed local tax revenues to help finance and implement locally-developed health action plans. The contributions vary from 20-80% of the costs of the health action plans. To date, all eligible communities have contributed monies to participate in the financing plan, and a total of about $300,000 in local tax revenues have been pledged to the activity. USAID will provide approximately $200,000 in matching funds to complete the financing of the program in the three districts in which PHR was asked to work.

In agreeing to finance their portion of the health activity, the community leaders made significant decisions that target their health priorities and allow them to exercise control over the health delivery system. This is the first time that tax monies from rural Senegalese communities have been used to finance the national health system. Specifically, these contributions will supplement the fees paid for consultations and medicines, thus greatly increasing the overall level of health financing raised at the local level.

The rural leaders help finance and manage each health district, which each comprise 6 to 12 rural communities. They do this in collaboration with the District Medical Officer (DMO) and her/his team of district supervisors. The local officials created their health action plans in cooperation with the nurse assigned to their health post by the MOH.
PHR held workshops and worked closely with technical health staff and the rural leaders, helping them understand one another’s positions and constraints and defining their roles and responsibilities in the new decentralized system. These workshops became so popular that national level officials - most notably the two vice presidents of the National Assembly - voluntarily participated.

Following completion of the plans, rural leaders, mayors, and DMOs met for a “validation meeting” to incorporate their individual plans into one district-based health plan for each of the three pilot districts. The local leaders were favorably disposed to the new health finance scheme and several of them have already applied to increase their participation and add health services for next year.

The inauguration of the NICHP follows a six-month planning process that involved top-level decision-makers in the Ministry as well as a July 1998 ministerial decree committing to reorganize the existing Information and Documentation Center. With the assistance of the resident PHR Health Information Systems Advisor, the Director General of the Information and Documentation Center drafted a reorganization plan that identified the mission of the new NICHP, its activities, departmental functions, staffing, and a space plan.

One of the important benefits from the creation of the NICHP will be the opportunity to consolidate and sustain information systems and resources developed for specific projects funded by USAID and other donors over the years. Prior to the formation of the NICHP there was no MOHP analysis and no central repository for the data generated by program and project specific information systems.

The NICHP will be the primary information services unit in the MOHP. It is responsible for the development and maintenance of a national MOHP information management and information technology system. The authority of the NICHP includes national initiatives related to information management systems, information technology, and consolidated data reporting services within the scope of the MOHP.

In addition, there are three special projects that work with the Governorate Health Information Centers: National Cancer Registry, Telemedicine, and the Health Directorate Support Unit.

**Insuring the Uninsured in Jordan**

Estimates of the number of Jordanians without health insurance range from 20% to 47%. Fees currently charged are estimated to cover only 20% of actual costs. Increasing fees, however, will make health services, including USAID/PHN priority services, less accessible to the uninsured poor. To address this problem the Jordanian Ministry of Health and Health Care (MOHHC) has proposed three policy initiatives:

- proceed with the increase of MOHHC fees;
- raise the poverty threshold for free services at MOHHC facilities to protect the poorest from fee increases; and
- launch a voluntary health insurance program for MOHHC services to help spread the financial risk from increased fees.

His Excellency, Minister of Health Dr. Nael Ajlouni, asked PHR to support the MOHHC in the articulation and implementation of these health policy initiatives. On November 23-24, PHR held a technical workshop in Jordan entitled “Insuring the Uninsured,” attended by the Minister and 20 other high-level MOHHC staff. PHR reviewed concepts and policy issues that need to be considered when designing insurance programs. A descriptive outline of financial flows among the various components of the Jordanian health sector established the population and financial considerations for designing an insurance program.

The Ministry presented its methodology to increase and restructure fees for government/ public health services. In response, PHR outlined next steps to implement the fee increase and to assess options for the implementation of a voluntary insurance program. PHR’s input will help policymakers avoid costly mistakes and manage the full range of tasks embodied in the proposed reforms. At the same time, PHR will help the Ministry to ensure access to health services for uninsured poor populations.

To help identify the uninsured, PHR completed a survey of the 192 firms listed on the Jordanian Stock Exchange regarding what health insurance, if any, they provide their employees and dependents. This group of firms represents a select class of larger companies that have greater access to capital and collectively employ 44,115 workers. While 75% of the firms provide health insurance to their employees, only 67% extend this coverage to family members. Groups least likely to have coverage were employees in the manufacturing and services sectors as well as female workers and their dependents.

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**PHR Highlights 1995-2001**

**Focus on Asia/Near East**

**Shalala Inaugurates National Information Center for Health and Population in Egypt**

On December 1, His Excellency Prof. Dr. Ismail Sallam, Egyptian Minister of Health and Population, along with Donna Shalala, U.S. Secretary of Health and Human Services, and Daniel C. Kurtzer, U.S. Ambassador to Egypt, presided over the opening ceremonies for the inauguration of the National Information Center for Health and Population (NICHP). This event marked the completion of the renovation of the 75-year old building located in the central headquarters of the Ministry that will house the NICHP. PHR provided both architectural and program design assistance to the Ministry of Health and Population (MOHP) in support of this project.

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... from January 1999
Focus on Latin America and the Caribbean

Evaluation of Bolivian National Mother and Child Health Insurance Program

Bolivia’s National Mother Child Health Insurance Program (Seguro de Maternidad y Niñez-SNMN), introduced in 1996, is a government program that aims to reduce both maternal and child mortality by removing service fees paid for essential medical care. The program covers selected priority health services for mother and child survival, such as birth and antenatal care, acute respiratory illness, and diarrhea. At the request of the Bolivian Ministry of Health (MOH), a joint PHR/Data for Decision Making (DDM) project team carried out an evaluation of the program.

The team collected data from February to July 1998 through interviews with officials from institutions involved in SNMN activities, reviews of information produced by the MOH, and surveys of users and persons in charge of delivering health services. Recommendations to improve the SNMN after evaluating the program’s cost, service delivery, and administrative components were given to the MOH.

On September 29, the evaluation team presented its results to the MOH’s Technical Council. PHR’s findings provided crucial information for the design of the government’s expanded health insurance program (Seguro Básico de Salud). As a result, the insurance program’s reimbursement rates were altered and an administrative unit will be created to manage the program’s operations. Further, the MOH will examine several issues including: subsidizing transport in rural areas, differentiating reimbursement rates at each level of service, revising the role of the DILOS (a body that currently plays a redundant administrative role in the program), and addressing the working capital issue. The vice ministers present recognized the importance of introducing personnel incentives and vowed to search for a politically viable solution in this area. They thanked PHR for an unbiased evaluation.

On September 30 another results presentation was given to a broad audience of some 100 people from throughout the MOH, USAID, and other donor organizations. A key member (from UNICEF) of the technical committee that created the insurance program was present and endorsed the evaluation results. The Bolivian Ministry of Health requested that the evaluation results be disseminated to the eight departments in Bolivia.

Focus on Africa

PHR Strengthens Local Management Capacity to Prevent Malaria in Zambia

As part of Zambia’s National Malaria Control Program, an initiative was launched in September to sell insecticide treated nets (ITNs) through selected rural health centers (RHCs) in three districts in Zambia’s Eastern Province. PHR is providing technical assistance to the Society for Family Health (SFH) to strengthen its capacity to manage the sale of ITNs.

Working with local partners, PHR developed financial and management procedures for tracking the sale of nets and for managing proceeds from the sales. Funds collected from the sale of the ITNs are held within the community and used to procure additional nets. PHR assisted in the initial implementation of the ITN distribution system and trained RHC staff on effective management procedures. SFH will oversee implementation of the distribution system and will provide ongoing monitoring of the sales in current project sites. This initiative is planned to be expanded in 1999 to cover all areas within the three districts and will add two additional districts.

Update: In the two years since the launch of this initiative, expansion has been completed to all 64 RHCs throughout three districts in Eastern Province. Through
August 2000, 31,600 nets were sold and the funds collected totaled $72,000. Household ownership of nets increased from 7% to 30% in two districts and 40% in the third. This initiative not only resulted in distribution of ITNs to prevent malaria, but also has improved management capacity of all the RHCs in the three districts.

Focus on Africa
Mutual Health Organizations in West and Central Africa (WCA)

PHR and its partners completed an in-depth study of mutual health organizations (MHO’s) (mutuelles de santé). MHOs are voluntary non-profit insurance schemes formed on the basis of an ethic of mutual aid, solidarity, and the collective pooling of health risks in which the members participate effectively in its management and functioning. The study developed a methodological guide and questionnaire to assess the MHOs, an inventory of 50 MHOs in six countries in WCA, in-depth case studies of 22 MHOs in six WCA countries, a literature review on MHOs, and a synthesis paper consolidating the findings and recommendations from the research.

This activity represented the first regional study of its kind, and was unique in including the Anglophone countries of Nigeria and Ghana, where the forms of MHOs observed differ significantly from the largely French/European model seen in Francophone Africa. The Anglophone countries provide alternate variations of financing mechanisms and can guide MHOs in Francophone Africa on issues relating to benefits packages to priority health issues and negotiating with service providers.

In general, the research on MHOs found that:

- most MHOs are young (<3 years) and relatively small (<1000 members);
- few MHOs engage in negotiating with providers, and where there have been negotiations, they have been on price and not quality of services;
- target group penetration by MHOs and premium contribution rates by members are low;
- the contributions to resource mobilization, access, and equity have been limited to date, but the potential for contributions in these areas is very high;
- most MHOs have some positive health insurance design features, but lack others; and
- donors can assist MHOs by helping them adopt more positive design features, performing better in terms of basic management and record-keeping, and promoting sharing of lessons learned and the best practices.

Update from April 2000
Promoting Financial Access to Health Care in West Africa

When PHR began providing technical assistance in developing training tools to improve the management of MHOs in Ghana a year ago, there were no more than four MHOs. Today, there are approximately 24. MHOs are increasingly playing an important role in health care financing in Ghana and Senegal, particularly for the informal sector and at the community level.

In February, PHR training tools were tested by some 40 MHO representatives at a workshop in Ghana organized by PHR and DANIDA. Participants agreed to set up a national secretariat to coordinate assistance to new and existing schemes, document experiences, and maintain a databank of MHOs in Ghana. A manual to guide MHO work is being completed by PHR Senegal and will be available in late summer.

... PHR Tool Box

Computer-based Applications
- Bed Needs Planning Model
- Community-Based Health Insurance Manual and Toolkit
- Facility Accreditation Survey Instrument
- Health Workforce Planning Model
- National Health Accounts User’s Manual

Handbooks
- Measuring Results of Health Sector Reform: A Handbook of Indicators
- Guidelines for Conducting a Financing Assessment of Immunization Services
- Immunization Financing Resource Kit
- PHR Primer for Policymakers Series

- LAC Policy Toolkit for Strengthening Health Sector Reform and Trainer’s Guide
- Stakeholder Analysis Guidelines
- Advocacy Guidelines
- Conflict Negotiation Guidelines
- Introduction to Strategic Management

In cooperation with:
From the Field, to the Field—PHR Resources for Global Learning and Exchange

PHR’s Information Dissemination and Communications component responds to PHR’s mandate as a global project to advance knowledge and methodologies pertinent to health sector reforms. PHR promotes the exchange of ideas and information and the discussion of issues and best practices critical to strengthening and sustaining health systems and priority services for the most vulnerable and underserved.

As a global “information broker,” PHR developed a multi-media knowledge management effort to publish and disseminate its own work as well as identify, collect, catalogue, and disseminate materials, tools, and information from other sources pertinent to developing country health sector reform. In the field, PHR used these materials along with diverse communications techniques to raise awareness of policy issues or reforms, promote dialogue, increase stakeholder participation, and build consensus.

To reach diverse sets of public and private health sector reform stakeholders—policy makers, providers and practitioners, providers and managers, donors—worldwide, PHR developed an array of products and used a variety of traditional and new dissemination media to facilitate easy access to the information and use of the information, as follows.

The PHR Resource Center houses and distributes all PHR publications and collects and catalogues documentation, including videos and CD-ROMs, on subjects pertinent to health sector reform, particularly hard-to-access grey literature. To date, the collection numbers close to 4,000 materials catalogued on an easy to search reference database at the resource center and online from anywhere in the world through the PHR website. Many materials are available in Spanish and French.

The Resource Center distributes PHR publications by mail and by e-mail, at conferences, in paper and CD-Rom formats. Over the last five years, the Resource Center developed a key contact and mailing list numbering 4,500 people, half of whom represent donor, government, research and NGO institutions based in Africa, Asia, Latin America and the Caribbean. To publicize new acquisitions and new online resources as well as report on PHR progress, the Resource Center periodically issued a quarterly highlights report and email bulletins and hosted more than 200 brown bag discussions, seminars, and exhibits at PHR, USAID, and other donor and cooperating agency venues.

The PHR website, designed specifically for quick, easy and inexpensive access from anywhere, publishes all PHR reports and papers, provides access to the Resource Center’s searchable reference database, and connects users to other pertinent and resourceful websites and listservs, vetted and annotated by the Resource Center. Activity updates along with staff contacts and email addresses facilitate up to the minute access to PHR information and technical staff.

Since 1997, through the Resource Center and the website, users in 30 developing countries, west and east Europe, and the US, ordered 25,000 PHR reports and publications and 3,000 CD-ROMs.

• 56 PHR Technical and Training Reports document analytical or methodological work in specific countries and regions.
• 33 PHR Special Initiatives Reports and 2 PHR Priority Services Journals present cross-country or cross-regional research and new tools and methodologies for addressing USAID priority health sector issues of global relevance.
• 37 PHR Applied Research Papers present new information on policy questions through both cross-country and country-specific studies.
• 35 PHR In Briefs provided short, up-to-date summaries and descriptions of PHR activities, results, and products.
• 5 PHR Primers for Policymakers orient decisionmakers and stakeholders to the terminology and concepts of health sector reform issues and approaches along with lessons from the field across regions.

To facilitate access and use, and whenever resources permitted, PHR translated many of the above materials into French or Spanish as appropriate, and occasionally, Arabic. The above numbers do not include translated editions. ▲

Visit PHR’s website: www.PHRproject.com for publications and access to the health reform database.
PHR Final Conference — January 2001
Results and Lessons for the Future

WELCOME AND OPENING REMARKS
Wendell Knox, CEO, Abt Associates: What Abt has Learned from PHR
Ray Kirkland, USAID/PHN
Bob Emrey, USAID/COTR

PLENARY PANEL
What PHR Is About
Nancy Pielemeier, PHR Project Director, Abt: Overview of Achievements
Lucy Gilson, University of Witwatersrand: Analyzing the Policy Process in South Africa: What We Have Learned
Mary Paterson, Abt: Implementing Policy Reform in Egypt: What We Have Learned

CONCURRENT SESSIONS
1—From muddling through to managing the policy process: Practical lessons from Morocco, Honduras, Egypt, and Malawi.
Session Chair: Derick Brinkerhoff, Abt
Dris Zine-Eddine El-Idrissi, Moroccan Ministry of Health (MOH): National Health Accounts Morocco
Francisco Vallejo, PHR Honduras, Abt: Health Regulations in Honduras
Wessam El-Beih, Abt: Egypt Resource Planning Model
Takondwa Mwase, WHO: National Health Accounts in Africa
Peter Berman, HSPH: Policy Lessons

Session Chair: Paul DeLay, USAID A.K. Nandakumar, Abt: Rwanda National Health Accounts
Anthony Kinghorn, Abt South Africa Regional Office: South Africa’s AIDS Sectoral Impact Studies
Catherine Connor, Abt: Enhancing NGO Contracting to Improve Health
Cheikh Mbengue, PHR Consultant: Impact of Decentralization on HIV/AIDS Services

3—Incentives to boosting quality, performance and cost-effectiveness: Examples from Jordan, Georgia, Egypt, Brazil, Argentina and Thailand.
Session Chair: Sara Bennett, Abt
Lynne Miller Franco, URC: Health Worker Motivation in Georgia and Jordan
Salim Malkawi, Jordan MOH: Incentives to Improve Jordan Hospitals
Ricardo Bitrán, Bitrán y Asociados: Provider Payment Systems in Latin America
Randa El-Turk, PHR Egypt: Accreditation in Egypt

PLENARY PANEL
Should Donors Advocate Health Reform?
Session Chair: Nils Daulaire, Global Health Council
Tom Merrick, World Bank
Patricia Moser, Asian Development Bank
Alfredo Solari, Inter-American Development Bank

CONCURRENT SESSIONS
1—Costing and Financing Priority Services in Bolivia, Cambodia, Morocco, Turkey, Zambia
Session Chair: Steve Landry, USAID
Marty Makinen, Abt: Immunization Financing
Tania Dmytraczenko, Abt: Bolivia’s National Mother-Child Insurance Program
Ann Levin, URC: Cost-Effective Approaches to Polio Eradication
Grace Chee, Abt: Financing Mosquito Nets in Zambia

2—Strengthening Access and Equity in the Financing of Local and National Health Systems.
Session Chair: Charlotte Leighton, Abt
Chris Atim, PHR West Africa: Mutual Health Organizations
Pia Schneider, PHR Rwanda: Prepayment Schemes in Rwanda
Allison Gamble Kelley, Abt: Equity Initiative in Mali

3—Specific examples of how health systems can be improved through organizational change and improved management: Senegal, Jordan, and Egypt.
Session Chair: Dan Kress, Abt
François Diop, PHR Senegal: Decentralization in West Africa
Dwayne Banks, PHR Jordan: Capacity Development in Jordan Hospitals
Ahsan Sadiq, PHR Egypt: Performance-based Management

CLOSING PLENARY
Reflections on Achievements and on the Road Ahead
Session Chair: Nancy Pielemeier, PHR Project Director, Abt
Charlotte Leighton: Special Initiatives
Sara Bennett: Applied Research
Zaheer Al-Faqih: Information Dissemination
Marty Makinen: Technical Assistance
H.E. Plutarco Castellanos, Minister of Health, Honduras
Karen Cavanaugh, USAID/PHR COTR: Global developments in health reform
Nancy Pielemeier: Closing Remarks

Poster Session:
A quick tour highlighting PHR products and achievements. The posters will be on display throughout the day. Posters will be presented on: National Health Accounts, Maternal Health, Child Survival, Health Financing, Immunization, HIV/AIDS, Infectious Diseases, Capacity Building, Training, the Policy Toolkit, Information Dissemination, and PHR’s Small Applied Research activities.
PHR 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. 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.

In partnership with local stakeholders, PHR promotes an integrated approach to health reform and builds capacity to support:

- 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; and
- Enhanced organization and management of health care systems and institutions to support specific health sector reforms.

Nancy Pielemeier, DrPH, Project Director
Cheri Rassas, Deputy for Operations
Steve Mason, Deputy for Finance

Focus on Africa

PHR provided technical assistance in Kenya, Malawi, Rwanda, Senegal, Zambia, and Zimbabwe in the areas of social insurance, health reform policies and processes, mutual health organizations and community financing mechanisms, hospital management, decentralization of health services, and cost recovery. PHR collaborated with USAID regional bureaus in West and Central Africa (WCA) and East and Southern Africa (ESA) to implement cross-cutting sub-regional activities in several other countries.

Focus on Asia and the Near East

PHR provided technical assistance in Egypt, Jordan, and Morocco in a wide range of health reform areas, including quality improvement, health information systems, National Health Accounts, primary care, health reform policies and processes, reform communications, expansion of health coverage, sustaining family planning programs, and hospital autonomy. PHR also worked with the Asia and Near East (ANE) Bureau to establish a regional network of countries working on National Health Accounts and to support and expand regional networks of health economists.

Focus on Latin America and the Caribbean

PHR provided technical assistance to USAID missions, ministries of health, and host-country counterparts in six countries in the Latin America and Caribbean (LAC) region: Bolivia, Dominican Republic, Ecuador, Guatemala, Honduras, and Peru. PHR also worked with USAID’s LAC Bureau on a region-wide initiative that trained a network of country counterparts in National Health Accounts (NHA) in eight countries, participated in the development of region-specific indicators of health system performance, and conducted research on the role of local NGOs in health reform efforts.

Focus on Applied Research

The PHR Applied Research Program prepared and implemented an agenda of research that advances knowledge about health sector reform at the global and individual country levels. The program had two components: Major Applied Research (MAR) and Small Applied Research (SAR). The MARs are cross-country studies using sophisticated research methodology to produce new information on health reform which is of value to a broad group of policymakers, while the SARs are more narrowly focused studies performed in a single country to evaluate a particular health policy or program and strengthen the country’s or region’s research capabilities.

Focus on Special Initiatives

PHR and USAID jointly developed six Special Initiatives, focusing on maternal and reproductive health, child survival (including activities in immunization financing, polio, vitamin A, and integrated management of childhood illness [IMCI]), infectious diseases, the role of NGOs in health sector reform, National Health Accounts (NHA), and indicators for measuring results of health sector reform for system performance.

Focus on Information, Dissemination, and Communications

To support decision-making, capacity-building, and global exchange across all areas of its work, PHR provided reference and research services, developed and distributed series of publications, held seminars, convened workshops and presented at conferences around the world. Through PHR’s Resource Center, use of the Internet, CD-ROMs, and the website, PHR helped to bridge the information gap and complement PHR’s field-based communications and dissemination efforts to advance health reform initiatives.