WORKING PAPER No. 5

IMPROVING HEALTH SERVICES AND STRENGTHENING HEALTH SYSTEMS:

ADOPTING AND IMPLEMENTING INNOVATIVE STRATEGIES

An exploratory review in twelve countries

World Health Organization

Department of Health Policy, Development and Services
Evidence and Information for Policy, WHO

Making health systems work

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IMPROVING HEALTH SERVICES AND STRENGTHENING HEALTH SYSTEMS: ADOPTING AND IMPLEMENTING INNOVATIVE STRATEGIES

An exploratory review in twelve countries

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The 'Making Health System Work' working paper series is designed to make current thinking and actual experience on different aspects of health systems available in a simple and concise format for busy decision makers. The papers are available in hard copy and on the WHO health system web site.

Working paper 5: Improving health services and strengthening health systems: adopting and implementing innovative strategies. An exploratory review in twelve countries

In recent years a number of specific strategies for improving health services and strengthening health systems have been consistently advocated. In order to advise governments, WHO commissioned this exploratory study to examine more closely the track record of these strategies in twelve low income countries. Data were gathered primarily from reviews of existing materials and interviews with key informants. Findings were reviewed at a consultation in July 2005. This paper presents the main findings and conclusions. The work was undertaken by Katja Janovsky (independent consultant) and David Peters (Johns Hopkins School of Public Health) with assistance from Aneesa Arur and Sandhya Sundaram (Johns Hopkins School of Public Health).

Further information

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1. INTRODUCTION

In recent years, a number of specific strategies for improving health services and strengthening health systems have been consistently advocated in papers and reports, at conferences and workshops and, increasingly, in policy documents and project proposals as the way forward. The 2003 and 2004 *World health reports* proposed improving rewards to health workers to improve productivity, along with deploying community health workers and engaging communities in their health care. The *World development report 2004* advocated contracting, local government financing, empowering communities, and using vouchers and other approaches to subsidize key health services for the poor.

In order to advise governments on innovative approaches to service delivery, WHO commissioned an exploratory study to examine more closely the track record of these strategies. This would also help WHO to better perform its role of generating and sharing knowledge both internally and externally.

A short list was drawn up, and instruments developed to examine whether and how these particular strategies are actually being adopted and implemented in a number of selected low-income countries.

In addition to analysing the role of the selected strategies in specific countries over the last five years, the study examined salient features and dynamics of each national health system and the broader context within which it operates, and highlighted developments and events that are likely to have had a bearing on decisions made in the health sector. Trends in key health service delivery outputs were also mapped as part of the context.

The study considered both scope and scale so as to shed light not only on the details of the strategies under review, but also to explore factors enhancing or inhibiting the country-wide implementation of promising innovations.

2. STUDY APPROACH

Selection of strategies

An initial list of strategies was reviewed at a meeting of WHO and World Bank staff and consultants. Following further discussions and initial country reviews, the final list comprised the following eight:

1. **Contracting** with NGOs, with other private sector provider organizations, and organizations within the government system, with a focus on health service delivery.
2. **Delegation of authority** for setting priorities, allocating and managing financial and human resources, and taking other key decisions, to provincial, district and/or other local level health authorities. Includes analysis of the flow of funds to the subdistrict/operational level.
3. **User fee exemptions,** specifically whether the poor were given an exemption from user fees, or other scheme in differential pricing designed to benefit the poor.
4. **Subsidies for the poor,** whether some form of cash transfer, vouchers, or financial risk sharing, either disbursed directly to beneficiaries or communities, or through providers.
5. **Performance-related pay and incentives**, considering new approaches to improve workforce performance, using benchmarks to determine the level of pay and incentives to be provided.

6. **Reorganizing outreach workers**, including changing the use of home-based and health post workers, and changing their professional requirements or volunteer status.
7. **Social marketing**, to influence the health behaviour of clients and use of health products such as bednets, condoms, essential drugs, oral rehydration salts (ORS).
8. **Community engagement**, including new ways to involve communities in the oversight, planning or operations of health services, approaches to give voice to community concerns, and public disclosure of information to improve transparency and accountability.

From the outset, two points were clear. Firstly, this set of strategies focuses on delivery mechanisms and management systems rather than on technical programmes or specific conditions. Secondly, this is a "mixed bag" of rather diverse strategies, chosen because they are frequently mentioned in recent documents and meetings rather than fitting into a coherent typology of interventions.

Selection of study countries

In all, 12 low-income countries were selected with a view to covering a wide spectrum of situations, including three falling in the category of "fragile states" (the OECD's Development Assistance Committee characterises fragile states by those countries where there is a lack of political commitment and weak capacity to develop and implement pro-poor policies). The countries and selected indicators are shown in the table below.

Table 1. Countries selected for review and selected indicators

Country	Population (millions)	GNI per capita (current $US)	Under-five mortality rate	Total fertility rate
Cambodia*	13.4	300	140	3.9
Ethiopia	68.6	90	169	5.6
Ghana	20.7	320	95	4.4
Indonesia	214.7	810	41	2.4
Kenya	31.9	400	123	4.8
Mali	11.7	122	220	6.4
Mozambique	18.8	210	147	5.0
Myanmar*	49.4	..	107	2.8
Papua New Guinea*	5.5	500	93	4.3
Tanzania	35.9	300	165	5.0
Uganda	25.3	250	140	6.0
Viet Nam	81.3	480	23	1.9

Source: *World development indicators 2005*, data for most recent year since 2000

* Considered fragile states according to the World Bank's country policy and institutional assessment (CPIA) ()

Method

Data were gathered primarily by desk reviews of existing reports, surveys and studies, doing a literature search through PubMed, and searching for unpublished documents from ministries of health, WHO country offices, World Bank reports, and other United Nations and bilateral development agencies. Field visits were undertaken to two countries, Ghana and Tanzania, to explore in greater depth the factors underlying the health service results, and the constraints to country-wide implementation of selected strategies. The preliminary findings were further reviewed in key informant interviews with selected WHO and World Bank staff. A consultation was also held in Geneva to review the findings and to engage in a wide-ranging discussion of their implications for WHO.

Context

As part of the review of the country contexts, key health services outputs across a range of health services were assessed for each country. A summary is attached as Annex 1. Details are provided for each country in the individual country reviews, and in the figures shown in Annex 2. There were divergent patterns of health service outputs across each country, with each country demonstrating improvements in some areas of health service delivery. In nearly all countries, when there was progress in health service outputs, the changes tended to be small and gradual, rather than showing radical change.

Progress in health service outputs tended to occur in one or only a limited number of areas. Viet Nam was closest to achieving "across the board" improvements, followed by Ghana. This suggests that even where a particular programme is achieving some success in service delivery, there was little positive effect on other programme areas. Health service outputs were not consistent for packages of care: high rates of antenatal care were not necessarily associated with skilled delivery, institutional delivery, or childhood immunization. Yet, even though most countries have achieved some high levels of health service outputs, there was little improvement in any indicator in, Cambodia, Ethiopia or Papua New Guinea. Data on health services are also quite limited, contributing to the difficulty of being able to assess effects of implementation of the different strategies. Many countries did not keep track of outpatient or inpatient utilization, even within the public sector, and trend data for bednet use or HIV/AIDS knowledge is usually lacking. Data on poverty differentials are limited, but when they exist, the services tend to favour the better off.

Information on the broader political and economic institutions and events was also collected in order to provide pointers to explain overall health system performance, but did not yield any clearly discernible patterns across the range of countries reviewed. Moreover, not surprisingly, formal documents and reports did not provide the type of information required for in-depth analysis of *how* and *why* strategies were adopted and implemented.

Adoption and Implementation

Developing a framework for comparing how and to what extent individual strategies had been developed, adopted and implemented posed a formidable challenge.

We decided to distinguish between three categories: (1) development and adoption of a strategy; (2) plans for scaled-up implementation; and (3) record of actual implementation. Within each of these categories, we classified varying degrees of adoption and implementation, taking into account whether or not pilot projects envisaged full-scale implementation from the outset; timeframe of implementation; and geographical coverage.

3. FINDINGS AND DISCUSSION

Details on the strategies pursued in each country are available in the individual country case reviews and are also summarized in Table 2.

Table 2. Summary of innovative strategies implemented in each country

	Organization & financing			Human resources		Creating demand/accountability	
	1. Contracting	**2. Delegation / decentralization**	**3. User fee exemptions; 4. Subsidies for the poor**	**5. Performance-related incentives**	**6. Reorganization of health workers**	**7. Social marketing**	**8. Community engagement**
Cambodia	Community trial of contracting in 10% of population, now doubling – better service at higher cost; National Centre for HIV/AIDS also contracting	Not within health sector – communes to provide public services, but no significant transfer of funds	Exemptions for poor implementation inconsistent	Performance incentives used in contracted NGO with bonuses for punctuality and performance of health facility; documentation on other plans not obtained	None	Yes, condoms and malaria treatment	Not significant scale; community membership on management committees
Ethiopia	None	*Woredas* receive block grants but have little authority and spend little	Special pharmacies to sell drugs cheaply; Subsidies intended through community insurance	Not performance-related – inconsistent provision of hardship allowances only	Piloting health extension workers	Yes, condoms; Reproductive health clinic franchises	Local communities intended to monitor and govern health centrer
Ghana	AIDS Commission on wide scale, but not MOH or Ghana Health Service	Yes, resources transferred to districts, but poor flow to sub-districts	New health insurance subsidy; user fee revisions inconsistent	Not significant scale	Yes – Community Health Officers with CHPS	Yes - condoms & oral contraceptives successful, not bednets	CHPS & other small scale
Indonesia	Not significant scale	Not within health sector -- poor tracking of funds to districts, poor capacity. Hospitals allowed to collect and use funds	*JPS-BK* fee exemption cards, multiple small scale initiatives	Not performance-related – higher employment contracts for workers in remote areas, considered not effective	Birthing homes established (with social marketing and transport)	Old successful family planning and vitamin A marketing; Some new marketing of birthing homes	Community involvement for JPS-BK insurance scheme
Kenya	None	Scheme exists, but not clear if district health management boards have much authority or funds	User fee exemptions not well implemented; health insurance does not cover the poor	None	None	Yes, condoms & bednets	Community representation on boards
Mali	Some community health associations and private providers contracted	Not within health sector -- slow transfer of resources to communes and circles councils	Not significant scale	None	None	Some condom and oral contraceptives	Bamako Initiative committees set up to manage local funds
Mozambique	None	Not significant scale	Exemptions for poor, unclear implementation	Not significant scale	Three new physician substitute cadres initiated with unclear effect	Yes, condoms	Not significant

	Organization & financing			Human resources		Creating demand/accountability	
	1. Contracting	**2. Delegation / decentralization**	**3. User fee exemptions; 4. Subsidies for the poor**	**5. Performance-related incentives**	**6. Reorganization of health workers**	**7. Social marketing**	**8. Community engagement**
Myanmar	Not significant	Finance, personnel, and service management delegated to district	Exemptions for the poor, unclear implementation; third-party payment of drugs costs for the poor	None	Village health workers trained	Yes, condoms, bednets, ACT	Women's groups and village health committees
Papua New Guinea	Not significant scale	Provincial Boards, but little flow to them or districts	Revise user fees, no subsidy for poor found	None	Village health volunteers initiated	Not significant scale	Not significant scale
Tanzania	None	Yes, poor flow; TEHIP	User fees plus CHF; vouchers (see 7)	Scheme approved, but inconsistently implemented on limited basis	Not significant scale	Yes, bednets	Community Health Fund
Uganda	Agreements with NGOs	Authority and block grants given to districts and subdistricts but overall funding levels decline	User fees abolished, no other significant subsidies to poor found	Pilot-test with NGO staff	None	Yes,seven different schemes for condoms, contraceptives, STD kits; franchising for VCT; some with vouchers	Community directed ivermectin treatment programmes
Viet Nam	Health Insurance contracts with public and private hospitals	Not significant scale	Exemptions for poor exist; compulsory medical insurance; Health Care for the Poor Fund; several other small subsidy schemes	Salaries based on performance of health facility led to overall declines in worker compensation	"Population collaborators" network established	Yes, condoms and oral contraceptives	Small initiatives and nationwide plan for community participation in PHC – unclear if any are significant scale

Development and adoption of strategies

We first assessed which of the strategies were being planned in each of the countries under review (Table 3). The results show that ministries of health in each country are either implementing or planning to implement at least two of the strategies under study, confirming the relevance of these strategies across a wide range of low-income countries.

Table 3. Strategy development and adoption

Country	Contracting	Delegation to local health agency	Use fee exemptions	Subsidies to the poor	Performance incentives	Reorganize health workers	Social marketing	Community engagement
Cambodia	2 | 2		1	2	1 | 1	1	2	2
Ethiopia		2		1 | 1		2	2	2
Ghana	1 | 2	2	2	2		2	2	2
Indonesia			2	2			1 | 2	2
Kenya		2	2	2			2	2
Mali	2						2	2
Mozambique			2			2	2	
Myanmar		2	2	2		2	2	2
PNG		2				2		
Tanzania		1	1	1	2		2	2
Uganda	1	2	2		1		2	2
Viet Nam	2		2	2	2	2	2	2

KEY

	No plan
1	Under review/development
2	Adopted strategy/plan
|	Two distinct strategies pursued

Ghana and Viet Nam have been adopting the largest number of the strategies under review. These two countries also happen to have the most positive trends in their health service delivery outputs, as can be seen in Figures 1 and 2. On the other hand, Mali and Papua New Guinea are not only planning or implementing the fewest number of these strategies, but also have the poorest set of health service delivery indicators of the countries included in this study. This suggests that there *may* be a relationship between openness to innovation and ability to deliver services that merits further investigation, at least in the context of these countries. Whether relative success in delivering health services allows countries to be more innovative, or whether it is the willingness to innovate that contributes to their relative success, would be worth examining. If the latter were the case, this would imply that even greater effort should be placed on finding ways to stimulate innovation.

Figure 1. Viet Nam health service outputs

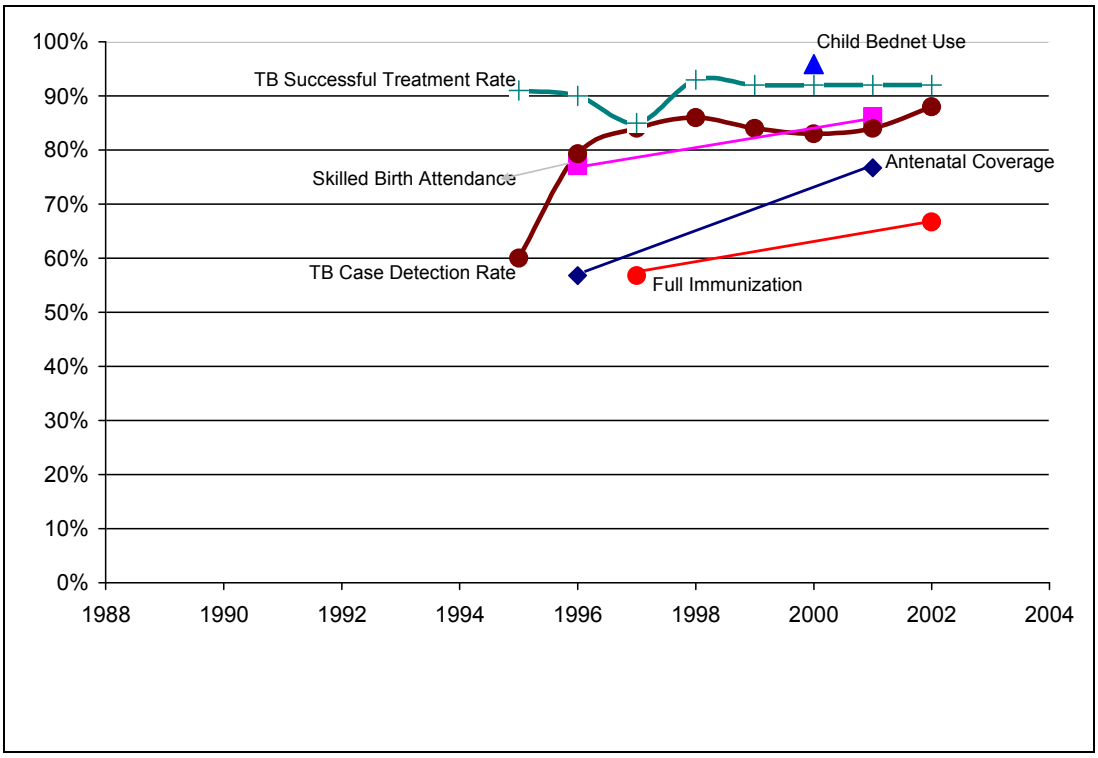
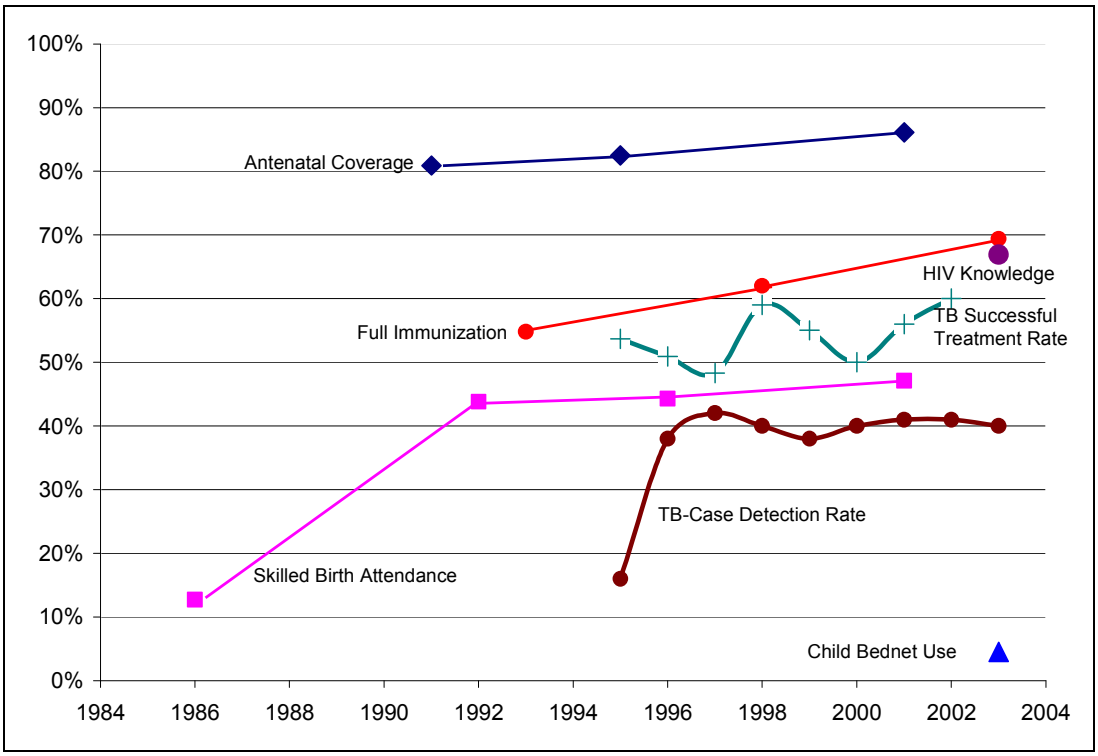


Figure 2. Ghana health service outputs



Of the various strategies, some have clearly been more likely to be adopted by ministries of health than others. Although there is general agreement of a worldwide crisis of human resource for health, the introduction of performance incentives for health workers was found to be the least likely strategy to be used (four countries), followed by contracting (five countries). Both contracting and performance-based health worker incentives require greater capacity for defining terms of reference, agreeing on results and monitoring implementation. Many of the countries under review lack this capacity, and few of the strategies made provision for system-wide capacity-building. Moreover, governments are usually reluctant to change working terms and conditions for a single sector, and many international agencies will not fund recurrent costs in general, and across-the-board salary supplements rewarding good performance in particular, all of which goes some way in explaining why these innovations are less likely to be adopted.

By contrast, nearly all countries had plans for social marketing (11 countries) and some form of community engagement (10 countries). Social marketing has been largely introduced, driven and financed by international actors working in close collaboration primarily with the private sector.

As for community engagement, it has been relatively easy for governments to pronounce policies and broad strategies that support communities, largely because it can be done with a rhetorical commitment that is usually consistent with the interests of government, often without providing the resources or transfer of control to communities. For governments to actually provide the needed resources and an empowering environment for communities are considerably larger challenges (see also below).

Plans for implementation during design

A second concern of the study was the degree to which the original plans for the innovative strategies were expected to be implemented on a national scale. Table 4 shows that relatively few cases were originally designed only as pilot projects without the intention for nationwide implementation, although the degree of clarity as to how this intent was to be put into practice varied considerably. We found twelve cases that were introduced as pilots with the stated intention to expand to a national scale if they were successful. Cambodia, Ethiopia, Ghana, Mozambique and Tanzania were engaged in several pilot projects, whereas Kenya, Mal and Papua New Guinea had no pilots for the strategies under review.

Furthermore, the purpose and quality of the pilot were quite different. With the notable exception of the Cambodian contracting experiment and the Tanzania Essential Health Interventions Project (TEHIP), most pilots were designed to test the feasibility of implementing a new strategy rather than its effectiveness in achieving results.

Many strategies started to be implemented on a relatively small scale but were not labelled as pilots or experiments. In general, pilots tended to be externally funded and so were explicitly subject to a decision about whether to proceed after the initial project period. Phased approaches did not have such a discernable decision point.

Strategies usually implemented on a country-wide basis from the outset were user-fee exemptions and decentralizing authority to local health agencies. Plans for social marketing strategies and reorganizing health workers tended to start out small, and then expand to a national scale. This phenomenon is likely related to the nature of the strategies. Social marketing usually takes time to build up both demand for the product and the supply channels to distribute the products, and thus tend to build up progressively larger operations over time. Reorganizing health workers involves a lag period for training or retraining of personnel, as well as built-in delays to hire and place workers. In contrast to this, user-fee exemptions can be defined, mandated and initiated at a national level, and delegation of authority to subnational levels is usually governed by national regulations and laws (although there have been cases where decentralization was introduced in phases, for example Uganda in the mid-nineties).

Table 4. Plans for scale of implementation of innovative strategies

Country	Contracting	Delegation to local health agency	User fee Exemptions	Subsidies to the poor	Performance incentives	Reorganize health workers	Social marketing	Community engagement
Cambodia	1 1		4	1	1 2	1	3	4
Ethiopia		4		2 3		2	3	4
Ghana	3 3	3	4	2		2	2	2
Indonesia			4	4			2 3	3
Kenya		4	4	3			3	3
Mali	3						3	3
Mozambique			2	1		3	3	
Myanmar		3	2			3	3	3
PNG		4				3		
Tanzania		1	4	2	3		3	4
Uganda	3	4	4		1		3	3
Viet Nam	3		4	4	4	2	3	4

KEY	
	Not applicable - no plan
1	Pilot only at outset
2	Pilot plus plan for full scale at outset
3	Phased implementation without pilot
4	National scale at outset

Implementation record

Documentation on the actual extent of implementation of different strategies was extremely limited in all countries. We were not able to obtain a clear picture on how well the strategies were actually implemented, or what effect these strategies had in terms of health services or health outcomes. We thus restricted ourselves to estimates about how far implementation had proceeded in time and space (Table 5). A large number of strategies had been developed and adopted more than two years ago, but with the exception of social marketing strategies, most were not yet being implemented on a national scale. For the other strategies that have been in operation more than two years, the results suggest that in the country contexts that we studied, one should not expect national-scale implementation in a short timeframe. No country stands out as being particularly able to implement the innovations on a national scale. But after excluding social marketing, Ghana, Uganda, and Viet Nam at least were able to implement more than one of the strategies under review on a national scale.

Social marketing in many cases has been implemented on a national level in a way that demonstrates progress. Mass-media promotion frequently has national coverage, at least for those with access to the media, and the programmes are usually monitored in a way to show large and growing sales of important health products, such as condoms and bednets. Although it is not always clear that the products are being used, or that they are used correctly and have the desired health impact, it is usually reported that sales are increasing. Based on observations of the experience in Ghana and Tanzania, there are a number of useful lessons on how social-marketing programmes can be implemented in low-income countries. The National Insecticide-Treated Nets (NATNETS) programme has been successful in Tanzania. The market was first primed though demand-creation activities and development of local manufacturing, wholesale and retail channels, and later supplemented by a voucher scheme that employs intensive logistics support, training and promotion, monitoring and evaluation, and auditing using

contracts with NGOs and private firms. Nevertheless, questions have been raised about whether vouchers will be able to overcome recognized equity problems. In Ghana, the bednet marketing programme is struggling, with members of the central organizing consortium unable to gain each other's trust. Moreover, resources have been limited and tied to specific donors. In contrast, condom and contraceptives have been well marketed in Ghana (by a private foundation outside government) whereas in Tanzania, there has been less success in this area.

Table 5. Record of implementation

Country	Contracting	Delegation to local health agency	User fee exemptions	Subsidies to the poor	Performance incentives	Reorganize health workers	Social marketing	Community engagement
Cambodia	3 3		3	3	3 2	3	3 4	3
Ethiopia		3		3 3		2	3	3
Ghana	1 4	4	3	2		3	3	3
Indonesia			3	4			3 4	3
Kenya		3	3	2			4	3
Mali	3						4	3
Mozambique			3			4	3	
Myanmar		3	3	3		3	4	3
PNG		3				3		
Tanzania		3	3	3	3		4	3
Uganda	2	4	4		2		4	3
Viet Nam	4		3	4	2	3	4	3

KEY	
	Not applicable
1	Not started
2	Early stage (<2 years)
3	Advanced timing; les- than-national coverage
4	Advanced timing; national coverage

We noted earlier that **user fee exemptions** are relatively simple to design and initiate at national level. However, this does not mean that the policy will be easily implemented across the country. Exemptions to user fees are usually reported as having inconsistent implementation and little discernable impact on reducing inequity, even in cases where the subject of user fees was generating controversy and more attention might have been paid to the effect of exemptions. In Ghana and Tanzania, we were able to get more information about user fee exemptions and subsidies to the poor through site visits. User fee structures have changed several times in both countries without any real benefit, and remain a point of considerable debate and attention of stakeholders, particularly in Tanzania. Arguably, local experimentation with different approaches to ensuring effective execution of the policy, coupled with close monitoring of results, would be a promising approach but this has not been done in the light of the political nature - both nationally and internationally - of the user fee debate.

Ghana is now courageously tackling its health-financing problems comprehensively with a National Health Insurance Fund, which is designed to be nationwide and subsidize insurance coverage for the poor. Capacity to manage risks and to monitor the ambitious scheme is limited, but its new secretariat is prepared to learn and modify as implementation proceeds. The Community Health Fund (CHF) in Tanzania is seen by many as a mechanism for community engagement (see below) rather than as a financing instrument. There were few other significant efforts to provide **subsidies for the poor**. In Tanzania, vouchers for the poor are part of a bednet social marketing programme that appears to be beginning to have a positive effect. The vouchers were designed as a supplement to a well-run and growing programme. It may be that such demand-side subsidies work best when combined with a successful supply-side component. In this case, the supply-side intervention was working slightly in advance of the introduction of the subsidy, but it is not clear whether this is a generalizable phenomenon.

Efforts to **delegate authority and resources** to local (usually district-level) health management teams were one of the more commonly-used strategies in these countries. Whereas we found no common set of data to conduct a rigorous cross-country evaluation of this strategy, it was also an area where there were frequent complaints that the strategy was not implemented according to stated policies and plans. In many countries, a common problem was that even if authority was granted to local agencies, the funds were usually held at either central or intermediate levels. In the case of Ghana and Tanzania, even where increasing funds were being allocated to district levels, operational units below this level (i.e. the sub-district) found themselves short of funds. Changes in the authority and resources of local governments have also created some uncertainty over personnel and financing in both countries. Decentralization is an important issue which extends considerably, however, beyond the scope of the current study and warrants fuller investigation.

Despite the popularity of the concept of **community engagement**, it is notable that none of the countries has achieved a strong national record of implementation of community-engagement strategies. This may be because of the difficulty and long-term horizon needed to effect change across communities. It may also reflect the inability to translate what are frequently small-scale interventions, often driven by external agencies and NGOs, into national programmes. Success is frequently attributed to able local leadership rather than to any approach that facilitates the transmission of success across communities. Another constraint may be that an approach that empowers communities is likely to require government and health professionals to relinquish control over decisions and resources. In general, community engagement strategies seem to offer another example where it is relatively simple for governments to state their good intentions, but much more difficult to implement successfully, given the need for an enabling political and legislative environment.

In both Ghana and Tanzania, there is a renewed focus on the role of the community and the need to be accountable to community members, but so far results have been limited. In Ghana, the Community-based Health Planning and Services Initiative (CHPS) and other related experiments are paying attention to this. CHPS is a concerted effort to involve district and community representatives in developing local health services. Six steps, including the creation of a new cadre, the Community Health Officer, have been sporadically applied in a nationwide effort. The scheme is promising but needs further development, including greater attention to supportive supervision. However, apart from CHPS, the community-based initiatives in Ghana tend to follow a project modality, are implemented with considerable extra financial and managerial resources, and do not seem to reach beyond the boundaries of the project. In Tanzania, though community planning and monitoring was an important part of the success of TEHIP, little has been done on a national scale until recently. Plans to use the Community Health Funds to more systematically strengthen community involvement in health services have been on the map for several years without being implemented countrywide (see also below).

The experience with **contracting** has clearly had success in Cambodia, though the results are somewhat mixed in the other countries reviewed. In Tanzania, there remains a lack of trust with the mission sector, and in Ghana, the ongoing unresolved conflict between the Ministry of Health (MOH) and the Ghana Health Service regarding authority over health service provision and contracting for health services has prevented further progress with contracting with the mission sector and other private providers. In contrast, the Ghana AIDS Commission (GAC) has been able to contract with NGOs, community-based organizations (CBOs), for-profit organizations, and government ministries, departments and agencies on a meaningful scale. The ability of GAC to operate at scale seems to depend on professional management with transparent rules that provides freedom from civil service rates and processes; clear but flexible proposal guidelines and independent review; no pre-qualification of small NGOs and CBOs but limits on spending and receiving new grants when funds have not been spent; independent review and auditing of contract performance. It is clear that concerted attention to the design and management of contracts is required for this approach to succeed.

There were no clearly-documented successes in implementing the use of **performance incentives or reorganization of health workers.** In Tanzania, there are many stakeholders, entrenched interests and dispersed authority on human resource issues, and little imagination or leadership has been applied. Yet there is much goodwill among development partners and the MOH to begin to address the issue seriously. In Ghana, there is a move to reorganize community health officers as part of community-based initiatives, but the performance-related incentives remain largely on the drawing board.
In Ghana and Tanzania, it was also possible to better understand how the two countries approach the question of **scale in the implementation of health programmes**. Ghana has had a long-standing tradition of implementing health programmes at a national scale. However, more recently, the structural institutional conflict between the MOH and the Ghana Health Service seems to create more projects and competing models without a mechanism for making decisions as to which to take forward. The Navrongo demonstration pilot has been used as a basis for scaling up CHPS, but the conditions in the rest of the country differs considerably from the pilot site, and the potential to scale up CHPS has not been yet been fully realized. However, the opportunity to do so exists, with some modifications and agreement by the key stakeholders. In contrast, GAC has rapidly scaled up contracting with NGOs, and the National Health Insurance Fund (and District Mutuals) is also rolling out on a national basis with large funding and political commitments, and with new organizations able to operate more freely than other parts of the government.

In Tanzania, TEHIP is a **successful demonstration project**, but thinking about how to scale up has been an afterthought and progressed little until recently. TEHIP developed and implemented several tools for district level health planning. A method for calculating and presenting burden of disease data and district health accounting was developed to help policy-makers better understand the effects of the burden of disease in their respective districts, to allocate resources based on the burden of disease, and to manage and track those allocations. Another tool, the Cascade Supervision System, evolved after the project was started in order to organize and integrate health service delivery at the district level more efficiently and economically. There are now efforts under way to fund a large extension from the Medium-Term Expenditure Fund/Common Fund, but not enough work has been done to tease out the essential ingredients that are responsible for the remarkable results of the pilot, and to agree what degree of “dilution” of the TEHIP formula is acceptable and effective.

With the exception of the TEHIP approach which does rely on evidence for developing annual plans, a common characteristic across countries was the apparently low dependence on the **use of information for determining policy** and strategic changes. Perceptions of success or failure of strategies seem to drive many decisions concerning strategies. In most cases, the documentation on how strategies are implemented or what results they have had does not appear to play a major role in decision-making.

Although the context of each country is different, we also noted that a number of the countries are engaged in a **Sector-Wide Approach (SWAp)**. SWAps have served a useful purpose in these countries in solidifying policies and ensuring a coherent programme of work. However, in both Ghana and Tanzania, it has become apparent that SWAp basket funds have generally not been used for developing innovative strategies or expanding them to a national scale. Once resources have been allocated early in a SWAp, there appears to have been little change, even as knowledge and priorities move on. In theory, the government, in collaboration with key SWAp partners, reviews and agrees on pilots and action research and ensures that the findings feed into health policy-making. The Uganda Health Policy Advisory Committee (HPAC) is a good example of this but in practice, many agencies, particularly WHO and UNICEF, continue to provide implementation support for relatively small area-based projects without sufficient attention to the analysis, documentation and policy advice required to ensure adoption and implementation of innovative delivery strategies.

4. SUMMARY OF KEY MESSAGES

This study was an exploratory inquiry based largely on desk reviews. Whereas it was known that comparable data on health systems delivery in low-income countries are very limited, the study reinforced the view that data are often confined to programmatic areas sponsored by external agencies, and tends to rely more on intermittent surveys rather than routine information systems. Documentation of how well strategies were implemented was particularly poor, with even less information that would convincingly link them to possible effects on health service delivery. This is especially the case for strategies that cut across programmes where monitoring is organized around those programmes. A number of contextual factors within countries influence how strategies are adopted and implemented, but the small sample of countries and the lack of this type of information in formal documents did not allow drawing any definitive conclusions. Nonetheless, there emerged a number of key messages from the analysis:

- Many low-income countries are pursuing new ways of delivering health services but frequently without plans for taking successful small-scale projects to a national level. The reasons for countries adopting new strategies are complex, but any evidence that these strategies have on affecting health services does not appear to be a major factor in their adoption. This is also reflected in the lack of processes put in place to learn from new strategies once adopted, further hampering the ability to take small-scale projects to national level implementation.
- There were no obvious associations between level of performance across health services and the types of innovations pursued.
- Common trends across several health service outputs within a country are rarely found, Viet Nam being the exception by demonstrating consistent improvements across a range of health services.
- Despite the promise of contracting and performance incentives for health workers, these strategies are less frequently adopted than others.
- Social-marketing strategies seem to be more likely to be implemented at a national scale than other strategies. This may be because social marketing is relatively simple and focused, and can be implemented outside the MOH bureaucracies while receiving considerable external financial and managerial support.
- Although community engagement policies and strategies are frequently adopted, they are not achieving national coverage. It may be that they require more time to reach this scale, but also that not enough attention has been paid to developing a broad-based framework within which a range of community-based strategies can be expanded nationally. The need to relinquish control to communities may raise too much opposition from governments and sponsoring agencies to achieve national coverage.

- Exemptions for user fees are common and controversial. Implementation of these strategies seems particularly fraught with difficulties and better use of data or greater efforts to learn from experience are needed.

There is an indication that countries that are more innovative also have better performance in health service outputs. Further study is needed to see whether this is a consistent finding, and to understand if it is the innovation that drives performance, or whether better performing health systems are simply more able to take on new strategies.

ANNEX 1: SUMMARY OF HEALTH SERVICE OUTPUTS CATEGORIZED BY TREND

Country	Improving or High Outputs	Little Change or Uncertain	Deteriorating or Low Outputs
Cambodia	TB treatment success: 91% (1995) to 94% (1996); 91% (1997) to 95% (1998); 93% (1999) to 92% (2002) DPT dropout: 25% (2000); 8.45% (2001) to 11% (2002)	Antenatal care: 28.1% (1998) to 30.5% (2000) Skilled delivery: 34% (1998) to 31.8% (2000) Institutional delivery: 10% in 1998 and 2000 Full immunization: 38.9% (1998) to 39.9% (2000) TB case detection: from 40% to 53% from 1995-1999, 49% to 47% from 2000 to 2001; 55% (2002) Bednet use: no data Outpatient use: no data AIDS knowledge[1]: 69.3% (2000), no trend data	
Ethiopia	TB case detection: 16% (1995) to 36% (2002). Low but increasing.	Antenatal care: 20.8% (2000), no trend data DPT dropout: 16% (2000) to 19% (2001); 17% (2000) Bednet use: no data TB treatment: 61% to 80% (1995 to 2000); 76% (2001 to 2002) AIDS knowledge[2]: 36.8% (2002), no trend data Outpatient utilization[3]: 0.27 (2000); 0.23 (2001)	Full vaccination: 39.9% (1998) to 14.3% (2000) Institutional delivery: 6% (1998) to 5% (2000). Little change and levels are very low (<10%). Skilled delivery: 6.5% (1998) to 5.6% (2000). Little change and levels are very low (<10%).
Ghana	Antenatal care: 80.9% (1993) to 86.1% (2003) Skilled delivery: 12.7% (1988) to 44.3% (1998) to 47.1% (2003) Full vaccination: 54.8% (1993) to 62% (1998) to 69.4% (2003) Outpatient utilization[4]: 0.4 (1999); 0.43 (2000); 0.6 (2001)	Institutional delivery: 42.2 (1993) to 43.4 (1998) to 45.7% (2003) TB case detection: 16% (1995) to 42% (1997); fluctuates around 40% (1998-2002) TB treatment: 53.7% to 48.3% (1995 to 1997); 59% to 50% (1998 to 2000); 56% to 60% (2001 to 2002) AIDS knowledge[5]: 72.9% (2003), no trend data	DPT dropout: 0% to 5% (2000 to 2001); 8% (2002) Bednet use: 4.5% (2003), no trend data. Levels are very low (< 10%)
Indonesia	Antenatal care: 74.8% (1991) to 92.4% (2002) Skilled delivery: 36.3% to 31.7% (1987 to 1991); 36.5% to 66.3% (1994 to 2002) Institutional delivery: 19.7 (1987) to 39.7% (2002) Full vaccination: 48.3% (1991) to 54.8% (1997) DPT dropout: 12.1% to 7% (2000 to 2002) TB case detection: 13% to 5% (1995 to 1996); 7% to 27% (1997 to 2002). Low but shows a substantial increase over baseline TB treatment success: 91% to 54% (1995 to 1997); 58% to 50% (1998 to 1999); 87% to 86% (2000 to 2002). Fallen but re-gained high level.	Bednet use[6]: 32% (2000), no trend data AIDS knowledge[7]: 20.9% (2002), no trend data Outpatient utilization: no data	TB case detection: low levels but substantial increases (see “Improving” column)
Kenya	Antenatal care: ~90% for most of 1990s, 84% in 2003 DPT dropout: 13.7% to 7% (2000 to 2002) TB case detection: 16% (1995) to 36% (2002). Low but increasing AIDS knowledge[8]: 37.5% (1998) to 61% (2003)	TB treatment success: 75% to 77% (1997 to 1996); 65% to 80% (1997 to 2001); 79% (2002) Bednet use[9]: 16.4% (2000), no trend data Outpatient utilization: no data	Skilled delivery: 50% (1989) to 41.6% (2003) Institutional delivery: 44.1% to 40.1% (1993 to 2003) Full vaccination: 78.7% (1993) to 56.8% (2003)
Mali	Antenatal care: 40.3% (1995) to 46.7 (2001) Institutional delivery: 30.4% (1995) to 37.8% (2001) Skilled delivery: 31.9% (1987) 40.6% (2001)	Full vaccination: 31.5% (1995) to 28.7% (2001) DPT dropout: 47.5% to 16.4% (2000 to 2001); 24% (2002) TB case detection: 14% to 18% (1995 to 1997); 17% to 15% (1998 to 2000); 17% (2002) Bednet use[10]: 68.4% (2001), no trend data AIDS knowledge[11]: 13.3% (2001), no trend data Outpatient utilization: no data	TB treatment success: 59% to 70% (1995 to 1998); 68% (1999); 50% (2001; 2002)

[1] % of women 15-49 years who know two or three programmatically important ways of avoiding HIV/ AIDS
[2] % of women 15-49 years who know of two or three ways to avoid HIV/ AIDS
[3] New consultations per 100 people per year
[4] Outpatient visits to public facilities per capita per year
[5] % of women age 15-49 who say that people can reduce the risk of getting the AIDS virus by using condoms
[6] % of children under 5 years who slept under a bednet the night preceding the survey
[7] % of ever-married women 15-49 years who know of two or three programmatically important ways of avoiding HIV/ AIDS
[8] The proportion of women 15-49 years who know that using a condom reduces the risk of getting HIV/ AIDS.
[9] % of children under 5 years of age who slept under a bednet the night before the survey
[10] % of households with children under 5 years where all children under 5 years slept under a bednet the night before the survey
[11] % of women 15-49 years who know 2 or 3 programmatically important ways of preventing HIV/ AIDS

Country	Improving or High Outputs	Little Change or Uncertain	Deteriorating or Low Outputs
Mozambique	TB treatment: 39% to 78% (1995 to 2002)	Antenatal care: 60.5% (1997), no trend data Institutional delivery: 43.6% (1997), no trend data Skilled delivery: 44.2% (1997), no trend data Full vaccination: 47.3% (1997), no trend data DPT dropout: 13.7% (2000); 15.8% (2001); 13% (2002) AIDS knowledge: no data Bednet use: no data Outpatient utilization: no data	TB case detection: 56% to 45% (1995 to 2001)
Myanmar	TB case detection: 26% to 73% (1995 to 2003) TB treatment: 67% to 81% (1995 to 2002) DPT (72%-90%) immunization between 1990-2003.[10] Some down trends, but levels remains high.	Antenatal care: 76% (1997) to 73% (2001) Skilled delivery: 56% (1997) to 57% (2001) Full vaccination: no data DPT dropout: no data AIDS knowledge: no data Bednet use: no data Outpatient utilization: no data	
Papua New Guinea		Antenatal care: 78% (1996), no trend data Skilled delivery:53.2% (1996), no trend data TB case detection: 31% (1995); 12% (1996); 22% (1997); 37% (1998); 34% (1999); 39% to 16% (2000 to 2002); 54% (2003) AIDS knowledge: no data Outpatient utilization: no data	DPT immunization[12]: 67% to 45% (1990 to 1997); 58% to 49% (1998 to 2002); 54% (2003) TB treatment success: 60%(1995); 93% to 53% (1997 to 2002)
Tanzania	Antenatal care: >90% in 1990s, 93% (1999) TB treatment: 74% to 80% (1995 to 2002). Decreased, but remains high.	Skilled delivery: 43.9% to 46.7% (1992 to 1996); 43.8% (1999) Full vaccination: 71.1% (1992) to 58.3% (1999); 71.1% (2004) DPT dropout: 7% (2002), no trend data Bednet use[13]: 20.7% (1999), no trend data AIDS knowledge[14]: 65.7% to 67.6% (1999 to 2003)	Institutional delivery: 52.6% (1992) to 46.5% (1996) to 43.5 (1999); 47.1% (2004) TB case detection: 55% (1995) to 43% (2002)
Uganda	Antenatal care: 84%, unchanged from 1995-2000 TB treatment success: 33% (1996) to 63% (2000); 56% (2001) to 60% (2002) AIDS Knowledge[15]: 78% (2000). Close to 80%, but no trend data.	Institutional delivery: 35.4% (1995) to 36.6% (2001) Skilled birth attendance: 38.3% to 39% (1988 to 2001) DPT dropout: 26.4% to 21% (2000 to 2002) TB case detection: 39% to 43% (1995 to 1999); 38% to 42% (2000 to 2002) Outpatient utilization[16]: 0.46 in 2001, no trend data	Full immunization: 47.4% (1995) to 36.7% (2000) Bednets use[17]: < 10% but no trend data
Vietnam	Antenatal care: 56.8% (1997) to 76.7% (2002) Institutional delivery: 61.7% (1997) to 78.5 (2002) Skilled delivery: 77.1% (1997) to 85% (2002) Full vaccination: 56.8% (1997) to 66.7% (2002) DPT dropout: 0.9% to 0% (2000 to 2002) TB case detection: 60% to 88% (1995 to 2002) TB treatment success: 60% to 88% (1995 to 2002) Bednet use[18]: 95.9%, no trend data	AIDS knowledge: no data Outpatient utilization: recent data not available	

[12] % children 12-23 months who received DPT vaccinations before 1 year of age
[13] % distribution of households with children under 5 years by use of bednets by all children under 5 years the night before the interview
[14] % of women aged 15-49 who know that people can reduce the risk of getting the AIDS virus by consistently using condoms and limiting sex to one uninfected faithful partner
[15] % of women aged 15-49 who know 2 or more programmatically important ways of avoiding HIV/ AIDS
[16] New outpatient visits per capita per year
[17] % of children under 5 years of age living with mothers who slept under a mosquito net the night before the survey
[18] % of children under 5 years of age who slept under a bednet the night before the survey

ANNEX 2: HEALTH SERVICE OUTPUTS BY COUNTRY

Figure 1. Cambodia Health Service Outputs

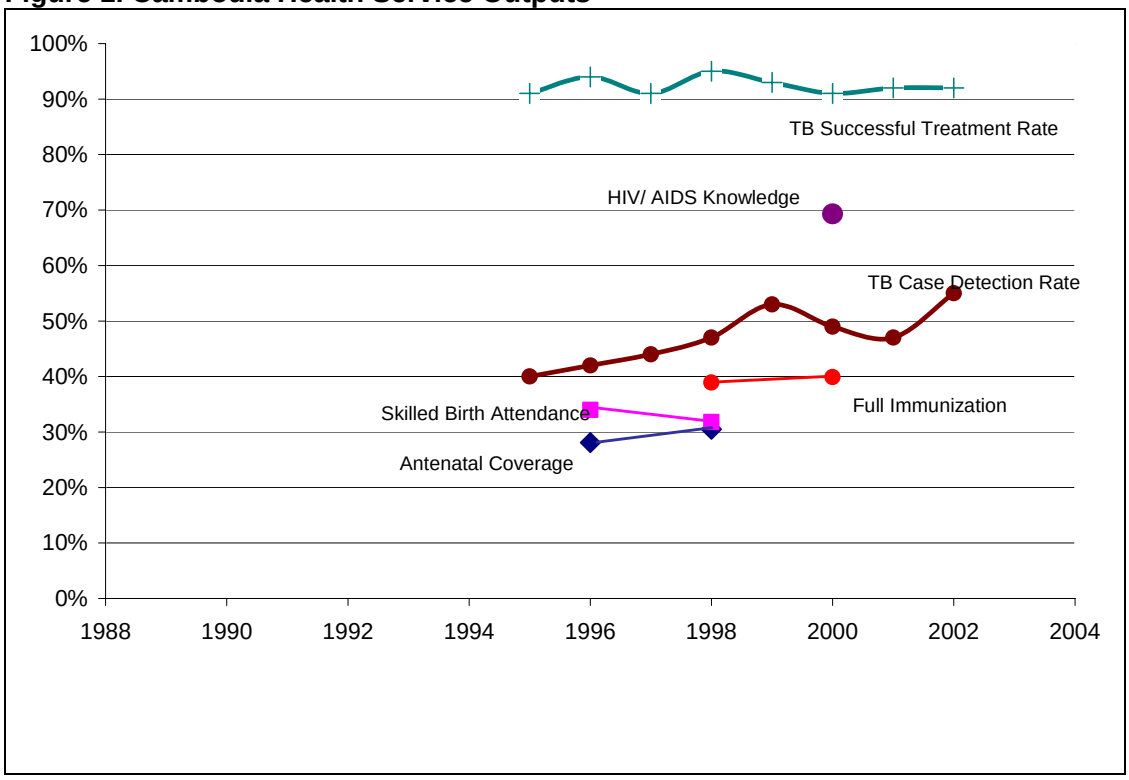


Figure 2. Ethiopia Health Service Outputs

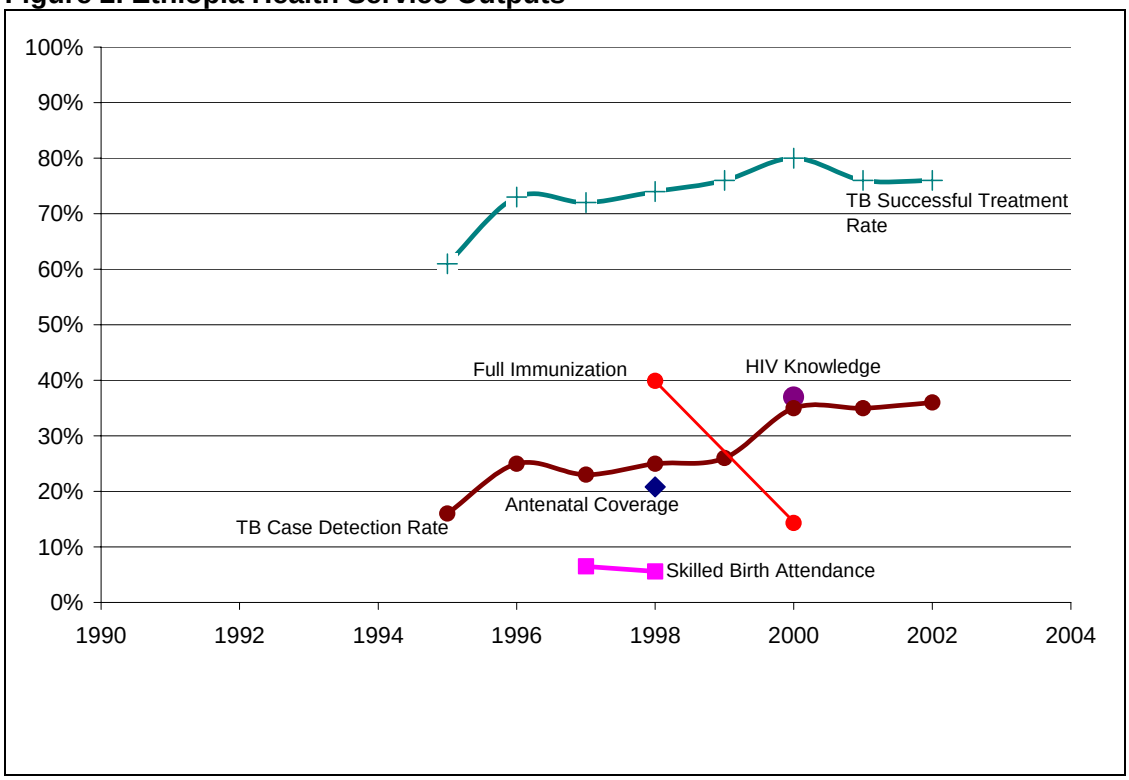


Figure 3. Ghana Health Service Outputs

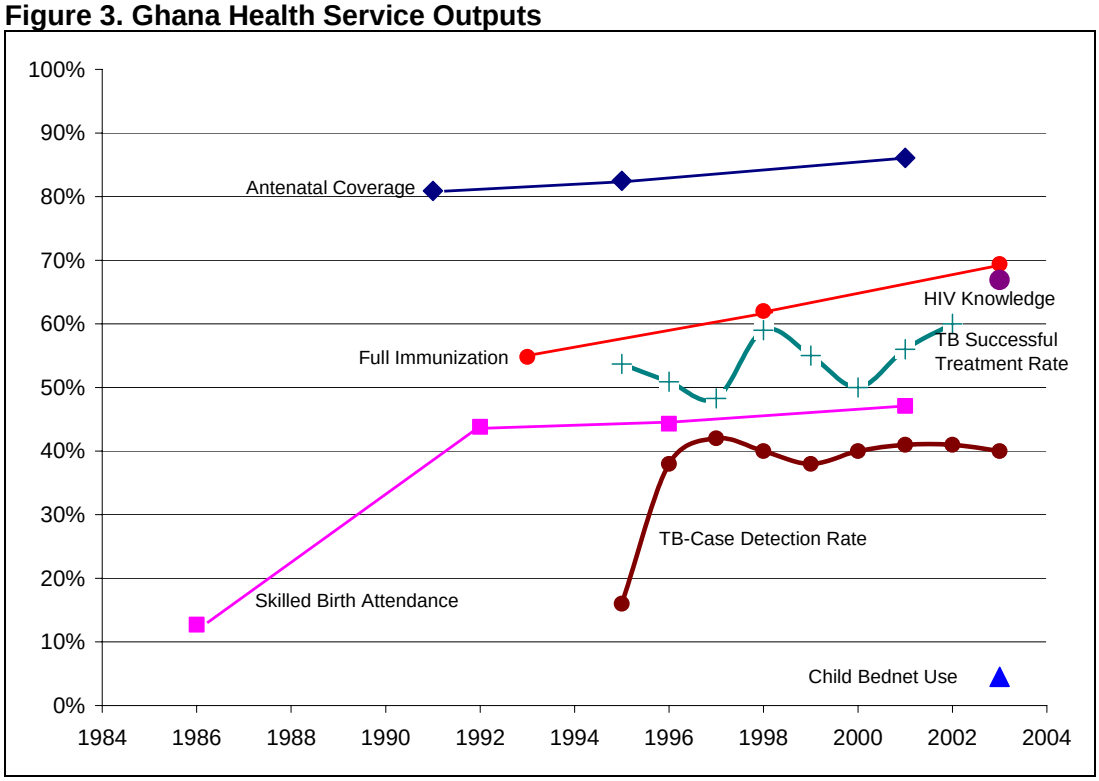


Figure 4. Indonesia Health Service Outputs

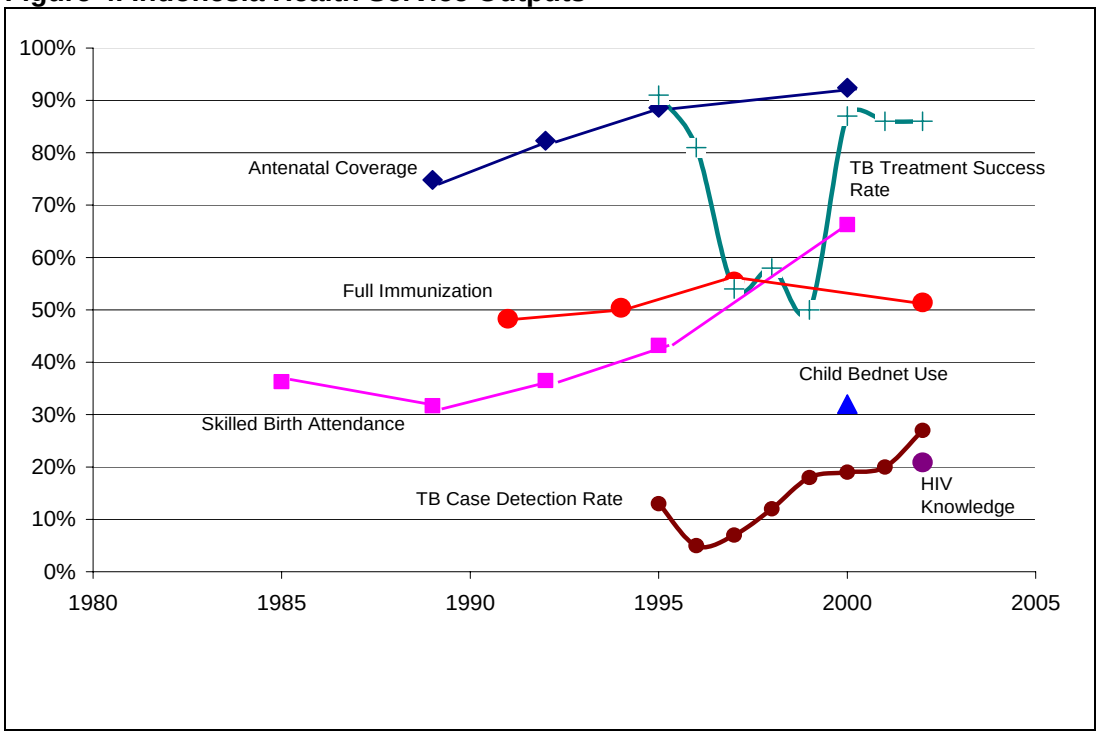


Figure 5. Kenya Health Service Outputs

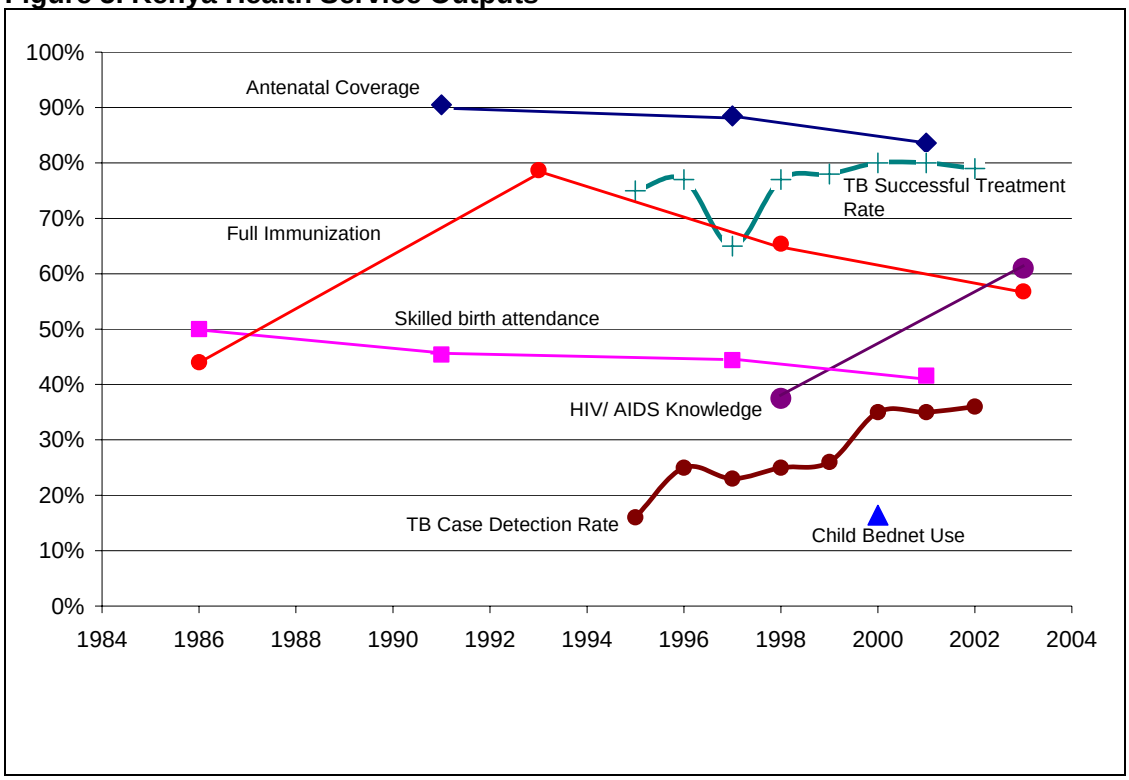


Figure 6. Mali Health Service Outputs

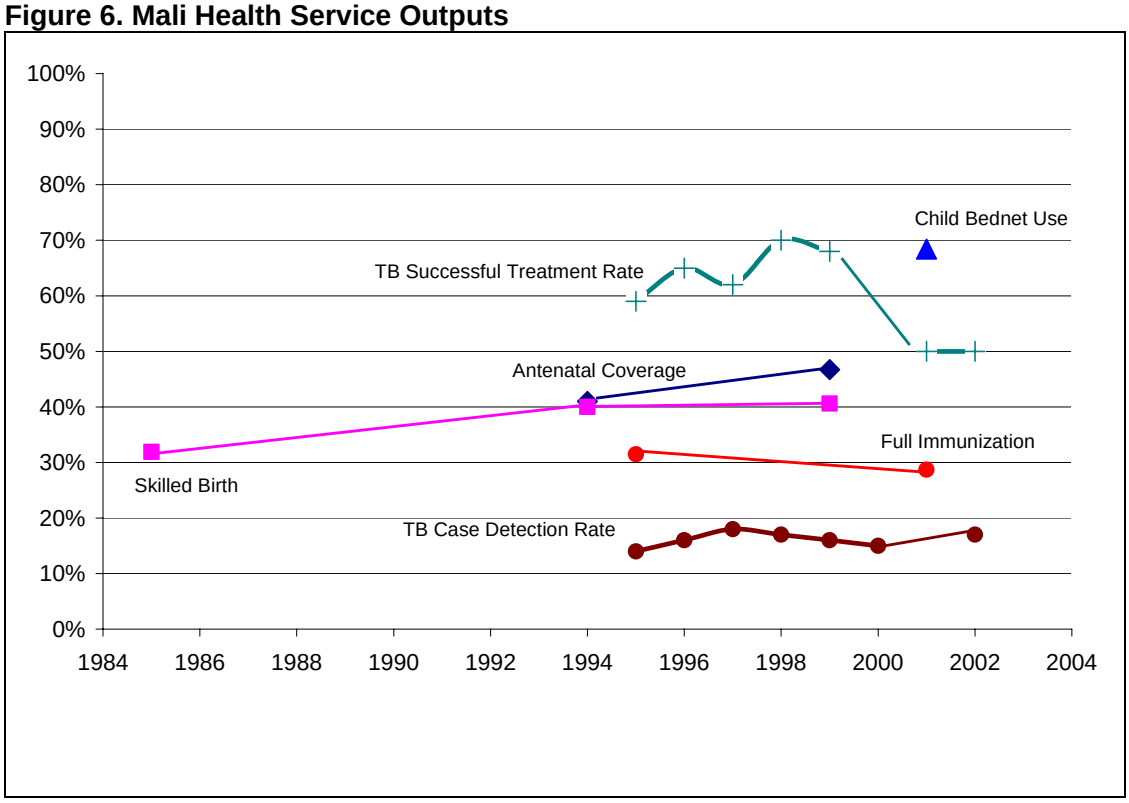


Figure 7. Mozambique Health Service Outputs

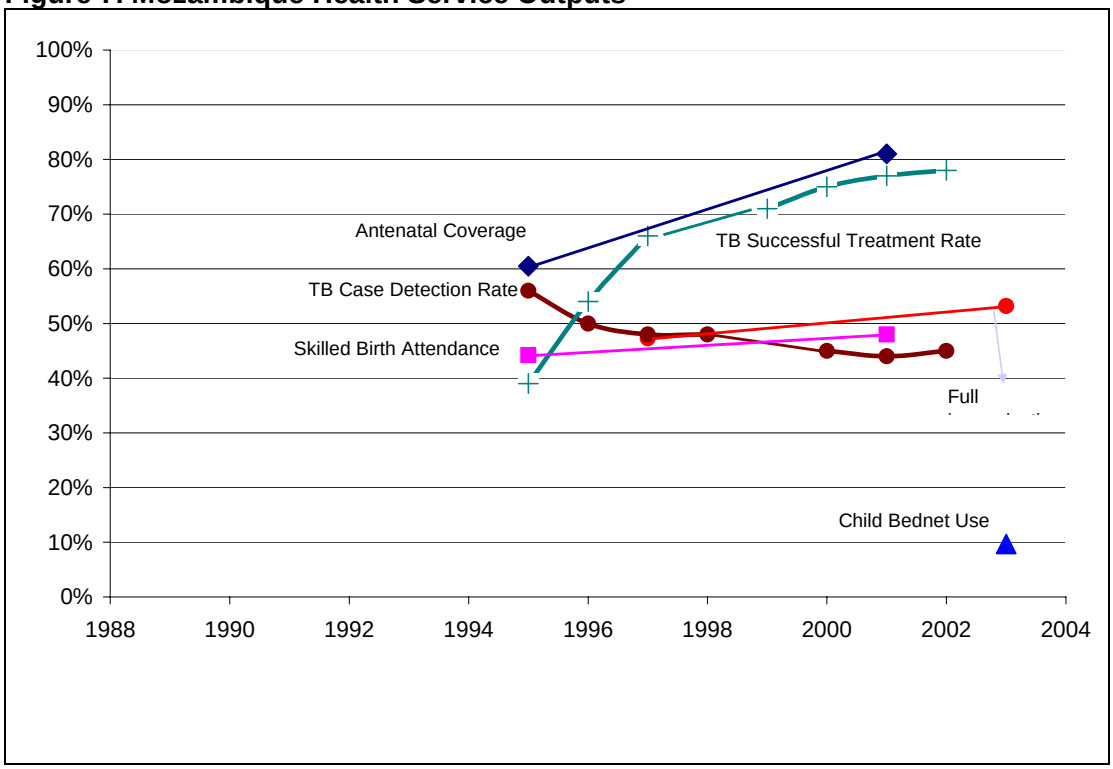


Figure 8. Myanmar Health Service Outputs

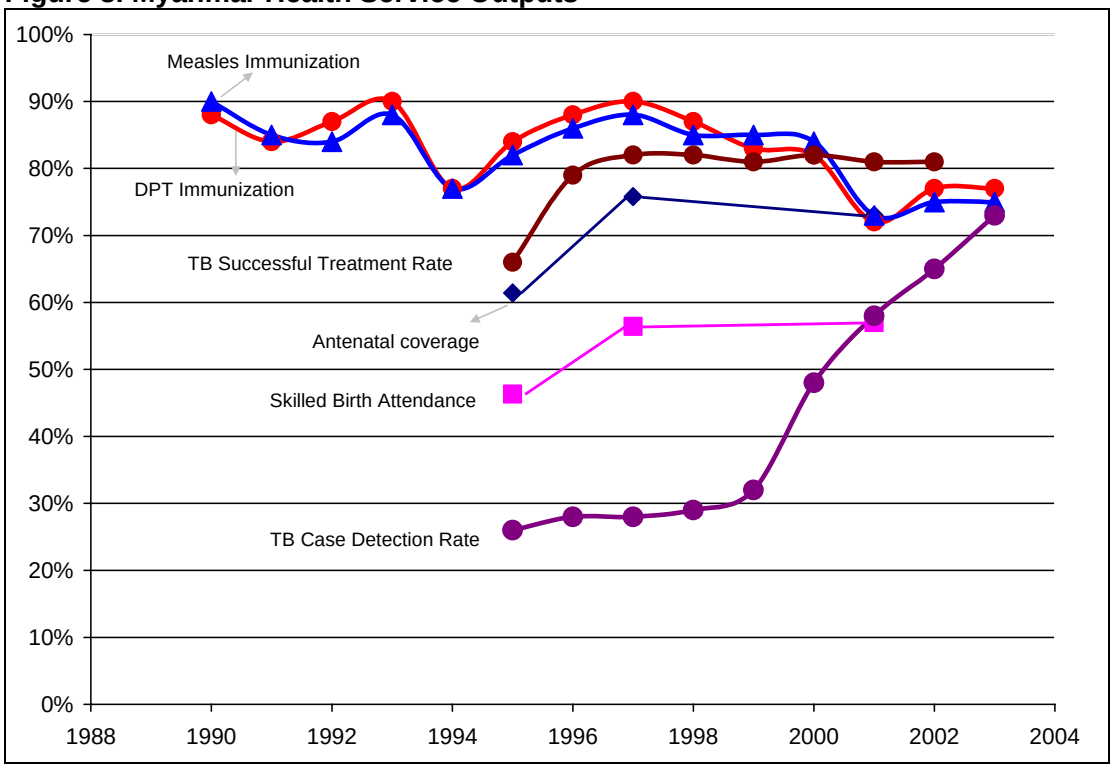


Figure 9. Papua New Guinea Health Service Outputs

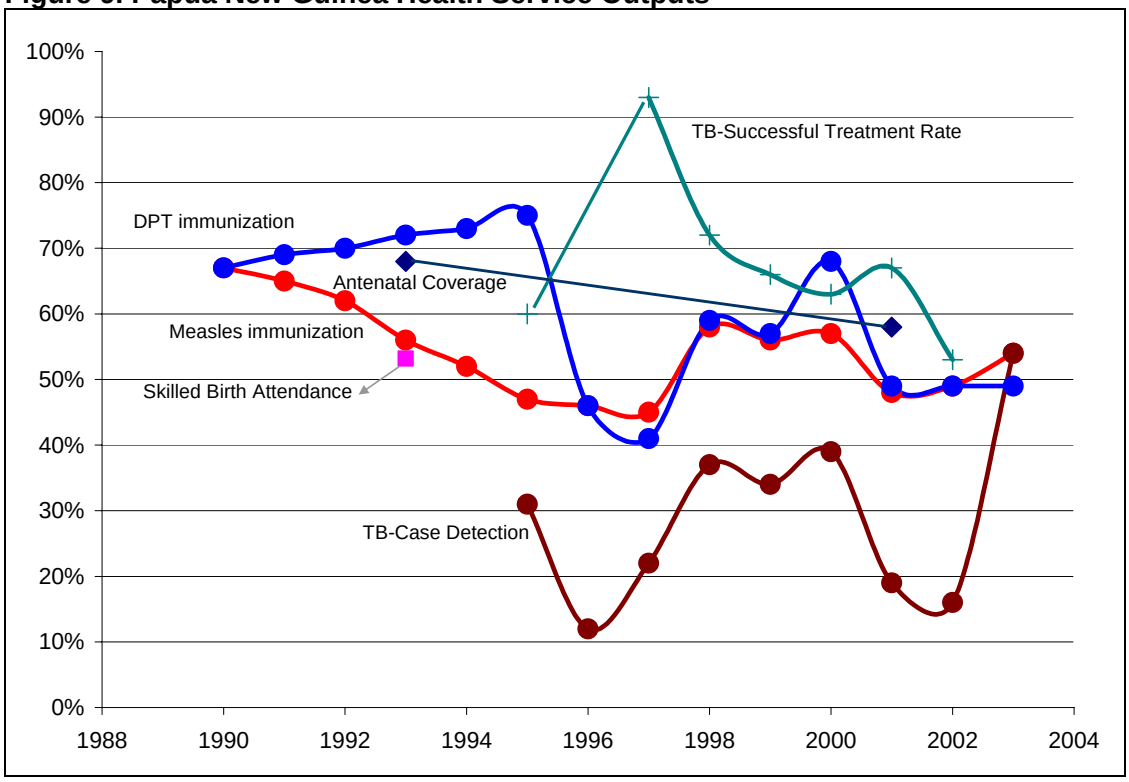


Figure10. Tanzania Health Service Outputs

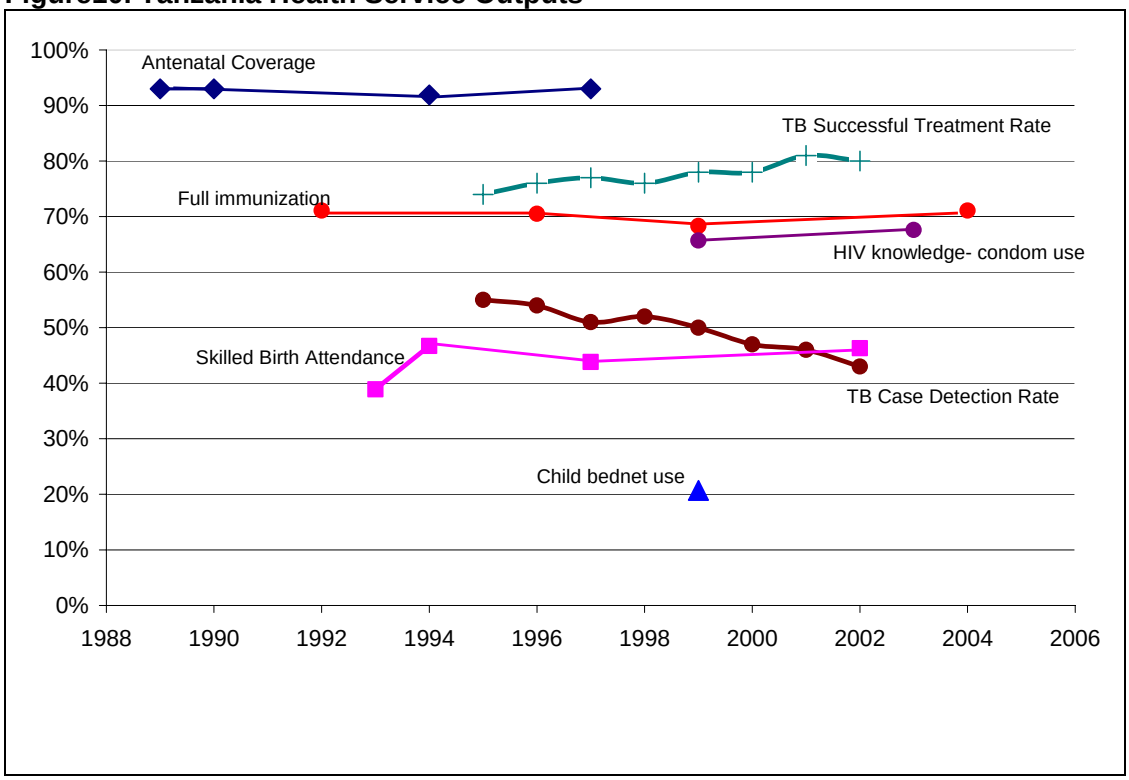


Figure 11. Uganda Health Service Outputs

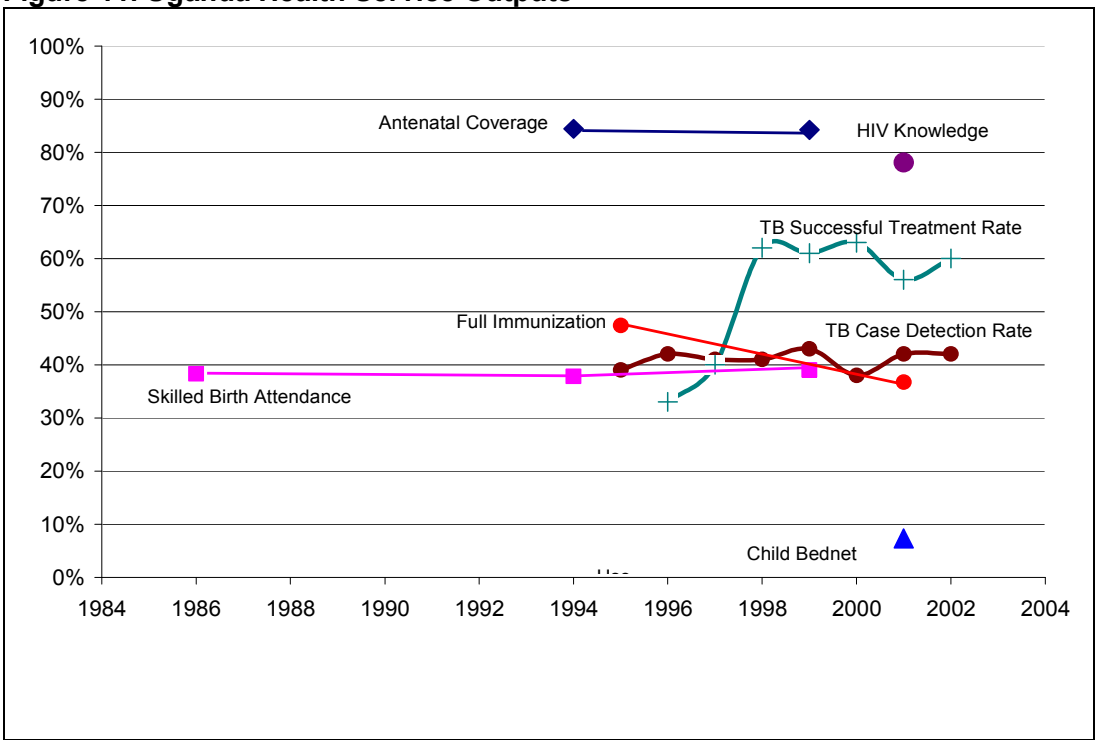
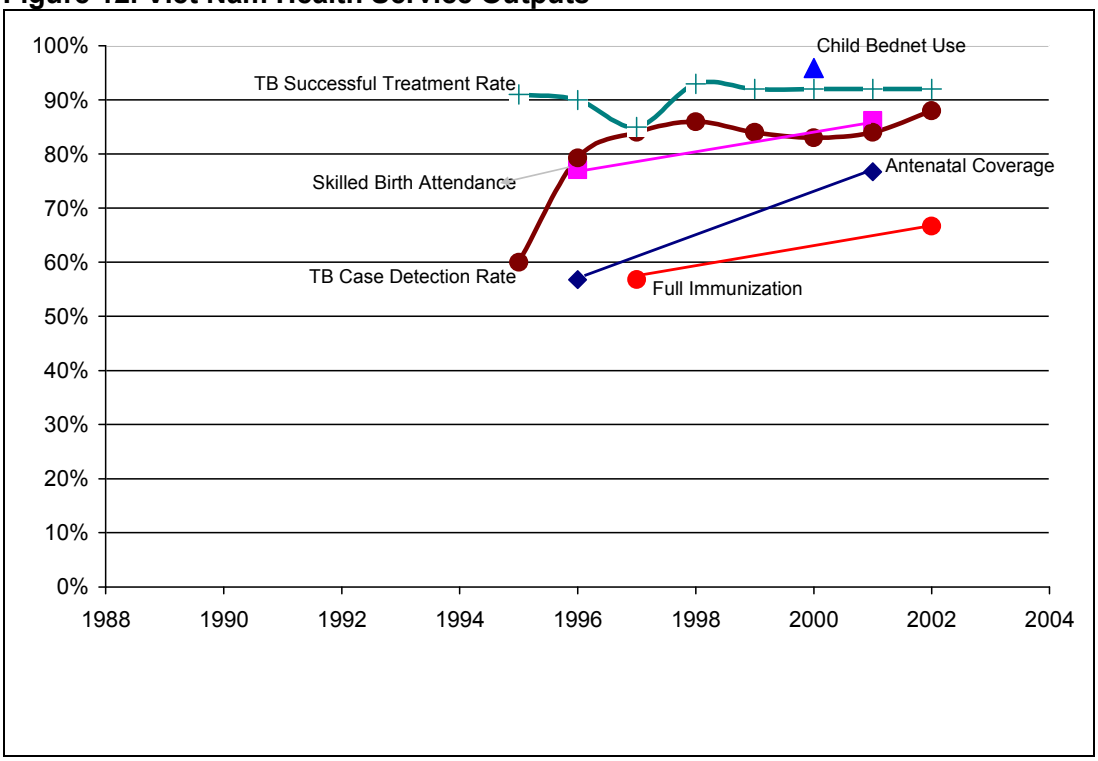


Figure 12. Viet Nam Health Service Outputs



Sources for graphs in Annexes 1, 2 and page 7: primarily Demographic and Health Surveys and WHO (TB rates); other sources include UNICEF (MICS - Multiple Indicator Cluster Surveys); and World Bank Development Indicators.

World Health Organization
Geneva
http://www.who.int