

HEALTH SECTOR REFORM: HOW IT AFFECTS REPRODUCTIVE HEALTH

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Many less developed countries are reforming their health systems in an effort to achieve public health goals more affordably and effectively. Many are also attempting to expand and improve reproductive health services, which include family planning, measures to ensure safe pregnancy and childbearing, preventing the spread of HIV and other sexually transmitted infections, and other measures to improve women's health. The need to pursue reproductive health objectives while implementing health sector reforms poses a major challenge for health managers.

If health sector reform works well, it should make basic preventive health care, including reproductive health services, widely available. Reforms should also make health providers more responsive to client needs. But some structural changes—such as decentralizing authority or integrating health services—can lead to a loss of focus and expertise on specific reproductive health issues. To avoid these and other pitfalls, reproductive health specialists need to understand the reform process and engage actively in debates about the financing, management, and structure of the health system. This brief provides an overview of health sector reform, discussing its potential impact on reproductive health services and ways to incorporate reproductive health priorities into evolving health care systems.

Background

Since the late 1980s, many developing countries have initiated efforts to improve their health systems. A number of factors prompted these efforts: the movement from state-controlled economies to market-oriented economies; insufficient funding for health in times of financial crisis; the lack of basic health services for many citizens; and the poor quality, low accountability, and inefficiency of existing health services.¹ To address these issues, many governments launched health sector reforms, which are intensive long-term efforts to strengthen and improve health systems and, ultimately, improve the nations' health (see Box 1).²

Box 1

Five Goals of Health Sector Reform

Health sector reforms try to correct systemwide problems in health care that hinder the delivery of priority services. Five goals underlie the reforms:

- **Efficiency.** Health improvements should be achieved at the lowest possible cost.
- **Quality.** Appropriate and safe clinical services, adequate amenities, skilled staff, and essential drugs, supplies, and equipment should be available.
- **Equity.** Health resources should be distributed fairly so that nobody is denied access to essential care.
- **Client responsiveness.** The system should meet people's expectations and protect their rights, including their rights to individual dignity, privacy, autonomy in decisionmaking, and choice of health provider.
- **Sustainability.** The health system can continue to achieve its goals using available resources.

SOURCE: World Health Organization (WHO), *World Health Report 2000*.

During the 1990s—especially after the 1994 International Conference on Population and Development (ICPD)—many countries also introduced initiatives to expand and improve reproductive health care. The ICPD agreement called for a wide range of social investments and specifically for primary health services that would provide a comprehensive package of reproductive health care. Such care includes family planning information and services; safe pregnancy and delivery services; prevention of sexually transmitted infections, including HIV/AIDS; and attention to other factors, such as violence against women, that contribute to poor health. The agreement also called for services to be more “client centered”; that is, geared toward meeting individuals' needs so that women and men can achieve their reproductive goals.

Components of Health Sector Reform

Health sector reform may involve a number of strategies, policies, and interventions designed to strengthen the health system so that it can better achieve public health goals. Countries' approaches

Box 2

Alternative Approaches for Financing Health Care

Alternative financing approaches can influence the demand for and use of health services by making services with more benefits to society, such as family planning, cheaper for the consumer. The following are examples of alternative approaches.

- In Rwanda, community-based insurance schemes are owned, managed, and financed by their members. Members who pay an annual premium receive basic health care—including preventive and curative care, family planning and reproductive health services, maternity care, and drugs—free of charge in health centers and district hospitals (for Caesarean sections). One evaluation found that insurance members use health services more frequently than nonmembers: 1.5 visits per year for insured individuals, compared with 0.2 visits for uninsured people.
- In three governorates in Egypt, contributions from individuals and employees are combined

into social health insurance funds that grant enrollees an essential package of health services. The package includes child immunizations, reproductive health services, and prevention and treatment of communicable diseases.

- In Kolokani, Mali, a transportation and referral system for women who need emergency care during labor and delivery is supported by contributions from the district, the community, and individual patients.
- In Bolivia, municipal governments must use at least 6 percent of the central government funds they receive to support an insurance fund that guarantees some reproductive health and child health services and other care free of charge to all clients. The fund has contributed to increased use and quality of health services.

SOURCE: Partnerships for Health Reform, Abt Associates.

to health sector reform vary widely: Some governments implement sweeping reforms, while others enact narrower changes. Most reform measures can be grouped into three broad categories: financing changes, organizational changes, and policy changes. A cross-cutting objective of these measures is to empower consumers by educating them and giving them more choices. Some typical reform measures are described below, with examples of how they have been applied.

Reforms in Financing

Health sector reforms generally address questions about how funds are to be raised and allocated to pay for health care for the population. Many health systems are plagued by overall resource constraints as well as poor allocation of funds; some relatively well-off households consume more than their share of scarce public resources. Increasingly, policymakers in developing countries are basing decisions about financing and resource allocation on evidence about how much is spent on health, who pays, and who benefits from health spending.

Alternative Financing Approaches

Some long-term measures try to mobilize additional funds for health care and channel funds to the most effective uses, allowing more citizens to

benefit from services and improving the quality of services. In order for such approaches to work well, however, systems must be strengthened and be able to identify and support those individuals most in need of public subsidies and support. Cost-sharing and risk-sharing arrangements are two types of alternative approaches.

Cost sharing or cost recovery involves imposing user fees for some or all health services as a way to get clients to share the expense of services. One premise behind cost sharing is that clients who pay for services will demand better quality and that funds will be used to improve it. Another possibility is that fees from better-off clients could be used to help pay for services for those who cannot afford to pay. Achieving this objective involves establishing waiver systems to exempt the poorest clients from payment, but putting such systems into practice has proven difficult. In some cases, imposing fees has led to a decline in the use of health services, and improvements in quality have been questionable.³

Risk-sharing arrangements, or insurance schemes—managed by either the government or for-profit or nonprofit private entities—can help prevent vulnerable populations from incurring major health expenses due to serious illness or injury. Under a basic health insurance plan, a consumer or member makes regular payments to a

managing institution that holds the funds and pays a health care provider for the member's care when required. Insurance lowers individual liability by spreading risk across a group of members and allows patients to avoid large payments when they are ill. Insurance schemes face several possible pitfalls, however, such as overuse of care by the insured, exclusion of high-cost individuals, and higher-than-expected enrollment by high-risk individuals. To work well, the schemes must be carefully designed to avoid possible pitfalls and ensure that the insurance responds to health policy goals, such as promoting preventive care and including vulnerable groups (see Box 2 for examples).

Provider payment reforms change how the organization holding the funds, such as the government or an insurance company, pays a health provider or facility for services rendered.⁴ Typically, government health systems pay physicians and other staff a fixed salary regardless of how many patients they see or the quality of care they provide, giving providers little motivation to improve performance. Private providers who work on a fee-for-service basis are also not under direct supervision and can make the system more expensive by providing more services than are medically necessary. Alternative payment mechanisms seek to make providers more responsive and accountable for the work they do by tying compensation directly to performance. The capitation fee system, under which providers are paid a fixed amount per patient regardless of how many times the patient visits during the year, is one example. The system is meant to encourage providers to emphasize preventive care and remove incentives to provide unnecessary treatments.⁵ As is true of cost-sharing and risk-sharing arrangements, however, good planning and oversight are needed to ensure that alternative payment systems work as they are supposed to.

Organizational Change

Organizational changes try to overcome weak management structures and a lack of performance incentives in the public sector. Typical reform measures have included decentralizing authority, promoting public-private partnerships, and integrating services.

Decentralization

Perhaps the most common organizational change under health sector reform has been decentraliza-

Experiences with decentralization have been mixed, and the principal lesson has been that decentralization requires time and patience to be successful.

tion, the transfer of decisionmaking authority and management from higher levels of government—typically from central agencies—to agencies at the regional, provincial, or local levels.⁶ Any number of responsibilities may be transferred, including planning, finance, human resources, service delivery, operations maintenance, and information management. Decentralization is not an all-or-nothing proposition: For example, the central government could retain the responsibility for purchasing commodities such as contraceptives, while local entities manage personnel and services. In many countries, governments have decentralized all development sectors, not just health.

The basic argument for decentralization is that local organizations are in the best position to respond to service users' needs, as client-centered care demands. Making the delivery of health services part of local administrations' responsibilities can also allow greater flexibility, efficiency, and accountability in resource use. Finally, local control enhances the potential for community participation and involvement in health care.

Experiences with decentralization have been mixed, and the principal lesson has been that decentralization requires time and patience.⁷ Sri Lanka's success provides one example: The country began decentralizing health services as early as 1952, when it transferred a limited number of responsibilities to districts. Only in 1992 did the central government hand over full responsibility for critical health services, such as maternal and child health care, to the districts. Similarly, gradual decentralization in Botswana began in 1965, but not until 1987 did regional teams begin to support district-level health services.

A number of issues often arise in decentralizing the health sector. For example, many local entities lack the technical, managerial, and financial skills needed to deal with their new responsibilities. In Senegal, few local leaders had participated in developing a district health plan, and only about one in five officials had received any training before the transfer of power.⁸ Case studies in

Table 1

Health Care Spending in Selected Countries, by Source and Type of Provider, 1996–99

	Percent of Funds, by Source			Percent of Spending, by Type of Provider		
	Public ^a	Private ^b	External Funds ^c	Public ^d	Private ^e	Other ^f
Eastern and Southern Africa						
Ethiopia	39	53	9	52	48	—
Malawi	25	45	30	42	58	—
Rwanda	9	40	50	66	33	—
Latin America and the Caribbean						
Bolivia	17	76	6	59	33	9
Dominican Republic	22	75	3	25	74	1
Ecuador	27	70	3	50	49	—
Guatemala	23	75	2	42	53	5
Middle East and North Africa						
Iran	30	70	—	65	34	1
Lebanon	18	80	2	3	88	9
Morocco ^g	27	69	1	30	68	1

— = Data not applicable.

^a Includes funds from central, regional, and local governments.

^b Includes out-of-pocket spending by households and employer funds (including contributions to social security, where applicable).

^c Referred to under National Health Accounts as “rest of the world funds.”

^d Includes ministry of health (MOH) and other government facilities, and social insurance facilities, where applicable.

^e Includes for-profit facilities, nongovernmental facilities, private pharmacies, and traditional healers, where applicable.

^f Facilities that could not be categorized as either private or public.

^g Sources of spending do not add to 100 percent because 2.5 percent of funds were nonassigned.

SOURCE: Compiled from National Health Accounts by the Partners for Health Reform^{plus}, Abt Associates.

Bangladesh, Indonesia, Mexico, South Africa, and Tanzania also found that human resources at the local level were poorly developed and unable to provide effective reproductive health services.⁹

Health care, including reproductive health services, may be a lower priority for local governments than investments in other areas, so health may be starved for resources. In Uganda, where decentralization involved all sectors, district administrators believed that health services were already well funded, so they allocated money to other services.¹⁰ The central ministry of health responded to the problem by establishing district grants to ensure that priority programs were adequately funded, and donors supplemented the grants with funding for key reproductive health programs. The combined response helped Uganda cope with its HIV/AIDS crisis.¹¹

Equity may also be a casualty of decentralization, since some local jurisdictions are likely to have more resources than others, as was the case in

Mexico.¹² To ensure that certain services are available for vulnerable populations, the central government can set aside or earmark funds for health when transferring central funds to the localities, or it can use weighted formulas to grant more funds to districts with higher concentrations of “at-risk” or poor populations.

Public-Private Partnerships

Health sector reform recognizes that the public and private sectors have separate but complementary roles and tries to make the best use of their comparative advantages. There are many possible sources of health care funds, both public and private: general taxation, payroll taxes for social health insurance, contributions to private or community-based insurance, and direct out-of-pocket payments from clients to providers. Most countries rely on a combination of public and private sources that are then used to pay for health services from a variety of public and private providers, such as the ministry of health,

nongovernmental organizations (NGOs), private doctors, and traditional practitioners (see Table 1).

In places where consumers can choose among providers, private providers have a strong incentive to tailor their services to meet client preferences, so as to retain more clients. But the providers may not serve the poorest citizens, provide a full range of services, or reach remote areas. Under health sector reform, many countries have chosen to implement a “purchaser-provider split.” Under such an arrangement, the government is responsible for raising money for health care but purchases some services through contracts with private-sector providers.¹³ Colombia and Ghana are among the countries that have used public-private partnerships.

In Colombia, insurance entities act as purchasers of health services, allowing patients to choose whether to use their insurance coverage at private- or public-sector providers. By regulating competition and giving users choices, the system creates incentives for both public and private providers to offer efficient, high-quality services to attract and retain patients.¹⁴

In Ghana, private providers in areas without public-sector facilities have begun offering a government-defined package of essential health services. The ministry of health provides training, equipment, and logistical assistance to these providers.¹⁵ The partnership has increased the coverage of family planning services in the country.

Integration of Service Delivery

In the pre-reform years, public health services such as family planning, immunization, and tuberculosis prevention and treatment were typically provided through stand-alone, “vertical” programs that rarely coordinated their efforts or pooled resources with other services. Combining separate health services into a single restructured system has been a key initiative in health sector reform. In principle, such a combination can improve services and reduce costs by putting the same infrastructure, equipment, supplies, and personnel to multiple uses. In addition, patients are likely to seek several services at each visit. Integration can improve overall efficiency, but it can also lead to a loss of focus on certain services—such as reproductive health—because providers must spread their time and resources over a wider range of health services.¹⁶

Experience shows that conscious efforts are needed to ensure that integration works well. Effective referral systems must be in place, and strong management skills are needed because administrative functions such as planning, budgeting, purchasing, and providing training are more complex under integrated systems than under stand-alone programs. In an integrated system, consumer demand influences which services are provided, so consumer education is another important part of integrating service delivery.

Policy Change

Most health systems have multiple subsystems, with an intricate network of entities that perform different functions at different levels of the system. As reform is implemented, a steward—usually the ministry of health—must monitor the system to ensure that the reform’s goals are attained. At the policy level, reform measures include setting priorities and providing oversight, as well as changing laws and regulations.

Setting Priorities and Providing Oversight

The government’s role in health sector reform is to set the vision and direction for the health system, outline priorities, and create policies to achieve its vision. The government’s oversight role covers the whole system, including the public and private sectors and the interface between the two (as in the case of public-private partnerships discussed earlier). The government’s role also extends to functions such as purchasing and service delivery that must be carried out in accordance with overall policy.

In countries where external assistance plays a significant role in the health system, priority-setting and oversight may have an international dimension. One option for coordinating programs, the sector-wide approach (SWAp), is a partnership between the host government and donor agencies. The SWAp creates a single program of work and spending for the health sector, with common planning, management, and monitoring arrangements. SWAps are designed to eliminate the inefficiencies and waste associated with multiple and parallel projects financed by different donors. Early SWAps have had varying levels of success. The successful efforts have increased the governments’ ability to plan and implement reform initiatives and there-

Box 3

Advantages and Disadvantages of Selected Health Sector Reform Initiatives

Reform Initiative	Advantages	Disadvantages
Alternative approaches to finance (user fees, insurance schemes, provider payment reforms)	Creates a broader financial base, reduces dependence on donors, and relies more on consumers' willingness to pay	May deprive poor and vulnerable groups of essential services and may put financial concerns before the population's health needs
Decentralization	Resources are allocated according to local needs rather than government dictates	May exacerbate problems related to weak capacity, mismanagement, politicized decisionmaking, and corruption
Greater private-sector involvement	Encourages more efficient use of resources and allows more flexibility and innovation	Quality, innovation, and efficiency are not guaranteed by private sector; no mandate to help the poor
Integrated services	Eliminates waste, duplication, and lack of coordination that arises from stand-alone services	May reduce the focus of funding and technical oversight for priority programs; makes more demands on managers and staff

SOURCE: Adapted from T. Merrick, *Reproductive Health and Health Sector Reform: Challenges and Opportunities* (2002).

fore have been an important step toward sustainable reforms.

When setting priorities for the nation's health budget, government planners must weigh reproductive health care against many other needs, such as combating malaria, tuberculosis, and serious childhood diseases. In some countries, governments have tried to establish priorities by creating a profile of the population's "burden of disease," an overall measure of the causes and consequences of premature death and disability in a population. Analysts estimate how many years of healthy life are lost to death or disability caused by a range of health conditions. Planners then adjust spending to address the most urgent needs. But policymakers who use these calculations may undervalue reproductive health—especially family planning—because pregnancy is not a disease and the benefits of preventing unplanned births go well beyond preventing death and disability.¹⁷

Changing Laws and Regulations

Whether or not the government provides services directly, it plays a critical role in regulating the health sector. The legal and regulatory reforms

that often accompany organizational reforms involve making rules to govern behavior and ensuring compliance from all actors in the health system. For example, the government can use this regulatory power to make contracts with private health care providers, specifying the services to be provided and the required level of quality. Since they establish the framework within which specific services can be delivered, regulation and oversight are key concerns for both governments and reproductive health advocates.

Useful legal and regulatory reforms include the development of new clinical protocols and standards for delivering services, as well as the dissemination of existing standards. Reforms might also include eliminating overly restrictive laws and regulations, such as those that prevent private practitioners from providing family planning services. For example, Chile, Morocco, Tunisia, and Turkey are exploring or implementing ways to allow midwives and nurses to provide certain types of obstetric care that were previously provided only by physicians. Eliminating heavy import duties or value-added taxes on reproductive health supplies such as contraceptives might also enhance reproductive health.

The Reform Process's Implications for Reproductive Health

Any of the changes made under health sector reform can alter the status quo, creating “winners” and “losers” in the health system. Health sector reform is therefore more than a technical exercise; it is an intensely political activity. The reform process requires elaborate efforts to build consensus among a number of stakeholders, both within and outside the health sector, including health workers, ministry officials, researchers, professional associations, consumer groups, other government agencies, the media, and international donors. Without broad support, health reform efforts are likely to fail.

Health sector reform profoundly alters how health services are financed and delivered, in turn influencing how reproductive health care is provided. Many reproductive health priorities, such as improving service quality and client satisfaction, educating consumers, and providing more choices, are consistent with health sector reform. However, reforms inevitably involve trade-offs and can have negative effects, as illustrated in Box 3. Reforms can also take years to complete, leaving many programs on hold until health systems are reorganized. But specific measures can be taken to avoid the potential pitfalls.

Another challenge for reproductive health proponents is gaining political support for services that serve mainly women. Women often have less political representation and less education than men, so their role in public policy debates has been more limited. Moreover, the people facing the most serious reproductive health risks—especially rural and illiterate women—are the least likely to have a public voice in deciding which services will be provided.

What Needs to Be Done?

Reproductive health managers and advocates interested in influencing how services are funded and provided need to become familiar with the objectives, principles, and strategies of health sector reform and to take part in policy discussions at the national and local levels.¹⁸

Engage in Continuous Dialogue With Health Planners

Mechanisms may vary from country to country, but groups working on health sector reform and reproductive health need to share information regularly.

Reproductive health specialists need a place at the table when critical decisions are made about the financing, organization, and regulation of services are made; having allies inside the government can be essential for gaining access to the process. Advocates and policymakers who are concerned about reproductive health should help ensure that reforms contribute to improvements in the health system's performance and in reproductive health and rights.¹⁹

Show That Reproductive Health Is a Good Investment

To influence the reform agenda, reproductive health advocates need to communicate with policymakers and provide evidence that reproductive health accounts for a significant proportion of the country's overall disease burden and has social implications beyond the burden of disease; that interventions for reproductive health are cost effective; and that gross inequalities in reproductive health status and the allocation of resources can and should be addressed.²⁰

Use Participatory Approaches to Influence Decisions and Monitor Progress

Participation at the local level, where reproductive health advocates can play a significant role in public debates, is particularly important. Various stakeholders, including religious organizations, community associations, professional groups, legislators, researchers, women's groups, and clients and consumers of services, should take part. Participatory processes that establish clear program goals and measurable indicators of progress can be essential in bringing together health reformers and reproductive health proponents. Donors might consider investing in increasing the technical and analytical capacity of local administrators and civil society organizations in order to help those groups take part in shaping health reform.

Health sector reform has the potential to improve both the quality and the sustainability of reproductive health services, but its success depends in part on participation from a range of stakeholders, including those who represent providers and consumers. It is also important that local health administrators know how to solicit and use the input of diverse stakeholders and be able to address reproductive health issues in a transformed health system.

For Further Information

Partners for Health Reform *plus*, Abt Associates Inc. (www.phrplus.org)
Adapting to Change, Learning Program on Population, Reproductive Health and Health Sector Reform, World Bank (www.reprohealth.org)
Clearinghouse on Health Sector Reform in Latin America and the Caribbean (www.americas.health-sector-reform.org/english/index1.htm)

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