Partners for Health Reform*plus*

Compendium of Publication Abstracts

August 2004

Partners for Health Reform*plus*

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PHR*plus*

Mission

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

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

August 2004

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Center for Population, Health and Nutrition
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United States Agency for International Development

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Technical Reports

Africa

Case Study on the Costs and Financing of Immunization Services in Ghana

Technical Report 001

Ann Levin, Sarah England, Joanne Jorissen, Bertha Garshong, and James Teprey

63 pages (September 2001) • Order No. TE 001

This study estimates the current and future costs of Ghana's immunization program, including the additional costs proposed for improvements to the program, both to assist planning and to inform the international community about global immunization costs. The estimated total cost of the national program, including national immunization days (NIDs) and surveillance, was about $8.0 million in 2000—about $0.41 per dose, $16.63 per fully immunized child, and $0.43 per capita. Forty percent of total cost was for personnel, 30 percent for vaccines, and 6 percent for capital costs. The estimated total cost of the routine program was $3.7 million—with personnel comprising 42 percent, vaccines 25 percent, and capital costs 8 percent. The estimated total cost of NIDs and surveillance was about $3.9 million, about 49 percent of total program costs. The largest cost component of NIDs was vaccines (37 percent), followed by personnel (34 percent) and social mobilization (16 percent). The recurrent, variable non-personnel costs of the program, for which the Ministry of Health must find financing each year, are approximately $4.3 million, or about 55 percent of total estimated costs; vaccines account for 55 percent of these costs. The annual cost of improvements proposed for the national immunization program range from $650,000 to $3,200,000 for catch-up campaigns, disease control campaigns, and cold chain improvements, to higher costs for the introduction of new vaccines. The cost of adding new vaccines is substantial and will vary on the presentation of the vaccine. If the DTP-HepB-HiB presentation is used, the new vaccine will cost $7.3 to $7.9 million for a full year; if DTP-HepB is used, the new vaccine will cost $2.8 million to $3.1 million annually; and if HepB is used, the new vaccine will cost $0.7 to $0.8 million. Cost savings can be realized in three ways: (1) improving vaccine distribution system, (2) decreasing vaccine wastage; and (3) motivating health workers to increase efficiency.

Impact of Prepayment Pilot on Health Care Utilization and Financing in Rwanda: Findings from Final Household Survey

Technical Report 002

Pia Schneider and François Diop

99 pages (October 2001) • Order No. TE 002

This household survey conducted by Partnerships for Health Reform (PHR) and the Rwandan Ministry of Health evaluates the impact of prepayment schemes on access to health care for poor households. Rwanda is one of the poorest countries in the world: approximately 70 percent of the population of 8 million lives below the poverty line (World Bank, 1998). During the humanitarian assistance period that followed the genocide in 1994, public health care services were financed by donors and the government and provided free to patients. In 1996, the Ministry of Health

re-introduced pre-war level user fees in health facilities. Following this, utilization of primary health care services dropped from a national average of 0.3 annual consultations per capita in 1997 to 0.25 in 1999. This sharp drop in demand for health services, combined with growing concerns about rising poverty and poor health outcome indicators, motivated the Rwandan government to develop prepayment schemes to assure access to the modern health system for the poor. In early 1999, the Ministry of Health in collaboration with the local communities and the technical support of PHR started the process to pilot test prepayment schemes in three health districts. At the end of their first operational year, the 54 schemes counted 88,303 members. Detailed analysis of the pilot phase has revealed that members reported up to four times higher health service use than non-members. Based on household survey data, the findings presented in this report reveal that insurance enrollment is determined by household characteristics, such as the health district of household residence, education level of household head, family size, distance to the health facility, and radio ownership, whereas health and economic indicators did not influence the demand for health insurance. The analysis confirms earlier findings reported by PHR based on provider data: health insurance has significantly improved equity in financial accessibility to maternal, preventive, and curative care for members while at the same time out-of-pocket spending has gone down per episode of illness. Survey findings suggest that the Rwandan health financing policy endorse and promote prepayment as a valuable alternative to the still dominating out-of-pocket user fee payments.

The Impact of Self-assessment on Provider Performance in Mali

Technical Report 008

Edward Kelley, Allison Gamble Kelley, Cheick Simpara, Ousmane Sidibé, and Marty Makinen

11 pages (March 2002) • Order No. TE 008

This study was a cross-sectional, case-control study testing the impact of self-assessment on quality of care in a peri-urban area in Mali. The two indicators of interest were compliance with fever care standards and compliance with structural quality standards. The study examined 36 providers, 12 who were part of the intervention and 24 who were part of the control group over a three-month period from May 2001 through July 2001. Overall, the research team found a significant difference between the intervention and control groups in terms of overall compliance ($p<0.001$) and in terms of assessment of fever ($p<0.005$). The total costs for the intervention for 36 providers was less than US$250, which translated to approximately $6 per provider. The data appear to suggest that self-assessment, when used in a regular fashion, can have a significant effect on compliance with standards. Future research on self-assessment should include a larger sample of providers and should examine the impact of self-assessment over time.

Preliminary Review of Community-Based Health Financing Schemes and Their Potential for Addressing HIV/AIDS Needs in Sub-Saharan Africa

Technical Report 010

Natasha Hsi, Janet Edmond, and Alison Comfort

30 pages (June 2002) • Order No. TE 010

The HIV/AIDS epidemic is present in many of the countries in Africa where Community-Based Health Financing (CBHF) schemes have taken hold, and it poses many problems for these communities and schemes due to the dynamic nature and pattern of transmission, the complexity of treatment regimens, the challenges of prevention, and the costs of delivering HIV/AIDS services. The Partners for Health Reform*plus* project (PHR*plus*) has been providing technical assistance to a number of CBHF schemes in sub-Saharan Africa over the past several years in areas such as financial management, social mobilization, and risk management. This paper examines what these existing CBHF schemes in sub-Saharan Africa have done to address HIV/AIDS in terms of providing

prevention and/or care and support services in the benefits package through either implicit or explicit mechanisms. The findings reveal that CBHF schemes know very little about the prevalence of HIV in their membership pool due to a lack of voluntary testing and counseling; nor are they aware of the impact that HIV/AIDS is having on their members. Some schemes cover HIV-positive patients implicitly because scheme benefits include coverage for specific diseases and conditions that may be HIV-related. Other schemes do not cover HIV-related diseases but refer those perceived as having HIV/AIDS to national AIDS control programs. HIV/AIDS poses problems both to the financial sustainability of a CBHF scheme and to the scheme's capacity to provide quality health services for HIV-related health problems. Based on the dearth of knowledge on the subject and the limited findings, this paper recommends two areas for further research and investigation: 1) examine whether it is feasible or desirable for international donors and governments to contract with CBHF schemes in order to provide HIV/AIDS services; 2) explore various aspects of incorporating HIV prevention and care and support services into existing benefits packages of CBHF schemes, or how they can link with existing non-governmental organizations that provide HIV/AIDS services.

A Survey of Health Financing Schemes in Ghana
Technical Report 013
Chris Atim, Steven Grey, Patrick Apoya, Sylvia Anie, and Moses Aikins
82 pages (September 2001) • Order No. TE 013

This report looks at health care financing schemes in Ghana, in the public, private commercial, and community sectors. Government schemes examined were an abortive pilot of national insurance, a User Exemptions scheme, and a program for public sector employees. The first private sector insurance company collapsed, though more recently company set-ups have increased greatly in number. Schemes in both sectors have struggled or failed due to non-compliance and abuse by users and providers, and poor communication between different kinds of schemes, which leads to overlap and wastage. Community schemes (mutual health organizations, or MHOs) have gained in popular and donor support especially in the past two years. While they are not a panacea for resolving health care financing and delivery issues, many of their limitations – small size, limited benefits, and inability to cover all segments of the population, especially the poorest – can be overcome with appropriate design and management. The report recommends ways to encourage sustainability of MHOs, such as regulation, coordination, and reinsurance, and a national underwriting fund. These issues and recommendations are intended to inform policymakers who must decide financing and other matters regarding the schemes.

Assessment of the Community Health Fund in Hanang District, Tanzania
Technical Report 015
Grace Chee, Kimberly Smith, and Adolph Kapinga
106 pages (July 2002) • Order No. TE 015

The Tanzanian Community Health Fund (CHF) was established by the Ministry of Health on a pilot basis in December 1995. Its purpose was to ensure the availability of quality health services at affordable prices and to mobilize additional resources for the provision of health care. The CHF is essentially a district-level prepayment scheme for primary care services targeted at the rural population and the informal sector. A household joins the CHF by paying an annual membership fee, which provides unlimited access to outpatient services at CHF-participating facilities. User fees at health centers and dispensaries are implemented as part of the introduction of the CHF, as is an exemption policy to ensure that families who cannot afford to pay the membership fees obtain a free CHF card. CHF providers are mainly public sector facilities, although the intention of the scheme is to include private sector and mission providers. The CHF is currently operating in 23 districts, with

the goal of implementation in all districts by 2003. In 2001, the CHF Act established the CHF as a key component of the health financing strategy. This assessment was conducted in Hanang District to provide CHF administrators with data and recommendations to improve the management and utilization of the CHF throughout Tanzania. The assessment findings reveal that the CHF is mobilizing resources (both CHF membership and user fees) for health care services, though the majority of the contribution for the last two years is from user fees. Membership rates are fairly low and, with the exception of 1999, have declined since the implementation of CHF in Hanang in 1998. CHF resources have been used to improve the quality and range of services throughout Hanang district. However, the majority of CHF funds have been used for the construction of the district hospital and many facilities/wards have significant unused balances of CHF funds. Assessment findings suggest that overall CHF management and information systems require improvement. The CHF has a decentralized management structure, which seeks to promote involvement of the communities, but in practice community participation is limited. Training for district, ward, and health facility staff is needed to strengthen their capacity to effectively manage the CHF. In addition, effective implementation of an exemption policy is required to ensure that the poor are not excluded from accessing care.

Sources of Financial Instability of Community-Based Health Insurance Schemes: How Could Social Reinsurance Help?

Technical Report 024
Alan Fairbank and François Diop
41 pages (July 2003) • Order No. TE 024

Community-based health insurance (CBHI) is a promising component of health financing reform in developing countries, offering protection to individuals against the potentially high costs of a sudden illness or injury. But, because CBHI schemes may themselves run the risk of insolvency, advocacy of CBHI scheme development has brought parallel concerns that the plans themselves need protection from the various kinds of financial risks that could jeopardize their survival. One potentially helpful mechanism is social reinsurance that would cover CBHI schemes for the risks of bankruptcy in return for their payment of relatively small premiums. In principal, social reinsurance offers such "survival" benefits primarily to relatively small insurance plans that would each have insufficient reserves to weather a bad year (when expenses would greatly exceed income). But, in practice, the requirements of developing a potentially beneficial social reinsurance mechanism are considerable. This paper is an effort to analyze the varied threats to financial stability that CBHI schemes face and to explore what role social reinsurance might play in helping to preserve their solvency. The paper discusses the range of potential threats to the financial stability of CBHI schemes, and distinguishes between those that are avoidable (due to nonrandom events) and those that are unavoidable (due to random events). The paper describes the terms and conditions under which a social reinsurance program could be designed to provide reinsurance coverage of the simplest type – excess loss (stop-loss) coverage. It discusses the requirements for designing and implementing such a program, describes a general rule for determining a fair premium, and explains why substantial (and indeterminate) subsidies would be required for at least five years before a social reinsurer would (at best) achieve breakeven status. It details how the lack of needed data and the threats from avoidable risks make the need for additional subsidies – particularly for technical assistance – virtually certain. With this kind of uncertainty about the requirements for subsidies and the length of time they may be needed, the early emphasis of technical assistance may be most profitably focused on preventing the *avoidable* risks faced by CBHI schemes, while the long-term prospects for social reinsurance – as designed to address the *unavoidable* threats – are more fully developed.

The Costs of Anti-Retroviral Treatment in Zambia
Technical Report 029
Gilbert Kombe and Owen Smith
40 pages (October 2003) • Order No. TE 029

This report analyzes the costs and resource requirements associated with the provision of anti-retroviral (ARV) therapy in the public health sector in Zambia. It provides per-patient cost estimates for highly active anti-retroviral therapy (HAART), voluntary counseling and testing, several opportunistic infections, and prevention of mother-to-child transmission services. These per-patient cost estimates are used to project total program costs, which are then compared to currently budgeted resources with an emphasis on financial sustainability. The report also explores a range of policy issues, including the importance of human resource constraints; the implications of alternative monitoring protocols and drug regimens; opportunities for resource mobilization; and targeting issues. The provision of ARVs in Zambia is a dynamic issue: certain programmatic decisions have yet to be made, and both prices and technologies are changing rapidly. Thus, the purpose of this report is to highlight the key questions related to HAART costs, rather than to propose any definitive answers.

Geographic Aspects of Poverty and Health in Tanzania: Does Living in a Poor Area Matter?
Technical Report 030
Mahmud Khan, David Hotchkiss, Andrés Berruti, and Paul Hutchinson
30 pages (October 2003) • Order No. TE 030

Previous studies have consistently found that that there is an inverse relationship between household-level poverty and health status, and that poor people tend to live in poor communities. However, what is not well understood is whether and how the average economic status at the community level plays a role in the household poverty–health relationship. This study investigates the concentration of poverty at the community level in Tanzania and its association with the availability and quality of primary health care services, the utilization of primary health care services, and health outcomes among both poor and non-poor households. The analysis uses an innovative approach of linking household-level data from 1996 Tanzania Demographic and Health Survey with facility information from the 1996 Tanzania Service Availability Survey. A principle component method is used to rank households separately by urban/rural status according to the reported levels of assets ownership and living conditions, and then classifies communities into three socioeconomic groups based on the proportion of households belonging the poorest wealth tercile. On average, both poor and non-poor households living in low poverty concentration areas were found to have better health outcomes and service utilization rates than their counterparts living in high poverty concentration clusters. Consistent with the finding is that high poverty concentration areas were farther way from facilities offering primary health care than were low poverty concentration areas. Moreover, the facilities closest to the high poverty concentration areas had fewer doctors, medical equipment, and drugs. Among poor communities in rural areas, the ten communities with the best women's body mass index (BMI) measures were found to have access to facilities with a greater availability of equipment and drugs than the ten communities with the worst BMI measures. Although this study does not directly measure quality, the characteristics that differentiate high poverty concentration clusters from low poverty concentration clusters point to quality as more important than physical access among the study population.

Improving Hospital Management Skills in Eritrea: Costing Hospital Services Part 1, 2001-2002
Technical Report 033
Stephen Musau
31 pages (November 2003) • Order No. TE 033

Information on the costs of providing health care services is critical in the decision-making process of any ministry of health. In many developing countries, such information is not readily available due to the inadequacy of the financial information systems to routinely produce useful information. This is often coupled with a lack of skills to do ad hoc cost analyses that would help bridge this information gap. In a vicious circle, the demand for financial information by health care managers is virtually non-existent, and this contributes to the paucity of such information since those who should produce it are not under any pressure to do so.

In contrast, the Eritrean Ministry of Health has expressed the need for good financial information in its efforts to reform the health sector. Hospitals consume a large portion of the resources available to the Ministry; thus, it is important to know how much it costs to provide hospital-based health care. This report describes the beginning of a process to address this need. The costing work was carried out as part of a technical assistance package to develop hospital management skills of senior staff in the Ministry headquarters and selected hospital and regional health management teams; the management skills targeted include financial management skills. This costing report represents the first phase in the costing of health services in Eritrea.

The Community Health Fund: Assessing Implementation of New Management Procedures in Hanang District, Tanzania
Technical Report 034
Stephen Musau
21 pages (January 2004) • Order No. TE 034

A key obstacle to the success of community-based health insurance initiatives in Africa is the dearth of well-trained health managers who can design and run the insurance schemes in a viable manner. Internal management controls are often not adequate to ensure the fund is protected from misuse and fraud carried out by members or its own staff. The Community Health Fund in Hanang district in Tanzania has introduced management procedures that help it to exercise control over revenue collection and reporting and provide management with sufficient information to assess the Fund's performance. This report looks at the implementation of the new management procedures, identifies successes and shortcomings in fulfilling record keeping and reporting requirements in particular, and recommends steps to improve record keeping at health care facilities, reporting of data to the district level, and use of the new data by the district**.**

Scaling Up Antiretroviral Treatment in the Public Sector in Nigeria: A Comprehensive Analysis of Resource Requirements
Technical Report 037
Gilbert Kombe, David Galaty, and Chizoba Nwagbara
27 pages (February 2004) • Order No. TE 037

This report presents estimates of the total cost of providing comprehensive antiretroviral (ARV) treatment in the public sector in Nigeria, using the AIDSTREATCOST model to estimate the cost of providing Highly Active Antiretroviral Therapy (HAART), Voluntary Counseling and Testing (VDT), and Opportunistic Infection (OI) treatment, and other resource requirements for implementing the national antiretroviral (ARV) treatment program.

Drugs are not the only major cost of an ARV program, but they are the largest single component ($368, or 62 percent of the total annual program cost of $591 per patient); monitoring tests account for almost 30 percent of total program costs.

A large proportion of current treatment costs is borne by the patient – $170 per year for monitoring and $86 for ARV drugs. This is equivalent to almost 75 percent of per capita GDP and therefore well beyond the resources of most Nigerians. Patients also are expected to pay for VCT services ($11), and for OI treatment costs when these arise. The development of an effective ARV program, therefore, must include support not only for ARV drugs but all aspects of patient cost.

The report also examines financial and human resources requirements for achieving the World Health Organization-recommended targets and recommends a number of strategies for the government and development partners to consider regarding program expansion, human resources training and requirements, support for VCT, the high cost of monitoring tests, and drug cost.

Knowledge, Attitudes, and Practices Related to Maternal Health in Bla, Mali: Results of a Baseline Survey
Technical Report 040
Kimberly Smith, Tania Dmytraczenko, Beaura Mensah, and Ousmane Sidebé
25 pages (May 2004) • Order No. TE 040

This report presents the results of a baseline survey conducted in the rural district of Bla in Mali to investigate levels of knowledge, attitudes, and practices related to maternal health care among women of reproductive age and corresponding household heads. The main objectives of the study were to guide the development of an information, education, and communication (IEC) intervention and to serve as a baseline for future comparison after the implementation of the IEC intervention.

The survey results show a significant discrepancy between perceived importance of maternal health services (prenatal, delivery, and postnatal) and actual use among women in Bla. General knowledge about maternal health care, including the number and timing of antenatal and postnatal visits and danger signs before, during, and after delivery, was moderately high. The main reasons cited for non-use of prenatal and postnatal care were lack of need and the costs related to visiting the health center. The findings suggest that both knowledge and financial constraints affect women's health seeking behavior. The survey also found that household heads and husbands are the primary decision makers regarding pregnancy-related care, and that they tend to have surprisingly similar perceptions of and knowledge about maternal health care as the women interviewed. However, financial and information constraints may affect the ability of household heads to make care seeking decisions that are best for women's health during and after pregnancy.

Estimating the Cost of Providing Home-based Care for HIV/AIDS in Rwanda
Technical Report 045
Rudolph Chandler, Caytie Decker, and Bernard Nziyige
32 pages (June 2004) • Order No. TE 045

Home-based care (HBC) for HIV/AIDS is increasingly looked to as a more accessible and affordable alternative to more costly inpatient care, both for patients who are unable to travel to or pay for inpatient care as well as for governments that must fund inpatient facilities. Partners for Health Reform*plus* estimated the cost of HBC for HIV in Rwanda, based on a sample of eight programs offering care in early 2004. The sample comprised facility- and community-based programs. Both types of program implement the medical care recommended in the Ministry of Health guidelines for HBC. Facility-based care focuses on health care, utilizing a combination of health professionals and volunteers, delivering higher levels of care and offering referrals to facilities with which they are associated. Community-based care offers a more holistic approach including psycho-social support, not only to people living with HIV/AIDS but to entire households. The study found that facility-based care has higher estimated costs per client than community-based care, with monthly costs per client ranging from approximately $ 31.20 to $36.01 per month, the cost of community-based care ranged from $ 12.75 to $ 24.53 per month. Up to 50 percent of program costs are attributed to food assistance – highlighting the poverty faced by many households. Staff and per diem costs account for 12-37 percent of total costs. Drugs and medical supplies costs account for small percentage of total costs, averaging only 2 percent of total costs. Both types of program rely on volunteer assistance, and staff attrition is a concern.

Asia and Near East

Implementing Hospital Autonomy in Jordan: An Economic Cost Analysis of Princess Raya Hospital
Technical Report 007
Dwayne Banks, Ayoub As-Sayaideh, Abdel Razzaq Shafei, and Alia Muhtaseb
59 pages (January 2002) • Order No. TE 007

Faced with limited resources and increased demands being placed upon its health care sector due to changing pattern of diseases and rising consumer expectations, the Ministry of Health (MOH), of the Hashemite Kingdom of Jordan is seeking ways to improve the operating efficiency of its 23 public hospitals. One way to achieve the objective is to provide hospital directors with greater managerial control over their daily decision-making. As such, the government of Jordan has been engaged during the past three years in a hospital autonomy (hospital decentralization) pilot project with Princess Raya and Al Karak hospitals. To date the MOH has completed the first three phases of that project: Phase 1 (the pilot site selection process), Phase 2 (the implementation of short-run changes in operating procedures), and Phase 3 (estimating the costs of services at the hospitals). This document details Phase 3 activities, presenting the first-ever detailed cost analysis of Princess Raya hospital. This analysis is of import, given that the MOH is considering the allocation of a partial or complete operating budget to the hospital director, at a later date.

Demographic Transition and Economic Opportunity: The Case of Jordan
Technical Report 011
David Bloom, David Canning, A.K. Nandakumar, Jaypee Sevilla, Kinga Huzarski, David Levy, and Manjiri Bhawalkar
33 pages (April 2001) • Order No. TE 011

To take economic advantage of the extensive demographic transition expected to take place in Jordan over the coming 40 years, that country's decision makers need to create policies that appropriately deal with demographic change. To do so, they need to be aware of the changes that have occurred in the past half-century due to improvements in nutrition, health care and sanitation, and to understand what more will occur in the future. The current study employs a sophisticated model of economic growth to examine the relationship between demographic change and economic development. It looks at how changes in mortality, fertility, and death rates, as well as recent immigration, will create a "population momentum." The model predicts an average 5.6 percent increase in per capita gross domestic product over the period 1990-2015, an accelerated rate of economic growth due to different demographic growth rates of working-age and overall populations. To realize such growth, however, will require policies to further reduce fertility rates; to encourage investment in human capital, job creation, and openness to the global economy; and to provide for health care and pension needs of an increasingly elderly population.

Implementing Hospital Autonomy in Jordan: An Economic Cost Analysis of Al Karak Hospital
Technical Report 014
Ayoub As-Sayaideh, Abdel Razzaq Shafei, Dwayne Banks, and Alia Muhtaseb
66 pages (June 2002) • Order No. TE 014

Faced with limited resources and increased demands being placed upon its health care sector due to the changing pattern of diseases and rising consumer expectations, the Ministry of Health (MOH) of the Hashemite Kingdom of Jordan is seeking ways to improve the operating efficiency of its 23 public hospitals. One way to achieve the objective is to provide hospital directors with greater managerial control over their daily decision-making. As such, the government of Jordan has been engaged during the past three years in a hospital autonomy (hospital decentralization) pilot project with Princess Raya and Al Karak hospitals. To date the MOH has completed the first three phases of that project: Phase 1 (the pilot site selection process), Phase 2 (the implementation of short-run changes in operating procedures), and Phase 3 (estimating the costs of services at the hospitals). This document details Phase 3 activities, presenting the first-ever detailed cost analysis of Al Karak hospital. This analysis is of import, given that the MOH is considering the allocation of a partial or complete operating budget to the hospital director, at a later date.

The Provision of Reproductive Health Services in Private Hospitals in Amman, Jordan
Technical Report 027
Dwayne Banks and Manal Shahrouri
31 pages (September 2003) • Order No. TE 027

To help the Jordanian Ministry of Health (MOH) gain baseline information on services offered by private acute care hospitals and assess the capacity and willingness of these hospitals to participate in a Health Insurance Pilot Program (HIPP), the Partnerships for Health Reform*plus* project carried out a survey of the 30 private acute care hospitals in Amman. The HIPP proposes to contract with hospitals to provide reproductive health services to MOH patients. The survey, which measured the availability of a broad range of hospital services, focused on prenatal, delivery, and postnatal services

in order to ascertain whether the hospitals offered the services that are included in the HIPP benefits package. It also looked at hospital staffing, and it queried the satisfaction of hospitals with existing contracts with the MOH and their willingness to expand contractual relationships, comply with clinical guidelines, and participate in the health information system being established for the HIPP. The survey found that, among the 25 respondent hospitals, more than 90 percent offered the reproductive health services in the HIPP package. While all hospitals expressed a willingness to engage in a contractual relationship with the MOH, many described frustrations with current contracting, and less than half were willing to use the clinical guidelines and the information system. The survey thus provides baseline information on services and helps the MOH to understand the steps it must take to enhance its contracting with private sector facilities.

The Impact of PhilHealth Indigent Insurance on Utilization, Cost and Finances in Health Facilities in the Philippines

Technical Report 039
Pia Schneider and Rachel Racelis
92 pages (April 2004) • Order No. TE 039

In the Philippines, the PhilHealth's Indigent Program (IP) is an insurance plan for the poor. The premium is subsidized by the local government budget, administered by mayors. The IP covers care in public rural health units (RHUs) and in hospitals. At present IP enrollment rates vary widely across the country. Because PhilHealth reimburses RHUs a capitation amount per IP enrolled household, revenue in RHUs increases with more IP members. PhilHealth reimburses hospitals on a fee-for-service basis. This study examines the effect of the PhilHealth IP on the delivery and financing of health care in RHUs, and eventual spillover effects in government hospitals in areas of high and low IP enrollment. The analysis uses monthly data collected in RHUs and hospitals to evaluate the financial situation in facilities; the availability of drugs and other medical supplies; utilization of medical and family planning serves; and recurrent costs of providing care in RHUs. Findings suggest that higher IP enrollment rates lead to a higher proportion of total provider revenue paid by PhilHealth, improved management of drugs and family planning, and higher utilization rates for IP insured. However, overall utilization rates in RHUs have remained on a very low level. Also, results from the econometric cost analysis suggest no association between total recurrent costs and IP visits in RHUs; rather, RHUs are operating under capacity, signifying wasted resources. The mayors of local governments, which own RHUs and are responsible for their financial management, could improve the financial situation in RHUs by decreasing average cost levels, by increasing the number of poor households in the IP and by informing IP members, and the uninsured about their right to use services.

Eastern Europe

Organization and Financing of Primary Health Care in Albania: Problems, Issues, and Alternative Approaches

Technical Report 021
Alan Fairbank and Gary Gaumer
70 pages (April 2003) • Order No. TE 021

The Albanian health system has recently experienced organizational and budgetary changes that have given important roles to relatively new agencies. Since 1995, the Health Insurance Institute (HII) has become a major funder of doctors' salaries and drugs for primary health care (PHC) services. Since 1998, as part of the government's decentralization initiative, the Ministry of Local Government and Decentralization (MoLG&D) has channeled budgets for operating and maintenance costs of PHC

facilities (previously funded by the Ministry of Health (MOH) budget) through block grants to local governments, which then determine how much is allocated to PHC. The effects of these changes have been to fragment the funding and administration of PHC services in Albania, which had previously been the exclusive responsibility of the MOH. While these changes have taken place, USAID and others in the donor community have partnered with the government to rehabilitate and reequip many health facilities that had been damaged during the civil unrest earlier in the decade. In this uncertain environment, the USAID-funded PHR*plus* Project is developing model PHC clinics in four sites in one region of Albania in an effort to demonstrate ways to improve systems performance. One element of the project is to assist the Government of Albania to design and implement improved methods for the planning, budgeting, and financing of these PHC services. A major part of the technical assistance in these areas has been to analyze the complex and disparate sets of data on flows of funding, how they have changed, and how those changes have affected accountability for PHC systems performance. Using these data, this report develops the basis for designing alternative ways to organize and manage the PHC service delivery system, taking account of a recent change in government policy that would unify all funding for PHC in one agency—the Health Insurance Institute (HII). After developing and applying criteria for choosing among two options for reorganizing management of PHC, assuming the HII would become the single source of financing, this paper recommends an alternative that would create regional health offices to supervise and manage PHC in each region, with increased levels of autonomy for individual PHC practices. The report also describes the principal elements of a proposal for a pilot project to test in one region the implementation of the recommended reorganization of PHC using the HII as a single source of PHC financing.

Assessment of Vaccine Preventable Disease Surveillance Systems in Georgia

Technical Report 028

Ministry of Labor, Health and Social Affairs of Georgia; and National Center for Disease Control

94 pages (July 2002) • Order No. TE 028

Surveillance of vaccine preventable diseases (VPDs) is an important part of estimating burden of diseases, identifying pockets of susceptibility, deciding on appropriate measures to prevent and control outbreaks, and formulating policy recommendations to reduce disease burden. A comprehensive understanding of the current Georgian VPD surveillance system is needed in order to provide specific recommendations for system strengthening, on which a plan outlining specific activities for future cooperation can be built.

This comprehensive assessment of the Georgian VPD surveillance system identifies major problems in the Georgian health system that limit the ability of current surveillance efforts to provide quality information to guide public health actions. Key findings include: the structural and organizational linkages and relationships between institutions responsible for VPD surveillance are not well established; a significant number of VPD cases are not recorded by the current system and are treated outside the formal system; VPD surveillance suffers from a lack of clear and recognized standards for case detection, investigation, and control; lack of proper specimen handling and transportation capacity compromises the laboratory confirmation; the system lacks sufficient resources to fully implement VPD surveillance. Strategic directions for VPD surveillance strengthening to counter these problems are also presented.

An Overview of GEOVAC: A Software Application to Monitor Immunization Performance in Georgia
Technical Report 035
Anton Luchitsky and Galina Romanyuk
21 pages (January 2004) • Order No. TE 035

The GEOVAC software application is a tool designed to help personnel of regional level centers of public health and the National Center for Disease Control in Georgia process a large flow of immunization-related data in much less time than the previous (manual) system. It allows them to quickly identify issues and deficiencies regarding immunization coverage, and use and distribution of vaccines, and to assess adequacy of supplies as well as major barriers (medical contraindications, parental refusals, etc.) to the functioning of the immunization system. In doing so, GEOVAC gives health workers more time to focus on the utilization of MIS data for management and disease outbreak response purposes. This second version of the application has gone through numerous revisions and suggestions based on testing in the pilot region. It is now being used nationwide.

The current document illustrates GEOVAC functions, relating them to the features of the upgraded Georgian immunization information system and demonstrating what it can offer immunization managers in the decision making process. It is designed primarily for policymakers in countries planning to strengthen their immunization and/or surveillance systems, donor organizations that can support such reforms and agencies working in these technical areas. It can also help policymakers and health workers in Georgia to plan and implement similar reforms in other sectors of the health care system.

Primary Health Care Reform in Albania: Baseline Survey of Basic Health Service Utilization, Expenditures, and Quality
Technical Report 038
156 pages (February 2004) • Order No. TE 038

A number of problems are thought to affect the provision of primary health care services in Albania, making their reform an important long-term objective. The Partners for Health Reform*plus* (PHR*plus*) Project is currently providing assistance to Albanian counterparts to carry out a primary health care pilot in two districts, whose results are expected to inform a proposed model for the provision of primary health care across Albania and potentially move the country towards a more efficient, higher quality health care system. In order to evaluate the impact of the pilot intervention, the Albanian Institute of Statistics (INSTAT) collected baseline information on the availability and utilization of selected primary health care services prior to pilot implementation in the two pilot districts and in one control district. This information was gathered through facility/provider and household surveys administered in fall 2002. The objective of this report is to describe the information gathered through these baseline surveys, especially with respect to health care supply and utilization patterns for key performance indicators. The facility/provider survey was conducted at 26 health care facilities and included interviews with 110 health care providers. Information was collected on facilities' infrastructure, availability and quality of services, provider training, and management practices. The household survey is based on a sample of 2,000 urban and rural families (8,142 individuals). Information was gathered on the sample's demographic characteristics, household assets, dwelling conditions, health problems, insurance status, preventive and curative health care utilization, contraceptive use, health care expenditures, and perceptions of service quality. As the pilot nears completion, the survey results will be used to investigate whether expected changes in quality, financing, and health care service use occur. Key findings from the baseline survey include the following: vulnerable groups (such as the poor and those living in rural areas) face barriers to accessing appropriate care; the bypassing of lower level health facilities is extensive; the use of modern

contraceptive techniques among women of reproductive age is very low; and out-of-pocket payments for many primary health care services are widespread.

Costs and Utilization of Primary Health Care Services in Albania: A National Perspective on a Facility-level Analysis

Technical Report 043
Alan Fairbank
60 pages (June 2004) • Order No. TE 043

Since 1989, the number of staffed health centers and health posts in Albania has declined significantly – by roughly 40 percent – while average utilization of them has declined even more rapidly – by about 60 percent, from 3.9 visits per person yearly to 1.6 visits per person yearly in 2002. During that period, the total cost of providing the declining level of primary health care (PHC) services has gone up substantially, so that, with much lower utilization, the overall average cost of a PHC visit to a health center or a health post has risen considerably. The clear implication is that the efficiency and productivity with which PHC services are being delivered are much lower than they used to be. This technical report provides and analyzes the evidence that supports this inference, and suggests what steps might be taken to improve productivity and what impact they might have. Two different perspectives are presented. The first part takes a broad perspective on resources spent nationwide on primary health care – including important measures of overall costs and productivity, and focusing on the expenditures by the Health Insurance Institute. The second part focuses detailed analyses on measures of costs and productivity at four specific facilities – the pilot sites of the PHR*plus* Project in Berat and Kuçove. The broader perspective of the first part provides the appropriate context within which to assess the results shown in the second part. Together, the two parts show how financial analysis of cost and utilization can be developed and used to inform policymaking. The data support the following conclusions: that productivity in health centers and health posts located in urban areas is significantly higher than that in such facilities located in rural areas; that the average cost of a PHC visit to a health center or a health post (Lek 500 in 2002) is higher than a visit to a polyclinic (which includes specialty visits) (Lek 310 in 2002); that overstaffing at health centers and health posts accompanies underutilization and results in very low average patient contact times per physician; but that there is potential for improvements in quality and in utilization if (some of the) savings from reductions in staffing were to be partly used to improve availability of supplies and equipment – and that these improvements would improve productivity by lowering the cost per patient visit. This paper presents a hypothetical illustration of such improved productivity from postulated changes in staffing and operations, and concludes with recommendations and with observations about the requirements for, and the implications of, designing and implementing alternative PHC financing and management policies that are suggested.

Informal Payments in the Public Health Sector in Albania: A Qualitative Study

Technical Report 047
Taryn Vian, Kristina Gryboski, Zamira Sinoimeri, and Rachel Hall Clifford
70 pages (July 2004) • Order No. TE 047

This report presents the results of a qualitative survey conducted by the Partners for Health Reform*plus* Project to examine the practice of informal payments for health in Albania's public health system. The main objectives of the study were to better understand the perspectives and experiences of the public and providers about why informal payments occur, the process through which such payments are made, and what these payments mean in the context of Albanian society and

the public health care delivery system. In-depth interviews and focus group discussions were held with members of the public, health care providers, and health facility administrators in three districts.

The evidence from this study suggests that the practice of informal payments for health services is more common in large towns and cities, and in inpatient care settings, particularly for surgery, childbirth, and gynecological care. Factors influencing informal payments in Albania include low salaries of health staff; a belief that health is extremely important and worth any price; a desire to get better quality care; fear of being denied treatment or missing the opportunity to get the best outcome possible; and the tradition of giving a gift to express gratitude. The findings provide insight into the meaning of gifts versus informal payments, highlighting important discrepancies between the providers' and the public's perceptions. Many providers feel that patients voluntarily give informal payments; however, most public informants do not feel that informal payments are voluntary but rather necessary to obtain services. The study shows that the interaction between patients, relatives, and various personnel at the many service delivery points in Albania is complex. Finally, informants' perspectives on the potential effects of informal payments vary. The paper includes a discussion of these findings and their implications for efforts to improve health care and service delivery in Albania, with some recommendations on how to address related issues.

Latin America and the Caribbean

Design Options and Data Needs for the Ambulatory Payment Innovation in the Public Health Care Sector of Peru

Technical Report 003
Alexander Telyukov, Miguel Garavito, Alfredo Sobrevilla, and Luz Loo
52 pages (February 2002) • Order No. TE 003

This report is the first technical deliverable under the Ambulatory Payment Innovation, a pilot project that seeks to identify and promote innovative strategies and mechanisms of ambulatory financing in the public health care sector of Peru. The report contains methodological proposals for provider financing, Health Care Network design, and information systems. The proposed methods of provider financing present an innovative combination of prospectively capitated budgets, service charges for select procedures, patient co-payments, and performance-based distributions according to provider-specific values of a Standards-of-Care Index. The report ponders over the definition of Health Care Networks as an organizational shell in which ambulatory financing reforms are expected to occur in Peru. The study team argues that the existing networks ought to undergo subdivision into more compact entities for the contractual, managerial, and budgeting purposes. The report offers five configurations of the prospectively budgeted systems within the currently defined networks. The proposed methods of financing call for an increased use of information by regulators, purchasers and providers of care. The authors of the report envision the emergence of a health and management information system that will integrate the proposed types of data, most of which can already be found in the institutional domain of the Integrated Social Insurance of Peru.

An Analysis of the Health Component of the Honduras National Household Income and Expenditures Survey: The Role, Fee Structure, and Performance of the Ministry of Health

Technical Report 005
John Fiedler
107 pages (January 2002) • Order No. TE 005

This report summarizes findings of the health module contained in the 1998 National Household Income and Expenditures Survey in Honduras and recommends steps to improve equity of access and

cost for health services. The ambulatory care consultation rate in Honduras is 2.1 visits per person per year, slightly more than the World Health Organization-identified minimum acceptable level of 2.0. The annual hospitalization rate, however, is only 3.3 percent. There is remarkable equality in the use of health care services in Honduras, with no systematic relationship between household income quintile and consultation rates. The high degree of equity is attributable to the equalizing role of the Ministry of Health (MOH), particularly with respect to its provision of primary care in small health centers. Overall it provides 61 percent of all ambulatory care and 71 percent of all hospitalizations, compared to the Social Security Institute, which provides a mere 3 percent of ambulatory visits and 7 percent of hospitalizations, and all private sector sources, which provide 35 percent. The cost of MOH-provided care is low in absolute and relative terms, and substantially less than care in the private sector. These prices capture only a portion of the total costs of care, however: Half of MOH patients are directed by providers to purchase ancillary goods and services—most commonly medicines—from another, off-site source, and the practice is even more common among private providers. The cost of ancillary goods and services is considerable, averaging 57 percent of all patients' total ambulatory care costs and 25 percent of all patients' total hospital costs. Although there is a high degree of equity in the use of services, the degree of equity in access to and cost for those services is highly unequal. The poor are more likely to pay for care than is any other household income quintile. Moreover, in most instances, MOH facilities charge the poor larger fees—in absolute terms—than they charge the average patient, and a high proportion of the total medical care given to persons with higher incomes continues to be provided by the MOH. Recovering a mere 2 percent of costs, the MOH user fee system is regressive and in need of reform so that it can be more productive, more equitable, and able to establish prices that signal to both patients and providers that it is consistent with MOH goals and priorities.

Available in Spanish: *Análisis del componente salud de la Encuesta Nacional de Ingresos y Gastos de Hogares en Honduras: El papel, estructura tarifaria y desempeño de la Secretaría de Salud* (Order No. TE 005S)

En este informe se resumen las conclusiones del módulo de salud incluido en la Encuesta Nacional de Ingresos y Gastos de Hogares de 1998 en Honduras y se recomiendan los pasos a seguir para mejorar la equidad en el acceso y costo de los servicios de salud.

La tasa de consultas de atención ambulatoria en Honduras es de 2.1 visitas por persona al año, levemente superior que el nivel mínimo aceptable de 2.0 indicado por la Organización Mundial de la Salud. Sin embargo, la tasa anual de hospitalizaciones es de sólo el 3.3%. La igualdad en el uso de los servicios de atención de salud en Honduras es sorprendente, sin que haya una relación sistemática entre el quintil de ingreso del hogar y las tasas de consulta. Este alto grado de equidad se puede atribuir a la función igualadora de la Secretaría de Salud (SS), especialmente con respecto a su entrega de atención primaria en pequeños centros de salud. En términos generales, la Secretaría presta el 61% de toda la atención ambulatoria y el 71% de todas las hospitalizaciones, a diferencia del Instituto de Seguridad Social que proporciona apenas el 3% de las consultas ambulatorias y el 7% de las hospitalizaciones y de todas las fuentes del sector privado, que entregan un 35%.

El costo de la atención que proporciona la Secretaría de Salud es bajo en términos absolutos y relativos y significativamente más bajo que en el sector privado. Sin embargo, estos precios sólo reflejan una parte de los costos totales de la atención: los proveedores instruyen a la mitad de los pacientes de la SS para que compren bienes y servicios anexos, normalmente medicamentos, en otras fuentes externas y esta práctica es incluso más común entre los proveedores privados. El costo de los bienes y servicios anexos es considerable, en promedio el 57% de los costos totales de la atención ambulatoria y el 25% de los costos hospitalarios totales de todos los pacientes.

Si bien hay un elevado grado de equidad en el uso de los servicios, no es así en el acceso y costos de estos servicios, que son muy desiguales. Los pobres tienen más probabilidades de pagar por la

atención que cualquier otro quintil de ingreso familiar. Es más, los establecimientos de la Secretaría de Salud en la mayoría de las circunstancias cobran tarifas más elevadas (en términos absolutos) a los pobres que lo que cobran a los pacientes promedio y un alto porcentaje de toda la atención médica prestada a las personas de los ingresos más altos sigue siendo proporcionada por la Secretaría. Con una recuperación de apenas el 2% de los costos, el sistema de tarifas que la SS aplica a los usuarios es regresivo y requiere de reformas para que sea más productivo, más equitativo y capaz de fijar precios que comuniquen tanto a los pacientes como a los proveedores que estos precios son coherentes con sus metas y prioridades.

Perú: Estudio de demanda de servicios de salud (Documento 1)
Technical Report 012S
Miguel Madueño Dávila
84 pages (May 2002) • Order No. TE 012S
(Available in Spanish only)

El nivel de pobreza en el Perú es un factor que limita el acceso a los servicios de salud de una parte mayoritaria de la población, dando origen a una significativa demanda reprimida. Este fenómeno se halla asociado a individuos que, por razones económicas, no se declaran enfermos o a individuos enfermos que por falta de ingresos u disponibilidad de atenciones, no hacen uso de los servicios de salud, aunque perciban su enfermedad. Como estos individuos no acuden a los establecimientos médicos, su demanda no se refleja directamente en las estadísticas del sector salud ni se captura en las encuestas. La omisión o consideración inadecuada de la demanda reprimida por parte de las autoridades de salud pueden conllevar a una percepción equívoca respecto a la real dimensión del problema de salud en el Perú y a diseño de políticas poco eficientes. En este sentido, el objetivo principal del presente documento es cuantificar el tamaño potencial del mercado de servicios de salud en el Perú, desagregándolo por áreas geográficas y según las condiciones de acceso de la población: población con necesidad de salud atendidas (demanda efectiva) y con necesidades de salud insatisfechas (demanda encubierta).

Tools and Guidelines for Implementing New Payment Mechanisms for Ambulatory Care in the Ministry of Health Provider System of Peru
Technical Report 016
Alfredo Sobrevilla, Luz Loo, Alexander Telyukov, and Miguel Garavito
141 pages (April 2002) • Order No. TE 016

This report is the second and final technical deliverable under the Ambulatory Payment Innovation, a pilot project that seeks to identify and promote innovative strategies and mechanisms of ambulatory care financing in the public health care sector of Peru. In the vein of the conceptual framework, presented in Report 1, *Design Options and Data Needs for the Ambulatory Payment Innovation in the Public Health Care Sector of Peru* (Telyukov et al., 2002), this material provides the Ministry of Health with methodological guidelines and numerical tools to put the new mechanisms of provider financing in operation. The aforementioned tools include as follows:

- A relative value scale for ambulatory procedures by CPT99 code;
- An algorithm for compiling packages and subpackages of ambulatory services out of CPT99 procedures;
- A cross-walk from the Schoolchildren's Health Insurance Program to CPT 99 classification of procedures in order to collate clinical reporting with financial data requirements;

- An experimental rate schedule for the financing of ambulatory care providers by service package.

The Villa El Salvador health care network in the Regional Health Directorate of East Lima and the Cono Sur health care network in the Regional Health Directorate of Tacna served as the empirical base to design and validate the aforementioned tools.

With the ambulatory procedure classifications, service packages, and experimental rate schedules in hand, the Ministry of Health is well equipped for pilot-testing the mix of prospective capitation and retrospective reimbursement. The combination of these generic provider payment strategies should be flexibly adjusted to diverse socioeconomic, supply, and demand conditions in different regions and health care networks of Peru.

Available in Spanish: *Herramientas y pautas de implementación para los nuevos mecanismos de pago ambulatorio en el sector salud del Perú* (Order No. TE 016S)

Este reporte es el segundo producto técnico de la Innovación del Pago Ambulatorio, una iniciativa que busca identificar y promover estrategias y mecanismos innovadores para el financiamiento de las atenciones ambulatorias en el sector público peruano. Conforme al marco conceptual presentado en el Informe 1 Opciones de Diseño y Requerimientos de Información para la Innovación del Pago Ambulatorio en el Sector Público del Perú (PHRplus, Febrero 2002), este informe proporciona al Ministerio de Salud las pautas metodológicas y herramientas cuantitativas de operación de nuevos mecanismos de pago. Entre ellos son los que siguen:

- Escala de costos para los procedimientos médicos ambulatorios CPT99;
- Algoritmo de generación de paquetes y subpaquetes de atención ambulatoria, basados en los procedimientos CPT99;
- Interfase de procedimientos SEG-CPT99 para viabilizar una rápida evolución del uso del sistema de registro clínico hacia aplicaciones presupuestales;
- Cuadro presupuestal para el financiamiento del sector ambulatorio según paquetes de atención y mecanismo de pago.

La microrred Villa El Salvador de la Dirección de Salud Lima Este, y la microrred Cono Sur de la Dirección de Salud Tacna sirvieron de plataforma empírica en el diseño y validación de las herramientas antes mencionadas.

Con las clasificaciones de procedimientos ambulatorios, paquetes de servicios y tarifarios experimentales, el MINSA ya puede seguir al piloteo de una combinación de la capitación prospectiva y el reembolso retrospectivo, variando la mezcla de estas estrategias de pago según las condiciones socioeconómicas, así como las de oferta y demanda en diferentes regiones y redes de salud del Perú.

Costing of HIV/AIDS Treatment in Mexico

Technical Report 020

Sergio Antonio Bautista, Tania Dmytraczenko, Gilbert Kombe, and Stefano Bertozzi

62 pages (Revised June 2003) • Order No. TE 020

This study documents the Mexican experience in HIV/AIDS treatment in three different health subsystems—the Ministry of Health, the Social Security Institutes, and the National Institutes of Health. Ultimately, the study will provide donors and policy makers the information necessary to guide planning and scaling up of comprehensive HIV/AIDS treatment. The study consisted of a multicenter, retrospective patient chart review and the collection of complementary cost data to

describe the utilization of services and to estimate costs of care for adult (18 years of age and above) HIV+ patients in the public sector who had at least one visit to a health facility between January 1, 2000, and December 31, 2001.

Researchers found that since antiretroviral drugs are the greatest single component within treatment cost, even a small reduction in drug costs would have a measurable impact on the overall cost of therapy. Other findings highlight several improvements that can be made in the quality of care patients are receiving.

Available in Spanish: *Análisis de los costos de atención del VIH/SIDA en México* (Order No. TE 020S)

El presente estudio documenta la experiencia mexicana en materia de tratamiento del VIH/SIDA en tres diferentes subsistemas de salud – la Secretaría de Salud (SSA), los Institutos Mexicano de Seguro Social (IMSS/ISSSTE), y los Institutos Nacionales de Salud (INS). Asimismo, proporciona a los donantes y a los encargados de políticas la información necesaria para planificar y proyectar un tratamiento completo del VIH/SIDA. El estudio consistió en analizar historiales clínicos de pacientes provenientes de múltiples centros de salud y en recabar datos complementarios relativos a los costos, con el fin de describir la utilización de los servicios y estimar los costos de atención de los pacientes adultos (de 18 años de edad y más) con VIH que se atienden en el sector público de salud y que acudieron al menos una vez a un establecimiento de salud entre el primero de enero de 2000 y el 31 de diciembre de 2001.

Los investigadores determinaron que, dado que los medicamentos antirretrovirales constituyen el componente de mayor impacto en el costo del tratamiento, incluso una pequeña reducción del costo de los mismos tendría un efecto significativo en el costo global de la terapia. Entre otros resultados, se destacan algunas mejoras que podrían obtenerse en cuanto a la calidad de la atención proporcionada a los pacientes.

Perú: El perfil epidemiológico en un contexto de demanda reprimida de servicios de salud (Documento 2)

Technical Report 025S
Jorge Alarcón Villaverde
102 pages (September 2003) • Order No. TE 025S
(Available in Spanish only)

El presente estudio epidemiológico intenta dar luces respecto a temas claves para el diseño de una política nacional de salud orientada tanto a reducir la carga de morbilidad de la población así como mejorar la eficiencia en la asignación de recursos. El instrumental metodológico se basa en el análisis de la mortalidad correspondiente al año 2000. Para ello, se han utilizado diversos indicadores de análisis a nivel regional, tales como (1) las tasas de mortalidad, (2) los años de vida potencial perdidos (AVPP), y (3) la esperanza de vida marginal bajo diferentes escenarios de prevención y control de enfermedades. Los resultados del presente estudio proveen un perfil epidemiológico que permite a las autoridades de salud identificar (a) cuánta carga de morbilidad hay en la población, (b) cuáles son los problemas de salud más significativos, (c) cómo se distribuyen geográficamente y (d) cuáles serán las tendencias en los próximos diez años. Finalmente, se propone un rol de prioridades sanitarias a nivel regional, que sirva tanto de instrumento para la definición de las estrategias de política sectorial e inter-sectorial, como de guía para las decisiones de inversión de mediano plazo.

Estudio de oferta de los servicios de salud en el Perú y el análisis de brechas 2003-2020 (Documento 3)
Technical Report 026S
Miguel Madueño Dávila and César Sanabria Montañés
107 pages (September 2003) • Order No. TE 026S
(Available in Spanish only)

La inversión es un determinante importante de los niveles de oferta de servicios de salud de un país y como tal, es un instrumento de política que puede ser utilizado para reducir las inequidades en el acceso a estos servicios. Sin embargo, en una economía como la peruana donde el principal prestador de servicios es el sector público, los criterios de inversión no son necesariamente establecidos por criterios técnicos; por el contrario, existe alto riesgo que las decisiones de inversión esté (a) influidas por factores políticos, (b) determinadas a partir de análisis de niveles históricos y (c) limitadas por restricciones fiscales, pudiendo generar asignaciones poco eficientes de los recursos y/o poco articuladas con las necesidades de salud de la población.

En este sentido, la Comisión de Alto Nivel de Inversiones solicitó a finales del 2001 el desarrollo de un instrumento para la programación de los requerimientos de los gastos de capital de mediano plazo en el sector salud que sirva de soporte para la definición de un Plan Nacional de Inversión en el marco de una política global orientada a mejorar las condiciones de equidad y eficiencia en la provisión de servicios de salud. Esto implica, definir criterios de asignación del gasto de capital por regiones y por componentes sobre la base de las necesidades prioritarias de atención de la población y la distribución geográfica de las dotaciones de recursos (criterio de eficiencia) que coadyuven a la reducción de los déficit de acceso a nivel intra e interregional y a un mejoramiento del estado de salud de la población (criterio de equidad).

Para atender los requerimientos de la Comisión de Alto nivel, la Agencia de los Estados Unidos para el Desarrollo Internacional (USAID) a través del programa Partnership for Health Reform Plus (PHR*plus)* dirigido por Abt Associates Inc., está financiando el desarrollo del proyecto global "Requerimientos de inversión de mediano plazo basados en el análisis de la brecha de la oferta y demanda potencial de los servicios de salud" compuesto de tres estudios interdependientes (1) Perú: Estudio de la demanda de servicios de salud, (2) Perú: El perfil epidemiológico en un contexto de demanda reprimida y (3) Perú: Estudio de oferta de servicios en el Perú y el análisis de brechas 2003-2020.

El presente estudio constituye la parte final del proyecto global, proporcionado información acerca de las condiciones reales de la oferta de servicios de salud en el Perú, en términos de su dimensión, eficiencia y capacidad productiva potencial, entre otros. De igual manera se da luces respecto a la direccionalidad y magnitud de los desequilibrios actuales y esperados en el mercado de salud peruano y se establecen lineamientos para la asignación de recursos sobre la base de la programación de las necesidades de gastos de mediano plazo. De manera específica, se intenta responder a preguntas claves para el diseño de una política de gasto e inversión sectorial, tales como: (a) ¿A cuánto asciende las necesidades de gasto del sector y cuál sería la composición óptima entre gastos recurrentes y de capital?, (b) ¿Cuál es el *timming* para la programación de inversión productiva?, (c) ¿Cuál debiera ser la distribución de la inversión entre gastos de depreciación, edificaciones y equipamiento? y (d) ¿Cómo debiera asignarse los gastos de capital según áreas geográficas y tipo de establecimientos?

OPV vs IPV: Past and Future Choice of Vaccine in the Global Polio Eradication Program

Technical Report 004

Xingzhu Liu, Ann Levin, Marty Makinen, and Jennifer Day

40 pages (Revised June 2003) • Order No. TE 004

With the world approaching the post-eradication phase of polio control, two questions have been raised: (1) should polio vaccination be stopped or continued after global certification of polio eradication? (2) if vaccination is continued, what vaccine should be used? There has been no decisive answer to the first question. However, the possibility of a global switch from current oral polio vaccine (OPV) to inactivated polio vaccine (IPV) after global eradication of polio (the second question) is being debated. One of the barriers to such a switch is that the cost is thought to be prohibitively high for developing countries. This study estimates the incremental cost of a vaccine switch in developing countries.

The estimates show that the switch from OPV to IPV in its current presentation for all developing countries together will result in an increase in total annual cost of $317 million, averaging $2.91 per child. Overall, in developing countries the switch will need $1 million to avoid a case of vaccine-associated poliomyelitis paralysis through the switch of vaccines. For the low-coverage countries, the vaccine switch will lead to a net increase in costs of about $26 million, averaging about $2.42 per target child. For intermediate-coverage countries, the switch will result in an increase in total cost of $129 million, averaging about $2.68 per target child. For high-coverage countries, it will result in an increase in the total cost of $162 million, an average of about $3.26 per target child.

A switch to an IPV only (or, IPV-only strategy, program, etc.) would entail significant incremental costs and introduce additional epidemiological risks, including unsafe injections and the release of wild virus in the IPV production process. The benefit of the switch would come from elimination of: (1) a limited number of vaccine-associated polio paralyses and (2) a few polio cases caused by circulating vaccine-derived poliovirus. These benefits ultimately will need to be weighed against the high incremental costs and increased risks that would come with the switch. There are reasons to challenge either continuing to use OPV or to switch to IPV post eradication in developing countries. Another option would be to cease all polio vaccination for those countries deciding not to switch to IPV. This option relates to the first question above and needs further investigation that is beyond the scope of this analysis.

PHR*plus* Knowledge Building Agenda

Technical Report 006

Sara Bennett, Derick Brinkerhoff, Lynne Franco, Charlotte Leighton, Mary Paterson, and Nadwa Rafeh

70 pages (March 2002) • Order No. TE 006

PHR*plus* is required to produce a Knowledge Building Agenda to guide research activities under the project. The first part (Part A) of the Knowledge Building Agenda reviews (i) ongoing PHR*plus* work (primarily technical assistance activities) with a view to identifying research needs and opportunities (ii) user demand for health systems research based upon a small survey of U.S. Agency for International Development mission staff and developing country health policymakers and (iii) emerging trends in health systems research. These three building blocks are used to identify a number of possible research areas from which five were selected for further elaboration. The five selected were:

- Approaches to strengthening accountability;
- The equity and sustainability of community-based health insurance as part of a national health system financing strategy;
- Hospital autonomy and the role of hospitals within reformed health care systems;
- Regulation and the quality of private health care providers in developing countries;
- Health worker motivation in reform contexts.

In Part B of the agenda short concept notes for each of the five research areas are presented. Each concept note briefly addresses the current state of knowledge with respect to this topic, arguments for why it is an appropriate research focus for PHR*plus*, potential research questions, and the research approach.

Literature Review and Findings: Implementation of Waiver Policies

Technical Report 009
Marie Tien and Grace Chee
46 pages (March 2002) • Order No. TE 009

Many countries are adopting user fees as part of their national strategies for financing for public health care. While these fees generate funding, they can also deter poor and vulnerable groups from seeking care in a timely manner. In an effort to protect these groups and allow them fuller access to health care, many countries, including Zambia, have instituted policies to excuse the groups from paying fees. In practice, however, these exemption (for characteristic targeting of groups, based on age, disease, employment, or other characteristics) and waiver (for targeting individuals, based on ability to pay) policies often do not produce the desired results, because they lack clear and consistent procedures for implementation and evaluation, and funding to reimburse providers who provide care to the target population. The current review, done by Partners for Health Reform*plus* at the request of USAID/Lusaka and the Zambia Integrated Health Program, looks at literature regarding these policies, with a focus on seeking out country-specific examples of individual, need-based waivers. The review found that evaluations that have been done focus on components of the implementation process, rather than on quantitative analysis linking implementation and its effectiveness in reaching the poor. However, some general conclusions and recommendations are supported by the literature: Waivers are most appropriate for higher-cost services. In addition, there must be simple waiver policies and guidelines that are clearly communicated to health care providers and beneficiaries, a funding mechanism to reimburse providers, and a system for monitoring and evaluating the waiver program to ensure it produces the intended outcomes.

Accountability and Health Systems: Overview, Framework, and Strategies

Technical Report 018
Derick Brinkerhoff
31 pages (January 2003) • Order No. TE 018

Improved accountability is often called for as an element in improving health system performance. At first glance, the notion of better accountability seems straightforward, but it contains a high degree of complexity. For accountability to serve effectively as an organizing principle for health systems reform, conceptual and analytical clarity is required. This paper elaborates a definition of accountability in terms of answerability and sanctions, and distinguishes three types of accountability: financial, performance, and political/democratic. The role of health sector actors in accountability is reviewed. An accountability-mapping tool is proposed that identifies linkages among health sector

actors and assesses capacity to demand and supply information. The paper describes three accountability-enhancing strategies: reducing abuse, assuring compliance with procedures and standards, and improving performance/learning. Using an accountability lens can: a) help to generate a system-wide perspective on health sector reform, and b) identify connections among individual improvement interventions. These results can support synergistic outcomes, enhance system performance, and contribute to sustainability.

Piloting Health Systems Reforms: A Review of Experience

Technical Report 019
Sara Bennett and Mary Paterson
45 pages (January 2003) • Order No. TE 019

Pilot approaches have been advocated as a means to reduce the risks associated with implementing complex health system reforms; however, there is a lack of guidance about when pilots may be appropriate or how they should be designed to respond to different contexts or objectives. This report presents the findings of a literature review and in-depth review of 17 health system reform pilots. The objectives of the review were to (i) synthesize lessons regarding conditions under which pilot projects are an appropriate means to further reform development, (ii) analyze how pilot projects and their monitoring and evaluation frameworks can best respond to alternative objectives and contexts, and (iii) develop guidance for the design of pilot projects. The study was hindered in achieving these objectives by the poor documentation on pilots; frequently documentation was only partial and was not consistently organized.

Results support previous studies that suggest that frequently pilot objectives are not clear and that this is a major impediment to successful design and implementation. The study identifies a number of different factors that should be taken into account in determining the piloting approach. The most critical of these are the pilot objectives, and, related to the pilot objectives, the degree of consensus about the proposed policy reform. Other important factors that should be taken into account include country capacity, the size of the country and the degree of decentralization within the country. These factors should determine dimensions of the piloting approach including how centralized the pilot is, the type of monitoring and evaluation framework used, and the extent to which policymakers are involved in the pilot. The study finds that extensive donor involvement in a pilot is likely to shorten the time frame for the pilot, and that this can sometimes have problematic effects. While success of a pilot is often discussed in terms of whether or not the pilot was "rolled out," the review shows that there are many other positive outcomes that pilots may achieve, and it argues that ultimately success should be judged against the objectives established for a particular pilot.

Has Improved Availability of Health Expenditure Data Contributed to Evidence-Based Policymaking? Country Experiences with National Health Accounts

Technical Report 022
Susna De, Tania Dmytraczenko, Derick Brinkerhoff, and Marie Tien
42 pages (May 2003) • Order No. TE 022

National Health Accounts (NHA) is a tool designed to inform the health policy process. It aims to do so by providing policymakers with valuable information on the distribution of health funds within the system. NHA was introduced and implemented in a number of middle- and low-income countries in the mid- to late 1990s. As sufficient time has passed for NHA findings to penetrate the policy processes in these countries, this study sets out to determine if NHA has actually met its principal goal of contributing to evidence-based policymaking. The paper examines the policy impact of NHA in 21 developing countries from the Latin America and the Caribbean region, East and Southern

Africa, the Middle East and North Africa, and the Asia Pacific region. The study describes how policymakers have used NHA and assesses the various factors and influences that determine the extent to which NHA impacts the policy process. It is hoped that lessons learned from this study can help other countries as they move forward with efforts to inform health policymaking using health expenditure information.

Financing of Artemisinin-Based Combination Antimalarial Drug Treatment

Technical Report 023
Yann Derriennic and Beaura Mensah
42 pages (September 2003) • Order No. TE 023

This paper was prepared for an Expert Consultation on the Procurement and Financing of Antimalarial Treatments to be held September 2003 in Washington DC. The paper looks at the financing issues raised by changing of first line drug treatment for uncomplicated malaria to artemisinin-based combination therapies (ACTs). These treatments are significantly more expensive than current first line drugs such as chloroquine and sulfadoxine pyrimethamine. Following a background section on health sector reform and financing, the paper outlines a framework for estimating the impact of ACT on people's ability to pay at the country level. This is followed by a model that presents a range of estimates of the overall financing impact at the level of sub-Saharan Africa, and for Ghana and Zambia as well. Finally, an approach to financing of ACT at the country level is outlined. This includes a financing situation analysis, applying the framework, and a sustainability plan.

The System-Wide Effects of the Global Fund to Fight AIDS, Tuberculosis and Malaria: A Conceptual Framework

Technical Report 031
Sara Bennett and Alan Fairbank
39 pages (October 2003) • Order No. TE 031

While the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) has an explicit focus on three diseases rather than on entire national health systems, certain operations of the Global Fund are designed to ensure a good fit between the disease-specific focus and health care systems. In addition, the GFATM may have system-wide effects due to the sheer magnitude of the resources it is distributing (particularly in low income countries) and its emphasis on efficient and rapid disbursement. These effects could be on equity, efficiency, access, quality, and sustainability of health systems, which in turn influence the utilization and coverage of non-focal services, and, ultimately, the burden of diseases from sources other than the focal diseases. The effects could be intentional or unintentional, and the unintentional effects could have positive or negative consequences for health system performance.

To help anticipate possible effects of the GFATM on the broader health system, and to provide a basis for monitoring and evaluating how the Global Fund disbursements affect national health care systems, this paper presents a conceptual framework that identifies the channels through which GFATM disbursements might have health system-wide effects. In doing so, it reviews the design, selection, and implementation processes associated with GFATM grant-making as well as the strategies and content of approved proposals, and discusses the potential effects each activity or strategy will have on the stewardship, resource development, financing, and service delivery functions of the health care system. The report concludes that it is of critical importance to monitor and evaluate the effects of the Global Fund on broader health systems, and identifies four aspects of

systems that the Global Fund appears particularly likely to affect, namely: the policy environment, the public/private mix, human resources, and pharmaceuticals and commodities.

Ensuring Contraceptive Security Within New Development Assistance Mechanisms

Technical Report 042

Caroline Quijada, Tania Dmytraczenko, and Beaura Mensah

30 pages (July 2004) • Order No. TE 042

Contraceptive security exists when people are able to choose, obtain, and use high quality contraceptives and condoms when they want them for family planning and prevention of HIV/AIDS and sexually transmitted infections. In many countries, people rely on the free or subsidized supplies made available by governments and international donor agencies. However, there is a growing financing gap as current levels of government resources and donor support are inadequate to meet increasing demand for contraceptives and condoms. There is concern that recent changes in the way that donors provide foreign aid will adversely affect funding levels for reproductive health commodities.

These changes include the emergence of global funds, movement away from targeted projects toward general budget support, and a new emphasis on poverty reduction. This paper presents findings from a study to examine the impact that two of these new mechanisms in development assistance – sector-wide approaches, or SWAps, and poverty reduction strategy papers, PRSPs – may have on contraceptive security. PHR*plus* conducted a study of three countries and examined in more detail the design and implementation of these mechanisms.

The study sought to determine: 1) whether contraceptive security issues, such as the availability of commodities, strengthened logistics systems, and quality counseling services, were explicitly addressed in the government strategies; and if so, to what extent they were included, 2) whether donor funding levels changed due to the new arrangements and 3) what plans, if any, exist within the SWAp and/or PRSP to finance reproductive health commodities.

Methodological Guidelines for Conducting a National Health Accounts Subanalysis for HIV/AIDS

Technical Report 044

Susna De, Tania Dmytraczenko, Catherine Chanfreau, Marie Tien, and Gilbert Kombe

67 pages (July 2004) • Order No. TE 044

The National Health Accounts (NHA) framework, an internationally accepted tool that provides a comprehensive estimate of national health expenditures, has been adapted to enable "subanalyses" that can be used to capture data on specific diseases, such as HIV/AIDS, by breaking down expenditures on related individual services and disease areas. These guidelines describe the approach used by Partners for Health Reform*plus* to conduct an HIV/AIDS subanalysis within the context of a general NHA exercise in low- and middle-income countries. It discusses definitions and boundaries of HIV/AIDS expenditures, suggests a NHA classification system adapted to HIV/AIDS, describes the data collection process for capturing HIV/AIDS spending, and addresses the specific issues of survey development to track for household spending on HIV/AIDS. Like the NHA methodology, the subanalysis framework aims to offer an approach that provides both international comparability and national flexibility in tracking HIV/AIDS health care spending.

Synthesis of Findings from NHA Studies in Twenty-Six Countries
Technical Report 046
A.K. Nandakumar, Manjiri Bhawalkar, Marie Tien, Roselyn Ramos, and Susna De
50 pages (July 2004) • Order No. TE 046

National Health Accounts (NHA) is a tool designed to inform the health policy process. It aims to do so by providing policymakers with valuable information on the distribution of health funds within the system. NHA was introduced and implemented in a number of low- and middle- income countries in the mid- to late 1990s. This study synthesizes NHA findings from 26 countries in the Eastern and Southern Africa network, the Middle East and North Africa network, and the Latin America and Caribbean network in order to provide a comprehensive picture of health spending and how it is financed in these countries. Comparisons are drawn within and across the regions, paying special attention to, among other things, the sources of financing, the role of insurance, households and donors in financing health expenditures, and expenditures on pharmaceuticals.

Working Papers

Mutual Health Organizations: A Quality Information Survey in Ghana
Working Paper 001
Sylvia Anie, George Kyeremeh, and Samuel George Anarwat
34 pages (November 2001) • Order No. WP 001

Mutual health organizations (MHOs), community-based health financing schemes, are becoming increasingly popular as an alternative financing mechanism in sub-Saharan Africa. One concern about these organizations is how they monitor quality of care provided. The survey reported on here was carried out in nine MHOs in Ghana in 2001 by the Partners for Health Reform*plus* project as part of a three-country study that looks at MHO conceptions of quality of care and how quality is built into MHO–provider agreements. This Ghana study found that several of the schemes studied are so young that they have not yet begun to administer benefits and thus had no historical data to report; but even those in full operation lacked record-keeping capacity. Five of the nine schemes operate without contracts, i.e., without record-keeping and monitoring requirements; in some cases, groups feel that quality monitoring and improvement is the responsibility of the central Ministry of Health. Nevertheless, the study found that many MHO managers are concerned about the issue of quality of care. There is need to help them implement steps to ensure a certain minimum standard of care.

Maternal Health Financing Profile: Tanzania
Working Paper 003
Caroline Quijada and Alison Comfort
22 pages (November 2002) • Order No. WP 003

This paper attempts to identify the key financing issues and constraints for accessing maternal health services in Tanzania. Access to the services is of concern because, despite high use of antenatal care, the 1990s saw an appreciable decline in the number of births that take place in a health facility (currently 44 percent) and in the number of births attended by skilled health workers (36 percent). The current analysis finds that the great majority of women who access antenatal care services do not pay for the services nor do they pay for drugs and transportation related to the services. While many delivery services (and related drugs and transportation) also are free of charge, a greater number of women who access the services do pay something. Costs are particularly high for caesarian-section delivery-related supplies.

Evidence is mixed on the impact of user fees, instituted in 1993, and especially on their impact on the use of maternal health services. Enrollment in the prepayment-oriented Community Health Fund (CHF), begun in 1996, is low and thus far available in only 23 districts; an exemption policy is inconsistently applied, so many members are still charged user fees. Evidence is not yet available to evaluate the effect on access of the more recent, and still limited, financing efforts of national health insurance and decentralization.

Given that financing barriers may play a role in preventing access to maternal health services, the paper recommends that further research on user fees be undertaken to help guide health policy implementation. The findings could solidify support for the country's national waiver and exemption policy and help determine which key maternal health-related expenses should be waived. The paper

also suggests that expanding the CHF and the national health insurance program could help reduce financial barriers and promote greater equity in access to these services. The Sector Wide Approach also has potential to improve efficiency of external funding by eliminating the duplication of efforts among donors and providing a single policy for the government to implement.

Situation Analysis of Infectious Disease Surveillance in Two Districts in Tanzania, 2002

Working Paper 004

Lynne Miller Franco, Rebecca Fields, Peter K.L. Mmbuji, Stephanie Posner, L.E.G. Mboera, Ann Jimerson, K.P. Senkoro, S.F. Rumisha, E.H. Shayo, and J.A. Mwami

19 pages (August 2003) • Order No. WP 004

In developing countries, successful implementation of an Infectious Disease Surveillance (IDS) system should result in staff at multiple levels, starting with the health facility, being capable and motivated to collect and use surveillance information for public health decisions and actions in both outbreak and routine situations. In order to inform the selection and design of strategies to strengthen IDS in Tanzania, a situation analysis in two districts was conducted that focused on examining systems and behavioral considerations as well as technical aspects of the disease surveillance system. The situation analysis was conducted by members of the IDS project team of the National Institute for Medical Research, with input from the Partners for Health Reform*plus* project, the CHANGE Project, and Centers for Disease Control and Prevention. Approximately two weeks of fieldwork were required for data collection per district. The situation analysis was conducted in Babati district in April 2002 and in Dodoma Rural district in August 2002.

The methodology included a quantitative survey at the district level; in-depth interviews with the district health management teams, district officials, and health workers; and focus group discussions with community leaders and members. The results identified a number of barriers and enabling factors important to effective and sustainable implementation, including normative, motivational, organizational, and participatory issues in addition to knowledge and skills. As a result of these findings, a series of interventions was developed to address 1) the Integrated Disease Surveillance and Response (IDSR) system design issues, 2) the reduction of contextual and organizational barriers, 3) technical competence related to IDSR at district and facility levels, 4) health personnel motivation and perceived value for IDSR activities, and 5) engagement of appropriate stakeholders for support and involvement in IDSR.

As the effects of such factors and their related interventions on IDS are measured in the future, the development and use of simplified tools for assessing and addressing the key technical, systems, and behavioral factors will be valuable for IDS strengthening in other developing countries.

Knowledge, Attitudes, and Behaviors Toward VPD Surveillance Among Health Care Providers and Community Members in Georgia

Working Paper 005

Mamuka Djibuti, Ivdity Chikovani, Khatuna Zakhashvili, and George Gotsadze

20 pages (May 2003) • Order No. WP 005

Surveillance of vaccine preventable diseases (VPDs) is an important measure to estimate burden of diseases, decide on appropriate policy to reduce diseases, identify pockets of susceptibility, and control potential outbreaks. An earlier assessment identified major problems in the Georgian health system that limited the ability of current VPD surveillance efforts to provide quality information to guide public health action(s). The present study aims to provide further insight into problems with the

current VPD surveillance efforts by obtaining research evidence on knowledge, attitudes, and behaviors toward VPD surveillance among health care providers and community members.

Researchers found that a variety of factors currently discourage a high percentage of infectious disease patients from self-reporting to health facilities through official channels and that, overall, the awareness of VPD is poor, though attitudes and behaviors toward VPD and immunization is positive.

Assessment of Public Health Laboratory Capabilities and Role in Surveillance of Vaccine Preventable Disease and Diarrheal Disease in Georgia

Working Paper 006
Antoine Pierson
39 pages (July 2002) • Order No. WP 006

Effective laboratories are an important component of any vaccine preventable disease (VPD) surveillance system. This assessment looks at the roles and capabilities of laboratories as they do surveillance and response for VPDs and other priority infectious diseases in Georgia. The paper discusses how standardized World Health Organization laboratory assessment tools were adapted to the Georgian context; gives an overview of the country's laboratory system for diagnosis of VPDs; evaluates operations at central, regional, district, and facility laboratories; and sets out recommendations for laboratory strengthening.

Workshop Reports

Workshop Summary: PHR*plus* Community-Based Health Financing Coordination Meeting Information Sharing, Key Findings, Knowledge-Building Needs
Workshop Report 001
Brant Silvers
23 pages (January 2002) • Order No. WS 001

PHR*plus* held a workshop on January 30, 2002 to discuss the work PHR*plus* has done with community-based health insurance/financing (CBHI/F). The purpose of the meeting was to exchange information, reflect on lessons learned, identify outstanding questions, and promote better information sharing across the project. The team recognized the continuing need for technical assistance to CBHI/F schemes especially in the areas of financial management and training. The team also concluded that as the schemes become larger and multiply, technical assistance must be provided in a more economical way. Given the experience PHR*plus* has in the field of CBHI/F schemes, workshop participants felt that facilitating information sharing on this subject is crucial. The idea of creating a portion of the website for best practices and discussion on the CBHI/F schemes was one such idea for promoting exchange. Workshop participants recognized that it is important to learn as much as possible from the activities PHR*plus* is undertaking presently. Monitoring and evaluation of technical assistance and some in-depth research into CBHI/F is needed.

Workshop on Monitoring and Evaluating the Health System-wide Effects of the Global Fund to Fight AIDS, Tuberculosis, and Malaria
Workshop Report 002
Kate Stillman and Sara Bennett
80 pages (June 2003) • Order No. WS 002

A conceptual framework for monitoring and evaluating the effects on health care systems of activities of the Global Fund to Fight AIDS, Tuberculosis and Malaria was developed by PHR*plus* for discussion at a June 2003 workshop: Representatives from the Global Fund Secretariat, Northern and Southern research organizations, U.N. agencies and bilateral donors, and selected Global Fund board members concluded that knowledge gleaned from this monitoring and evaluation is critical to help maximize the Fund's positive effects and minimize negative effects on health systems that receive Fund support. Participants also reached consensus about the principles, scope, and general research components for a select number of Fund-recipient country case studies that will contribute to monitoring guidelines. These principles include:

- Establishment of a close relationship with key stakeholders to ensure that study findings feed into policy and implementation;
- A country-driven approach;
- A commitment to the timely dissemination of findings;
- Sensitivity to the complex environment within which the Fund and countries it supports operate, in particular to avoid drawing premature conclusions about the overall impacts of the Fund;

- A commitment to ensuring the legitimacy of research.

Core research questions will include:

- What are the effects upon the health care systems of recipient countries of the processes involved in applying for and receiving a Global Fund grant, and of Fund-supported activities?
- How can the Fund and recipient countries ensure that these activities enhance health care systems?

Next steps will be to identify additional donors to the Fund and to draft a research protocol. A second workshop will finalize the protocol, establish a workplan to carry out the research, and resolve any funding concerns.

Use of Information to Address TB/HIV in Cambodia: Workshop Proceedings from Banteay Meanchey, Battambang, Phnom Penh, and Sihanoukville

Workshop Report 003
Jayaseeli Bonnet, So Phat, and Kunrath Seak
77 pages (June 2004) • Order No. WS 003

Cambodia is one of the countries most severely affected by tuberculosis (TB) and HIV. Adult HIV prevalence is 2.7 percent, 64 percent of the total population is infected by TB, and hundreds of thousand of people with HIV/AIDS are at risk to develop TB. In response, the Cambodian Ministry of Health has made addressing TB and HIV co-morbidity a priority and the National Tuberculosis Program and the National Center for HIV/AIDS, Dermatology and STDs are working to jointly plan, implement, and monitor TB/HIV interventions, starting with pilot activities in four sites.

At the Ministry's request, the Partners for Health Reform*plus* (PHR*plus)* is providing technical support to develop an information component to support the TB/HIV activities. PHR*plus* is standardizing the information being collected across all sites and facilitating its use by implementing partners in order to increase case detection and strengthen case management of TB/HIV co-morbidity. In January–March 2004, PHR*plus* conducted workshops with the four sites to review information and data it had collected, to identify current pilot accomplishments, and to recommend how work could be improved. This report presents the workshop findings.

Resources and Tools

A Step-by-Step Methodological Guide for Costing HIV/AIDS Activities
Toolkit 001
Margaret Phillips and Maggie Huff-Rousselle
50 pages (March 2001) • Order No. TK 001

Many developing countries have recognized the need for comprehensive national reforms and comprehensive prevention, treatment, and care and support initiatives to reduce future transmission of and to meet the growing demand for HIV/AIDS services. As a part of these national health reform initiatives, governments are exploring ways to allocate resources in the most efficient and effective way to mitigate the HIV/AIDS epidemic. However, many countries lack information on the level and nature of the costs of HIV/AIDS programs. This document provides an introduction to the procedure for calculating and analyzing the costs of HIV/AIDS programs and describes how to measure directly the actual costs of a program that is up and running. The step-by-step guide is intended to provide project managers in the field with a framework for how to do measure costs for a single, recent year in the life of an HIV/AIDS program. An illustrative activities list in the report annex will assist the user to develop an activities-based framework. The information gleaned from the costing framework will enable policymakers and program managers to make informed resource allocation decisions.

Guidelines for Surveillance and Control of Vaccine Preventable Diseases in Georgia
Toolkit 004
Ministry of Labor, Health and Social Affairs of Georgia; and National Center for Disease Control
104 pages (July 2003) • Order No. TK 004

The Georgian National Health Policy, adopted in 1999, declares the reduction of communicable and socially dangerous diseases a major priority for maintaining and improving the health of the Georgian population over the next decade. Uniform and comprehensive guidelines for health workers who deal with infectious disease surveillance are a critical component of ensuring the effective functioning of the surveillance system.

The guidelines outlined in this report are the first attempt to develop a comprehensive document to help Georgian health workers comply with the above goal. The guidelines outline how to: identify and register cases of infectious diseases; confirm and classify cases; notify and report; analyze data; investigate outbreaks; and utilize available information for making decisions to prevent and control infectious diseases and improve the functioning of the surveillance system. They are designed primarily for health personnel working at rayon and regional centers of public health. Besides the general norms for the surveillance system as a whole, the guidelines include eight disease-specific sections devoted exclusively to guiding public health workers for effective prevention and control of vaccine-preventable diseases.

Handbook for Health Providers on Surveillance and Control of Vaccine Preventable Diseases in Georgia
Toolkit 005
Ministry of Labor, Health and Social Affairs of Georgia; and National Center for Disease Control
40 pages (July 2003) • Order No. TK 005

The handbook is an abridged and modified version of the *Guidelines for Surveillance and Control of Vaccine Preventable Diseases in Georgia*. The handbook is designed specifically to guide providers of health services at the facility level on all issues related to their day-to-day work in the field of infectious disease surveillance: case detection, laboratory confirmation, case notification/reporting, data analysis, response to cases and outbreaks, and self-monitoring of performance. In addition to discussing the general norms for the surveillance system as a whole, the handbook includes sections devoted to each of the eight vaccine preventable diseases in Georgia. These sections guide health workers through the steps of effective case confirmation and response to cases and outbreaks.

The handbook was developed for piloting in the Imereti region in 2003-2004; the pilot test will produce recommendations on how to improve the design and implementation of the tool, and on whether it has proved to be useful for improving the functionality of the surveillance system and therefore should be adopted for use in other regions of Georgia as part of the scale-up of the surveillance reforms.

Workbook for Rayon Centers of Public Health on Surveillance and Control of Vaccine Preventable Diseases in Georgia
Toolkit 006
Ministry of Labor, Health and Social Affairs of Georgia; and National Center for Disease Control
48 pages (July 2003) • Order No. TK 006

This workbook, which accompanies *Guidelines for Integrated Surveillance and Control of Vaccine Preventable Diseases in Georgia*, is a four-in-one tool for data collection, analysis, planning of responses, and self-monitoring of performance. It helps rayon-level health workers establish the link between IDS information and response, as well as document their data analysis and utilization for management purposes. Its self-explanatory worksheets and tables assist the health workers to better record, analyze, and utilize infectious disease surveillance (IDS) data. The IDS data are recorded in a standardized format, typically on a quarterly basis. Analysis allows for the identification of IDS performance and operational problems and for formulating specific responses to the problems. A format is also present for documenting the implementation of suggested measures. The workbook was developed for piloting in the Imereti region in 2003-2004; the pilot test will produce recommendations on how to improve the design and implementation of the tool, and on whether to scale up the intervention to other regions in Georgia.

Reporting and Recording Documentation for Monitoring Immunization Work in Georgia – Level 1: Providers of Immunization Services
Toolkit 007
Ministry of Labor, Health and Social Affairs of Georgia; and National Center for Disease Control
44 pages (February 2003) • Order No. TK 007

The third edition of the training manual for health care providers is a comprehensive compendium of the Georgia immunization program documentation for the facility level. It contains current recordkeeping and reporting requirements of the Ministry of Labor, Health and Social Affairs (MoLHSA) and the National Center for Disease Control; guidelines for immunization data analysis

and utilization; and materials for monitoring and evaluating the immunization system and provider performance. The MoLHSA has adopted these guidelines for nationwide implementation after a year-long pilot in Kacheti region.

The manual is designed primarily for personnel in health care facilities that deliver immunization services. Materials in the section on the evaluation of work at immunization points can be used both by facilities, to guide them through self-evaluations, and by rayon centers of public health, to monitor and supervise facility work.

The worksheets for monitoring of immunization work that are recommended in this manual are illustrative. A full set of worksheets has been published in a separate workbook.

Reporting and Recording Documentation for Monitoring of Work on Immunization – Level 2: Rayon Centers of Public Health and Polyclinics

Toolkit 008

Ministry of Labor, Health and Social Affairs of Georgia; and National Center for Disease Control

59 pages (February 2003) • Order No. TK 008

The third edition of the training manual for rayon centers of public health and polyclinic-ambulatory units (PAUs) is a comprehensive compendium of the Georgia immunization program documentation: current recordkeeping and reporting requirements of the Ministry of Labor, Health and Social Affairs (MoLHSA) and the National Center for Disease Control; guidelines for immunization data analysis and utilization; and materials for monitoring and evaluating the immunization system and provider performance. The MoLHSA has adopted these guidelines for nationwide implementation after a year-long pilot in Kacheti region.

The manual is designed primarily for health personnel working at the rayon level who are responsible for the implementation of the immunization program. The section on evaluation of the work at rayon public health centers and PAUs can guide both the rayon-level facilities in doing self-evaluations and regional centers for public health in monitoring and supervising rayon-level work.

The worksheets for monitoring immunization work that are contained in this manual are illustrative. A full set of worksheets has been published separately in an immunization workbook for centers of public health and PAUs.

Workbook for Rayon Centers of Public Health: Monitoring of Immunization Activities and Use of Vaccines at Rayon Level in Georgia

Toolkit 009

Ministry of Labor, Health and Social Affairs of Georgia; and National Center for Disease Control

87 pages (September 2003) • Order No. TK 009

This workbook, which accompanies training manuals for monitoring of immunization work in Georgia, is a tool designed primarily for personnel of rayon-level centers of public health and polyclinics to help them monitor and evaluate immunization work, use of vaccine and adequacy of cold chain on their services territories. It helps these workers to establish the link between MIS data and response, as well as to document the data analysis and utilization for management purposes.

The current version of the workbook has gone through numerous revisions and suggestions from the pilot region. It is now recommended for use nationwide.

Health System Strengthening and HIV/AIDS: Annotated Bibliography and Resources
Toolkit 0011
Lena Kolyada
75 pages (March 2004) • Order No. TK 011

Over the past few years, a united battle against HIV/AIDS has gained momentum worldwide. Non-governmental and community-based programs, national and international organizations – all are confronting the myriad of challenges posed by the HIV/AIDS pandemic. Activities range from human rights protection for people living with HIV/AIDS and for vulnerable groups, to condom distribution, developing national HIV/AIDS strategies, providing access to HIV drugs, vaccine research, resource allocation, and the costing of treatment and prevention programs. A multitude of publications have been written on these and other aspects of the HIV/AIDS pandemic. PHRplus, in an effort to provide policymakers comprehensive information on the costs of interventions and the impact of the HIV/AIDS on health systems, has prepared this annotated bibliography of documents, focusing on issues of economic impact, financing and resource allocation, costing, health system strengthening, antiretroviral therapy, surveillance, and monitoring and evaluation. The bibliography includes summaries of 101 publications from 1997 to the present as well as a directory of web resources for additional information.

About the Partners for Health Reform*plus* Project

Highlights
8 pages (April 2004) • Order No. HR 04/04
Back copies available upon request

Highlights
8 pages (October 2003) • Order No. HR 10/03
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Highlights
12 pages (April 2003) • Order No. HR 4/03
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Highlights
8 pages (September 2001) • Order No. HR 09/01
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PHR*plus* Resource Center

The Resource Center distributes project publications and serves as an information broker to increase and facilitate access to information on all aspects of health reform. The Resource Center provides reference services to staff, counterparts, and to USAID. A monthly electronic bulletin announces new acquisitions and highlights websites of particular interest.

Bibliographic Database on Health Sector Reform

The PHR*plus* Resource Center bibliographic database cites books, papers, gray literature, videos, CD-ROMs, and journal articles related to health sector reform and the work of PHR*plus*. The database contains over 5,000 entries and can be searched by title, author, publisher, organization, date, country, region, language, and subject. To facilitate access to constituents around the world, ordering information and livelinks to documents are provided with each entry as available. The database can be accessed on the website at *http://www.PHRplus.org.*

Ordering Information

All HFS, PHR, and PHR*plus* documents are available at the project website, www.PHRplus.org.

For further information, please contact us at:

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