FORWARD-LOOKING ANALYSIS OF FUNDING AND STRUCTURAL OPTIONS FOR THE HEALTH SECTOR GOING FORWARD, AND HOW THEY COULD BE OPERATIONALISED

For: Delegation of the European Union to South Sudan, and the Ministry of Health – Government of the Republic of South Sudan

August 2017

FINAL REPORT ANNEX E: Health Service Delivery and Health Sector Governance: International comparands

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Disclaimer: The views expressed in this study do not necessarily reflect the views of the European Union
The models for health service delivery and health sector governance from 12 disrupted health arena are reviewed.

(a) Neighbours: Ethiopia, DRC, Uganda
   (NB. Absent neighbours: CAR, Sudan, Kenya)
(b) Near-Neighbours: Somalia & Somaliland
(c) Cousins in conflict: Liberia, Sierra Leone, Rwanda
(d) New countries: Timor-Leste
(e) Others: Malawi, Zambia, Ghana, Haiti
NB: Beware of the ‘it-worked-in-Peru’ argument...

• There are empirical threads and “laws”, but no universal recipes.

• Success stories should inspire, not be replicated (they can never be replicated, as they are context-bound)

No imported solution can replace:
- a deep knowledge of the specific context
- a thorough search for a realistic solution

(realistic = in line with resources, capacity and context)

(Source: Pavignani, 2017)
And, never forget or downplay the resource and capacity constraints.

Examples of what happens when these constraints are overlooked:

- a major but seriously underfunded expansion of the healthcare network (Cambodia)
- a wasteful health sector delivering very poor services (Angola)
- an overgrown, severely donor-dependent health sector (Palestine)
- unused health policies and plans (South Sudan).

(Source: Pavignani, 2017)
## DR Congo Overview

<table>
<thead>
<tr>
<th>Country population; GDP; pc GDP; health expenditure % GDP; population supported by programme</th>
<th>78,736, 153 (2016); USD 34.999 billion (2016); USD 444.5 (2016); 4.3% (2014)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ASSP supports an estimated 9.2 million people across 56 health zones in 5 Provinces.</td>
<td></td>
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</tbody>
</table>

### Subnational political structure (decentralised/deconcentrated, number of tiers etc)
- 11/14 provinces (new structure partially implemented), in principle sub-divided into districts and each district into administrative areas (zones)
- Major ongoing conflicts
- Fiscal deconcentration (sector salaries remain largely under control of national ministries: "mecanisation" etc)

### Health sector subnational governance structure
- Most services practically administered at zonal level

### Structure of health sector, from community health interventions up to tertiary
- Central, including the Public Health Ministry and the General Secretariat
- Provincial, including the Health Provincial Inspectorate
- District with three divisions (General, Medical and Hygiene Services)
- Local: Health Area (Zone de Santé)

### Donor and partner funding approaches (e.g. pooled funds, alignment to full on-budget support)
- Partner funding does not go through GoDRC Budget
- IMA World Health support a network of predominantly FBO partners working in co-management with local Zones de Santé
- User fees are charged in ASSP-supported facilities, but are tightly limited and monitored, and with extensive exemptions for vulnerable and indigent categories

### Fragility and conflict context, and responses
- Large FCAS context
- Central government, despite some economic growth in the last ten years, has had uniquely limited reach in terms of up-country service delivery, over a uniquely sustained period
- Exceptionally developed faith-based service delivery (majority of health and education services), working in relatively equal partnership with government
- DFID’s second largest bilateral health programme (after Ethiopia)
- Integrated nutrition programming focused on sustainable nutrition

### Impact/successes
- Headline achievement of ASSP in increasing coverage delivered by DFID funding *4
- Key achievements by end of year three (2015) of ASSP:
  - 779,022 births during the year were attended by skilled health personnel
  - Reached 834,782 children under one year of age with vaccinations against measles
  - 675,287 pregnant women were provided with two doses of IPT prophylaxis for malaria
  - $16m+ in medicines were procured for distribution and use at health facilities within ASSP’s 52 health zones
  - By the end of year three, 21 new health centers were built and 93 health facilities were rehabilitated
DR Congo health service delivery:

• 2012-2018; Accès aux Soins de Santé Primaire (IMA World Health managed, DFID + Sweden funded);
• Co-management of service delivery – joint Gov’t/FBO “Equipes Cadres Zones de Santé”;
• Public health-led approach; at scale HSS (incl DHIS2 and iHRIS roll-out);
• Programme funds health services for 9 million in FCAS context at low pc unit costs
DRC health sector governance:

• Most services administered by >600 Zones de Santé, co-managed by Equipes Cadres Zones de Santé;
• data systems support this (and partially compensate for limited role of Provincial Government)
Tiers

National
- Public Health Ministry; General Secretariat; Directorates

Provincial Health Departments
- Technical and logistical support
- Health Provincial Inspection

Administrative Health Districts (Sub-Provincial)
- General, Medical and Hygiene Services

Peripheral (Zones de Santé)
- Secondary Health Care
  - General Referral Hospital (34% FBO-owned)

- Primary Health Care
  - Health clinics (extensive)

- Community Health
  - Community Health Workers
  - Community health promoters (community mobilization)
  - Community treatment workers (interventions and FP commodities)
<table>
<thead>
<tr>
<th><strong>Ethiopia Overview</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Country population; GDP; pc GDP; health expenditure % GDP; population supported by programme;</strong></td>
</tr>
<tr>
<td><strong>Subnational political structure (decentralised/deconcentrated, number of tiers etc)</strong></td>
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<tr>
<td><strong>Health sector subnational governance structure</strong></td>
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<tr>
<td><strong>Structure of health sector, from community health interventions up to tertiary</strong></td>
</tr>
<tr>
<td><strong>Donor and partner funding approaches (e.g. pooled funds, alignment to full on-budget support)</strong></td>
</tr>
<tr>
<td><strong>Fragility and conflict context, and responses</strong></td>
</tr>
</tbody>
</table>
Ethiopia health service delivery:

- Partner funding to federal/decentralised subnational administrations supporting highly cost-effective delivery of primary coverage by government;
- now Health Extension Worker programme ratio is 1 health worker: 3000 population
Ethiopia’s Health System

• Uniquely extensive community/universal health network, in Federal context: not all elements equally transferable outside a “developmental state” governance context
Tiers:

National
- Tertiary Health Care
  - Specialised Hospitals

Regional
- Secondary Health Care
  - General Hospitals

District / Woredas
- Primary Health Care Unit
  - Primary Hospitals
  - Health Centres
  - Satellite Health Posts

Kebeles
- Community Health
  - Health Extension Programme
    - Operated by community-selected health extension workers
  - Community volunteers
  - Model family households
**Uganda (1980s - present): Overview**

| Country population; GDP; pc GDP; health expenditure % GDP; | 41,487,965 (2016), 12,549,540 (1980); USD 25.528 billion (2016), USD 1.245 billion (1980); USD 615.3 (2016); 7.2% (2014) |
| Subnational political structure (decentralised/deconcentrated, number of tiers etc) | Effectively single-tier: MoH and National Referral Hospital at national level; >100 Districts |
| Health sector subnational governance structure | Straight-through single-payer/FHCI basis, and high geographical coverage of health units But shortages of supplies and staff, resulting in reliance on faith-based and private units with user fees. |
| Structure of health sector, from community health interventions up to tertiary | Extensive reliance on “Private-Not-for-Profit organisations (PNFPs), with mixed funding from user fees and subsidised by Government and donors. Seventy five percent of the facility-based PNFP organisations exist under four umbrella organisations: the Uganda Catholic Medical Bureau (UCMB), the Uganda Protestant Medical Bureau (UPMB), the Uganda Orthodox Medical Bureau (UOMB) and the Uganda Muslim Medical Bureau (UMMB). Village health team, Health Centre 2-4 and District Hospital structure. |
| Donor and partner funding approaches (e.g. pooled funds, alignment to full on-budget support) | Funding of c$30 pc pa. Budget support 1998-2012, with acrimonious end. |
| Fragility and conflict context, and responses | Current high refugee inflows to Uganda; ‘settlement’ policy, and link to infrastructure serving host communities (broadly defined) |
Uganda 1980s- health service delivery:

- Government and FBO service delivery;
- positive effect of straight through PFM reforms, and Free Health Care initiative (2001): but “crumbling edge of quality” and informal fees as funding has not kept pace
Uganda Health Sector Governance:

- Positive effect of subnational PFM reforms from late 1980s – straight through funding to Districts and Service Delivery Units (including Private Not-For Profit)
Tiers

National
- Tertiary Health Care
  - National Referral Hospitals

Regional
- Secondary Health Care
  - Regional Referral Hospitals

District Health System
- Health sub-districts
  - Primary Health Care Unit
    - General Hospitals
    - Health Centres I, II, III, IV
    - Satellite Health Posts
  - Community Health
    - Village Health Teams
## Somalia & Somaliland overview

<table>
<thead>
<tr>
<th>Country population; GDP; pc GDP; population supported by programme</th>
<th>14,317,996 (2016; all zones); USD 6.217 billion (2016); USD 434.2 (2016); USD &gt;2m</th>
</tr>
</thead>
</table>
| **Subnational political structure** (decentralised/deconcentrated, number of tiers etc) | • Somaliland is autonomously administered; FGS MoH in practice functions as coordinating MoH for South Central; Interim Jubbaland Administration MoH incipient; Puntland MoH has full practical autonomy  
• Across the zones 18 administrative regions, which are, at least in principle, subdivided into 90 districts |
| **Health sector subnational governance structure** | • Zonal MoHs coordinate, lead, and fund basic staff remuneration ($<100 pc pm) for core staff  
• Local governance and management structures at Regional and District level: Regional Health Office, Regional Health Board, District Health Board and Community Health Committees |
| **Structure of health sector, from community health interventions up to tertiary** | • Referral Health Centres - Hospital Directors report to Regional Health Officers  
• Primary Health Care units, Health Centres, Mat & Child Health Care facilities - report to District Health Officers  
• Community based programme - staffed by home-based female CHWs, aimed at providing maximum coverage |
| **Donor and partner funding approaches** (e.g. pooled funds, alignment to full on-budget support) | • Alignment of donor funding with government systems, plans and programmes is based on 2 themes:  
  • Consolidated Appeals Process or the humanitarian response - delivering relief operations  
  • Health sector development - improving equitable access to acceptable, affordable and quality health services through the implementation of the essential package of health services and HSS  
• Established coordination with implementing partners and promoted partnerships is evolving |
| **Fragility and conflict context, and responses** | Prolonged conflict spanning over two decades has left Somalia as one of the world’s most fragile states. This has ruined the health system, resulting in a number of parallel and fragmented systems and structures for health care and has led to the worst global health and nutrition. More than 40% of the population live on less than US$ one dollar a day and 73% on less than US$ two dollars per day. Somaliland and Puntland have remained relatively stable. Very extensive private |
| **Impact/successes** | By the end of 2016, the programme achieved the following specific results:  
• 134,000 modern birth spacing methods distributed in Somaliland;  
• An additional 35,457 women having an HCS trained skilled birth attendant in target areas;  
• 87,432 children under 5 years fully immunised (DPT3) through routine services  
• 114,250 children under five in target areas received emergency and basic nutrition services |
Somalia & Somaliland health service delivery:

• 2009-2016; Health Consortium for the Somali People – high-performing NGO consortium with thin Secretariat layer, rather than fund manager;

• National lead donor (DFID); contracting-in by NGOs for funding of staff, NGO-supported service delivery;

• Somaliland and Puntland MoHs have stronger coordinating and leadership roles, as ‘base funders’ of health staff wages, despite budgets in low single-digit millions
Somalia & Somaliland health sector governance

• Zonal administrations make intergovernmental transfers to regions for basic salaries;
• Contracting-in payments at zonal, region and PHCC levels
• Somalia has countless NGOs on the ground
• Role of informants in a healthcare arena with feeble written information assumes greater importance.
• Hard-won local knowledge was at risk of being ignored or bypassed by powerful institutional actors.
## Tiers:

### National/Zonal

- **Somali Federal MOH, Puntland MOH, IJA + New Admin’s MoHs; Somaliland MoH**

### Regions

#### Tertiary Health Care
- **Tertiary hospitals**

#### Secondary Health Care
- **Referral Health Centres**

#### Primary Health Care
- **Health Centres**
  - Operated by qualified nurses and midwives
  - Provide BEmONC services
  - Provide outreach support to PHCUs
  - Maternal and Child Health Care Facilities

#### Community Health
- **Primary Health Care Units**
  - Operated by trained Community Health Workers
  - Provide as FCHWs PLUS vaccination
  - Community programmes
  - Female CHWs providing health promotion & education, nutrition, hygiene and treating common diseases
## Sierra Leone Overview

| Country population; GDP; pc GDP; health expenditure % GDP; population supported by programme; | 7,369,190 (2016); USD 3.669 billion (2016); USD 496.0 (2016); 11.1% (2014) |
| FHCI offers free health care in public facilities to pregnant women, lactating mothers and U5s, latterly it expanded to include people living with disabilities and EVD survivors |

### Subnational political structure (decentralised/deconcentrated, number of tiers etc)
- 3 rural provinces (soon to be 4), plus a capital city administrative province; 14 districts (soon to be 16) - 12 rural, 2 covering the capital Freetown; 149 chiefdoms which are hereditary, tribal units of local governance
- Elected Local Councils were introduced in 2004 following an Act of Parliament
- In 2011 a national chiefdom governance and traditional administration policy reaffirmed the need to strengthen Councils and Development Committees and align with the decentralisation framework

### Health sector subnational governance structure
- District Medical Officers head up the District Health Management Teams alongside the Medical Superintendents who lead the District Hospitals both clinically and administratively. Service Level Agreements were put in place between IPs and MoHS / DHMTs to rationalise distribution of resources and encourage increased accountability of both partners and government.
- Leadership and governance challenges: Lack of performance management systems; Weak planning, budgeting, monitoring and evaluation processes (poor data management and use); Weak coordination mechanisms; Weak culture of accountability.

### Structure of health sector, from community health interventions up to tertiary
- Single-tier decentralised health care delivery system:
  - Tertiary – limited specialized services provided at regional and national hospitals
  - Secondary – District Hospitals (in each current District)
  - Primary – Peripheral Health Units – Mat & Child Health Posts, CommHealth Posts, Comm Health Centres
  - Community Health Workers are now operational in all Districts providing basic services, referrals and surveillance

### Donor and partner funding approaches (e.g. pooled funds, alignment to full on-budget support)
- Signatory of the IHP+ Compact, committing the Govt and partners to adhere to agreed aid effectiveness principles
- Since the end of the EVD outbreak, coordination through Health Sector Coordination Committee, the highest consultative and strategic decision-making body in the sector - chaired by the Minister of Health and Sanitation
- No formal mechanism in place for pool funding
- Range of on budget and aligned support for 2010 FHCI – incl DFID and GF.

### Fragility and conflict context, and responses
- 1990s civil war, followed by strong recovery and economic growth. Recently severely affected by Ebola outbreak. Remains one of the world’s poorest countries. Minimal security/conflict issues.

### Impact/successes
- FHCI brought real gains - number of staff on payroll and upgrading of health facilities, and innovation like civil society monitors. Modelled cost-effectiveness was high. Evidence suggests that there were tangible reductions in U5 mortality, however, the same cannot be concluded about maternal mortality, although most mother and child health indicators showed a closing of gaps between richer and poorer households, and between well and less well performing regions over the period.
Sierra Leone (2010 – Present): Free Health Care Initiative

• Government-led switch to free at point of use care for priority populations, major expansion of coverage and services; donor support on-budget and aligned.

• Pharma supply chain heavily UN-led.

• But lack of mechanism for long-term funding of health commodities threatens FHCI, and GoSL and Partners relations were better earlier in the decade.
Sierra Leone’s Health Sector Governance:

• Unitary management of health services by 14 Districts;
• systematic bringing together at district level of health management and clinical/technical (district hospital leadership)
Tiers

MoHS

Health Training Institutions

District Council
- District Health Management Teams
- Village Development Committees
  - Facility Management Committees
  - Peer Supervisors

Secondary Health Care
- District / Referral Hospitals
- Private and FBO Hospitals

Primary Health Care
- Community Health Centres
- Community Health Posts
- Maternal and Child Health Posts

Community Health
- Community Health Workers delivering iCCM++, CBS
# Liberia Overview

<table>
<thead>
<tr>
<th>Country population; GDP; pc GDP; health expenditure % GDP; population supported by programme;</th>
<th>4,613,823 (2016); USD 2.101 billion (2016); USD 455.4 (2016); 10.0% (2014)</th>
</tr>
</thead>
<tbody>
<tr>
<td>10 / 15 Counties are included in the Health Sector Pool Fund implementation; One third of the government hospitals and clinics in Liberia are financed through it.</td>
<td></td>
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</tbody>
</table>

| Subnational political structure (decentralised/deconcentrated, number of tiers etc) | 5 regions with 15 political subdivisions, called counties; Monrovia is the largest city and serves as the administrative, commercial and financial capital  
In 2012 the MoH introduced the National Health and Social Welfare Decentralisation Policy and Strategy |
|---|---|

| Health sector subnational governance structure | County Health and Social Welfare Teams, headed by the County Health and Social Welfare Officer, are responsible for coordination of all activities at the health facility level  
In 2015, the MoH through its Governance and Decentralization Unit established governance and leadership structures including County Health Boards, Hospital Boards, District Health Boards, and Community Health Committees to have oversight responsibility and monitor the implementation of health service delivery in the counties |
|---|---|

<table>
<thead>
<tr>
<th>Structure of health sector, from community health interventions up to tertiary</th>
<th>The system is based on three main levels of service delivery: primary, secondary and tertiary. In the 2010 the MOHSW reported 550 open health facilities (378 public and 172 private), this increased to 725 in 2014 - 35 hospitals, 51 health centres, 639 clinics and 137 pharmacies. Facility density ranged from 1.0 per 10,000 population in Bong County to 2.9 in Sinoe County</th>
</tr>
</thead>
</table>

| Donor and partner funding approaches (e.g. pooled funds, alignment to full on-budget support) | Health Sector Pool Fund was established in April 2008 by the GoL on the grounds the large number of health initiatives translated into excessive transaction costs for the government.  
The objectives of the pool fund were To help finance priority unfunded needs; to increase the leadership of MoH in the allocation of resources; and to reduce transaction costs associated with managing multiple donor projects |
|---|---|

| Fragility and conflict context, and responses | Post-conflict  
Upcoming transition |
|---|---|

<table>
<thead>
<tr>
<th>Impact/successes</th>
<th>HSPF mechanisms were utilised to support Ebola outbreak response, focusing efforts on MoH-led Surveillance pillar, as well as contributing to other pillars. Outside of Ebola response, HSPF supported HRH activities including monthly processing of incentive payments, payroll monitoring and integrated supervision. Post-Ebola, restoring essential health services is a top priority and a restoration of health services plan has been developed – MoH is awarding performance contracts for managerial functions at key health facilities, contracting-out management of services to selected NGOs, and establishing MOUs with private and faith-based institutions - in all, 14 hospitals, 13 health centres, and 21 clinics (a mix of private and public facilities) were funded.</th>
</tr>
</thead>
</table>
Liberia Health Service Delivery

• The Health Sector Pooled Fund that wasn’t, at least initially, what it was widely supposed to have been!

• Co-management by government (rather than donor-driven); initially, focused on supportive actions, rather than service delivery – but moved into funding health worker incentives.

• Now also some contracting-out (cf. Liberia education sector)

• The engagement of donors in the Liberia recovery process was a positive example of negotiation skills.
Liberia’s Health System:

- Unitary management of health services by Counties; extensive reliance on non-state actors
### Tiers

**Ministry of Health and Social Welfare**

<table>
<thead>
<tr>
<th>Tertiary Health Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Referral Hospitals - provide specialized consultative care AND is designated teaching hospital</td>
</tr>
<tr>
<td>Regional Referral Hospitals - provide specialized consultative care</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Secondary Health Care</th>
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</thead>
<tbody>
<tr>
<td>County Hospitals - referral facility for the county network of clinics and health centres. Provide CEmONC</td>
</tr>
<tr>
<td>Health Centres - transition between primary and secondary levels of care. Provide mostly primary care, inpatient capacity makes them a referral facility. Provide BEmONC.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Primary Health Care</th>
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<tbody>
<tr>
<td>Clinics - offers the whole Essential Package of Health Services including curative care, maternal and child care with immunization and delivery</td>
</tr>
</tbody>
</table>

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<thead>
<tr>
<th>Community Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-facility based Service Delivery Points – skilled providers delivering through mobile clinics or outreach</td>
</tr>
<tr>
<td>Community Health Volunteers, Household Health Promoters and Trained Traditional Midwives link communities to the nearest facility</td>
</tr>
</tbody>
</table>
## Malawi, Zambia, Ghana Overview

<table>
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</thead>
<tbody>
<tr>
<td>Malawi</td>
<td>18,091,575</td>
<td>5.442 billion</td>
<td>300.8</td>
<td>11.378%</td>
<td>XXX</td>
</tr>
<tr>
<td>Zambia</td>
<td>16,591,390</td>
<td>19.551 billion</td>
<td>1,178.4</td>
<td>4.987%</td>
<td>XXX</td>
</tr>
<tr>
<td>Ghana</td>
<td>28,206,728</td>
<td>42.69</td>
<td>1,513.5</td>
<td>3.557%</td>
<td>XXX</td>
</tr>
</tbody>
</table>

### Subnational Political Structure

- **2004** - Health devolution guidelines & policy framework for implementation of the decentralization process introduced

### Health Sector Subnational Governance Structure

- Admin & ops responsibility for health at the district level has been delegated to local govt with its governance structures

### Structure of Health Sector, from Community Health Interventions up to Tertiary

- **PHC** – Community initiatives, health posts, dispensaries, maternity units, health centres, community & rural hospitals
- **SHC** – District Hospitals provide specialized services to patients
- **THC** – Consists of highly specialized services at central hospitals

### Role of CHA in Health Sector

- Public-Private Partnership Bill promotes partnership between the public & private sector for service delivery. CHAM has a network of over 175 healthcare facilities and 12 training hospitals making a substantial impact on the health sector

### Donor and Partner Funding Approaches (e.g. pooled funds, alignment to full on-budget support)

- Health Sector Review Group is mandated as the coordinating body for the sector to enhance partnership for health development.

### Impact/Successes

- XXX
Malawi, Zambia, Ghana Health Systems

• Role of faith-based service delivery in a range of African countries – both stand-alone and contracted (Christian Health Associations etc) basis:

• Parallel but harmonised faith-based systems (incl service delivery units, drug supply etc), funded on MoU/Service Level Agreement basis: resilience through plurality, comparator role;

• Ghana possible transition of church clinics into ‘National Health Service’?
### Rwanda Overview

<table>
<thead>
<tr>
<th><strong>Country population; GDP; pc GDP; health expenditure % GDP; population supported by programme;</strong></th>
<th><strong>11,917,508 (2016); USD 8.376 billion (2016); USD 702.8 (2016); 7.5% (2014)</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>More than 90% of the population are enrolled in community based health insurance or mutuelle de santé</td>
<td></td>
</tr>
</tbody>
</table>

### Subnational political structure (decentralised/deconcentrated, number of tiers etc)

- 4 provinces subdivided into 30 districts, plus Kigali City
- Each district is divided into sectors, which are further divided into cells and finally into villages, Imidugudu. On average, a village can accommodate 50 to 150 households.
- Pursuing an ambitious decentralization programme to empower local communities and increase transparency and accountability - decentralization is enshrined in the Constitution of Rwanda

### Health sector subnational governance structure

- Local governments are the focal point for delivery of and accountability for health services, being responsible for all their operations including controlling programme implementation
- Health personnel, infrastructure, equipment, and financial resources are decentralized to the district level
- CBHI is coordinated at the district level, where each of the 30 districts has a pooled-risk fund; each CBHI section has a health centre; and all villages have a CBHI mobilization committee
- At the sector level, there are Health Centre Committees that provide oversight on the work from various units in the health centre, its outreach, supervision activities, and general financial controls.

### Structure of health sector, from community health interventions up to tertiary

- Different types of providers – public, confessional, private-for-profit and NGO, provide services as follows:
  - 4 referral hospitals at national level, provide advanced care in cases of medical complications
  - 42 district hospitals - transfer patients to the RHs for complex care
  - 438 health centres – oversee one CHW cooperative each
  - 45,011 CHWs operating in 14,873 villages - organized into CHW cooperatives

### Donor and partner funding approaches (e.g. pooled funds, alignment to full on-budget support)

- Common Performance Assessment Framework indicators and policy actions selected from the government’s poverty reduction strategy; joint governance assessment by donors and govt forms the basis for budget support
- Joint dialogue between donors and govt has led to an increase in public spending on health, better access by the poor to health care packages and the expansion of social protection mechanisms such as mutuelles

### Fragility and conflict context, and responses

The country is stable and at peace. While the legacy of the genocide persists, the country has made good progress toward resettlement, national reconciliation, demobilization, and reintegration of ex-combatants. Rwanda’s political and economic stability is also closely linked to the rest of the Great Lakes Region and to the regional programs to demobilize and reintegrate combatants and to build a sustainable peace.

### Impact/successes

Over the first decade, national Mutuelle de Santé covered more than 90% of the population, has reduced out of-pocket spending for health from 28% to 12% of total health expenditure, and increased service use to 1-8 contacts per year.
Rwanda

• Community-based health insurance programme, 2004 - present, *Mutuelle de Santé*, local assessment of wealth for contributions, unique governance context delivering exceptionally high participation in insurance – “the exception that proves the rule”
Rwanda’s Health System:

- Two-tier government context;
- unique ‘*imihigo*’ individual performance contracts;
- not all elements equally transferable outside a “developmental state” governance context.
Rwanda’s Health System:

National
- Tertiary Health Care
- • Referral Hospitals

District Health Unit
- CBHI Committees
- Secondary Health Care
- • District Hospitals

Sector
- Health Centre Committees
- Primary Health Care Unit
- • Health Centres
- • Health Posts

- CHW Cooperatives
- Community Health
- • Community Health Workers
- • Community based health insurance scheme
## Timor-Leste Overview

<table>
<thead>
<tr>
<th>Country population; population supported by programme; GDP; pc GDP; health expenditure % GDP</th>
<th>1,250,000 pop (2015) 70% of whom live in dispersed hard-to-reach mountain villages. Heavy involvement from DFAD (Australia) &amp; UN family. GDP USD 1.4 billion (USD 1,136.6 per capita); pc GDP 643.7 (2008). 1.5% (2014 )Broadly cohesive traditions/ norms across 13 different language groups</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subnational political structure (decentralised/deconcentrate)</td>
<td>Capital – 13 municipalities with increasing autonomy (but Ministry functions de-concentrated) - 70 counties -442 suku (lowest significant level)-- 1000s villages</td>
</tr>
<tr>
<td>Health sector subnational governance structure</td>
<td>Municipal director health answers to Min of State Administration (since 2016) and manages support staff and small infrastructure budget. Health professionals recruited and managed technically by central MoH staff.</td>
</tr>
<tr>
<td>Structure of health sector, from community health interventions up to tertiary</td>
<td>Massive (very new) commitment to ‘Family Health’, house-to-house universal health coverage model based on Cuban model, sister of Ethiopian Health Extension Worker model served by health posts (in villages &gt; 1500 pop), managed by Community Hlth Centres, overseen by Municipal Hlth Office. 4 dispersed Referral Hosps (24 beds each) + 1 Regional Hosp (120 beds) + 1 National Hosp (230 beds)</td>
</tr>
<tr>
<td>Donor and partner funding approaches (e.g. alignment to full on-budget support)</td>
<td>Govt spending derived from interest from oil revenue fund, front-loaded to drive investment. Australians support Finance Min, Min Public Admin etc with financial &amp; technical support but not full budget support). No pooled funds</td>
</tr>
<tr>
<td>Fragility and conflict context, and responses</td>
<td>UN-ranked 11th most susceptible country to climate change. (Restoration of) Independence 2002. Last internal conflict 2006. Zero conflict now. Multi-party presidential democracy with marked social equality constitution</td>
</tr>
</tbody>
</table>
Timor-Leste health service delivery:

- Skilled human resource-led local provision, including house-to-house UHC, (based on Cuban model):
- Increasing decentralisation
- Resource-wealth investment: (what could have been for South Sudan?)
Timor-Leste Health System

• Doctor-led integrated primary health teams;
• Static and mobile UHC approach
• Reliance on overseas transfer of complex cases
## Tiers:

### National

- **Tertiary Health Care**
  - Tertiary Referral Hospital

### Municipalities

- **Secondary Health Care**
  - Multi-Municipality Referral Hospitals

- **Primary Health Care Unit**
  - Community Health Centres (large and small)
  - Health Posts

- **Community Health**
  - Integrated Primary Health Care outreach to villages
  - Community Health Workers
Haiti Overview

<table>
<thead>
<tr>
<th>Country population; GDP; pc GDP; health expenditure % GDP</th>
<th>10,847,344 (2016); USD 8.023 billion (2016); USD 739.6 (2016); 7.556% (2014)</th>
</tr>
</thead>
</table>
| Subnational political structure (decentralised/deconcentrate) | • Haiti is divided into 10 departments, 41 *arrondissements* (similar to districts), 135 communes, and 565 communal sections  
• Despite constitutional support, little has been done to decentralize; line ministries are not motivated to share power with local governments. Although the Ministry of Health’s has made efforts to deconcentrate |
| Health sector subnational governance structure | • Public health services are managed by the Ministry of Public Health and Population  
• 54 Municipal Health Units, each serving a population of between 80,000 to 140,000 local residents are mandated to ensure the provision of a minimum package of services and coordinate the primary health care network. |
| Structure of health sector, from community health interventions up to tertiary | • Nearly half of Haiti’s health services are concentrated in the capital, with the remainder located in rural areas—just 47% of the population are served by the formal health system  
• Many health centres are managed by either NGOs or by FBOs; 615 health service delivery outlets in the country, of which 209 (34%) were public, 241 (39%) private and 151 (25%) mixed.  
• Maternity waiting homes were first introduced into Haiti in 2001; quality-related issues affect effectiveness, including staffing, availability of supplies and clean water, and costs to the clients |
| Donor and partner funding approaches (e.g. alignment to full on-budget support) | Capacity building at the MoH empowered departmental directors to coordinate activities of all donors and NGOs working in the health sector. Now Directors monitor performances, avoid duplication, & target neglected areas |
| Fragility and conflict context, and responses | Like many fragile states, Haiti has repeatedly emerged from and descended into crisis. Natural disasters, violence, and declining political, economic and social conditions have been detrimental to not only the fabric of society, but also the capacity, infrastructure, human resources, and systems of health service delivery |
| Impact/successes | Maternal Waiting Homes provide residential care for women with high risk pregnancies who would otherwise might have to walk for hours to receive treatment and risk their own lives and those of their unborn children. MWH allow women to be close to hospital and helps to decrease maternal and neonatal mortality. At MWHs women typically receive prenatal care, nutritious meals, housing, as well as education about delivery, newborn health, birth preparedness, breastfeeding. Criteria for eligibility include presence of danger signs, short stature, low weight, age (young or old) and nonclinical factors such as living far from the health facility |
Maternity waiting homes in Haiti

• EmONC referral chain works better so reducing maternal deaths

• Cuts delays (UNFPA ‘s 3 Delays: delay in deciding to seek help; delay in arranging transport; delay in transportation)
## Haiti health sector structure

<table>
<thead>
<tr>
<th>National</th>
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</thead>
<tbody>
<tr>
<td><strong>Tertiary Health Care</strong></td>
</tr>
<tr>
<td>• National Referral Hospitals</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Departments</th>
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</thead>
<tbody>
<tr>
<td><strong>Secondary Health Care</strong></td>
</tr>
<tr>
<td>• Department Hospitals</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Arrondissement</th>
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<tbody>
<tr>
<td><strong>Primary Health Care</strong></td>
</tr>
<tr>
<td>• Government Health Centres</td>
</tr>
<tr>
<td>• Private and FBO Health Centres</td>
</tr>
<tr>
<td>• Mixed (Govt &amp; private joint-funded) Health Centres</td>
</tr>
<tr>
<td><strong>Community Health</strong></td>
</tr>
<tr>
<td>• Community-based health agents (<em>agents de santé</em>)</td>
</tr>
<tr>
<td>• Trained local birth attendants</td>
</tr>
<tr>
<td>• Mobile clinics</td>
</tr>
<tr>
<td>• Community volunteers</td>
</tr>
<tr>
<td>• Community-based organizations</td>
</tr>
<tr>
<td>• Traditional medicine</td>
</tr>
</tbody>
</table>
Education and health synergies:

- Multiple international examples of school health interventions;
- Fewer examples of full allocation of services (not just school mother/school nurse) being harnessed
- “School health” approaches can include:
  - provision of health services at schools, incl WaSH-friendly status
  - basic health training for teachers; incorporation of health education into the curriculum
  - health promotion events at schools; dedicated education areas at health facilities
  - outreach by health workers/school mothers/school nurses
  - Specific peripatetic interventions (eg vaccinations, de-worming)
• Full allocation of health services in schools can provide a low-cost way to rapidly increase coverage. This makes the most of existing infrastructure and supports both local governments and communities.

• It is easier to plan and conduct health promotion activities, both for students and the community at large, if facilities are close together.

• In Zimbabwe popular ‘School Health Clubs’ are effective in leading a range of community-level health promotion activities. These are usually run by teachers who have been given basic health training.

• Healthy children learn better. If students can readily access health services (including advice) they can be encouraged to adopt healthy behaviours, seek early treatment and avoid time off school.

• Schools (and teachers) outnumber health facilities (and health workforce) by factor of two in South Sudan (relatively similar ratio in e.g. Sierra Leone)
## International comparisons summary

<table>
<thead>
<tr>
<th>Country and period</th>
<th>Services/programme/project</th>
<th>Feature</th>
</tr>
</thead>
<tbody>
<tr>
<td>Somalia 2008-</td>
<td>Health Consortium for the Somali People (incl. relatively advanced forms of contracting in), Joint Health and Nutrition Programme, new DFID SHINE programme</td>
<td>National lead donor role (in this case, played by DFID). Contracting-in for funding of staff (under HCSP); NGOs in technical support role. Different service delivery models in one country (HCSP versus JHNP, and soon SHINE). Operations in severe conflict context (including service delivery in non-government-controlled areas).</td>
</tr>
<tr>
<td>Sierra Leone 2010-2015</td>
<td>President’s Free Health Care Initiative FHCI</td>
<td>Government-led switch to free at point of use care for priority populations, major expansion of coverage and services. Donor support on-budget and aligned. Pharma supply chain UN++.</td>
</tr>
<tr>
<td>Liberia</td>
<td>Health Pooled Fund</td>
<td>A much misunderstood case – a health pooled fund that was, at least initially, focused on supportive actions, rather than service delivery.</td>
</tr>
<tr>
<td>Malawi, Zambia ++</td>
<td>Role of faith-based service delivery in a range of African countries – both stand-alone and contracted (eg CHAM) basis</td>
<td>Indigenous non-governmental service delivery.</td>
</tr>
<tr>
<td>Ethiopia</td>
<td>Federal Ministry’s national roll-out of Health Extension Worker programme</td>
<td>Exceptional UHC coverage of territory with limited resources. Government-led, donor-supported; an exceptional governance context.</td>
</tr>
<tr>
<td>Rwanda</td>
<td>Para-compulsory National Health Insurance</td>
<td>Unique governance context driving high uptake of insurance scheme.</td>
</tr>
<tr>
<td>East Timor</td>
<td>Skilled human resource-led local provision</td>
<td>Quarter of workforce are doctors.</td>
</tr>
<tr>
<td>Uganda 1980s-</td>
<td>Free Health Care initiative and PFM reforms</td>
<td>Indigenous service delivery, with straight-through funding… but crumbling edge of quality and re-emergent user fees.</td>
</tr>
<tr>
<td>Haiti</td>
<td>Maternity waiting homes</td>
<td>Making EmONC referral work in resource-constrained FCAS context.</td>
</tr>
<tr>
<td>Afghanistan</td>
<td>Extensive contracting out</td>
<td></td>
</tr>
</tbody>
</table>
Observation 1: “No Health without a Workforce”

(Global Health Alliance, WHO Geneva)

An expansion of the number of skilled health workers, delivering universal health coverage (to each household) can deliver rapid gains in health outcomes (and economic development).

- Ethiopia’s adoption - led by the current Secretary-General of WHO - is much-lauded (and is being adopted in Timor-Leste).
- A focus on HRH over infrastructure is wiser. (‘Good staff in poor buildings’ is better than ‘Poor staff in good buildings’)
- Risks: Training costs are enormous and are ‘sunk costs’; increased HRH numbers need a corresponding increase in management and supervision (otherwise productivity falls)
Observation 2: Beware of “It worked in Peru” argument

The pooled fund model (e.g. Liberia, Afghanistan) have been used as blueprints in South Sudan, but key aspects have not been mapped across

- The Liberia Health Sector Pool Fund (located in, and co-managed by, the Ministry of Health and Social Welfare) evolved markedly over time in scale and structure over several years.
- The full (and accepting) engagement of donors over many years was key.
- Its near-collapse from the Ebola onslaught nevertheless demonstrated its inherent (and entirely unanticipated) weakness.
- The rolling put of the Basic Package absorbed most of the available capacity
Observation 3: There is no ‘empty void’: the healthcare space is richly diverse.

• Faith-Based Organisations (FBOs) and NGOs proliferate
• But also present are informal providers, traditional healers, quacks, private for-profit entrepreneurs, remittance holders, non-Western aid donors, charities, political groups and criminal rings.
• Public providers may be in there somewhere, but are not dominant.
• The health space is fragmented and system-less, the whole being less than the sum of its parts.

(Source: Pavignani, 2014, Murru et al 2015)
Disrupted Arena: General health-related aspects

- Health space fragments
- Official portrait disconnected from reality
- Provision degenerates to questionable value
- Private health expenditure increases
- Traditional care expands
- Public-private, foreign-domestic, formal-informal, qualified-unqualified, traditional-modern, legal-illegal become inadequate and misleading binary categories

(Pavignani et al, 2014)
Conclusion: Comparative analysis is potentially fruitful

Some examples of fruitful comparative analysis are:

• Mozambique vs. Angola (similar starting conditions, diverging trajectories), or
• Cambodia vs. Kosovo (donor-driven Health Sector Reforms)
• Liberia vs. Sierra Leone

Some “technical imports” may be valuable... but only if appropriate to the resources available and the context.

(Example: Aid management in post-conflict Liberia.)