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Constraints to the Scale-Up of Priority Interventions: Factoring in Quality of Governance and Policy Framework

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Improving Health Outcomes of the Poor

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I. Introduction

Working Group 5 of the Commission on Macroeconomics and Health has been asked to undertake an evidence-based evaluation of policies relevant to "improving health outcomes of the poor".

To that effect it has set out to answer three basic questions:

- What set of measures will significantly improve health of the poor in a relatively short time period?
- What factors hamper the widespread implementation of these measures amongst the poor and what options are available to deal with these?
- What are the total costs of scaling up and sustaining interventions in differing, but generalizable scenarios?

This Paper addresses the second question with particular emphasis on the constraints which reflect deficient governance and inadequate policy frameworks.

Based on desk review of reports about the implementation of priority program which could significantly improve health of the poor, this Paper:

- proposes a typology of recurrent implementation constraints,
- identifies typical settings or "enabling environments" which capture essential differences in quality of governance and policies, and
- makes a first attempt to group low income and lower middle income countries by the quality of their governance and policy frameworks.

In its operational conclusion the Paper argues that a country's enabling environment, as defined by its governance and policies, dictates the strategies for scale-up of priority interventions, and sets the medium-term limits to attainable coverage. Possible strategic responses to enabling environments of fundamentally different quality are put up for discussion.

II. Constraints to the Implementation of Priority Programs

1. Available Evidence:

Actual experience with the implementation of priority programs has been the subject of scattered, intermittent program reviews carried out with variable quality and objectivity by national and international agencies. These reviews have identified a wide range of implementation constraints which are reducing the efficacy of the individual interventions, drive up their unit costs even in modest scale ups, and are setting serious limits to the widening and deepening of the deserving interventions.

Several priority programs such as TB/DOTS and HIV containment efforts have been given substantial coverage, while for others the coverage is at best sporadic.

For its inventory of implementation constraints the desk review has drawn on the analysis of implementation constraints provided by the periodic WHO/STB Reviews of the Implementation of National Tuberculosis Control Programs, on UNAIDS program reviews and on material prepared for WHO's Roll Back Malaria Program.

Operational issues have also been identified on the basis of World Bank Reports about the implementation of its Health Projects.

Pending completion of a broader inventory of implementation constraints based on a structured de-brief of program specialists in WHO and other agencies along the lines suggested in Annex 3, the recurrent constraints which have so far been identified are set out below. A "typology of constraints" is proposed in Annex 1.

2. Recurrent Constraints:

(a) On the Demand Side:

Health-Seeking Behavior has been found to be constrained by:

- lack of health education,
- limited dissemination to the poor of salient information about the diseases which impact most severely on health outcomes for the poor,
- lack of public information about public health programs, standards of service and entitlements,
- financial barriers due to formal or "informal" cost recovery applied by the public health services, inability to pay for travel to public health station or primary hospital, and general lack of health insurance,
- lack of confidence in the public health service coupled with inability to pay private providers,
- lack of confidence in private provider,
- fear of stygmatization, and
- gender discrimination.

(b) On the Supply Side:

Supply of Public Health Services has been found to be constrained by:

- lack of funds relative to the requirements of the assigned mission,

- lack of trained, motivated staff,
- lack of quality drugs and materials,
- lack of buildings and equipment,
- lack of infrastructure (water, sanitation, power and transportation) in support of public health centers and hospitals,
- lack of program management capacity, standards and processes,
- lack of accountability for resources and results,
- lack of effective outreach programs for social marketing,
- lack of professional consensus regarding program strategy, regimen and protocols.

Services of Private Providers have been found to be constrained by:

- lack of relevant, up-to-date training,
- dependence on an unregulated, haphazard drug supply,
- lack of effective regulation to enforce commonly accepted professional standards,
- general reluctance of public programs to rely on properly screened and monitored private providers in service delivery.

(c) Missing Links Between Supply and Demand:

Lack of Community-Based Organizations capable of intermediating access of the poor to the public health services and to competent private providers has been identified as an important institutional constraint. The general absence of community-based organizations which can connect supply and demand reinforces the constraints on the health-seeking behavior of urban and rural poor, and prevents more cost-effective, needs-based operation of the public health services.

There is urgent need to inventory and evaluate "best practices" in the promotion, establishment and operation of community-based organizations operating which have made it their mission to improve health outcomes of the poor. Models with proven replicability need to be identified and disseminated.

3. Cross-Cutting Constraints

The following provides a summary of cross-cutting constraints to the widening and deepening of priority interventions in low- and lower middle income countries:

- lack of Government commitment to improving the health outcomes of the poor,
- lack of expenditure priorities between government programs and within health programs,
- deficient planning, programming and budgeting processes
- seriously under-financed programs
- lack of performance standards and accountability for results
- inadequate remuneration and motivation of PHS staff
- major problems in the supply of quality drugs and materials including frequent stock-outs
- weaknesses in general infrastructure (water, electricity, sanitation, communication)
- malnutrition among the poor and disadvantaged
- lack of professional consensus about basic protocols and regimens
- lack of coordination between programs promoting priority interventions
- lack of policy response and managerial response to ongoing or threatening co-epidemics
- lack of communicable disease surveillance
- weak health education and limited communication about patient rights and entitlements

- unregulated, poorly trained private providers relying on an unregulated, haphazard drug supply
- non-existing, disfunctional or weak health insurance schemes
- lack of community-based organizations and limited availability of qualified Health-NGO's.

The cross-cutting nature of many of these constraints reflects in the first instance the fact that most of the core interventions depend for their implementation on weak and frequently disfunctional public health service; however, more fundamentally, it reflects basic, systemic deficiencies in governance and policies.

For example:

- At the most general level, the lack of Government commitment to improve the health outcomes of the poor tends to reflect political systems which fail to empower the poor and are unable to generate and sustain a political commitment to poverty alleviation. Typically, this results in national health policies which fail to set clear priorities relevant for improving health outcomes for the poor. Frequently only passing reference is made to the basic responsibilities of Governments for effective communicable disease control. In almost all of these cases a very general constraint can be identified in the fact that civil society is too underdeveloped or too weak to re-dress these failures of the political system through effective advocacy and non-governmental efforts.
- Under-financed, disfunctional public health programs are in most cases the direct, unavoidable consequence of ineffective, socially irresponsible public expenditure policies. In many cases this is exacerbated by fiscal adjustment programs which have been designed to

correct unsustainable macro-economic imbalances without paying attention to the social dimensions of the adjustment process.

- Similarly, inadequate remuneration and motivation of the public health staff reflects quite directly the cumulative mismanagement of the public payroll, the impact of protracted inflation caused by unsustainable public deficits, and the protracted inability of most governments to pursue public sector reforms and civil service reforms.
- More directly, the recurrent major problems in the supply of quality drugs reflect quite specific governance and policy problems which range from ill-advised import substitution- or industrial policies, through corrupt and or paralyzed procurement processes and systems, deficient programming- and budget processes, defective and/or corrupt quality controls, and weak drug logistics to widespread petty pilferage at the primary service level.
- Overall, most of these cross-cutting constraints reflect an underdeveloped civil society which does not have the capacity and will to support a free, independent press, a court system with the independence and courage to prosecute high-level corruption, professional organizations which establish effective self-regulation, and civic actions which induce government agencies to improve coordination and management of government services.

These linkages between the observed program-level implementation constraints and the general qualities of governance and policies require further examination because they are crucial in determining the scope for cost-effective scale-up of the core interventions. Such an examination requires an operational definition of the elusive term “governance” and criteria for the assessment of its “quality”. The “state-of-the art” of evaluating governance and policy frameworks is briefly reviewed below.

III. The Enabling Environment for Scale-Up as Defined by Quality of Governance and Policies

1. Governance and Criteria for the Assessment of its Quality

Governance is generally defined and assessed with reference to:

- the rule of law,
- the containment of corruption, and
- the effectiveness with which basic public services are being performed.

The following questions are frequently used to assess the *general* quality of governance.

Several of these questions are also *directly* relevant to the impact of governance on the implementation of core interventions:

- Is there rule of law?
- Are there pronounced and protracted law and order problems?
- Is the judiciary independent?
- Is there a credible criminal justice system?
- Are contracts enforceable?
- Are the standards of electoral democracy being upheld?
- Does a majority of its citizens consider the current government to have legitimacy?
- Is there a free and independent press?
- Does the press engage in investigative reporting?
- Does the Government encourage the development of a diverse civil society?
- At the minimum does the Government tolerate NGO activities?
- Is there pronounced ethnic or gender discrimination?

- Is there a credible budget process?
- Is there a credible audit process for public accounts?
- Is Government procurement of goods and services carried out with “minimal” corruption (usually defined as involving “surcharges” of no more than 10%)?
- Is the supply of public services relatively free of corruption (usually defined to mean that no more than 20% of those polled about their interactions with public service providers report that they were asked for bribes as a condition of service).

2. Criteria for Assessing the Quality of the Policy Framework

For purposes of this discussion, the policy framework is defined to comprise macro-economic-, sector- and health policies. As in governance, the quality of the policy framework is assessed with reference to results in terms of economic growth, stability, social equity and environmental sustainability. The performance of macro-economic- and sector policies is also judged by their ability to promote efficient resource use including efficient mobilization and deployment of capital.

In assessing the health policy the focus would be on the effectiveness of infectious disease control and on the cost-effectiveness with which the private and public health systems provide the basic health services.

The following questions would generally be used to broadly assess the quality of the policy framework:

(a) Macro-Economic and Sector Policies:

- How severe are the macro-economic imbalances? Are they causing severe open or suppressed inflation? Are monetary and fiscal policies coordinated or are they working at cross-purposes toward more and more unsustainable macro-economic imbalances?
- Has the balance of payments been liberalized on current account? Is the tariff regime efficient?
- Is the regulatory regime and the functioning of public sector enterprises and services consistent with the efficient operation of the markets for goods and services?
- Is the public expenditure program (including expenditures on subsidies) responsive to the objectives of social equity?
- Is the capital account of the balance of payments managed with a view to stabilizing the economy and maintaining its access to international capital?
- Is the policy framework supportive of bona fide private sector development including direct private foreign investments?
- Are the policies governing the financial sector supportive of financial stability and efficient use of capital in the national economy?
- Are the public sector activities broadly consistent with the comparative advantage of public versus private management and ownership of the respective economic activities?

(b) Health Policy:

- Does the Health Policy accord priority to communicable disease control in line with up-to date results of epidemiological surveillance?
- Does it accord priority to cost-effective provision of basic health services? Is the priority accorded to the public health services in the provision of basic services and other services

based on a realistic assessment of the comparative advantage of both public and private providers?

- Does it take a clear position on cost recovery for public services consistent with these priorities and conducive to improving the health outcomes of the poor?
- Does it make a commitment to the improvement of health seeking behavior? Does it recognize the special issues which need to be addressed to improve both, the health seeking behavior of the poor, as well as their access to quality services?
- Does it recognize the responsibility of Government to establish and maintain an appropriate enabling environment for the cost-effective and socially responsible operation of properly qualified private providers?
- Does it address the need for coordination of the public health programs with the policies and programs which aim to improve the supply of water and sanitation.

IV Typical Enabling Environments or Settings

1. Defining Typical Settings

Results-based assessments of governance and policies can be used place low income and lower middle income countries into one of four groups which are defined by similarities in:

- the current quality of their governance and policies, and
- their commitment to and capacity for making improvements in their governance and/or policies.

Accordingly, it is proposed to use the following four "typical" settings or enabling environments in the susequent analysis and discussion:

(While this approach will "sort" sovereign countries by these criteria, it will also be necessary to pay attention to the fact that the very large countries, and especially those with a federal or regional government structure, comprise quite populous states, regions or provinces which in their quality of governance differ markedly from that assessed for the country at large.)

Setting A: Governance and Policies are adequate and there is capacity to make further improvements;

Setting B: Governance and Policies are inadequate, but there is commitment and some capacity to make improvements. This is evidenced by significant, ongoing improvements;

Setting C: Governance and Policies are inadequate and there are no near-term prospects for significant improvements; and

Setting D: Governance has completely failed.

Examining the Cross-Cutting Constraints in these Typical Settings

The rather low estimates for global coverage of priority interventions published by WHO in its 1999 World Heath Report attest to the pervasiveness and severity of the constraints discussed above.*/

A first examination of the nature and severity of the cross-cutting implementation constraints which are likely to be found in each of these typical settings (see Annex 2) suggests that the

same set of constraints is operative in all four settings; but that the severity of these constraints increases, and the capacity to ameliorate these constraints decreases as one moves from the higher quality enabling environments of Settings A and B to the "disabling" environments of Settings C and D.

However, these conclusions, which in their operational implications for planning and design of scale-up are further discussed below, require detailed examination based on a thorough inventory of implementation experience with priority interventions in the high-burden countries.

*/ Coverage of the target population was estimated by WHO to be: IMCI: 20%;
Malaria Radical Presumptive Treatment: 40%; Bednets: 15%; EPI-Plus: 50%;
Prenatal Care: 25%; TB-DOTS: 25%; STD Management: 33%;
HIV/AIDS Targeted Interventions: 10%; HIV Voluntary Testing: 15%.

IV Applying the Typology

In this section of the Paper a first attempt has been made to apply the typology proposed above. Using two well established indicators which capture salient aspects of a country's enabling environment, 55 low income countries and 49 lower middle income countries have grouped into four types of settings proposed and defined above.

1. Available Indicators:

Over the course of the last two decades the evaluation of economic development policies has given increased attention to the quality rather than mere "quantity" of economic development. In turn this has focussed attention on the importance of the institutional framework for both, the quantity, but more importantly the quality of social and economic development. In the pursuit of this type of analysis numerous attempts have been made to "measure" the quality of institutional- and policy frameworks, and to supplement national income statistics with composite measures of social and economic development. While this work has generated a wide range of very imaginative indicators, few of them are available for a global cross-country comparison.

In addition to national income statistics, two indicators have been used in the following analysis:

- the *Freedom House Country Ratings* (FHR) which provide a comparative assessment of the state of political rights and civil liberties. Freedom House does not rate Governments per se, but rather the rights and freedoms actually enjoyed by the citizens of the respective country. On political rights the surveys focus on the rights essential to the functioning of representative government. With regard to civil liberties, the focus is on : freedom of expression and beliefs,

rights to associate and organize, rule of law and human rights, personal autonomy and economic rights;

- the *UN Development Program's Human Development Indicator* (HDI) which measures the socio-economic attainment of a country based on three dimensions of human development: longevity (life expectancy), knowledge (adult literacy and years of schooling) and standard of living (per capita income corrected for purchasing power parity). The HDI sets a minimum and a maximum for each dimension and then shows where each country stands in relation to these scales. The designers of the indicator acknowledge the correlation between material wealth and human well-being, but note that the HDI shows that countries with similar per capita income levels have significantlly different human development indicators depending on the use they have made of their national resources.

A third indicator compiled bt Transparency International about "Perception of Corruption" in public administrations would have been very useful, but since it was found to cover only about half of the countries considered in this exercise, it could not be used.

For the purposes of this analysis, the country ratings of Freedom House have been taken to capture the quality of the country's governance. The Human Development Indicator has been taken to reflect the cumulative impact of the country's governance and policy framework on the attainment of commonly accepted human development objectives. While this last rating is strongly influenced by the country's per capita income level, the variance in human development among countries with similar income levels does provide insights into the quality of governance and policies.

In applying the HDI the total set of 174 countries which has been ranked by this indicator was divided into Quintiles, and the placing of a given country by Quintile was used in the ratings shown below.

2. Application of the Indicators

Grouping the Low Income Countries:

Using the per capita net income figures provided by the World Development Indicators 2000 published by the World Bank, 55 *low income countries* (countries with per capita net income below US$ 750) were rated as follows:

Human Development Indicator: Quintiles	Freedom Rating: Free (F)	Freedom Rating: Partly Free (PF)	Freedom Rating: Not Free (NF)
I st	0	0	0
II nd	0	0	0
III rd	1	2	2
IV th	4	4	10
V th	2	17	13

Seven countries rated rated F/III, F/IV and PF/III would seem to be candidates for Setting A (see Annex Table 1).

The 13 countries rated NF/V would seem to display Setting D or C (see Annex Table 2).

As regards Settings B and C, the indicators used relate to current status only, and do not capture commitment to change. The 6 countries with the rating F/V and PF/IV would seem to be candidates for Setting B by virtue of their more responsive political systems.

By the same token, the 27 countries rated NF/IV and PF/V would seem to be candidates for Setting C, subject to further analysis of their commitment and capacity to reform. The two countries rated NF/III (Azerbaijan and China) represent special cases of a repressive, relatively corrupt governance which, with disproportionately high social costs, has been successful in making selected aspects of human development one of its state priorities.

Grouping Lower Middle Income Countries:

The same ratings were applied to 49 Lower Middle Income countries with per capita net income levels between US$ 760 and 3310. This bracketing follows that employed by the World Bank in the World Development Indicators 2000. South Africa, with a per capita income of US$ 3310, is at the upper bound of this bracket.

The results of the rating are shown in the following matrix:

Human Development Index: Quintiles	Freedom Rating: Free (F)	Freedom Rating: Partly Free (PF)	Freedom Rating: Not Free (NF)
I st	0	0	0
II nd	8	5	2
III rd	10	6	4
IV th	4	2	7
V th	0	1	0

The ratings F/II, F/III and PF/II would suggest Setting A for 23 countries (see Annex Table 3).

By contrast, the ratings NF/IV and PF/V suggest Setting D or C for 8 countries (see Annex Table 4).

Depending upon their commitment and capacity to reform, the 15 countries rated PF/III, PF/IV and NF/IV would seem to be candidates for Settings B or C.

V. Performance of Priority Programs in the Typical Settings

In the following section a first attempt has been made to examine the comparative performance of priority interventions which employ strategies that differ in their dependence on the overall health system. Countries which have been identified as Candidates for Setting A and Setting D have been used in this comparison.

Unfortunately very little comparable information is available about priority program performance in low- and lower middle income countries. Only one priority program, Measles Vaccination has published data which cover the set of countries under examination in this exercise. Thus, the national coverage achieved in the Measles Vaccination Program has been used to assess the performance of a campaign-style, vertical program in Setting A versus Setting D. Coverage data were rated "High"(>75%), "Moderate" (>50% to 75%), "Low" (>25% to 50%) and "Very Low" (< 25%).

Mortality rates for girls under five years of age were used to capture the impact of the so called "childhood cluster" of priority interventions. This cluster of intervention employs a mix of strategies comprising vaccination campaigns as well as interventions which are crucially dependent on the public health services. For purposes of this analysis it is viewed as covering the middle ground between specialized, highly targeted vertical programs and Programs totally dependent on delivery by the private or public health system.

In order to evaluate the mortality rates generated by these interventions in the different country settings, the average mortality rate for girls under five years of age attained by the 51 European member states of WHO (about 25 per 1000) was used a reference point.

Finally, maternal mortality rates were used to capture the impact of maternal care in the different settings, considering that this cluster of interventions is very dependent on access to and performance of the general health system and in its outcomes also reflects a wide range of other cross-cutting constraints. As in the case of the under five mortality rate for girls, the average maternal mortality rate attained by the 51 European member states of WHO (about 60 per 100 000) was used as a reference point.

All three data sets were taken from Annex Table 1 of WHO's 1999 World Health Report.

The results of the analysis are summarized below:

Measles Vaccination Coverage in Different Settings:

Among low income countries, the 7 countries which can be considered candidates for Setting A (F/III, F/IV and PF/III) all achieved at least "medium" level coverage in their measles vaccination programs, with 5 out of seven achieving "high" coverage. The 10 out the 13 low income countries which with their NF/V rating would appear to be candidates for Setting D or C, the vaccination strategy also succeeded in achieving "medium" or better coverage. Only in three countries (Chad, Congo D.R. and Mauritania) did the measles vaccination strategy fail to overcome the general disabling environment.

Imputed Performance of the Childhood Cluster and of Maternal Care

The mortality rates which for purposes of this comparative evaluation have been taken to capture the impact of these priority programs are summarized in the following table:

	Setting A Low Income	Setting A Lower Middle Income	Setting D or C Low Income	Setting D or C Lower Middle Income
Mortality of Girls under Five (1 in 1000)	Average: 49 Range: 25-97	Average: 33 Range: 13-76	Average: 152 Range: 94-208	Average: 92 Range: 33-169
Maternal Mortality (1 in 100 000)	Average: 71 */ Range: 60-570	Average: 118 Range: 27-300	Average: 1228 Range: 660-1600	Average: 353 Range: 55-820

*/ excludes India at the "outlier" rate of 570 per 100 000

Possible Interpretations:

Girls' Mortality under Five: The fact that the average rate in Setting A is about double the target rate (25 per 1000) for both, low- and lower middle income countries, while average mortality rates in Setting D or C are four to six times the target rate, would suggest that the mixed strategies of the childhood cluster with their partial dependence on the overall health system find it more difficult to generate results in the more difficult enabling environments.

Maternal Mortality: Leaving aside the "outlier" India, Setting A seems to generate average mortality rates for both low- and lower middle income countries which are at most twice the target rate (60 per 100 000). The variance is substantial, but even the maximum rates, again setting aside India, are no larger than five times the target rate.

By contrast, Setting D or C generates outcomes for maternal health care which place the average for the lower middle income countries at about six times the target rate and the average for the low income countries at twenty times the target rate. Overall, this would suggest that the dependence of maternal health care on the performance of the general health system and on the availability of other infrastructure undercuts these programs much more severely in Setting D or C than in Setting A.

(As regards the relatively low performance of India, it could be argued that its F/IV rating overstates the quality of its enabling environment for effective health service delivery, because the HDI registers neither distributional inequalities, nor severe, cross-cutting constraints of environmental sanitation and rural transportation. Both aspects are special weaknesses in India's enabling environment which are undermining its health systems performance. Reflecting the differences in program strategies, these constraints do not weigh so heavily on the measles vaccination program which has achieved "high" coverage. They are impacting adversely on the interventions making up the childhood cluster (the rate of mortality for girls' under five is four times the target rate which is significantly above the average rate achieved by countries in Setting A. But they hit home with full force in the delivery of maternal health care where they have settled the country with a maternal mortality rate which is almost ten times the target rate.)

VI. Conclusions

Actual experience with the implementation of the priority interventions relevant for improving health outcomes of the poor has been the subject of scattered, intermittent program reviews carried out with variable quality by national and international agencies.

Within the boundaries set by concerns for political correctness and program advocacy, these reviews have identified a wide range of implementation contraints or limiting factors which reduce the efficacy of the interventions, drive up their unit costs even in modest scale-ups, and set serious limits to the widening and deepening of the most deserving interventions.

Desk review of the recurrent constraints suggests that they are cross-cutting and systemic in nature, and derive from broader, basic weaknesses in governance and policies. In support of this conclusion specific linkages between these operational constraints and the "enabling framework" provided by governance and policies can be identified. However, these linkages require further corroboration in systematic country reviews which should be focussed with priority on the high-burden countries.

As a working hypothesis, it is suggested that program performance and potential for scale-up is best analyzed by grouping countries with reference to "typical" settings or "enabling frameworks" which reflect discernable differences in the quality of governance and policy frameworks. It is also suggested that, in low- and lower middle income countries, these typical enabling environments generate sets of program-level constraints which are quite similar in their composition, but which differ distinctly in the severity of these limitations and in the national will and capacity to alleviate these constraints.

Four "typical" settings have been identified and a first attempt has been made to "sort"
A set of 55 low income countries and 49 lower middle income countries according to the quality of their governance and policy frameworks. For this rating exercise two well established indicators have been used: the country ratings issued by Freedom House and the Human Development Indicator published by UNDP. As one would expect, these indicators can only

support a crude first sort. More detailed country reviews are required to factor in distributional considerations as well as significant variances in governance within some of the larger countries. Country reviews are also needed to assess commitment and capacity to reform in the many cases in which the current status of governance and policies is indicated to be clearly inadequate. Nevertheless, it is suggested that these ratings can be used to guide the design of the more detailed country reviews.

However, even this first, crude rating exercise has highlighted stunning differences between the ratings of low income and lower middle income countries. It is suggested that these differences provide evidence that the vicious circle in which bad governance, ill-advised policy frameworks, deficient and inequitable human development, and low productivity of the limited physical and human capital reinforce each other, operates with special viciousness in the low income countries.

Moreover, to the extent that this vicious circle tends to defeat the efforts of external finance and technical assistance, the rating analysis makes it very clear that a global, international effort to improve health outcomes for the poor will not be possible without carefully chosen, feasible strategies for the scale-up of core interventions in the 30 plus low income countries rated NF/V and PF/V. By the same token, special attention needs to be given to the populous NF/V and PF/V regions of some of the larger countries which, as national units operate with a relatively adequate governance, but which leave substantial units of their national polity subject to disfunctional regional governance. Overall, it is worth noting that the total population of low income and lower middle countries which is dependent on national or regional/provincial

governments which inflict on them truly *disabling* environments (of NF/V or PF/V quality) adds up to about 1 billion people.

Finally, the first attempt at a comparative evaluation of different program strategies in favorable and adverse settings seems to corroborate the message conveyed by most country program reviews that, in the final analysis, the performance of the program and the scope for sustainable scale-up is crucially dependent on the choice of a program strategy which is well adapted to the cross-cutting constraints set by the quality of governance and policies.

Following through on this operational conclusion, the final section of this Paper discusses possible strategic responses in the planning and design of scale-up with reference to the four typical settings.

VII Strategic Considerations in Planning and Design of Scale-Up of Priority Interventions

For each of the "typical" settings the following generalizations are offered for discussion:

Setting A:

Most of the cross-cutting, systemic constraints are operative. With the possible exception of the reported recurrent, substantial problems with the supply of quality drugs, the constraints tend to be light to moderate in nature. Capacity to address these constraints exists; however the political will to address these constraints is frequently lacking.

In this setting a three-pronged strategy for the widening and deepening of the core interventions is indicated. This strategy would comprise:

- mobilization of civil society for intensive policy dialogue with government about effective poverty alleviation measures and about the role of the core interventions in improving health outcomes of the poor. This policy dialogue should aim to bring about a significant redeployment in public expenditures to the budgets which support scale-up of core interventions.

Where the country's epidemiological setting includes the clear and present danger of the dual epidemics of HIV/AIDS and TB, this dialogue should also be used to induce an appropriate policy response to this threatening situation.

- Adoption of a strategy for the scale-up of the priority interventions which uses the widening and deepening of these interventions (which in many cases will employ a "vertical" approach) to strengthen the capacity and credibility of the public health service and improve the cooperation between public and private providers.

- Initiation of broad-based health systems improvements with priority given to addressing the systemic constraints to cost effective scale-up of the priority interventions. This would have to include improving the coordination with environmental health programs, strengthening health education, and mobilizing community-based organizations to intermediate access of the poor to public and private providers.

The country assistance strategies of external donors should be aligned with this three-pronged national strategy. The donors should reinforce the policy dialogue initiated by civil society through effective aid coordination and by offering to assist with base-line reviews of the ongoing programs involving the priority interventions. Technical and financial assistance should be used

to assist with two types of projects, projects which are sharply focussed on supporting the scale-up of specific priority interventions, and projects which support broader health systems improvements and, in that context, address the systemic implementation constraints.

Setting B:

Constraints to scale-up range from substantial to severe. While there is evidence of growing commitment to make improvements in the policy framework, the capacity to address the pervasive and often deeply ingrained structural deficiencies is in the near- to medium term quite limited.

Past omissions and commissions have substantially degraded the public health system, and in many countries characterized by this setting, the growing burden of AIDS care and the general resurgence of infectious diseases caused by the neglect of basic control programs, is accelerating the general break-down of the public health services.

The specialized national resources and the institutional capacity required for broad-based reform and rehabilitation of the health system are in short supply. These shortages in turn also limit the utilization of external assistance. The still ongoing broader fiscal and structural adjustment tends to compound these shortages and the lack of political will generally precludes redeployment of public resources to the areas of highest priority.

In this setting the recommended scale-up strategy would comprise the following elements:

- sharply focussed health policy dialogue promoted by international donors in order to establish clear, limited objectives and priorities consistent with the limited national implementation

capacity. In setting these priorities, care should be taken to shape an appropriate policy response to both, the importance of STD control for HIV containment, and to the special requirements of the dual epidemics of TB and HIV/AIDS.

- External assistance for the health sector should be concentrated on scale-up of the highest priority interventions, coupled with program assistance for the other ongoing core programs. The latter type of assistance should have the objective to protect the capacity of these programs from further degradation with a view to their eventual rehabilitation and scale-up, once national implementation capacity has been re-built and increased. This would require sharply focussed, results-oriented project formulation which would aim to maximize the economic and social return to the most limiting factor, which in this setting is the national implementation capacity. To that effect it is likely that "vertical" approaches to rehabilitation and scale-up will have to be favored over more holistic project formulations which would seek to promote scale-up through broad-based sector reform. This should be considered acceptable, as long as care is taken that the "vertical" design is not prejudicial to the eventual establishment of a proper, horizontally integrated public health service.

Setting C:

In this setting most constraints are severe and increasing in their severity. There is no proven will to pursue improvements in the enabling environment, and the existing, but limited capacity to effect improvements is not being mobilized.

Externally sponsored and financed attempts to rehabilitate the largely disfunctional public health service and/or to rehabilitate and scale-up specific priority interventions are at best meeting with benign neglect from the concerned government. Consequently externally financed attempts to

restore standards and scale to the most important of these services will have to be pragmatic and opportunistic. To be reasonably effective, ways and means will have to be found to circumvent ill-advised government policies, ineffective or counter-productive processes, and corrupt or ineffective agencies. So called "vertical" approaches recommend themselves in this setting because of their ability to instill motivation and standards in well-defined, limited segments of the largely discredited, disfunctional public service. Strategic alliances between properly safeguarded externally financed programs and competent NGO' will in many cases represent a limited tactical option to disintermediate bad governance. However in countries rate "partly free" and "not free" the operation of credible independent NGO's will generally be precluded by the lack of the necessary "right to organize".

External assistance finds itself in this setting confronted with a serious policy dilemma: there are projects involving priority interventions which are highly relevant in humanitarian terms and which could also provide urgently needed infectious disease control, but these projects generally do not meet the standards set by donor policies regarding national ownership, sustainability and additionality.

Setting D:

In this tragic setting, humanitarian relief utilizing NGOs appears to be the only available option to by-pass the failed governance. Conventional donors normally cannot operate in this setting, however, they should be encouraged to coordinate their efforts and establish a high degree of readiness for quick, well-coordinated intervention upon the return of some degree of law and order. This preparation should be guided by the strategies proposed for Settings C, or possibly B.

HVERGIN

6/12/00

Annex Tables and Annexes:

- Annex Table 1: Low Income Countries – Candidates for Setting A
- Annex Table 2: Low Income Countries – Candidates for Setting D or C
- Annex Table 3: Lower Middle Income Countries – Candidates for Setting A
- Annex Table 4: Lower Middle Income Countries – Candidates for Setting C or D
- Annex Table 5: Low Income Countries – Ratings (Master Table) Pending
- Annex Table 6: Lower Middle Income Countries – Ratings (Master Table) Pending
- Annex 1 : Typology of Constraints
- Annex 2 : Cross-Cutting Constraints in the Typical Settings
- Annex 3 : Proposed Survey of Current Status of Priority Interventions in High Burden Countries (Pending)

Annex Table 1: Low Income Countries: Candidates for Setting A

Armenia	PF/III
India	F/IV
Kyrgyz Republic	PF/III
Moldova	F/III
Mongolia	F/IV
Sao Tome &Pr.	F/IV
Solomon Isl.	F/IV

Annex Table 2: Low Income Countries: Candidates for Setting D

The following 13 countries have been rated NF/V:

Angola
Bhutan
Burundi
Chad
Congo D.R.
Cote d'Ivoire
Eritrea
Gambia
Guinea
Mauritania
Rwanda
Sudan
Yemen

Annex Table 3: Lower Middle Income Countries – Candidates for Setting A

Rated F/II:

Belize
Bulgaria
Costa Rica
Dominica
Fiji
Latvia
Lithuania
Romania

Rated F/III:

Cape Verde
Dominican Rep.
Ecuador
El Salvador
Guyana
Jamaica
Philippines
Samoa
South Africa
Thailand

Rated PF/II:

Colombia
Georgia
Macedonia
Russian Fed.
Suriname

Annex Table 4: Lower Middle Income Countries – Candidates for Setting C or D

Rated NF/IV:

Algeria
Egypt
Equatorial Guinea
Iraq
Swaziland
Syria
Uzbekistan

Rated PF/V:

Djibouti

ANNEX 1: Typology of Constraints

Starting Point: Inventory of Constraints identified in Program Implementation Reviews

Sort 1: Recurrent Constraints by Core Intervention

Setting aside the unique, one-of-a kind constraints

Sort 2: Cross-Cutting Constraints grouped according to;

- demand side,
- supply side
- etc..

Setting aside the constraints which are unique to specific core interventions

Sort 3:

Cross-Cutting Constraints directly reflecting specific weaknesses in governance and policies	Cross-Cutting Constraints attributable to general weaknesses in and policies

ANNEX 2: Cross-Cutting Constraints to the Improvement of Health Outcomes of the Poor in the Typical Settings

Constraints	**Setting A**	**Setting B**	**Setting C**	**Setting D**
Constraints to Health Seeking Behavior	**0**	**2**	**3**	**3**
Constraints to the Supply of Services by the Public Primary Health System	**1- 2**	**3**	**3**	**4**
Constraints on the Supply of Quality Drugs	**2**	**3**	**3**	**4**
Constraints to the Supply of Services by Private Providers	**0**	**2**	**2**	**3**
Lack of Community-Based Organizations	**1**	**2**	**3**	**3**
Lack of Aid Coordination	**1**	**2**	**3**	**4**

The constraint is:

Light: 0
Moderate: 1
Substantial: 2
Severe: 3
Extreme: 4