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Global Health Initiatives and National Level Health Programs: Assuring Compatibility and Mutual Re-enforcement

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Abstract

The main objective of this study is to assess the extent to which Global Health Initiatives are translated to the country level as effective and long-term sustainable programs for health improvements and how this can best be done. To achieve this objective the study

- presents previous experience with specific disease control programmes;
- discusses the development of sector-wide development and sector investment approaches;
- reviews the Global Health Initiatives and,
- discusses what approaches and mechanisms are needed to ensure that targeted disease control programmes and integrated sector development approaches become compatible and work together for sustainable systems support.

The study concludes that collaboration between Sector-wide Approaches (SWAp) and disease control programmes must be based on dialogue and partnership. Standard models can only guide, not dictate, sector development at country level. Disease control programmes and Global Health Initiatives should reduce their emphasis on global or regional targets to allow for more flexibility in priority setting at country level. Preconditions for successful implementation of SWAp should be further analysed. In some poor settings, resources may not be sufficient to run a consistent sector development programme.Under such circumstances, diseases of particular concern, such as HIV/AIDS, may have to be given priority.

Integrated Mangement of Childhood Illness (IMCI) may be a model for disease control designed in order to facilitate integration into wider health sector development programmes. The IMCI has no global targets, a focus on health services activities and process, and presents a generic disease control algorithm that can fit into most health systems.

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1 Introduction

In the past recent years, a number of Global Health Initiatives (GHI) have been initiated in view of improving disease control, notably for the poor. Examples of such initiatives include Roll-back Malaria (RBM), Global Alliance for Vaccine Initiative (GAVI), Stop-TB and Tobacco-free Initiative. All of the initiatives include a number of partners, although WHO is the common denominator.

The GHI are, generally, widely welcomed by the international health development community, as they offer an important opportunity to improve the health of the poor and to raise additional financial resources.

At the same time, it is important to assure that the GHI are translated into effective health interventions at the national level that respect existing national health care systems and institutions in a comprehensive and sustainable manner. Moreover, health outcomes are achieved through work in multiple settings and contexts, meaning that GHI cannot substitute for effective national health systems that ensure sustainable service delivery.

As such, the main objective of this study is to assess the extent to which GHI approaches are translated to the country level as effective and long-term sustainable programs for health improvements and how this can best be done. To achieve this objective the study

- presents previous experience with specific disease control programmes;
- discusses the development of sector-wide development and sector investment approaches as a reaction to fragmented health sector development based on separated programmes;
- reviews the Global Health Initiatives and, finally,
- discusses what approaches and mechanisms are needed to ensure that targeted disease control programmes and integrated sector development approaches become compatible and work together for sustainable systems support.

The study and the discussion included in this report is based on information from programme documents and studies, some of them documented in endnotes in the text, discussions with professionals with experience from health development processes at international and national level and 16 years of personal experience from work with disease control and sector development programmes in approximately 30 countries in Asia, Africa and Latin America.

The Terms of Reference for the study are given in Annex I.

2 Development of Disease Control Programmes

A tradition of disease control was established from the onset of international assistance for health development. Malaria and smallpox were diseases that were specifically targeted already in the 60ies. Malaria for the reason that it always had been a major threat to inhabitants and visitors in tropical countries. Smallpox because it had over generations put a major scourge on populations. It was also identified as a viral disease which could possibly be eradicated for the reason that man is the only known host to the virus and that immunisation had provided effective protection.

Following the success of the smallpox campaign which lead to eradication of the disease, disease-oriented target-driven health programmes became a model for public health work in developing countries. In 1979 the concept of "selective primary health care" was established[1].

2.1 Expanded Programme on Immunization

After the successful campaign against smallpox a significant pool of experienced immunisation workers had been established in many countries and at the international level. This resource was channelled to a new global programme called the Expanded Programme on Immunization (EPI) which started in 1974[2]. The EPI programme had the objective to reduce morbidity and mortality from six target diseases - diphtheria, whooping cough, tetanus, polio, measles and tuberculosis. The means to achieve that was primarily immunisation. In 1977 the goal of providing immunisation services for all children in the world by 1990 was set by the World Health Assembly [3]. This was a bold target since it was estimated that at the onset of the programme coverage with the EPI vaccines in developing countries was less than 5%[4].

The inspiring achievement of the smallpox campaign was one reason why the EPI soon received significant support from national governments and the international community. Another reason was that immunisation was feasible in a poor setting and that it appeared to be a cost-effective intervention[5]. In comparison with many other preventive interventions, vaccination is fairly simple and straight-forward. Immunization can be done by health auxilliaries. Limited behavioural change in the community is required. It was for instance quite possible to make people co-operate in immunization activities in the poorest settings during the smallpox campaign.

It was estimated in 1989 that globally approximately 1.9 million children were saved every year as a result of the impressive progress in immunisation coverage made by countries under the EPI[6] and by 1990 global immunisation levels stood at 80%.

This result has been achieved by a very systematic commitment by national and international communities to immunisation. Of great importance was the alliance formed between Unicef and WHO to focus on child survival including EPI. Unicef supported countries in direct implementation of their programmes through the provision of vaccines and equipment for the cold chain. WHO provided technical guidance at global level, developed standard training programmes which were given financial and technical assistance at country level and monitored progress of the immunisation programmes.

Other organisations also came in at large scale, such as the Rotary International which raised funds for the support of Polio eradication from 1985 on-wards. To date, the PolioPlus program has contributed $373 million to the protection of nearly 2 billion children. By 2005, Rotary's financial commitment will reach nearly $500 million[7]. This is an early example of how a decision by a private organisation has contributed to the development of international health. The commitment by Rotary has made it possible for the international health community to keep polio eradication high on the global health agenda.

2.1.1 EPI and health systems development

How then has EPI related to the development and support of health systems? The programme has been critisized for being too focussed on achieving its own targets thereby not only ignoring the long term development of sustainable health services but also attracting resources from other pressing needs in the health sector[8]. Programme documents however carry evidence of a different way of looking at things within WHO. For instance, it was stated in a report to the Executive Board of WHO in 1988 that "EPI itself is a building-block of Primary Health Care: immunisation services, because of their basic simplicity, provide an excellent means for strengthening the health infrastructure to deliver other services at the same time to ensure maximum combined benefits for both women and children. When children thrive, parents gain the confidence to limit the number of births to the number of children they desire, and this, in turn, provides further health benefits for mother and child."[9]. According to this viewpoint EPI will contribute to health services development by providing opportunities to deliver services that may otherwise not reach the target population. Secondly, the programme will have other positive health effects than mere protection from the target diseases.

EPI programme documents have not discussed in detail if the positive effects when allocating scarce resources on a focussed intervention such as immunisation outweigh the negative. However, the comprehensive review of possible interventions for health that was made in 1992-93 by experts engaged by WHO and the World Bank showed that immunisations are among the most cost-effective interventions of all[10]. This review did not discuss or assess the effects on long term health system development and health from allocating resources to immunization.

At the point of delivery, EPI services have generally been delivered within the existing health infrastructure. Typically, health facilities have had an EPI or immunization room to which parents have brought their children, directly or through referral. This arrangement has contributed to separate management of children and women who come for immunization and those who come for illness[11].

EPI has been seen as a possible vehicle for the delivery of other services. Vitamin A supplementation is the foremost example of this mechanism being realized. At times EPI outreach services have been combined with delivery of other essential services, such as treatment of diarrhoea and respiratory infections.

In the last few years, the EPI has addressed health systems issues in a more systematic way. As a result EPI has now developed guidelines for assessing immunization services which have as one of five objectives to support health system development. The reason given for this is that the "health system structure, the location of authority and responsibility, and the mix of public and private participation are changing significantly in many countries." The methodology proposed in the

guidelines examines the health system and the external environment in which immunization services operate, as well as the services themselves[12].

2.1.2 Impact of EPI programmes

The current health impact from EPI is now estimated to almost 3 million lives saved each year, and 750 000 children saved from disability[13] [14]. With regard to polio it has been reported that globally poliomyelitis incidence has declined by over 80% since 1988 [15].

2.2 Programme for Control of Diarrhoeal Diseases

In 1980 the World Health Organization initiated a special programme for Control of Diarrhoeal Diseases (CDD). The programme made reduction of mortality its immediate objective and a decrease in morbidity a longer-term objective[16]. It was estimated at the time when the programme was launched that globally around 4.6 million deaths due to diarrhoea occurred each year[17]. The primary intervention chosen to reduce diarrhoeal mortality was promotion of oral rehydration therapy (ORT) with a fluid containing glucose, sodium, potassium and a base. It had been found already in the late sixties that such solutions enhanced absorption of sodium and water, a finding of great importance in the treatment of acute watery diarrhoea[18] [19]. It was estimated by the WHO CDD programme that about two thirds of all diarrhoeal deaths in children were due to acute watery diarrhoea and hence could be prevented with ORT[20]. A powerful remedy for a global child mortality problem had thereby been identified and this was a reason for establishing a special programme to promote this knowledge that was still little used among health professionals and the public.

The Expanded Programme on Immunization was well established in 1980 and had already had considerable success in raising immunisation coverage in developing countries. The programme model used by EPI was largely replicated to the CDD programme. An approach based on the same Logical Framework Approach (LFA) that had been used by EPI was established[21]. It contained clear objectives, targets and activity plans. CDD developed similar training manuals as the EPI had been using for several years and encouraged training of national programme managers and mid-level managers in planning and implementation of CDD programmes. Sometimes these courses were combined with EPI training. The mid-level managers were usually province, district or hospital managers and they were typically in charge of several programmes.

The CDD programme selected clear strategies to control diarrhoea: proper case management, promotion of proper nutrition, promotion of proper hygiene and provision of ample quantities of safe water[22]. In reality, the focus of the programme was on case management and education of caretakers on when to refer their child to health services. The programme largely worked through the established health services. A significant component of many national CDD programmes was also social marketing of key messages directly to the public through media and local leaders and opinion makers.

Initially the CDD programme of WHO recommended countries to set targets for morbidity and mortality reduction[23] but later it revised these targets to reflect to what extent case management (rehydration and feeding during diarrhoea and, for dysentery, correct antibiotic given) was properly

carried out. Indicators for training coverage were also developed and included in programme monitoring[24].

2.2.1 CDD Programme Management

The CDD programme advised countries to develop National CDD programmes with a specific plan and an appointed national manager. However, they did not explicitly recommend countries to have full time programme managers below that level. The programme as such depended on the cooperation of the established health services for the implementation of proper case management of those cases which could not be managed at home. Therefore it never sought to establish separate or "vertical" structures which would go parallel to ordinary health services from ministry to peripheral level.

2.2.2 Impact of CDD Programmes

The impact of activities for control of diarrhoeal diseases has been documented in several country reports[25] [26] [27] and in global reviews [28] [29]. The review carried out by Victora et al shows positive trends in diarrhoea management in most parts of the world. Oral rehydration therapy appears to be given to the majority of children with diarrhoea in the world. As a result, it is estimated in the study that the annual number of deaths attributable to diarrhoea among children under 5 years fell from the estimated 4.6 million in 1980 to about 1.5 million in the year 2000.

It should be pointed out that the estimates of mortality reduction for both EPI and ORT impact are indirect, measured through the adoption of control measures and their assumed life saving effect. In a study of the decline in child mortality from 1990-1999 it was estimated that 2.2 million children less than five years old fewer died in 1999 as compared to 1990[30]. As the world population has risen in the same period the corresponding decline in child mortality rate is around 30%, from 96/1000 live births in 1990 to 67/1000 in 1999. This has been achieved in spite of the HIV/AIDS epidemic. Some of this decline is no doubt due to the implementation of child health programmes.

2.3 Programme on Acute Respiratory Infections

As EPI and CDD programmes made further progress, childhood mortality causes gained in relative importance. The next group of diseases to get attention were Acute Respiratory Infections (ARI)[31]. It was estimated by WHO that ARI diseases accounted for around 4 million deaths[32]. Officially a programme for their control was launched by WHO in 1982 [33] but it took some years for the programme to really take off[34]. The programme stressed proper management of ARI cases and in particular identification of cases with pneumonia or severe pneumonia for treatment with carefully selected antibiotics . Like the CDD programme its focus was on reaching health workers and caretakers with some key messages on clinical signs and management. Through a careful review of data, prevention other than proper nutrition and immunization had been found to have little impact on morbidity and mortality from these diseases[35]. The delivery of proper management for children falling ill from ARI was the main priority of the programme[36].

ARI programmes similar to those established to fight diarrhoea were consequently set up in many countries[37].

2.4 Integrated Management of Childhood Illnesses

From the beginning of the 90'ies WHO and Unicef started to integrate CDD and ARI into one programme for Integrated Management of Childhood Illness (IMCI)[38]. The purpose of presenting a new approach to control childhood illness was to rationalise case management in health facilities and households as children often have several symptoms and diseases at the same time. Another intention was to address some further illnesses of importance, such as malnutrition, malaria and measles in a comprehensive treatment package.

Today, IMCI is a broad strategy to improve child health outcomes which encompasses interventions at home, in the community and in the health system. The aims are to reduce childhood deaths, illnesses, and disability and to improve children's growth and development, with a particular focus on the poorest and most disadvantaged children.

IMCI has three main components:

- *Improve family and community practices related to child health and nutrition;*
- *Improve the health system for effective management of childhood illness;*
- *Improve health workers' skills*.

IMCI is a flexible strategy that in each country addresses the major health problems of children under five years of age. It includes preventive and curative interventions, such as improved infant and child nutrition, breastfeeding promotion, immunization, and use of bednets in areas with malaria. The programme has not set any global targets, has a focus on health services activities and process, and presents a generic algorithm for prevention and cure of the targeted diseases that can fit into any health system. The World Development Report 1993 identified IMCI as one of the most cost-effective services that could avert 14% of the global burden of disease for only US$1.60 per capita per year[39].

2.5 Strengths and weaknesses of child health programmes

All the programmes described above have child survival as their common element. They also have some essential managerial characteristics in common. What have been the strengths and weaknesses of these child health programmes?

It is an undisputed fact that the programmes described have had an impact on child mortality, the main objective of their activities. In terms of value for money it appears that donors and ministries have been rewarded. Clearly, these programmes with their target-oriented approach have created models for the new disease-oriented programmes which are now being established under the umbrella of Global Health Initiatives. It seems therefore essential to discuss the strengths and weaknesses of the child survival programmes in relation to objectives of long term development and sustainability of the health sector.

The contributions of the child survival programmes to health sector organisation and management have been the following:

1. Establishment of a planning and management structure which is focussed on clear objectives, defined and measurable targets, evidence-based strategies and activities related to the strategies

2. Establishment of epidemiological tools, such as the cluster survey methodology, which have proven valuable to many other programmes.

3. Training of large numbers of health managers in programme planning and management. The skills adopted in these courses have been of general use in daily management of health services.

4. A large number of health workers trained in management of immunisation services and management of cases with common childhood diseases. In this, the dissemination of rational algorithms for assessment and treatment of sick children has taken place.

5. The establishment of skills in the logistics for procurement of vaccines and drugs. In the case of EPI, the establishment of skills in the organisation and maintenance of the cold chain and equipment meant for storing and distributing products sensitive to heat.

The possible negative effects have been:

1. Incorrect priority setting. The child survival programmes have received hgh priority by the international community. Countries which have given them priority have been rewarded with significant external support for these activities. This may have created an incentive for governments to give higher priority to these programmes than what would have been the case if the resource allocation had been done on entirely rational grounds.

2. The second point follows from the first. The child survival programmes may have deviated scarce resources from more pressing activities. They have also consumed significant portions of joint resources such as manpower, again in possible conflict with more pressing needs.

3. The child survival programmes may have worked against a coherent and integrated health sector policy as they have been focussed on specific disease categories. Many times they have been run as projects with their own budgets and staff at central level.

4. The child survival programmes have not considered long-term sustainability of the health sector sufficiently as they have been strongly focussed on short- and mid-term targets.

3 Development of Integrated Health Programmes

3.1 The Alma Ata Declaration and the development of Primary Health Care

In 1978 WHO and Unicef agreed on a platform for delivery of Primary Health Care in Alma Ata[40]. The Declaration of Alma Ata stated that primary health care is the key to attaining health for all. The Declaration called on governments to formulate national policies, strategies and plans of action to launch and sustain primary health care as part of *comprehensive national health system development and in coordination with other sectors.* (Author's italic). The Declaration said that at least the following should be included in primary health care;

- ✓ education concerning prevailing health problems and the methods of preventing and controlling them;
- ✓ promotion of food supply and proper nutrition;
- ✓ an adequate supply of safe water and basic sanitation;
- ✓ maternal and child health care; including family planning;
- ✓ immunisation against the major infectious diseases;
- ✓ prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and
- ✓ provision of essential drugs.

At the same time WHO concluded that widely different approaches could be used to implement the primary health care strategy. A full range of services could be provided, starting with those in greatest need and progressively reaching the whole population. Alternatively, limited services could be provided to the total population from the beginning and the range of these services could then be progressively extended (WHO 1979). The choice of strategy would be chosen by each country depending on the basis of various factors, such as level of development and type of health system. Each country were to develop its health policies as part of its overall socio-economic development policies, considering its own problems and possibilities, social and economic structures, and existing political and administrative mechanisms. This meant that both "selective" primary health care, in which some interventions were promoted, and comprehensive primary health care would be endorsed by WHO.

Almost from the onset of the Primary Health Care movement dispute arose around which strategy would be the better in order to attain health for all[41 42]. The issue was not so much whether to incorporate cross-sectoral interventions or not, as envisaged in the declaration, but rather how comprehensive an ideal intervention package should be. The dream of a broad action for health with many sectors and ministries joining hands under a common strategy never really materialized. Instead services within the health sector tended to become more concentrated as compared to what they had used to be. "Selective" primary health care, particularly immunisation, was energetically promoted by

many countries as a fast track to "health for all". It was felt that such a strategy would at least provide some essential services to everybody.

The Primary Health Care ideology paved the way for ”selective” policies as it advised that action plans for the attainment of Health for All should lead to " detailed formulation of country-wide programmes that have been identified as being required to deal with priority problems,…..A programme implies a series of interrelated actions aimed at attaining defined objectives, such as the improvement of child health or the provision of safe drinking-water to a population…..Each country-wide programme to be developed in the light of the master plan will include specific objectives and related targets, quantified if possible, and including the manpower, technology, physical facilities, equipment and supplies required, means of evaluation and financial estimates, a calendar of action, and ways of ensuring appropriate correlation among all the above.(WHO 1979)". Clearly, what is described here is in a nutshell the design of various disease control programmes, such as the EPI and the CDD.

3.2 Development of integrated health sector development programmes

The criticism against the limited priority setting resulting from the PHC concept and the growth of the so called vertical programmes led to formulation of policies for comprehensive health sector development[43] [44].

While this move towards defining models for more integrated planning and delivery of health services took place, the World Bank increased its lending to the health sector significantly[45]. The World Bank supports macro-policies which should lead to long-term and sustainable development. Since the loans from the bank are given on long-term basis, the lender must work to establish a stable and positive economic development for many years in order to be able to pay off its debts.

In the mid-90ies The World Bank developed a broad sector approach to lending formulated in so called Sector Investment Programmes (SIP)[46]. A SIP

1. Is sector-wide in scope;
2. Is prepared by local stakeholders;
3. Includes all donors in the sector;
4. Involves common implementation arrangements;
5. Minimises the use of long-term technical assistance;
6. Is based on a clear sector policy framework and strategy.

It has been felt that SIPs can address several long-standing issues of concern to both donors and recipients, such as the fragmented nature of traditional project assistance, the resulting distortions in the allocation of resources, and the lack of broad-based sectoral policies and priorities[47].

An intention behind the SIP ideology is to obviate the need for a ministry to adopt specific procedures for planning, implementation and evaluation of each donor-assisted programme or project. Ideally, the SIP will have all donors come together and support a coherent policy framework

and strategic plan, coupled with expenditure projections based on a calculation of all available resources, whether domestic or external[48]. This means that the government will set priorities within a framework in which all needs and options should have been identified. This priority setting will then lead the decisions on where both domestic and external funds should be allocated.

The SIP idea has much in common with a concept named Sector-wide approach (SWAp) which was developed by WHO together with several donor agencies from 1990 onwards. The basis of the SWAp concept was presented in a WHO guide which developed in a thorough process in which several prominent donors participated[49]. The guide is an example of how donors felt an increasing need to gather around a common agenda in order to speed up development and support health sector development in recipient countries. The basic attributes of a SWAp are set out as follows in the guide:

1) A sustained partnership, led by national authorities;

2) With the goal of achieving improvements in people's health and contributing to national human development objectives;

3) In the context of a coherent sector, defined by an appropriate institutional structure and national financing programme;

4) Through a collaborative programme of work focussing on:

    a) The development of sectoral policies and strategies;

    b) The preparation of medium-term projections of resource availability and sector financing and spending plans, consistent with a sound public expenditure framework;

    c) The establishment of management systems, by national government *and* donor agencies, which will facilitate the introduction of common arrangements for the disbursement and accounting of funds; procurement of goods and services; and monitoring sectoral performance;

    d) Institutional reform and capacity building in line with sectoral policy and the need for systems development.

5) With established structures and processes for negotiating services and management issues, and reviewing sectoral performance against jointly agreed milestones and targets.

The basic idea behind a sector-wide approach is that governments will be in a better position to achieve sectoral goals if development assistance is used to support nationally defined policies and strategies, rather than specific projects. The most fundamental element in SWAp is that some donors will give up support to specific projects, in exchange for the right to have a voice in the process of developing a sectoral strategy and the ensuing overall resource allocation. For these donors, becoming a recognised stakeholder in negotiating how resources are spent replaces donor-specific project planning, and joint reviews of sectoral performance replace evaluation of discrete projects.

An important characteristic of SWAp and SIPs is that they seek to define a set of preconditions for successful implementation of health sector reform. These preconditions will be addressed through a

well defined macro-policy framework developed by the ministry of health. The framework will not be seen as the end-product of a development process, but rather the platform from which development will take place. This means, as compared to a fragmented project scenario in which each donor will support specific programmes or specific geographical regions, that the donor consortium will have significant influence over the policy development in the recipient country. To quote the WHO guide, the concept of national ownership must allow for negotiation based on a joint (between the country and the donor consortium) scrutiny of policy and spending priorities - similar in many respects to the negotiation that takes place between a private company seeking additional finance and a commercial bank[50].

3.3 The case of Ghana – The Sector-wide Approach realised

Ghana is generally seen as one of the best examples of a well integrated sector support programme with strong leadership from the Ministry of Health[51] [52]. The basis for the sector-support programme in Ghana is an agreement between the MoH and the leading donors which was signed in 1997. The process which lead to the agreed programme of work started in 1993. The following excerpt from the document which lays the foundation for the present World Bank support to the health sector in Ghana[53] provides insights into the fundaments of the programme.

"The vision for the future development in the health sector and the policy framework has been articulated in the Medium Term Health Strategy Towards Vision 2020 (MTHS), and given an operational description in the Programme of Work (POW). The main strategies are to: (a) improve access, quality and the efficiency of primary health services; (b) strengthen and reorient secondary and tertiary service delivery to support primary health services; (c) develop and implement a programme to train adequate numbers of new health teams to provide defined services; (d) improve capacity for policy development and analysis, resource allocation, performance monitoring and evaluation, and regulation of service delivery and health professionals; (e) strengthen national support systems for human resources, logistics and supplies, financial management and health information; (f) promote private sector involvement in the delivery of health services; and (g) advocate for support in inter-sectoral action, specifically in population, food and agriculture, social welfare, local government, education, and water and sanitation agencies.

The policy and operational frameworks are the product of widespread consultations, and have received the endorsement of a wide number of stakeholders, including the donor community. ……Under this framework, the government maintains its leading role in health sector reform and has strong ownership of the program. The role of the Ministry of Health is clearly defined as one of policy making, financing, monitoring and regulation, while service provision is being moved out of the bureaucracy to a Ghana health service, the mission sector, and increasingly with private providers. The consolidation of multiple donor projects into a sector wide approach further reduces duplication in managing various donor-driven projects and builds local capacity in planning and managing health services."

In a review of the Ghana SWAp, Anarfi Asamoa-Baah and Paul Smithson have identified some of the challenges facing the programme[54]. One of them is that donors will no longer be able to attribute particular inputs or activities to their own support. Instead they must have the confidence that the Ministry is able to deploy all resources - external and domestic - to achieve the outputs and targets specified for the sector as a whole. However, as the authors point out, it is impossible within the

existing accounting systems to specify the level of health service output that can be achieved with a given increment in funding. Therefore, it will be essential that the MoH is able to link more clearly the resources provided to the sector with the results achieved. If not, donors may face increasing criticism from their own domestic constituents that they are unable to demonstrate results and then again require that their funds are linked to clear projects with measurable outputs.

3.4 SWAp developments

Though most SWAp programmes are still in their first and early phase, it is already clear that the actual implementation of these programmes is not easy. The discrepancy between formal and real commitment to the principles of SWAps has been apparent in several cases. In Bangladesh for instance it was found in a survey among donors and Bangladeshi government officers that positive attitudes toward the theoretical SWAp give way to cautious and sceptical responses in practice[55].

A review of studies of SWAp processes at different stages in five countries[56] found that

- There was improved diagnosis of barriers to service utilisation and improvement, including better understanding of corruption and incentives problems as a result of the SWAp process.
- Sector programmes were becoming better integrated within the budget planning process, and the need to develop links to other public sector reform processes was recognised, if not yet realised.
- The links between policy and implementation were growing. Governments in the countries under review had the resources to implement sector-wide policies without negotiating multiple projects, and donors had a forum for raising sector-wide concerns.

At the same time it was also found that other expected changes had not yet occurred. Among them were

- Broad participation in SWAp design and planning had been limited, both within the government and externally within civil society.
- Monitoring systems were underdeveloped and much remains to be done before donors gain confidence in them as the main source of sector performance information. This has meant that donors are still keeping close to the detail of sector programme development and implementation, expecting close liaison and consultation with government officials throughout the process.

The five countries under review were at very different stages in developing a SWAp and only one of them (Tanzania) really had a framework in place which could be seen as a complete SWAp.

The report by Foster et al. highlights some causes for concern in relation to the SWAp-process:

- As a result of SWAp overloaded ministries of Health have to achieve and maintain high levels of momentum and productivity, especially when transaction costs have increased as a result of SWAp negotiation. There is a danger of burn out in the ministries involved.

- SWAp programmes tend to be orientated towards immediate expansion of health provision without concomitant emphasis on increased effciency.
- As health services move from vertical to horizontal delivery, outcomes may suffer. A sector-wide approach to sector reform must be used to address these problems, not exacerbate them.
- Not all donors are using common systems.

4 Global Health Initiatives (GHI)

At the end of the last decades several new Global Health Initiatives were taken. Two of them were launched by WHO as a new Director General, Dr Gro Harlem Brundtland, came into office. These were Roll Back Malaria (*RBM*) and the Tobbaco-free Intiative. A programme against Tuberculosis, Stop TB, was adopted by the World Health Assembly in 1998 and at a meeting in Davos in the year 2000 an alliance to support immunisation activities and vaccine development was formed (GAVI - Global Alliance on Vaccines and Immunization). Lastly, the fight against HIV/AIDS is getting increased attention by many ministries and international organisations contributing to the focus on disease control.

This chapter contains a presentation of three of these initiatives. The Tobbaco-free initiative is not included here since its main focus is on activities outside the health sector.

The information below is based on official information from the programmes.

4.1 Roll-back Malaria

Upon taking office in July 1998, the World Health Organization's (WHO) new Director-General, Dr Gro Harlem Brundtland, decided that malaria was to be one of WHO's top priorities. It was evident that malaria was still a major health scourge in many parts of the world, in Africa above all. The top political priority given to malaria control among African leaders was confirmed in the adoption of the Abuja Declaration on Roll Back Malaria in Africa in April 2000[57].

There are an estimated 300-500 million cases of malaria per year. The majority of these occur in Africa, while the vast majority of the estimated 1 million annual deaths from the disease occur among children, and mainly among poor African children. Malaria is above all a disease of the poor, impacting at least three times more greatly on the poor than any other disease.

Roll Back Malaria (*RBM*) is seen by the programme designers as an attempt not only to beat a devastating disease, but also to develop endemic countries' health systems and build new means of tackling global health concerns.

The general objective of *RBM* will be to significantly reduce the global burden of malaria through interventions adapted to local needs and by reinforcement of the health sector. Goals are to be set by countries based on situation analyses and assessment of feasibility, and could include: malaria morbidity and mortality goals; financial goals (e.g., significant increase in resources available for community level activities in health care); accessibility goals (e.g., Percentage of population with access to early and adequate treatment); coverage goals (e.g., Proportion of the targeted population with insecticide treated bed nets); health sector reform goals (e.g., New partnerships with private sector health care providers); goals of policy change (eg., Significant changes in policy favouring evidence-based strategy development). Performance indicators will be used to assess the *RBM* Project.

RBM's implementation at country level will provide an indicator of the effectiveness of the health systems, while the programme will also serve as a model for WHO in developing other global health and development initiatives and new methods of controlling infectious diseases.

The Roll Back Malaria campaign first focus is Africa. *RBM* in Africa is aimed at:

- upgrading health delivery systems at both the local and national levels in malarious countries;
- intensifying use of bed-netting (nets coated with insecticide) to prevent night-time biting by malaria-carrying mosquitoes;
- mapping of malaria regions and of medical facilities to better direct health resources;
- developing new drugs for victims already infected with malaria;
- coordinating the development and testing of new malaria drugs and vaccines;
- developing methods to address malaria in emergencies, (eg., refugee and post-war situations).

The regional targets set for RBM at the Abuja Summit are to

- Halve the malaria mortality for Africa's people by 2010
- At least 60% access to and ability to use correct, affordable and appropriate treatment within 24 hours of the onset of symptoms by 2005
- At least 60% of those at risk of malaria, particularly pregnant women and children, benefit from the most suitable combination of personal and community protective measures by 2005
- At least 60% of all pregnant women who are at risk of malaria, especially those in their first pregnancies, have access to chemoprophylaxis or presumptive intermittent treatment by 2005.

At country level, *RBM* will work towards development of sustained capacity to address malaria (and other priority health problems) that is adapted to local realities, and delivering measurable and properly validated results. *RBM* will support the building of coalitions for action at regional and country level, and assist with development of clear, evidence based action plans at country and regional levels. *RBM* will develop a systematic approach to monitor progress and results, and broker financial and technical inputs into countries.

RBM will support Resource Networks which will facilitate the implementation of *RBM* in endemic countries by providing support in specialised areas, e.g.:

- Needs assessment and intervention at district level;
- Sector-wide approaches and financing;
- Quality and supply of anti-malarials at the local level;
- Implementation of bed net programmes, including supply of nets and insecticides;
- Improving quality of care at the home;
- Geographic mapping of malaria and health care;
- Prevention and control of epidemics;
- Monitoring of drug and insecticide resistance;
- Malaria control in war-torn zones.

Most victims of malaria die simply because they do not have access to health care close to their home, or their cases are not recognized as malaria by health care professionals. In addition, life saving drugs are often not available.

In Africa, *RBM* will create a network of teams to go into villages and analyse treatment and prevention practices at the household and community level, the availability and quality of health care by the public and private sector, and potential local partners. *RBM* will provide technical and financial support for each analysis through this network at the district level.

In African districts with stable, high transmission malaria, *RBM* will simultaneously seek to significantly improve early diagnosis and appropriate treatment of malaria-related fevers in children, early treatment/prevention in pregnant women, and personal protection for children and pregnant mothers through the use of insecticide impregnated bednets (IIBNs). In many districts, this will require reinforcement of the local public and private health sector, focusing on activities at the community level. *RBM* will also attempt to upgrade the training of health care providers to ensure quality care after the campaign ends.[58]

It is clear from this and other information sources on the malaria initiative that its main focus is on malaria activities and that its success will depend on the degree to which malaria control services will become available and used and the subsequent morbidity and mortality reduction. The *RBM* policy documents creates links between ambitions to establish wider health sector development and malaria control. The primary aim of such links are to further strengthen malaria control. Health sector development is therefore a means, and not an end. The *RBM* Documents underline that improved activities for malaria control will strengthen health services.

4.2 Global Alliance on Vaccines and Immunization

The Global Alliance for Vaccines and Immunization (GAVI) is an international coalition of partners which includes national governments, international organisations, philanthropic institutions, the private sector, and research and public health institutions.

GAVI is created to continue and build upon the work of the earlier Children's Vaccine Initiative, which had been launched in 1990. In GAVI, the pharmaceutical industry's participation as a full partner is an innovation. The Global Fund was created with an initial grant of US$ 750 million from the Bill & Melinda Gates Foundation. Since that time other donors have joined in supporting the Global Fund, pushing its total resources to above US$ 1 billion for 2001-2005. More countries are expected to contribute to the Global Fund and contributions from corporations and foundations will also be pursued.

The rationale given for the GAVI initiative is as follows.

In the 90ies immunisation levels decreased in many countries and fell to 74% in 1999 from 80% in 1990 (WHO 1999). One in four children in the world still remains without immunisation against the six diseases initially covered by EPI (measles, polio, pertussis, diphtheria, tetanus and tuberculosis). Nearly two million children world-wide still die each year of vaccine-preventable illnesses.

For only US$ 17 per child, lifetime protection against the six historical scourges can be provided and for not much more, the protection can be extended to include hepatitis B, yellow fever and *Haemophilus influenzae* type B (HiB). WHO has been recommending vaccination against Hepatitis

B since 1993, yet it kills approximately one million people each year. Recommendations have also been made for yellow fever, yet 30 000 deaths occur each year.

Access to immunisation varies greatly across the world. In some countries, up to 70% of children do not receive the full set of vaccines; the lowest coverage is found in sub-Saharan Africa. In Africa as a whole, over 40% of children are not immunised against measles, a major cause of infant mortality that kills one child every minute.

There is a lack of investment in research and development for new vaccines to combat the diseases that are prevalent in developing countries: diarrhoeal diseases, malaria, tuberculosis, pneumonia and HIV/AIDS.

The GAVI partners consider immunisation to be a key element of public health, a prerequisite to economic and social development and a crucial element in enabling every child to reach his/her full physical and intellectual potential. The Alliance recognises the need to:

- Reverse the decline in vaccination coverage in many countries;
- Increase R&D efforts for vaccines against disease of public health importance in the developing world;
- Revitalise global commitment for immunisation at national, regional and international levels.

At the country level, governments should collaborate with the Alliance partners through a national Inter-agency Coordinating Committee (ICC), which explores ways of strengthening immunisation services and the financing of those services through national, bilateral and multinational resources.

GAVI has set five strategic objectives:

- Improving access to sustainable immunisation services.
- Expanding the use of all existing safe and cost-effective vaccines.
- Accelerating the development and introduction of new vaccines.
- Accelerating research and development efforts on vaccines and related products specifically needed by developing countries, especially those against HIV/AIDS, malaria and tuberculosis.
- Making immunisation coverage an integral part of the design and assessment of international development efforts, including deep debt relief.

The Alliance has put together targets to guide its own work at the global level and to help governments in their national immunisation programmes.[59]

- By 2002, 80% of developing countries with adequate delivery systems should have introduced hepatitis B vaccine; by 2007 this should have been achieved in all countries.
- By 2005, 80% of developing countries should have systematic immunisation coverage of at least 80% in all districts on the basis of diphtheria-tetanus-pertussis (DTP3) and measles vaccines.
- By 2005, 50% of the poorest countries with high disease burdens and adequate delivery systems should have introduced immunisation against *Haemophilus influenzae* type b (Hib), which remains a major cause of pneumonia.

- By 2005, the vaccine efficacy and disease burden in respect of rotavirus and pneumococcal disease should be known for all regions, and a mechanism should have been identified to make the vaccines available for the poorest countries

4.2.1 Polio eradication

A particular component of the global immunisation activities is Polio Eradication. In 1988, the World Health Assembly responded to the remarkable successes of the Americas in controlling poliomyelitis by selecting this disease as the next disease to be targeted for global eradication. A target was set for eradicating polio globally by the year 2000 and certification of a polio free world should be achieved by 2005. Eradication has not yet been achieved but at the turn of the millennium the number of polio-infected countries was no more than 20[60].

The key to polio eradication lies in effective surveillance for all cases of acute flaccid paralysis in children. More than one hundred countries are now conducting surveillance specifically for cases of acute flaccid paralysis. Specialised reference laboratories as well as regional and national laboratories are providing virological confirmation of diagnosis in suspected cases. In addition, these laboratories are able to identify the source of the virus by molecular studies.

All countries embarking on polio eradication have undertaken mass campaigns using OPV, followed by "mopping-up" (house-to-house visits) in locations where cases persist. The incidence of polio has continued downward and, more importantly, increasing areas of the world are becoming free of the disease. In 1994, the Americas were declared polio-free.

The global strategy to eradicate polio is four-pronged, involving[61]:

- high routine immunisation coverage with OPV,
- supplementary immunisation in the form of national immunisation days (NIDs)
- effective surveillance for acute flaccid paralysis (AFP) and wild poliovirus,
- door-to-door immunisation (”mopping up” campaigns)

4.3 STOP TB

Stop TB is a global movement to accelerate social and political action to stop the unnecessary spread of tuberculosis around the world. The mission is to increase access, security, and support to ensure that every TB patient has access to TB treatment and protect vulnerable populations from TB. The initiative also seeks to reduce the social and economic toll that TB exerts on families, communities, and nations.[62]

The main intervention of the Stop TB initiative is DOTS which stands for Directly Observed Treatment. DOTS means that health workers observe TB patients when they take their medicine to ensure that a full course is taken. This is to prevent that intake of drugs, which must be given for periods of 3 to 9 months, is interrupted. Such interruption means that the disease is not fully cured. It may also lead to development of strains of the tuberculosis bacteria which are resistant against the medicines given.

The priorities of the Stop TB Partnership are to expand, adapt, and improve strategies to control and eliminate TB. The will be done by

1. Promoting wider and wiser use of existing strategies to interrupt TB transmission, by:
    1. increasing access to accurate diagnosis and effective treatment, by accelerating expansion of DOTS to achieve the global targets for TB control
    2. increasing the availability, affordability and quality of TB drugs
2. Adapting existing strategies to address the challenges posed by emerging threats, for example, by:
    1. developing an effective strategy to prevent and manage multi-drug resistant TB
    2. developing an effective strategy to reduce the impact of HIV-related TB
3. Accelerating elimination of TB, by:
    1. promoting research to develop new and improved diagnostic tests, drugs and vaccines
    2. promoting adoption of new and improved tools by ensuring access and affordability

The Partnership develops advocacy and resource mobilisation strategies in support of these priorities, and co-ordinates and 'brokers' resource flows.

The targets set by Stop TB are[63]*:*

- By 2005: 70% of people with infectious TB will be diagnosed, and 85% cured
- By 2010: The global burden of TB disease (deaths and prevalence) will be reduced by 50% (compared with 2000 levels)
- By 2050: The global incidence of TB disease will be less than 1 per million population

Stop TB is programme with a clear focus on a specific disease. Action given priority by the programme is selective and specific for TB control but focussed on management and treatment within an established health system.

5 Global Health Initiatives and Health Sector Support

The Global Health Initiatives described above are disease-oriented and in most instances target-driven. These are two characteristics which they share with programmes like EPI, CDD and ARI which were described earlier. With the launch of the Global Health Initiatives the global health agenda has entered into a new cycle which has much in common with the cycle that started with the smallpox eradication and later developed the child survival programmes some 20-25 years ago. A difference is however that since then, other models for the delivery of health care and the transfer of international support for health development, represented by the SIP and SWAp models, has been established. The disease-control programmes are now faced with a different challenge as compared to 25 years ago. At country level, they need to fit into a more complex system for national health systems development as compared to before. They need to design their strategies so that they do not conflict those of governments who have set out their development objectives within the framework of a Sector Investment Programme or a SWAp.

To what extent do the Global Health Initiatives consider the thoughts and intentions behind the sector-wide development approach? What are the policies of the *RBM*, GAVI and Stop TB with regard to health system development and long term sustainability of health sector investments? Are these policies compatible with comprehensive health sector development?

Answers to these questions can be sought in different ways. One is to review the policy statements and implementation directives which the programmes have made. Another is to study at country and district level how the programmes are actually implemented. In this study we will concentrate on distilling from various programme documents their official policies on health sector development.

5.1 Roll Back Malaria

Roll Back Malaria has dealt with relationships of malaria control programmes to health sector reforms thoroughly. The following is an excerpt from a report from WHO's expert committee on Malaria[64]. Certain sections have been marked with italics by the author.

"Effective management of malaria control activities requires that certain national-level competence and coordinating functions be retained or developed at the central level of the programme (not necessarily the nation's capital) during the process of decentralization. These functions include providing strategic direction to the programme, developing malaria policy at the national level, and setting standards, norms and indicators for monitoring the progress of operational activities. In addition, they include mobilizing and coordinating external funding, epidemiological analysis, quality assurance, providing technical training and support for malaria team members at the local level, coordinating the response to epidemics, and evaluating and validating programme activities, including operational research undertaken at the district level. Thus, effective management of control programmes will require not only expertise in disease management, epidemiology, surveillance and vector control, but also social, economic and behavioural studies and adequate administrative, statistical and logistic support. In countries where malaria is a high priority within the ministry of health, *part-time staff who do not work exclusively on control programmes cannot normally provide this level of competence.*

Important benefits of a decentralization policy to malaria control are that decision-making and planning capacity would be based at the level where the problems occur. At the district and sub-district levels, where responsibility for the successful execution of control activities is centred, functions required would include local-level planning, resource allocation, disease surveillance, monitoring of programme activities, health education, training and vector control. District staff must serve as an effective liaison between field staff and national-level staff and provide continuous operational guidance to the peripheral level. Epidemiological information collected at the periphery should be initially analysed at this level, with feedback and technical guidance provided to field staff for rapid action, while the central team is provided with a summary of the data on a regular basis for more detailed analysis. *Local capacity for surveillance and rapid response needs to be strengthened, especially in high-risk and epidemic-prone areas.*

It is crucial that responsibility for the implementation of malaria control activities at the district and sub-district levels be accompanied by adequate funding. Furthermore, *sufficient logistic support must be provided* to enable local authorities and staff to carry out their responsibilities and respond rapidly and effectively to changes in the epidemiological situation."

This section illustrates that disease-focussed programmes primarily assess the capacity of a health system from the perspective of how well it can fulfil the requirements of the programme itself.

This is further illustrated by the analysis of decentralisation made by the committee:

"The poorly managed decentralization of malaria control programmes has undermined their effectiveness and hampered their ability to fulfil their responsibilities. As a result of this decentralization, which often occurs without any input from malaria control programme staff, programmes that were previously highly effective have lost direction and focus. In addition, experienced and dedicated personnel with specific technical expertise have retired or moved to other positions. Thus, programmes have lost the capability to respond rapidly and effectively to changing conditions (e.g. epidemics), and their commitment and ability to guide operations at the community level.

These losses have generally not been counterbalanced by the creation and development of technical competence and resources at the district and sub-district level, thus creating a vacuum in malaria control expertise and implementation. As a result, many of the potentially positive outcomes of decentralization, such as local ownership and responsibility for the programme, more active community involvement, increased ability to tailor control measures to local epidemiological situations, and greater intersectoral collaboration, are not being seen. Similar problems have also been observed in countries which lacked an effective national control programme when the decentralization process began: such countries are left disorientated and unable to deal effectively with the challenge of building up human resources and technical competence at the central and local levels."

There is a certain risk that most disease-control programmes will find that the capacity to deliver services and information which is required to achieve the targets set by the particular programme is not sufficient. In consequence, special resources and staff ear-marked for the programme are often called for. This is well illustrated in the sections marked by the author above.

One of *RBMs* six basic elements deals with principles on support to health sector development.[65]

Element 5: **Well Co-ordinated Action**	■ Efforts to roll back malaria are implemented in a way which contributes to sustainable and effective health care systems ■ Health systems take account of local situation when responding to the threats people face as a result of malaria ■ National health services, private practitioners and local healers work together to respond effectively to malaria and other diseases. ■ Many organizations join in a synchronized effort to roll back malaria (including schools, community groups, local business, government departments and NGOs)

In this element it is mentioned that efforts to roll back malaria should be implemented in ways which contribute to sustainable and effective health care systems. At the same time the urgency signified by the quotations above may lead to a discussion on what such a contribution represents. The real challenge to a programme like Roll Back Malaria comes when the programme may have to sacrifice short term goals for the sake of longer term sector development goals. Will the programme at country level for instance be prepared to abstain from spending funds on separate transport for malaria workers (identified as a possible necessity by the expert committee above) if such a decision will jeopardise co-ordination of broad programme activities in which cost-effective delivery of services has been achieved? A country or a district may have found that it is more cost-effective to deliver outreach services in comprehensive packages once or twice a month. The conclusion may have been made by the ministry based on an assessment of how resources can best be used to maximise the *overall* health impact. The malaria programme would however be more interested in having the health workers go out every week to look for cases of malaria as it would reduce *malaria* morbidity and mortality more than if the programme participated in integrated out-reach services.

Rarely are policy documents from disease control programmes specific enough to provide sufficient guidance to managers on how to deal with complex issues of priority setting. If anything, the documents from *RBM*, like for most other disease-specific programmes, would suggest to a manager that he should fight for his programme to seek to maximise the share of resources allocated for combating his target disease. Programme documents underline that malaria control programmes should be implemented "in a way which contributes to sustainable and effective health care systems" while the active participation of the programme in a general health sector development process is less emphasised.

5.2 GAVI

Programme documents produced in relation to GAVI in general contain little on relations between immunisation activities and health sector development. The policy is the one adopted and promoted by the EPI and the Polio eradication. It has a clear and specific focus on immunisation activities and vaccine logistics. As such they do not require special arrangements but could be integrated in regular health services. However, concerns have been expressed that the launch of GAVI may distract interest and resources from integrated health sector support programmes and sector-wide approaches.

The issue was discussed at the first meeting of GAVI partners in Noordwijk, the Netherlands last year under the topic "Integrating immunization services within the health system". At the meeting, Dr Tore Godal, Executive Secretary of GAVI said that "The Alliance is committed to enabling countries to strengthen their own immunization programmes as part of an integrated health sector." He gave as an ensurance of this commitment the example of the proposal process for the Global Fund for Children's Vaccines which requires countries to set their own priorities and targets, gives countries maximum freedom in the use of funds for strengthening immunisation services through the "share" concept, and emphasises national control by requiring each country to have its own national inter-agency co-ordination committee (ICC) focused on immunisation.[66]

Dr Godal addresses in this statement more the issue of national ownership than the relation between the immunisation programme and other health sector activities. The maximum freedom of use of funds referred to is likely to be limited by the directions of implementation given by the global EPI programme.

At the meeting in Noordwijk a ministerial symposium was held on how to extend access to health services for their citizens. The report of the meeting is of interest as it contains many of the issues on how to implement immunisation programmes in integrated health service delivery that have been raised. The following is an excerpt from the report.[67]

Ministerial symposium: new health priorities within the health sector: complementary not competing efforts

More than 20 Ministers of Health from developing countries, and other high-level health ministry staff, participated in a lively discussion of the issues, challenges and mechanisms to extend access to quality health services for all their citizens.

The Ministers largely agreed that international initiatives such as GAVI are valuable for bringing agencies and organisations together around agreed priority outcomes. This focus increases the likelihood of efficient resource use, of demonstrated results, and of inspiring greater investment.

Ideally the new initiatives would:

- help national authorities highlight particular activities that will be needed if people are to be enabled to benefit;
- help national authorities to better deliver these activities through expanding and improving capacity of their health systems;
- strengthen the capacity of national authorities to co-ordinate partners and monitor progress

Furthermore, the Ministers agreed that international health initiatives can be successfully integrated into sector wide approaches, provided that certain conditions are met:

- respect for national planning and implementation processes (including decentralisation),
- appreciation of the real shortages in human and financial resources, and
- response to the need for "core" financial support to health systems.

To this end, it would be best if new resources were to be made available without tight earmarkings, were available over a long time frame, and within budget. The initiatives should be carried forward in ways that minimize unnecessary duplication at the country level.

Ministers believe that the new global priorities will prove essential for mobilizing resources and raising health issues on the international political agenda. The desire to see results quickly in meeting specific health targets should not tempt governments to adopt unsustainable approaches or approaches which compete with broader health goals. In a well-managed system – provided sufficient resources can be mobilized – targets can be met in a sustainable way and the wider health system can be enhanced in the process.

As can be expected from a high-level statment of a large number of ministers the document does not go into detail on how to actually help national authorities to better deliver activities through expanding and improving capacity of their health system. However, the meeting has set the priorities in stating that "The desire to see results quickly in meeting specific health targets should not tempt governments to adopt unsustainable approaches or approaches which compete with broader health goals. In a well-managed system - provided sufficient resources can be mobilized - targets can be met in a sustainable way and the wider system can be enhanced in the process."

The question is how GAVI supported activities will take into account this consideration. What has happened in the past is that programmes driven by short- to medium term targets have met health systems in which resources have been insufficient and therefore not well-managed. In this situation it has often been tempting to seek a "short-cut" through a direct pipeline for delivery of services in order to reach the targets. As discussed before this may not necessary mean that such a course has been detrimental to overall health sector development goals. It could in some instances even have contributed to them. However, the question if the resources invested could have generated more value from a long-term development perspective remains unanswered.

That the EPI is aware of the issues is documented in the "Assessment guidelines" referred to earlier. In these guidelines it is said that

"Investments in outcome oriented programmes usually have consequences for the whole health system. Activities, which benefit the whole health system, should be favoured. Recommendations that short term may benefit immunization services, but have potential negative impact on other services should be discouraged. Sustainable solutions should be sought."[68]

An assessment of the health system is included in the guidelines. This assessment has a focus on how the health system will affect immunisation activities rather than how these activities can fit into the overall health sector development policy.

Even so, it must be concluded that GAVI/EPI is increasingly taking into consideration the discussion on "vertical programmes" and sector-wide approaches. The ministerial statement above from the first partner meeting of GAVI will no doubt speed up this process.

Many of the questions around implementation of immunisation and other disease-oriented control programmes can only be answered by assessing how they perform at country and district level. A serious effort was made some years ago to make such a study of the Polio eradication programme[69]. Three country studies were made and the results synthesised. The study concluded in essence that Polio eradication programmes may strengthen the health sector, rather than weaken it, but that this will require co-ordinated planning and a strong leadership which has wider responsibilities than just polio eradication.

5.3 STOP TB

The documents on Stop TB contains little on the relation between TB control and the health sector. However, the TB control strategy is based on full integration of the activities in a functioning health system. The programme does not suggest that separate structures or functions be established within the health system to reach programme targets[70]. The TB programme has, from that point of view, more in come with initiatives such as the Integrated Management of Childhood Illnesses (IMCI) and the Safe Motherhood Initiative (SMI), programmes which focus on activities which occur in the household or in the health facility when a health worker meets a patient[71]. To quote a recent paper funded by the Ireland Aid "These initiatives (i.e IMCI and SMI author's note) address best practices and their implementation, so their inputs do not conflict with the Ireland Aid sector approach and serve only to build human capacity in health care. In turn this improves the range and quality of primary care delivered to poor communities at the periphery."[72]

6 Discussion and conclusions

This study has documented that targeted disease control programmes often have been relatively successful in achieving their targets. These programmes have however often had a short- to mid-term perspective and they have been very focussed on the specific targets they have set up for themselves, sometimes ignoring the need for systematic and coherent approaches to health sector development. At the same time this study has concluded that these programmes have generated system effects which should have benefitted the health sector as a whole. Development of skills in management and programme planning are examples of such effects.

The costs of the disease control programmes in terms of lost opportunities for sustainable health sector development have not been assessed, much for the reason that such estimates necessarily would have to be based on a number of questionable assumptions. Even so, it should be pointed out that the resources used for programmes aimed at controlling specific diseases can and could have been used in a different way. It cannot be excluded that such use could have lead to larger health gains in a long-term perspective than what has actually been generated.

Much as a result of the piece-meal organisation of health services that specific disease control activities and projects have lead to, new models for health sector support have been developed. These models have sought to create a common platform for all health sector support, a platform based on integrated, balanced and coherent development of the health sector. These models, gathered under the concept Sector-wide Approach (SWAp), have been thorough in their system design and support, but have been less specific on the actual content of the services to be delivered through the health system. From that point of view they complement targeted disease control programmes which often have less to say on the health system through which they work or will be implemented. It would therefore seem that there would be opportunities for collaboration.

The SWAp concept has after ten years of preparation and methodological work become functional in several countries and the approach is gradually being introduced in more countries, in particular in Africa. It has been said that "The sector approach in a concept whose time has come."[73]. However, the concept now faces the challenge of being tested through real implementation. Unless it can prove its value in a short- or medium-term perspective, donors may not have the patience to wait for the approach to become fully viable.

New targeted disease control programs are now being launched. Malaria and tuberculosis are among the targeted diseases.The Global Alliance on Vaccines and Immunization (GAVI) is strengthening the already existing Expanded Programme on Immunization which has shown signs of weakness as donors have tried to withdraw from its support. HIV/AIDS is also getting increased attention as the epidemic is getting worse. All this puts the coordinated approaches to sector-wide support which are now gradually being adopted by many countries at risk. Since large sums are now being invested in disease control through various global initiatives, countries may give priority to short-term morbidity and mortality reduction at the expense of more long-term investments which may yield more sustainable health gains.

How will the GHI programmes affect the SWAp process? Will the Initiatives interfere with the basic idea of running an integrated sector programme or will they form part of it? Will they disrupt the sector-wide approach and force ministries to adopt an organisational matrix based on projects with separate line orders of responsibility down to the periphery? Or will they rather provide the substance of SWAps that will lead to the impact on health indicators that ministries and donors alike hope will be the result of integrated programme planning and implementation?

These are essential questions now facing the international health community. The Global Health Initiatives represent both a threat and an opportunity to the sector-wide approach concept. A serious discussion on modes of implementation must be initiated to ensure that international support to the health sector in deprived countries and populations leads to improved health on a short- as well as a long-term basis.

The challenge for the coming years is to ensure integration of disease control in sector investment programmes. It is felt that both disease control programmes and sector-wide approach models can gain from such an integration. Through the adoption of SWAp, disease control programmes will be implemented in a health system which provides the infrastructure and management support required for sustainable achievements in disease control. Through integration of disease control, SWAp will fill the system with specific and clearly structured content which will motivate managers and health workers to fully participate in the sector-wide approach.

Arguments for such an approach can be found in a recent World Bank report where it is concluded that "A major thrust in the HNP (Health, Nutrition and Population) sector is health reform or health systems development (HSD). Only about 20 percent of health reform projects have defined the basic services that could facilitate linking project budget allocations with health outcomes. However, some HSD projects support public health functions that are critical for sustainable implementation of the best buys, for example, surveillance and pharmaceutical systems."[74]

The collaboration between SWAp models and disease control programmes must be based on dialogue and partnership. Both sides must be prepared to make compromises and adjustments to ensure that forces are joined for increased health gains. These increases are in particular to come in a long-term and sustainable perspective. Short-term and long-term targets must therefore be balanced. It should also be acknowledged that standard models can only guide, not dictate sector development at country level. In some poor settings, resources may not be sufficient to run a consistent sector development programme, in which case some areas of particular concern, such as malaria or HIV/AIDS may have to be given priority. (See Annex II for a discussion on HIV/AIDS control and SWAp in Tanzania.) Preconditions for successful implementation of sector-wide approaches should therefore be further analysed. At the same time, disease control programmes and Global Health Initiatives should reduce their emphasis on global or regional targets to allow more flexibility in choice and priority setting at country level.

The model for Integrated Mangement of Childhood Illness (IMCI) may be an example of how disease control activities can be designed in order to facilitate integration into wider health sector development programmes. The IMCI has not set any global targets, it has a focus on health services activities and process, and it presents a generic algorithm for prevention and cure of the targeted diseases that can fit into any health system.

The support mobilised for disease control and the theoretical framework for integrated and coordinated health sector development which has been established through the Sector-wide Approach provides a unique opportunity for true development of the health care systems in resource-scarce settings. This opportunity should not be missed by allowing theoretical concerns or inflexible attitudes to dominate the international arena for assistance to health development. Work in international health must now be focussed on integration of disease control in health sector development models. All forces should come together to find a common platform for maximum health outputs from sustainable and yet efficient health services.

Annex I

WHO Commission on Macroeconomics and Health (CMH)

Working Group 6: Health and International Development Cooperation

Terms of Reference

Topic 2: Effectiveness of Development Assistance in Health (DAH)

Paper 2.4: Global Health Initiatives and National Level Health Programs: Assuring Compatibility and Mutual Re-enforcement

1. Background

The Effectiveness of Development Assistance in Health: Lessons from the Literature and from Case Studies. The objective of this paper is to ensure that the WG's consideration and recommendations on future directions in DAH build on the record of past experience. At least two perspectives on the definition of effectiveness will be considered in developing this work. First, it will be important to acknowledge the complexity of the chain of links that intervene between the injection of money and ideas and better health outcomes. It is inherently difficult to thinking about the impact of development assistance in isolation. Except in very unusual circumstances one is looking at the impact of spending from a variety of sources (including, of course, domestic ones) on health outcomes. Attributing impact to aid alone is rarely going to be useful. This paper will help structure the WG's considerations of issues such as the role of DAH in various policy and institutional settings that are less propitious for sector reform than others.

Effectiveness of DAH is understood as aid financed health interventions reaching its stated objective however defined – i.e. 'doing the right thing'. Further, the notion of efficiency, or cost-effectiveness, refers to whether effective DAH reaches its objectives in the least costly manner – i.e. 'doing the right thing in the best possible way'. Moreover, it is also emphasized that it is of equal importance to incorporate aspects of sustainability, i.e. effectiveness over time, in this work.

2. Global Health Initiatives and National Level Health Programs: Assuring Compatibility and Mutual Re-enforcement

In the past recent years, a number of global health initiatives (ghi) have been initiated in view of improving disease control, notably for the poor. Examples of such ghi include Roll-back Malaria (RBM), Global Alliance for Vaccine Initiative (GAVI), Stop-TB and Tobacco-free Initiative. All of the initiatives include a number of partners, although WHO is the common denominator.

The ghi are, generally, widely welcomed by the international health development community, as they offer an important opportunity to improve the health of the poor and to raise additional financial resources.

At the same time, it is important to assure that the ghi are translated into effective health interventions at the national level that respect existing national health care systems and institutions in a comprehensive and sustainable manner. Moreover, health outcomes are achieved through work in multiple settings and contexts, meaning that ghi cannot substitute for effective national health systems that ensure sustainable service delivery.

As such, the main objective of this study is to assess the extent to which ghi approaches are translated to the country level as effective and long-term sustainable programs for health improvements.

To this end, the study will address these issues and questions:

A. the positive analysis:

- To what extent are specific disease targeted programs included in national plans and priorities, for example in PRSPs, Health Sector Strategic Plans and SWAp processes?
- To what extent are recipient countries represented in the on-going discussions on ghi at the national, regional and global levels?
- How is the notion of national ownership of specific disease programs assured and accounted for?
- Support to national health care systems: to what extent are disease specific programs systems dependent on, and to what extent do such programs actually support national health care systems?
- To what extent are targeted programs included in existing administrative and financial report and planning systems?
- Accountability: what is the pattern of accountability among the different partners involved in targeted programs, i.e. who is accountable to whom and for what?
- How is the long-term sustainability of programs assured?

B. the normative analysis:

- What approaches, reforms and mechanisms are needed to ensure that targeted disease interventions are systems supporting and compatible with sector approaches? What actions are needed to ensure that all partners are truly involved in the discussions of formulating the future of DAH and ghi?
- How can partners ensure that targeted programs also contribute to improvements in public health (as opposed to only medical care) through behavioral changes when such changes are needed, e.g. in combating HIV/AIDS?
- How can partners ensure that targeted programs contribute toward a comprehensive health policy dialogue that incorporates the overall macroeconomic and other issues at stake; e.g. civil service reform, poverty reduction strategies and resource mobilization for local and global public goods?

3. Methodology

The study should address the above issues by means of a host of approaches: the author's own experiences; discussions with relevant individuals; existing literature, reports and evaluations of past and current programs and initiatives.

Annex II.

Comments on each of the issues raised in the Terms of Reference

In the Terms of Reference (ToR) for this assignment a number of issues and questions have been raised. In this annex each one of them is systematically addressed.

1. *To what extent are specific disease targeted programs included in national plans and priorities, for example in PRSPs, Health Sector Strategic Plans and SWAp processes?*

A review of documents from countries where SWAp processes are under way or already much in place, such as Mali, Senegal, and Ghana, and general policy documents on integrated health sector development shows that specific diseases are little addressed in these documents[75] [76] [77] [78] [79]. The reports deal with overall issues of development of planning processes, management and implementation, human resources development and monitoring and evaluation. The target groups which are often identified as prioritised tend to be the same as those targeted by disease control programmes, such as women, children, and HIV/Aids affected. When the content of the actual health services to be delivered is discussed the activities which are mentioned are usually those promoted through various specialised programmes. They may be child health services (promoted through the IMCI and EPI), maternity services (promoted through the Safe Motherhood Initiative and other related programmes), services to those afflicted by HIV/Aids (promoted through Stop TB, programmes for control of Sexually Transmitted Infections and Aids) or other specific diseases. It would therefore seem that there would be opportunities for broad sector investment programmes to incorporate various disease control programmes within their framework. This has been done in several countries for the Integrated Management of Childhood Illnesses where advisers on this programme has been on the planning team for a Sector Investment Programme from the start[80]. In fact, there has been little controversies around this initiative because it has from the onset abstained from any ambitious programme design which would include establishing a management structure separate from the one already in place for broader health sector development in most ministries[81]. Apart from this, limited work has been done so far on building bridges between sector-wide approaches and disease-oriented control programmes, maybe creating unnecessary conflicts between "vertical" and "horizontal" approaches. It is quite possible that much could be achieved if a serious effort was made to define how disease control fits into sector-wide support programmes.

2. *To what extent are recipient countries represented in the on-going discussions on GHI at the national, regional and global levels?*

There has been involvement of recipient countries from the onset of the Global Health Initiatives, either on a consultative basis or through partnerships.

WHO has initiated Roll Back Malaria. WHO is an organisation in which countries from Africa, Asia and Latin America are represented on the same terms as countries in Europe and North America. They have therefore been involved from the start of the discussions on this initiative. The African ministers of health were also quick to adopt the initiative at the African summit on malaria in Abuja in April 2000.

With regards to GAVI, recipient countries have over the years developed significant expertise in the implementation of immunisation programmes. These experts have had good participation at global level in the discussion on vaccination policies and programme developments. EPI programmes have been given highest priority by many countries in Africa, Asia and Latin America over the years and the support for GAVI has been received positively by their governments. At the same time the statement made by the African ministers in Noordwijk expresses a concern over some critical elements in the launch of the initiative. This may suggest that they have not been fully involved in the development of the policies set out by GAVI.

Stop TB has been developed over several years by WHO in close collaboration with other international organisations such as the International Union against Tuberculosis and Lung Disease, an organisation gathering professionals from all over the world. This has ensured a participatory process in which the recipient countries also have played an important role. Several of the principles guiding the programme have also been tested in Africa, Asia and Latin America before adoption.

While participation of recipient countries often has been good in the development of disease control programmes and Global Health Initiatives, it is also important to note that there is a limit to how much each country can influence the generic and global programme. The purpose of these programmes is to combat diseases globally and as has been illustrated they often set global targets. The success of the programmes will depend on how well the generic programme is implemented in each country. Some adaptation to local conditions for the implementation may be required but the overall targets and design cannot be changed. A ministry of health may not necessarily see tetanus elimination as a priority in their own country but it will be under pressure to adopt it as a target in order to make its contribution to the global health agenda. Each county's share of the global health indicator will depend on the size of its population so the bigger the population, the more pressure will there be on a country to implement the various health initiatives which set global targets.

The actual freedom of choice for a country may be more limited once a global programme has been established than what it may appear to be when just reviewing the participatory process before a global agenda is set. The benefit of setting global or regional targets is that targets tend to provide an incentive for hard and determined work to reach these targets. The cost of such targets is however that they reduce the freedom of choice in priority setting for each country in the region or the world.

3. *How is the notion of national ownership of specific disease programs assured and accounted for?*

National ownership of disease programmes is ensured through the participatory programme development process described above. It is also up to each country to adopt or adapt the programmes according to their priorities. However, as already discussed there is in reality a limited degree of freedom for each country in selecting disease control initiatives and programme design.

Once the World Health Assembly has decided on a global health programme, member states are expected to adopt it. So far, these programmes have also developed rather detailed guidelines for programme policies and implementation, leaving little room for local adaptation. IMCI has however emphasised the participatory process and advised countries to go through an adaptation phase before launching the initiative. The choice of antibiotic to be recommended for treatment of, for instance, pneumonia will depend on the patterns of resistance against antibiotics among the bacteria causing the disease.

4. *Support to national health care systems: to what extent are disease specific programs systems dependent on, and to what extent do such programs actually support national health care systems?*

Disease specific programmes rely heavily on national health care systems. The programmes require a health sector infrastructure through which their services can be delivered, they need skilled manpower who can readily take on the messages on programme design, prevention and case management and then implement programme guidelines, and they need the financial resources and political commitment from the leadership in the health sector. Without all this support a disease specific programme will achieve little.

Disease specific programmes support national health care systems in various ways. They deliver guidelines for disease control including details of how to deal with prevention and disease episodes. They provide generic models for health programme management. They contribute to improved skills of health care personnel by transferring knowledge on programme and case management and they support monitoring and evaluation by introducing methods for follow up and feedback to programme managers and personnel.

5. *To what extent are targeted programs included in existing administrative and financial report and planning systems?*

The diseases which are targeted by disease specific programmes are usually included in the general disease reporting systems of countries. However, some of these programmes have not found this reporting detailed enough and have therefore advised countries to develop separate reporting systems. This has caused much debate and contributed to the need for coherent and integrated approaches to health sector development.

On financing and accounting, programmes have often had separate budget lines in the Ministry of Health budget. The principles of book-keeping and accounting have often been the same as for other ministry activities. The issue at hand is not whether or not targeted programmes have set up parallel systems for reporting and accounting because it is not typical. The issue is rather that they have been treated as separate entities *within* the ministry system. Planning has therefore tended to be separated from other activities within the public health system. At lower levels, implementation has however more often than not been integrated with other services.

6. *Accountability: what is the pattern of accountability among the different partners involved in targeted programs, i.e. who is accountable to whom and for what?*

In countries, lower level staff is accountable to their superiors within the government structure. These superiors often have a wider responsibility than only one targeted programme. Even for EPI it is more common than not, to have the programme being supervised by a person who is overall responsible for Communicable Disease Control (CDC) at district level. Special EPI managers may be found at provincial level, but it appears to be as common to find a CDC person in charge here as well. AIDS control programmes may have separate management down to district level[82].

At country level it is common to have a national manager for a targeted programme. The person supervising the programme at province or regional level will report to this person. The line of authority often goes, however, from the head or director of the CDC department in the ministry to the person in charge at lower level, and not from the manager of the specific disease control programme. The CDC director may sometimes delegate supervision and decision making to the latter but it is as common to find that the specific disease managers in the ministry are seen more as experts within their field of work and as such advice the CDC director and other directors on necessary action to be taken with regard to control of the targeted disease. In reality, formal lines of authorities in disease specific control programmes therefore are much less "vertical" than what they may appear from outside. A reason for the misperception, is that the actual power may follow the money and not the formal line of responsibility. Since many of the targeted programmes have received substantial funding from donors and international organisations like Unicef, those in charge of these programmes have had more influence than what their formal positions imply.

Ministries have been responsible to the donors and since programme performance has been important for decisions on further support, the programme managers have been quite important in the political process within the ministries of health.

The situation described has sometimes made the actual line of authority and accountability somewhat unclear at country level.

7. How is the long-term sustainability of programs assured?

It has been discussed above that disease specific programmes tend to have a short- and medium term perspective since they are usually driven by targets with such a perspective. Even so, long-term sustainability has been addressed in various ways. One way has been to seek to integrate teaching on the specifics of disease control in basic teaching at medical faculties and nurse training schools[83]. Another, has been to encourage countries to establish regional or local production of medicines or vaccines required for the implementation of the programmes[84]. A third has been to substitute foreign funding of programme activities for national, in a phased manner.

So far, these attempts have been met with little success. Sustainability of EPI has for instance been discussed and planned for in most countries for the last ten years at least, but in very few cases has the international community been able to withdraw its assistance. One reason why immunisation coverage levels have gone down is that national ministries have not had the capacity to take over the full responsibility for these programmes. This failure to transfer the full responsibility of immunisation programmes to national governments can be seen as a strong reason for the establishment of GAVI.

To conclude, specific disease control programmes have not been successful in ensuring long-term sustainability of programmes.

The normative analysis:

8. *What approaches, reforms and mechanisms are needed to ensure that targeted disease interventions are systems supporting and compatible with sector approaches? What actions are needed to ensure that all partners are truly involved in the discussions of formulating the future of DAH and GHI?*

In order to ensure system support and compatibility with sector approaches, targeted disease control programmes need to take into consideration the existing structure when designing their implementation plan. They need to adapt their training programmes to the existing manpower structure and the overall plans for human resources management. They need to co-ordinate their transport and logistics with other similar activities.

The disease specific programmes should be integrated with overall health plans from their onset. Planning should be made in common at all levels in the health care system and it should involve all essential actors. The targeted programmes should fit into the existing macro-structures in the health sector and they should be put under same responsibility at provincial and district level as other health programmes. Targeted programmes should not establish their own systems for reporting, monitoring and supervision but rely on integrated approaches for these functions.

Health sector development programmes, on the other hand, should include targeted disease control as an essential element. Sector-wide approaches should bring their framework and policies to the implementation level. When doing so they will need concrete plans for the daily work in the health services and at community level. These plans can often be provided by the disease specific programmes. These programmes provide the technical guidelines and information required for a holistic and credible sector programme. Such information is also often needed in order to gain the confidence of professional groups in a sector programme.

Involving disease specific programmes in the planning of comprehensive health sector development or sector investment programmes should ensure these programmes that their agenda is considered and listen to. It would provide an incentive for these programmes to support the overall sector development. When involved, programme managers may find that they have more to gain than to lose from integrated planning and implementation.

In order to ensure that all partners are truly involved in the establishment of Development Assistance for Health as well as Global Health Initiatives, all parties should acknowledge the right of each partner to bring his agenda to the planning process and respect his right to get listened to. True participation can only be ensured by gaining the confidence of partners and people. This is as true at international level as at village level. The commitment of the GHI programmes to sector-wide approaches cannot be won without creating the confidence among these programmes that their particular interests are better looked after in a Sector-wide Approach than in an arrangement in which the programme is implemented separately.

To allow for greater flexibility at country level more emphasis in the Global Health Initiatives should be put on national targets than on global or regional targets. As discussed, such targets may put pressure on individual countries to allocate more resources to control of diseases than what they would have done otherwise. It would therefore be beneficial if disease control programmes could emphasise national system development and national priority setting to ensure that the interventions they promote are systems supporting and compatible with sector approaches. What these programmes could offer would then be the policies and approaches that a country could adopt and adapt in order to be successful in its endeavours to control a particular disease. An example of a programme that is designed in this way is the programme promoting Integrated Management of Childhood Illnesses (IMCI). This programme has abstained from defining global targets[85] and is focussed on developing and testing best practices on how to prevent and treat childhood illnesses.

A serious and open discussion on which approach and strategies to chose must always be held at country level when sector planning takes place. As has been pointed out the recent article on Tanzania by Hanson[86] it may be better if specific disease control programmes, such as the Aids control programme, are supported by integrated and horizontal system functions, but in poor countries, resources are not sufficient to cover the costs for their build-up and maintenance. The author argues that in such settings there is a risk that resources will be spread so thinly in a highly integrated system across the different service delivery activities and horizontal functions, that activities fail to reach the minimum quantity and quality for any impact on health. Theoretically at least, it may be better in such settings to base services on different disease specific programmes as it would allow one programme to fail without a serious effect on the others. The article goes as far as to say that below a certain resource level the service output of integrated systems are likely to be lower than in systems based on vertical programmes. It should be kept in mind that these arguments derive from a situation in which there is grave concern over the AIDS situation.

A study from Tanzania on Iodine deficiency control found that distribution through special programme activities was more cost-effective than distribution through the general health services[87].

The examples from Tanzania illustrates well that there are no given answers to the questions on how to best organise health service delivery. This will depend on the resources available, the planning perspective, priorities set and the urgency in achieving a health impact. A good starting point for health sector planning would therefore be to enter the planning process with an open agenda and no ready-made solutions or formats.

9. *How can partners ensure that targeted programs also contribute to improvements in public health (as opposed to only medical care) through behavioral changes when such changes are needed, e.g. in combating HIV/AIDS?*

From the description of the targeted programmes in this report it can be concluded that they usually have significant programme components aimed at behavioural change. The programmes have increasingly become aware of the need to have a community oriented approach.

Child health programmes have a strong component of community involvement, emphasising proper management of cases at home and referral to health services when danger signs occur[88]. UNAIDS was formed partly for the reason that it was realised that combating Aids requires multi-sectoral

collaboration towards community-based action. A medical approach which had dominated the work up to that point was proven to be far from sufficient. The immunisation programmes have always worked with community mobilisation as an essential element. This element has in particular been supported by Unicef. Malaria control programmes have over the last ten years been struggling with dissemination and use of impregnated bed-nets. Sleeping under nets means in many communities a behavioural change which does not come easily. Stop TB seeks to change the behaviour of patients by encouraging them to return frequently for treatment even after their symptoms have subsided, something that has proven to be difficult enough.

In essence, this means that most of the targeted programmes today have a rather strong focus on community behaviour. Donors, international organisations, governments and other partners need to ensure that this community focus is also realised and given proper priority and funding. The political structures from top to bottom needs to become engaged. Non-governmental organisations should be involved in programme implementation. Comprehensive plans for action aimed at behavioural change needs to be worked out in each country.

10. How can partners ensure that targeted programs contribute toward a comprehensive health policy dialogue that incorporates the overall macroeconomic and other issues at stake; e.g. civil service reform, poverty reduction strategies and resource mobilization for local and global public goods?

The confidence, engagement and commitment from any individual or organisation is gained by conviction, not by coercion. Targeted programmes, such as the Global Health Initiatives, should be involved in a participatory process at international, national and local level in which comprehensive policies and broad issues are discussed. Their contribution in this dialogue should be respected and listened to without being judged by preconceived ideas. Targeted programme leaders and policy makers, on the other hand, need to prepare themselves for participation in broad development strategies in which conflict of goals may require their compromises so that they can count on full support from all actors.

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