

**PROCEEDINGS OF THE CONSULTATION ON
“INTEGRATION OF HEALTH SYSTEM OPERATIONS
AND PRIORITY HEALTH, NUTRITION AND POPULATION
INTERVENTIONS:
CONCEPTS, EVIDENCE AND APPLICATION”**

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1 SUMMARY

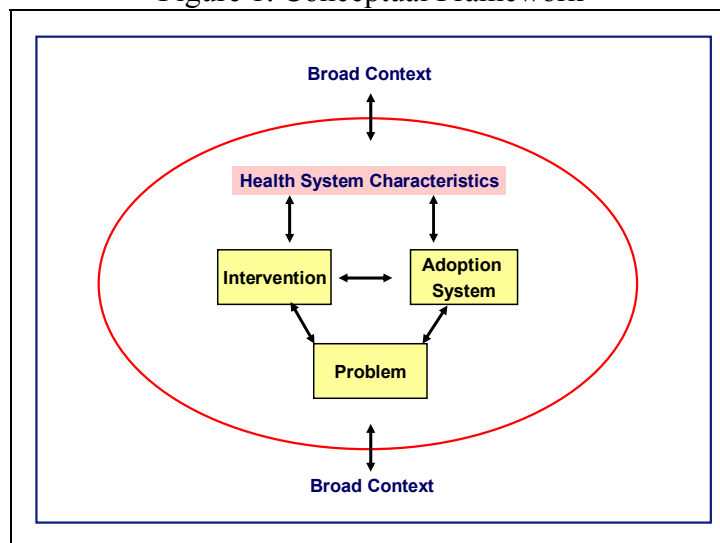
1.1 BACKGROUND AND PURPOSE

This report summarizes the consultation on “Integration of Health System Operations and Priority Health, Nutrition and Population Interventions: Concepts, Evidence and Application”, which was held at the World Bank on May 12-13, 2008. The purpose of the consultation was to provide inputs into the early stage of a global learning exercise that is being undertaken by the Health, Nutrition and Population (HNP) Department of the World Bank. This work program is derived from the new World Bank strategy for HNP results, *Healthy Development*, which has as one of its five strategic directions the improvement of synergies between health system strengthening and priority HNP interventions. This multi-year exercise will focus on key questions, evidence and assumptions of which policy makers and financiers need to be aware as they make decisions in different contexts. Participants included senior policymakers and researchers from a number of countries (Bangladesh, Cambodia, Ghana, India, Nigeria, Pakistan, the Philippines, Rwanda and Vietnam), academic institutions, international organizations, technical agencies and public-private partnerships. The list of participants is shown in [Annex 1](#).

1.2 CONCEPTS AND APPROACH TO QUESTION OF “EVIDENCE”

Participants discussed a framework that draws on theoretical propositions and empirical research in innovation studies, specifically on the adoption and diffusion of innovations within health systems ([Figure 1](#)).

Figure 1: Conceptual Framework



Source: Atun, R., Ohiri, K., Adeyi, O. 2008, *Forthcoming*

In sum, the framework suggests that adoption and diffusion of new priority health programs and the extent to which they are assimilated or integrated into the ‘general’ health system will be influenced by (i) the nature of the problem being addressed, (ii) the intervention/innovation, (iii) the adoption system which adopts and assimilates the innovation, (iv) the health system characteristics, and (iv) the broad context. The framework also captures the interactions and interconnections between the innovation, adopters, the health system and the broad context which critically influence the adoption process.

This led into a discussion of the quest for evidence-based policies and programs, with attention to evidence for policy and evidence from policy, where a number of questions were raised. First, can we find the “best evidence” on how to integrate health systems and priority interventions? Second, can we find the “best approaches” to scaling up integration? Third, how do these “best approaches” translate to practice for different interventions in varied contexts?

There is a growing body of evidence on successful health systems strategies but the evidence also suggests that few of these are readily transferable and replicable—hence the need to shift emphasis from efficacy of strategies and interventions to their effectiveness. While the same labels may be used to describe an approach, given country differences, different strategies need to be developed rather than relying on prescriptive approaches that emphasize “one size fits all”. The evidence also suggests that implementation failures are common and that policymakers often determine many of the health sector policies, but they do not necessarily determine how policies are implemented. Given this, it is essential to understand the distinctions between knowing *what* is needed, and *how* it is to be implemented. This then leads to an important question on the nature of evidence to inform policy design and implementation: do randomized controlled trials and systematic reviews provide sufficiently robust evidence to inform policy and practice across various contexts? Policymakers and practitioners care about *how*, in addition to *what* and *why* something worked in a particular context or under ideal circumstances. In this regard it is important to not only understand what has happened in the past, but how to inform current and future policies and practice. Crucially, a key message emerging from the consultation is that countries would like more information on *how* to make a transition from one approach to another.

1.3 REFLECTIONS ON COUNTRY EXPERIENCES AND NEEDS

Country perspectives informed discussions on the following critical health system functions captured in the analytical framework, namely: service delivery; financing; stewardship and governance; priority setting; monitoring and evaluation; and demand generation. These informed discussions of the following issues:

- (i) In many countries, programs emphasize specific interventions to achieve health, nutrition and population outcomes. Given this, when might it be necessary to integrate them into broader health systems, and how might this be done?
- (ii) What elements of health systems and service delivery are required to ensure/augment the success of programs that emphasize specific interventions? What contextual factors affect

- the success of such programs? How can these programs contribute to strengthening systems in different contexts?
- (iii) What are the effect of large, externally financed programs for priority HNP interventions on financing and budgeting, planning, service delivery and monitoring and evaluation systems at the country and sub-country levels?
 - (iv) Conversely, what are the effects of general health system strengthening programs on priority HNP interventions at the country and sub-country levels?
 - (v) How do the roles of other contextual factor influence modes of financing and organization of health service delivery? These factors may include urgency or perceived urgency; definitions of success; and external and internal political factors.

Group discussions and conclusions illustrated similarities and variations across country contexts. The following are highlights of key themes that emerged from the discussions:

- There are differences across and within countries in approaches that might be suitable for implementing single or multiple interventions. The approach to implementation might change during phases of a particular intervention, such as start-up, expansion, consolidation, or maintenance. One size does not fit all, and there is no universally applicable norm.
- An understanding of the political economy of health interventions is essential for understanding the factors that influence various stakeholder actions and approaches. This is true for both country and global levels.
- Integration tends to occur at different levels of the health system, e.g. at the District level, or within different critical functions of the health system. It is possible to have interventions integrated at the point of service delivery, yet have different financing and reporting mechanisms
- Distortions could arise from implementing programs in a non-integrated manner. Some distortions can be positive, particularly when they are deliberate and coordinated to resolve specific priorities. But they could be negative, and detrimental to the health system when uncoordinated, fragmented and unfocused.
- Several approaches have been adopted by countries to coordinate design financing and implementation of various interventions/activities by donors to be in line with national strategic plans, through mechanisms such as sector wide approaches (SWAs), pooling of funds and direct budget support. These approaches have hidden costs and suffer from insufficient systematic evaluations of their intended and unintended consequences. What are the *net* costs and benefits of these mechanisms.
- There is a need for clear taxonomy/clarification of definitions of what is meant by integration, vertical, horizontal and so on.
- Future studies should include case studies, an expansion of the literature review to capture grey literature and reports. In addition, case studies should examine ‘vertical’ programs that are implemented in clusters or in combination.

1.4 CONCLUSIONS

The consultation met the objectives of establishing a forum to provide conceptual, policy and operational guidance to the work program on “Integration of Health System Operations and Priority Health Interventions: Concepts, Evidence and Application”. In particular, it helped to:

- examine and provide inputs into a draft conceptual and analytical framework for the work program, which was found to be a useful for analyses and discourse
- provide country perspectives to inform the next stages of the work
- identify questions and country examples that can serve as case studies, including opportunities in several of the countries represented at the consultation and
- focus attention on the importance of know-how

Participants from the World Bank (hosts) noted the importance of following up on these conclusions and recommendations, including a potential reunion of the group after exploration of the key issues raised in the consultation through country case studies that are relevant to the concerns of policymakers. The following products and processes are priorities for 2008-2009:

- Publication of the conceptual and analytical framework in the World Bank’s HNP Discussion Paper Series to encourage further discussion, debate and application at the country level.
- Publication of reviews of the evidence on integration of priority HNP interventions and health system operations, including a systematic review (using the Cochrane collaboration criteria) and an extension of that review to include additional studies that are relevant to the work program but do not meet the Cochrane criteria.
- Application of the conceptual framework and relevant evidence to explore key issues raised in the consultation in a series of country case studies, with the aims of (i) improving our understanding of country needs and actions as identified in this consultation and (ii) enabling policymakers and senior analysts at the country level to implement country-led changes and improvements in their intervention and health systems.

It is expected that these products and experiences will form the basis for a follow-up consultation on the same topic, with emphasis on lessons learned.

2 INTRODUCTION AND OBJECTIVES

This report summarizes the consultation on “Integration of Health System Operations and Priority Health, Nutrition and Population Interventions: Concepts, Evidence and Application”, which was held at the World Bank on May 12-13, 2008. The purpose of the consultation was to provide inputs into the early stage of a global learning exercise that is being undertaken by the Health, Nutrition and Population (HNP) Department of the World Bank. This multi-year work program will transcend the binary positions of "for" or "against" integration to focus on key questions, evidence and assumptions of which policy makers and financiers need to be aware as they make decisions in different contexts. It will address several questions:

- (1) How can health systems be improved to meet the objectives of increasing access to essential health, nutrition and population interventions? Where has this been done successfully, under what contexts, and what are the opportunities for doing so in other places?
- (2) In many countries, programs that emphasize specific interventions are important and necessary for the achievement of health, nutrition and population outcomes. When might it be necessary to integrate them into broader health systems, and how might this be done?
- (3) What elements of health systems and service delivery are required to ensure the success of programs that emphasize specific interventions? What contextual factors affect the success of such programs? How can these programs contribute to strengthening systems in different contexts?
- (4) What are the effects of large, externally financed programs for priority HNP interventions on financing and budgeting, planning, service delivery and monitoring and evaluation systems at the country and sub-country levels?
- (5) Conversely, what are the effects of general health system strengthening programs on priority HNP interventions (in terms of financing and budgeting, planning, service delivery and monitoring and evaluation systems) at the country and sub-country levels?
- (6) What are the roles of other factors and how do they influence modes of financing and organization of health service delivery? These factors may include urgency or perceived urgency; definitions of success; and external and internal political factors.

A video of the plenary sessions is available online at:

<http://info.worldbank.org/etools/bSPAN/EventView.asp?PID=2307&EID=1025>.

A list of participants and organizations they represent is provided in [Annex 1](#).

3 DAY 1 (MONDAY MAY 12, 2008)

The plenary session was officially opened with a key note address by Mrs. Joy Phumaphi, Vice President, Human Development Network, World Bank, who welcomed the participants. In her introduction Joy Phumaphi emphasized the rationale, objectives, and expectations of the consultation which are captured below.

Rationale

- This work program is derived from the new World Bank strategy for HNP results, *Healthy Development*, which has as one of its five strategic directions the improvement of synergies between health system strengthening and priority HNP interventions.
- There is a need to define, update and clarify the intellectual, operational and cost basis for integrating or not integrating health system operations and priority HNP interventions in a manner that will transcend the binary positions of “for” or “against” integration. The work program will focus on key questions, evidence and assumptions of which policy makers and financiers need to be aware as they make decisions in different contexts.
- The Bank commits significant resources to these ‘priority HNP programs’ and recognizes the need to address systemic hurdles to improving health outcomes with increasing resources for the health sector. The work program will focus on cross-cutting themes that are relevant to the impact and sustainability of interventions in HNP.

Objectives

- The purpose of the consultation is to solicit views and identify inputs from global experts, senior analysts, advisors and policy makers from several countries, research institutions and international agencies.
- The overarching questions that this consultation seeks to answer are:
 - How can health systems be improved to meet the objectives of increasing access to priority HNP interventions?
 - Where has this been done successfully, in what contexts, and what are the opportunities for doing so in other places?

Expectations

The consultation is expected to inform the scope and conduct of a multi-year work program. Specific expectations include the following:

- Discussion, identification and clarification of the issues related to the objectives, across the selected themes, drawing from the scholarship and experience of the participants.
- An exploration and outlining of opportunities and options for generating evidence for context-specific solutions, and identification of specific cases for further study.
- A consultation that moves the discourse beyond the circular debate that pits ‘vertical’ approaches against ‘horizontal’ approaches, towards clarifying these definitions, defining important contextual elements, and ensuring synergies of various interventions at the country level.

Olusoji Adeyi (Team Leader for the work program) also welcomed the participants and pointed out that often the question that confronts policy makers should not be an either/or approach but rather what is the most appropriate course of action based on specific needs, capacity, and country context. In addition, the core World Bank task team members working on this program were acknowledged. They included Kelechi Ohiri (Health Specialist), Sadia Chowdhury (Senior Health Specialist), Meera Shekar (Senior Nutrition Specialist), Jana Brooks (Consultant), Ayanna Anderson-Bellard (Program Assistant)

Brad Herbert (Consultant to the World Bank) outlined “ground rules” for the consultation, introduced the agenda ([Annex 2](#)) and requested that all participants sign up for one of the six discussion groups by thematic area which included: (1) Service Delivery; (2) Financing in the Health Sector; (3) Stewardship, Governance, Monitoring & Evaluation; (4) Priority Setting, Resources allocation and M&E; and (5) Demand Generation.

3.1 DAY 1, SESSION 2 (PLENARY)

3.1.1 Findings from literature review and conceptual framework.

Rifat Atun (Professor, Imperial College, London) presented findings from two literature reviews (a systematic review using Cochrane Collaboration criteria, and an extended review, entitled here as “Cochrane Plus” which incorporated a wider range of published studies, including those that did not meet ‘Cochrane Collaboration Criteria’ for inclusion) and a conceptual framework for analysis. See [Annex 3](#) for the presentation.

3.1.1.1 Summary of Conceptual Framework

[Source: Atun, R., Ohiri, K., Adeyi, O., Forthcoming.]

An examination of the introduction of priority health interventions to health systems was carried out using a new conceptual framework that draws on theoretical propositions and empirical research in innovation studies, specifically on adoption and diffusion of innovations within health systems and builds on earlier empirical research.

In this framework, we view priority health interventions through an innovation lens, and consider them as “...an idea, practice, or object that is perceived as new by an individual or other unit of adoption”¹ while recognizing that in some cases the interventions which have previously been implemented in small scale are scaled up and increased in intensity. In such instances, the ‘newness’ relates less to the technical element of the intervention itself but the organizational changes, new financing schemes and novel processes that accompany scaling up, intensification, integration and eventual institutionalization of the intervention.

¹ Rogers, E.M. 1995. Diffusion of Innovations. 4th Edition. New York: Free Press.

Empirical evidence suggests that adoption and diffusion of innovations in health systems are influenced by the nature and complexity of the innovation and how it is perceived, contextual and health system factors. In addition, adoption and diffusion processes are shaped by factors pertinent to the adoption system. These factors include, prevailing cultural norms, beliefs and values of the key actors and institutions within the adoption system in particular professional groups and opinion leaders; social networks; systems and structures that enable learning within an organization; and, the absorptive capacity for new knowledge within the adopting organization.

Drawing on relevant empirical evidence and theoretical propositions, we propose that adoption and diffusion of new priority health programs and the extent to which they are assimilated or integrated into the 'general' health system will be influenced by five factors: the nature of the problem being addressed, the intervention/innovation, the adoption system which adopts and assimilates the innovation, specific health system characteristics, and the broad context. Our conceptual framework integrates these five constituents that influence the rate and pattern of adoption of an innovation within a health system, namely: the nature of the innovation, the adoption system (key actors and institutions), the health system characteristics, and the context within which innovation diffusion takes place. The framework also captures the interactions and interconnections between the innovation, adopters, the health system and the broad context which critically influence the adoption process (Figure 1)

Priority HNP interventions are introduced as innovations to health systems which are complex adaptive systems that change and adapt in response to endogenous and exogenous disturbances or triggers. As with other dynamic complex systems, health systems comprise interacting feedback loops and non-linear relationships. In such systems the effects of decisions are separated in time and space, hence, the consequences of actions that involve one or more elements of the system are not immediately visible nor the outcomes easy to predict accurately. These relationships extend beyond the health system elements and are intricately linked to the context within which the system is embedded, changes in the context influence system elements and in turn changes in system elements affect the context.

Further, each intervention/innovation is internalised within a distinctive adoption system consisting of a collection of agents (individuals and organizations that operate within a set of cultural norms and values) that act in ways that are not predictable. The actions of these agents are interconnected—action by one agent changes the context for other agents. The interaction of the innovation and the adoption system with the context influences the responsiveness of the context, which, in turn, influences the adaptation, translation, integration and assimilation of the innovation in the health system. These dynamic interactions result in unpredictable system responses to interventions. In addition, the non-linearity of the diffusion process and can lead to unintended consequences. Not surprisingly therefore, the rate, nature and extent of adoption, integration, and eventual assimilation of priority health interventions into general health systems will vary from one setting to the next.

3.1.1.2 Discussion

Following the presentation, there were several points and questions raised, which are outlined below:

The Ex-Ante Definition of Integration

- A: There was no pre-existing agreement on a definition, and that is part of the challenge. The researchers looked at the extent to which a program was integrated; i.e. was it a routine part of a mainstream ‘critical health stream functions’ (yet another phrase that can have varying definitions)? The team tried to unpack what was meant by integration- the extent to which the program was jointly working with/part of the framework, joint reporting, joint accountability, performance management along with main health system, integration of financing, pooling of funds along with health system (e.g., SWAps), or whether separate or same provider payment methods were used. Integration was also examined along the following lines: the planning function- joint needs assessment, joint priority setting, resource allocation, service delivery, M&E, and demand generation. Open to suggestion and improvement.

The Use of Secondary Sources of Information: (Why use secondary sources and not primary to study indicators?)

- A: Because of the nature of the subject. It was necessary to first look at the evidence base, peer reviewed literature, reports, and expert input in terms of studies that may have been missed. The next phase is to work in several countries to see what happened at the ground level, to generate robust evidence with well-designed studies.

Integration as a Continuum

- We are really looking at a continuum; from limited integration to total integration. What are missing are the extreme ends. On question that arises is whether available data exists regarding these points. The continuum can exist within the same country, for example, India’s National HIV/AIDS Prevention and Control Program is not solely financed by the Global Fund. It is also a national program, and relatively vertical, less ‘integrated’. On the other hand, The Reproductive and Maternal, Infant and Child Health program is highly integrated. Given the complexity, it might be helpful to utilize control groups in program evaluation in order to make adequate interpretation. It would also be helpful to look at the determinants of success and sustainability among the studies that were included in the review.
- A: The concept of Integration is complicated. This is why a framework approach was used to deconstruct the term integration. To date, the research has involved looking at several peer reviewed publications. Subsequent phases of the work program will involve expansion into gray literature.

Distinction between different Studies reviewed: (Which of these studies were projects and which were countrywide implementations?)

- Some of the studies such as those on Integrated Management of Childhood Illnesses (IMCI) were at district level. The US and UK programs were trials at a clinic level, not scaled up regionally or nationally. Some programs were based at a few clinics, some at the district, and

some trying to expand to national level. This important trait is being classified. There are sustainability and effectiveness implications. If the program is in 1 or 2 clinics as an experiment, it may not be sustainable until it is institutionalized.

Methodology and Research Question being asked by the Literature Review

- What exactly is the research question being addressed by the literature review, and how does this follow the methodology you have chosen? One may be left with the impression that the research question is: Is it better to have a more integrated or more vertical approach (is treatment A better than treatment B)? Yet in the introductory comments it was made clear that there is no right or wrong answer. Secondly it appears as though the intervention being tested is *not* the health intervention; rather it is “integration vs. not integration” across a vast array of health intervention
- Our starting point was to look at integration vs. non-integration outcomes. Next, we unpacked, “integration”; the extended structured review which we entitled “Cochrane Plus” is not as clean as there a vast range of studies analysing interventions with varied research methodologies that do not allow direct comparison; there is not a clear intervention that you can put your finger on. It is one of the problems to using a highly positivist/reductionist approach for organization interventions because the intervention may not be simple. It can be complex and messy: HIV, nutrition, or TB interventions—they are multifaceted, with multiple elements, user engagement and a length temporal dimension. Secondly, there isn’t an easy recognizable thing called integration. That is the problem we tried to address. There are multiple levels and facets to where ‘integration’ can be achieved.

3.1.2 Evidence and Scaling Up: Meaning and Implications.

What we conventionally call evidence would not be enough to help answer how and whether to integrate to health systems and services. What do we know? How do we apply these?

David Peters (Associate Professor, Johns Hopkins University) was invited to facilitate a plenary session on “***Evidence for policy, and evidence from policy: what do we know from research and practice?***” His presentation (Annex 4) raised two questions. First, can we find the “best” evidence” on how to integrate health systems; and secondly, can we find the “best approaches” to scaling-up integration?

Dr. Peters suggested that an adequate study design to provide evidence was needed for systematic reviews and techniques such as randomized controlled before and after trials; non-randomized controlled before and after trials; randomized control post-only trials; and interrupted time series designs with at least 3 data points before and after the intervention would be appropriate approaches. These form the basis for current thinking about evidence.

Based on the evidence Dr. Peters suggested that we do know quite a bit about successful health systems strategies. For example, we know that many work but few are replicable. The same labels may be used to describe an approach but given country differences, different strategies need to be developed – thus echoing the earlier discussion in the first plenary session.

In reviewing the “causal chain” from strategies and interventions to results, there is usually a fairly good understanding of what is required in terms of effective health interventions. We also have a good understanding of why these interventions would lead to the change in health behavior and service use, which results in the desired health outcomes. However, the most critical part of the “casual chain” is implementation or what Dr. Peters refers to as the “black box”. In other words, in the absence of knowing who will do what, when, where, and how, it does not matter what the intervention is or whether it is fully integrated within a health system or is a stand alone intervention.

While understanding the “causal chain” there are still a number of constraints on development agencies to assist countries in scaling up both in terms of coverage (more people reached) and absorption of donor aid. These constraints include: (1) pressure for immediate results; (2) contradictions between purpose and procedure; and (3) demands for detailed up front planning and schedules, which assumes the problem is well understood when it is actually ill defined (the “black box”).

Given that donors can overcome some of these constraints, there are a number of factors that can influence scaling up. These include the characteristics of the strategy, the ability and process for learning from the past, public accountability and political engagement. Of course it is also necessary to have a good fit between key actors such as the beneficiaries and implementing organizations. To increase the likelihood of success, the programs should focus on delivery of services; the program need to match the competence of the organizations (processes, structures, and norms that govern technical and social capabilities); there should be a good match between the needs of the beneficiaries and programs; and beneficiaries need to have the ability to define and voice their needs into the process and to the decision makers.

The discussion that followed David Peters’ presentation highlighted a range of issues related to scaling up: the importance for measuring results, ensuring that lessons from country experiences are shared, and the importance of sound monitoring and evaluation. Some of the items are outlined below:

3.1.2.1 Key elements for effectively scaling up services

- Sound policies and good regulatory frameworks.
- Following this, there must be the capacity to implement programs. However, this capacity does not have to be limited to public health service delivery. The issue of absorptive capacity needs to be rethought to include opening new channels of delivery, including reaching out to community, NGO, and the private sectors
- Political economy and changes in government can affect country ownership and commitment to scaling up.
- Small-scale demonstration projects done in ideal environments can provide valuable lessons learned but can also have misleading results due to the favorable conditions in which they are implemented. They often benefit from strong commitment by senior policy makers, significant funding, and staff who have already been fully trained. This also applies to the “cherry picking” that often takes place to demonstrate support for a specific position.

3.1.3 Country-level Feedback

Country led experiences from a number of ministries of health demonstrate that while continual experimentation should be acceptable there are many constraints that need to be monitored. The following are some examples used to illustrate the range of issues which emerged from countries:

- In **Ghana**, three key elements that contribute to success of programs include:
 - Availability of the commodity
 - Continued operational funding
 - Adequate human resources
- Certain caveats are important to consider prior to implementation and scaling-up
 - Before you design the strategy, clarify the theoretical foundation.
 - Sometimes, the answer to “what are the key components in implementation or scaling-up?” is “we don’t know”. Personal experience may not be replicable.
 - Need for continued measurement, learning, evaluation
- Some vertical programs have performed well. A documentation of these would be helpful and might offer lessons to inform health system strengthening initiatives. Some of these include the following:
 - Clear indicators of success from scaled-up vertical programs include EPI= coverage rates; TB control= case detection, treatment success rates
 - Regular monitoring of key indicators including the use of new methods such as EPI Cluster surveys. This might also require regular external reviews of the programs
 - Adequate Human Resources including a cadre of experts (e.g WHO experts for EPI. In Health Systems however, everyone has “opinion”.
 - Procurement and other logistical and operational issues are critical for program success, whether integrated or not. In Afghanistan: more decentralized processes allowed for more successful implementation of programs, given the capacity constraints at the central level.
 - Short term results are often needed, especially by constituencies to which the donors and governments are accountable such as politicians and parliaments. This leads to the focus on quick returns on the invested amounts.
- More often than not, attempts to scale up are countered by the emergence of new ideas and ‘evidence’ which result in different approaches. In other cases, evidence is not taken up and used by several programs

In **Cambodia**: Vertical programs are implemented as a national priority mostly to catch up with neighboring countries. For instance it was the last country in the sub-region to achieve Polio Eradication; Infant mortality was rate reduced, but maternal ratio was not improving. Programs are dependent on funding, which could be better coordinated with the Government.

- The balance between vertical and horizontal approaches depends on what you are trying to tackle. Some interventions do not require robust health system.

3.2 DAY 1, SESSION 3. GROUP DISCUSSIONS, “DIAGNOSTICS”

The first round of group discussions was expected to focus on the “*diagnostics*” (not solutions) by exploring issues pertaining to integration for each of the group themes. In doing so, the groups were asked to focus on the following questions:

- In many countries, programs emphasize specific interventions to achieve health, nutrition and population outcomes. Given this, when might it be necessary to integrate them into broader health systems, and how might this be done?
- What elements of health systems and service delivery are required to ensure/augment the success of programs that emphasize specific interventions? What contextual factors affect the success of such programs? How can these programs contribute to strengthening systems in different contexts?
- What are the effects of large, externally financed programs for priority HNP interventions on financing and budgeting, planning, service delivery and monitoring and evaluation systems at the country and sub-country levels?
- Conversely, what are the effects of general health system strengthening programs on priority HNP interventions at the country and sub-country levels?
- How do the roles of other contextual factor influence modes of financing and organization of health service delivery? These factors may include urgency or perceived urgency; definitions of success; and external and internal political factors.

Participants had the opportunity to “self-select” the thematic area in which they wanted to join, before breaking into smaller working groups.

3.2.1 Summary of Plenary Session following group discussions (diagnostics)

3.2.1.1 Group 1: Focus on Service Delivery:

The group discussion on Service Delivery first focused on the different problems which should be addressed. These included:

- Competing or conflicting goals of different programs
- Reducing duplication of efforts, time spent by staff, etc.
- Getting a more comprehensive/coherent response
- Assuring easy-to-use services
- Imbalances in resource allocation
- Increasing a collective sense of responsibility
- Aligning incentives to achieve goals

In addressing the issues of how to integrate, the group pointed out the following:

When to integrate?

Three phases in program implementation were proposed, each with potentially different strategies and different needs. They include — Initiation, scaling up, and maintenance phase. Integration is said to largely occur during the maintenance phase. When there are urgent needs to be met, integration might not be the appropriate approach

How and by whom should integration be done?

- Public sector, private sector, CSO
- The context in which integration happens is an important consideration: social factors, politics, history and financing instruments

Country Experiences

The group benefited from the country level experiences of a number of participants. These experiences of Cambodia and Ghana were contrasted with each other. It was noted that in Cambodia, tying funds to projects rather than the health system constrained the use of funds. In Ghana, where funds were allocated to health system as a whole (through a SWAp), the resources were fungible and could be allocated to meet the needs of the system.

Lessons learned from other country examples were also discussed by the group including:

Cambodia

- Some ‘integration’ of service delivery was achieved through the EPI program. For instance, additional interventions such as the provision of mebendazole and Vitamin A were included.
- There are separate sources of funding and distinct interventions – all delivered by one person – the midwife at the service delivery point. In addition to this integration of the service delivery, integrated supervision of programs has been introduced.
- Therefore there was structural and functional integration at the service delivery level, but planning and financing remained separate.

Vietnam

- There are about 15 specific intervention programs and 10 National Target Programs in health alone. All these programs are integrated at the point of service delivery at the commune and district levels, but not at the national level.
- There is no special or separate infrastructure for the implementation of these projects. Services are provided within the existing health infrastructure.
- The principal reason for the lack of total integration is the need for additional financial resources targeted to priority programs which usually come from the central government and are specific for health conditions deemed to be national priorities. So far, these programs have worked very well.
- Services are integrated at the Commune Health Center level. Each commune health center has about 6 staff (about 60% of CHCs have doctors). Staff is responsible for the

implementation of all national targeted programs. There are about 15 National Programs, all financed separately. Hence monthly reporting to each program occurs separately.

Ghana

- The representative stated that the issue of integration not be considered as a binary (either/or) choice. Rather, it is to be seen from the view of there being a baseline system, which is the existing health service delivery system. If there is a need for rapid scaling up of certain services in response to a need (an emergency, or a priority area), then, earmarking (and other non-integrated approaches) may be used to speed up the process. While this is occurring, there must efforts to ensure that other programs are not overlooked.
- Strong management systems at all levels are essential, especially the district. District management must be capable of allocating appropriate resources to address a variety of programs and issues. Individual program managers, if left alone, tend to go vertical. There is a need to bring the various parts together ensuring a collective plan and responsibility for all programs
- Complex interventions are difficult to turn into vertical programs.
- There tends to be more structural and functional integration at the district level, with mixed funding at the national level.
- With the SWAp in place, key sector-wide indicators for health sector have been selected and all programs report on the basis of these indicators.

Nigeria

- PEPFAR program was being implemented through a grant to Harvard University. These funds were then channeled to specific programs through a sub-contracting arrangement with some university teaching hospitals. In principle, they were to follow guidelines of the Nigerian government. The most recent development is that there is an NGO group has been established, with representation from the national government, poised to take over the responsibility from Harvard.
- In Ghana, it was a joint effort between the donors and the government of Ghana. The experience of Ghana and Nigeria may not be generalizable to other African countries nor should they be regarded as 'blueprints'. In particular, in Ghana, in addition to the pool of resources available through the SWAp, there was additional funding available to the district that was fungible. Secondly, a new type of financing has been introduced — the health insurance scheme, likely to completely change how health financing works in Ghana.

3.2.1.2 Group 2: Focus on Financing in the Health Sector

The group's discussion focused on verifying the conceptual framework. Noting that financing is an instrument to achieve a given set of objectives, the group concluded that whether or not integration is appropriate depends on the objectives. The group also re-phased the questions and discussed the following:

- What are the distortions and advantages of non-integrated financing?
- What are the contextual factors that make non-integrated financing a necessity?
- Financing mechanisms to facilitate integration?

The distortions caused by non-integrated financing include:

- Sustainability issues
- Misalignment of priorities
- Lack of ownership
- Long lasting distortions (e.g., Human Resources)
- Economies of scale not taken advantage of
- Hidden costs of running a non-integrated system
- Limited capacity to plan
- Political costs (loss of autonomy)
- Transaction costs to Government
- Political problems related to rejecting funding

The advantages of non-integrated financing

- Useful when it is needed to show results (tie inputs to outputs)
- Useful to overcome constraints and to show results (procurement)
- Best practices from abroad (capacity building)
- Generates pressure to reallocate resources better

Contextual factors that may necessitate non-integrated financing

- Government failure (collapse, corruption, capacities)
- Emergencies, disasters, failed states
- Rapidly changing technical interventions (science base constantly changing and demanding expertise)
- Circumvent hard budget ceilings of MoF

Financing mechanisms that may facilitate integration

- Output based budget support
- Programmatic budget
- Financing tied to sector outcomes
 - Integrated financing as a continuum: Two extremes may present;
 - Donor channels non-earmarked financial resources to the Ministry of Finance, leaving the allocation decision up to the country
 - Donor bypasses the government and provides services to country through a network of NGOs.
 - Vertical funding may work well in certain contexts such as in fragile states; or in countries such as Vietnam, with a relatively strong health system, where the funding can be channeled with minimal untoward effects. Vertical funding may not work well in areas where the health system is weak. It only perpetuates health system problems.
 - The same distortions can occur with internal government financing. Money is earmarked at the central government level for the local district government level, with little flexibility. This affects financing streams. Success is difficult when integrated financing occurs only at the top with no downward flow to where the action is.
 - Integration of financing may have two implications. One refers to the integration of financing within the government system. The second refers to the coordination and alignment of objectives and priorities with that of the country (This doesn't dictate how funding is channeled.)

- Accountability to the national systems goes beyond just coordination and alignment. Considerations of financing needs to be preceded by considerations of planning.

3.2.1.3 Group 3: Focus on Stewardship, Governance, M&E

The group discussion first focused on two assumptions or “givens”: Firstly, integration is not an either/or proposition, rather it is usually a question of what/when/how; secondly, the right solution needs to be within a results orientation.

Key points from the discussions

- Of the six critical health system functions identified in the conceptual framework, (i.e., stewardship and governance, financing, planning, monitoring and evaluation, service delivery, and demand generation), governance and financing are fundamental to enable and support all others.
- The reform process is political, and must focus on incentives and rules of the game, stakeholders, gains/losses, resistance and receptivity.
- The temporal dimension is key, but often lacking from discussions: ripeness, maturity, capacity; initiation of attention to issues vs. integration phase; transition from reaction to epidemics to building integrated preparedness/response capacity; “focused management” can facilitate the transition, so that no issue suffers due to integration processes.
- Coordination among various partners around a government-driven agenda may reduce some of the problems associated with partner fragmentation, competition, etc, which tend to be marked in lowest income countries. Initiatives such as SWApS need monitoring and accountability to prevent unintended consequences.

Positive externalities from ‘vertical programs’ are possible. They could result in the strengthening of management, leadership, M&E capacities (if designed to do so) for instance trachoma drugs example. Failure to take the potential impact of these programs into account could lead to the opposite effects.

Governance and financing are critical for the integration of the rest of the health system functions

- In the Philippines, there has been a shift from vertical programs to a SWAp.
 - Development partners organized into a Health Partners Group which meets monthly, conducts joint program assessments and is currently designing a joint M&E system for all the projects under the SWAp.
- It was observed by GAVI, that among the GAVI HSS proposals, some of the best proposals have come from the ‘fragile states.’ But who owns those proposals?

How to identify “maturity” of the programs in the temporal sequence outlined.

- Three stages have been identified: (1) introduction (2) scaling up and (3) maintenance. The first two phases may require ‘vertical’ programs, whereas the last one may be integrated.
- In Ghana: For instance, there has been no single measles-related death — this requires maintenance; however if there was an outbreak of a disease and a need to urgently

address this, it might be necessary to introduce an intervention, which if effective, would need to be scaled up.

3.2.1.4 Group 4: Focus on Priority Setting, Resource allocation and M&E

The group discussion focused first on an underlining principle. Namely, resource flows should be determined by disease burden and must be focused on the poor or marginalized parts of the population.

Issues

- Country-level systematic priority setting for resource allocation is largely absent or poor due to the non-acceptance of disease burden data and information on efficacy of interventions
- Is a SWAp in terms of pooled funding an end or means to an end? Planning SWAps often takes up huge efforts for the harmonization and coordinating, at the expense of contents and monitoring. Does generalized budget support marginalize health and nutrition interventions?.
- Donor-driven distortion occurs, but is that good or bad?
- Are budget allocations routinely reviewed in terms of consistency with disease burden?
- Planning is needed for both the short and long term. Consider both the timing and phasing of implementation.
- Focus on implementation, beyond resource allocation alone. Pay attention to the context, the country-specific bottlenecks, human resources, out-of-pocket expenditures
- Learning from what made EPI and other programs work. For example, accountability and feedback are important.
- What indicators to use: process focused vs. outcome and impact?
- Measuring the impact of health systems strengthening. This should be based on the contents of programs and what outcomes are being achieved, and not process alone.

Potential Case Studies

- Resource allocation by GAVI and GFATM: Do they cause distortions in terms of disease burden, and sustainability)?
- Internal dynamics – what happens when earmarked funds end?
- Generalized budget support/sector support vs. earmarked (partly or whole)
- What can be achieved through performance monitoring?
- Test effect of modes on financing on focus on household-level accountability and quality of care
- Focusing on the processes is as important as the outcomes. Indicators are needed.
- Budget support may not explicitly link the available resources to the strategy for achieving the health outcomes.
- What are the other options on which priorities should be based?
 - Key stakeholders for consultation on how to prioritize apart from using disease burden
 - Political self-interest is not necessarily aligned with the public interest

- Perhaps we need to spend less time on planning and more on learning. Work on choosing which indicators to use, and how to use the indicators better. Using disaggregated indicators – across income quintiles; using indicators for decision making.
- In Pakistan, with devolution in the past 7 years, the experience has been mixed, with varying results across 130 districts, based on capacity, local priorities, etc. Time must be taken into consideration, so that there is adequate time to allow for a learning curve.

3.2.1.5 Group 5: Focus on Demand Generation

Current discourse includes an implicit assumption that the availability of services would result in increased access to them. Whereas in several instances this may hold true, it is also well recognized that there are demand-side constraints to accessing services. Yet, demand generation generally receives little recognition:

There was no discussion on demand generation in the previous plenary as in most of the discourse in service delivery. In addition, it does not resonate with most providers.

Does one rely on the health system to generate demand for services, or is there a need for an intervention external to routine service delivery for this?

The group considered four current approaches that could stimulate demand.

- Promotional approaches – These tend to mostly focus on supply side, to encourage uptake of certain services and interventions. Examples include:
 - IEC/Advocacy – which tend to address the lack of knowledge, attitudes and practices including socio cultural factors that impede utilization of services
 - Quality of services – This is based on the premise that with improved perception of quality of services, utilization is likely to increase.
 - Use of Community Promoters to ‘advertise’ and provide information of services. This is the model on which a lot of social marketing strategies are based.
- Reducing cost of service – to remove financial barriers to access.
 - Direct costs of care such as the removal of user fees in Uganda.
 - Indirect costs of care such as food and transportation as is being piloted in parts of Vietnam.
- Fiscal Transfers – These are still relatively new but have proven effective in several settings, particularly in parts of Asia, and Latin America. They are used partly as an incentive for utilization of services, and partly to cover the opportunity cost of utilizing the particular service.
- Interventions outside the health sector
 - Demand for good governance – (absenteeism, accountability) thru report cards.
 - Education of girls.

While the above approaches do increase the demand the group identified a number of issues associated with demand generation.

- Vertical, externally-driven programs: Sustainability is an issue. Would the programs be sustained after funding ceases? Would the behavior changes that have resulted persist after the program stops?
- Competition among various programs
- How do we know what the client demands?
- Evidence on Behavior Change Process. The change in behavior is often documented, but the process that led to such a change is less well documented, which would be a challenge to scaling up demand generation interventions.
- Where does demand fit in the health system and in the various conceptual frameworks?

4 DAY TWO: TUESDAY MAY 13, 2003

4.1 PLENARY SESSION

Country representatives were invited to share their experiences in dealing with the integration of health systems and priority interventions. A number of observations, opinions and questions came up during the discussion. Some of these are outlined below.

- Service delivery is a central issue. But what is the purpose of service delivery? What is the purpose of integration or non-integration?
- In the discussion of finance, should there be a significant focus on aid fragmentation?
- Institutional strengths and weaknesses and how this is brought to bear in the discussion as the conversation on integration moves forward.
- Who was most responsible for success or failure of Bank projects? Tendency to blame the country, but is this accurate? What about the instruments, design, etc.?
- The role of terminologies and buzzwords in diverting the attention of country level policy makers. This is mostly because the way the terms are used has certain implications.
 - For instance health system strengthening is used interchangeably with integration; that there is an impression that health system strengthening is good and verticality is bad.
 - That acceleration of implementation is not health system strengthening. For example, moving from control to elimination of measles required drastic action in some places. There was a need to switch to campaign mode, and after the objectives had been achieved, it was switched back to routine services.
- Absence of evidence doesn't mean evidence of absence; hence we need to move beyond limiting ourselves to evidence of what has worked.

4.2 COUNTRY EXPERIENCE

Sometimes from within the health system an area that requires specific attention must be identified (quasi vertical program)

- *The example of neonatal tetanus.* Several decades after the finding that 2 – 3 doses of Tetanus Toxoid (TT) would protect children, children were still dying from tetanus in spite of the availability of TT. UNICEF showed that if you left it to broad systems approach, a cluster of people in each country was left out. A 'vertical program' was introduced and this has 'worked.' There were immediate and steep declines in neonatal tetanus. Even though health system strengthening can be advocated for, there are instances where there is a "crack in the wall," you don't go and paint the entire house; your focus must be on that problem.

Philippines

The Philippines has had a lot of experience in both integrating health systems and in managing priority health interventions. Based on this experience it is clear that some programs are easier to integrate than others. For example, there is a package of services for maternal and child health using a lifecycle approach and integrating care on a holistic basis. However, integration has been more difficult in dealing with infectious disease where vertical programs have had better success. There has also been some reluctance on the part of human resources, especially health care workers to move towards a fully integrated system.

Bangladesh

In Bangladesh integration occurs at the top level and lower levels, however, it is less so in the middle level and there has been little success in integrating MIS. The Bangladesh experience indicates that the overriding need is to ensure some flexibility and allow for prioritization. There is also a need to be cautious and avoid basing decisions only on the availability of empirical evidence and to look at not only what has been done but how things can be done.

India

India has focused its health service delivery towards achieving health outcomes through improving access to and utilization of health services. India has a very integrated program at all levels. However, nutrition is not integrated and resides with another ministry. At the village level there are synergies between nutrition and RCH. India also finances most of its health programs, so aid plays a minor role. Distortions may be caused by the vertical programs such as the polio program. This was one of the big reasons the First Reproductive and Child Health Project (RCH 1) did not make a big impact due to “paralysis by polio.”

Cambodia

In Cambodia most of the health service delivery system is integrated at the facility level. Failures of programs usually arise from implementation failures and not from the structure of the system. Awareness of the population and access to services are the two important contextual factors which has led to good health outcomes.

Vietnam

Vietnam has focused on “context-specific” interventions. The approach is to identify specific financing from Government revenue for specific projects. In fact, if the system were to be integrated, the provinces would then have to spend money from their own budgets, which are very limited and vary by income level. In addition, some other provinces might not prioritize these programs. Therefore, the Vietnamese experience suggests that from a financing and planning aspect, programs should not be integrated but implementation should be integrated, to

offset the limited capacity. Capacity remains an issue, and so does the need for improved management.

Rwanda

- Despite a lot of interventions in the health sector, there is continuing stigma and fragmentation in service delivery, with separate WHO site, Global Fund site, Government site, etc. Having a general pharmacy for the general health services and a specific HIV pharmacy works against integration.
- Data collection: The government has a health information management system (HMI), but there are other NGOs or bilateral interventions with the tools to collect information. The government of Rwanda is trying to coordinate international interventions, yet it is not easy to come together with all partners to mainstream activities as scheduled by the government
- Health clusters, technical working groups, and annual meetings promote an understanding of and alignment with government objectives.

Pakistan

- Vertical programs have a mixed track record.
- The Lady Health Worker Program is integrated at the point of delivery, but its fiscal management is vertical. This is a flagship program, and is achieving success using CHWs — the backbone of primary care of MCH. The LHW program is a great case study. As a program that has been protected, it illustrates how vertical programs can succeed.
- The issue is not what has been done; it is important to look at what can be done
- How can vertical and horizontal programs coexist?

4.3 DAY 2. GROUP DISCUSSIONS (CONTINUED) FOCUS ON “FUTURE DIRECTIONS”

Based on the “diagnosis” from the previous day, Rifat Atun requested the participants to explore opportunities and options for generating evidence for context-specific solutions and identify specific cases for further study. In exploring these opportunities, he requested that the participants use the analytical framework that was presented in Day 1. He also summarized some of the issues that were raised and to be kept in mind during the day’s discussion: service Delivery as a means for improving outcomes; financial protection; sustainability – reasonable probabilities that a particular approach will be sustainable; equity and net transaction costs.

Guidance for the group discussions

- Citing case studies – What worked, why was the approach adopted, and that was the rationale for approach (e.g. scale up quickly)
- Given your experience, what might work?
- What other sources would you suggest that we access?
- Where should we look for new evidence?

4.3.1 Plenary Discussions (solutions)

4.3.1.1 Group 1: Health Service Delivery and Demand Generation

The following is an outline of key points from the group.

- Access to basic package of services at community level — one-stop-shop
- Linkage among levels of the health system
- Primary Audience: National Policy Makers
 - Issue of conceptual clarification— what does integration mean?
 - Transition knowledge: How has integration of services been achieved?
 - Look at experiences from developed countries.
- Type of information needed from case studies
 - Rationale, objectives, opportunities and constraints
 - Process of evolution and adaptation from initial design
 - Look at demand
 - International development partners: how they affect provider network (public and private)
 - Preventive vs. curative services: what is included?
- What has to change in management support services?
 - Financial, planning, M&E staff training
 - Integration might mean dropping some services
 - Are some services harder to deliver?
 - How has the use of services changed?
- How to choose experiences to study
 - Reasonable time of experience?

- Types of documentation available. (Some published studies do not explain how change happened. Tacit knowledge is important).
- Scale is important

Recommendations for the work program on integration

- Choose experiences with reasonable length of time.
- Documentation should include the grey literature.
- Use both qualitative and quantitative methods, as well as structured interviews with major stakeholders
- What to capture:
 - Evolution and adaptation
 - Process of managing change
 - Contextual influences
 - Demand-side as well as supply-side lessons
 - How partners influence provided network and health system integration
 - Funding and planning
 - Clarify terminologies

4.3.1.2 Group 2: Financing, Priority Setting and Resource Allocation

The group identified the following propositions for policymakers:

- Integrated planning/priority setting framework with goal of improving health outcomes and financial protection, allocating resources to match burden of disease, selecting cost effective interventions, focusing on poor & marginalized
- Use framework and system review to select areas for concentrated focus, based on criteria: such as high burden/high cost diseases;
- Manageable problem (does reduction of maternal mortality ratio meet the criteria in all countries?)
- Focus on research/innovation to reduce cost of addressing high burden problems
- Global priorities like MDGs should not override national priority setting based on this type of analysis. Global priorities are hard to justify (except where the positive or negative externalities are very large, except as priorities for research/innovation

The group also identified the following questions for study under the work program on integration:

- Is financial protection is the only type of systemic intervention that has been shown to provide value for money?
- Are vertical programs generally better able to demonstrate value for money
- Are there benefits from “broader” vertical programs that encompass a cluster of diseases and interventions? (MMR, IMR compared with polio eradication)
- Do narrower vertical programs have fewer negative spillovers?

Other options for investigation:

- Decentralization: country evaluation of different approaches to handling vertical programs in the fiscal and functional decentralization (e.g. India federal government and states, Pakistan, Indonesia, Philippines)
- Compare how countries handle these choices about vertical versus integrated planning and budgeting in federal or de-concentrated health systems with how external aid handles these issues
- Financing and organization of public goods, prevention/promotion programs, priority public health programs vis a vis curative/treatment services
- Discussion of why countries have dysfunctional, inefficient verticalization or fragmentation
- Distinctive issues for countries that are highly aid dependent, especially fragile states: ad hoc selection of priorities, bad data driving major misallocation
- Distinctive issues for countries in rapid transition (epidemiological and economic transition): resource allocation and organizational structures still based on disease burden and population distribution of 20-30 years ago, obstacles to organizational change

4.3.1.3 Group 3: Stewardship, Governance, and M&E

The group proposed the following for inclusion in the work program on integration:

- Review of budget support and its impact. Review of the impacts of various SWAps.
- Potential studies from India include the following:
 - What are the lessons from the state-level projects (re: the integrated reproductive maternal infant and child health national program)
 - What are the effects of non-integration of nutrition with MCH and other programs?
 - How can the private sector play a more effective role, for example, in obstetric care in Gujarat?
- Donor score cards: It is also worth noting that while many donors put forward “score cards” for recipient countries, in the Philippines, a donor score card is being developed which scores donors along several lines, including: consistency with the Paris Declaration, support to National objectives, and the policy framework.
- Transition Research. How did countries achieve integration (getting from here to there)? How did they manage the change process in terms of governance and financing?. This is a matter of “craft knowledge”.

How does fractioning vs. integration of *donors* affect the functioning of services?

Next Steps

- Guidance for countries to move from one place to another
- Taxonomy (countries where donor-funding predominates or government)
- Specific programs
- Centralization vs. Decentralization
- Sub-regional workshops to get expertise from local experts

- Working with agencies such as UNAIDS, Stop TB to get their knowledge on country case studies

It is also worth noting that while many donors put forward “score cards” for recipient countries, in the Philippines, a donor score card is being developed which scores donors along several lines, including (a similar scoring system is in place in Ghana and Ethiopia.)

- Consistency with the Paris Declaration on Aid Effectiveness
- Support to National objectives,
- Policy framework

5 CONCLUSIONS

The consultation met the objectives of establishing a forum to provide conceptual, policy and operational guidance to the work program on “Integration of Health System Operations and Priority Health Interventions: Concepts, Evidence and Application”. In particular, it helped to:

- examine and provide inputs into a draft conceptual and analytical framework for the work program, which was found to be a useful for analyses and discourse
- provide country perspectives to inform the next stages of the work
- identify questions and country examples that can serve as case studies, including opportunities in several of the countries represented at the consultation and
- focus attention on the importance of know-how

Participants from the World Bank (hosts) noted the importance of following up on these conclusions and recommendations, including a potential reunion of the group after exploration of the key issues raised in the consultation through country case studies that are relevant to the concerns of policymakers. The following products and processes are priorities for 2008-2009:

- Publication of the conceptual and analytical framework in the World Bank’s HNP Discussion Paper Series to encourage further discussion, debate and application at the country level.
- Publication of reviews of the evidence on integration of priority HNP interventions and health system operations, including a systematic review (using the Cochrane collaboration criteria) and an extension of that review to include additional studies that are relevant to the work program but do not meet the Cochrane criteria.
- Application of the conceptual framework and relevant evidence to explore key issues raised in the consultation in a series of country case studies, with the aims of (i) improving our understanding of country needs and actions as identified in this consultation and (ii) enabling policymakers and senior analysts at the country level to implement country-led changes and improvements in their intervention and health systems.

It is expected that these products and experiences will form the basis for a follow-up consultation on the same topic, with emphasis on lessons learned.

6 ANNEXES

6.1 LIST OF PARTICIPANTS

Consultation on "Integration of Health System Operations and Priority Health Interventions: Concepts, Evidence and Application." 12-13 May, 2008. World Bank, Washington, D.C.

<u>Participant Name</u>	<u>Institutional Affiliation</u>
Adeyi, Olusoji	World Bank - HDNHE
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Thompson, Antony
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Travis, Phyllida
Vaillancourt, Denise
Villaverde, Mario
Vujicic, Marko
Waddington, Catriona
Yazbeck, Abdo

World Bank - HDNHE
PRB
World Bank - AFTHD
Abt Associates Inc., AED/Africa Health 2010
Project
World Bank - HDNGA
Vietnam - MOH
WHO
World Bank - IEGSE
Philippines - MOH
World Bank - HDNHE
Health Economist
World Bank - WBIHD

6.2 AGENDA

Consultation on “Integration of Health System Operations and Priority Health Interventions: Concepts, Evidence and Application”

May 12-13, 2008. The World Bank, Washington, DC.

OBJECTIVES

The overarching question that this consultation seeks to answer is: How can health systems be improved to meet the objectives of increasing access to essential health, nutrition and population interventions? Where has this been done successfully, under what contexts, and what are the opportunities for doing so in other places? The following are more specific questions for discussion:

1. In many countries, programs that emphasize specific interventions are important and necessary for the achievement of health, nutrition and population outcomes. When might it be necessary to integrate them into broader health systems, and how might this be done?
2. What elements of health systems and service delivery are required to ensure/augment the success of programs that emphasize specific interventions? What contextual factors affect the success of such programs? How can these programs contribute to strengthening systems in different contexts?
3. What are the effects of large, externally financed programs for priority HNP interventions (for example GFATM, GAVI, IAVI, PEPFAR) on financing and budgeting, planning, service delivery and monitoring and evaluation systems at the country and sub-country levels?
4. Conversely, what are the effects of general health system strengthening programs on priority HNP interventions (in terms of financing and budgeting, planning, service delivery and monitoring and evaluation systems) at the country and sub-country levels?
5. How do the roles of other contextual factors influence modes of financing and organization of health service delivery? These factors may include urgency or perceived urgency; definitions of success; and external and internal political factors.

Discussion Groups by Thematic Area

- *Group 1: Focus on Service Delivery:* David Peters & Agnes Soucat, *facilitators*–
Breakout room MCC2-125
- *Group 2: Focus on Financing in the Health Sector:* Catriona Waddington & Pablo Gottret/Tania Dmytraczenko, *facilitators*–
Breakout room MCC2-131
- *Group 3: Focus on Stewardship, Governance, Monitoring & Evaluation:* Adetokunbo Lucas & Abdo Yazbeck, *facilitators*–
Breakout room MCC2-132
- *Group 4: Focus on Priority Setting, Resource allocation and M & E:* Don de Savigny & Gayle Martin, *facilitators*–
Breakout room MCC2-135
- *Group 5: Focus on Demand Generation:* Zulfiqar Bhutta & Sadia Chowdhury, *facilitators*–
Breakout room MCC2-136

**Consultation on “Integration of Health System Operations and
Priority Health Interventions: Concepts, Evidence and Application”**

Day One: Monday May 12, 2008

8:30-9:00 Continental Breakfast served in reception area outside Room MC-C2 131

Session 1

- 09:00–09:15** **Welcome and Introduction – objectives and expectations**
Joy Phumaphi, *Vice-President, Human Development Network, World Bank*
- 09:15–09:30** **Ground Rules for Discussions**
Brad Herbert, *Brad Herbert Associates*
- 09:30–10:30** **Findings from Literature Review and Conceptual Framework**
Rifat Atun, *Imperial College*

10:30-11:00 Coffee and Tea served

Session 2

- 11:00-12:15** **Plenary Session. Evidence *for* policy, and evidence *from* policy: what do we know from research and practice?**
David Peters, *Johns Hopkins University, facilitator*
Objective: To provide the opportunity for broad discussion around the evidence presented in Session 1 and on the experience of participants. Consider how this experience can be systematically captured.
- 12:15–12:30** **Assignment into Groups with Guidelines**
Brad Herbert, *Brad Herbert Associates*

12:30-13:30 *Lunch served in the MC-CI Private Dining Room ABC*

Session 3

- 13:30–15:15** **Group Discussions, “Diagnostics”**
Rifat Atun / Kelechi Ohiri
Objective: Using the five questions identified above, to explore issues pertaining to integration for each of the group themes

15:15-15:30 Coffee and Tea served

Session 4

15:30–17:30 **Plenary Discussion – Presentation of summary of group discussions from Day One and open discussion**

Panel format

Rifat Atun/ Kelechi Ohiri / Marko Vujicic, *facilitators*

17:30–19:30 **Reception**

Please join us for a reception in the 12th Floor Gallery of the MC Building

**Consultation on “Integration of Health System Operations and
Priority Health Interventions: Concepts, Evidence and Application”**

Day Two: Tuesday May 13, 2008

8:00-9:00 Continental Breakfast served in reception area outside Room MC-C2 131

Session 5

8:30–9:00 **Summary from Day One discussions, Achievements and Diagnoses**

Brad Herbert

9:00–9:15 Comments on the summary

9:15–10:45 **Group discussions to continue, focus on “Future Directions”**

Same group/room assignments as Day One

Objectives:

- (i) Using the analytical framework presented in Day 1, explore opportunities and options for generating evidence for context-specific solutions, and identify specific cases for further study.
- (ii) Identify methods to address questions identified in prior sessions.

Rifat Atun

10:45-11:00 Coffee and Tea served

Session 6

11:00–13:00 **Plenary Discussion – presentation of summary of group discussions from Day Two and open discussion**

Panel format

Rifat Atun/ Kelechi Ohiri / Marko Vujicic, *facilitators*

13:00-14:30 Lunch served in the MC-C1 Private Dining Room ABC

Session 7

14:30–15:30 **Plenary Discussion – discussion of study plans, methods, and case studies (criteria for selection, and methodology for generating new evidence). Suggestions and next steps for studies and deliverables in Phase 2.**

David Peters/ Soji Adeyi

15:30–16:00 **Conclusions and final remarks**

Keith Hansen, *Sector Manager, HNP, Latin America and Caribbean Region*