



GLOBAL PUBLIC HEALTH SYSTEMS INNOVATIONS:

A SCAN OF PROMISING PRACTICES

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SUMMARY

The United States spends more money on health care than any other nation, but the citizens of many other countries live longer and healthier lives than those in the United States. Studies also show that countries that invest more in social and community programs have better health care outcomes and also healthier populations. To explore how other countries' health improvement efforts could inform similar efforts in the United States, AcademyHealth, with support from the Robert Wood Johnson Foundation, reviewed and synthesized promising approaches to public health systems innovations in countries that are responding to changing population needs by transforming their public health, health care, and social service systems. We looked for and analyzed organizational, programmatic, financial, and policy innovations that are being used to improve public health systems abroad and that might offer lessons that can be adapted to the United States. We were particularly interested in systems-level innovations that involve cross-sector collaborations (e.g., inter-governmental and public-private initiatives), new funding sources, and new data sources. Our findings suggest that innovations anchored in public-private partnerships that build data and communications infrastructure, engage communities in co-creating solutions, draw on diverse perspectives, and make crucial data and knowledge publicly accessible hold great promise for replication in the United States.

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INTRODUCTION: HEALTH AROUND THE WORLD

In 2013, the Institute of Medicine (IOM) **report** *Shorter Lives, Poorer Health* observed that the United States is one of the wealthiest countries in the world, but not one of the healthiest.¹ Compared to peer countries, Americans die at younger ages and have more chronic illnesses, including obesity and diabetes, heart disease, lung disease, and HIV/AIDS.

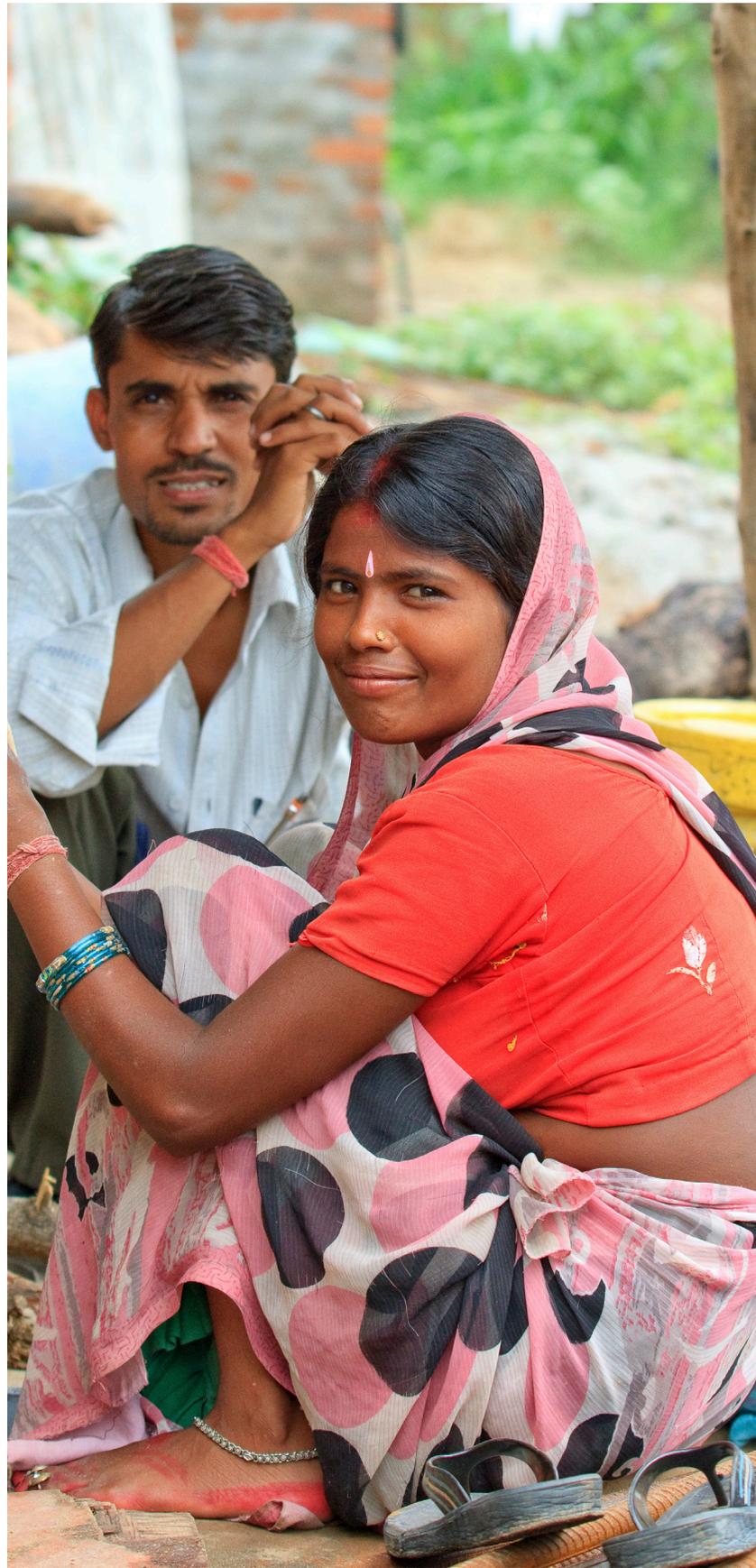
Studies show that countries and communities that invest more in social support services² and **community** programs³ have better health care outcomes and also healthier populations. Paying more attention to employment, education, housing, and lifestyle factors - such as smoking, nutrition, and physical activity - can produce positive results for overall health. In 2009, the United States ranked 32nd among Organization for Economic Cooperation and Development (OECD) countries in its ratio of social spending to health spending.⁴

In the United States, the public health system is comprised of a mixture of federal, tribal, state, and local agencies, with some support from private foundations. The U.S. funding streams often target a particular disease or geographic area, with program-specific performance measures. The Department of Health and Human Services is the largest source of funding for state and local public health programs, and the Centers for Disease Control and Prevention is the lead federal agency for public and population health, with responsibilities for health promotion, prevention, and preparedness. However, it is the states that bear the statutory responsibility for health, and there are 50 separate state legal systems that have their own structures and policies for funding and organizing state and local health agencies. This mixture of governance entities and funding sources can result in fragmentation, lack of coordination, and service gaps that contribute to poor health, with a disproportionate impact on communities of color and low-income communities.

Alternatively, most other countries have a ministry of health or a central national government entity that oversees public health services and systems. This body works with international donors and other non-governmental organizations (NGOs) on projects and programs to improve health and health care.⁵ At the global level, the World Health Organization (WHO) provides guidance on policies and resource allocation for its 191 member countries, and the multi-donor nature of global financing requires coordinated accountability systems to facilitate donor reporting and sustainability.

For our review of systems-level innovations, we looked for some promising examples of coordinated, collaborative initiatives involving public health, social service, and health care systems in other countries that might be adapted to the United States. We were particularly interested in learning from systems-level innovations, rather than individual programs, or interventions that involve cross-sector collaborations, such as public and private sectors, or different governmental agencies, including different departments or national, regional, and local levels. We also looked for a variety of donors.

The initiatives chosen for this study represent innovations in high, medium, and low-resource regions in Africa, Asia, North and South America, and Europe. We purposefully chose regions that were racially, ethnically, and economically diverse in an attempt to find innovations that would reflect the diversity of the United States and thus, increase the applicability of our findings. Although each innovation was unique, interviews with key leaders, participants, and stakeholders revealed that those implementing the projects and programs faced common challenges and experienced similar factors that facilitated their progress.





OUR CONCEPTUAL APPROACH TO PUBLIC HEALTH SYSTEMS INNOVATIONS

Early in our search, we began to use the World Health Organization Health Systems **Framework**⁶ as a guide to developing interview questions, focusing on what worked in developing, maintaining, and evaluating these innovations, and what had not worked. We focused on the WHO approach not only because it has been used widely by many countries and regions to guide the development of health systems, but also because it focuses on how to plan and organize new initiatives.

The WHO Framework is represented by a diagram (see Figure 1) that describes the components of health systems, organized into building blocks (organizational structures, people, and activities) and overall goals/outcomes, such as improved health. The framework combines health care and public health components that are separately funded and maintained in the United States.

In the United States, evaluations of public health projects often focus on the relationship between interventions and goals or outcomes. The foundational elements, or “building blocks,” in the WHO Framework have been used widely in evaluating U.S. health care outcomes, but they have not been widely used by public health practitioners.

To help map the WHO framework to the U.S. public health system, we added the three core public health functions (assessment, policy development, assurance) identified in 1988 by the **Institute of Medicine**⁷ and included “partnerships” and “performance management/accountability,” which were identified in 2008 by the Public Health Quality Forum of the **U.S. Department of Health and Human Services**⁸ as important components of public health quality improvement. To further update the list of interventions, we added “incentives” and “strategic communication,” two emerging areas of interest in public health systems and services research and practice (see Figure 2).

WHO SYSTEM BUILDING BLOCKS

Leadership/Governance: involves ensuring strategic policy frameworks exist and are combined with effective oversight, coalition building, the provision of appropriate regulations and incentives, attention to system-design, and accountability

Financing: raises adequate funds for health, in ways that ensure people can use needed services, and are protected from financial catastrophe or impoverishment associated with having to pay for them

Information: ensures the production, analysis, dissemination and use of reliable and timely information on health determinants, health systems performance and health status

Workforce: works in ways that are responsive, fair and efficient to achieve the best health outcomes possible, given available resources and circumstances.

Source: Everybody's Business: Strengthening Health Systems to Improve Health Outcomes: WHO's Framework for Action

FIGURE 1.

THE WHO SYSTEM FRAMEWORK

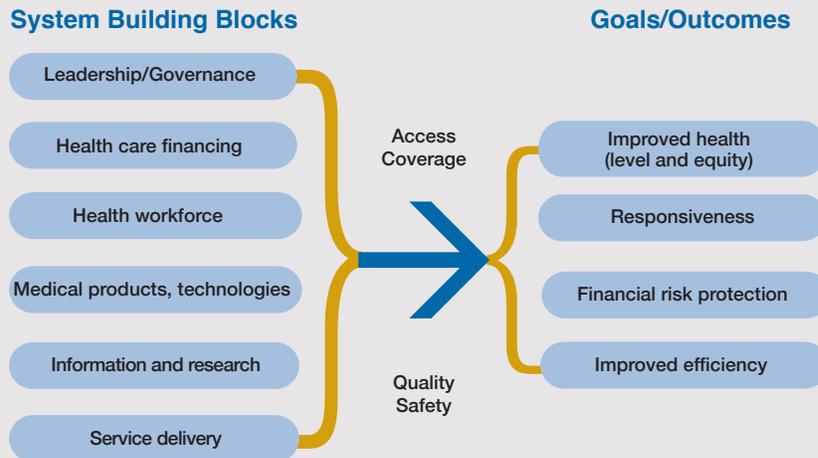
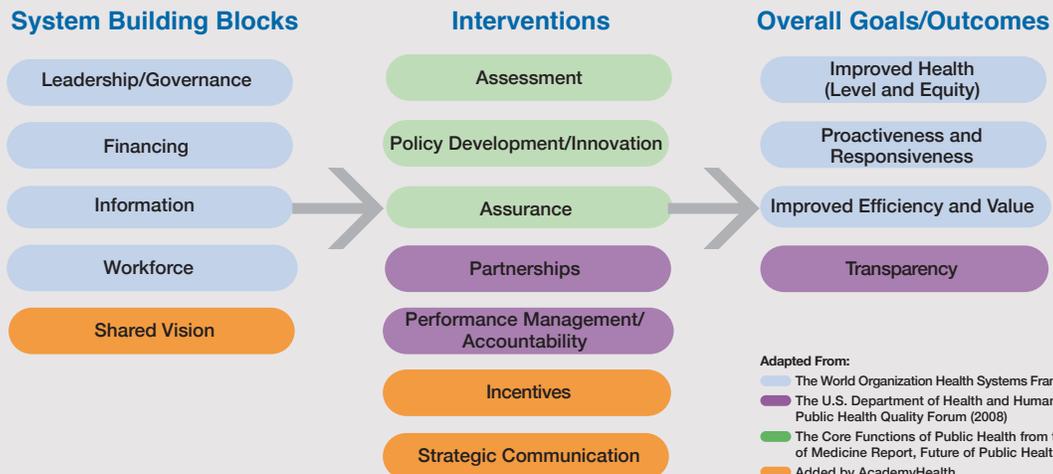


FIGURE 2.

OUR CONCEPTUAL APPROACH



OUR TECHNICAL APPROACH

In our search for innovations, we scanned a variety of health initiatives from economically, racially, ethnically, and geographically diverse areas of the world.

Recognizing that the published, peer-reviewed research literature would not cover the operational and practical aspects of planning, launching, and maintaining systems-level innovations, we began our search with global health reports, websites, and lists of currently funded projects from the WHO, the public health arm of the United Nations; the OECD; the U.S. Agency for International Development (USAID); and the Center for Global Health at the CDC.

At the recommendation of our Advisory Group, we also scanned reports and projects funded by the Bill & Melinda Gates Foundation, the Clinton Global Initiative, Global Health Council, mHealth Alliance, PATH, the World Bank, and the World Federation of Public Health Associations—recognized leaders in global health. In particular, we looked for reports to donors, annual reports by donors, and third-party evaluations of various initiatives.

In addition, we did Google searches using the following terms: public health innovation, global health innovation, population health innovation, reverse innovation, social innovation, systems innovation, health system development, capacity building, systems strengthening, and inter-governmental collaboration. We reviewed publications and websites in English, French, German, Portuguese, and Spanish.

As the search progressed, we refined our strategies to focus on public health systems-level innovations that involved inter-governmental collaborations, public-private collaborations, new funding sources, and new data sources. We did not include initiatives based solely within health care systems or programs, even if these were designed to promote population health through universal health care coverage.



We included some initiatives that were far enough along to have had external evaluations published, some with multiple stages and phases, and some that were relatively new. We presented a preliminary list of 70 initiatives to our Advisory Group, which suggested some refinements in search and selection criteria, including: expanding our search beyond country-specific initiatives to include regional innovations, focusing less on innovations implemented by national governments, and searching for more public-private partnerships or NGO-funded innovations.

The final list (see Figure 4) reflected geographic, racial/ethnic, and economic diversity; included at least two projects in each of the three core U.S. public health functions of assessment, policy development, and assurance; had produced some self-evaluation documents through grant reporting or third-party evaluations; and had a variety of population health goals, including reducing obesity and diabetes, promoting community-based maternal and child health, and building communications and data infrastructure. Because we sought practical information that could

assist future implementation efforts, we focused on maximizing variety in approaches rather than trying to identify or rank “the best” initiatives. We also recognized that approaches had varying levels of evidence and were in different stages of development, thus making it inappropriate for us to compare and rank.

When we agreed on a final list of eight initiatives based on the criteria outlined above, we developed an **interview guide** and a list of individuals we wanted to interview for each. Our interviews took an ‘implementation science’ approach and were organized into the four stages of planning, implementation, evaluation, and dissemination.

Using email, phone calls, and Skype, we talked with program managers, administrators, and advisors; sponsoring organizations; and others familiar with the initiatives, including journalists and global health experts from other organizations. We took notes and recorded and transcribed all interviews, which helped to identify themes and synthesize the findings.



FIGURE 3.
MAP OF SELECTED INNOVATIONS

FIGURE 4.
INNOVATIONS SELECTED FOR OUR SCAN

This table lists the innovations selected for our scan, grouped by their alignment with the **core functions of public health**⁹ in the United States. More in-depth profiles of each of these innovations can be found in **Appendix A**.

Innovation	Location	Funders/Implementers	Goals
Assessment: Innovations that took a unique approach to assessing local needs and the resources or services available to address those needs			
Innovation Laboratories	Brazil	PAHO and Brazil's Ministry of Health	Identify and evaluate promising innovations; disseminate the resulting case studies, tools, and lessons learned throughout Brazil's public health and health care system
U-report	Uganda	UNICEF, Government of Uganda, and others	Provide a platform for Ugandans, particularly youth, to directly report on the health status, available health services, and issues facing their community via SMS
EURO-URHIS 2	Europe	European Union and many other academic and governmental partners	Develop a system of urban health indicators that can be used to describe the health status of urban areas and to implement evidence-based policy to improve urban health
Policy Development: Innovations that engaged diverse stakeholders in the development of public policy related to health			
Strategy to Control Overweight and Obesity	Mexico	Government of Mexico	Engage multiple sectors of the government and industry to reduce the prevalence of overweight and obesity through the development of new policies, regulations, and programs
National Health Assembly (NHA)*	Thailand	Government of Thailand	Involve diverse stakeholders in a participatory process for reaching consensus on public policy issues related to health.
Assurance: Innovations that sought to increase access to critical services through different models of delivery and through engaging communities in the design and delivery of those services			
A Healthy and Smart Generation (PNPM Generasi)	Indonesia	Government of Indonesia, The World Bank, Australia's Department of Foreign Affairs and Trade, and the Millennium Challenges Corporation	Improve access to maternal and child health services and universal education through community-driven block grants
Community-based Health Planning and Services (CHPS) Initiative	Ghana	Ghana Ministry of Health, USAID, The Population Council, Japan International Cooperation Agency, UNIFEF, Danish International Cooperation Agency, and others	Provide basic health care and public health services at the "doorstep" of people in primarily rural areas through community health nurses and volunteers.
Strengthening Civil Society Engagement for Family Planning	Benin, Mali, and Senegal	William and Flora Hewlett Foundation and Intra-Health	Increase access to and uptake of family planning services by building the capacity of civil society to advocate for family planning and hold governments accountable for improving their family planning programs

*Although we originally planned to include the National Health Assembly (NHA) in Thailand as part of our review, we were unable to get in contact with anyone involved with the NHA to interview during the timeframe of this project. For more information on the NHA, please visit: <http://en.nationalhealth.or.th/nha2013>.

FINDINGS FOR BUILDING BLOCK LEADERSHIP AND GOVERNANCE:

Leadership and Governance Must Involve Collaborative Partnerships

Although the innovations included in our scan employed various leadership and governance models, all innovations built partnerships where multiple stakeholders participated in decision making.

- **Collaborative leadership models.** The governance committee for **U-report**, a SMS-based system that allows Ugandan youth to speak out about concerns in their communities, includes representatives from UNICEF, the project’s funder, and each of their nine non-governmental partners. Each representative gets one vote, ensuring that all partners have a voice in the direction of the project. Also employing collaborative methods, PAHO senior staff, in its management of the **Innovation Laboratories in Brazil**, felt it was important for Innovation Labs to be directed by those closest to the communities, while staff still provided overall management and support.
 - **Decision makers across sectors and levels.** In addition to a collaborative leadership or governance structure, the innovations reviewed often brought in diverse perspectives.
- **Leaders with local experience.** While many of the innovations featured in this report were funded by organizations that work internationally, they all engaged leaders with local knowledge and experience. For instance, in the **Strengthening Civil Society Engagement for Family Planning project**, IntraHealth found local people in Benin, Mali, and Senegal who had the experience necessary to help establish and sustain family planning coalitions.
 - **Leaders who have relationships with government, donors, and other stakeholders.** In discussing the importance of building relationships with government officials, staff from **PNPM Generasi** spoke of “having ministers on speed dial.” Similarly, **U-report** partners include the Ugandan government and many other NGOs, and UNICEF has also reached out to private-sector technology companies to train local people to provide technological support for U-report.

Mexico’s National Agreement for Nutritional Health is based in the Ministry of Health, with buy-in from the other cabinet-level secretaries, whose respective agencies have created plans to address the Agreement’s 10 objectives. Likewise, the World Bank’s **PNPM Generasi** program engaged decision makers at the highest levels, as well as local villagers who had a direct voice in choosing which projects were funded by the program.



FINDINGS FOR BUILDING BLOCK FINANCING:

Financing is Right-Sized and Coordinated

Across the innovations, there was no single funding pathway or mechanism that was considered the best or only way to launch and implement. These innovations received funding from national governments, foundations, NGOs, and other international bodies, each with their own sources of funds, priorities, funding cycles, and reporting requirements. They used a variety of strategies to implement their innovations that could be applied to multiple funding mechanisms and could increase the sustainability and replicability of the innovation.

- **Strategic coordination of funding among donors and implementers.** At a conference of family planning experts from eight francophone countries in West Africa, country delegations made concrete commitments to family planning and major donors pledged unprecedented coordination and cooperation in their support. Named for the location of the conference in Ouagadougou, Burkina Faso, the Ougadougou Partnership created momentum in participating countries that has been coordinated through coalitions supported by the **Strengthening Civil Society Engagement** project.

- **Realistic funding cycles.** Funders need to recognize that different projects or similar projects in different locations may require different funding cycles, and as a result timelines may need to be revised as projects get underway. For example, in **Benin, Mali, and Senegal**, it took longer to establish independently functioning civil society coalitions than originally anticipated, and the Hewlett Foundation worked with IntraHealth to fund a second phase of the project, which allowed the coalitions to grow and engage in some of the activities originally envisioned.
- **Accountability for all parties, including donors and implementers.** An important aspect of coordinating funding and of building successful, collaborative partnerships, as discussed in the Leadership and Governance Building Block, is accountability. One way UNICEF was able to win champions in the Ugandan government was by positioning **U-report** as a tool for the government to hold donors accountable for the services they commit to deliver. U-report aims to create an “accountability chain” by directly channeling reports of local service delivery challenges to the proper authorities.
- **Engagement with local leadership and stakeholders.** As mentioned previously, it is important to engage local leaderships and stakeholders and to include their input on funding decisions. **PNPM Generasi** did this by allowing local villagers a direct voice in choosing which projects would receive funding. They also created a climate in which local people were encouraged to provide constructive feedback about what interventions would not work in practice.



FINDINGS FOR BUILDING BLOCK INFORMATION:

Effective Communications and Information Sharing are Essential At All Stages

Another theme was the importance of being able to communicate and share information with the right people at the right time. This was true at all stages of the innovations, from planning to implementation to public reporting and dissemination of results.

- **Choose the right communication platforms.** By using a widely accessible, low-cost technology such as SMS, **U-report** has been able to reach youth in areas where access to the Internet and other social networking platforms is low. U-report also conducted targeted recruitment by placing advertisements on the radio and in newspapers, which are widely accessible in Uganda.
- **Build strategic communication plans and social networks.** Communications plans are an important part of an organization's operations by helping to integrate internal and external activities to support common goals. All innovation teams had regular email contact and conference calls, often using Skype, which is particularly useful in rural countries where transportation is a challenge and face-to-face meetings are not possible. We were struck by the size and strength of the social networks that were built and mobilized among the many

individuals working on these efforts, and which were evidenced by the consistency of their project descriptions, keen awareness of what others were doing, and shared goals.

- **Involve local journalists and media in dissemination.** To promote public awareness and hold decision makers accountable, the **Strengthening Civil Society Engagement project** in West Africa held workshops for journalists and communication specialists to educate them on the current status of family planning in the country and the commitments made by governments; held a competition on family planning reporting for journalists; and held press luncheons attended by high-profile speakers. Most other projects had working relationships with local print and radio journalists.
- **Create, utilize, and share data that can be widely understood.** In the second phase of developing an urban health indicator system to drive evidence-based policy, **EURO-URHIS 2** wanted to ensure that policymakers would be able to easily understand and act on the immense amount of data and information produced by the project. They consulted mayors and other local officials from participating countries to get feedback on the design and content of the data profiles to promote consistency, comparability, and usefulness for comparing health determinants of different urban areas, and many of those officials have incorporated the standardized data into public speeches and programs.



FINDINGS FOR BUILDING BLOCK WORKFORCE:

Recruit the Right Workforce

Across innovations, individuals we interviewed commented on how their projects were only made possible because of the people involved in the implementation phase. The workforce involved in the operationalization of a given initiative plays a key role in the project's success. Therefore, identifying, recruiting and sustaining the right workforce, though often a challenge, is an important consideration to address.

- **Passion and commitment are key.** In the **Strengthening Civil Society Engagement** project, project leaders wanted people who would “eat, sleep, and breathe” family planning, since establishing and growing family planning coalitions took substantial time and effort. Other innovations, such as **EURO-URHIS 2** and **PNPM Generasi**, noted that project implementation was helped by the continuity and commitment of key personnel who had been with the project since the very beginning.

- **Workforce gaps and shortages cannot be met by volunteers alone.** Ghana's **Community Health Planning Services (CHPS)**, a national service delivery model, pays the salaries of full-time community health officers (CHOs) to provide basic health care and public health services at the “doorstep” of people in primarily rural areas. The program also mobilizes and relies on community health volunteers, who want to be paid for their services as a pathway to employment, in many ways. Ghana is finding that this reliance on volunteers, developed from current resource constraints, is not sustainable in its current form.
- **Opportunities for advancement and incentives increase retention.** In order to retain CHOs in the **CHPS program**, Ghana has offered the opportunity for some to gain additional training, especially in midwifery. In Uganda, **U-report** has experienced the workforce challenges of many other global health projects, where there are few middle managers in the technology sector because many leave the country for better opportunities after they are trained. Commitment to the project—which can be created through strong relationships between team members, a sense of that the work can have impact, and the ability to see progress—and sustainability of funding are key to retaining personnel.



FINDINGS FOR BUILDING BLOCK A SHARED VISION:

System Building Blocks are Connected by Common Goals

Each of the four building blocks is necessary, but not sufficient, to create and implement public health systems innovations. The combined building blocks need to be driven by a shared vision of what can be accomplished. Yet, our interviews revealed that additional factors are often necessary to bring such a vision into reality.

- **Opportune political climate for change.** Even with all of the ‘building blocks’ in place, it can be difficult to implement any systems-level changes without an opportune political environment or political will. In Mexico, extensive media coverage about the high rates of overweight and obesity, combined with having Ministry of Health staff in place that were willing to push for change, created the right climate for the **National Agreement on Nutritional Health**.
- **Dedicated and sufficient resources.** Even with a strong, shared vision for the innovation and the right political climate, if dedicated and sufficient resources are not allocated, the innovation cannot be fully implemented. In Mexico,

15 governmental agencies crafted detailed action plans for how they would achieve **the Agreement’s** objectives, but the national budget did not dedicate enough funding to move all of these plans into action.

- **Building on previous relationships, infrastructure, and experiences.** Each of the innovations we reviewed built on previous pilot projects, professional and personal relationships, or other pre-existing infrastructure. **Ghana’s CHPS** built on a model that was already being tested and tried in other countries; **Brazil’s Innovation Laboratories** were based on an Italian program led by some of the same people; and many of **Mexico’s** strategies were based on a 2005 **IOM report** *Preventing Childhood Obesity: Health in the Balance* that contained strategies for countering obesity. But each innovation also adapted these strategies, pilot projects, and other previous experiences to a new context or a larger population, or used information and infrastructure in a new way to work toward new goals.
- **Meeting real needs.** Finally, each of these innovations sought to address the documented needs of the people being served by the innovation. The opportunity to have a real impact on people’s health motivated, and in some cases inspired, those involved at all levels to implement these innovations.



CONCLUSION

Our approach focused on system building blocks and the capacity, or infrastructure, needed to support innovative approaches to promoting and maintaining population health. Despite the fragmented multi-donor nature of global financing, we found that the leaders and participants in these systems-level initiatives were committed to building sustainable foundations to promote population health. All of the building blocks – leadership and governance, financing, information, and workforce – carried equal weight, and innovative approaches were found in all of the building blocks. We were particularly struck by the variety of approaches to the workforce, which ranged from citizen scientists and community health workers to highly educated professionals and elected and appointed officials.

Of course, public health practitioners in the United States are also committed to promoting population health, and face competing priorities and uncertainties in financing. However, in the United States the focus tends to be on evaluating the effectiveness of programs based on measurement of outcomes in an attempt to make better calibrations of the characteristics of interventions that are likely to lead to success. In part, this focus may be due to the need for state and local health agencies to meet specific, categorical policy and performance goals as a condition of funding.

However, this also shows that U.S. infrastructure is not well-coordinated or maintained, not visible – and not valued or adequately supported. The shortcomings of the organization and financing of the U.S. public health system have been well-documented in a series of IOM reports addressing public health **data and measurement, law and policy**, and **funding**. Taken together, the IOM reports call for transformation and innovation in the way the United States invests in public health and health care by shifting resources to community-based preventive strategies, while spending less on the delivery of health care. In the language of the WHO, the United States should consider focusing on the systems building blocks – governance, financing, information infrastructure, and workforce – and investing more in population-based innovations like the ones we reviewed in this study.

As a first step, public health departments can bring community stakeholders together to assess local needs, inventory local assets, and develop new partnerships to leverage existing resources and experiences and solve immediate problems. For example, collaborations could explore the role of citizen scientists and

volunteers in helping build an information infrastructure to track community health at the neighborhood level, a strategy used in the environmental health community for many years to track pollutants and document health impacts. Some communities might want to develop a neighborhood health record¹⁰ to document and publicize their progress in meeting local health goals.

In sum, our findings suggest that innovations anchored in public-private partnerships that build data and communications infrastructure, engage communities in co-creating solutions, draw on diverse perspectives, and make crucial data and knowledge publicly accessible hold great promise for replication here in the United States. In focusing on system building blocks, and by engaging local experts, these innovations were designed with replicability, customization, and sustainability in mind.

We invite U.S. public health practitioners, public health services research (PHSR) implementation scientists, and the larger public health enterprise to learn more about the ways systems in other countries and regions have addressed population health problems. The project profiles in the appendix can serve as a starting point for local community conversations about how to improve population health here in the United States.

Endnotes

1. National Research Council and Institute of Medicine. 2011. *U.S. Health in International Perspective: Shorter Lives, Poorer Health*. Washington, DC: National Academies Press. Also see <http://www.iom.edu/Reports/2013/US-Health-in-International-Perspective-Shorter-Lives-Poorer-Health.aspx>
2. Bradley E.H. and L. Taylor. 2013. *The American Health Care Paradox: Why Spending More is Getting Us Less*. New York: Public Affairs.
3. Mays, G.P. and S.A. Smith. "Evidence Links Increase in Public Health Spending to Declines in Preventable Deaths," *Health Affairs*, Vol. 30, No. 8, July 21, 2011, pp. 1,585-93.
4. Bradley, E.H. *The American Health Care Paradox: Why Spending More is Getting Us Less*, National Health Policy Conference, AcademyHealth, February 9, 2015.
5. Hall, T.L., et al. *Global Health "Actors" and their Programs*, Consortium of Universities for Global Health, April 14, 2011. http://cugh.org/sites/default/files/content/resources/modules/To%20Post%20Both%20Faculty%20and%20Trainees/22_Organizations_involved_in_Global_Health_programs_FINAL.pdf
6. World Health Organization. *Everybody's Business: Strengthening Health Systems to Improve Health Outcomes: WHO's Framework for Action*, World Health Organization, 2007. http://www.wpro.who.int/health_services/health_systems_framework/en/
7. Institute of Medicine. 1988. *The Future of Public Health*. Washington, DC: National Academies Press. Also see <http://iom.edu/Reports/1988/The-Future-of-Public-Health.aspx>
8. U.S. Department of Health and Human Services. *Consensus Statement on Quality in the Public Health System*, Public Health Quality Forum, August 2008. <http://www.hhs.gov/ash/initiatives/quality/quality/phqf-consensus-statement.pdf>
9. Centers for Disease Control and Prevention. *Core Functions of Public Health and How They Relate to the 10 Essential Services*. http://www.cdc.gov/nceh/ehs/ephli/core_ess.htm. Accessed December 15, 2014.
10. Edmunds M., et al. "The Future of Public Health Informatics: Alternative Scenarios and Recommended Strategies," *eGEMs*, Vol. 2, No. 4, December 22, 2014. <http://repository.academyhealth.org/cgi/viewcontent.cgi?article=1156&context=egems>.

APPENDIX A: INNOVATION PROFILES

Innovation Laboratories

Funded by: PAHO and Brazil's Ministry of Health

Amount of funding: Each Innovation Laboratory had a budget of approximately \$50,000 USD or less

Implemented by: PAHO and Brazil's Ministry of Health

Timeframe: 2008-2014

The Innovation Laboratories (Labs) sought to create an “ecosystem of innovation” to disseminate innovations that can address issues facing Brazil’s decentralized public health and health care system, such as transportation obstacles faced by patients traveling to a clinic or population health approaches to combatting chronic diseases. Recognizing that innovation is not a top-down process, the Innovation Laboratories focused on fostering the dissemination and adoption of innovative projects that have arisen from local initiatives in the country’s public health system.

The development of an Innovation Lab took place in three phases that spanned, on average, 18 months:

- **Preparatory Phase:** This phase began with discussion between Brazil’s Ministry of Health and PAHO to choose the topic of the Lab and identify the members of the workgroup and the coordinator that will lead the Lab. Since the Innovation Labs were targeted at middle managers who Lab leaders believed had the greatest ability to create system change, the topics and projects chosen were typically those that were of interest to the managers, such as a field on which he/she would like to gain more in-depth knowledge.
- **Operational Phase:** This phase consisted of discovering innovations, completing case studies that appeared to be the most promising, and maximizing the lessons learned from these projects. This exploration was completed through discussions, workshops, seminars, and exchange visits. Staff from the Innovation Lab worked with managers who implemented the innovations to produce additional technical materials that described the innovation and how it was implemented.

- **Dissemination of Results:** Each Innovation Lab produced a booklet that contains the case studies, lessons learned, and tools used by the managers who implemented the innovations. These booklets are freely available for download from the Innovation Labs’ website, and the lessons learned are spread through videos, newspaper articles, and various other dissemination channels.

As reported by staff from the Innovation Labs, the model of the Innovation Labs in Brazil stems from a similar project launched in Italy in 2002 called “Cantieri,” which means “work in progress”. The goal of Italy’s program, which involved all major government agencies and over 1,000 municipalities, was to identify “hot” issues at the time for government agencies, such as innovative financing models, and widely disseminate knowledge from “implementers” to middle managers to bring the innovations into wider practice.

This middle-out model of innovation and dissemination, which relied on middle managers and others closest to the issues, differs significantly from a more traditional corporate model that relies heavily on consultants and extensive, time-consuming studies. Staff managing the Innovation Labs credit this model as part of the reason for the Innovation Labs’ success. Similarly, staff who managed the Innovation Labs felt it was important for them to allow the Innovation Labs to really be directed by those who are closest to the issues, while Innovation Lab staff still provided coordination and support.

TOPICS OF THE INNOVATION LABORATORIES

- Social/community participation in health care
- Home assistance and care
- Care for chronic conditions
- Obesity management in health networks
- Private health insurance

The success of the Innovation Labs was evaluated on a variety of factors, including the expansion of the conversation to include new and different actors (e.g., academic, federal, state, local, civil society, international organizations), their capacity to inspire and motivate middle managers to introduce innovations, and their ability to influence public policies related to the specific

topics of the Labs. According to Innovation Labs' staff, all of its products were well-received, and in 2013 alone, there were 113,000 downloads of the Innovation Labs' publications. Given the Innovation Labs' design as a "quick and dirty" tool, some criticism was raised questioning the capacity of the Innovation Labs to produce solid scientific evidence. However, the featured innovations do not claim to be a one-size-fits-all solution for the challenges facing the health system, as these challenges can differ based on context, resources, and the level of independence accorded to managers and project officers.

The information in this profile is based on semi-structured interviews with staff involved in the implementation of the Innovation Laboratories. We also consulted the following sources, which can be accessed to learn more about this program:

- Atun, R. *Brazil-PAHO Innovation Laboratory*, Imperial College London Business School; April 22-23, 2013.
- Portal Da Inovação na Gestão do Sus. <http://apsredes.org>

U-report

Funded by: UNICEF

Amount of funding: Undetermined

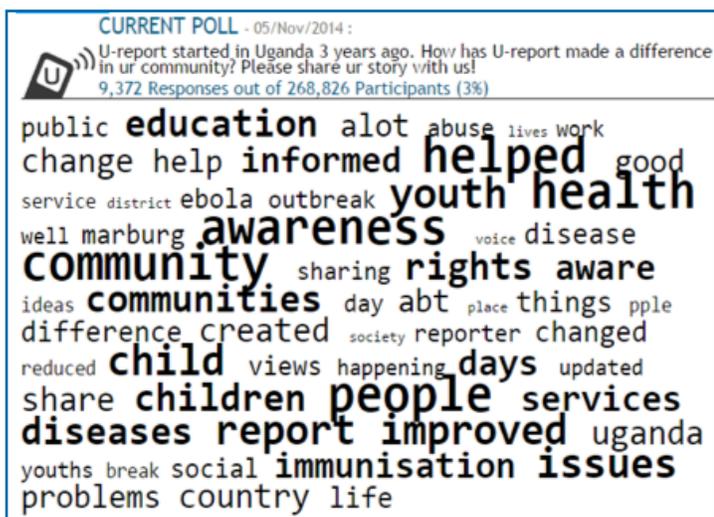
Implemented by: UNICEF and 9 NGO and governmental partners

Launched: Piloted in 2010; launched nationally in 2011

U-report is a free SMS-based system designed to help Ugandans, particularly youth, speak out about what is going on in their communities regarding health, available services, job opportunities, human rights, and more. U-report sends a weekly poll question to its subscribers, also known as U-reporters. These U-reporters, now numbering almost 300,000, send back their responses, which are then mapped and aggregated. U-report also provides feedback to U-reporters on the results of the poll and will sometimes send a follow-up question designed to elicit more descriptive information than received from the first polls. U-reporters can also send in unsolicited messages at any time to voice their concerns. Among its benefits, U-report can serve as an important vehicle for disseminating important health information. For instance, during specific disease outbreaks, U-report has hosted various live Q&A sessions, which included a specialist from the World Health Organization and Ministry of Health staff, to answer questions from U-reporters.

U-report provides a way for UNICEF and other implementation partners to better understand and represent the youth voice and to be an amplifier, rather than a gatekeeper, for their concerns. Using a widely accessible technology tool such as SMS, U-report has been able to reach youth in areas with low penetration of Internet, who lack access to other social networking platforms. U-report recruits subscribers through radio and newspaper advertisements.

AN EXAMPLE OF U-REPORT POLL AND RESPONSES



Although U-report is primarily led by non-governmental organizations (NGOs), U-report maintains partnerships with members of parliament and with several ministries, including the Ministry of Health. One way it was able to win champions in government was by positioning U-report as a tool for government to hold donors accountable for the services they commit to delivering. U-report aims to create an “accountability chain” by directly channeling reports of local service delivery challenges to the proper authorities. U-report also provides a mechanism for government officials to communicate directly with many of their constituents. For example, U-report may pose a question to an official about an issue sent to the system and then publish the official’s response in the newspaper. Members of parliament have also approached U-report about sending a poll related to an issue currently being discussed in parliament; all members of parliament are U-reporters.

U-report’s implementation has not been without challenges, particularly in ensuring there is an adequate infrastructure to support information and communications technology. Specifically, UNICEF has encountered a workforce lacking in sufficient management-level staff with technical-expertise, an outdated government staffing structure for information systems, and lack of a national strategic e-health or technology framework or policy. Nevertheless, UNICEF staff report that overall, U-report has been successful, and UNICEF has launched, or has plans to soon launch, similar projects in over 20 additional countries, including Nigeria, Somalia, and Afghanistan.

The information in this profile is based on semi-structured interviews with individuals involved in or familiar with U-report. We also consulted the following sources, which can be accessed to learn more about this program:

- Blaschke, S. *U-Report & DevTrac: Citizen Participation to Strengthen Community-Led Development*, Technology for Social Accountability Expo, May 21, 2011. <http://www.slideshare.net/tsa-expo/ureport-devtrac>
- UNICEF-Uganda. *U-report Application Revolutionizes Social Mobilization, Empowering Ugandan Youth*, March 14, 2012. Accessed November 13, 2013. http://www.unicef.org/infobycountry/uganda_62001.html
- U-report. <http://ureport.ug/>

EURO-URHIS 2

Funded by: European Union

Amount of funding: €3.6 million

Implemented by: European Union and a **wide variety of academic and governmental partners**

Timeframe: 2009-2014

EURO-URHIS 2 was the second phase of a European Union (EU) initiative to develop an urban health indicator system that can drive evidence-based policy to improve urban health. The first phase, EURO-URHIS 1, looked across 60 urban areas in the EU to determine the ability to collect standard measures for a variety of health indicators from routinely available data, and to describe certain factors that have a significant impact on the health of people residing in urban areas. From EURO-URHIS 1, researchers were able to show what data were available, where there were gaps, and what was needed in order to fill those gaps. EURO-URHIS 2 built on these efforts and attempted to fill these gaps by developing, testing, and validating a set of standardized urban health indicators that allow for comparisons between different urban areas.

These indicators, including diet, exercise, risk behaviors, and more were developed by collecting existing data and administering surveys, which had been translated into over 30 languages, to youth and adults, including hard-to-reach populations (e.g., migrant or travelling groups and certain minority groups). While EURO-URHIS 1 was focused on urban areas within the EU, EURO-URHIS 2 also included some cities outside of the EU so that the resulting indicators could have wider applicability. The researchers also used existing population-based registries and databases to validate the indicators. According to researchers who led EURO-URHIS 2, these efforts resulted in the largest set of urban health indicators in the world.

As part of the indicator development process, researchers also conducted focus groups with policymakers in order to understand which indicators were of the most importance and interest to them. These policymakers included individuals responsible for preparing data in city governments and both elected and non-elected officials who make decisions on policies impacting health, including some individuals who were the highest-ranking policymakers signing-off on urban policies.

An important part of the discussion with the policymakers was the way in which they wished for the data to be presented. The consortium took policymakers, lay members of the public, and researchers into account when deciding on the presentation of data. EURO-URHIS 2 wanted to develop tools that would be useful to policymakers at the city level, so the correct presentation was vital. At the request of policymakers, EURO-URHIS 2 created health profiles for 26 European cities. Policymakers were consulted regarding both the design and content of these profiles, which characterize the health and health determinants of the selected urban areas and allow for comparisons of health indicators with those of other urban areas. An interactive website also allows users to visualize the data using tables, bar and pie charts, and interactive maps for detailed comparisons at the national and local levels.

Researchers involved in EURO-URHIS 2 report that one of their partners in Eastern Europe has built momentum for improving data collection and analysis and the monitoring of health status by being exposed to what other urban areas are accomplishing. Government officials' use of the data from EURO-URHIS 2 was also facilitated by some partners having joint positions in both a university and a local authority.

A MAP OF THE 26 CITIES FOR WHICH HEALTH PROFILES WERE CREATED



While the funding for EURO-URHIS 2 has ended, researchers involved with the project feel that it will continue to have an impact through the wealth of information that was collected and published, the program's influence on the researchers and other governmental and academic partners across Europe, and the dialogue it has furthered about the importance of comparative data within the World Health Organization and the United Nations.

The information in this profile is based on semi-structured interviews with staff involved in or familiar with the implementation of EURO-URHIS 2. We also consulted the following sources, which can be accessed to learn more about this program:

- EURO-URHIS. "The EURO-URHIS Project." *EURO-URHIS Newsletter*, Vol. 1, EURO-URHIS, June 2007; Volume 1. Also see http://www.northwesthealth.eu/cms/images/urhis%20news/urhis_news_1.pdf
- EURO-URHIS 2: <http://www.urhis.eu/>
- EURO-URHIS 1: <http://urhis.eu/euro-urhis1/>
- For a full list of partners who helped make EURO-URHIS 2 possible, please see <http://www.urhis.eu/media/mhs/internationalconferenceonurbanhealth/Newsletter-01.pdf>

Agreement for Nutritional Health: Strategy to Control Overweight and Obesity

Funded by: Various Mexican government agencies

Amount of funding: Undetermined

Implemented by: Various Mexican government agencies and industry and academic partners

Timeframe: 2009-present

Mexico's National Agreement for Nutritional Health – Strategy to Control Overweight and Obesity is a multi-sectoral campaign initiated to achieve three goals:

1. To decrease the prevalence of obesity and overweight in the 2- to 5-year-old population.
2. To stop obesity and overweight prevalence growth in the 5- to 19-year-old population.
3. To slow the increase of obesity and overweight prevalence in adults.

10 OBJECTIVES OF THE NATIONAL AGREEMENT FOR NUTRITIONAL HEALTH

1. Increase physical activity
2. Promote drinking water over sweetened beverages
3. Decrease sugar and fat content in beverages
4. Increase consumption of vegetables, fruits, legumes, whole grains, and dietary fibers
5. Develop simple labeling and nutrition literacy
6. Promote breastfeeding
7. Decrease sugar added in industrialized foods
8. Decrease saturated fats and trans fats in industrious foods
9. Decrease portion size
10. Decrease salt intake

In the lead up to the National Agreement's passing there was increasing media coverage of Mexico's high rate of overweight and obesity. Those involved in the National Agreement credit this heightened public awareness with helping build support for the policies and programs that have been put forth. Additionally, having high-ranking health officials who were willing and able to make the case for overweight and obesity prevention to their counterparts in other agencies assisted in securing buy-in for the National Agreement.

Ultimately, the agreement was signed by 15 different government agencies, each of which must develop a plan to address the 10 specific objectives of the National Agreement, outlined in the box above. Often, these actions are the result of partnerships between multiple

government agencies. For example, the Ministry of Public Education and the Ministry of Health worked together to develop interventions that could be delivered in the school setting, including the promotion of nutritional literacy, increasing opportunities for physical activity, and increasing access to healthy foods and beverages by changing the school nutrition guidelines.

Despite the involvement of government, academia, industry, and civil society, some proposed policies and programs have not been implemented. Even when there was broad support for programs, the absence of dedicated funding in a given agency's budget prevented them from moving forward. Other policy proposals, such as taxing junk food and regulating advertising to children, have faced political and industry pushback.

Still, the National Agreement has led to positive steps forward, including agreeing to decrease salt in bread products and eliminate trans fats from processed foods, implementing a widespread marketing campaign to promote a healthy lifestyle, and applying easier-to-understand nutritional labels on food. In addition to monitoring the objectives of the plan, the Ministry of Health is also working with researchers in the United States to evaluate the effects of the tax on sugar sweetened beverages.

The information in this profile is based on semi-structured interviews with an official involved in the implementation of the National Agreement for Nutritional Health—Strategy to Control Overweight and Obesity. We also consulted the following sources, which can be accessed to learn more about this program:

- Hernandez-Avila, M. *Public Policy to Contain Obesity: Highlights from Mexico*, Active Living Research International Symposium, March 9, 2014. http://activelivingresearch.org/files/2014_Symposium_Hernandez.pdf
- Latinovic, L, L.R. Cabrera. "Public Health Strategy Against Overweight and Obesity in Mexico's National Agreement for Nutritional Health," *International Journal of Obesity Supplements*, Vol. 3, June 2013, pp. S12-S14.
- Latinovic, L. *National Agreement for Nutritional Health Strategy Against Overweight and Obesity in Mexico: Nutritional Interventions for School Population*, PAHO/PAHEF Workshop on Childhood Obesity, June 2012. <http://www.paco.aw/paco2docs/4%20Workshop%20PAHO%20PAHEF/6%20National%20Agreement%20for%20Nutritional%20Health%20Strategy%20Against%20Overweight%20and%20Obesity%20in%20Mexico%E2%80%A6.%20Ljubica%20Latinovic.pptx>
- Villalobos, J.A.C. *The Role of the State in Preventing Obesity and Supporting the Community-Based Programme*, Epode International Network, October 16-18, 2013.

PNPM Generasi



Funded by: Government of Indonesia; Australia's Department of Foreign Affairs and Trade; and the Millennium Challenge Corporation through the World Bank-administered PNPM Support Facility

Amount of funding: \$432 million (~\$10,000/village/year)

Implemented by: Government of Indonesia's Ministry of Home Affairs

Timeframe: 2007-2017

PNPM Generasi is a block grant program in Indonesia designed to support community improvement on three Millennium Development Goals—maternal health, child health, and universal education—by targeting 12 health and education indicators. With the help of trained facilitators, participating villages decided how to allocate the yearly block grants they received. For some villages, the amount of the following year's grant was partly based on the previous year's performance on the targeted indicators, incentivizing villages to focus on the most effective interventions. The program began in just over 1,600 villages across five provinces, expanding to over 4,500 villages by 2014.

The idea for the PNPM Generasi program originated from another community-driven development initiative called the Kecamatan Development Program (KDP). From 1998-2008, KDP provided block grants to the poorest villages across Indonesia to fund basic infrastructure projects chosen by the community. While KDP was deemed to be an effective and cost-efficient method of delivering needed infrastructure, officials in the Indonesian government and the World Bank recognized that the major challenges for people in poverty often involved lacking access to basic services, such as health care and education. Additionally, as the most pressing needs of villages vary greatly across the country, community-driven models allow communities to allocate resources to their most pressing needs.

TARGETED HEALTH AND EDUCATION INDICATORS

Maternal and Child Health:

- 4 prenatal visits for pregnant women
- Taking iron tablets during pregnancy
- Childbirth assisted by a trained professional
- Two postnatal visits
- Completed childhood immunizations
- Adequate monthly weight increases for infants
- Monthly weighing for children under 3 and biannual for children under 5
- Vitamin A twice a year for children under 5

Universal Education

- Primary school enrollment of children 7-12
- Attendance rate of at least 85% for primary school children
- Junior secondary school enrollment of children 13-15
- Attendance rate of at least 85% for secondary school-aged children

PNPM Generasi incorporated random assignment into the selection of participating villages and into which villages received performance incentives, resulting in one of the largest randomized social policy experiments in the world. Baseline (2007), mid-term (2009) and impact (2011) evaluations were conducted, showing that the PNPM Generasi program had a statistically significant positive impact on average across the 12 specific indicators, with the largest long-term impact on reducing malnutrition. Ultimately, 463,000 cases of underweight children were eliminated. Other results include:

- 2.3 million pregnant women received iron supplements
- 907,000 children were immunized
- 1.01 million children received scholarships, transportation money, and uniforms for school
- 196,000 community health volunteers received training and support

The information in this profile is based on semi-structured interviews with World Bank staff involved in the implementation of PNPM Generasi. We also consulted the following sources, which can be accessed to learn more about this program:

- Olken, B.A., et al. *Indonesia's PNPM Generasi Program: Final Impact Evaluation Report*, The World Bank, June 2011. http://www-wds.worldbank.org/external/default/WDSContentServer/WDSP/IB/2012/05/25/000356161_20120525020526/Rendered/PDF/691420ESW0Whit0Final0IE0Report02011.pdf

- Olken, B.A., et al. *Indonesia's PNPM Generasi Program: Interim Impact Evaluation Report*, The World Bank, January 2010. http://www-wds.worldbank.org/external/default/WDSContentServer/WDSP/IB/2011/02/11/000356161_20110211020027/Rendered/PDF/595670WP0P11961t0FINAL0January02010.pdf
- The World Bank. *Indonesia: A Healthy and Smart Generation (PNPM Generasi)*, July 3, 2012. Accessed November 15, 2013. <http://www.worldbank.org/en/results/2012/07/03/indonesia-healthy-and-smart-generation-pnpm-generasi>

Community Health Planning Services



Funded by: Ghana Ministry of Health, USAID, Population Council, the Japan International Cooperation Agency, UNICEF, the Danish International Cooperation Agency, and others

Amount of funding: At start-up in 2000, \$2.95/capita for initial costs + \$1.97/capita/year added to a primary health care budget of \$14/capita/year

Implemented by: Ghana Health Service

Timeframe: Overlapping phases including Navrongo three village micro-pilot (1994-1996); Navrongo experimental study (1996-2003); Replication projects (1998-2004); National scale-up (2000-present)

Community Health Planning and Services (CHPS) is a national service delivery model that supports paid community health officers (CHOs) to provide basic health care and public health services at the “doorstep” of people in primarily rural areas. CHOs have received two years of community health nurse training, and they are provided with a community health compound (CHC), where they live, and a form of transportation, such as a motorbike, to make home visits. CHOs typically support a community of approximately 3,000-5,000 and are supported by community health volunteers (CHVs) who assist in mobilizing the community around health issues and maintaining community registers. Through this CHPS system, new innovations can also be piloted. For instance, one pilot program is exploring the use of mobile phones to supplement in-person visits between the CHO and women who are pregnant or have children under the age of two.

CHPS is designed to incorporate involvement from the community through health committees, which are composed of traditional and opinion leaders at the village level. These committees oversee and support CHVs, provide upkeep for the CHC, and facilitate community meetings to provide health education.

CHPS is a national scale-up of an experimental pilot study of the Navrongo Health Research Centre that demonstrated that this CHO model could effectively mobilize community residents and resources to increase coverage and responsiveness of health care and public health services and to deliver care in a cost-effective manner. The CHPS model has continued to be effective in expanding access to health care and public health services through its national scale up and has led to demonstrated improvement in health. For example, some CHPS service areas experienced a decline in the under-five mortality rate from 108 per 1,000 live births in 1998 to 80 per 1,000 live births in 2008. CHPS has now been introduced into every region and district in Ghana, and the Ghana Health Service has begun establishing a modified model for urban areas. At various stages from its pilot to the national scale-up the CHPS program has been evaluated and been the focus of many peer-reviewed publications (see below).

SERVICES PROVIDED BY CHPS

- Antenatal and postnatal care
- Emergency delivery
- Immunizations
- Family planning
- Treatment for malaria, acute respiratory infections, diarrheal disease, and other ailments
- Nutrition education

Although the CHPS program has been implemented in Ghana for several years now, challenges still remain. Included in the financing challenges are that CHVs increasingly want to be paid for their work and the start-up costs of community facilities, including building a compound and purchasing essential equipment, such as motorbikes for transportation; the Ghana Health Services budget lacks dedicated funding for launching a CHPS location. Although attrition among CHOs is low, it can sometimes be difficult to attract new CHOs; they are often placed in remote communities by themselves and may face logistical challenges related to upkeep of the CHC or the lack of fuel or replacement parts for their motorbikes.

The information in this profile is based on semi-structured interviews with staff and officials involved in the implementation of CHPS. We also consulted the following sources, which can be accessed to learn more about this program:

- Awoonor-Williams, J.K., et al. "Lessons Learned from Scaling Up a Community-based Health Program in the Upper East Region of Northern Ghana," *Global Health Science and Practice*, Vol. 1, No. 1, March 1, 2013, pp. 117-133. Also see <http://www.ghspjournal.org/content/1/1/117.full>
- Awoonor-Williams, J.K., et al. "The Ghana Essential Health Interventions Program: A Plausibility Trial of the Impact of Health Systems Strengthening on Maternal & Child Survival," *BMC Health Services Research* Vol. 13, No. Suppl 2, May 31, 2013 pp. S2-S3. Also see <https://www.scienceopen.com/document/vid/4249e67a-4336-47bd-9491-e0c403020417;jsessionid=tzQCRaQVjFELboYP9YD62DmJ.master:so-app1-prd?0>
- Ntsua, S., et al. *Repositioning Community-based Family Planning in Ghana: A Case Study of Community-Based Health Planning and Services (CHPS)*, The Population Council, 2012. http://www.popcouncil.org/uploads/pdfs/2012PGY_CaseStudyCHPS.pdf
- Nyongator, F.K., et al. "The Ghana Community-based Health Planning and Services Initiative for Scaling Up Service Delivery Innovation," *Health Policy and Planning*, Vol. 20, No. 1, January 2005, pp. 25-34. Also see <http://heapol.oxfordjournals.org/content/20/1/25.abstract>
- Phillips, F.J., et al. "Accelerating Reproductive and Child Health Programme Impact: The Navrongo Experiment in Ghana," *Bulletin of the World Health Organization*, Vol. 84, No. 12, December 2006, pp. 949-955. Also see <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2627578/>

Strengthening Civil Society Engagement for Family Planning



Funded by: Hewlett Foundation

Amount of funding: \$1.5 million

Implemented by: IntraHealth International

Timeframe: 2011-present

The Strengthening Civil Society Engagement for Family Planning is a project in Benin, Mali, and Senegal to build civil society capacity to advocate for family planning and hold governments accountable for improving their family planning programs, ultimately increasing the uptake of family planning (FP) services. It supports the formation and reinforcement of civil society coalitions to hold governments accountable for strengthening their family planning services and honoring commitments they have made to their national family planning programs.

The Strengthening Civil Society Engagement project is an outgrowth of the Ouagadougou Partnership. This partnership originated at a 2011 conference on family planning in Ouagadougou, Burkina Faso, where 9 francophone West African countries, including Benin, Mali, and Senegal, agreed to take concrete steps to increase the uptake of family planning in their countries and major donors pledged unprecedented coordination and cooperation in support of family planning.

In pursuit of its objectives, the Strengthening Civil Society Engagement for Family Planning project has supported a variety of efforts in each country. For instance, in order to strengthen civil society coalitions working on family planning, IntraHealth staff worked to help coalitions expand their membership and make them multi-sectoral, bringing in stakeholders working not only in health, but also in education, agriculture, economic development, and human rights. Importantly, the coalitions focused on engaging family planning champions among religious

leaders. There have also been efforts to cultivate future family planning advocates and leaders, with each country conducting an orientation for family planning youth ambassadors and providing them with kits that include sample contraceptives, educational materials, and referral cards.

To encourage governments to make and keep commitments to family planning services, coalition members have partnered with governments during national family planning campaigns by participating in opening ceremonies and organizing activities that align with the campaign. Youth ambassadors have developed and performed skits and written and read poetry designed to pressure authorities to address the barriers people face in accessing family planning services. The coalitions have also sought to hold the governments accountable through frequent and accurate reporting by engaging the media. To do so, they have held workshops for journalists and communication specialists to educate them on the current status of family planning in the country and the commitments made by governments, a competition on family planning reporting for journalists, and press luncheons attended by high-profile speakers.

PHASE II: OBJECTIVES OF STRENGTHENING CIVIL SOCIETY ENGAGEMENT FOR FAMILY PLANNING

1. Strengthening civil society coalitions in Benin, Mali, and Senegal that are contributing to the implementation of national FP action plans, and demanding government and donor accountability for investments in FP programming
2. Encouraging governments in Benin, Mali, and Senegal to demonstrate achievements on commitments outlined in the national FP action plans, including allocating additional resources for FP programs and partnerships with civil society
3. Articulating a vision and roadmap for wider regional scale-up of the civil society engagement initiative to other Ouagadougou Partnership countries in consultation with regional and country-level stakeholders.

In order to exchange lessons learned among Benin, Mali, and Senegal and to spread the commitment to family planning throughout the region, the program created a website and social media pages to share information, drafted and shared a reference guide, and held an inter-country panel during the Ouagadougou Partnership auxiliary meeting at the International Conference on Family Planning in Addis Ababa, Ethiopia in 2013.

Although IntraHealth reports that the coalitions in each of the countries played an important role in building and strengthening momentum for the governments to finalize and implement their national family planning action plans, the project has also encountered some challenges. Establishing independently functioning civil society coalitions has taken longer than anticipated and they require ongoing support. Providing support across multiple countries is difficult, especially when considering how many of the organizations already face resource challenges. Communication and coordination within a country requires substantial time and effort, as the coalitions all involve many different stakeholders trying to move forward together. Thus, agreement upon a common advocacy strategy has taken longer than originally anticipated.

Throughout the duration of the project, IntraHealth has reported back to the Hewlett Foundation on its progress, and the Hewlett Foundation has decided to expand the project in 2015 to create advocacy coalitions in Burkina Faso and Niger and will continue to deepen engagement through the current work in Benin, Mali, and Senegal.

The information in this profile is based on semi-structured interviews with individuals involved in or familiar with the implementation of the Strengthening Civil Society Engagement for Family Planning initiative. We also consulted the following sources, which can be accessed to learn more about this program:

- IntraHealth International. *Strengthening Civil Society Engagement for Family Planning in West Africa: Final Report*, IntraHealth International, June 2014.
- IntraHealth International. *Strengthening Civil Society Engagement for Family Planning in West Africa: Final Report*, IntraHealth International, June 2013.
- IntraHealth International. Strengthening Civil Society Engagement for Family Planning. Accessed January 15, 2014. <http://www.intrahealth.org/page/strengthening-civil-society-engagement-for-family-planning>
- IntraHealth International. Can New Voices on Social Media Influence Attitudes about Contraception in West Africa? August 10, 2012. Accessed January 15, 2014. <http://www.intrahealth.org/page/can-new-voices-on-social-media-influence-attitudes-about-contraception-in-west-africa>

APPENDIX B: INTERVIEW GUIDE

Development Phase: Concept and Planning

1. Tell us a little bit about how [insert name of innovation] came to be. What were its origins and history?
 - a. What was the goal of the project?
 - i. Probe: What issue/problem was the innovation designed to address?
 - b. Where did the motivation to address the problem come from?
 - c. What were the political, economic, social, leadership, environmental, or legal influences?
 - d. Who were the leaders, key supporters, and key stakeholders of this project?
 - i. Probe: What, if any role, have national or subnational governmental public health agencies played?
2. Were there setbacks or resistance during the development of the project?
 - a. Probe: If so, from where/whom? How were they dealt with?

Implementation:

3. How was the project launched?
 - a. Probe: Was the project launched in stages or all at once?
 - b. Who was involved when the project got started?
 - c. Did the team remain the same throughout the different phases of the project?
4. What did you encounter during this project that you did not expect?
 - a. Probe: What were the political, economic, social, leadership, environmental, or legal influences?

5. As you began to implement the project, what was the biggest challenge that you encountered?
 - a. How did you respond to the problem?
 - b. What were the political, economic, social, leadership, environmental, or legal influences?
6. What were some of the other challenges that you face throughout the project?
 - a. Did you overcome them? If so, how?
7. How do you see this effort moving forward?

Evaluation:

8. How did the project measure its goals?
 - a. Can you tell me about the major milestones in the project?
9. Which goals has the project had a lot of success on?
 - a. What are some of the things [success factors] that helped the project achieve these goals?
 - b. Probe: Were there political, economic, social, leadership, environmental, or legal influences?
10. Which goals has the project not been able to achieve and why?
 - a. Do you think the goal will be met in the future? If so, why? What will help this happen?
11. What advice would you give to someone implementing a similar project?

Dissemination

12. How has the project communicated its progress/how do you plan on communicating progress?
 - a. Probe: For example, do local organizations, funders, and/or the general public know about [innovation] and what it has accomplished? If so, how? Was this planned in advance?

Final Question:

13. What are you most proud of accomplishing?