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Bangladesh: Background

Bangladesh was a low-income country until 2013 and graduated to the low/middle-income category in 2014. Bangladesh has also made substantial progress on reducing poverty and on improving health and nutrition outcomes in the last decade. Since independence in 1971, Bangladesh has achieved impressive improvements in population health status and reached Millennium Development Goal 4 by reducing child mortality before the 2015 target, receiving a UN award for it in 2010. It has also improved on other key indicators, including Millennium Development Goal 5 indicators such as maternal mortality and survival from some infectious diseases, including malaria, tuberculosis and diarrhoea.

Reform of focus

Two tracer policies on health reforms were chosen for the study: (a) the introduction of the Sector Wide Approach (SWAp) in 1998; (b) community clinics, which started at the sub-district level in the 1990s and were then revitalised from 2009.

Key findings

Donors facilitate learnings from other countries: Donor partners enjoying strong credibility and influence have successfully facilitated learning from other countries to initiate policy reforms. The shifting of health sector engagements from project to programme mode (SWAp) in Bangladesh was preceded by presenting examples from Tanzania and Uganda by the donors, led by the World Bank, following a homegrown need to consolidate 120+ projects for better management and control. To succeed, such transfer of policies inevitably requires reform champions in the government at leadership level. Learning also happened when donors facilitated exposure visits to other countries. Government officials in Bangladesh who were sponsored to go on visits to other countries (e.g. Indonesia), were positively influenced to experience clinic-based services. Conferences presenting models to address specific problems could also facilitate learning from other countries.

Reforms often happen in absence of systematic evidence, provided there is a political need: The community clinics as a concept enjoyed strong patronage from political leadership, and was strengthened further by making them a technical solution to improve coverage of family planning services, as well as to address the broader agenda of catering to the reproductive health of women living in poverty.

Demand for technical assistance needs to be met by donors at the operationalisation stage: Policy transfer in the context of the country needs substantial support through the donors for operationalisation. Technical assistance is an essential follow-through action needed for evidence-based policies, as mechanisms to operationalise the conceptual framework are highly valued by government staff.

Direct implications for Bill and Melinda Gates Foundation

Identify the key drivers to facilitate learning: These include: (a) latent and “homegrown” needs for reforms; (b) evidence to justify reforms; and (c) key reform champions in the government leadership. **Build a critical mass of influencers:** Early engagement with other development partners and NGOs in the host country is needed to create a critical mass of entities that could influence the leadership in government to learn from other countries. **Conduct full-scale evaluations of current programmes:** Large donors need to conduct or encourage government to conduct evaluations of programmes to highlight gaps. Consequent positioning of evidence from other countries stand a better chance of acceptance, which could lead to reforms. The Bangladesh case study has shown that partial evaluations of programmes by NGOs were not accepted or recognised by government.

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Burkina Faso: Background

Burkina Faso is a low-income West African country of nearly 19 million people. Between 1990 and 2015 the under-five mortality rate fell from 202 deaths to 89 deaths per 1,000 live births, and the maternal mortality rate fell from 727 to 371 per 100,000 live births. While neither of these met the Millennium Development Goal targets, they represented significant improvements.

Reform of focus

Two reforms were the focus of our analysis: the transition from the *Mutuelles de Santé* to *Assurance-Maladie Universelle*; and the removal of user fees for pregnant women and children under five.

Key findings

Some form of international evidence, mainly from the region, has been used across the whole policy process. The transfer of knowledge was different by stage of policy transfer and generally easier at the 'concept' stage. It became more difficult at the 'operationalisation' stage, according to key informants, because of the lack of transferability across contexts. The evidence used during the contextualisation stage was mainly national, and mainly from the assessment and evaluation of nationally driven and led-pilot experiments. Nonetheless, during the contextualisation and operationalisation phases, a few examples of cross-country learning were reported, for example the use of implementation guides for *Mutuelles de Santé* developed at a sub-regional level.

A few institutions, individuals and mechanisms of cross-country learning, acting at the regional and sub-regional level, were identified. The regional platform *La Concertation* conducted information and experience-sharing activities for about a decade. It no longer exists but relations between countries continue. The PROMUSAF programme supported insurance schemes and coordinated networks in Burkina Faso and in four other West African countries, thus fostering inter-country experience-sharing. The UEMOA (the West African Economic Union) and the World Health Organization regional office based in Burkina Faso regularly brought together different ministries at the sub-regional level, for meetings and workshops, which fostered regional cross-country experience-sharing. More globally, international partners (international non-governmental organisations, donors, consultants and researchers) were important stakeholders of knowledge transfer from other countries. They brought ideas and helped to contextualise (by offering technical support, sharing documentation and providing tools). The International Labour Organization provided consequent technical support, targeting mid-level ranked officials through international training events. International non-governmental organisations conducted and shared documentation and evaluation for pilot experiments, which have been used for advocacy towards the scaling-up of free healthcare for pregnant women and children.

Direct implications for the Bill and Melinda Gates Foundation

Create or support existing multi-disciplinary institutions in the countries, acting as sustainable and independent sharing platforms, to systematically bring in all learning and ensure capitalisation on knowledge and experiences (including from abroad). Ensure that knowledge transfer happens but also that actions can be derived from this learning process, through building national capacities (at the Ministry of Health, of researchers, etc.) Develop or strengthen existing 'professional' national and inter-country networks between professionals, for the sharing of high-quality evidence.

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Cambodia – Background: Over the last 30 years, Cambodia has emerged from conflict, widespread poverty, extremely high mortality rates and near international isolation to become a fast-growing, highly open country. Between 2005 and 2012 the official poverty rate fell from 50% to 18% and, in 2016, it achieved lower middle income status. This all happened alongside substantial improvements in population health. Since the 1980s, life expectancy has more than doubled and, since 2000, the maternal and child mortality rates have both fallen by more than two thirds.

Reform of focus: We focused on Health Equity Funds (HEF) and Special Operating Agencies (SOAs). HEFs are an innovative demand-side funding mechanism used to reimburse hospitals and health centres for the user fee exemptions they afford to poor patients. SOAs are given innovative contracts to manage government health service delivery, designed to improve system efficiency.

Key findings: Both reforms were conceptualised by international organisations working in Cambodia. Moreover, the first few rounds of domestically generated evidence were demanded by those international organisations as a means of persuading others (both nationally and internationally) that the schemes were working. Functioning internal networks were an effective vehicle for spreading these lessons among relevant stakeholders, but where one group came to dominate they were less effective. Internationally available information was not systematically canvassed for effective policies (although this does appear to be happening now). Instead, arguably, 'learning from other countries' was a matter of learning how to make these two international ideas work in Cambodia through repeated cycles of operationalisation, evaluation, negotiation and further operationalisation – domestic trial and error, or imitation and adaptation. The overall learning process has taken more than 20 years and has been 'organic'. Two of the key factors have been cumulative experience for Cambodians through 'learning by doing' – working alongside international advisors – and increased opportunities for formal study and travel. The overall level of skilled human resources working within the health sector (both clinical and non-clinical) rose from nearly nothing in the early 1980s to today, when experienced Cambodians are available to lead on policy design, implementation and evaluation.

Two further key findings relate to demand. First, as the Ministry of Economy and Finance invested more in these two policies they also demanded evidence regarding effectiveness. Whereas earlier demand for evaluation was led by the international community (then the main funders), in recent years this has shifted. Second, some components of reforms may not be politically feasible, even given relatively clear evidence. For example, the government has consistently resisted 'contracting out' to NGOs, even in instances where positive evidence has been presented.

Direct implications for Bill and Melinda Gates Foundation: First, a large component of the learning process occurs within the learning country after the initial idea has been shared. Local adaptation of ideas transferred from other countries to enable application in a domestic context is complex but important (contextualisation, internalisation, operationalisation).

Second, it is possible to build a critical mass of skilled nationals to lead and learn at each stage of the reform process if a long-term perspective is adopted (15–30 years).

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Ethiopia: Background

Ethiopia is Africa's second most populous country with an estimated total population of 99.3 million. Although it is a low-income country with a per capita income of $590, it is one of the fastest growing economies in the world. Poverty levels were cut from 55.3% in 2000 to 33.5% in 2011 and the country has made remarkable progress towards achieving the health-related Millennium Development Goals 4, 5 and 6. One of the policies credited with making a substantial contribution to these gains is the government's flagship Health Extension Program (HEP), which is the subject of this case study.

Tracer policy

The HEP, launched in 2003, which developed a new cadre of paid female community health workers (CHWs), supported by volunteers at community level, was selected as a tracer policy because of its contribution to the achievement of the health Millennium Development Goals and because of the growing interest in the potential contribution of CHWs and task-shifting to improving outcomes within health systems. This case study seeks to: (1) provide insights into the contribution of international evidence to (and learning from) the conceptualisation, internalisation, contextualisation, operationalisation and evaluation of the health extension programme; and (2) gather country-level stakeholder perspectives on how they could better use and contribute to other countries' experience. Key informant interviews are the main source of information, backed up by document review: 18 informants were selected and interviewed face-to-face between 18 and 22 September, at national level and in the Tigray region. The key informants included government health officials at federal, regional and district level, including a health extension worker. We also interviewed staff of development partner organisations, and researchers and consultants with relevant experience.

Findings

The HEP had largely home-grown roots, though it was in a general sense inspired by the Alma Ata Declaration of 1978 and wider international experiences, such as the Chinese 'barefoot doctors'. It was directly inspired by cross-sectoral learning from agricultural extension workers, and informed by the experience of community mobilisation during the civil war period in Ethiopia. The HEP was developed in the face of opposing international opinion and evidence at the time, and so provides an example of when not to be influenced by international evidence, given its later success in this context. The Ethiopian government was convinced that a community-based approach was the only realistic and feasible approach, given the scale of the country, its huge population needs, the limited health facility infrastructure and low health financing resources. The general pattern observed in Ethiopia is for the government to carry out its own problem diagnosis, then seek external insights as policy responses to problems are developed. At the stage of developing national guidelines for the HEP, for example, relevant international programmes such as the Kerala CHW programme were visited. Piloting and roll-out is swift if the intervention is seen as effective. There is active monitoring, though less frequently full-blown, independent evaluations. Learning across sites internally (e.g. through internal study tours and meetings) is encouraged. There is a strong focus on results and the programme has continued to adapt to the rapidly changing context in Ethiopia. There has been an active approach to sharing lessons from the HEP with other countries, especially in the Africa region.

Recommendations

This case study highlights the importance of engaging with and developing domestic mechanisms at national and sub-national levels to be able to prioritise, analyse, filter and share experiences. Learning *across* systems (understood as countries) is useful but secondary, given their different contexts, needs and cultures. It suggests a focus on strengthening local organisations which are delivering internal and South–South learning, and which could be further developed.

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Georgia – Background: Georgia is a small, lower-middle income country (population around 3.72 million, 2016) in the Caucasus region of Eurasia, with life expectancy at birth of 73 (2016), and gross national income per capita (using purchasing power parity rates) of $3,810.[1] Georgia was selected as a case study for 'why, when and how' countries learn from each other for three reasons. First, the country has pursued broad system-wide reforms since the collapse of Soviet Union, moving from low income to lower-middle income and shortly upper-middle income (in 2015 only) status in the past two decades. Second, it has made significant progress against the Millennium Development Goals. Third, it has pursued extensive health sector reforms, with some directions closely resembling developments in the region, but with others being almost unique and sometimes quite radical.

Reform of focus: We chose health financing reforms and hospital privatisation reforms as the units of analysis. The rationale behind the choice was that Georgia broadly applied internationally approved approaches to health financing reforms, while defining its own pathway for hospital privatisation.

Key findings: The importance of evidence-based policies is fully recognised by key health sector actors in Georgia. However, evidence is applied with different levels of intensity through the phases of conceptualisation, formation, internalisation, contextualisation, operationalisation and evaluation; evidence is applied most in the conceptualisation and least in the implementation and evaluation phases. The choice and application of evidence is often 'purpose-driven' and predefined by political agenda. Key decision-makers have a critical role in searching, applying (or blocking) and disseminating evidence.

Evidence is best provided when international agencies support health care reforms through the whole policy cycle (often by means of long-term Technical Assistance (TA) projects). The World Bank, USAID, EU and UN agencies played a critical role in supplying evidence to the government of Georgia and helping in its application. When large TA projects cease, UN entities are the main providers of evidence (as they remain in the country); however, their role is limited in supplying evidence primarily in the conceptualisation phase. Overall, there is limited funding for supporting evidence-generation nationally. While selective players have a say, civil society still has limited ability to help generate and accumulate evidence, and to reach out to decision-makers. In this context, the role of national policy institutions is critical in supporting sustained evidence-based policies. Both the generation/collection and the application of evidence is hampered when these institutions are abolished or absent.

Direct implications for Bill and Melinda Gates Foundation: First, working with the national decision-makers is critical to securing political willingness and conducive environment for evidence, informed decisions and learning.

Second, investments in establishing and institutionalising national (health policy) institutions are seen as offering valuable support to generating sustained institutional demand for learning, and creating a continued platform for applying evidence in policy decisions.

Third, consistency and continuity in supplying evidence, as much as the quality of the evidence matters in accelerating learning from other countries (large, well-delivered TA projects being an example).

[1] World Bank, 2016.

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Nepal - Background: Nepal is one of the poorest countries in Asia and has achieved only modest growth over the past two decades. Despite this, and despite its land-locked status, difficult topography, a decade-long armed conflict, political instability and vulnerability to natural disasters (such as the 2015 earthquake), it has achieved sharp reductions in poverty and achieved Millennium Development Goal Four. Coordinated efforts by the government and increased financial investment by international partners may have taken the lead in enabling this to happen, but huge national social capital in the form of Female Community Health Volunteers also played a vital role.

Reform of focus: Our analysis traces three connected interventions: Community Based Integrated Management of Child Illnesses (CB-IMCI); Community Based New-born Care Package (CB-NCP); and Community Based Integrated Management of New-born and Childhood Illness (CB-IMNCI). The first targeted under five mortality and was the product of a contextualised World Health Organization (WHO) recommendation. The second reflected the government's attempt to reduce neonatal mortality when a contextually implementable WHO recommendation was not available. The third is a merger of first two, taking into account the current state of Nepal's health system (what is possible now was not possible when CB-IMCI or CB-NCP were first launched) and adjusting some of the more controversial components of CB-NCP.

Key findings: The existence of a clinical guideline that could be implemented in Nepal's health system (and was endorsed by the WHO) significantly grounded the policies adopted (allowing for minor contextualisation). Where there was no applicable guideline (in the case of CB-NCP), the evidence base alone was not strong enough to dictate the outcomes. The design of CB-NCP included, to some extent, a canvassing of the international literature. Issues arose where there was not enough evidence to categorically inform a decision, but a clear need to do something (for example, how to treat asphyxia in the community).

Both international and national evidence played a role in the conceptualisation and contextualisation of the reforms. A network of technical working groups reporting to steering committees and then to Directors and Ministers enabled the contextualisation of international evidence into a nationally implementable policy. Locally generated evidence and the credibility of the WHO were both facilitators of internalisation (at different stages). Decision-makers looked to India, Bangladesh and Pakistan primarily for the international evidence that was used. Internalisation needed to go beyond government decision-makers. Key donors and the general public also needed to internalise lessons for the reforms to be successful.

Direct implications for Bill and Melinda Gates Foundation: There is significant scope for learning between countries with respect to the package of services provided to the population and the manner in which that package is delivered. In some instances, international guidelines exist and the challenge is to adequately contextualise them. In other instances, health systems may have to develop packages from scratch. In such cases, it is still possible to learn from other countries, but achieving buy-in from the necessary range of key stakeholders with regards to the final package may be more difficult.

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Rwanda: Background

Rwanda is a low-income country located in East Africa with a population of just under 12 million. Over the last twenty years Rwanda has emerged from a genocide which killed up to a million people (nearly 20% of the population at the time).

Reform of focus

This case study focuses on the introduction and development of Community-Based Health Insurance (CBHI) and Performance Based Financing (PBF) in the past two decades. This case study is particularly interesting as Rwanda went from a country seeking evidence from others to a country providing evidence to others.

Key findings

International evidence and experience was used significantly for both policies at the conceptualisation stage. In relation to CBHI, some West African experiences, recounted in the literature and by individual experts, and clarified through study tours, were key during the first years of experimentation in Rwanda. The diaspora coming back to Rwanda after the genocide had also observed health insurance policies in other countries (for example, Burundi). The CBHI concept initially seemed to be an adapted solution at a time where there was a felt need for health insurance. For PBF, some experiences from Cambodia and Afghanistan were shared with the Rwandese during international meetings held in the early 2000s, and afterwards brought to the country by international non-governmental organisations and individual international experts. At the contextualisation stage, as the first experiments for both policies were implemented in the country in the early 2000s, the decision-makers used national evidence (data from preliminary pilots' evaluation reports and population health indicators) and some international evidence was regularly brought in by international experts and organisations. But the Rwandese quickly felt that their system was unique in a sense that no other low-income country had successfully achieved CBHI and PBF reforms on a large scale. It was not clearly reported whether any evidence was used to inform the internalisation stage. At the operationalisation stage, Rwanda learned from international experiences through study tours and technical assistance from international consultants and international organisations. National evidence available in Rwanda is well coordinated and led by the Ministry of Health. The use of international evidence was limited by a lack of availability of relevant international data in the country and globally, in particular regarding the reforms chosen, which made Rwanda a unique success story, amongst low-income countries, for the achievement of both CBHI and PBF. A significant number of international meetings are organised at the sub-regional and regional level, but it seems that there is no global coordination mechanism. Many countries have come to Rwanda to learn about its health system. In particular, study tours about CBHI and PBF reforms have been organised. A platform, created in 2011 and embedded in the School of Public Health, aims to coordinate these tours.

Direct implications for the Bill and Melinda Gates Foundation

First, build on and strengthen existing national institutions aimed at sharing national and international evidence. Second, invest in mechanisms that would foster the production of high-quality data in each single country, as at country level national data is highly valuable for decision-making. Third, create a global knowledge and experience management platform, linked to credible institutions, with accurate and up-to-date data (theory, practical guidelines and tools, etc.).

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Solomon Islands – Background: Solomon Islands is a small lower-middle income country (population around 650,000) in the Pacific. It is an interesting case study for 'why, when and how' countries learn from each other for three reasons. First, this is a country that has pursued broader, equity-focused, system-wide reforms at various stages in its volatile economic history. Second, it is a recent post-conflict country. Third, it shares similar public policy and health challenges to other countries in the Pacific, including high levels of dependence on government (and donor) financing and a pronounced double burden of communicable and Reproductive, Maternal, Neonatal and Child Health challenges alongside the rapid rise of NCDs.

Reform of focus: We chose the Role Delineation Policy (RDP) – a tool for better defining the range and level of services and packages of care to be delivered to given populations across Solomon Islands, including especially in rural areas – as the unit of analysis.

Key findings: Strong, stable, competent, domestic leadership has been the prerequisite for and driving force behind the RDP in recent years. Direct learning from Fiji and PNG was important at the early conceptual and contextualisation stages. However, this became less relevant at the implementation stages as officials came to terms with local restrictions. Development partners were key vehicles for transmitting learning. Short- and longer-term technical assistance provided policy guidance, although of varying quality. The World Health Organization provided technical advice drawn from international experience, and provided advocacy and support for Universal Health Coverage; this, in turn, helped to give legitimacy and credibility to the RDP. The World Bank used broader regional and international experience to stimulate thinking and planning more systematically about the cost implications and financial sustainability of rolling out the RDP nationwide. There were missed opportunities for the broader development partner community to provide coordinated, coherent learning from others. In addition, personal credibility and personal relations, particularly with colleagues in the region, can be much more influential in sharing learning from other countries than institutions themselves.

Solomon Islands officials do learn from other countries by participating at international conferences. However, the distinctive health system characteristics of Solomon Islands means participation in international conferences can be an expensive and not particularly effective platform for learning. Regional conferences – particularly when they focus on a specific common theme, such as responding to the rise of NCDs in the Pacific region – can be more useful. However, crowded agendas at such conferences, a show and tell format rather than a genuine dialogue, and weak dissemination and institutionalisation of any lessons in the home country can dilute practical learning. Restrictions on evidence-based learning at the national level include limited authority/accountability for achieving results, bureaucratic fragmentation, politically driven decisions about health resource allocation, and weak civil society pressure for evidence-based results.

Direct implications for Bill and Melinda Gates Foundation: First and foremost, it is an essential prerequisite to have stable and strong leadership that is genuinely interested in evidence and outcomes if any form of learning is to have traction. Second, there needs to be a visible and sustained institutional demand for learning, a situation that arises more frequently as bureaucracies move from mechanistic input-based resource allocation decision-making to more outcome-oriented decision-making. Third, whether the supply of learning from other countries gains traction depends to a large degree on who is supplying the evidence, when it is provided in the planning, budget and political cycles, how it is provided, and perceptions about its overall quality.