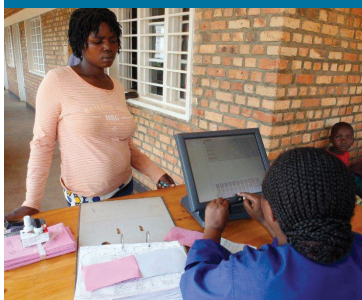


**Final Report**



**January 2011**

**Midterm Evaluation**

# Transforming Health Systems Initiative

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## Executive Summary

The Rockefeller Foundation is currently in the midst of a five year, \$100 Million initiative called “Transforming Health Systems” – which aims to help developing world countries improve health services and financial protection (from the cost of health services) for their overall populations.

At the halfway point, the foundation embarked on an independent evaluation, led by consultant Arnon Mishkin, to record the progress that has been made, examine the strategy and impact to date to identify opportunities for mid-course corrections, as needed.

As part of the evaluation, the team:

- Reviewed all strategic plans and grants terms and reports, as well as activities of the team, with an eye to assessing how all the component parts of the initiative – grants, conferences, speeches and articles – fit together
- Debriefed all current and past members of the initiative team and Rockefeller Senior Leadership
- Interviewed roughly 40 partners and grantees, representing 60% of total grants to date and roughly 40% of all projects, including both projects deemed successful as well as those that were stopped midway
- Conducted a panel discussion with the team and five outside health systems practitioners and leaders with knowledge of the overall health systems environment as well as of the Rockefeller project
- Surveyed global health leaders and attendees at international fora focused on global health issues

## Key Findings

### 1. *The work of the initiative is relevant to Rockefeller and its key stakeholders*

- a. The project is consistent with the mission of the Rockefeller project and aimed at clear needs in the developing world
- b. The Rockefeller Foundation has played a leadership role in highlighting the issues underpinning health systems – Universal Health Coverage, the private sector and e-health
- c. The Rockefeller Foundation is seen as providing value above and beyond its financial support in all of its health systems activities

- d. The work of THS is seen as quintessentially what The Rockefeller Foundation is best at: Identifying new approaches to affect development that others are not focused on –showing how it can have a substantial benefit in the developing world and getting others to follow.
- e. There is strong support for the integrated country work that the project has recently launched, with some belief that it would have been better to start earlier and would take three or four additional years to flourish.

**2. *The initiative has been effective in achieving a set of accomplishments in two of the Foundation’s strategic areas – Policy Influence and Network Formation. The initiative is working on efforts to strengthen capacity.***

- a. In terms of policy influence, the initiative has:
  - i. Helped drive increased attention on Universal Health Coverage at the global and regional levels, including via the WHO’s 2010 World Health Report, focused on UHC
  - ii. Helped ensure that the UN Secretary General and the “Elders” meeting in Atlanta in 2008 endorse strengthening Health Systems as a global priority
  - iii. Helped ensure that the G-8 in Japan, 2008, endorsed the focus on Health Systems Strengthening
  - iv. Helped get the World Health Assembly in 2010 to pass a resolution urging all member countries to better engage with the private sector in providing essential services including health
- b. In terms of network formation, the initiative has helped to convene – as sought at the launch of the initiative – and attract the support of other donors and set up:
  - i. The HANSHEP Alliance, focused on supporting the Private Sector in Health, with funding of \$20-\$50Million
  - ii. The Center for Health Market Innovations – enabling developing country health providers to learn about new innovations, and enabling donors to learn about innovations in the global south that may be worthy of support
  - iii. The Joint Learning Network for Universal Health Coverage, which enables developing countries to share experiences in moving to UHC, and which will also focus on e-health, among other things

- iv. The foundation at the helm of “openMRS” – an “open source” medical records platform for developing countries – which will enable the network to continue to grow
- v. The mHealth Alliance<sup>1</sup>- and now with several other partners, to advocate for the value and drive for the adoption of e-health tools, particularly on mobile platforms
- vi. Curricula and setting up of health informatics training, particularly in Rwanda and Bangladesh. Early efforts to set up a “Ministerial Academy for Health” were moved to now work with the specific ministries in the four focus countries and the Joint Learning Network for UHC.

**3. *The work of the initiative is having substantial influence – with other donors and in the developing world***

- a. The Rockefeller Foundation has had an impact in focusing greater global attention on key issues of UHC, e-health, private sector. Beyond, focus countries such as Bangladesh, where a good part of the UHC discussion appears to result from RF direct work, UHC is now being actively discussed or planned in India, South Africa and other countries in our target regions.
- b. There are clear signs of progress in the work streams particularly at the level of convening support for the RF strategies. As noted above, RF has helped set up a number of network alliances and helped ensure policy influence in its target areas – UHC, Private Sector and e-health.
- c. In one of the four focus countries – Rwanda – the country work (focused on e-health) has high visibility, the clear support of the President, and appears to be making progress in demonstrating the value of the Rockefeller approach to e-health, which is now being considered for adoption in Ghana, Indonesia and other countries.
- d. In the other three focus countries – Bangladesh, Ghana and Vietnam – the work is in its early stages; while the country and situation analysis is strong, the constraints of time, country visits (vs. presence), and the size and number of projects make it harder to achieve the kind of visibility that the foundation might prefer.

<sup>1</sup> In addition, the Summer Series 2008 on “Making the e-Health Connection” at our Bellagio Conference Center was recognized as a watershed in the advancement of the overall field of e-health in the global south

- e. While THS and RF are viewed by peers and stakeholders as more supportive of local grantees in the Global South than most, in a number of cases there appeared to be opportunities to make more clear the involvement of local grantees, in order to ensure sustainability on the ground. While the analysis in this evaluation is focused on the period until mid-2010, the proportion of grants to southern grantees did substantially increase in 2010 with the acceleration of the country work.

**4. *The work of the Initiative is showing initial signs of sustainability***

- a. The launch of the HANSHEP Alliance suggest other donors are in the process of stepping in to increase their work on the Private Sector.
- b The institutionalization of the openMRS medical record platform, through the Regenstreif Foundation, together with evidence that other countries are beginning to learn from the Rwanda experience, provide initial evidence of the sustainability of the e-health efforts.
- c .The World Health Report focused on Universal Health Coverage, together with the number of countries either launching or evaluating UHC initiatives, suggest the sustainability of the Agenda Setting strategy.

**5. *In terms of achieving the desired Initiative outcomes of improved financial protection and better health,***

- a. we believe that by the end of the Initiative there should be available metrics indicating whether the strategies of THS – especially Universal Health Coverage – do have a measurable impact on out-of pocket, catastrophic health expenditures.
- b It has been less clear all along whether it will be possible to assess (and attribute) whether the strategies have an impact on health outcomes (e.g. maternal mortality & stroke incidence) which have multiple determinants beyond health systems.

**6. *In terms of efficiency, resource usage and results due to that investment, to date, the initiative has spent or committed ~\$50 Million.***

- a. ~\$9 Million went to Research and Agenda Setting. In addition to a body of research, the most visible accomplishment has been helping to increase attention on Universal Health Coverage
- b ~\$12 Million was spent on Leveraging the Private Sector, including re-

search and setting up networks. The most visible accomplishments have been setting up the CHMI and the planned \$20-50Million annual support by the HANSHEP Alliance in the future

- c ~\$16 Million was spent on e-health, including research, setting strategy, advocacy and the demonstration of tools development. The most significant accomplishments have been the institutionalization of the “openMRS” platform for medical records and the mHealth Alliance, as well as the initiative to create an enterprise architecture in Rwanda, which appears to be resulting in encouraging other countries to adopt a similar approach.
- d. ~\$6 Million has been spent specifically on Health System Capabilities efforts. Of that ~\$1-2 was spent during search exploring a potential Ministerial Academy and other platforms. The most visible accomplishment here is the launch of the Joint Learning Network for UHC, a South-South learning exchange network with increasing traction among countries and donors.
- e. \$3-4 Million is now committed for in-Country/Integrated work in Bangladesh, Ghana, Rwanda and Vietnam. Half of the budget going forward is dedicated to country work.
- f. Five percent of the grants accounted for 40% of the total budget and nine grantees accounted for almost half of total spending.
- g. The money spent on the global efforts appear to have had clear results, and thus be a good use of money, it appears the money being spent within countries may not be sufficient to have the kind of impact RF would desire.

While impressed by the scope and achievements of the initiative, the Reference Group, in particular, suggested the need for greater focus of the activities of the initiative, and concern that the Initiative was trying to do too much with too little capacity and resources.

**7. *The RF team has been very effective at managing grantees and the individual workstreams, though there is evidence of a desire for improved communication and clarity of the overall initiative.***

- a. From sources consulted, grantees and partners are impressed with how RF manages its grantees. A donor partner in particular noted “they’re more hands-on than we are.” While some did raise concerns about the



level of attention, most believed the Rockefeller team added substantial value to their projects.

- b. The individual workstreams have a clearer approach than the overall Initiative, which resulted from the coalescence of initially separate searches.
- c. There is an opportunity and desire for greater coordination & communication among grantees.
  - i. Because of the fact that Rockefeller seeks both to conduct activities that have a beneficial impact on its target population – and to convene others to follow in its lead, the clarity and communication of its overall strategy and effort is extremely important – and possibly even more important than for other foundations.
  - ii. As many pointed out, THS is a vastly ambitious initiative, and even a budget ten times the size of the \$100Million RF has committed would be considered small given its ambitions. Therefore it is particularly important to have a very clear strategy that shows what is achievable that would truly transform health systems.
- d. There is a need for greater/simpler clarity of how the work of THS – UHC, e-health, Private Sector, Stewardship/Country work ties together into a something that will synergistically affect health systems.
- e. There is a need for a tighter, explicit linkage between the activities of THS and the overarching Theory of Change and the Results based Framework.
- f. There is also an opportunity for greater clarity around Initiative-wide capacity strengthening efforts – defining clearly what capacity building means in the context of health systems, and clearly setting out strategy and resource allocation to achieve this end.

**8. *There is room for improved team dynamics, to maximize the value of group and the potential synergies among all initiatives in The Foundation.***

### Suggested Course Corrections:

We recommend the THS team take the following steps:

- 1 . Refine the articulation of the “Theory of Change” and the “Results Based Framework” of the initiative to better reflect how it is going to be transformative and how all the workstreams fit together. Ensuring clarity of the overall strategy will both improve team dynamics as well as enable external donors and countries to learn and leverage the overall lessons of the THS initiative.
- 2 . Define more clearly the target end points for the final two and a half years, across all workstreams and the overall initiative.
- 3 . More clearly define the strategy in each of the four target countries around the specific achievable goals – and better articulate how the work in the countries will support the global efforts of THS.
  - *Given the late start of integrated country work, the limited time remaining until the conclusion of the initiative and the limited level of funds available for country work, the foundation should either enable additional time or budget or the team should recalibrate the scope and objectives of country work to focus on the most feasible yet significant activities that are likely to create the most value both in that country as well in affecting change in other countries. In particular, it should consider focusing on two of the four target countries where they have already shown the best signs of progress, e.g. Bangladesh and Rwanda.*
- 4 . Continue to build on the positive momentum of the JLN, as a focal point for bringing together and demonstrating and communicating the value of the different components of the initiative.
- 5 . The Initiative should clarify and make more explicit how its specific tools in e-health areas will result in improved systems and outcomes, and investing in systematic assessment and evidence at country level.
- 6 . Use the good policy influence mapping that the team has done to work with the VPMI to:
  - set explicit policy targets for the remainder of the Initiative, particularly for UHC at G8/G20 summits and the UN general assembly (allowing for some flexibility),

- ensure that there is a consensus around these targets with the leadership of the Foundation, and what these target requires in terms of grant making.
  - Focus on achieving those targets for the remainder of the Initiative.
1. While THS and RF are viewed by peers and stakeholders as more supportive of local grantees than most, the initiative should take steps to make more clear and increase the involvement of such grantees. It should also ensure that during the remainder of the work is managed in a way that transfers support and responsibility to local institutions.
  2. Define capacity strengthening in the context of health systems, and articulate a strategy for ensuring either that capacity is built within the life of the Initiative or that projects are launched that will continue to build capacity beyond the five year time frame of the Initiative.
  3. Continue to work on improving team dynamics by further empowering team members to lead and manage specific aspects of the THS Initiative. Use the re-articulation of the overall theory of change and the Results Based Framework of THS to ensure that everyone on the team feels their work ties together as a group.
  4. The team should build on its approach for communicating the strategy and learnings of the initiative and the foundation with its grantees, peers and partners, including holding more side sessions and learning events with grantees and partners, and disseminating written briefs on the Initiative.
  5. The Team should improve its process for capturing, analyzing and sharing the learnings – findings, demonstrated hypotheses and accomplishments – from major clusters of significant grants.
  6. To enable a transparent approach to the management of large grants, the Initiative should clarify the specific management roles and responsibilities for each major component of large grants and ensure these are integrated into the grant database systems.

Similarly, there are a number of steps that the Foundation can take coming out of this study:

1. Sharpen the “theories of change” that initiatives use to define themselves and the operational management tools that Initiatives use to implement and monitor their work.

2. Align the different components of Initiatives with:
  - A more explicit development approach that underpins the work of the Foundation – (defining more equitable growth, in particular)
  - Identifying the underlying assumption or theory of cause and effect that is at the heart of an initiative
  - Setting the overall strategy and identifying more clearly annual milestones that are likely to be achieved
  - Putting in place operational management tools to assist managers and VPs to oversee the work – workplans, dashboards,
  - Increasing the demand and opportunities for teams to capture learning and report on progress so that there is real purpose in tracking the work.
3. Consider having outside groups, such as the Reference Group involved in this evaluation, help guide the development of an initiative strategy as well as to monitor and evaluate the ongoing progress of initiatives.
4. Improve the data systems for capturing ongoing information related to the outputs and outcomes of its Initiatives.
5. In order to improve the management of “intermediary” grants, the Foundation should improve its data base systems and knowledge capture processes to enable tracking, monitoring and reporting on progress towards deliverables and learning from each of the multiple components of an intermediary grant.
  - Even though a project may be a single grant, the foundation systems should enable different components to be managed by different officers and draw from different budgets.
6. Consider adopting a formal review process for each of the largest grantees to assess and ensure effectiveness.

## A. Background and Summary of the Transforming Health Systems Initiative

With the emergence and maturation of a set of very large foundations focused on global health, the Rockefeller Foundation in 2007 was faced with the question of how it could best use its resources. Would their efforts in health be merely smaller and redundant, or could RF leverage its historical “convening power” as well as a heritage of high quality analysis to find a niche in global health that would both make a difference to the “poor and excluded” and stand separate from the multitude of efforts pursued by other foundations.

To address this, the foundation brought together 20 of the top leaders in global health for a two day consultation at Pocantico Hills in September 2007. The group both reviewed some ideas from the Rockefeller staff, as well as discussed their own work in the area of health systems. The meeting, “Meeting the Challenge of Health Systems” sought to focus on thinking “horizontally” about health systems – as opposed to “vertically” about specific diseases. In particular, leveraging various preliminary searches, it discussed:

- The Need to Build Capacity of National and Local Health Systems
- Public Health Competences and Superior Technology
- Achieving the Goals of Global Vertical Initiatives: Ensuring Access to Essential Products and Innovations
- The Need for Improved Surveillance, to identify new global disease threats
- Leveraging the Private Sector, as Rockefeller had done in setting up a series of PPPs (Public Private Partnerships) as part of its “Harnessing the New Technology” program in the 1990’s.

The group agreed that there was a substantial role that a nimble and well-respected player, such as Rockefeller, could play, and recommended focusing attention on:

- Surveillance systems – to track and respond to new diseases and outbreaks – monitoring the overall system rather than measuring specific diseases
- Defining the Required Competences for Public Health Professionals – to ensure local expertise in managing the health system
- Ensuring access to technologies/social interventions – to ensure that the supply chain of health systems can respond to the opportunities likely to be presented by the “Verticals”.

- Using Information Technology to improve health care delivery and health systems by ensuring platforms for e-health in the developing world
- Leveraging the Private Sector – using the sector that has historically been ignored by global health, but increasingly is seen as an essential tool in the financing and provision of health services.

The foundation took up the challenge and developed initiatives in four of the five areas: Disease Surveillance, The Private Sector in Health, Global e-health and defining the new competences/Agenda Setting.

In 2008, the leadership of the foundation decided to pull together three of the initiatives: The Private Sector, Global e-health and overall Research and Agenda Setting in the field as part of a larger initiative, “Transforming Health Systems.” The Foundation continued to pursue its initiative in Disease Surveillance, but considered it separate from health systems per se, as it equally could be seen as taking a “vertical/disease focused” view of the field.

The foundation initially agreed to fund the initiative with a budget of \$150 Million over five years, later cutting it to \$100 Million after the financial crisis and the board approved.

In the core proposal, the team described the “Transforming Health Systems” initiative as follows:

At a high level, the THS initiative intends to address the inadequate attention to the momentous transformation of health systems and the insufficient priority, research and capacity for high performing health systems... Given the breadth and complexity of HS, this initiative will not attempt to address every barrier to stronger health systems, particularly those already addressed by others (health infrastructure, workforce, and drugs & vaccines). THS will concentrate on high-impact strategies honed during the search and development phase and fitting RF’s comparative advantages in agenda setting, capacity building and technological innovation. They are:

1. Fostering HS Research and Agenda setting,
2. Enhancing HS Capabilities in developing countries,
3. Harnessing the Private Sector for a holistic HS, and
4. Leveraging interoperable e-health Systems.

At the time that the four were brought together into a Transforming Health Systems initiative, the research on each of the specific workstreams was clear and well-articulated. What it would do in each, how it would do it, and what the probable impact would be were laid out:

1. *Fostering HS Research and Agenda setting*: “RF has been one of the key leaders on the global health systems agenda during the past year. We have engaged with the G8, the UN Secretary General, and the Elders to promote a global HS agenda. We have also hosted many Bellagio meetings on HS challenges, and will play a strong role in the November Bamako Ministerial meeting on health research agendas.”
2. *Enhancing HS Capabilities in developing countries*: “For nearly a century, RF has led the way in public health, medical education and capacity building. The Foundation has unquestioned credibility in this space, and can catalyze new interdisciplinary programs, and leverage our regional presence to build country HS capacity.”
3. *Supporting the development of models that harness the private health sector*: “RF’s path-breaking leadership in creating public-private partnerships to develop drugs and vaccines for diseases of poverty positions the Foundation to act as an “honest broker” among donors, governments, and the private sector, moving the discussion beyond public/private ideologies in ways other multilateral agencies have been unable to do.”
4. *Promoting the design and implementation of interoperable e-health systems*: “Following a successful Bellagio series on e-health in 2008, RF has emerged as a leader in the arena of health information technology for the global south, and is seen as a neutral player compared to other philanthropies with closer ties to IT corporations.”

In defining the overall initiative, the team laid out a “Theory of Change” focused on seeking to ensure improve access and affordability. Over the first two years of the initiative, the team increasingly pursued the goal of “Universal Health Coverage,” which has become central in their “Theory of Change:”

## THS Theory of Change

*Harnessing the transformation of health systems for*  
**Better Health and Financial Protection for All**

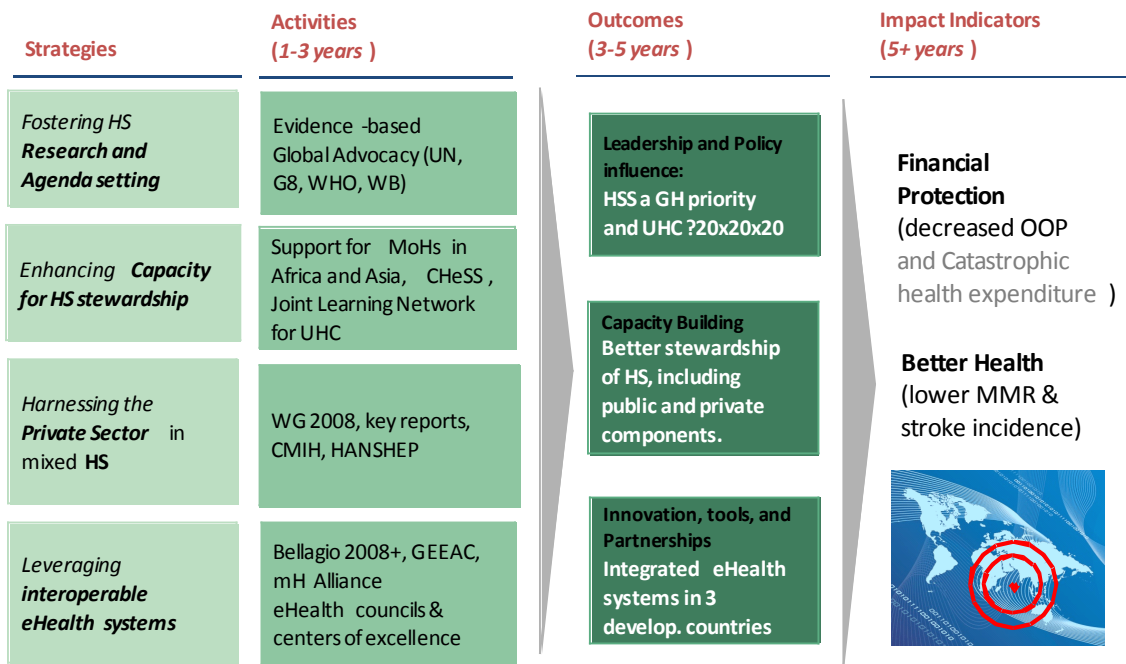


Figure 1: Theory of Change



## B. Methodology and Sources for the Evaluation

The evaluation qualitatively and quantitatively leverages and synthesizes six key data inputs:

- A complete review of all strategic plans, grants plans and grant reports, with an eye to assessing the internal logic of the strategic plans, the consistency between strategy and grant choices and sequencing and the potential impact and quality of the grant reports/outputs.
- A full portfolio review of all grants and activities/speeches and advocacy. In reviewing the grants and activities, we sought to recreate, from ground up, the overarching strategy of the initiative and identify the milestones that have been achieved. We also sought to ensure the congruence between activities and existing plans, and identify areas where the actual activity sequence appears to follow a slightly different de facto strategy than originally planned.
- Interviews with all members, current and past, of the initiative team, both to get their individual views on what they and their workstreams are seeking to achieve, identify differences between strategy and tactics, identify recognized or unrecognized synergies among the team's efforts and assess the effectiveness of the group
- Interviews with grantee leaders to understand to understand what their projects are trying to achieve/have achieved, to assess how they view the value and support provided by the Rockefeller team and to identify their recommendations for how the Rockefeller team could make their projects more successful. We conducted roughly 40 interviews, representing 60% of total grants and 40% of all projects
- A panel discussion with the team and five outside health systems practitioners and leaders with knowledge of the overall health systems environment as well as of the Rockefeller project. We sought to get their views on the key changes in the field of health systems and how Rockefeller might adjust its initiative to better ensure success in the remaining two and a half years. A complete summary of the panel is included as an Appendix.
- A survey of global health leaders to assess their views of how the field of health systems has changed in recent years and determine both where Rockefeller is viewed in the field, and determine the extent to which Rockefeller's goals for changing the field have been realized.

- A case study of one large element of the THS initiative – how it was developed, what it is doing and what its likely impact will be. The case study, of the Joint Learning Network for Universal Health Coverage, is included as an appendix

The results of the data inputs were then synthesized and reviewed with the team and incorporated into this document.

## C. Evaluation Findings & Discussion

### **1. Relevance and Positioning: To the mission of the Foundation, key issues of the world and key stakeholders**

In this area, we sought to assess the extent to which the THS initiative is relevant to the mission of the Foundation and the needs of the populations it wishes to serve, and whether it leverages and builds on the comparative advantages of the institutions

#### **Findings**

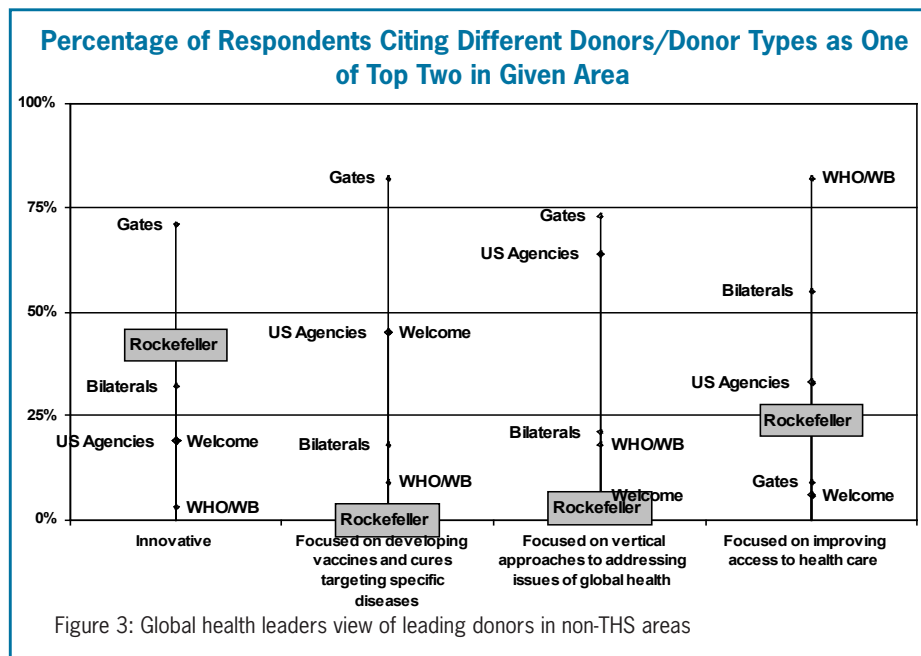
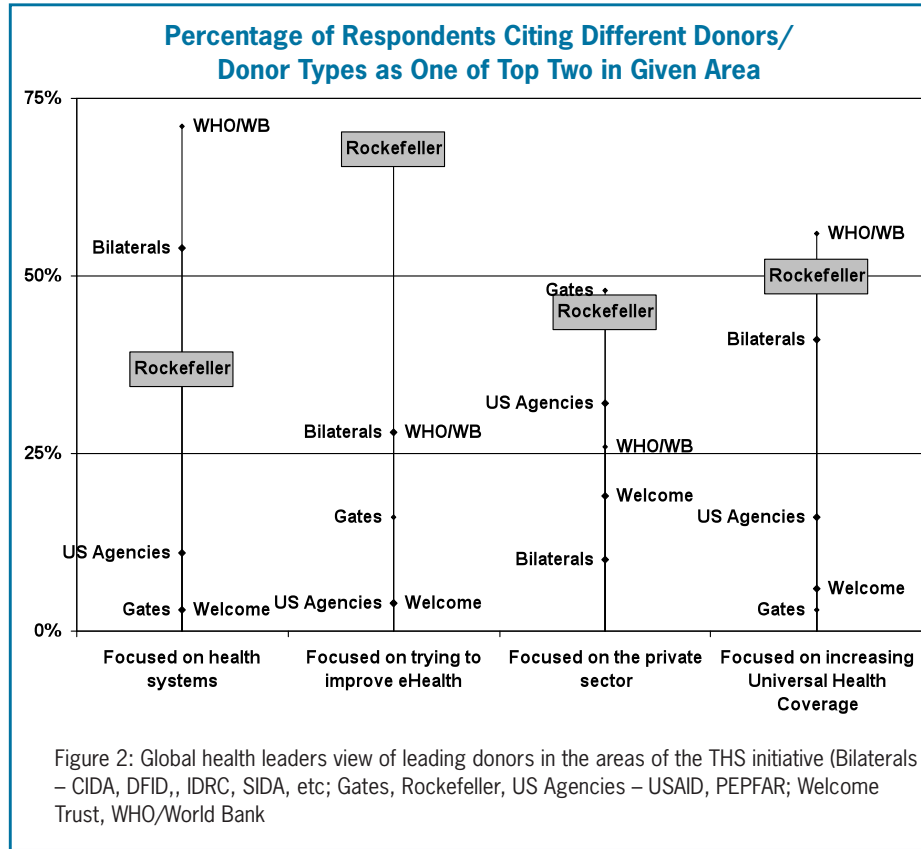
- The project is clearly relevant to the mission of the Foundation in serving the needs of the poor and excluded.
- THS leverages the comparative advantage of RF – its historical convening power as well as its intellectual leadership – in terms of identifying new important areas of philanthropic focus and need and getting others – often with greater financial support – to follow RF’s lead
- THS was created and conceptualized in response to a demonstrated need, following a systematic stream of research and consultation with a variety of global health leaders and stakeholders
- The initiative clearly responds to a need given the extent of investment donors have provided to vertical programs in recent years and the resulting need to ensure that the health systems of the developing world were both able to accommodate that investment, as well as not be inappropriately impacted by it
- In executing the initiative, RF has clearly played a clear leadership role in the specific workstreams – leveraging the private sector, building interoperable ehealth systems, and advocating for Universal Health Coverage, as well as a significant, though lesser role in getting people to focus on health systems

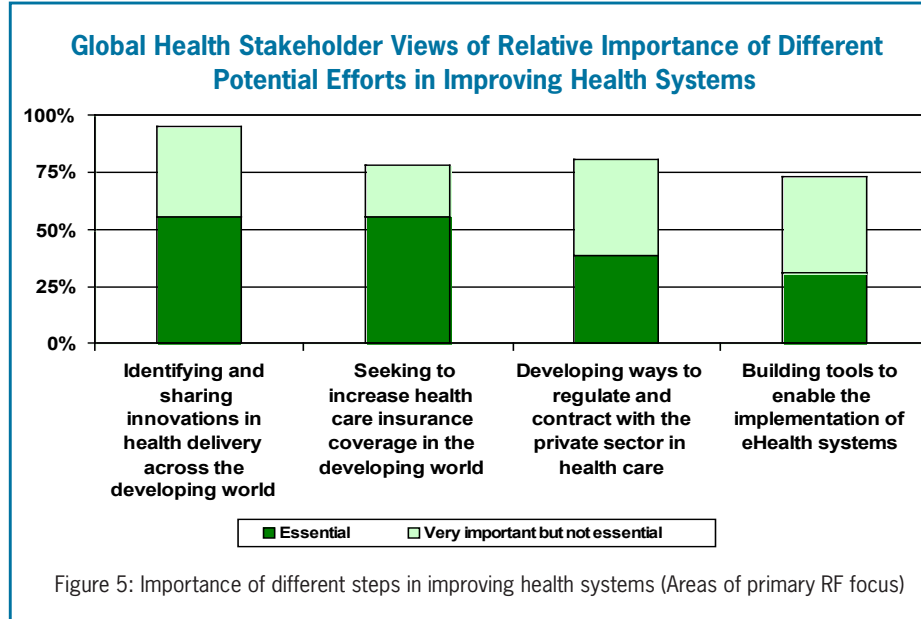
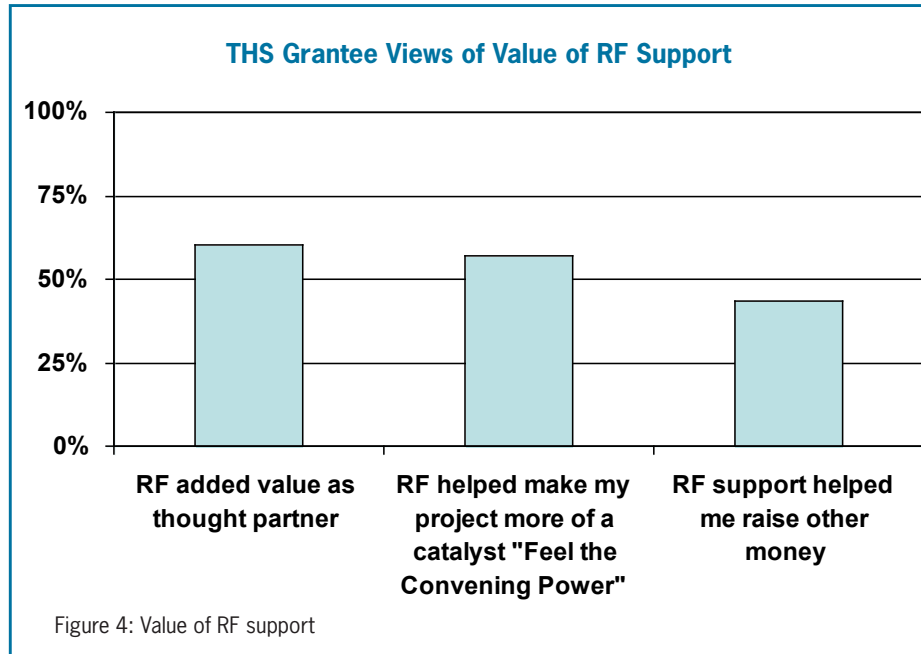
- Grantees and others see RF as providing the convening power, not just to the overall initiative but to specific projects as well. Large numbers of grantees believe their project received non-RF money in part because of RF presence, as well as that their project received greater attention because of RF's involvement.
- Rockefeller's comparative advantage in providing intellectual capital is believed by many to be of ongoing importance in the future – especially as many developing countries grow wealthy enough to afford their own programs, but continue to need the technical assistance and leadership that only players like RF can provide
- While all the specific workstreams of the THS initiative received substantial support and approval, a number of grantee partners and health leaders recommended that RF seek to be more clear about what it is trying to do in health systems – communicating better about the overall goal and theory of the THS initiative as well as about specific workstreams.
- There was substantial support for RF's rearticulation of the THS mission around Universal Health Coverage, although even there, there was a belief that it could be better shown to fit with the other components of the initiative.

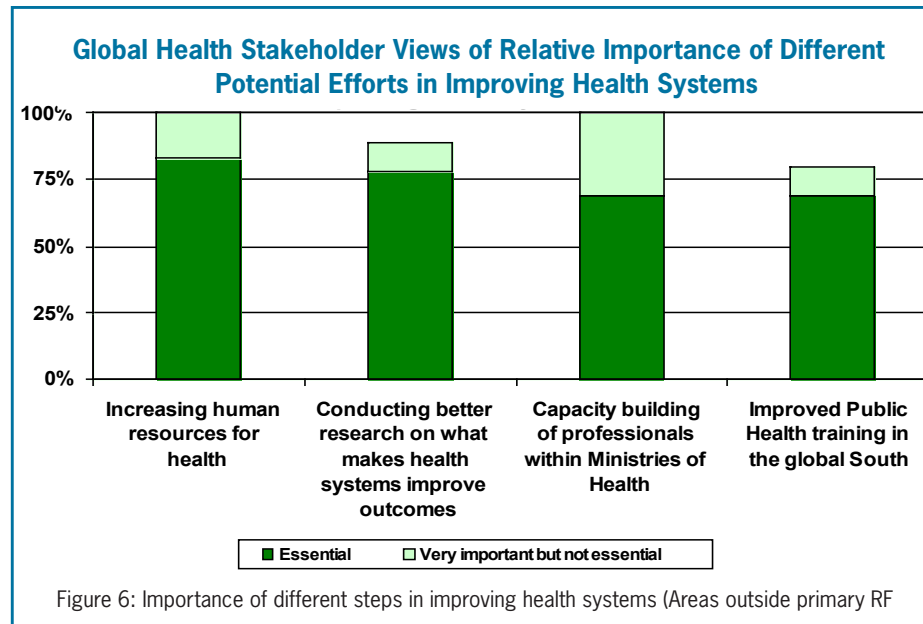
### **Suggestions for Improvement include:**

- Clearly refine the articulation of the “Theory of Change” of the initiative and the “Results Based Framework” to align with the TOC – better reflect how it is going to be transformative and how all the workstreams will or do fit together. Ensuring clarity of the overall strategy will both improve team dynamics as well as enable external donors and countries to learn and leverage the overall lessons of the THS initiative
  - Particularly as RF seeks to continue to grow its convening power and ensure the impact of its intellectual efforts, it is important to focus attention on improving communication about the theory of change and the impact of the specific workstreams.
- In order to get others to focus more on interoperable e-health systems and improving the stewardship of the private sector, RF should seek to do a better job explaining how its specific tools in those areas will result in improved systems and outcomes

### Results of Survey of Global Health Stakeholders and Grantee Interviews focused on Rockefeller Foundation Leadership & THS Relevance and Positioning







## Discussion of Relevance & Positioning Findings

The overall “Transforming Health Systems” initiative is clearly relevant to the Rockefeller mission and its key stakeholders – both target populations and potential partners/other donors. The needs of key stakeholders were clearly considered in the planning and execution, and the strategy leveraged Rockefeller’s historical comparative advantage. Results of interviews conducted with grantees, partners and global health leaders and the meeting of the Reference Panel demonstrate clearly that the Rockefeller Foundation has established itself as one of the top leaders, occupying a very clear niche of intellectual support in development and a recognized role in health systems and its components. Despite the presence in the space of many other foundations, substantially larger in endowment than Rockefeller, RF is successfully identifying a set of issues that have not been seen as of primary focus – but are becoming more mainstream in part as a result of the attention and work of the Rockefeller Foundation. The convening power is clear.

In designing and setting up the initiative, the foundation consulted with a set of developing world and global health leaders and did extensive research on the needs of the foundation’s target populations, as described above. The foundation planned methodically, with an eye both to ensure that RF operate in an advantaged niche and to that it would not be wasting resources in the face of many large foundations focused in the health space. The focus on

health systems arose from a clear analysis of the need in the global health sector. As the team explained:

Global health aid has tripled over the past decade, but much of this increase has been directed at programs for HIV/AIDS, tuberculosis and malaria<sup>2</sup>. For example, 80% of U.S. funding for global health goes to HIV/AIDS, which is responsible for fewer than 4% of all deaths<sup>3</sup>. Despite the effectiveness of priority programs for the diseases they target, there is evidence that increasing disease-specific funding crowds out resources for other key health services and can be detrimental to HS overall.<sup>4 5</sup> The growing burden of chronic diseases on top of the unfinished agenda of infectious killers, will be compounded by continual increases in real health costs and catastrophic health expenditures.<sup>6</sup> This creates an opportunity for RF to promote innovative and catalytic approaches to comprehensive HS strengthening.

In the specific topics within “Transforming Health Systems,” Rockefeller has played a recognized leadership role in each of the areas of focus of the Transforming Health Systems initiative, including:

- e-health
- the private sector
- Universal Health Coverage
- Thinking more broadly about health systems as opposed to vertical administration of care focused on particular diseases (both prevention – vaccines – and treatment)

Our survey of health leaders found that Rockefeller was named as one of the top two donors/leaders in each of the areas of ehealth, the private sector and seeking to get countries to move to Universal Health Coverage. It was not the top two in seeking to get people to think more about Health Systems, where the World Bank and the bilaterals were seen as taking more of a leadership position: (See figures 2&3)

<sup>2</sup> Donor Funding for Health in LMIC 2001-2006. Kaiser Family Foundation & CSIS. July 2008.

<sup>3</sup> World Health Report 2008.

<sup>4</sup> Jacques van de Gaag 2008. Manuscript under preparation.

<sup>5</sup> Shiffman J. Has donor prioritization of HIV/AIDS displaced aid for other health issues? Health Policy Plan 2008;23:95-100.

<sup>6</sup> There is strong empirical evidence of this trend which has been described as Baumol’s disease.

And both grantees and other stakeholders recognized the importance of the support that Rockefeller has provided. A representative sample of opinions and observations we heard includes:

- “While they were not the first to identify the importance of the “private sector,” they have played an essential role in ensuring attention on the private sector and in influencing other donors”
- “Rockefeller was correct in identifying e-health as important in maternal health. No one was doing that”
- “They’re geniuses at putting an issue on the table and raising its profile. That’s what they’ve done for the past year on “Universal Health Coverage.” Grantee whose project had been stopped in the middle.

Despite the foundation’s limited resources – a fact recognized by many grantees – not surprising given that many of them are also funded by Gates or other large donors/bilaterals – Rockefeller is seen as providing value above and beyond the financial support. In the graph above (figure 4), we show 60% of grantees thought that Rockefeller’s support helped make their project more of a catalyst – that they were able to “feel the convening power” than it otherwise would have been and 43% thought that they were able to raise money from other sources, because Rockefeller was a supporter.

Illuminating those figures, we were told by grantees:

- “This is not a conventional donor relationship. There is much more interaction about an idea – and the power of the UNICEF footprint and how it can come together”
- “They are very supportive and committed. They work very closely with us. They have introduced us to many experts in the field”
- “Rockefeller wants to get substantively in the work – it has its downsides as sometimes we need to go through more cycles of work. NIH is more efficient, and give you more autonomy. The net with RF is positive, though.”

In general, almost all the stakeholders consulted recognized Rockefeller’s role in focusing on important issues that other donors are either missing or not fully focused on. Among the things we heard were:

- Rockefeller always identifies and focuses on the “orphan issues” and soon others realize how important they really are.



- RF is a reservoir of intellectual support. Gates is very operational and plugged in. RF sits above everything. They have a long tradition of new ideas and new agendas. They are good at bringing others along.
- RF seems interested in funding the types of projects that others aren't funding. There are plenty of donors for clinical work and infrastructure, but not too many donors interested in supporting innovative systems.
- They fund areas that normally people will shy away from because the results are slower.
- They punch above their weight because they really know how to play the game.

The importance of Rockefeller's niche in supplying "intellectual capital" and the continued opportunity in that niche was highlighted by one of leaders we consulted from India, a rapidly growing but still developing country: "Many developing countries increasingly have the money to afford programs and projects, but we still need technical assistance and a better understanding of what we should do. Rockefeller is doing that. If anything, Rockefeller should act more as a think tank integrating all their initiatives – urban, climate, agriculture and health."

While Rockefeller's THS initiative is clearly relevant to Rockefeller's comparative advantage and stakeholder needs, that relevance was not always fully recognized and there were clearly opportunities to improve how the team communicated about what it is seeking to do and why it is relevant.

A review of all the data the evaluation collected – team, grantee, partner and other stakeholder interviews, a reference panel discussion with global leaders, a survey of global health leaders – the few recommendations for improvement – but a recommendation we heard consistently from grantees as well as observers on the Reference Panel – had to do with a set of issues which we believe comes down to communication:

- It seems they are doing too much
- I don't fully understand the clarity of the overall theory of change

In the reference panel discussion, there was a consistent sense that the team was doing many different – and different types of things – demonstration projects, advocacy, technology building and even scale up. Our detailed read of the actual plans and projects suggest that all of their initiative fall into the area of demonstration projects/analysis and related advocacy of those dem-

onstrations. But because of the communication challenges, it can appear as though the team is working on a host of potentially unrelated things, and thus doing “too much.”

Our review of the “Theory of Change” and the accompanying planning documents also suggest the opportunity to develop an improved overall clarity of the overall initiative.

In laying out the logic for putting the four streams together in an initiative designed to transform health systems, the team opted for an inductive rather than deductive approach. Rather than explaining why these were the four highest – or even four of the highest – leverage points for affecting a health system – the document presented to the Foundation leadership and board explained that most of the other leverage points were either taken or had already been pursued by Rockefeller:

These four strategies have been selected from a range of potential interventions because they share the following key traits: they address important barriers to health systems improvement, they require timely interventions if their impact is to be maximized, they are not being fully addressed by others, they leverage the comparative advantage of the Foundation, and they are mutually reinforcing.

While the document says they are mutually reinforcing, it does not fully explain how. Moreover, the “theory of change” reads more like a set of independent business plans and goals, as opposed to “theory” with hypothesized causes and anticipated effects.

While this reviewer happens to agree that these are four very important initiatives in any effort to transform health systems, the rationale boils down to they are important and others are not pursuing them, as opposed to, for example:

- With access to the tools and attention we are developing, a system would be able to transform itself
- Working together, these initiatives will both call attention to the importance of transforming health systems – and provide mutually enforcing enablers of that transformation.

Part of this is a historical reality; because the streams were initially independently planned – albeit arising and being reviewed by the same group of global health leaders brought together to identify an approach to meeting the “Challenge of Global Health Systems” – there was less attention paid to what was important to do within each, and less focus on either how they would

transform health systems – or how they would work together. And given the size and challenge of each, it may not have been the wisest use of people’s time.

Still, as one of the team members expressed, “well the truth is, if we had started from scratch, we might not have chosen these initiatives as the most important to transform health systems.”

Our read of the Initiative documents, our participation in the planning meetings and our interviews suggest that – while that view has been articulated in one form or another by essentially every member of the team – the initiatives would probably have been selected if RF was starting again from scratch, there are opportunities to ensure they are reinforcing in a way not articulated today and they share the classic RF “DNA” of appropriate initiatives leveraging your convening power and desire to demonstrate development opportunities that others scale up or leverage.

Starting roughly in 2009, the team rearticulated its mission to revolve more around achieving “Universal Health Coverage<sup>7</sup>” as a way of ensuring financial protection, given the extent to which unexpected and large out of pocket health costs either result in financial ruin or prevent individuals from getting needed treatment. Even so, however, the theory of change appears more a set of independent activities as opposed to a set of interrelated attempts at moving a set of high value levers.

As we will see in this document, we heard a clear desire for improved clarity about the potential impact of both the overall program as well as the individual workstreams:

- A large grantee in the e-health space said they wanted the initiative team to spend more time articulating how e-health would transform health systems. This grantee said that they still ran into skepticism about how and why improved information systems would cost-effectively transform health systems. While they clearly believed this (it was their main work), they felt there remained roadblocks in getting their work adopted that RF could help address.
- In the private sector there remained many skeptical – including some large donors – about having the public and private sector work together on health. Several grantees agreed with the need for greater explanation of how the private sector could be better used to deliver improved health care.
- Overall, in trying to get countries to agree to work with Rockefeller on

<sup>7</sup> Defined as access for all to appropriate health services at an affordable cost

their THS initiatives, at least one country pushed back on the specific initiatives that Rockefeller was proposing, thinking that the specific initiatives were not the primary efforts that country needed. An improved articulation of the overall theory of change may have made it easier to get that country to agree to work with Rockefeller on the overall program.

At the same time, there was very strong support for the team's decision to rearticulate its mission less around health systems and more about universal health coverage. As one partner of RF said, "people can grab onto UHC in a way that you can't grab onto the concept of 'transforming health systems.'" With UHC, they know exactly what is being proposed as opposed to an amorphous notion of a 'system.'"

But even with the rearticulation around UHC, it remained unclear as to why and how the private sector and e-health were related.

Communication is both irrelevant and essential. As we will show in working through each of the efforts (grants, conferences, speeches, etc) that RF has pursued and interviewing all types of stakeholders, the team has clearly carved a path that could clearly be seen as being transformative in health systems. They are creating tools that countries appear to want; they have identified programs and initiatives that – so far at least – have galvanized the attention and support of other donors who could be said to be planning on carrying on the work of Rockefeller, should/when it moves on; and they are a very important component of an initiative to get global health leaders to focus on essential new approaches. The fact that outside observers don't fully comprehend the underlying intelligence of the program from the program documents does not detract from the impact it is having. Indeed, it may explain why Rockefeller (Figure 2) is seen as a top donor in the specific workstreams of THS (e-health, Private Sector and Universal Health Coverage), but not in the overall effort to focus on health systems. At the same time, if Rockefeller Foundation's strategic advantage is its ability to identify the 'orphan' issues that other are ignoring and demonstrate their importance and relevance to the underlying issues – then the ability to communicate its hypotheses of cause and effect is a competence essential for its continued success.

It is clear that the efforts of transforming health systems are very relevant to the needs of the stakeholders. Partially as a result of the efforts of RF/THS, there is increasing awareness in the developing world of the need for the specific efforts in THS. In our survey of global health leaders showed that

respondents believed that the specific efforts of RF were either essential or very important to the improving the health systems of the developing world, as indicated in the figure below

The data are consistent with a number of conclusions – that these steps are important, that they are not viewed as the most important, which is consistent with the Rockefeller role in focusing on the “orphans,” and potentially that there are opportunities to improve the communication and thus increase the number of leaders who view them as very important.

Finally, it is clear that the initiative is relevant to a group that is increasingly important and strong in the developing world, namely civil society. Several participants on the reference panel highlighted the importance of civil society and the increasing demands that it is making for improved health care which the THS initiative seeks to address.

## **2. The Effectiveness and Efficiency of the Overall Effort and Specific Projects**

In this area, we looked for intermediate signs that the overall initiative and the workstreams were effective at executing projects with high quality outputs.

### **Findings**

- The initiative has generated important research on ways to manage the private sector. This has been credited by DFID with laying the intellectual foundation for the HANSHEP Alliance focused on the private sector
- The initiative has generated high quality research on the value of Universal Health Coverage and on ways to ensure that the scale up of vertical programs can help foster improvements in health systems
- The initiative has generated several high profile articles in medical journals that are seen as able to affect the overall attitudes towards health systems
- The effort in e-health has focused on a. galvanizing attention on e-health (through a series of Bellagio-based meetings), b. ensuring the viability of an open-source Medical Records system, which is well regarded, and c. on setting up an enterprise architecture for an open, interoperable systems in Rwanda, which appears to be on the correct track in developing an e-health system that can both improve efficiency of a system and also increase the focus on improving the lives of patients.

- The team has launched the “Joint Learning Network for UHC” which is seen as a perfect example of a platform for good South-South learning.
- In terms of the Rockefeller Foundations objective in Policy influence, the team has leveraged an explicit mapping of their strategy and:
  - Helped focus attention on Universal Health Coverage at the global and regional levels, including ensuring that the WHO’s World Health Report this year is about UHC
  - Helped ensure that the “Elders” in Atlanta endorsed the concept of strengthening Health Systems
  - Helped ensure that the G-8 in 2008 endorsed Health System Strengthening
  - Helped get the World Health Assembly in 2010 to pass a resolution urging all members countries to better engage with the private sector in providing essential services including health
- In terms of network formation, the initiative has helped to convene support and set up:
  - The HANSHEP Alliance, which appears to be ensuring funding of \$20-\$50Million/year
  - The Center for Health Market Innovations
  - The Joint Learning Network for Universal Health Coverage, which enables South-South learning exchanges
  - The institutionalization of “openMRS” – which is in now in over 40 developing countries
  - Helped set up the M-Health Alliance, now with other partners, to advocate for the value of e-health tools on mobile platforms
- Some of the efforts could do a better job of ensuring participation of the developing world players. For example, the Center for Health Markets Innovations (CHMI) very clearly creates value for donors and researchers (from the north). It is less obviously apparent – from their website – that it will also create value for medical providers in the developing world
- Some people suggested that the advocacy efforts – on UHC – should be sure to assess both sides of the issue, and that some of the output has taken too strong an advocacy approach

- The work in the four target countries has only recently started, with the exception of Rwanda, where much of the work is very clearly a part of the global e-health. In the other countries, a strategy has been set and several projects have or are launching. Although it is too early to be able to fully assess the projects, it does appear that the limited amount of time remaining in the initiative will make it very difficult to have the kind of impact the Foundation would like to have in countries.
  - it appears the money being spent within countries may not be sufficient to have the kind of impact RF would desire, and may be less efficient than desired
- The effectiveness of the work in three of the four global areas, suggests an efficient use of funds in Research and Agenda Setting, e-Health and the Private Sector. In Stewardship and Capacity strengthening, the team has gotten to a very promising place with Join Learning Network; but early explorations such as the Ministerial Academy were less effective uses of funds.

#### Suggestions for Improvement

- Use the good policy influence mapping that the team has done to work with the VPFI to:
  - Set explicit policy targets for the remainder of the Initiative, particularly for UHC (allowing for some flexibility),
  - Ensure that there is a consensus around these targets with the leadership of the Foundation, and what these target requires in terms of grant making.
  - Focus on achieving those targets for the remainder of the Initiative.
- More clearly define the strategy in each of the four target countries around the specific achievable goals – and better articulate how the work in the countries will support the global efforts of THS.
  - Given the late start of the country work, the limited time remaining until the conclusion of the initiative and the limited level of funds available for country work, the scope and objectives of country work should be recalibrated to focus on the most feasible yet significant activities that are likely to create the most value both in that country as well in affecting change in other countries. In particular, it should consider focusing on two of the four target

countries, where they have already shown the best signs of progress, e.g. Bangladesh and Rwanda.

- While THS and RF are viewed by peers and stakeholders as more supportive of local grantees than most, the initiative should take steps to make more clear and increase the involvement of such grantees. It should also ensure that during the remainder of the work is managed in a way that transfers support and responsibility to local institutions.
- The Initiative (or the Foundation) should seek to improve its job of tracking the learnings from every initiative/grant.
  - We would suggest having a database that records in 1-2 paragraphs, a summary of what the project found or created.

#### Discussion of Effectiveness Findings

We did a full ground up analysis of the work of the initiative. Our look at each workstream demonstrated that the activities/grants seemed closely related, that they reinforced each other and that they appeared headed in the direction of achieving desirable change development. But in each case, we saw and heard about opportunities to improve the communication both about the workstream and its relationship to the overall initiative.

### Research and Agenda Setting

In fostering HS Research and Agenda Setting, the team sought to advocate on behalf of a greater research and analytic focus on “health systems” as opposed to a vertical focus.

Within research, the Foundation supported a number of research efforts focused on assessing the relative value of investments in vertical programs vs. horizontal health systems. Notably, the team funded a study of the impact of the scaleup of vertical HIV programs on the underlying health system, showing that under certain conditions, a vertical program can strengthen a health system while in other ways, the vertical program could take attention and reduce the overall effectiveness of a health system. In addition, the team supported a number of conferences and other research on health systems, including the 2008 WHO high level consultation on health systems research. There is some evidence that these efforts have contributed to the continued growth of research on health systems, given the increase in the number of peer reviewed research papers focused on health systems overall. In 2005, Medline tracked 803 papers focused on health systems; in 2008, the number



had grown to 1,132, and in 2009, there were 1,214.

The team invested over \$1 Million on assessing the real drivers of quality health outcomes. The main component of this, “Good Health at Low Cost,” is just now being finished, and so it may be too early to judge the significance of the work. The study was a follow-up to a 1985 Rockefeller funded initiative assessing why some lower income countries were able to achieve high quality health outcomes. Analyzing five different lower income countries with high quality health outcomes as well as following up on the five countries that had been assessed in 1985, the study identified a set of factors – both health system based as well as non-health based (e.g. economic growth, environment, etc) – that appear to correlate with improved health outcomes.<sup>8</sup>

The team invested \$1 Million for the WHO to develop a data tool for analyzing health systems for its Country Health Systems Surveillance program (CHeSS).

In terms of Agenda Setting, the team supported a number of efforts to set a global agenda focused on improving health systems, in particular, supporting efforts leading up to the 2008 Tokyo G8 summit, the 2008 Atlanta meeting of “The Elders,” which agreed that health systems was a priority, and the 2009 G8 Summit in Italy.

Starting in 2009, the team began to focus in particular on trying to set an agenda focused on Universal Health Coverage as a way to better communicate Health System Strengthening efforts. The team distinguished Universal coverage from universal care. The goal of expanding coverage is to foster equitable access and ensure that no family becomes destitute paying for health care. Secondly, there is a belief that the economic incentives of coverage put pressure on the health system to improve -- that when people can pay for access, the stewards of a health system of necessity work to improve in order to provide that paid care and by empowering people to demand better care.

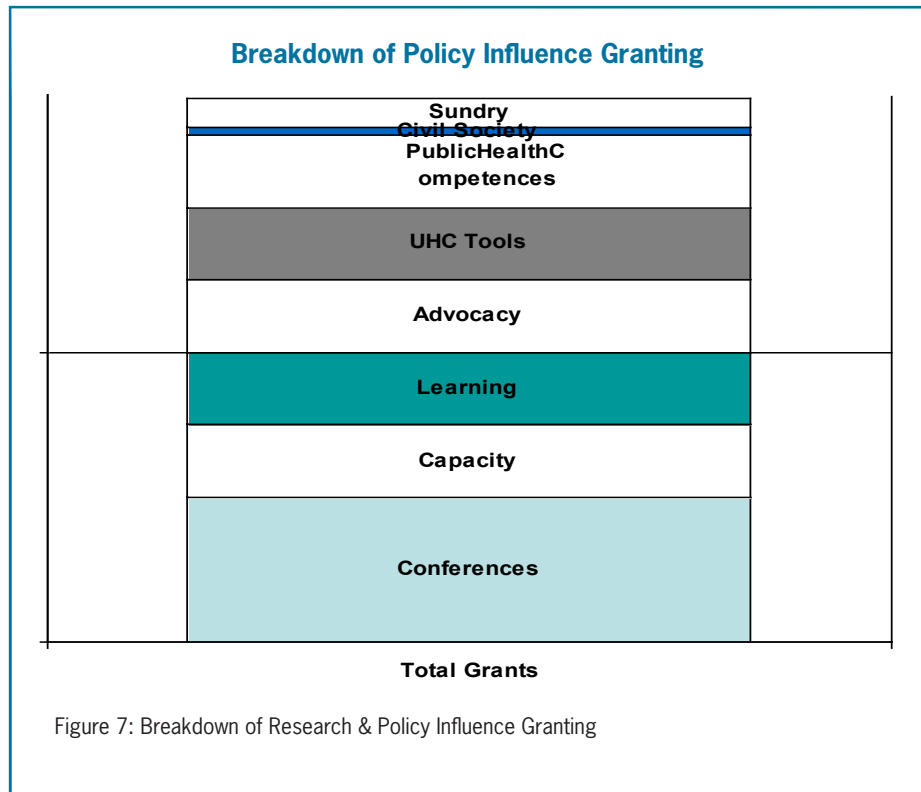
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<sup>8</sup> The factors include:

- The strength of government leadership and the level of support among “elites” for ensuring high quality care across income groups, including developing an overall reform plan, ensuring stepwise approaches to changes and a commitment to responding to the population’s needs
- The strength of bureaucracies and institutions, including autonomy and flexibility, as well as their ability to manage the private sector in health
- The ability to deploy and use scarce human resources in innovative ways
- Improved health financing – while the availability of financing was not as important as expected, it was important in protecting families from the potentially catastrophic cost of health care
- Health System Resilience

The team supported a high level forum at the UN General Assembly on UHC, a large scale study by McKinsey on the cost of Universal Health Care, a forum led by Mary Robinson at the 2010 World Health Assembly and support for the 2010 World Health Report and World Health Assembly, which focus on Universal Coverage. Not all of these efforts studies were equally effective, and some have raised questions about the McKinsey study in particular, but it is clear that there is an increased amount of attention, at the global level, on Universal Health Coverage, and Rockefeller is considering expanding its efforts to advocate for UHC.

As noted above, while there is some concern that the international advocacy efforts do not appropriately leverage RF's comparative advantage, a greater number of stakeholders believed that the team had been very effective in getting their support for UHC, and earlier for the private sector, onto the international agenda.



Still, we did hear some concern that research linked to the international advocacy efforts may have been conducted in a manner that could limit its effectiveness. One person who had been interviewed by the McKinsey team thought that their questions were clearly focused with an eye to their conclu-

sion, and that the team had not interviewed sufficient numbers of people who would be likely to hold an alternative view. This person, who said that they were supportive of UHC thought the studies would be more persuasive if they gave greater attention to the other view. While that is just one view, we thought it relevant given that they were very positively inclined towards the concept of UHC.

Overall, the team has spent roughly \$9Million on Research and Agenda Setting, including ~\$1M on analyzing the impact of Vertical disease focus vs. a horizontal/systems focus, ~\$1.5M on assessing the drivers of health outcomes, \$2M on health care financing, including advocating for Universal Health Coverage, and roughly \$1M on other elements of agenda setting. The breakdown, for spending on the goal of policy influence, is above.

### **Health Systems Capacity**

Early on, the team sought to help improve stewardship of health systems by creating tools for training Ministry of Health officials and for improving Public Health training in the developing world.

The effort to develop a new curriculum for schools of Public Health in the developing world as part of considering developing a “Ministerial Academy” to ensure training of Ministerial officials was curtailed, although the team is still trying to promote improved Stewardship of health systems through its Research and Agenda Setting workstream. The work of developing new curricula for Public Health was half completed. Overall at a global level for both Stewardship and new public health competences, the team spent a little over \$2million.

The focus of the stewardship part of the THS initiative is now just focused in the four countries where RF is doing focused work (Bangladesh, Ghana, Rwanda and Vietnam), and is described later in this document.

### **Private Sector in Health**

The Foundation has so far invested ~\$12 Million in support for initiatives to help manage and leverage the private sector. The team considers the Private Sector important because it delivers up to 80% of the care in many developing countries, but typically operates entirely independently of Ministries of Health and is often not even considered by health authorities as they develop ways to improve health delivery in a country.

The Private Sector work stream<sup>9</sup> began with a set of initiatives designed to assess more about how the private sector works and what the optimal intervention points would be. The research was synthesized into a monograph on “Public Stewardship of Private Providers in Mixed Health Systems.”

The Monograph on Public Stewardship was based on 14 papers funded by the initiative, which focused on:

- Developing new data on the private health sector
- Identifying innovative ways that service is delivered
- Approaches for pooled financing
- Approaches for regulating the private sector
- Purchasing, Contracting and managing the Supply Chain
- Innovative financing and delivery models
- Regulatory capacity in LMIC

As a result of the research and learning behind the monographs, the team focused on

- Garnering additional attention at the global level, for the private sector, traditionally an orphan in global health
- Tracking new innovations in service delivery and financing

Within the private sector, the team has achieved a set of interim milestones suggesting the positive impact of the work.

- Because the research indicated the wide and growing scope of private sector activities, RF decided it was important to track these innovations on an ongoing systematic basis. In July 2009, Rockefeller, together with the Gates Foundation, funded CHMI, “The Center for Health Market Innovations,” which will continue the RF work on tracking innovations in the private sector market. It will help health system stewards learn about new ways of managing and leveraging the private sector, help global funders identify new programs to support, help social entrepreneurs identify new sources of support for their initiatives and enable researchers to continue to track innovations in the private sector in health market. As an interim measure, the fact that Gates decided to jointly support this initiative is consistent with the idea that RF is on the right track in pursuing it.

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<sup>9</sup> The private Sector work stream was the only one that had a separate development phase before execution as part of THS.

CHMI generally received very positive feedback from participants. We did however hear concerns that as of today the CHMI website appears to focus more on the needs of donors rather than the needs of policy makers or developing world health providers to learn about innovations. Indeed, a look at the homepage of CHMI, [healthmarketinnovations.org](http://healthmarketinnovations.org) does, show that it prominently displays both the core funders as well as links for donors, “implementers” and researchers to go for more information. It is less clear where a developing world policy maker or health provider would go to learn about improving their approaches<sup>10</sup>. Our respondent thought that it was important to address these issues in order to ensure that CHMI grow into the kind of developing world resource it should become.

- In May 2010, the World Health Assembly, based on Rockefeller-sponsored advocacy by the Working Group on PSH (convened by RF in 2007) and others, passed a resolution recognizing the importance of the private sector and calling on countries to work more closely with the private sector in managing and delivering health care. While the resolution itself neither changes nor improves health delivery, it is likely to encourage other funding agencies to increase support for private sector initiatives. Should it do that, it would be an achievement of the Rockefeller initiative.
- In April 2010, the Rockefeller team was named as the founding Secretariat of the HANSHEP Alliance [Harnessing Non-State Actors for Better Health for the Poor]. In addition to Rockefeller funding, HANSHEP received support from the Gates Foundation, USAID, The World Bank, and several bilaterals including the UK’s DFID. Indeed, the DFID representative cited the RF published research on the private sector as providing the intellectual foundation for the alliance. Rockefeller’s work in the private sector will now be carried out in larger part with HANSHEP. As with the WHA resolution, setting up HANSHEP is an indication of growing support for the private sector initiative, though by itself it does not demonstrate that the initiative has improved health systems. Still, its establishment suggests the continued “convening power” of the Rockefeller Foundation and that that element of the THS initiative has been on the correct track. Indeed, as one participant explained, ““Rockefeller is the small player and yet they move the whole thing [HANSHEP] forward. The others don’t have the time or aren’t as interested. It is very impressive.”

<sup>10</sup> Unfortunately as well, and clearly not deliberately, a Google search for “Center for Health Market Innovations” comes up the Results for Development and Rockefeller Foundations description of their efforts to set CHMI up higher than the actual home page (which comes up 15th on the Google list). When we mentioned this to Results for Development, they said they would look into the question and also contact [google.org](http://google.org) about the search engine issue.

- And, in 2010, RF helped to establish the Joint Learning Network for Universal Health Coverage of developing country's Ministries of Health to share ideas on moving to Universal Health Coverage, along with other elements of health system stewardship. The participation of thus, far six, countries again suggests the growing support for pursuing the private sector in health, as well as a very good example of south-south learning. As this moves forward, RF will need to decide if it should expand the network, as other countries are seeking to join, and risk turning it into an unwieldy forum, or keep it limited and risk not involving others who could benefit from it.

In one of the interviews, a person who works primarily with USAID – which has been historically alone in supporting private sector initiatives – told our evaluator in an interview, “While Rockefeller has not been solely responsible for the increased attention on the private sector, their work and their voice has been an essential catalyst for getting others in the field to focus on the private sector.”

## Global e-health

The Global e-health workstream has sought to catalyze the creation of interoperable e-health systems for developing countries as well as to enable capacity building within those countries.

The initiative was launched with a large BCG study as well as a number of smaller pilot studies that set strategy for the overall initiative and helped launch a series of Bellagio conferences on the importance of e-health, ways of implementing scalable interoperable systems and the importance of m-health (mobile health).

Initially, the team launched a number of smaller initiatives, which the team considers early searches, such as:

- Support for the eGranary digital library to be a low cost electronic information resource of educational materials, not requiring broadband access to be effective (\$125K)
- Support for the UK Consortium on AIDS, to increase and document the usability of its AIDSPortal, to facilitate knowledge sharing (\$200K)
- Support for a pilot project to evaluate the effectiveness of using a handheld device rather than paper based processes to manage childhood illnesses in Tanzania (\$140K)

Coming out of the Bellagio series, it has pursued a series of larger projects aimed at:

- Advocating for e-health and the importance of ensuring interoperable systems as a way of improving health systems
- Supporting the development of a set of e-health tools, including knowledge sharing, electronic medical records, supply chain management and m-health, ensuring that they are scalable, interoperable and open source.
- Capacity building and ensuring ongoing capacity strengthening in using e-health tools

The funded advocacy activities primarily took place through the six weeks of Bellagio conferences as well as communications following those sessions.

The work on the e-health tools has involved:

- Supporting the Ministry of Health in Rwanda in developing the overall national e-health architecture for the country. This multi-year effort seeks to result in the implementation of scalable interoperable systems for managing patient care.
- Developing and piloting a tool to enable the Rwanda Ministry of Health to track resources and activities in all districts in the country, and linking the results from the tool into their overall planning process to improve stewardship of each district's health system.
- Partially funding the development of an interoperable open source Electronic Medical Record (EMR) using the OpenMRS platform
- Developing tools to enable the management of supply chain systems for all types of health technologies (vaccines, drugs, equipment, etc.)
- Setting up the mHealth Alliance to spur the growth of mobile-based health tools

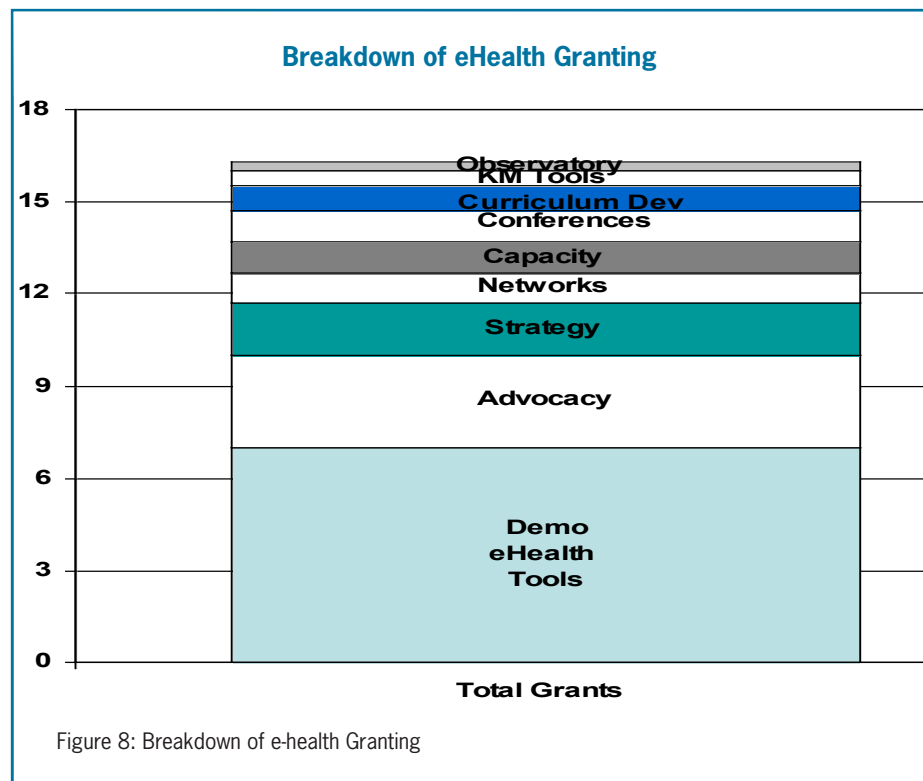
As all these tools are still in the process of development, it is really too soon to assess them. Once they are completed, one will be able to assess, first, whether experts think they are good, second, whether they are accepted by people by being implemented, and lastly, whether they have a measureable positive impact on health systems.

Based on interviews with the people involved in their development, there is substantial support for them and for the strategy involved in developing them.

There is a belief by the people on the ground and in the Ministry in Rwanda, that they can have a transformative effect on the health system.

There is some initial evidence that RF’s convening power has coalesced support for e-health systems, particularly for mobile. Mobile is considered particularly important in the developing world because it is universally deployed. As part of the initiative, Rockefeller helped set up the M-Health Alliance. The alliance seeks to accelerate the growth of mobile health tools in the developing world. Rockefeller has generated support for the initiative in the private sector, and from the foundation and International organization worlds. In addition to Rockefeller, the M-Health Alliance has support from the UN Foundation, PEPFAR (The President’s Emergency Plan for AIDS Relief), the Vodaphone foundation and Palm.

In terms of Capacity Building, the initiative is supporting efforts to build a center of excellence in Rwanda focused on training for Informatics, as well as supporting efforts by the American Medical Informatics Association to create a distance learning program for bioinformatics.



Moreover – in contrast to some other grantees who did complain that too many of the RF grantees were from the “north” as opposed to from the global



south, a number of the ehealth grantees explicitly credited Rockefeller with funding local initiatives, led by local grantees with an eye to developing and demonstrating the value of e-health tools.

The Global e-health strategy is quite clear – building a set of interoperable tools, proving a scalable architecture in one country (Rwanda), implementing those tools in Rwanda and ensuring that there is a training center of excellence in that country – to encourage rollout in other countries. In addition, by setting up the M-Health Alliance, with other sponsors, they have built a position to enable the handoff of the initiative even after Rockefeller has moved on to other efforts.

As one can see from the breakdown of grants targeting the creation of interoperable e-health systems, over a third of the support has gone to the creation and demonstration of e-health tools. A little of \$2M towards Advocacy, not including conferences, and a bit over \$1Million on setting the initial strategy of the initiative. The breakdown of grants can be seen in the chart above (figure 17).

At the same time, interviews with partners and grantees suggest opportunities to focus greater attention on communication about the initiative. Several grantees pointed out that there continued to be a sense among their stakeholders that e-health was not as transformative as RF – and the grantees – believe. The grantees felt that it was important for Rockefeller to focus on improving the communication about the importance of e-health to transform health systems. As one explained, “I find many folks are still skeptical about the importance of e-health in improving health systems. I need Rockefeller to do more to communicate how and why e-health tools will transform health so that I can enlist people’s support in my project.” For example, in one of the interviews, a grantee pointed out that the implementation of a strong interoperable medical record tool can be instantly transformative of a health system, “Currently, almost all the systems in place about practice management or donor monitoring of a vertical program; by putting in a system that tracks patients, we get the medical establishment to think/analyze what is best for the patient, not the donor or the practice.

Indeed, the Rockefeller team themselves have begun to appreciate the need for this communication. They supported a study evaluating the impact of e-health tools that were implemented in Sao Paulo, Brazil. That study (of an implementation that was independent of Rockefeller) found that the impact of e-health was dependent on how it was implemented. In some circumstances, one could implement the system and have a major impact on standardization

of care and improvement of delivery and in other cases, one could have far less of an impact. Given the results of such a study, as well as the opinions articulated by the grantees, it may be important for the team to develop new ways of communicating why and how e-health tools can transform health systems.

## Country Work

This year, the team has embarked on in-country work, in Bangladesh, Ghana, Rwanda and Vietnam, as a way of demonstrating the importance of the initiative's tools and strategies in transforming health systems. A number of interviews did suggest that the team would have been better starting the country work earlier in the process, less for the specific impact, given Rockefeller's resources, that it would have had, but more to build credibility.

### Bangladesh

The work in Bangladesh is focused with an eye towards a country with a very strong "civil society" but a relatively weak government. They are now focused on advocating for expanding health coverage by supporting a center of excellence on UHC, at the local school of public health, as well as by exposing the Ministry of Health to the progress in Thailand and India on expanded coverage.

The team is supporting some training for the Bangladesh ministry of health, to improve analytic and managerial capacity in the government through one of the public sector medical schools, but mainly is investing in ensuring interaction between the Ministry and others around key THS objectives.

In terms of the private sector, the team is supporting improving private medical schools as well as supporting a program to offer micro-credit approaches to health coverage.

In terms of e-health, the team is supporting building an MPH program in e-health, a health informatics training program and an initiative in m-health.

All of these initiatives are just getting underway now. The goals are to increase government capacity to steward the health system, expand health coverage, particularly for the poor, improve capacity to manage and use e-health systems both at the Ministry level, as well as within care delivery, and to improve quality in the private sector.

## Ghana

In Ghana, which has both a strong government and an increasingly strong civil society, the team is seeking to gain further support for Universal Health Coverage, enable the ministry to better leverage the private sector in health and ensure traction for e-health.

Ghana has been expanding health insurance coverage but the growth faces economic challenges. The team is funding a study and working with the Centre for Health and Social Services to assess the economic impact of UHC and identify potential approaches to speeding the move towards it as well as to try to expand capacity in the Ministry of Health to develop Health Policy and improve the management of the private sector. They are building capacity by supporting training and coaching for a group of professionals in the Ministry as well as helping them improve how they leverage the private sector.

The team is supporting the African Center for Economic Transformation to assess ways to ensure the growth of the Ghanaian private sector in health, including equity investments. And the team is supporting planning at the University of Ghana to build a training center in health informatics. In the past, the team had considered supporting Ghana in building a national architecture for e-health, but decided to concentrate its resources in Rwanda.

As the work progresses, it has become clear that, not surprisingly, the progress towards Universal Health Care is not a “straight trip north,” something that was recognized both by the Reference Group panel as well as by grantees on the ground and the RF team. The team is trying to figure out its most appropriate approach, whether it be supporting Ghana in overcoming their hurdles, which a donor of RF’s scale would have enormous challenges doing, or identifying and assessing the lessons of those hurdles, for use by both Ghana as well as other countries considering UHC.

In Ghana, the team had to overcome some hurdles in setting up programs in Ghana. Initially the stakeholders at the ministry were not convinced that the Transforming health Systems initiative was focused on the issues they were primarily concerned with and believed there were other places to focus besides the private sector and e-health, which were not part of the Rockefeller initiative.

Although the activities in Ghana are just now getting underway, they do provide an example of many of the workstreams of THS coming together in a single setting. As the projects progress it would be useful to set up monitoring efforts to see the extent to which the different streams support or each or act fully independently.

## Rwanda

In Rwanda, as noted above, the in-country work has been very closely tied to the e-health workstream, and is described there.

## Vietnam

Vietnam is almost the mirror image of Bangladesh. It has a strong government but very weak civil society. In transforming the health system, the team has sought to leverage that strong government, and help nurture civil society where possible.

To strengthen civil society, RF is funding an initiative to monitor and assess the economics of provider payments. The Health Economics Association is generating data suggesting that the current system of provider payments provides incentives for less efficient and effective care which they will use to try to encourage the government/legislature to change the system and make it more patient focused.

In terms of Research and Agenda Setting, the team is funding the building of a Center for Health Systems Research at Hanoi Medical University as well as supporting other efforts on health economics and building an informatics program at the Hanoi School of Public Health.

Working with the Ministry of Health to improve stewardship, they are conducting a study of the implications of expanding health coverage, ways of better managing the private sector, assessing the needs for hospital management and provincial health planning, and developing approaches for e-health.

To improve care of marginalized groups in rural areas, the team is piloting a project to communicate with rural residents about their health, using SMS and other messaging to mobile devices, working to expand health coverage among those groups.

All these country initiatives are either just now getting underway or still in the planning stages, however, as in other countries, the work in Vietnam will enable the team to monitor how the different workstreams can support each other in helping to transform health systems.

Across the full initiative, while the achievement of measurable milestones in each of the workstreams is clear – and in each it appears they are on track – it is less clear how they will reinforce each other to transform health systems.

Not just the “theory of change” but also the “Results Based Framework” are built around the 3-4 separate workstreams. This has the benefit of enabling each workstream leader to focus primarily on their work and its impact, but

it makes it harder to set priorities for changing and moving budget between one workstream and the other. Moreover, the different workstreams appear to leverage the RBF with differential levels of efficacy. The section focused on Research and Agenda Setting seems to capture very effectively the work of the RAS workstream. The sections related to private sector, stewardship and e-health seem to be seeking to do things slightly different than what an analysis of what is being worked on seems to reveal.

### 3. The Influence, Impact and Resource Mobilization of the Overall Initiative and Key Workstreams

In this area, we looked for intermediate signs that would measure the extent to which the initiative was having the desired impact on health systems, influencing the world of global health and has mobilized resources for the efforts to continue once the five year initiative had ended.

#### Findings

- There are a substantial number of signs that the world of global health is moving in the direction that RF believes is important. Results of interviews suggest that this is in part, at least, due to the efforts of the THS team
  - Global health leaders see the importance of Universal Health Coverage, leveraging the private sector and implementing interoperable e-health systems
  - International organizations and networks are focused on Universal Health Coverage
  - A significant number of countries are embracing the goals of Universal Health Coverage
  - Health system stewards appear to be increasing their attention on the private sector
  - Health systems stewards in the developing world are looking more closely and trying to implement interoperable e-health systems
- There is evidence that RF's focus on the private sector has been embraced by other foundations and bilaterals, both endorsing RF's approach as well as helping to assure its sustainability
- There is initial evidence that RF's approach to e-health – building national information architectures – is being adopted by others, as a number of countries have sought advice from Rwanda, where RF has supported the initial initiative

- In order to help ensure sustainability, RF has built networks focused on the areas of THS focus. These networks include the M-Health Alliance(e-health), the HANSHEP Alliance (private sector), the Center for Health Market Innovations (private sector) and the Joint Learning Network for Universal Health Coverage (UHC)
- RF has successfully gotten international organizations to endorse or support its approaches. The G8 endorsed the concept of strengthening health systems; The World Health Assembly passed a resolution endorsing the need for public health authorities to work with the private sector, and the WHO has issued its World Health Report on Universal Health Coverage.
- There are opportunities to better tie the global networks to work in countries (both THS focus countries and others). The CHMI could make more clear its efforts to try to track and bring innovations from one part of the developing world to another.
- In the THS focus countries, the team is clearly pushing forward on efforts in implementing e-health systems, Universal Health Coverage and stewardship of the private sector and capacity in civil society. The country work has only recently started and so it is harder to assess whether it is on track. There is some concern that the start date of the country work will make it difficult to have the kind of impact on the ground that might have been possible
- There is less evidence that the individual workstreams have supported each other in building and having a strong impact on Health Systems<sup>11</sup>

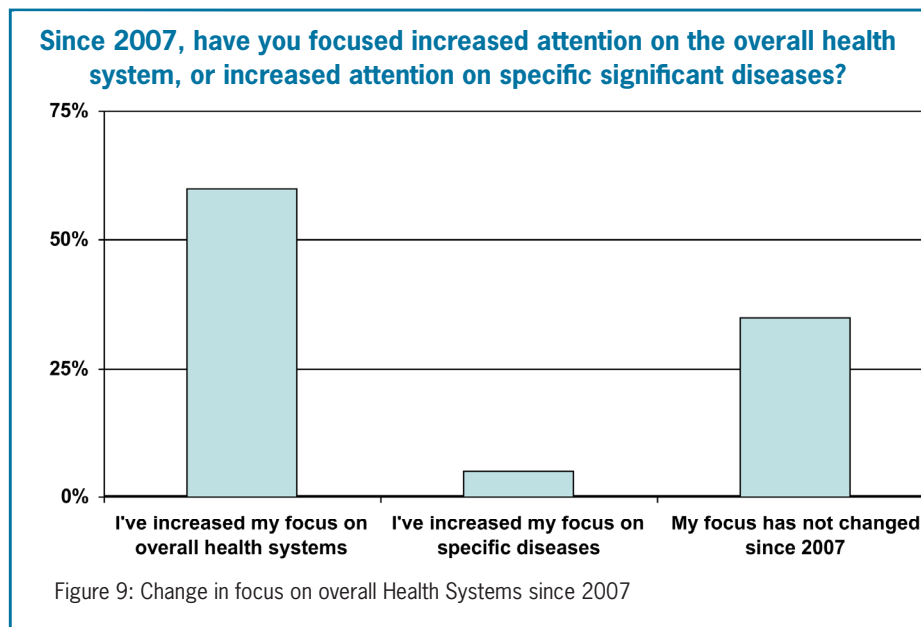
### **Suggestions for Improvement Include:**

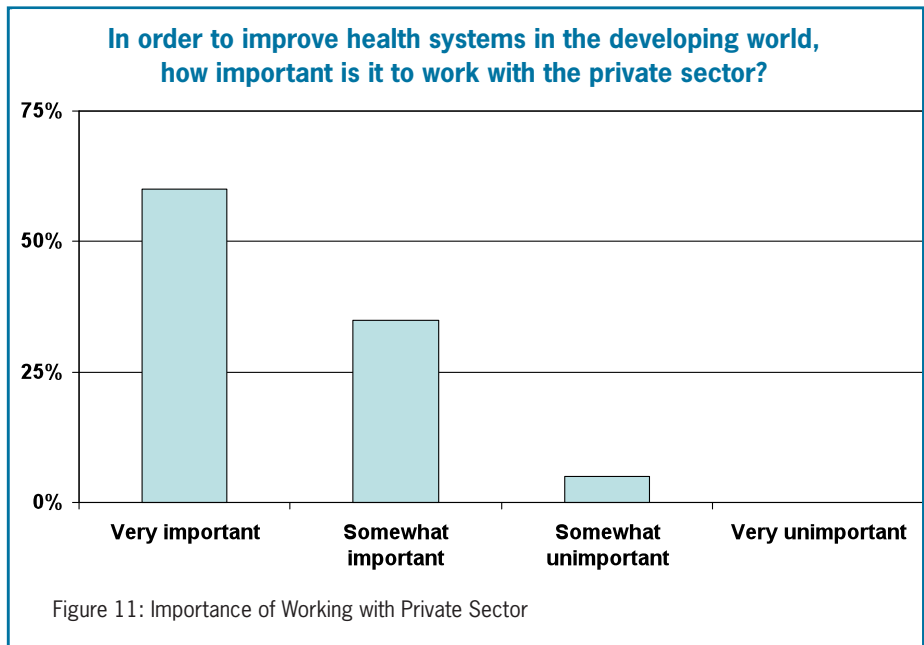
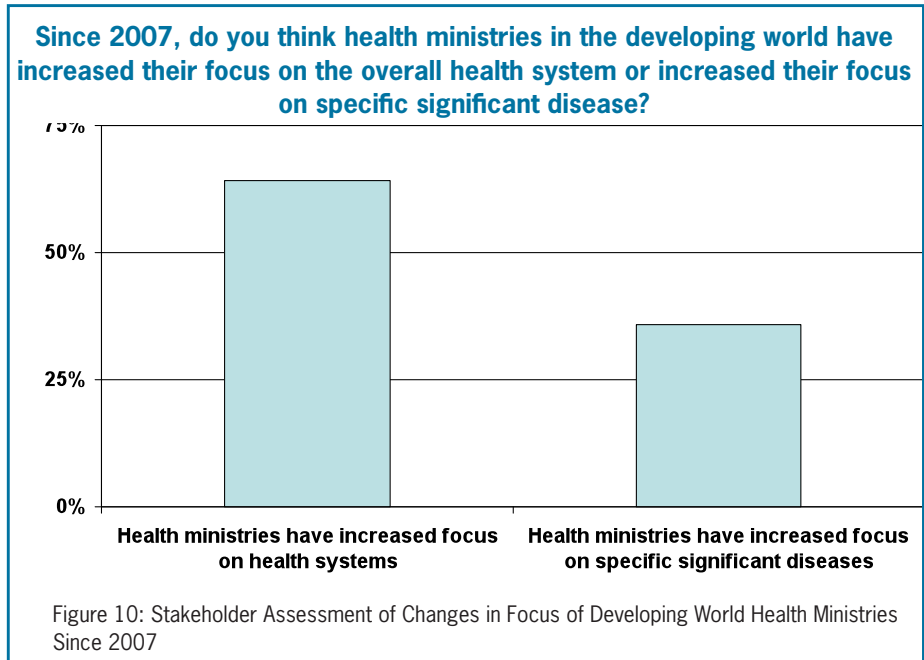
- Continue to build on the positive momentum of the JLN, as a focal point for bringing together, demonstrating and communicating the value of the different components of the initiative
- More clearly define the strategy in each of the four target countries around the specific achievable goals – and better articulate how the work in the countries will support the global efforts of THS.

<sup>11</sup> The team would point to several examples of cross-work stream efforts which have recently launched, including examples of the JLN (which is a combination of Agenda Setting and Capacity Strengthening) and the e-health initiative is developing an effort with the JLN on UHC. We think that a better articulation of the overall theory of change – and how it involves the different work streams – would enable the team to ensure that all of its work more synergistically fits together.

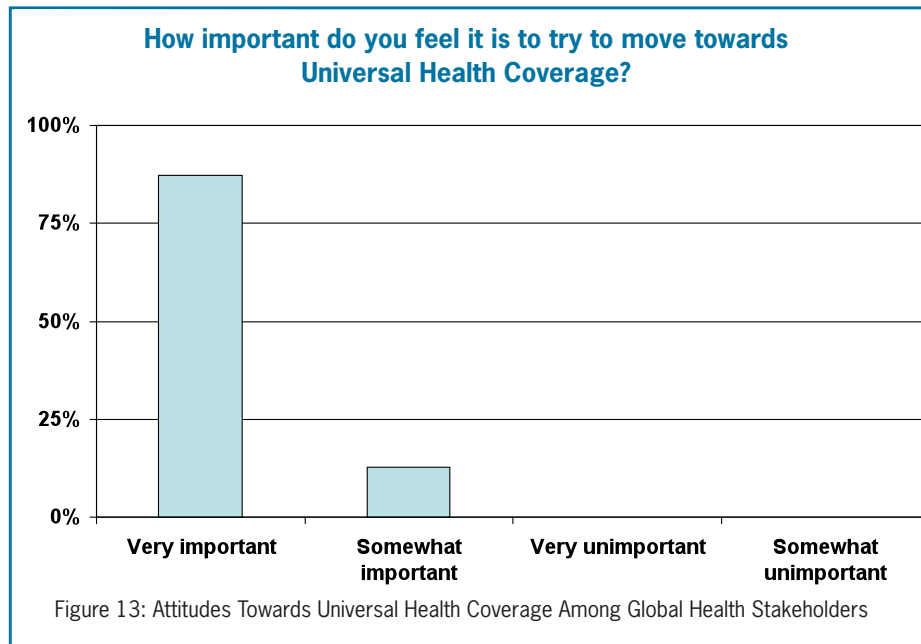
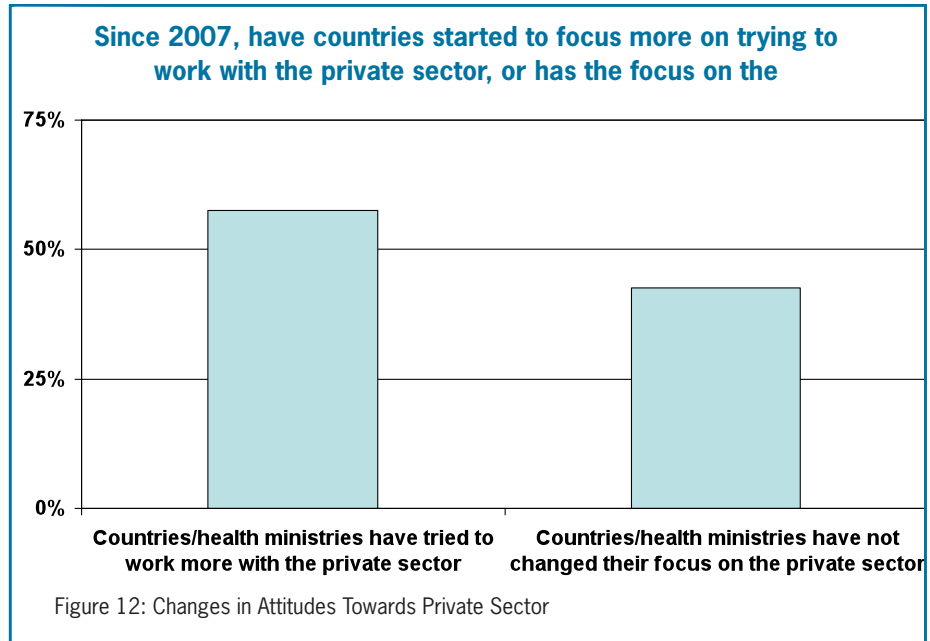
- Given the late start of the country work, the limited time remaining until the conclusion of the initiative and the limited level of funds available for country work, the scope and objectives of country work should be recalibrated to focus on the most feasible yet significant activities that are likely to create the most value both in that country as well in affecting change in other countries. In particular, it should consider focusing on two of the four target countries, where they have already shown the best signs of progress, e.g. Bangladesh and Rwanda.
- Define more clearly the target end points for the final two and a half years, across all workstreams and the overall initiative.

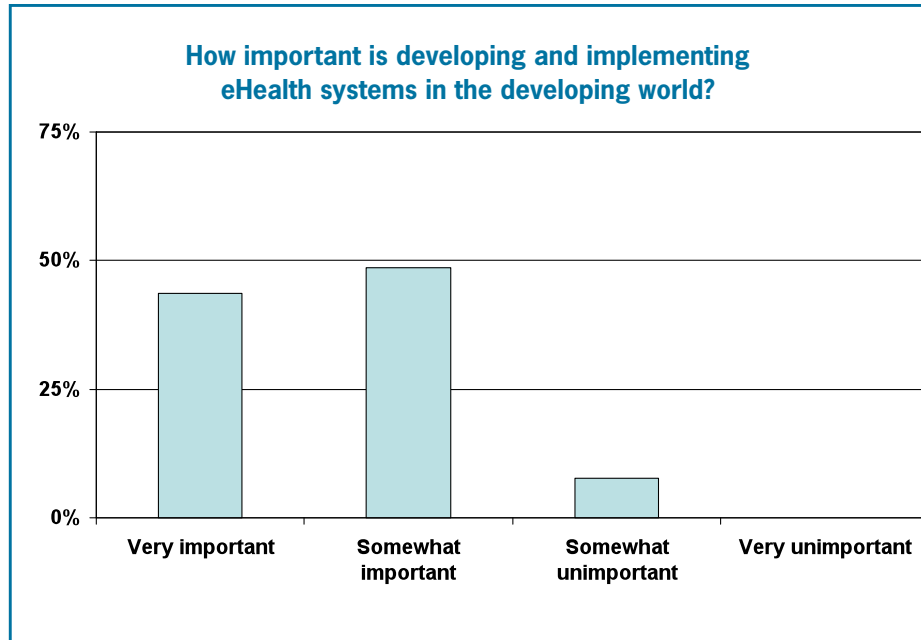
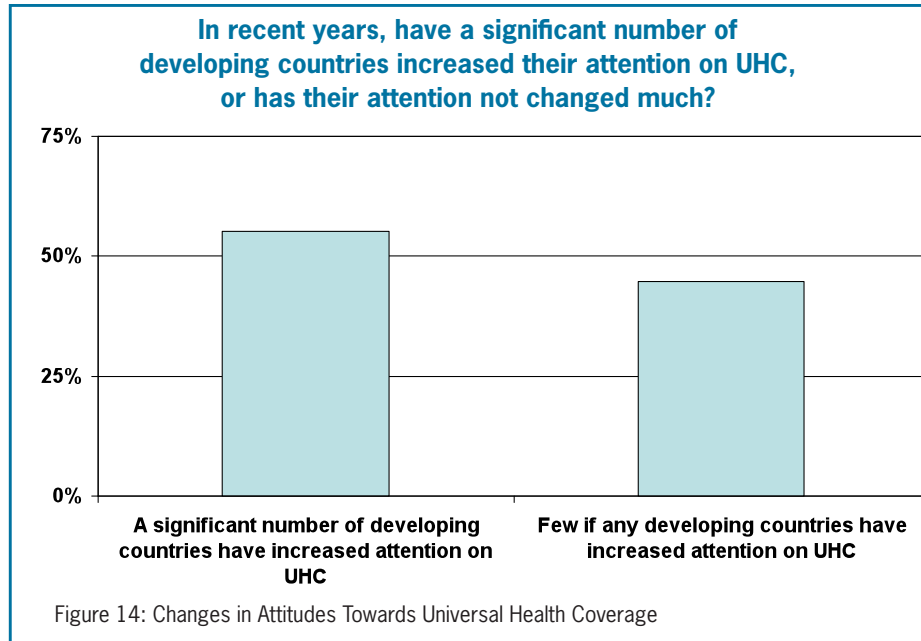
**Results of Survey of Global Health Stakeholders Focused on Potential Impact of THS and Changes in Attitudes in Focus Areas of THS**











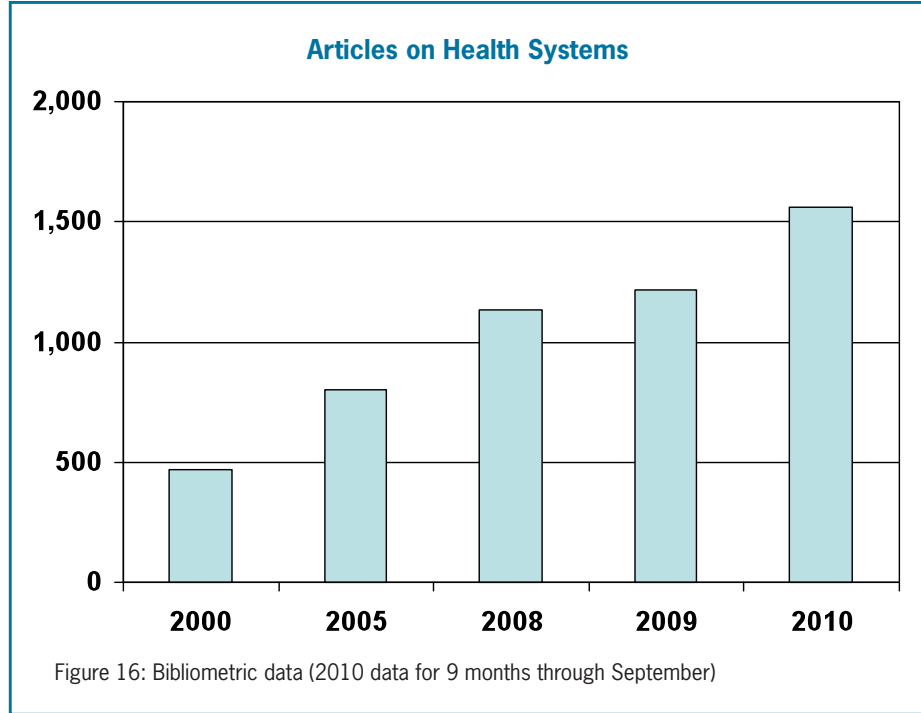
## Discussion of Findings on Impact, Influence and Sustainability

While there are few “end point” signs that Rockefeller’s Transforming Health Systems Initiative has changed individual health systems and resulted in improved outcomes of the target populations, there are many signs that Rockefeller has been effective in transforming the field of health systems and helping to get others to focus more on the areas of high impact that Rockefeller has identified, ensuring the initiative’s sustainability.

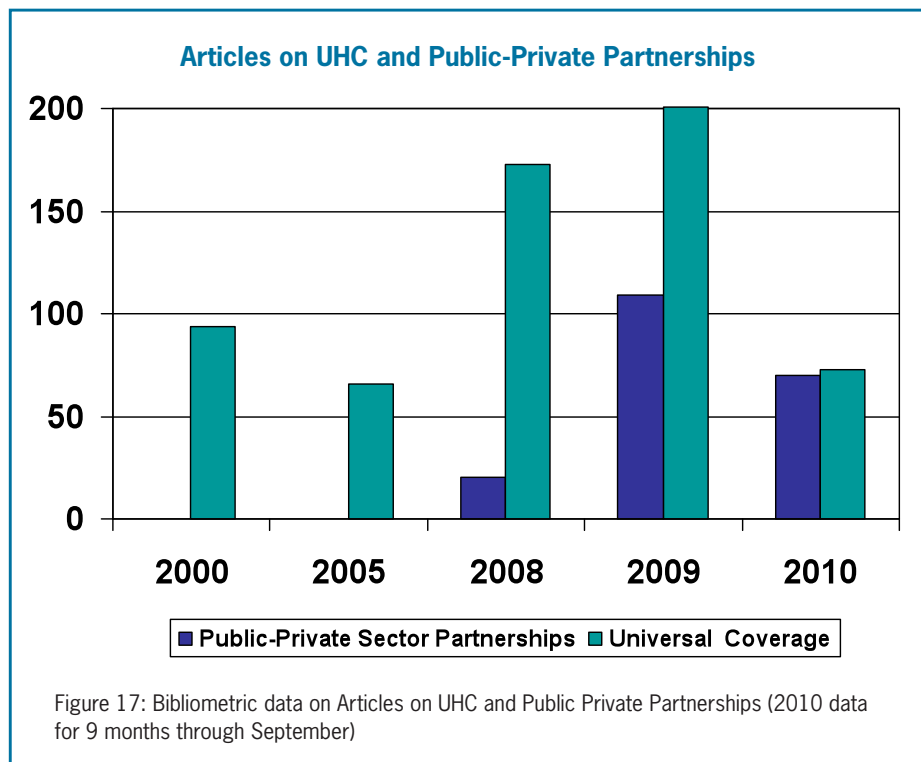
- Attention paid to analyzing health care from the horizontal lens of “health systems” as opposed to the vertical lens of disease treatment
- Recognition of the importance of the private sector in health by both international organizations and from other donors coming together with Rockefeller to establish and ensure greater funding or private sector initiatives
- The attention paid to expanding health insurance coverage and moving to universal health coverage – both at the level of international organizations as well as by regional bodies and countries
- A desire to move to greater use of ehealth tools as a way of standardizing health treatment and making the health system more efficient (and thus able to treat more for the same cost.)

In the survey of global health leaders, we asked people to what extent the developing world health systems were embracing the ideas of THS, and found that in recent years that number has been growing in all the areas of THS focus (See Figures 7-13 above).

Similarly, the level of academic research on issues of health systems has been growing in recent years, consistent with what Rockefeller has been trying to do in the research and agenda setting area.



Similarly, there has been an even more marked increase in papers on two specific areas of THS focus: Universal Health Coverage and building public-private partnerships (The Private Sector)



While Rockefeller has not been the first to promote the importance of the private sector in health – USAID has been very aggressive in promoting its importance for many years – the private sector has clearly been getting traction in recent years, in part due to THS.

- In the spring of 2010, the World Health Assembly, acting at the urging of the Thai delegation, whom in turn had been spurred by the Working Group for PSH supported by RF, passed a resolution calling on member countries' health ministries to work more closely with the private sector in each country to promote better health outcomes.
- A number of donors, leveraging the published research work on the private sector that was Rockefeller's initial foray into the private sector, are coming together to form the HANSHEP Alliance which represents their commitment to continue to fund work on the private sector
- Rockefeller has established the Center for Health Market Initiatives, which gets cofunding from Gates and others, to track and provide tools for developing countries and private sector providers to improve their services.

While none of these three short-term accomplishments necessarily ensure better care for the poor, and while they are not proof that what Rockefeller is doing will eventually improve care, they are an indication that a number of Rockefeller peers have concluded that what Rockefeller has pursued with respect to the private sector is on the correct track.

In terms of e-health/m-health, given the state of current tools, the only way to demonstrate that they work (i.e. improve health systems) and galvanize others to try them is to build them and implement them in a real setting and then demonstrate/measure their quality and impact. As a result, the results in the e-health area are somewhat earlier than the current state of the private sector initiative. At the same time, there are similar signs that others are increasingly recognizing its importance in transforming health systems.

- Rockefeller has established the M-Health Alliance, with support from the UN Foundation, the Vodafone Foundation and Gates, which seeks to mobilize support for innovation in mobile e-health tools. The participation of Gates is significant. Several years ago, Gates himself said that the developing world didn't need new e-health systems, they needed new vaccines, and this year he is giving the keynote address at the M-Health Alliance Annual meeting.
- Rockefeller's support for Rwanda's effort to build a country-wide enter-

prise architecture in e-health has galvanized the attention of a number of countries, including Indonesia, South Africa and others who are now thinking of adopting a similar approach

- The openMRS system (an electronic health record), which is to be the centerpiece of the Rwanda system, and for which Rockefeller funded the creation of the support infrastructure to manage its ongoing open source development, is now being deployed in over 40 developing countries.

Rockefeller has also been effective in gaining attention for Universal Health Coverage – ensuring the coverage of payments for health services. Many observers credit Rockefeller with being the true leader in moving the issue to center stage. Among its accomplishments, the team has:

- Funded and gotten the WHO to focus the 2010 health report on Universal Health Coverage.
- Helped set up the Joint Learning Network for Universal Health Coverage, which is allowing five countries – and considering expanding – to share learnings from their efforts to move to Universal Health Coverage.
- Seen a number of countries move closer to embracing Universal Health Coverage as a goal. In recent weeks, for example, the Indian Prime Minister, announced the establishment of commission, to investigate the viability of India moving to Universal Health Coverage. The commission will likely receive support from RF and is headed by a Rockefeller grantee who had been earlier been funded by Rockefeller to investigate the viability of different health financing efforts.
- Convened a Global Task Force on UHC (just announced in Montreux as this report was being finalized) which includes the WHO, World Bank, UNICEF as well as NGO and LMIC champions.

In our interviews and from the Reference Panel, we heard generally strong support for Rockefeller’s advocacy efforts on Universal Health Coverage. Still, one of the panelists, Laurie Garrett of the Council on Foreign Relations, was vocal in saying that international advocacy was not part of Rockefeller’s comparative advantage and it should not focus in this area. Others, including someone from the World Bank, thought that Rockefeller was actually quite good in the area – and cited the support RF gave which resulted in the passage of the World Health Assembly Resolution on the private sector. All other interviews who discussed RF’s efforts on UHC gave credit to them for helping to make the issue more prominent. Indeed, one grantee we interviewed, whom

we sought out because their project had had a challenging reception at RF and had not received additional funding, specifically credited the team on their success in making the UHC issue important.

#### 4. Sustainability

In this area, we assessed where the initiative is in terms of ensuring its ongoing sustainability

##### Findings

- The launch of the HANSHEP Alliance and of the Center for Health Market Innovations suggest other donors are in the process of stepping in to increase their work on the Private Sector, with up to \$40M pledged to date.
- The institutionalization of the openMRS medical record platform, through the Regenstreif Foundation, together with evidence that other countries are beginning to learn from the Rwanda experience, provide initial evidence of the sustainability of the e-health efforts
- The World Health Report focused on Universal Health Coverage, together with the number of countries either launching or evaluating UHC initiatives, suggest the sustainability of the Agenda Setting workstream
- The M-Health Alliance which has seen over \$20M in commitments from other donors, on top of the initial grant of \$1.5M by RF

Two and a half years into the Initiative, there are clear signs of sustainability in the establishment of a set of partnerships or institutions. In order to move from signs of sustainability to true permanence, the team should use the next two years to ensure that each of these partnerships deliver real examples of achievements or value so that the stakeholders involved see the value of continuing to participate. Thus,

##### Suggestions for Improvement include:

- Ensuring the institutionalization of the various partnerships – CHMI, HANSHEP, M-Health Alliance, the Joint Learning Network for UHC, etc, by seeking to identify specific changes and impacts coming out of each one

- Continuing to focus on assessing the value of UHC – as well as focusing a clear light on the challenges that any country moving to UHC will face – and therefore help ensure that the country will seek to overcome those hurdles<sup>12</sup>
- Seeking to institutionalize the value of an enterprise architecture such as that being developed in Rwanda either through the JLN (which is more focused on UHC) or through the establishment of a similar network.

## 5. Capacity Strengthening

In this area, we assessed the capacity strengthening initiatives, which get the largest amount of funding, of the three main Rockefeller Outcomes.

### Findings

- The team has embarked on several different types of Capacity Strengthening initiatives, developing tools for stewardship and UHC, ensuring South-South learning (networks), Curriculum Development to help set up Centers of Excellence, funding developing world scientists for research and to attend conferences and Strengthening civil society.
- While the largest segment of support has gone to tools development, for example, research on regulation of the private sector, the tools to develop an enterprise architecture, it is not fully clear how the tools can best be implemented and used by Ministries of Health.

### Suggestions for Improvement include:

- Define capacity strengthening in the context of health systems, and articulate a strategy for ensuring either that capacity is built within the life of the Initiative or that projects are launched that will continue to build capacity beyond the five year time frame of the Initiative.
- Investing in making more explicit the tools for managing the private sector – to enable them to be used in other capacity strengthening efforts
- Better ensuring that the value of the tools get realized by developing world providers and policy makers

<sup>12</sup> At the team retreat following the completion of this report, the team articulated a hypothesis that a decision to move to UHC – and restructure the financing of a country’s health system to include risk pooling – would in fact cause resulting benefits in health system performance as the system sought to respond to the increased demand. This “demand-based” hypothesis or “theory of change” should, obviously, be a key component of work on UHC in the future

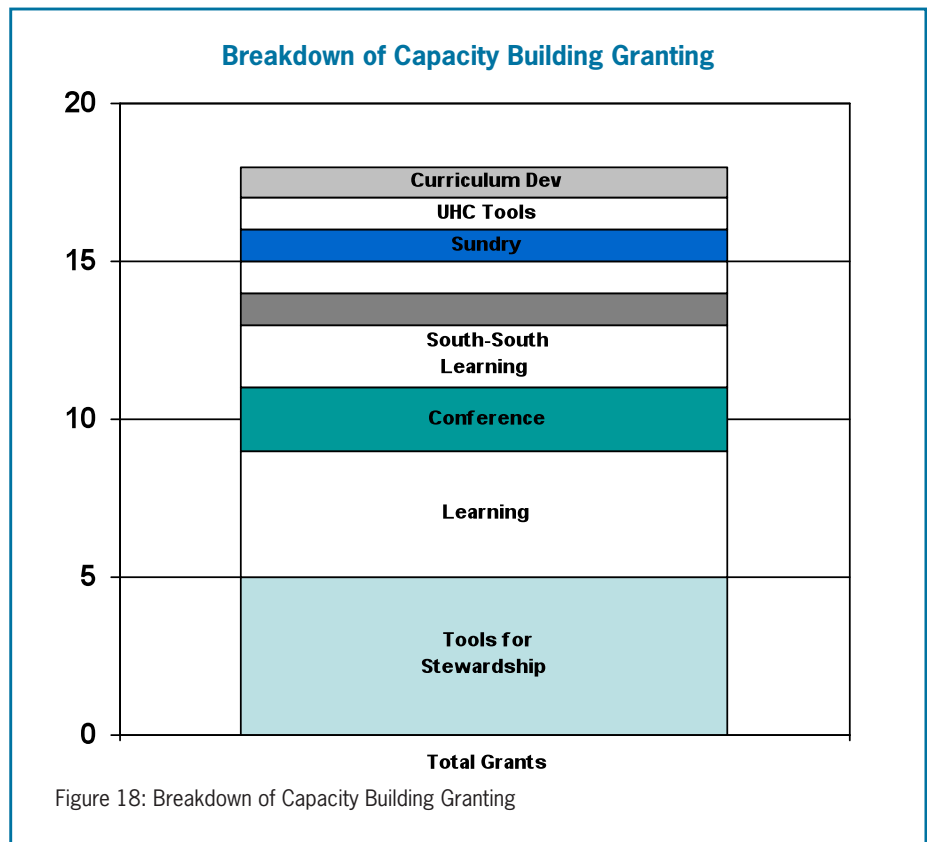


### Discussion of Findings Focused on Capacity Strengthening

Each of the workstreams is engaged in capacity strengthening activities, in different variations:

The initial focus on public health schools to build new Public Health Competences and potentially a “Ministerial Academy,” was shifted. Instead, capacity strengthening at the Ministerial Level has been focused on the JLN and at the country level in one of two ways:

- Funding Ministries to send professional staff to a separate training program
- Conducting research to identify new tools for managing and regulating the private sector
- Capacity efforts in Research and Agenda Setting is primarily done through funding research by developing world scientists (in a few cases) and by supporting conferences that include professionals from the developing world



- Capacity efforts in e-health are primarily focused on designing curriculums and trying to set up informatics centers of excellence in various countries, notably Rwanda and Vietnam.
- Capacity efforts in civil society are done primarily by funding research programs to be conducted by civil society groups.

The different approaches to capacity strengthening become clear when looking at the Capacity Strengthening grants that the team has supported. In the chart above (figure 18), we see the scale of different approaches, within the \$19Million of Capacity Strengthening support that RF has provided. Based on our assessment of the outputs of the initiatives and interviews with the grantees, we think that many of the “capacity strengthening” projects may not be optimally grouped in the same area. For example, the development of research on the importance of the private sector and the development of a curriculum to build a center of excellence in informatics are both worthwhile initiatives, but we are not sure they should both be grouped under “capacity strengthening.”

There may be opportunities to standardize the team’s approach to Capacity Strengthening – or explicitly decide that they are leveraging different approaches and articulate them as such. A number of interviewees suggested that Capacity Strengthening is a very ambiguous term and that the team should very carefully consider using different terms for different approaches. In particular, the team might consider:

- Investing in making more explicit the tools for managing the private sector – to enable them to be used in other capacity strengthening efforts
- Better ensuring that the value of CHMI and other tools get realized by developing world providers and policy makers.
- Standardizing the approaches for measuring capacity strengthening

## 6. Effectiveness in Working Externally with Grantees

In these areas, we assessed the effectiveness of the THS team both in how it supported and managed grantees as well as how it functioned as a team. We leveraged RF’s own foundation wide assessment of its grant management processes and our interviews with all current and former team members as well as with grantees

## Findings

- The THS team – in fact the RF team, as many grantees and partners had worked across RF – gets very high marks for its management, support and value added provided to grantees.
- The THS team is seen as very hands on and seeking to maximize the value created by any one project – in contrast to other foundations, which are seen more as ‘managing a portfolio.’ Most grantees find the “hands on” approach very valuable; while a few do feel that they would like more independence. Partners (including donors) are impressed by the level of hands on attention RF provides.
- The vast bulk of grants appear to be being made to projects that clearly link to the RF strategies, though in only about a quarter of the cases are those links made explicit in the grant memo.
- A large number of grantees would like increased communication about what other grantees are doing for RF – and how they might coordinate with them, while most grantees feel they are part of a larger initiative than just their project<sup>13</sup>.

## Suggestions for Improvement include:

- Explicitly deciding if RF likes its positioning as the “hands-on” foundation – and leveraging it further, if that is how it wants to operate
- Building a more formal process for communication among grantees. The team should build on its approach for communicating the strategy and learnings of the initiative and the foundation with its grantees, peers and partners, including holding more side sessions and learning events with grantees and partners, and disseminating written briefs on the Initiative.
- The Team should focus on improving its process for capturing, analyzing and sharing the learnings – findings, demonstrated hypotheses and accomplishments – from major clusters of significant grants.

## Discussion of Effectiveness Findings

In terms of working with and managing grantees, the THS team received very positive feedback, and in the areas where the feedback was less positive, it

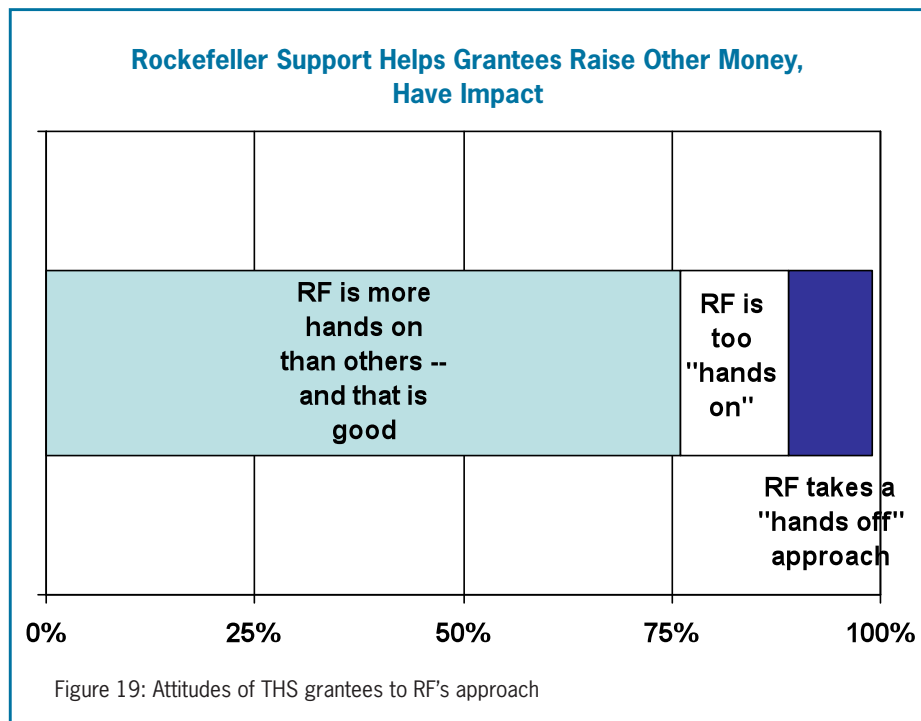
<sup>13</sup> The new RF website will likely facilitate this.

seems the team may be doing exactly what Foundation leadership wants them to do. At the same time, the team should consider if it wants to do more to ensure optimal coordination among grantees, evaluate the implications of the large concentration of grants in a few grantees and consider ways to improve the process of gathering and leveraging “learnings” from each grant and using them to feed back into the overall process.

Internally, as a team, the group should try to use efforts to improve communication about the initiative to improve their internal management, as well as continue to work on improving team dynamics.

Grantees almost universally speak positively of the working relationship with Rockefeller.

- “This is not a conventional donor relationship. There is much more interaction about ideas and what we and they can bring. Other donors are much more focused on their portfolio rather than maximizing the value of each project.”
- “I love working with RF [and has received funding from outside THS as well]. They are very good to work with. They are willing to take risks. RF takes their convening power very seriously, and others should try to do the same [citing Gates].”
- “They feel like a collaborator, unlike other grant officers at other foundations who are constrained by their bureaucracies. They have a far greater ability to be flexible when needed.

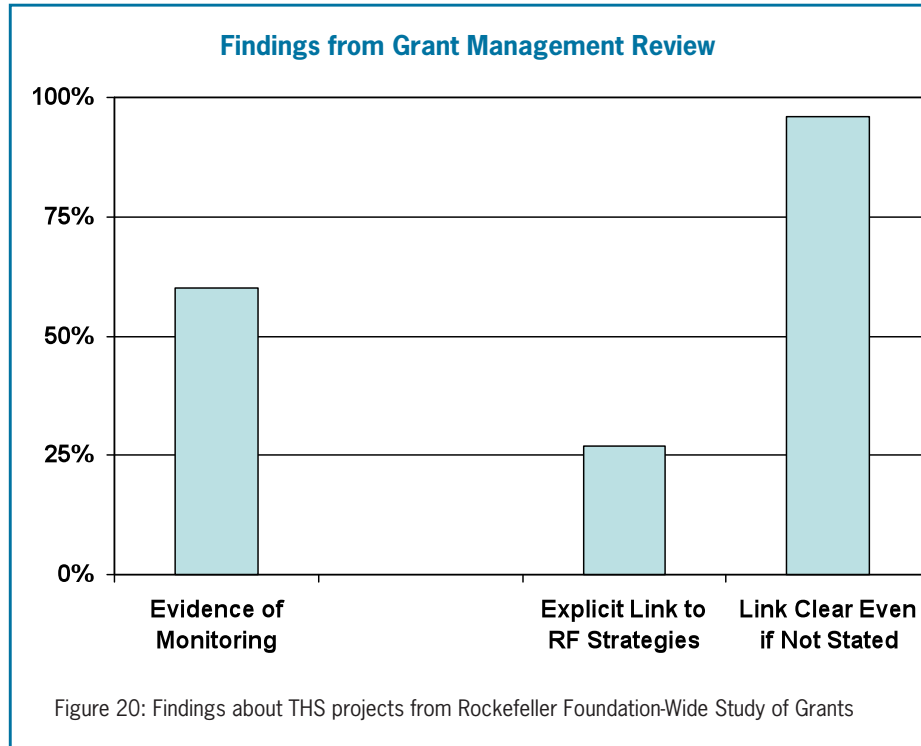


Rockefeller is generally perceived as being more hands on than other donors. Indeed, 90% of the grantees interviewed spoke of how hands on Rockefeller was, and the 10% who said a variation of “they left us alone” tended to be small grantees who were getting funded for a conference or support for a publication. For 75% of grantees, Rockefeller’s hands on approach was seen as a positive. For 15%, it was perceived somewhat or fully negatively. One explained “there is a ‘not invented here’ syndrome, that all the ideas have to be their ideas;” another pointed out that it was often difficult to get the team to see a different way of doing things.”

Our sense is that the Foundation leadership is or should be pleased that their teams (and we heard this from grantees who had also worked with non-THS teams) are perceived as “hands on.” Indeed, one of THS’s donor partners, expressed strong admiration for the way the team had interacted with their co-grantees; as he said, “they’re a lot more hands on than we are.” We believe that has something to do with the vastly larger amount of funds that the partner needs to provide annually; but even so, RF leadership may want to consider if that ought to be an explicit part of the role of their Managing and Associate Directors.

At the same time, there is some evidence of an ability to increase monitoring of grantees. In the overall Rockefeller Foundation evaluation of monitoring approaches, the team found that in only 60% of THS grants, was there clear evidence, in the grant files that monitoring was being conducted, which is somewhat inconsistent with the level of “hands-on involvement” that the interviews found, but may be a function of heavy involvement at the start of a project, and lesser involvements as the project proceeds to conclusion.

Moreover, it was clear to the Grants management project that the projects aligned well with the overall RF strategies. While only about a quarter of the grants plans explicitly linked the project to one of the goals, the Grants Management team found an implicit link in 95%, as is seen in the chart below.



Roughly a third of the grantees expressed a desire for greater communication about the overall initiative and what other grantees were doing. A number cited the Gates Foundation which has a web site for all grantees summarizing what each is up to and enabling grantees to see where their project fits. As one person said, “I’m not totally sure how my effort fits with other efforts in e-health, private sector etc. Ariel and the Board should write a two page summary of their vision of health systems.” Another, a recent grantee in one of the countries, said “I don’t know about other efforts in this country. It’s not a problem now, but if I haven’t met them by next year, then it would be a problem

## 7. Effectiveness in Working Internally as the Team

In this area, we assessed the effectiveness of the THS group as a working team. We based our findings on interviews with all members of the team – current and past.

### Findings

- While everyone on the team is proud of the work they are doing, there are signs of stress within the team, which appear to come from more than just the expected differences of opinion that are inevitable in any group of high powered individuals.
- While everyone on the team believes in their workstream, many do not see how the workstreams fit together as a whole. They express a desire for greater coherence in order that they can plan their own workstreams better.
- This is particularly important given the multi-location of the team and the fact that program officers are not assigned to the initiative full time.

### Suggestions for Improvement include:

- Use the rearticulation of the overall theory of change and the Results Based Framework of THS to ensure that everyone on the team feels their work ties together as a group.
- Continue to work on improving team dynamics by further empowering team members to lead and manage specific aspects of the THS Initiative.

### Discussion of Team Effectiveness Findings

Internally, there is a need for improved team coordination and team dynamics.

Though everyone on the team believed strongly in the value of their particular work and workstream, there was some frustration expressed about the opportunity to better articulate the overall vision of the initiative. Some blame is placed on the history of how the separate initiatives had been brought together. But people could see value in a better articulation. As one person put it, “If I had a better understanding of what we were trying to do in Transforming Health Systems, I could do a better job identifying grants that truly fit with overall goal.”

In addition to making it harder for individual officers to set priorities, it makes it harder to explain – and thus assess whether leadership decisions to shift funds from one stream to another are appropriate steps or arbitrary fiats.

While the team is clearly doing good work, there appears to be an opportunity for the team to improve its overall dynamics. There is less dynamic creative tension – which typically improves output – than one might anticipate, particularly given the apparent success of the work to date. In meetings I’ve attended there is less give-and-take than one would anticipate. There is a tendency to view document and output requests as “corporate requirements” rather than development and management tools. Of greatest concern, some people on the team put a high stock in not confronting differences of opinion, while others resent decisions made that are not first hashed out in public.

This manifests itself in several suboptimal ways.

- Too much of the overall communication and overall documents needs to be written by the team leader, who presumably knows slightly less about each different workstream than the workstream leaders themselves.
- There is less opportunity to improve the communication of the hypotheses and results of each of the initiatives than one might hope
- Differences of opinion that need to be resolved sometimes do not get discussed in an appropriate forum
- Leadership decisions get perceived as arbitrary fiat rather than appropriate. [There is no way to know for sure if a given decision is appropriate or arbitrary if it’s not full vetted in discussion with the group.]

Interviews with team members, outside Rockefeller staff, grantees and observers, we’ve heard various explanations for the sources of the tension. Some blame management skills of the participants, other say it is a function of the difficulty foundation/academics have in working in groups where decisions need to be made as a team rather than individuals getting a particular budget and then deciding how best to use it in granting, others say it stems from challenging interpersonal dynamics given the personalities in the group.

Everyone on the team is aware of the challenges and has been receiving appropriate coaching. We believe it is essential to keep working with the team to seek to improve the dynamics. In particular, we think the team should

- Continue working with team coaches
- Set itself a challenge to try to work as a group on the revised theory of change – and to not allow any one individual to take the sole lead in its development
- Refocus on the tool of the “Results Based Framework” – and seek to ensure that it aligns with the actual work of each of the work streams



D. Analysis of the portfolio of activities of the THS initiative, aligned against measures or interim signs of impact

In this area, we assessed the portfolio that the THS initiative had pursued, to align different streams of work – and specific grants – with actual deliverables or impact. The goal was to understand both patterns of granting – and whether there were implications to the pattern as well as to identify questions of “value for money” if any.

### Findings

- The THS initiative has spent about \$46 million grants in pursuit of its main strategies or workstreams – Research and Agenda Setting, Enhancing Capacity for Stewardship, Harnessing the Private Sector and Leveraging interoperable e-health Systems.
- The grants have been in pursuit of three core RF outcomes: Universal Health Coverage is accepted as a feasible and desirable goal, Capacity for stewardship is built, and Interoperable e-health systems, Public Private partnerships & International networks are developed. Roughly \$8 million has been spent in pursuit of the leadership agenda, \$22 million in capacity building and \$16 million in building innovation, tools and partnerships.
- Each of the workstreams, with one exception, has achieved a clear set of interim milestones or indications that it is on track, as described above.
  - The one exception is Strengthened Capacity for Stewardship. RF had to change its strategy early in the project and now the bulk of the focus on capacity strengthening resides in the country initiatives. To the extent that the team wants to continue to focus on Stewardship, they may want to revisit the earlier challenges and identify how they will now overcome them.
- The different workstreams and subworkstreams are arrayed below against the outputs and achievements of each.
- Roughly 5% of the projects accounted for 40% of the total money provided. Many of these very large grants appeared to be “contractor” type grants where the grantee is in fact managing several sub-grantees. While there are many good reasons for those kinds of grants, RF may want to be more explicit about them, particularly so it can better link outputs to amount invested.
  - The team may want to review these grants to ensure that they were as efficient as possible

- It was difficult to identify the set of specific learnings and outputs that had come out of particularly projects – although many projects had resulted in a specific published output. RF may want to track more explicitly the “output” and value created/learnings from each particular project
- The nine largest grantees accounted for roughly \$22 million, or almost half of the overall grant support to date. It is straightforward to align these grantees against the achievements provided in order to assess “value for money.”

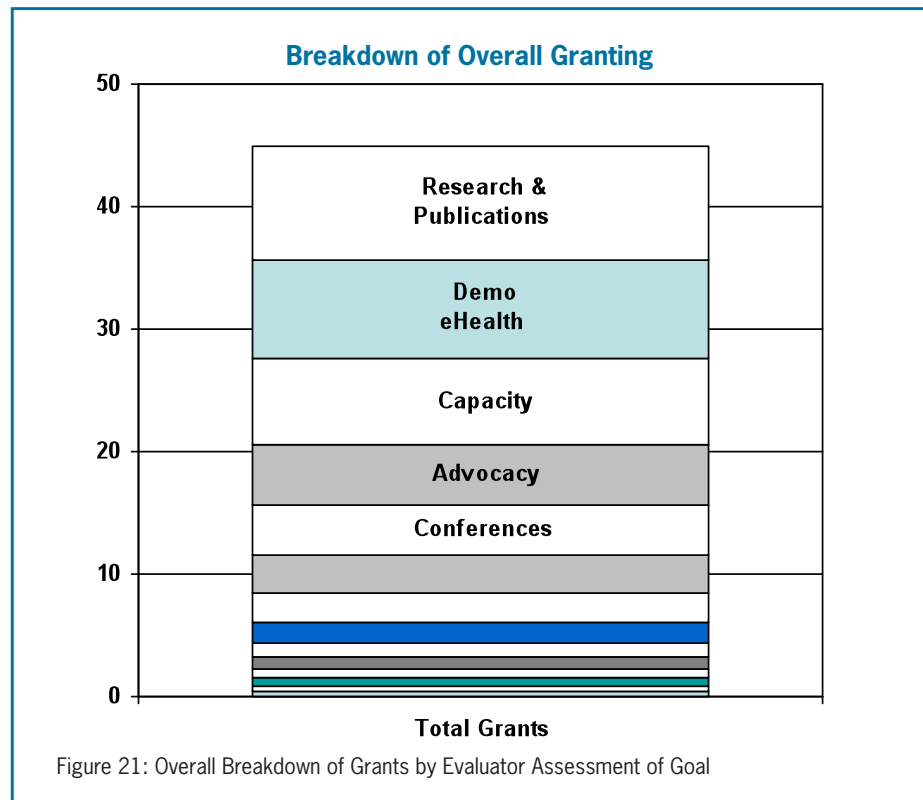
### **Suggestions for Improvement include**

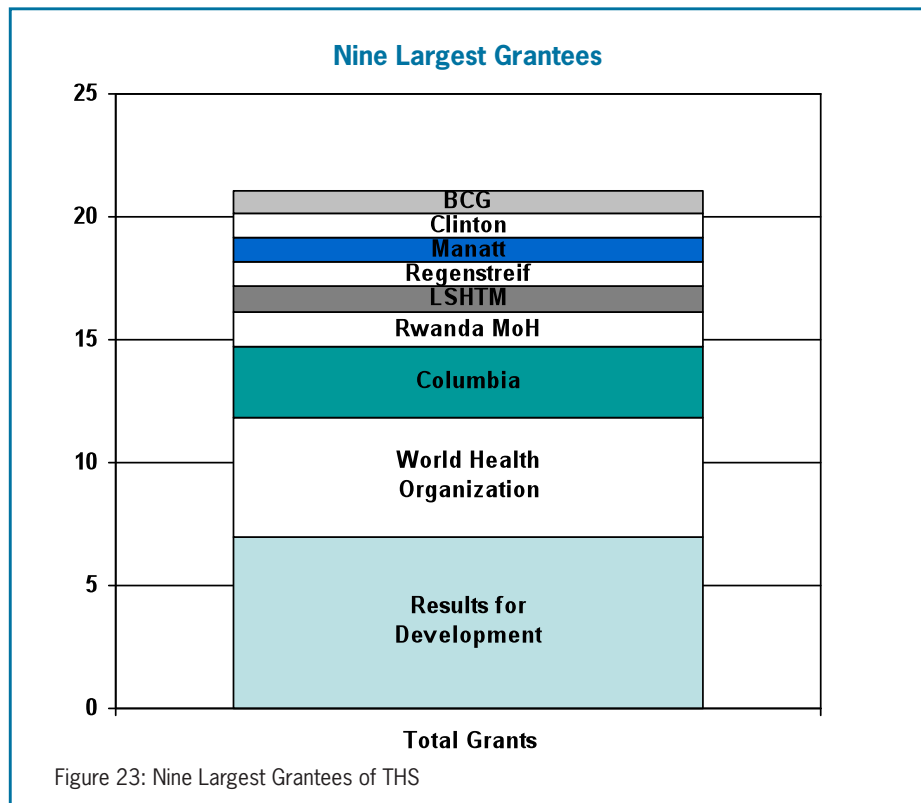
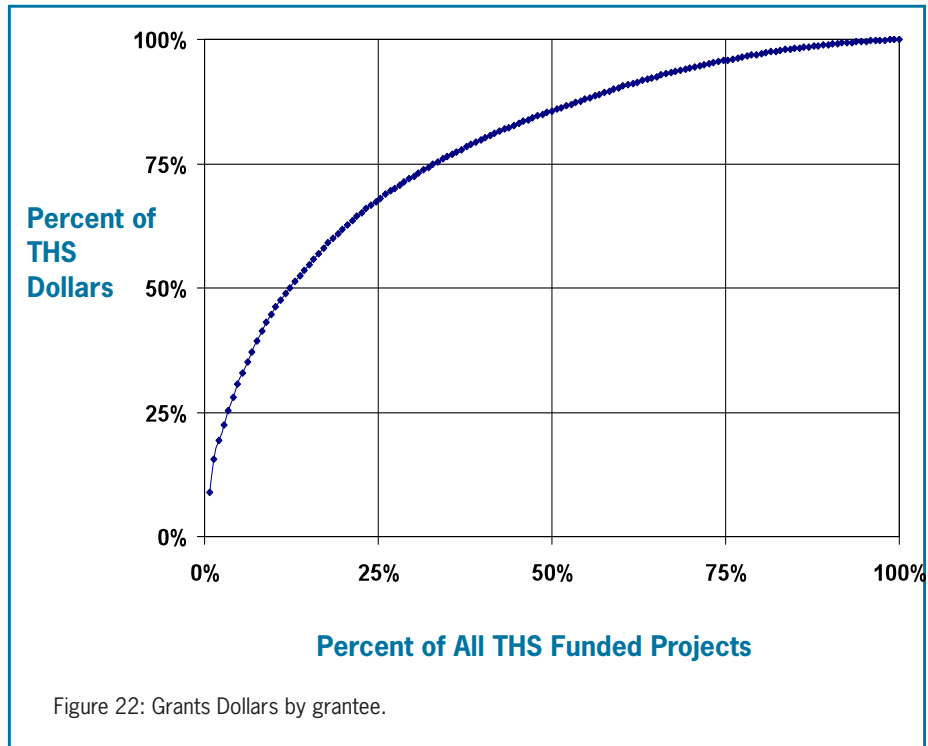
- Make more explicit the specific learnings of each of the projects – ensuring 1-2 paragraph descriptions of findings and accomplishments of each, in order to better be able to track inputs and outputs
- To enable a transparent approach to the management of large grants, the Initiative should clarify the specific management roles and responsibilities for each major component of large grants and ensure these are integrated into the grant database systems.
- Improve the data systems for capturing ongoing information related to the outputs and outcomes of its Initiatives.
- In order to improve the management of “intermediary” grants, the Foundation should improve its data base systems and knowledge capture processes to to enable tracking, monitoring and reporting on progress towards deliverables and learning from each of the multiple components of an intermediary grant.
- Even though a project may be a single grant, the foundation systems should enable different components to be managed by different officers and draw from different budgets.
- Consider adopting a formal review process for each of the largest grantees to assess and ensure effectiveness
- In the remaining 2 years of the project, the team will want to focus very clearly on reaching key milestones in the following areas:
  - Expanding its efforts in UHC and ensuring successful implementations where it is being tried. While the team will globally focus on setting a UHC agenda, it will want to monitor very closely the countries that are starting to implement it.

Ghana, one of the THS focus country, had earlier embarked on a UHC program, but it reportedly is having some implementation challenges. While Ghanaian UHC was not an RF initiative, any problems in Ghana will likely make the global agenda setting harder. The team will want to focus on Ghana either to make sure the implementation is successful, or to learn key lessons that can be applied to other countries.

- Taking CHMI, the JLN for UHC, HANSHEP and the M-Health Alliance and seeking to make the more permanent, effective and sustainable institutions
- Ensuring a successful outcome of the architecture initiative in Rwanda, so that it can become a true showcase of the value of the RF e-health approach
- The team will want to ensure that it devotes sufficient resources to make those goals real

### Analysis of Portfolio Review





In analyzing the portfolio, we found a small number of “grants” accounted for the bulk of the spending. The graph in figure 22 shows the number of grants on the x-axis as well as the cumulative percentage of total spending. As it indicates, roughly 5% of the grants accounted for 40% of total spending. A deeper drill down into those specific grants suggested that many of them were “contractor” or “intermediary” type grants where the grantee was also managing a number of sub-grantees, often with the consultation of the initiative team. This is a frequent practice among foundations, as often the “contractor” is responsible not just for their piece but for the supervision of the other grantees. Still, we think the foundation would benefit from greater visibility, perhaps even in Atlas – of all the grants and the subgrants, even those not specifically representing a direct Rockefeller Grant.

While the grant process review identified a very strong sequence of very strong projects resulting thus far in intermediate signs that each work stream is moving forward effectively, there are opportunities for the initiative to benefit more efficiently from the learnings of each project as they move ahead. Indeed, in the Foundation wide analysis of grantee management, only 6% of available paper deliverables was extent in the Foundation files for THS. In terms of particular learnings, for example:

In the private sector workstream, the findings from the initial research were used as the intellectual foundation for HANSHEP Alliance, yet it was not clear how closely the team was using those findings to build on its own work.

In e-health, the evaluation of the impact on health outcomes and health economics of the implementation of the Sao Paulo e-health system indicated ways in which ehealth can help health systems – but also ways in which they would have limited benefit. There are opportunities to ensure that the learnings from that study are captured and leveraged in the overall initiative, but it is not fully clear what the process is for the team to put those results back into their planning process.

The team has invested one million dollars in a study of “Good Health at Low Cost,” while the study is still in draft form it still seems that there are opportunities for a better process to leverage the learnings into future planning.

It strikes us that every completed grant should have a 1-2 paragraph summary that clearly articulates what was learned or not learned as part of the study.

We retrospectively analyzed each specific workstream and sub-workstream as well as each of the grants. That work, together with the specific high level milestone it has achieved or appears on track to achieving is summarized below

## Rockefeller Foundation Transforming Health Systems Initiative

Workstream	Funds to Date	Key Milestones to Date
Research & Agenda Setting	\$ 9M	
Advocacy for HS research/ Analysis of impact of Vertical/Disease vs. Horizontal/ Systems view	1.5	Increase in attention on Health Systems
Assessment of drivers of health outcomes	1.5	Aug 2010: Good Health at Low Cost Identification of characteristics of health systems in lower income countries that have better outcomes
Development of tools for HS research	3.0	In progress
Advocacy for UHC	2.5	Increased numbers of countries exploring expanded coverage
Support for Insurance programs	0.4	Clear evidence of global support for UHC
Health Systems Capabilities	\$ 6M	Global work has now been moved to be pursued in the four countries of focus
Stewardship	0.75	Work on Stewardship development has now been moved to Countries
Public Health Competences	1M	
South-South Learning	4M	Launch of JLN for UHC
Workforce	0.1	
Global e-health	\$16M	
Advocacy for GEH/Bellagio	4.5M	Growth in importance of e-health Assessment of lessons of e-health – Sao Paulo study not as clear as one might prefer Adoption by Rwanda of strategy to develop national architecture Convening of other countries interested in leveraging the Rwanda experience Launch of M-Health Alliance Launch of openMRS central platform
Development and Implementation of Tools (Architecture, Knowledge Management, EMRs, m-health, supply chain)	8.0M	Development of tools in progress Demonstration of interest from Rwanda as well as some other countries
Knowledge Management	1.3M	
Capacity building & enabling ongoing capacity building in GEH	2.2M	Launch of programs imminent
Private Sector in Health	\$12M	
Research and Learning on regulating/ managing private sector	3.2	Overall study identifying approaches for managing private providers of care
Advocacy for PS	1.3	Resolution passed by WHA supporting need to work closely with
Convening donor support for PS	1.7	Launch of HANSHEP Alliance & roughly \$20 million of annual support for the private sector
Innovations in Private Sector/market	5.3	Launch of CHMI
Country/Integrated Work	\$3-4M	Focus of countries/Underlying rationale
Advocacy for HS view		Initiatives launching now
Stewardship of Health systems		
Demonstration of integration of initiatives		

Only nine grantees accounted for almost one half of the total funds, as seen in figure 23. For many of these grants, it is very clear that there is solid evidence of successful partnerships, however, we would suggest a formal mechanism for reviewing the progress of the specific grantee, as opposed to the overall initiative. For simplicity, we aligned the largest grantees against key milestones achieved and delivered:

Grantee (including Agents)	Funds to Date	Key Milestones Achieved
Results for Development	\$7M	Achievements of the Private Sector workstream as well as the launch of the Joint Learning Network for UHC
World Health Organization	4.8	Increased attention and support for UHC, including World Health Report on UHC
Columbia University	2.9	Support for Capacity Strengthening as well as sundry projects on e-health & Health Systems
Rwanda MoH	1.4	Development of Enterprise Architecture for e-health – and identification of other countries interested in pursuing strategy
LSHTM	1.1	Identification of Key Drivers – Good Health at Low Cost
Regenstreif	1	Institutionalization of the OpenMRS medical record platform, ensuring its use in over 40 developing countries
Manatt	1	Support for advocacy for e-health and UHC
Clinton Foundation	1	Development of planning tool for Rwanda MoH
BCG	0.9	Strategy for pursuit of e-health

## E. Recommendations for MidCourse Corrections

Both the THS team and the overall Rockefeller Foundation should justifiably feel pride in what the team has or appears on track to accomplishing in “Transforming Health Systems.” At the same time, there are a number of mid course corrections that both the team and the foundation ought to consider to better ensure the overall effectiveness of this and other initiatives. We highlight here the most important ones, that one might consider ensuring a process to monitor ongoing progress in the correction.

1. Clearly refine the articulation of the “Theory of Change” of the initiative and the “Results Based Framework” to align with the TOC – better reflect how it is going to be transformative and how all the workstreams will or do fit together. Ensuring clarity of the overall strategy will both improve team dynamics as well as enable external donors and countries to learn and leverage the overall lessons of the THS initiative

During the Reference Panel, and in subsequent conversations, a number of ideas were raised which the team can consider:

- a. Trim a set of activities from the initiative to better focus on a few core areas
  - b. Rearticulate the theory around improving the overall “intelligence” of a health system – and creating the essential tools for stewardship
  - c. Rearticulate the theory of change around the results of the “Good Health at Low Cost” study findings, which fit with some of the essential elements of THS
  - d. Unpack the initiative into its component parts, as they had been at the time of initial launch
2. Define more clearly the target end points for the final two and a half years, across all workstreams and the overall initiative.
  3. More clearly define the strategy in each of the four target countries around the specific achievable goals – and better articulate how the work in the countries will support the global efforts of THS.
    - a. Given the late start of the country work, the limited time remaining until the conclusion of the initiative and the limited level of funds available for country work, the scope and objectives of country work should be recalibrated to focus on the most feasible yet significant activities that are likely to create the most value both in that country as well in affecting change in other countries. In particular, it should consider focusing on two of the four target countries, where they have already shown the best signs of progress, e.g. Bangladesh and Rwanda.



4. Continue to build on the positive momentum of the JLN, as a focal point for bringing together and demonstrating and communicating the value of the different components of the initiative
5. The Initiative should clarify and make more explicit how its specific tools in e-health areas will result in improved systems and outcomes
6. Use the good policy influence mapping that the team has done to work with the VPFI to:
  - a. set explicit policy targets for the remainder of the Initiative, particularly for UHC (allowing for some flexibility),
  - b. ensure that there is a consensus around these targets with the leadership of the Foundation, and what these target requires in terms of grant making.
  - c. Focus on achieving those targets for the remainder of the Initiative.
7. While THS and RF are viewed by peers and stakeholders as more supportive of local grantees than most, the initiative should take steps to make more clear and increase the involvement of such grantees. It should also ensure that during the remainder of the work is managed in a way that transfers support and responsibility to local institutions.
  - a. Define capacity strengthening in the context of health systems, and articulate a strategy for ensuring either that capacity is built within the life of the Initiative or that projects are launched that will continue to build capacity beyond the five year time frame of the Initiative.
8. Use the rearticulation of the overall theory of change and the Results Based Framework of THS to ensure that everyone on the team feels their work ties together as a group.
9. Continue to work on improving team dynamics by further empowering team members to lead and manage specific aspects of the THS Initiative.
10. The team should build on its approach for communicating the strategy and learnings of the initiative and the foundation with its grantees, peers and partners, including holding more side sessions and learning events with grantees and partners, and disseminating written briefs on the Initiative.
11. The Team should focus on improving its process for capturing, analyzing and sharing the learnings – findings, demonstrated hypotheses and accomplishments – from major clusters of significant grants.

12. To enable a transparent approach to the management of large grants, the Initiative should clarify the specific management roles and responsibilities for each major component of large grants and ensure these are integrated into the grant database systems.

Similarly, there are a number of steps that the Foundation can take coming out of this study:

1. Sharpen the “theories of change” that initiatives use to define themselves and the operational management tools that Initiatives use to implement and monitor their work.
  - a. Align the different components of Initiatives with
    - i. A more explicit development approach that underpins the work of the Foundation – (defining more equitable growth, in particular)
    - ii. Identifying the underlying assumption or theory of cause and effect that is at the heart of an initiative
    - iii. Setting the overall strategy and identifying more clearly annual milestones that are likely to be achieved
    - iv. Putting in place operational management tools to assist managers and VPs to oversee the work – workplans, dashboards,
    - v. Holding teams’ “feet to the fire” to ensure that they are explicitly articulating what they are trying to do and the progress they are making so as to ensure that – at the “15,000 foot level” there is a full understanding of the strategy of an initiative and alignment between the strategy and the workstreams
    - vi. Increasing the demand and opportunities for teams to capture learning and report on progress so that there is real purpose in tracking the work.
2. Consider having outside groups, such as the Reference Group involved in this evaluation, help guide the development of an initiative strategy as well as to monitor and evaluate the ongoing progress of initiatives.
3. Improve the data systems for capturing ongoing information related to the outputs and outcomes of its Initiatives.

4. In order to improve the management of “intermediary” grants, the Foundation should improve its data base systems and knowledge capture processes to to enable tracking, monitoring and reporting on progress towards deliverables and learning from each of the multiple components of an intermediary grant.
5. Even though a project may be a single grant, the foundation systems should enable different components to be managed by different officers and draw from different budgets.
6. Consider adopting a formal review process for each of the largest grantees to assess and ensure effectiveness

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## Appendix A: Project Terms of Reference

### Terms of Reference and Scope of Work Mid-Term Evaluation of the Rockefeller Foundation's Transforming Health Systems Initiative (THS)

#### Introduction

This document provides an overview of the Scope of the Mid-Term Evaluation of the Rockefeller Foundation's Transforming Health Systems Initiative (THS) to be undertaken during the period of May- September 2010.

#### Purpose and Objectives of the Evaluation

**The purposes** of the mid-term formative evaluation are learning, mid-course correction and accountability:

1. Learning from the first three years of THS grant making and testing the THS hypothesis and Theory of Change in order to make mid-term course corrections and/or improvements in the implementation of THS for the remainder of the Initiative (2010-2013)
2. Accountability to the Board of Trustees of the Rockefeller Foundation for the funds invested in the THS Initiative.

**The main objectives** of the mid-term formative evaluation are:

1. To assess the ongoing relevance and rationale of the underlying hypothesis and “theory of change” of the Initiative that better health systems performance and the expansion of universal health coverage can measurably improve the health status and financial resilience of poor and vulnerable populations. This includes taking into account the results of the THS Strategy Soak.
2. To assess the effectiveness of the Initiative in delivering its outputs and in making progress towards achieving its outcomes in the first phase of execution (2007-2010). This includes assessing achievements, influence, challenges and lessons from the THS initiative at global and regional level.
3. To assess the quality and quantity of the outputs to date of the Initiative in relation to the desired outcomes of the Initiative.

4. To assess the cost effectiveness and efficiency of the Initiative in using its resources wisely to achieve its outputs and outcomes.
5. To make recommendations to the Foundation on mid-term course corrections in the global and country strategy, management of the execution of the Initiative, including grantee and country engagement, relationship management, team management, and resource management and allocation, forward looking linkages with other Initiatives of the Foundation and its key partners.

### Context for the Evaluation

In 2008, the Board of Trustees of the Rockefeller Foundation approved \$100 million in support for the THS initiative with the aim of achieving policy change, stewardship capacity, partnerships, and technological innovation. The desired impact of the THS Initiative is that *the health status and financial resilience of poor and vulnerable populations are measurably improved as a result of better health systems performance and the expansion of universal health coverage, defined as access to appropriate health services for all at an affordable cost.* , The Initiative seeks to achieve the following outcomes:

#### **Outcome Area 1 – Leadership and Policy influence**

Health System Strengthening is prioritized and Universal health coverage is accepted by key global forums as a feasible and desirable goal and policy framework and is adopted and successfully implemented by a growing number of countries in Asia and Africa.

#### **Outcome Area 2 – Capacity Building**

Capacity is built in selected THS countries for the development of robust stewardship of health systems, including public and private components.

#### **Outcome Area 3 – Innovation and tools, and Partnerships**

Interoperable eHealth systems, supported by new global public-private partnerships and networks, are developed, deployed, and used in selected THS countries to improve quality, access, and affordability of health services.

## Strategy Overview

The THS initiative stemmed from a belief that while health spending had increased dramatically around the world, access to affordable, quality services had not, particularly in developing countries. Achieving good and equitable health outcomes for poor people around the world depends, in part, on the performance of health systems—networks of organizations, people, and government entities with the primary intent of promoting, maintaining, or restoring health.

Historically, global health focused on disease and population-specific programs, while health systems were neglected. This resulted in weakened stewardship of health systems, dysfunctional service delivery, and inequitable financing, especially for poor people. Many in under-resourced areas have no access to health services, millions are impoverished by catastrophic personal health expenditures every year, and quality care is considered a luxury. While the challenge of creating high-performing health systems is universal, the problems are especially acute in developing countries, where nearly 10 million children and over 500,000 women die every year from addressable causes.

Yet as globalization advances, new technologies and demographic, epidemiologic, and economic shifts are transforming health systems in countries around the world. There is a window of opportunity to promote strategies that steer this transformation toward better health outcomes and financial protection through improved health systems performance and the expansion of universal health coverage in low- and middle-income countries.

The Rockefeller Foundation's Transforming Health Systems (THS) initiative was developed to catalyze system-strengthening activities that create broader access to affordable health services in developing countries. The initiative includes both global and country-specific work. At the global level, the initiative focuses on research and agenda setting to generate the evidence needed to elevate the profile of health systems on the global agenda and promote concerted action by the international community. At the national level, Rockefeller supports cross-cutting and synergistic activities in selected sub-Saharan African and Southeast Asian countries that can serve as demonstration projects for replication and expansion.

Like all systems, health systems are complex and holistic—not just the sum of its parts; and the parts are also similar to other organizational systems which include governance, human resources, financing, technology, etc. THS does not take on every component of health systems; while important, THS does

not build hospitals, develop millions of clinical cadres, or provide drugs and vaccines for particular diseases. Instead, THS focuses on strategic levers with potential for catalytic transformation and impact.

## STRATEGIES

The team identified four strategies where they thought that RF could both make a difference and have an impact on the long term goals of improving the health status and financial resistance of poor and vulnerable populations:

- **Fostering health systems research and agenda setting.** There has been a lack of attention and funding for health systems among key donors and technical agencies, and universal coverage is considered unaffordable even in the United States. Evidence is needed both for advocacy and to enhance health systems performance. The Foundation is promoting increased attention and funding of health systems among key donors and technical agencies to focus on more research, better policies, and larger funding flows to support integrated health systems work and the costs of transitioning to universal health coverage in low- and middle-income countries.
- **Enhancing professional capacity for health systems stewardship.** Developing countries have weak capacity to collect, analyze, and use health systems data to plan and manage high-performing comprehensive HS. The Foundation supports training activities that build capabilities at the ministerial, academic, and professional levels in targeted countries to promote stewardship of health systems and to improve those nations' capacity to collect, analyze, and use data to plan and manage high-performing health systems.
- **Harnessing the private sector as an important component of health systems.** In the developing world, 75% of health spending takes place in the private sector, which is a potential hub of innovation but which is largely neglected by ministries of health and donors. The Rockefeller Foundation supports the development of models that harness the private health sector in the financing and provision of health services for poor people, directly or by enabling more technical assistance and funding flows to these models, as well as by fostering better public stewardship of mixed health systems.
- **Leveraging interoperable eHealth systems in the Global South.** As connectivity is leapfrogged in Africa through wireless and fiber-optic networks, and before we see the emergence of a jungle of incompatible eHealth applications, there is a window of opportunity to create interoper-



able eHealth systems (not silos). The initiative promotes the design and implementation of interoperable eHealth systems by supporting national planning and policies, developing common models that can be shared among countries, strengthening capacity in the Global South for eHealth, and supporting new and existing networks working in this space.

Of the total \$100 million, \$18.5 million in grants were awarded during the development phase of the Initiative in 2007-2008, and another \$30 million have been awarded so far in the execution phase of the Initiative (2009 – 2011).

Annex 1 provides an overview of grant making at global and country level, and by outcome area.

### **Audience and Users of the Evaluation**

The Evaluation is commissioned by the President of the Foundation and the Managing Director of the THS Initiative, and managed by the Foundation's Evaluation Office.

The primary audiences for the evaluation (i.e. those who are expected to act on the findings and recommendations) are the President, the Board of Trustees, the Executive Team and the managers of the THS Initiative.

### **Key Performance Areas - Evaluation Questions**

A detailed Evaluation Matrix will be developed with the Evaluation consultant to expand upon the following set of key performance areas and evaluation questions:

**Relevance**, including ongoing rationale, niche, role, comparative advantage and value added of the Initiative.

**Effectiveness** – an assessment of the results of the Initiative to date, including:

- The changes or outcomes that have occurred
- The quality and utility of the products and services provided.
- The extent to which the Initiative built capacity at the individual and institutional level globally, as well as initial indications of capacity building in selected THS countries.

- The degree of influence that the Initiative has had on policies, public discourse, and practices in the fields of public health and development.
- The extent that the various THS workstreams are geographically and/or thematically complementary.

***Cost effectiveness - efficiency*** - an assessment of the use of resources to obtain results (time, funds, skills, core competencies).

- The extent to which the Rockefeller Foundation is using good management and governance practices in THS, and whether those practices are providing good value for money. This area covers 1) the management practices of the Initiative such as: strategy and planning of the Initiative, resource allocation, management and leadership, relationship management with grantees, peers and partners, use of core competencies (innovation, convening, partnerships/networks); and 2) the extent to which the Foundation's Executive Team, Operations and other RF units are providing adequate support (or not) for the Initiative Team.
- Management of the grant portfolio – selecting the right grantees, developing a strategic portfolio of grantees, assessing capacity, developing and supporting the delivery of results, use of and accounting for resources, monitoring, evaluation and learning, and knowledge management (lessons learned, sharing of information, knowledge).

***Influence and impact*** - an assessment of the influence that the Initiative has had at global, regional and country levels on policies, and where possible an assessment of the extent to which THS has contributed to, or directly affected improvements in the lives of poor and vulnerable people within the broader population served by the work of grantees.

***Sustainability*** - the extent to which the Initiative has developed both financial and/or institutional supports to continue the work started by the Initiative. This will assess the extent to which:

- The efforts (outputs and outcomes) of the Initiative are embedded in ongoing practices of individuals, institutions and communities.
- There is an explicit exit strategy for the Initiative that creates a high probability of the main outcomes of the Initiative continuing beyond Rockefeller Foundation funding.
- Expanded partnerships exist for scaling up the work, and sustaining the Initiative beyond the Rockefeller Foundation's support.

## Sub-questions

The sub-questions that were included at the time of Board approval will be refined, revised and integrated into the detailed Evaluation Matrix as the first step in the evaluation. The original sub-questions include in the Board approval document were:

- Agenda setting, Consensus building, Data gathering
  - How much do RF-introduced tools & research approaches have the potential to transform health systems to improve overall health and to track both systems performance & improved health?
  - To what extent do Global Health decision makers focus on improving integrated performance of public and private health systems to improve health outcomes for poor & vulnerable?
- HS Training Network
  - To what extent are RF capacity building programs being used?
  - What are the attitudes of people who participate in them (immediate, at 6months)?
  - How are people who participate in programs changing how they work?
  - What impact is it having?
- Ministerial Network
  - Are global professional networks being formed, seen as useful?
  - Are intermediation tools being developed, seen as useful, being used to exchange information & facilitate support of high performing players in non-state sector?
  - How much are standard setting groups being used/set up to focus on eHealth/ information exchange?
- Fostering Collaborative Networks
  - How many country level demonstrations have been set up?
  - What has been their impact within their area, country? Are they providing the evidence that is needed?
  - How many others are looking at demonstration results for roll-out?

### Intermediate Outcomes(Years 3-5)

- Health Systems a Global Priority
- To what extent have global health leaders taken ownership for analytic work on “health systems?”
  - How much has visibility improved?
  - How have policies changed?
  - How many other foundations, global funds and NGOs focusing on HS
  - How has overall investment in HS research grown?
- Professional Stewardship in LDC
  - To what extent are RF-trained managers using new, different tools
  - Are tools changing the way health systems managed?
  - Are the planning and management processes different?
  - Improved Private Sector
    - To what extent are organization tracking & assessing private sector?
    - How have regulations affected activity of the private sector?
    - To what extent is the private sector serving all equity quintiles?
- Integrated e-Health systems
  - What is the growth of e-Health across targeted countries, developing world?
  - Are others supporting e-Health growth?
  - To what extent are the different systems integrated within & across practice areas
  - What is the impact of e-Health?

### Methodology

Mixed methods will be used for the methodology of the mid-term evaluation, including a combination of data from the following sources:

1. A peer review of the rationale, global positioning, value added and strategic progress of THS by a Peer Review Panel consisting of health systems and development experts (approximately 5-6 experts).
2. An analysis of the grant portfolio against the intended outcomes of the Initiative (quantity and quality of outputs by outcome, coverage, etc). This will draw on the results of the Grant Portfolio Review.

3. A review of the quality and quantity of products produced by the Initiative. This includes an analysis of citations of THS articles and papers, articles published, and a google search and Web media analysis of THS products, papers, speeches, etc.
4. Interviews with key stakeholders, policy makers, practitioners, RF staff, partners, users of THS services and products globally, regionally and in four countries – Ghana, Rwanda, Bangladesh and Vietnam.
5. A Case Study illustrating the influence and impact of the THS Initiative, including issues and challenges.
6. A survey of attendees of global forums targeted by THS as key to THS Outcomes.
7. The THS results of the Centre for Effective Philanthropy Grantee Perception Survey.

#### Outputs and Deliverables of the Evaluation

The following deliverables are expected of the Evaluation Team:

1. Draft and final work plan and detailed evaluation matrix.
2. A review and analysis of the THS portfolio.
3. A quality review of THS products.
4. A written report from the Peer Review Panel.
5. A Case Study illustrating the influence, impact and challenges of the THS Initiative.
6. A draft and final report that synthesizes the findings from all components of the review. (2,3,4 plus results of interviews and global survey)
7. A set of summary slides of the key findings of the Evaluation suitable for briefing the Executive team, IMT, and the Board of Trustees of the Foundation.
8. If appropriate, a management note highlighting any specific RF and management issues that should not form part of the public record.

#### Management of the Mid-Term Evaluation

The roles and responsibilities for managing and implementing the evaluation are as follows:

**The Lead Evaluator and Evaluation Team**

- Designing the Evaluation with the RF Evaluation Office, in consultation with the THS Initiative MD and Team, the President and Executive Team.
- Managing and conducting the evaluation data collection, analysis and reporting.
- Managing the relationship between the Evaluation Team, THS RF grantees, Regional Offices and RF managers.
- Conducting high quality, ethical evaluation.
- Briefing RF managers on the results of the evaluation, and the Board of Trustees if required.
- Providing an internal management letter if appropriate.

**The Evaluation Office** will be responsible for:

- Developing the TOR and Scope of Work for the mid-term evaluation in consultation with the RF Executive Team and the THS Team.
- Setting the standards for the THS evaluation, based on international best practice evaluation standards for evaluation.
- Overseeing the design of, and signing-off on, the TOR, the Evaluation Matrix and data collection instruments for the mid-term evaluation (Interview protocols, panel review questions, etc.).
- Reviewing and signing off on the quality of the evaluation report and products.
- Reporting the results of the THS mid-term evaluation to the President, Executive Team and if appropriate to the Board of Trustees of the Foundation, in collaboration with the THS Managing Director and the VPFI and VPSE.

**The THS Team and RF Asia and Africa Regional Offices** will be responsible for:

- Providing input to the TOR and Evaluation Matrix.
- Providing ongoing operational guidance to the Lead Evaluator and Evaluation Team

- Providing administrative liaison for the Lead Evaluator and Evaluation team with the THS regional and country level grantees.

### Qualifications of the Lead Evaluator and Evaluation Team

The Lead Evaluator will be a senior program evaluator with significant experience in: program evaluation and in public health and development at global and regional levels, and communication with diverse global and regional evaluation audiences.

The Lead Evaluator will recruit appropriate team members with extensive knowledge of health context and evaluation regionally and in the four THS countries. These team members will conduct regional and country interviews under the supervision of the Lead Evaluator.

### Schedule

<b>Date</b>	<b>Deliverables and Milestones</b>
Early May 2010	Lead evaluator team appointed and contracted
May 2010	Detailed methodology developed including a detailed Evaluation Matrix, and interviews with key stakeholders, RF staff, partners
Late May 2010	Portfolio Review of quantity and quality of THS outputs
Late May - June 2010	Global Survey, and interviews with global and regional key stakeholders
June-July 2010	Interviews with regional stakeholders, in selected THS countries, and beginning of analysis of data
August 2010	Convening of peer panel
September 2010	Analysis and synthesis of data from multiple sources
September 2010	Draft report presented and discussed with RF management
October 2010	Final report

### Reporting

The Lead Evaluator will report to the Managing Director for Evaluation and will work in close collaboration with the THS Team and the Regional Offices as required.

## Appendix B: Evaluation Matrix

	Key Questions	Sub-questions	Indicators-evidence	Data sources & methods	Hypotheses & Current Questions
Key Performance Area  Relevance	<p>To what extent is the work of THS relevant to 1. key issues and trends in the world, 2. the needs of stakeholders and 3. the mission of the Foundation</p> <p>To what extent does RF occupy a niche in health systems and add value to the field</p> <p>To what extent is RF recognized as a leader in THS</p>	<p>Concept/rationale</p> <p>To what extent is the THS initiative based on robust conceptual thinking in health and development</p>	<p>Clear conceptual &amp; theoretical frameworks in initiative documents</p> <p>Content of documents</p> <p>Alignment with global analysis</p>	<p>Desk review</p> <p>Global Lit analysis</p>	<p>In some interviews, questions raised about the overall conceptualization – and anecdotal evidence that that made it harder to convince some country stakeholders to participate</p>
		<p>Is there a clear situation analysis providing rationale</p>	<p>Written analysis</p>	<p>Situation analysis</p> <p>Interviews with stakeholders</p>	<p>Analysis is clear – but logic that gets from the overall ToC to key workstreams less so</p>
		<p>To what extent does THS respond to global &amp; regional issues</p>	<p>Trends analysis; foresight</p>	<p>Survey of stakeholders</p> <p>Peer panel</p>	<p>Yes</p>
		<p><b>Logic</b></p> <p>To what extent is the logic of THS supported by evidence</p>	<p>Content of research documents</p> <p>Peer review</p>	<p>Literature search</p> <p>Interviews</p>	<p>Clear support for individual workstreams, e.g. ehealth, private sector, now UHC, etc</p>
		<p><b>Alignment</b></p> <p>To what extent is THS aligned to the RF mission?</p>	<p>Linkage and alignment to overall Mission, strategy and results framework of foundation</p>	<p>Situation analysis at RF</p> <p>The RBM</p> <p>Senior leadership interviews</p>	<p>Clear alignment with overall mission of foundation</p>
		<p><b>User needs</b></p> <p>To what extent is the THS relevant to needs of stakeholders in developing world?</p> <p>To what extent is the THS relevant to stakeholders at global and regional levels?</p>	<p>Evidence that institutions in Asia and Africa have identified this area</p>	<p>Work of global institutions</p> <p>Work of key Asian/ African institutions</p> <p>Team interviews</p> <p>Grantee/potential grantee interviews</p>	<p>Clear interest in Health Systems</p> <p>Some difference of opinion about specific workstreams</p>
		<p>Were key stakeholders involved setting THS strategy?</p>	<p>Degree of participation of stakeholders in situation analysis and level of agreement of stakeholders with program definition.</p>	<p>Peer/partner/co-funder interviews</p>	<p>Yes (Pocantico)</p>
		<p><b>Role / niche / comparative advantage</b></p> <p>To what extent is this area of work a historical niche of the Foundation? If not, is there a clear rationale why the Foundation chose this Initiative area?</p> <p>To what extent does Rockefeller have a comparative advantage in seeking to transform health systems?</p>	<p>Definition of the size and scope of the field – other players, role, size, levels of investment, the specific role of Rockefeller</p> <p>Ratings of stakeholders from interviews</p> <p>Scanning analysis</p> <p>Legacy grants analysis</p>	<p>Benchmarking</p> <p>Global health leaders survey</p> <p>Peer panel</p> <p>CEP Grantee data</p>	<p>Interviews suggest RF has clear advantage in the health space – even given other large participants</p>
		<p><b>Value added</b></p> <p>To what extent can the Foundation add value to the health systems field; the work of stakeholders? In what ways?</p>	<p>Ratings of stakeholders – interview data</p>	<p>Peer, partner &amp; stakeholder interviews</p>	<p>Interviews with partners/ peers suggest some look to RF for leadership in health systems</p>
		<p><b>Leadership</b></p> <p>To what extent is RF seen as a leader in the field of health systems. (thought leadership, practice leadership, positioning in key global forums and events)</p>	<p>Ratings of stakeholders, peers.</p> <p>Reports from key global events – RD presence reported, noted.</p>	<p>Global health leaders survey</p> <p>Media impact</p> <p>Peer panel</p>	<p>Initial signs of leadership</p> <p>Reference panel should discuss</p>



Midterm Evaluation and Recommendations for Course Corrections

	Key Questions	Sub-questions	Indicators-evidence	Data sources & methods	Hypotheses & Current Questions
Effectiveness	To what extent is THS – and the specific projects within THS – on a path to achieving a set of clear goals that will affect health systems	<b>Planning and Strategy</b> Was the Initiative adequately planned?	Work planning standards	Reports Team interviews	
		Is there a strategy which rationalizes the grants across developing world?	Presence of a clear and coherent strategy, strategy standards	Portfolio analysis	Clear division of initiative into component parts – less clear mechanisms for shifting resources where needed
	To what extent is THS achieving/has achieved its goals and anticipated outcomes	To what extent was the strategy planned from the beginning, or did it evolve over time? Was everyone on board with the changes as they happened		Team interviews	
		Is there clear programmatic logic and coherence of the grant portfolio (the clusters of grants within each objective)? Is it supported by the situational analysis?	Alignment of grants to the strategy and program logic (domain of grants selected aligned with the objectives of the Initiative, specific deliverables of grants aligned with needs assessment)	Grant documents Interviews with stakeholders and RF managers	Progress on deliverables and milestones Opportunity for greater alignment on ToC and RBF
	What changes and outcomes have occurred and are they consistent with the goals/strategy of THS	What is the impact to date of the workstreams? What is the impact of the overall initiative?	Evidence of impact or influence in behavior of key stakeholders	Workstream/Portfolio analysis Global health leaders survey Stakeholder interviews Media analysis	Limited signs of direct change on the ground Signs of convening and getting others to follow RF lead (JLN, HANSHEP, Indonesia?)
	The quality and utility of the capacity strengthening initiatives that THS has undertaken – in stewardship, private sector and eHealth	<b>Overall Capacity Strategy:</b> How does the initiative define capacity strengthening? To what extent is the initiative – are the workstreams – focused on building capacity	Presence of documented discussions of capacity & capacity strengthening at the launch of the project – and in monitoring/reporting throughout the project	Strategy planning documents Grant documentation Monitoring & reporting Individual studies	Stewardship – goals clear from start Private Sector/ eHealth – less obvious initially, but clearly moved in that direction Country level – clear need demonstrated at start of country activities
		<b>Target Users:</b> Did the initiative identify appropriate users for capacity strengthening	Clear identification of audiences in initiative logic	Grant memos Monitoring & reporting	Stewardship – yes Private Sector & eHealth – not clear Country level – currently yes
		Target Impact: Is the desired impact identified in the plans	Identification of a specific change(s) in capacity desired	Grant memos Project workplans	Not clear as different workstreams appear focused on different types of capacity strengthening
		Identified strategy: Is there an identified approach(es) for achieving the desired capacity strengthening	Identification of desired approach to achieving capacity goals	Grant memos Project workplans	Different approaches – some have been sidelined
		Are measurable changes in capacity identified	Methods/tools exist and are being used/recommended	Monitoring tools Monitoring reports Interviews with project teams	Not clear

Rockefeller Foundation Transforming Health Systems Initiative

	Key Questions	Sub-questions	Indicators-evidence	Data sources & methods	Hypotheses & Current Questions
<b>Key Performance Area</b>	To what extent has THS built/is building <b>capacity at the individual and institutional level in selected THS countries..</b>	What kind of capacity has been built – or is being built – by each workstream?	Evidence of capacity strengthening, to date or planned	Grantee interviews	Need for greater capacity at country level – or for process for improving capacity, especially for stewardship
		What kind of capacity has been built in stewardship? What kind of capacity has been built in leveraging the private sector What kind of capacity has been built in eHealth	Nature of stewardship capacity building Nature of private sector capacity building Nature of informatics/eHealth capacity building	Grantee interviews	Investment in capacity strengthening, though outcomes not clear yet – in ehealth, informatics
		What kind of capacity has been built by the overall initiative – to manage health systems		Grantee interviews Team interviews	Some programs have started, but not possible to point to capacity expansion as of yet
<b>Effectiveness</b>	The degree of <b>influence</b> that the Initiative has had on policies, public discourse, and practices in the fields of public health and development	What kinds of changes have taken place In public discourse In public policy discussions In public policy In scientific papers	Evidence of different behavior by international organizations or other key stakeholders (donors, etc) Evidence of different behavior at country and regional level	Global health leaders survey Review of changes in landscape since launch of initiative Review of changes at country level Bibliometrics	Some interview quotes consistent with substantial influence. Health Systems is clearly growing as a field, with increase in papers Some interviews suggest that Private sector and eHealth has increased in awareness, importance UHC increase in awareness
		What changes are seen in stewardship, UHC, approach to private sector and moving to eHealth/ interoperability	Evidence of different behavior in each area of THS	As above Literature review Peer panel review	Signs of emerging consensus about recommended different behaviors, but not yet about new behaviors, e.g. in Private Sector – more stakeholders now focus on goal, but not clear if private sector is being leveraged better yet
<b>Management and governance</b>	Has the Initiative been well managed and led by the Foundation.	<b>Management of the overall THS initiative</b> Is the management and leadership model for the THS initiative clear and effective?	Extent to which overall team is operating as a cohesive unit	Internal interviews with all parts of team	Opportunity for better management and improved team cohesion
		Are there adequate management systems in place to enable each part of the team to operate independently	Explicit management plans Roles and responsibilities	Management plan for THS Interviews with RF and grantee staff, senior managers and team	Some indication that RF accounting or expected systems make individual roles on team less transparent
		<b>Monitoring, learning, adaptation</b> To what extent is there a monitoring plan that supports learning and continuous improvements? Is it used? Was it useful in adaptation of the Initiative?	Monitoring plan Learning and revisions of workplans for networks Reporting and dissemination of information	Workplans Lessons learned Interviews	Some steps put in place, e.g. workplanning tools and monitoring. Team provides examples of improvements in execution, but not clear if there is a formal process for monitoring, continuous improvement
		What has been the effect of recent changes in workplanning etc	Differing utilization of workplanning tools	Internal interviews	Initial positive reaction to new work planning tools, etc
		Is the team acting as a cohesive whole or do they each pursue their own individual “silo”	Evidence of synergy pursued across team	Team interviews Team workplan analysis	Most of the efforts are focused within the specific workstreams
		How cohesive is the team; how effective is it operating		Team Interviews Team workplan analysis	Opportunity to continue working on team cohesion, possibly along with improved overall communication about overarching initiative/ToC

Midterm Evaluation and Recommendations for Course Corrections

	Key Questions	Sub-questions	Indicators-evidence	Data sources & methods	Hypotheses & Current Questions
<b>Key Performance Area</b>	The extent to which the Rockefeller Foundation is using best <b>management and governance</b> practices in THS, and whether those practices are providing good value for money	How has the grant process operated? How have resources been used? To what extent to grants align with identified and sought outcomes	Evidence of fast effective decision making Evidence of empowerment of team Evidence of linkage between sequence of grants and sought outcomes	Team interviews RBM Grant memo review	
<b>Cost effectiveness - efficiency</b>	Management of the <b>grant portfolio</b> - picking the right grantees, assessing capacity, developing and supporting, delivering results, use of and accounting for resources, monitoring, evaluation and learning, and knowledge management (lessons learned, sharing of information, knowledge).	What types of scoping and landscaping has been done to identify optimal grantees? What types of grantees have been involved? How have the grantees been monitored, evaluated?	Evidence of high performing grantees Evidence of solid monitoring of grantee progress	Outcomes analysis Grantee interviews Team interviews Analysis of grant resource allocation (Board books)	
<b>Influence and impact</b>	Influence at global level	What changes have taken place at the global level	Evidence of increased focus on health systems...and on private sector/eHealth	Grantee reports Peer panel Global health leaders survey	WHA
	Influence on other donors	To what extent are donors behaving differently	Evidence of increased focus on health systems...and on private sector/eHealth	Donor/partner interviews	Hanshep/CHMI mHealth alliance JLN for UHC
	Influence at country/ "coal face" level	To what extent are countries/ ministries of health behaving differently?	Evidence of increased focus on health systems...and on private sector/eHealth	Country partner interviews	Convening in Rwanda around RF theme; initial signs in Ghana
<b>Sustainability</b>	To what extent are the efforts (outputs and outcomes) of the workstreams embedded in ongoing practices of people, institutions and communities.	What emerging evidence of sustainable activities can be identified to date? What appears likely in near future?	Plans to change methods of operating	Stakeholder interviews Plan review	Impact at global level – not yet clear if enough in countries
	To what extent is there an explicit exit strategy for the Initiative that creates a high probability of the main outcomes of the Initiative continuing beyond Rockefeller Foundation funding.		Donors/partners in place to carry on RF work Countries planning on continuing the work, even after RF funding ends	Stakeholder interviews Plan review	Partners in place to carry on private sector work More time needed to see if folks will continue to run with eHealth Signs from Rwanda of clear country interest
	To what extent do expanded partnerships exist for scaling up the work, and sustaining the Initiative beyond the Rockefeller Foundation's support.		Partnerships in place to continue the RF work	Stakeholder interviews Plan review	Hanshep/CHMI/Joint Learning Network for UHC

	Key Questions	Sub-questions	Indicators-evidence	Data sources & methods	Hypotheses & Current Questions
<b>Key Performance Area</b>  <b>Impact</b> (changes in the lives of people and the systems upon which they depend)	Are the initiatives designed with clear measurable impact identified? What is the emerging and measurable impact on overall health from the THS Initiative? (contribution to improved lives, not attribution)	Have/will the lives of poor and vulnerable people improve/d as a result of the THS Initiative and related efforts?	Improved health status of people in networked countries		
		What is the emerging impact of the private sector initiative?	Review of recommendations from the team Extent to which work is being accepted globally, regionally and country-wide Evidence of global impact	Hanshep Alliance CHMI WHA resolution Peer attitudes towards steps	Good evidence of initial changes Need to follow-up with impact of WHA resolution Does Reference panel think it sufficient
		What is the emerging impact of the eHealth initiative?	Evidence that the work RF is supporting is resulting in useful tools Evidence that the tools are being adopted by countries, health systems Evidence that the tools are/will have a substantial impact	Countries adopting systems Countries pursuing eHealth Impact of eHealth in places where implemented (Sao Paulo)	Have we adopted a strategy to learn from the lessons of Sao Paulo? Desire for greater communication about need/value of eHealth tools Too early to assess quality of tools being built
		What is the emerging impact of the Research & Agenda Setting workstream	How much has RF changed attitudes towards the concept of health systems? How much has RF changed attitudes towards stewardship	Literature review Peer review	Has the shift in interest in Health Systems been sufficient?
		What are the emerging impacts of the country workstreams?		Examples of countries looking to adopt RF tools	Signs of adoption of tools, but thus far with RF support

## Appendix C: Health Leader Internet Survey

Mishkin Associates conducted an internet survey of Health Leaders, chosen randomly from lists of people who had interacted with RF in the past few years. The results were included as part of the final report. The questions asked and the top line results are as follows:

### 1. Which of the following most closely describes your role in the global health arena

Academic researcher focused on global health	15%
Foundation professional focused on supporting global health initiatives	13%
International organization professional focused on global health	35%
Professional at an NGO focused on health issues	24%
Regional organization professional focused on health issues	2%
Professional in a country working for or with the Ministry of Health of the country	9%
Professional in a country working on behalf of an international or bilateral organization providing health services to the country	2%

### 2. In thinking about the delivery of health care, how important is thinking about the overall system vs. thinking about the delivery of care for a specific very significant disease

The Health System should be of primary importance, and vertical initiatives should be secondary	48%
They are both of equal importance	48%
Determining how best to deliver interventions for specific significant diseases is of primary importance; thinking/analyzing the overall health system should be secondary	4%
The Health System should be of primary importance, and vertical initiatives should be secondary	48%

### 3. In your work, do you focus primarily on health systems, specific diseases or a combination of both?

Primarily health systems	22%
Primarily specific diseases	11%
A combination of both	67%

**4. Since 2007, have you focused increased attention on the overall health system, or increased attention on specific significant diseases?**

I've increased my focus on overall health systems	62%
I've increased my focus on specific diseases	7%
My focus has not changed since 2007	31%

**5. Since 2007, do you think health ministries in the developing world have increased their focus on the overall health system or increased their focus on specific significant disease?**

Health ministries have increased focus on health systems	65%
Health ministries have increased focus on specific significant diseases	35%

**6. In order to improve health systems in the developing world, how important is it to work with the private sector?**

Very important	59%
Somewhat important	36%
Very unimportant	0%
Somewhat unimportant	5%

**7. Since 2007, have countries started to focus more on trying to work with the private sector, or has the focus on the private sector not changed much?**

Countries/health ministries have tried to work more with the private sector	57%
Countries/health ministries have not changed their focus on the private sector	43%

**8. How important do you feel it is to try to move towards Universal Health Coverage?**

Very important	86%
Somewhat important	14%
Very unimportant	0%
Somewhat unimportant	5%

**9. In recent years, have a significant number of developing countries increased their attention on UHC, or has their attention not changed much? [please use your own definition of significant -- i.e. do you think the number of countries that have increased attention on UHC is significant or not?]**

A significant number of developing countries have increased attention on UHC	56%
Few if any developing countries have increased attention on UHC	44%

**10. How important is developing and implementing eHealth systems in the developing world?**

Very important	42%
Somewhat important	49%
Very unimportant	2%
Somewhat unimportant	7%

**11. Why do you think seeking to build eHealth systems is important?**

It can standardize and improve the quality of care	49%
It can enable increased capacity by health professionals in the developing world	39%
It is really not that important to improving health systems in the developing world	12%

**12. We'd like to ask you a set of questions about a number of foundations, international organizations and bilaterals focused on improving care.** We will have a set of statements. For each statement, please identify which 2 (up to 2) organizations the statement most applies to. The organizations we would like you to focus on are: • The Bill & Melinda Gates Foundation • The Rockefeller Foundation • The Wellcome Trust • The WHO and World Bank • Northern bilaterals, (e.g. CIDA, DFID, IDRC or SIDA) • US government initiatives (e.g. USAID and PEPFAR) For each of the statements/descriptions in the rows below, please check up to two types of organizations/foundations that you think it most applies to?

	Gates Foundation	Rockefeller Foundation	Wellcome Trust	WHO/ World Bank	Bilaterals (CIDA, DFID, IDRC, SIDA)	US Govt (USAID, PEPFAR)
Innovative	71%	40%	23%	3%	31%	20%
Focused on developing vaccines and cures targeting specific diseases	83%	0%	42%	8%	17%	44%
Focused on health systems	3%	39%	3%	72%	51%	13%
Focused on trying to improve eHealth	17%	66%	3%	28%	24%	7%
Focused on the private sector	49%	43%	17%	26%	9%	31%
Focused on increasing Universal Health Coverage	3%	47%	6%	56%	42%	14%
Focused on vertical approaches to addressing issues of global health	68%	3%	11%	19%	19%	65%
Focused on improving access to health care	14%	25%	6%	75%	53%	33%

**13. In trying to improve health systems and health system stewardship in the developing world, which of the following do you think should be pursued? For each of the following rows, please check whether you feel it is essential, very important but not essential, somewhat important, or not very important in improving health systems and health system stewardship**

	Essential	Very important but not essential	Somewhat important	Not very important
Conducting better research on what makes health systems improve outcomes	75%	15%	10%	0%
Building tools to enable the implementation of eHealth systems	28%	43%	23%	8%
Identifying and sharing innovations in health delivery across the developing world	55%	40%	5%	0%
Developing ways to regulate and contract with the private sector in health care	40%	43%	18%	0%
Seeking to increase health care insurance coverage in the developing world	54%	23%	15%	8%
Capacity building of professionals within Ministries of Health	68%	35%	0%	0%
Improved Public Health training in the global South	65%	13%	25%	0%
Increasing human resources for health	83%	15%	3%	0%



## Appendix D: Data Collection Instruments for Partner/Grantee Interviews & Summary

### Rockefeller Foundation Transforming Health Systems Initiative External Evaluation Interview Guide for Grantees

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#### Introduction

The Rockefeller Foundation (RF) has commissioned an external evaluation of its activities in global health. It is in the middle of a five year initiative called “Transforming Health Systems” and is trying to determine what has been accomplished and how it should adjust the project in order to achieve more before the end of the initiative (2013).

While the evaluation is not focused on individual projects, the Evaluation Team members are looking at a sample set of projects across the initiative in order to learn more about key strategic dimensions of the THS initiative. We are interviewing people managing grants as well other stakeholders and partners at the country, regional and global levels.

Your project has been selected as part of this process. In this interview we would like to give you the opportunity to provide your views to the Evaluation Team. Your interview responses will be completely confidential and will be reviewed only by the External Evaluation Team. An aggregate summary of project level responses will be synthesized in the Evaluation Report. The Evaluation results will be used by the Foundation leadership and board for purposes of accountability, guidance for future programming, and improving the effectiveness of the initiative.

The interview should take approximately one hour.

*Thank you for taking the time to meet with the Evaluation Team and for your valuable feedback.*

#### A. Identification and Profile

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Name and position: \_\_\_\_\_

Project: \_\_\_\_\_

Workstream of RF’s THS Initiative: \_\_\_\_\_

Date of interview: \_\_\_\_\_

Interviewer: \_\_\_\_\_

## B. Strategy & Goals

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Please describe the goals of your project, as you see them?

To what extent do you see your project as fitting with the goals of transforming health systems?

- Why or Why not?

If not, what other types of projects do you think would fit more clearly with the goal of transforming health systems?

## C. Stewardship

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What tools are you seeking to build to improve stewardship of health systems?

How is the project designed to improve stewardship of health systems?

How important is the work of your project to affecting stewardship of a health system?

Who are you targeting for the initiative?

What sort of research did you do on the target audience as part of the project? What did you find out?

What kind of impact do you think it will have on the target audience?

How will you measure the impact?

## D. Private Sector

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What tools are you developing to improve the management of the private sector in health?

Who are you targeting to use those tools?

Are there others who should be targeted?

What did you [do you expect to] learn from the initiative that you found surprising?

What did you demonstrate that was consistent with your expectations/hypotheses?

How are you measuring the impact of the initiative?

How could you measure the impact?

## E. eHealth

---

What tools are you seeking to build in eHealth?

To what extent do you believe they will be interoperable? Did you have to take specific steps to ensure interoperability? What steps?

How do you think these tools will improve health systems or health care?

Who are you targeting to use these tools?

What sort of research on the target users did you do as part of the project? What did you learn?

Who else should be targeted?

What measurement systems have you put in place to assess the impact of the project?

What other measurement systems would you put in place for the project?

## F. Country Work

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To what extent do you think your project will affect the underlying health system in your country?

- How and why?

What other projects or types of projects do you feel would be needed to improve the health system?

- Would those projects be less important or more important than your current project?

Who are you targeting for the initiative?

What research did you do as part of the planning of this project on that target audience?

Are there other people, groups or institutions who should be targeted?

What kind of measurement systems are you putting in place?

What other kinds of measurement systems should be put in place?

How much scepticism (if any) have you received about the importance of this project?

- How did you react to that?

How have people reacted since the launch of the project?

## G. Capacity strengthening

---

What is the approach you are using to building capacity?

What groups are you targeting in your initiative?

Are there other groups that should also be targeted? Which ones?

What is the desired impact on the group?

How was that desired impact identified in your plan?

What changes in capacity to you expect?

How can they be measured?

## H. Cost Effectiveness

---

How did you find working with the Rockefeller Foundation team compared to other donors you've worked with?

- Much easier to work with RF
- Somewhat easier
- Somewhat more difficult
- Much more difficult
- If more difficult, why?

How much value did you find the Rockefeller Foundation team provided your project compared with other donors you've worked with?

- RF was much more helpful than other donors
- RF was somewhat more helpful
- RF was somewhat less helpful
- RF was much less helpful than other donors
- If less helpful, how?

How closely do you coordinate with the RF team?

To what extent do you think your project is part of a larger effort by Rockefeller, vs just a standalone grant?

What advice would you have for Rockefeller in terms of working with grantees?

What advice would you give other donors based on your experience with RF in terms of working with grantees?

*Thank you for your valuable feedback!*

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**Rockefeller Foundation Transforming Health Systems Initiative**  
**External Evaluation**

*Interview Guide for Partners and Peers*

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**Introduction**

The Rockefeller Foundation (RF) has commissioned an external evaluation of its activities in global health. It is in the middle of a five year initiative called “Transforming Health Systems” and is trying to determine what has been accomplished and how it should adjust the project in order to achieve more before the end of the initiative (2013).

As a partner or peer of the THS initiative, the Evaluation Team would like to interview you on a range of aspects related to RF’s niche, value added and positioning in the field of health systems.

This interview should take approximately thirty minutes, and your responses will be completely confidential.

*Thank you in advance for your valuable insights.*

**A. Identification and Profile**

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Name and position: \_\_\_\_\_

Partner or Peer: \_\_\_\_\_

Relationship to RF’s THS Initiative: \_\_\_\_\_

Date of interview: \_\_\_\_\_

Interviewer: \_\_\_\_\_

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## B. Familiarity

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How long have you been aware of RF’s work on global health?

How familiar are you with the Transforming Health Systems Initiative – globally or regionally?

- Very familiar
- Slightly familiar
- Somewhat familiar
- Not at all familiar

If not at all familiar with the Transforming Health Systems Initiative, then please terminate the interview.

How familiar are you with the Rockefeller Foundation’s concept of Health Systems?

- Very familiar
- Slightly familiar
- Somewhat familiar
- Not at all familiar

## C. Relevance

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In your opinion who are the major players in Health Systems globally, regionally (if appropriate)? Please list three.

**How relevant do you think Rockefeller’s THS work is to:**

	Not at all relevant	Not very relevant	Relevant	Very relevant	Neutral / No opinion
Your work, or the work of your organization (please specify the focus of your work)					
Global Health					
Tropical Medicine					

**How relevant do you think Rockefeller’s work on global eHealth is to:**

	Not at all relevant	Not very relevant	Relevant	Very relevant	Neutral / No opinion
Your work, or the work of your organization (please specify the focus of your work)					
Global Health					
Tropical Medicine					

**How relevant do you think Rockefeller’s work on managing the private sector and how it delivers care in the developing world to:**

	Not at all relevant	Not very relevant	Relevant	Very relevant	Neutral / No opinion
Your work, or the work of your organization (please specify the focus of your work)					
Global Health					
Tropical Medicine					

**How relevant do you think Rockefeller’s work on moving to Universal Health Coverage in the developing world to:**

	Not at all relevant	Not very relevant	Relevant	Very relevant	Neutral / No opinion
Your work, or the work of your organization (please specify the focus of your work)					
Global Health					
Tropical Medicine					

**D. Comparative Advantage**

Does the Rockefeller Foundation have a comparative advantage in global health and health systems that other major organizations do not have? If yes, please describe their comparative advantage.



### E. Added Value

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Does RF add value to the work of your organization, or others whom you know? If so, please give us an example.

Do you have any suggestions to improve the relevance, positioning or added value of RF's Transforming Health Systems work?

### F. Quality

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How would you describe the scientific quality of the results of the Transforming Health Systems Program:

High, medium low quality.

Do you have any suggestions to improve the quality of Rockefeller's THS initiative's results?

### G. Policy Influence

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In your view, does Rockefeller's THS initiative influence policy at

- 1) global level
- 2) regional level
- 3) national level
- 4) local level.

What is the single most influential aspect of the THS work that you have seen?

Do you have any suggestions to improve the policy influence of Rockefeller's THS work?

### H. Sustainability

---

Are you a co-funder of Rockefeller's THS work?

If yes, how well does RF manage co-funded work on health systems? (manage well, average, poor)

Do you have any suggestions for improving co-funded work with Rockefeller?

If you are not a co-funder, would you consider co-funding Rockefeller's THS work? Please explain why, why not.

Do you have any other suggestions to help strengthen Rockefeller's THS work?

*Thank you for your valuable feedback!*

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## Appendix E: Summary of Meeting of Reference Group

### THS Reference Group Summary Report of Discussion September 24, 2010

*Prepared by Arnon Mishkin, Evaluation Consultant*

As part of the midterm evaluation of the Rockefeller Foundation's Transforming Health Systems initiative, the Foundation brought together five experts in the health systems field.

The main purpose of the Reference Group meeting was to enable the Foundation leadership and Initiative staff to:

1. Hear from recognized experts in the field of health systems and development about the current key trends, challenges and opportunities in the field of health systems.
2. Discuss the relevance and positioning of the work of the Initiative in relation to these trends, challenges and opportunities.

The meeting was designed to be a high level discussion and the panelists were not expected to intimately know the work of the Initiative, beyond reading a prepared background paper, nor were they expected to opine on the quality of the work of the initiative as a "peer review" group might.

The panel included:

- Prof Sara Bennett, Associate Professor, Johns Hopkins School of Public Health
- Prof Fred Binka, Dean, Ghana School of Public Health and Project Manager, Malaria Clinical Trials Alliance
- Ms. Laurie Garrett, Senior Fellow on Global Health, The Council on Foreign Relations
- Ms. Ruth Levine, Director of Evaluation, Policy Analysis & Learning, USAID
- Mr. Alexander Preker, Lead Economist, World Bank

From RF, the discussion included, Zia Khan, the Vice President for Strategy and Evaluation, Nancy MacPherson, the Managing Director for Evaluation, Ariel Pablos-Mendez, the Managing Director responsible for THS, Karl Brown, Stefan Nachuk and Mwihaki Muraguri<sup>14</sup>, Associate Directors and Lily Dorment and Robert Marten, Research Associates. Arnon Mishkin, the external evaluation consultant conducting the evaluation also attended. The panelists were asked to prepare to discuss six core questions:

1. What are the **major trends** in health systems reform?
2. Given those trends, what are the **major opportunities** that the foundation should be aware of, and/or should integrate into its health systems work? What **emerging innovations** should we be looking into?
3. What are your reactions to the THS **theory of change**? How will it help overcome (or not) **major challenges, constraints and barriers** to achieving more effective and efficient health systems
4. What are **competing alternatives** to achieving the intended impact of the THS initiative?
5. How important are current developing world efforts towards expanding health coverage? And to what extent should the Foundation focus on / invest in encouraging developing countries to move towards **Universal Health Coverage**?
6. Based on what you have heard of the work of the Foundation's Transforming Health Systems work, do you have any **recommendations for mid-term corrections** in focus and strategic positioning of the Initiative?

This document represents a summary of the key points raised by the panel. Both the agenda –focused on identifying overall trends and ensuring the relevance of the RF work to those trends – and the limited time (six hours) of the day dictated that the focus of the panel was on how to improve the initiative. The discussion is one input into the broader evaluation rather than an overall evaluation itself.

<sup>14</sup> by video-conference from Nairobi

## Key Messages of the Panel

The key takeaways from the day were:

1. Confirmation of the global relevance and importance of the work of the THS Initiative in the area of health systems, and its ongoing relevance to the Rockefeller mission – to improve the wellbeing of the poor and vulnerable.
2. Identification of the opportunity to improve the coherence and the clarity of communication of the “Theory of Change” of the Initiative
3. Suggested need for greater focus of the activities of the initiative, and concern that the Initiative was trying to do too much with too little capacity and resources
4. A recommendation for the team to define the development paradigm within which it is working in order to clarify its goals and ensure consistency of its efforts

## Summary of the Discussion

The day began with Ariel and the team providing a presentation with a high level summary of their “Theory of Change,” their Strategy and their efforts to date. Following that, the panel discussed core global health system trends, their reaction to the work and strategy of THS and their recommendations for how they might refocus or re-position the initiative.

We have summarized the comments by topic, occasionally deviating from the exact chronology of the discussion.

### A. Major Trends and Opportunities for the Rockefeller Foundation

The panel identified a set of important over arching trends that affect any discussion on developing world health systems, including the increasing focus on chronic diseases and their economic impact, the impact of the financial crisis and the ongoing growth of civil society in the developing world – with the concomitant demand for greater focus on health issues.

The financial crisis has triggered a greater emphasis on accountability. From 1990 until 2010, there had been an enormous growth in the provision of support for global health, however, some people are questioning the benefits of this investment.

There is a rapid development of civil society in the global south, which is fueling a growing demand for transparency and accountability of system stewards – and the need to ensure evidence of the value of investments in programs in order to generate support within civil society for them.

Overall, there was agreement about the need to increase the focus on health systems in general given the historically strong vertical disease focus which has a tendency to make it harder for countries to manage and harmonize the demands and support of all various global initiatives.

Fred Binka from Ghana pointed out that there was a need to strengthen all components of the system and that the vertical initiatives were creating an imbalance with certain sectors very strong (for example, medical issues over public health issues), but too many people focused on just parts of the overall system.

He thought that the most neglected part of the overall system was measurement and that there was a need to put measurement systems in place to assess the overall health system and identify ways to strengthen the system.

In line with the rapid development of civil society, Binka thought there was a major opportunity for RF? because key stakeholders in countries were beginning to be critical about progress that was not taking place – and that therefore there was increased demand for the kind of system, horizontal improvement programs that would be helpful – underscoring the need for measurement.

He cited Ghana which had created an imbalance in the health system. He pointed out that the increased coverage of the population, through insurance, had increased funding for the overall medical system, but that public health programs had lost funding in order to fund the insurance.

Moreover, too many players are trying to get into the measurement business – and not able to figure out how to piggy back on other systems. For example, with the introduction of insurance in Ghana, the insurance system is setting up its own measurement system, which in effect means the need to recreate a national identity system – and now wants others to use their insurance system – rather than working together, as a system to identify the best measurement system possible.

A number of people pointed out that different stakeholders have somewhat different views of the definition of health systems – is it just the system of delivering health care, does it include issues of public health including sanitation and food security, does it include the cost/process of people getting to a health facility – including their families. But, while one person suggested the

need to define health systems – and decide what aspect of the health systems was to be the focus – financing, treatment, supply chain, etc.—the general consensus was that Rockefeller – and others – should use the basic WHO building blocks of “health systems” – and that even though it was not an optimal definition, too much time would be spent trying to improve it.

In terms of opportunities for the Foundation, there was a belief that there has been a remarkable amount done since the Pocantico meeting, where the overall health strategy of the Rockefeller Foundation was first discussed in September 2007. As Sara Bennett put it, “given how much you are doing, I always think I’m talking to one small part of the team – but now I realize that I’ve actually seen the entire team that is doing this work, and that is impressive.”

Sara Bennett suggested that there were far too many solutions being provided from the outside and that there was a need to invest in country capacity to assess for itself the value of specific programs and that as a result there was huge opportunity for “south-south” learning, such as the Joint Learning Network for UHC, which RF is currently launching. She also highlighted the increasingly interdisciplinary nature of issues facing Ministers of Health, including food security, substance abuse (alcohol, tobacco) and obesity, and called for RF to use its comparative advantage in developing networks and capacity building to address these challenges.

While several pointed out that there is a continued need for investment and development of human resources for health, which RF had initially identified with the investment in the Joint Learning network – but had explicitly decided was outside the scope of THS, Sara Bennett suggested that with the focus on health systems, it was clear that increased human resources for health was not always the answer.

In terms of trying to affect the ongoing international discussion about issues facing health care, Alex Preker thought that the WHA resolution expressing support for countries to improve how they leverage the private sector in delivering health care represented a significant achievement for RF. While no one disagreed with this view, others thought the Foundation should not invest too much time in getting various UN resolutions passed.

Several people on the panel acknowledged that they had originally been skeptical about the value of eHealth programs but that they were now very supportive of eHealth and the value it can bring.

Several people thought the country work more important than the global level work. Both Fred Binka and Ruth Levine thought that work at the global level was less important than work at the local and country level where the impact

of the work can be much more clearly identified – and then used to influence at the global level.

Many people suggested that Rockefeller was historically very effective at identifying difficult and important issues that others were ignoring – “the orphans” – and then leveraging its “moral authority” or development expertise and demonstrating the importance of those issues and getting others to focus on them.

Sara Bennett thought it important for the Foundation to think about the important work of the Disease Surveillance Network Initiative in the context of health systems, and not just as a separate initiative.

## B. Reactions to the “Theory of Change” and Competing Alternatives

While the panel was impressed by the scope of the THS work, some thought it too broad and some concerns were raised about the strategic vision of the overall initiative and the coherence of the “theory of change.”

Ruth Levine was concerned that she did not see the overall strategic vision of the initiative and that the theory of change was articulated at too high a level to indicate what specifically the initiative was going to do and what levers it was going to move to result in the desired change. Others suggested that the articulated strategy in the Theory of Change did not appear to lead to sought-after outcomes of the theory.

Several people – notably Alex Preker and Laurie Garrett -- thought that the Theory of Change should be more explicit about the development paradigm – is the Rockefeller goal to do demonstration projects that are then scaled up by others...or to focus on advocacy...or to build technology...or to scale up in certain areas...or to leverage the Rockefeller “moral authority,” etc. Laurie said that it was very important to decide whether Rockefeller was trying to leverage a political or technical expertise, and that it could not do both.

Laurie Garrett thought it particularly important to think strategically not just about RF’s own initiative but also about how it fit with all the other initiatives going on at the same time. She also thought it important from the beginning of the initiative to think about what kind of additional support was going to be required at the end of the initiative – specifically how much capacity needed to be strengthened in order to ensure that the local partners with whom the initiative worked would be able to sustain the progress of the initiative at the end.

Ruth suggested that it was important to distinguish between the parts of the initiative that were fundamental for influence – and getting other donors and countries to follow the lead of Rockefeller, as opposed to identifying countries where one should work because the country is influential in the south.

Overall, the group appeared to have a consensus that there were opportunities to improve the overarching “theory of change” to improve its clarity and to focus the initiative on a more limited set of achievable goals.

### C. Discussion of Potential “mid-course corrections” particularly with regard to the “Theory of Change”

In thinking about and potentially refining the theory of change, the panel thought that Rockefeller should take into account more the activities of others in the space – and ensure that Rockefeller is not duplicating, but potentially taking advantage and ensuring synergy with those efforts.

There was general agreement on the need for and the value of focusing the initiative and improving the theory of change – and then ensuring that all the grant making and other activities of the initiative support that overall theory of change.

The overall panel seemed to agree with the notion that there is a need for greater clarity about what Rockefeller is trying to achieve with the Transforming Health systems initiative. In thinking about trying to improve both the coherence of the “Theory of Change” and the focus of the initiative, a number of points were made.

The panel suggested the need for Rockefeller to identify the ultimate target it is trying to achieve and then ensure that it happens. As Ruth put it, “define the problem you’re trying to solve” and make sure that both the problem is solvable and that Rockefeller is on a path to solving it. That point had clear resonance with some on the THS team

In terms of focus, a number of different ideas emerged from the panel – some people felt the need to strip away certain elements of the initiative and just focus on specific components. Others thought that the initiative could retain its components, but focus the effort either geographically or at specific stakeholders

Sara Bennett articulated the view that there was an underlying problem with the portfolio approach and that the 3-4 work streams being managed don’t fully line up with the overall goals. She would potentially go so far as to



unpack the different components of the initiative – e.g. eHealth, private sector, potentially universal health coverage – become separate initiatives rather than being treated under one umbrella, “Transforming Health Systems” rubric.

Both Laurie Garrett and Ruth Levine expressed to trim down and seek to focus in fewer areas.

Two other panelists thought that Rockefeller should maintain the overall Transforming Health systems initiative, but focus it in a different manner.

Fred Binka thought that Rockefeller should continue to focus on health systems – but primarily focus at the country level, while leaving the global discussion to others. If Rockefeller can demonstrate impact at the country level, its basic approaches will quickly be mirrored and scaled up by others.

Alex Preker thought that Rockefeller should continue to focus on health systems but improve the coherence of the theory of change by focusing it primarily around stewardship – the intelligence and information sharing behind/within a system. The thought was that each of the different components of the initiative to date could be considered elements of helping to improve that stewardship.

Alex Preker noted Rockefeller’s strategic comparative advantage and its moral authority for bringing critical, but underappreciated issues, to the global agenda in a way that some institutions, like the World Bank, might not be able to do because of political constraints.

Most important, the panel appeared to agree with the notion that Rockefeller should think about its health systems role in the context of the move to a “G20” [as opposed to “G8”] world in five to eight years, and the move away from a focus on infectious diseases to a focus on chronic conditions – and to think about what the impact of growth and changes today – and assess what the health systems world will look like in five years and ensure that Rockefeller’s intervention will be helpful in either getting to that or in ensuring that it gets to the optimal place it can.

#### D. Thoughts about the THS focus on UHC

There was general agreement about the importance of UHC, although there was no consensus on how to approach it. The panelists talked about the difficulty many countries have had in implementing UHC, where it has occurred, and in ensuring that many people sign up for it. There was also discussion about the potential political challenges because of the terminology and how

the term could mean different things to different people.

Laurie Garrett in particular did not think that Rockefeller was best suited to the international advocacy role or capacity required in promoting Universal Health Care, or working with the Caribbean community in support of a UN resolution on non-communicable diseases– and that other institutions were better able to try to pursue the kinds of International resolutions that are involved. Alex Preker disagreed citing the success of the WHA resolution on the private sector.

The results of the overall discussion will be used to feed into the data collection of the evaluation on questions of relevance, rationale and positioning. The results of the overall evaluation will be used by the team and foundation leadership in deciding on appropriate mid-course corrections.

## Appendix F: Portfolio Review & Analysis Methodology & Notes

As part of the evaluation, we did a full analysis of the portfolio of projects that had been supported by Rockefeller's Transforming Health Systems Initiative. In doing the analysis, we sought to understand – from the project up – what the de facto strategy had been. Even though the project had set up a number of specific “work streams,” we thought it appropriate to revisit to ensure that the project streams were consistent with initial plans.

In reviewing the ~140 projects, we categorized each one into the apparent workstream where its grant memo and proposal document indicated it belonged. In so doing, each project typically fit – almost entirely – into one of the five initial workstreams:

1. Research and Agenda Setting – which evolved into a focus on supporting Universal Health Coverage
2. Building Capacity and Improving Stewardship of the Overall System
3. Leveraging the Private Sector
4. Global e-Health
5. Country and Integrated Work

In addition, we reviewed the planned “outcomes” of each of the initiatives, as defined by the team. The team had been asked by the Evaluation group, to categorize the anticipated outcomes of each of the initiatives, according to the three outcomes sought by the foundation:

**A. Outcome Area 1** – Leadership and Policy influence

**B. Outcome Area 2** – Capacity Building

**C. Outcome Area 3** – Innovation and tools, and Partnerships

We used both lenses in the assessment of the activities and accomplishments of THS. And the findings from the activity analyses are included in the body of the evaluation, particularly pages 59-63. The findings from the outcomes analysis are included as well, particularly pages 26-28 (Policy Influence), 49-51 (Capacity Building) and 28-34 (Innovation and Partnerships).

In particular, we assessed and included in the report:

- The investment in each workstream (Table on page 62)
- The range and location of grantees (figs 17, 18 & 21)
- The density of grants (figs 22 & 23)
- The outcomes/learnings from each project (within each section)
- The implications of specific grants on the launch of other projects

In reviewing the analysis, we found the following that may make sense for further consideration about managing a portfolio of projects within an initiative.

- The grants/projects clearly fit within a high-level, logical sequence, starting with “learn/explore a field,” “test certain approaches,” “prove the value of specific tools/concepts,” “ensure sustainability.” However, the sequence was not always clearly stated in the overall strategy – and, as noted before, the project would benefit from that improved clarity.
  - Of necessity, there is rarely a one-to-one correspondence between specific projects and the desired/anticipated outcomes. For example, projects that create tools typically also are building – or at least enabling – capacity; given the desire for policy influence in the private sector, in particular, those projects have a component focused on capacity building.
  - At the same time, the planning within an initiative is usually (and appropriately) focused at workstream (input) level rather than the outcome. Initiatives could benefit from more focused attention on desired outcomes and how they are likely to be achieved.
  - The outcomes/learning of specific projects was harder to determine than one might expect. Although papers/monographs were published and reports completed, it would appear beneficial to have a simple database that captures the 3-7 high level findings/outcomes of each project that would be readily accessible.
1. As noted by many grantees, there was a desire by many of the participants to have a better understanding of how each grant fit within the overall plan.

## Appendix G: Case Study of THS' Joint Learning Network for Universal Health Coverage

The Joint Learning Network for Universal Health Care was launched in 2010 as a way of ensuring knowledge and capability transfer among countries launching wider financial coverage plans. Consistent with the overall Rockefeller foundation belief and strategy that one of the ways to ensure sustainability of initiatives is to support the launch of networks that can carry on the initiative, it seeks to embed in a South-South network, both support for Universal Health Coverage, as well as link in the other workstreams of the THS initiative.

As part of the evaluation, Mishkin Associates developed a case study of how the network was launched, and its impact to date.

### Key Findings

- While the initial idea came from funders and technical partners, the initiative appears to have the strong support and active participation of the developing country members who are clearly playing a leadership role in choosing the topics of research and knowledge sharing
- It appears to represent a more promising way of developing capacity and capabilities, than the THS originally envisaged approach to capacity development, because it is clearly more focused on South-South knowledge sharing rather than teaching.
- It is an effort that is bringing together the different streams of THS – including advocacy for UHC, capacity building, private sector and ehealth.
- The effort appears very consistent with the overarching strategy of THS, especially as re-articulated in Montreux (See Appendix H)
- It has generated support from partner funding partners, technical agencies and developing countries, suggesting its sustainability if and when RF decides to curtail its involvement
- It has a built-in evaluation mechanism of the extent to which developing (client) countries value the initiative – via their willingness to participate at the appropriate level as well as requests for additional research.

Questions that RF will have to wrestle with as the project/institution evolves

- Determining the appropriate size of the group and what is the right selection criteria

- Developing ways to share learnings outside the network, where appropriate
- Monitoring and ensuring impact from developing countries leveraging that which is shared by the JLN – beyond the impact on the individual participants
- Using the results of the JLN to help in the overall effort to promote UHC and to measure, track and report on the impact of UHC in the countries that are adopting it

The Joint Learning Network was initially planned in 2009 – involving representatives from Ghana, India, Thailand and Vietnam, as well as a number of donor partners – who observed the number of countries who were in the process of considering moving to UHC and decided there was a need to share learnings and help them meet the challenges of implementation. The network was formally established in 2010 with the following core objectives:

- Establishing a multi-country learning platform for countries committed to UHC through demand-side financing and help them overcome the challenges associated with implementing such reforms
- Leveraging the joint learning platform as a hub for dissemination of timely and relevant information and analysis, idea exchange across countries and partners, ensuring linkages to technical and financial resources, and stimulating practical research on the issues
- Helping create a global network of country-level practitioners and development partners to ensure both formal and informal joint-learning and problem-solving to accelerate progress and improve the impact of reforms

In discussions with potential members, it was clear that the countries were less interested in additional development projects or even in additional technical assistance, than they were in learning more about how other countries – at similar development stages – were working with the issues of UHC and Health system improvements in general.

Working with the World Bank and GTZ, the Rockefeller Foundation and Results for Development created the approach for the JLN.

The structure of the JLN is designed to maximize participating countries' ability to set its direction. It is run by an Advisory Group, which consists of all 6 member countries, and 3 representatives of funding and technical partners. The Secretariat – which seeks to take direction from the Advisory Group – consists of support from the technical and funding partners (ACCESS Health

from India, GTZ, IHPP from Thailand, Results for Development and the World Bank.) Rather than setting up a full time Secretariat, as of now, the functions are dispersed across the partner organizations.

In addition, the organization set up a “Joint Learning Fund” to provide support for specific learning efforts by member countries, such as study tours of other countries to learn first hand how they are implementing UHC. While much of the control in the JLN does appear to rest with and direction set by member countries, decisions about use of the fund does reside within the Secretariat, and thus more with donor partners than with member countries.

Initially, the JLN sought only to involve countries that were both implementing UHC and had institutions capable of providing technical support to other members. Although not all initial members perfectly fit the criteria, the initial six were Ghana, India, Indonesia, The Philippines, Thailand, and Vietnam. From the beginning there was an expectation that others would apply and be able to join, notably, Brazil, Colombia, Chile, Kenya, South Africa, Rwanda, Nigeria, and Sri Lanka. As of December 2010, Colombia has joined, which enables the JLN to have representation from all three continents of the global “South.”

There is an ongoing discussion of the advisability of expanding. Some we spoke with believe that by keeping it small, one can maximize the impact in the (limited) number of countries involved. They believe that expanding it too rapidly could in effect have it evolve into another World Health Assembly, and possibly a less effective knowledge sharing forum. Others believe that expansion would be consistent with making it into a more permanent institution, with minimal impact on the quality of that being shared.

An examination of the materials reviewed and presented at the first core meeting – in India in February 2010 – does suggest both the value of keeping the institution small as well the potential power inherent in what it is doing – and thus the value of expanding involvement. The work involved an in-depth comparison of the UHC/financing approach taken by each of the six countries – looking at the methods of financing, the scope (target population), design (nature of benefits) and the institutional structure of the various UHC programs. A read of the 76-page document suggests that participants would likely have learned a great deal about what was working and what was challenging in each of the countries – and that with that in-depth knowledge, the participants would clearly have the potential to have substantial impact for applying that knowledge within their countries.

Indeed, interviews with participants indicated the extent to which they valued learning in detail about other countries – as opposed to a cursory survey of a wider group of countries.

The first meeting, which focused on comparing health systems among the six member countries, clearly demonstrated a desire to continue the initiative. Among the topics that countries asked for follow-up work, information and discussion, were:

- Coverage and how best to expand it – particularly among the poorest populations or the “informal sector.” Fully four of the six countries were specifically interested in the issue of the informal sector.
- Provider Management and the maintenance of quality
- How to inform policy discussion – and help make policy decisions about coverage and programs
- Evaluations of the impact of UHC across countries implementing it

There was also clearly support for ongoing learning through the JLN – with support for a web portal/clearing house, continued joint meetings, as well as ensuring support for countries that were implementing UHC, either through developing teams to travel to countries considering/in early stages of UHC or via enabling in country visits by countries considering UHC.

The web site already has forty studies posted, including 23 case studies covering almost half of the roughly twenty developing countries that are implementing a form of UHC<sup>15</sup>.

The network is continuing to meet, holding and scheduling conferences to share learnings about:

- The informal sector (people without fulltime organized employment, who are often the majority in many developing countries)
- Payment mechanisms
- Hurdles to moving to UHC in Africa
- Health insurance in Asian countries
- Information requirements for UHC

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<sup>15</sup> Several countries have more than one study.



As it pursues its mission, it will have to address the question of size and figure out how to navigate a course that balances breadth and depth -- maintaining the benefits of a small forum – with the attendant increased potential impact on each participant, while also maximizing its impact on as many developing countries pursuing UHC as possible.

Moreover, while it has a built-in evaluation mechanism – the level of interest in country and individual participation – it should also look to assessing the impact of the organization on the underlying country health system. It can do this both by tracking changes in country health systems and implementation programs and by ensuring ongoing interviewing of participants to identify key takeaways from the JLN that they are hoping to use.

The JLN appears to represent the potential for sustainability of the RF effort in UHC – given the enthusiasm of the current members, the apparent desire of other countries to join, and the willingness of other funders to support it.

Moreover, it is well positioned to be a vehicle that ties together the different workstreams – and could represent one of the institutions to carry forward the overall Transforming Health Systems, particularly given the re-articulation of the overall strategy. The subjects of studies span across UHC to include issues of e-health and the private sector and how they can help a health system meet the demand for greater services due to a UHC program.

Following the completion of the evaluation, the THS team met in Montreux to review the findings of the evaluation and decide whether and how to readjust the strategy. A full report on the off site is reprinted at Appendix H. In essence, the team decided that what ties together all the different workstreams of the initiative is a strategy of:

1. Advocating to get international alliances to support and countries to adopt risk pooling plans that will enable a greater share of their populations to access health services
2. Demonstrating how e-health and approaches to harness the private sector will enable health systems to meet this increased demand
3. Establishing South-South learning networks and other approaches to improve stewardship of overall health systems in LMICs

The hypothesis behind the strategy is that a country's adoption of UHC will result in a dynamic which causes the underlying health system to improve in order to respond to the UHC-fueled demand. The JLN is optimally positioned to assess the extent to which this overall hypothesis is correct, and to understand how best to ensure that health systems transform appropriately to deal with the increased demand of UHC, by leveraging e-health tools, better managing the private sector and other approaches as required. By focusing on both the tools of UHC and the impact that UHC has on the overall health system, the JLN will both help countries better implement UHC, and understand the value it creates.

## Appendix H: Results of THS November Retreat to Review and Respond to the Evaluation

Following the completion of the evaluation, the team met with the lead evaluator both to review the findings of the evaluation and to make adjustments to the strategy as needed. There appeared to be general acceptance of recommendations – particularly about improving the overall clarity of the initiative.

The team made more clear both its overarching vision – as well as how the different components of the initiative fit together. At a very high level, the team articulated a “demand based” strategy for transforming health systems: A hypothesis that the adoption of Universal Health Coverage would result in increased empowerment/demand for health services – and that health system would respond by meeting this demand – enabled in particular by the tools of e-health and managing the private sector. As a result, the team articulated the following *strategy*:

1. We will advocate to get international alliances to support and countries to adopt risk pooling plans that will enable a greater share of their populations to access health services
2. We will demonstrate how e-health and approaches to harness the private sector will enable health systems to meet this increased demand
3. We will help establish South-South learning networks and other approaches to improve stewardship of overall health systems in LMICs

As the team drafted their report from the retreat:

The *problem* addressed by THS has global and country dimensions:

Developing countries traditionally relied on public/NGO supply of health services (and financing). With economic growth, accelerating in recent decades in LMICs, private demand, provision and spending are outstripping the model with inefficient & regressive effects.

- In Africa and Asia out-of-pocket expenditures account for 50 to 80% of the total health spending; globally, 150 million people each year suffer catastrophic health expenditures and 25 million families are thrown into poverty because of them.

In global health and development circles, where support in the fight of select diseases has been unprecedented, inadequate attention to this momentous transformation of health systems, and insufficient funding for health systems research and capacity in LMICs, has resulted in weak stewardship, dysfunc-

tional service delivery, information silos (even as IT connectivity grows), and inequitable financing as noted above.

- To the extent that there has been focus on health systems, the focus has been just on growing the supply of services in the system, with limited attention to where that supply is most needed and can be most effective

The long term **Goal** of the Rockefeller Foundation's Transforming Health Systems (THS) initiative is to improve the health status and financial **resilience** of poor and vulnerable populations (both of which lead to more **equitable growth**) as a result of better health systems performance and the expansion of universal health coverage, defined as *access for all to appropriate health services at an affordable cost*.

- Approximately 40% of all human beings today enjoy pre-paid, risk pooled, public or private health financing; by 2020 that figure could double, halving out-of-pocket health expenditures in LMICs.

Hypotheses:

An overarching vision guides our work: to harness smart globalization and transform health systems to achieve universal health coverage in the 21<sup>st</sup> century throughout the world. THS has three core hypotheses:

- As globalization and economic development advances, new technologies, changing burden of disease and increasing health care costs are transforming HS around the world, and there is a *historical window of opportunity* for RF to promote strategies that steer this inevitable transformation towards better and more equitable HS performance and financing in LMICs.
- National commitment and reorganization of domestic health financing through large pre-paid risk pools empowers the population to demand & access health services across public and private sectors
  - This induces organic adjustments in supply distribution and quality to better fit with the population's more equitably empowered demand.
  - This makes more salient the need for improved stewardship and enables economies of scale.
- Synergistic efforts to focus global attention and resources on health systems and UHC, with greater LMICs capacity for HS stewardship and south-south learning, leveraging interoperable eHealth platforms, and harnessing the private sector with new public-private partnerships would

enhance HS performance, improving access, quality, and affordability of health services for all, leading to greater financial protection and, over time, improved health outcomes.

**Strategy:**

1. We will advocate to get international alliances to support and countries to adopt risk pooling plans that will enable a greater share of their populations to access health services
2. We will demonstrate how e-health and approaches to harness the private sector will enable health systems to meet this increased demand
3. We will help establish South-South learning networks and other approaches to improve stewardship of overall health systems in LMICs

**Key assumptions:**

- The sun setting on the MDG paradigm (1990-2015) will call for innovation and renewal in international development priorities. RF's brand in global health and development, and scarcity of foreign aid directed at health systems, positions the Foundation to play a catalytic role in the shift towards UHC including at the United Nations.
- The meltdown of the financial markets paradoxically has catalyzed the need for a greater role of nation states to provide social health protection, as illustrated by the passage of UHC legislation in the USA and other countries more recently.
- Health spending will rise considerably in LMICs in coming decades as a result of unprecedented growth in GDP rather than foreign aid. In LMICs, 50-80% of the total health spending is private, and yet the important role of the private sector is suspect to many ministries of health.
- IT connectivity and cell-phones will bring unprecedented opportunities for eHealth in LMICs requiring local capacity, interoperable systems and new PPPs to leapfrog their health systems for better access, affordability and quality in the 21st century

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UHC is not about increasing levels of capital; rather it's about national commitment and better organization of domestic financing and contingent on government stewardship of mixed, public-private health systems.

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## Appendix I: Bibliography of THS Publications, Articles and Speeches

“Americas Quarterly” Summer 2010, Vol. 4, No. 3 “Who gets coverage (and who doesn’t)” Section:  
“[Ask the Experts: How do we contain rising health care costs?](#)” A. Pablos-Mendez Response.

“Education of health professionals for the 21st century: a global independent Commission,” *The Lancet*, [Volume 375, Issue 9721](#), Pages 1137 - 1138, 3 April 2010

*Health Affairs*, February 2010, Vol. 29, No. 2; Special edition: “E-Health in the Developing World.” (RF Supported)

THS Better health and financial protection for all PMAC Poster.

“An Agenda for Action of Global E-Health,” *Health Affairs*, Supplement 2010; 29(2): 233-236 (T. Gerber, V. Olazabal, K. Brown, A. Pablos-Mendez)

Forthcoming: “**Good Health at Low Cost II**” 2011, London School of Hygiene & Tropical Medicine

“**Strong Ministries for Strong Health Systems**,” Bellagio Conference Report, Francis Omaswa & Jo Boufford

“**Silos to Systems: The Sparks of Global eHealth Ignite**,” *Health Affairs*, Feb. 2010; Authors: Ticia Gerber, Veronica Olazabal, Karl Brown, Ariel Pablos-Mendez

March 2010: “**Health Information and Integrated Urban eHealth Systems in the Developing World**,” Chapter 13 in *Urban Health: A Global Perspective* by The New York Academy of Medicine. Authors: Veronica Olazabal, Ticia Gerber, Beatriz de Faria Leao, Claudio Giulliano da Costa, Karl Brown, Ariel Pablos-Méndez

“**The Impact of HIV Scale-up on Health Systems: A Priority Research Agenda**,” Miriam Rabkin, Kevin M. De Cock, Wafaa El-Sadr, *JAIDS* 2009; in press. <http://journals.lww.com/jaids/toc/2009/11011>

Forthcoming article: “**Ministers of Health: A Revolving Door?**” Miriam Rabkin, Aisha Jaifri, Denis Nash, Kevin Schulman, Michael Merson.

Symposium Report: “**The Role Of The Private Sector In Health**” Pre-Congress Symposium The World Congress Of The International Health Economics Association (Ihea) Beijing 11 July 2009

Forthcoming: “**Speculating a New, More Integrated World for Health after the Economic Crash: A Historical Perspective**” *American Journal for Public Health* or *WHO Bulletin*: Authors: Ariel Pablos-Mendez, Socrates Litsios, Sania Nishtar, Veronica Olazanabal, Paulo Buss

“**Partnerships with the Private Sector in Health: What the International Community Can Do to Strengthen Health Systems in Developing Countries**,” Report of the Center for Global Development’s Private Sector Advisory Facility Working Group

“**Public Stewardship of Private Providers in Mixed Health Systems**,” Gina Lagomarsino, Donika Dimovska, Sapna Kundra, Stefan Nachuk, ‘Corporate Council on Africa Newsletter’ September 18, 2009

**“All for Universal Health Coverage”** Laurie Garrett, A Mushtaque R Chowdhury, Ariel Pablos-Mendez, August 20, 2009 - The Lancet

**“Public stewardship of mixed health systems”** Gina Lagomarsino, David de Ferranti, Ariel Pablos-Mendez, Stefan Nachuk, Sania Nishtar, Suwit Wibulpolprasert, The Lancet (doi:10.1016/S0140-6736(09)61241-1) Volume 374, Issue 9701, Pages 1577 - 1578, 7 November 2009

**“Public Stewardship of Private Providers in Mixed Health Systems,”** Gina Lagomarsino, Stefan Nachuk, Sapna Singh Kundra; Synthesis Report from The Rockefeller Foundation-Sponsored Initiative on the Role of the Private Sector in Health Systems in Developing Countries, Results for Development, 2009; ISBN 978-0-9788790-9-9

**“Innovative Pro-Poor Healthcare Financing and Delivery Models,”** Donika Dimovska, Stephanie Sealy, Sofi Bergkvist, Hanna Pernefeldt; Landscaping from The Rockefeller Foundation-Sponsored Initiative on the Role of the Private Sector in Health Systems in Developing Countries, Results for Development, 2009; ISBN 978-0-9788790-8-2

**“The global financial downturn—imperatives for the health sector”** Sania Nishtar, Ariel Pablos-Mendez, The Lancet, Volume 373, Issue 9658, Page 124, 10 January 2009 (doi:10.1016/S0140-6736(09)60037-4)

**“ The U.S. Commitment to Global Health, Recommendations for the New Administration,”** Institute of Medicine of the National Academies, (RF Sponsored)

**“Leveraging HIV Scale-Up to Strengthen Health Systems in Africa”** Bellagio Conference Report, September 2008; International Center for AIDS Care and Treatment Programs, Mailman School of Public Health, Columbia University;

Bulletin of the World Health Organization; Special Theme: public health education, Volume 85, Number 12, December 2007, 901-980

**“Making the eHealth Connection: Global Partnerships, Local Solutions, Pathways and Progress,”** Pamphlet, The Rockefeller Foundation 2008

**“The Role of the Private Sector in Health Systems, Challenges and Opportunities,”** Pamphlet 2008 The Rockefeller Foundation, Results for Development, iHPP Thailand

**“Pocantico II, The Global Challenge of Health Systems,”** Conference Report, 2007 The Rockefeller Foundation

Intellectual Property Management in Health and Agricultural Innovation, a handbook of best practices, MIHR

