Escaping the "Graveyard of Pilots": Addressing the Political Economy of Pilotitis in Public Health

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Introduction

In 2012, the government of Uganda imposed a moratorium on new mobile health pilot projects, citing growing frustration with the proliferation of small-scale digital health experiments that rarely progressed beyond their trial phase (Huang et al., 2017, p. 2). The decision reflected a broader concern within global health systems: despite promising results, many pilot programmes fail to transition into routine policy or large-scale implementation. Rather than serving as temporary testing mechanisms, pilot initiatives frequently become permanent features of the policy landscape, repeatedly demonstrating effectiveness without producing sustained change.

This phenomenon has increasingly been described in the literature as "pilotitis." Schiffelers et al. (2025, p. 2) define pilotitis as a pattern in which healthcare innovations are repeatedly tested in pilot settings but rarely advance to full-scale integration within health systems. Similar concerns appear in development studies, where global health programmes have been described as a "graveyard of pilot projects," with promising interventions abandoned once project funding or research support ends (Spicer et al., 2018). The persistence of pilot programmes therefore raises an important policy question: why do interventions that demonstrate measurable benefits so often fail to scale?

This article argues that pilot programmes have devolved from bridges to political commitment into substitutes for it. While pilots are intended to generate evidence that justifies national implementation, structural funding arrangements, institutional barriers, and short project cycles frequently prevent this transition from occurring. As a result, evidence of effectiveness does not automatically translate into policy adoption.

The following sections examine why this gap between evidence and implementation persists. First, the article outlines the intended role of pilot programmes and explains why the bridge from experimentation to scale often breaks down. It then examines two cases: the implementation of the WHO mhGAP programme in Tunisia and donor-funded health pilots in low- and middle-income countries, to illustrate how structural and political constraints limit scale-up. Finally, it proposes policy recommendations to address these systematic barriers.

The Logic of Pilots and Why It Breaks Down

Pilot programmes are widely used in public health policy as a mechanism for testing new interventions before broader implementation. In theory, pilots function as a bridge between experimentation and national policy adoption. By demonstrating effectiveness in a controlled environment, they generate the evidence needed to justify scaling an intervention across health systems. International guidance on health programme scale-up emphasises that pilot initiatives should

provide policymakers with the information necessary to determine whether an intervention is feasible, effective, and sustainable at larger scale (WHO & ExpandNet, 2011, p. 1).

In practice, however, this bridge between evidence and implementation frequently fails. A key reason is that evidence alone does not automatically translate into policy reform. Even when demonstration projects produce positive results, the expansion of these initiatives often depends on political decision-making processes that are shaped by institutional constraints and competing priorities. As Rocco and Kelly (2020, p. 69) note, successful demonstration projects may still fail to produce policy change because institutional veto points allow multiple actors to block or delay implementation. This dynamic helps explain why pilot programmes are frequently chosen as a policy instrument in the first place. Precisely because they operate outside routine health system structures, pilots face fewer of the political constraints that full-scale reform would require — they do not demand legislative change, broad stakeholder consensus, or large-scale budget reallocation. While this makes pilots easier to initiate, it also creates a structural paradox: the conditions that make pilots politically viable are the same conditions that make scaling them institutionally difficult. Once a pilot moves beyond its controlled setting, it encounters the very veto points and competing priorities it was originally designed to avoid.

Another factor limiting the scalability of pilot programmes is the conditions under which they are implemented. Pilot initiatives are frequently conducted with levels of financial, technical, and human resource support that are difficult to replicate at scale. The WHO ExpandNet framework notes that pilot projects often succeed under these artificially favourable conditions but struggle when the intervention must operate within routine health system environments (WHO & ExpandNet, 2011, p. 1). Without structural adaptations to accommodate new programmes, innovations risk remaining temporary additions rather than becoming integrated components of healthcare delivery (Schiffelers et al., 2025, p. 7).

Short project cycles further reinforce this dynamic. Many development and global health pilots operate within funding periods of three to four years, limiting the time available for long-term implementation or institutional integration (Spicer et al., 2018). As a result, programmes may spend much of their lifespan establishing operations and preparing final evaluations rather than demonstrating sustainable impact.

Together, these factors illustrate why pilot programmes frequently fail to fulfil their intended purpose. Although pilots are designed to provide evidence for scale-up, the political, institutional, and financial conditions necessary for implementation are often absent.

Mental Health Integration in Tunisia

Efforts to integrate mental health services into primary care systems illustrate many of the challenges associated with scaling successful pilot programmes. One widely cited example is the implementation of the World Health Organization's Mental Health Gap Action Programme (mhGAP) training initiative in Tunisia. The programme was designed to address shortages of specialist mental health providers by training primary care physicians to diagnose and manage common mental health conditions within community healthcare settings (Spagnolo et al., 2021).

The pilot programme demonstrated measurable improvements in physician capacity. Following mhGAP training, primary care physicians reported increased knowledge of mental health conditions, improved attitudes toward patients with mental illness, and greater confidence in their ability to diagnose and treat common psychiatric disorders (Spagnolo et al., 2021). These findings suggested that integrating mental health services into primary care could significantly expand access to treatment within Tunisia's health system.

However, the pilot also revealed structural barriers that limited the programme's effectiveness. Existing regulatory frameworks prevented primary care physicians from prescribing several psychotropic medications that were central to the mhGAP treatment guidelines (Spagnolo et al., 2021). As a result, although physicians had received training to diagnose and manage mental health conditions, they lacked the legal authority to prescribe the medications required for treatment. This regulatory constraint significantly limited the practical impact of the programme.

The Tunisian case therefore illustrates a broader challenge associated with pilot programmes: evidence of effectiveness does not automatically translate into policy change. While the pilot demonstrated improvements in clinical knowledge and provider confidence, scaling the intervention required regulatory reform and institutional adjustments beyond the scope of the pilot itself. WHO guidance on programme scale-up emphasises that such policy and regulatory changes must often be initiated during the pilot phase, as reform processes can take significant time to implement (WHO & ExpandNet, 2011, p. 8).

Furthermore, the translation of pilot evidence into national policy depends on political timing. Policy reforms may only become feasible when political opportunities emerge, meaning that successful pilot programmes must align with broader policy windows to achieve scale-up (Rocco & Kelly, 2020, p. 70). In Tunisia, the mhGAP pilot ultimately contributed to broader discussions about mental health system reform, but the pathway from evidence to implementation required sustained political commitment.

Rather than representing a failure, the Tunisian mhGAP pilot illustrates a central lesson of pilot programmes: demonstrating effectiveness is only the first step in achieving large-scale policy change. Without parallel regulatory and institutional reforms, even successful interventions may remain confined to pilot settings.

Global Health Pilots and Donor Dependency

While the Tunisian mhGAP programme illustrates the regulatory challenges that can obstruct scale-up, similar patterns are visible across the broader landscape of global health interventions. In many low- and middle-income countries (LMICs), pilot programmes are frequently implemented through short-term donor-funded projects that operate alongside, rather than within, national health systems. Although these initiatives are often introduced with the expectation that governments will later absorb and expand them, this transition rarely occurs in practice (Spicer et al., 2018).

Donor-funded pilot programmes are typically structured around project cycles lasting three to four years. During this period, external funding supports programme design, implementation, and evaluation, often providing resources that exceed those available within routine public health systems (Spicer et al., 2018). While these conditions can enable promising short-term results, they also create a structural barrier to long-term sustainability. Once project funding ends, national governments may lack the financial capacity or institutional incentives required to maintain the intervention.

A further challenge arises from the way donor-supported pilots are frequently organised outside national health planning frameworks. Many initiatives operate independently of government budgeting processes, service delivery structures, and long-term policy strategies (Spicer et al., 2018). This separation can make it difficult to integrate successful interventions into existing health systems even when evidence of effectiveness exists. Rather than forming the foundation for national programmes, pilot projects may remain isolated experiments that disappear once external funding concludes.

Competition among donor organisations can further fragment the policy landscape. Multiple agencies may introduce similar interventions in parallel, each implemented as a separate pilot with distinct reporting requirements and evaluation frameworks. This fragmentation can complicate coordination and make it difficult for governments to determine which initiatives should be prioritised for scale-up (Spicer et al., 2018). As a result, health systems may become populated with numerous small-scale projects rather than coherent national programmes.

The cumulative effect of these dynamics has produced widespread frustration among policymakers. In 2012, the Ugandan government responded to the proliferation of digital health pilot

projects by imposing a moratorium on new mHealth pilots, arguing that the health sector had become saturated with small-scale experiments that failed to deliver sustainable system improvements (Huang et al., 2017, p. 2). This decision warrants closer examination. On one hand, the moratorium can be read as a rational and justified policy response — a government protecting finite health system resources from being absorbed by fragmented projects that generate evidence without producing change. On the other hand, it raises a more troubling concern: if the structural barriers to scale-up are left unaddressed, moratoriums risk entrenching the status quo by halting experimentation altogether rather than fixing the conditions that prevent implementation. The Ugandan case therefore crystallises the central tension running through this article.

The problem is not pilot programmes themselves, but the absence of the political commitment, regulatory reform, and institutional coordination needed to move beyond them. Without these foundations, even well-designed interventions will continue to accumulate in the pilot phase, consuming resources, and producing evidence that goes unused.

Conclusion and Policy Recommendations

The persistence of pilot programmes across global health systems reflects a structural problem rather than a failure of evidence. As the cases of Tunisia and Uganda illustrate, interventions can demonstrate clear effectiveness and still fail to transition into national policy. This occurs not because pilots are poorly designed, but because the political, regulatory, and financial conditions necessary for scale-up are rarely in place when pilots conclude. In this sense, pilot programmes have increasingly become substitutes for political commitment rather than pathways toward it.

These findings carry important implications for how policymakers approach health system innovation. If pilots rarely progress to implementation under current conditions, continuing to invest in them without structural reform risks perpetuating the same cycle. This does not mean pilot programmes should be abandoned, but it does suggest they should only be pursued under specific conditions — namely, when there is credible political will to act on results, and when regulatory and institutional reform processes are already underway in parallel.

To address these structural limitations, three policy recommendations follow from the analysis above. First, donor funding for pilot programmes should be made conditional on the existence of pre-agreed scale-up pathways, requiring governments and funders to specify in advance how a successful intervention would transition into routine health system delivery. Second, regulatory and institutional reforms identified during the pilot phase should be initiated concurrently rather than sequentially, as reform processes frequently take longer than project cycles allow. Third, donor coordination mechanisms should be strengthened to reduce the fragmentation of pilot initiatives,

ensuring that governments can identify and prioritise interventions with the highest potential for implementation rather than managing competing parallel projects. Together, these measures would shift the function of pilot programmes from repeated demonstration back to their intended purpose: building the evidence base for sustained policy change.

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