

**SECTION 2: STEPS TO CONDUCT THE ASSESSMENT**

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# ACRONYMS

DIFD	United Kingdom Department for International Development
HIS	Health Information Systems
HMIS	Health Management Information Systems
HRH	Human Resources for Health
HSA	Health System Assessment
HSS	Health System Strengthening
MOH	Ministry of Health
SOW	Statement of Work
SWOT	Strengths, Weaknesses, Opportunities, and Threats
TPM	Team Planning Meeting
UHC	Universal Health Care
USG	United States Government

# I. STEP I—SHAPE THE ASSESSMENT

## I.1. Identify Client Priorities

The HSAA is a tool designed to allow the health system assessment (HSA) to be tailored to the country and purpose. HSAs are used to inform development of recommendations and action planning. Although the HSAA standardizes indicators, analysis method, and knowledge base across the health system functions, application of an HSA must be country and purpose specific. Since 2006, the HSAA has been applied 30 times to respond to specific client needs at a point in time to inform program and action

“The MOH would find this useful. In terms of the results, packaging these so that they could be used to lobby the Ministry of Finance for more resources for instance would also be of benefit.”

—DFID

planning, for example, a new Ministry of Health (MOH) strategy or a future development partner project.

Ideally, the country should drive the initial HSA prioritization and scoping during Step 1. Discussions between the MOH and assessment team should include topics such as the government’s goals for the health sector; whether other,

similar assessments have been conducted in the recent past; how the HSA might contribute to achieving sector goals; the level of participation from MOH staff; and the types of outcomes the MOH expects. Discussions should accomplish the following:

1. **Clarify the purpose of the HSA and how the HSA findings and recommendations will be used and by whom.** These client needs should be identified and discussed early on in the HSA planning process to ensure that the structure and focus of the assessment reflect client priorities. See Section 1, “Purpose of HSA Manual.”
2. **Clarify time and resource constraints.** The client and team leader must discuss how an individual HSA will produce the information the client needs, within the given time and resource constraints, and modify the HSA approach to these constraints. Table 2.1.1 describes a low-resource HSAA.
3. **Clarify HSA data sources.** Make sure it is clear that the HSA takes full advantage of secondary data, key informants, and limited primary data collection that does not normally include a survey or representative sampling in the field. Although primary data collection is rarely part of the HSAA, it has been done to meet client needs when there is adequate time and funding (e.g., facility survey, a political economy analysis).
4. **Identify recent country health sector studies to ensure that this HSA adds value.** The client and/or the MOH may be able to inform the assessment team of such studies or the team may identify them during its document review. It is important to clarify with the client how the HSA adds value to previous assessments.

4. **Define the structure and scope of the final assessment report.** The client and team should discuss and customize the structure and scope of the final assessment report. Note that among the technical chapters, the Country Overview is mandatory, although it may be customized to reflect client needs and the country situation. See Annex 2.1.A for a suggested outline for the final assessment report.
5. **Agree on deliverable timeline and final scope of work (SOW).** See Annex 2.1.B for a sample SOW and timeline.

## Building Country Ownership

Even with HSAs that were not initiated by the MOH, the country is the ultimate client of any assessment to strengthen a health system. Even if the HSA is funded by a development partner, MOH leadership guarantees ownership of the HSA findings and, thus, the likelihood of recommended health systems structuring (HSS) interventions being funded and implemented. In addition to the MOH shaping the HSA SOW, other ways to build country ownership are:

- Work with the MOH to identify consultants and build the team together;
- Ensure that MOH staff are on the assessment team;
- Brand the HSA report as MOH; and
- Coordinate with the local WHO office, which may have more continuous engagement with the MOH.

“This is a useful reference point for Democracy, Human Rights, and Governance officers (DRG) interested in integration, and also can serve as a starting point around how different assessments (e.g. PEA) can complement each other to inform project design.”  
—USAID

### 1.2. Agree on the Scope of Work and Cost

The HSA should respond to clients’ priority questions and needs as well as the time and resources available to conduct the assessment. Based on more than 30 applications of the HSAA since 2006, there is a range in the scope and resource intensity (cost) of the HSA. Table 2.1.1 describes the range in HSA scopes and details what drives the variation. There are three other factors that affect the cost:

1. **The number of assessment modules** determines the overall level of effort (person days). It is recommended that all the technical modules be covered (Section 3, Modules 1–7). Each will require 3–4 person weeks to complete:
  - One week for document review, analysis, and writing the zero draft.
  - Two weeks for fieldwork, participating in the analysis across modules, and formulating recommendations.
  - Up to an additional week to finalize the chapter.
2. **The depth of the private sector assessment**, including the range and number of organizations and stakeholders to consult. Tools to assess private sector participation, such as through the Strengthening Health Outcomes in the Private Sector (SHOPS) project and others could be utilized by team members with experience in assessing the private sector.

3. **Delays:** Another cost driver is any delay in the HSA process. Steps that commonly take longer than clients expect include recruiting team members, engaging local stakeholders, receiving government approval (except when MOH is the client), negotiating the scope and budget with multiple parties, and reviewing the HSA report by multiple parties.

## Rapid, low-resource HSA

It may be possible to address the client’s questions using a small team that analyzes only documents and secondary data. Table 2.1.1 has a separate column to describe what a rapid, low-resource HSA application might look like, although this model has not yet been applied.

“I have always been a fan of this manual and would like to see it uniformly applied in all countries. Even as part of the [strategic policy and planning] Project Appraisal Document (PAD) process.”  
—USAID

**Table 2.1.1. Range of Health System Assessment Scopes and Cost Drivers**

Scope and Cost Drivers	Range of Full HSA Applications	Rapid, Low-resource HSA Application
Needs and priorities of the clients who typically represent the MOH, a health partner (e.g., external development partner), or both	<ul style="list-style-type: none"> <li>The need for the HSA can vary, for example, to inform: revision of multiyear national sector plan; a new MOH strategy (e.g., to achieve universal health care (UHC), a future external development partner project, country application for external development partner funding (e.g. Global Fund grant), private sector partnership, or investment.</li> <li>The priorities for the HSA analysis can vary, for example: specific population groups, specific service or program priorities (HIV/AIDS, maternal and child mortality, family planning); focus on the private sector; or post-crisis assessment (civil unrest, epidemic, natural disaster).</li> <li>A separate purpose can be to build the capacity of local experts in health system assessment and strengthening.</li> </ul>	Same as full application, excluding capacity building
Time (from initial request to final report)	<ul style="list-style-type: none"> <li>6–12 months or more</li> <li>Note that delays are possible</li> </ul>	3–5 months assuming no delays
Staffing size	<ul style="list-style-type: none"> <li>Team leader, 3 or more core experts, international coordinator, in-country coordinator, MOH focal point, technical reviewer.</li> <li>A larger team that includes local experts or MOH client staff for on-the-job training to conduct HSA.</li> </ul>	Team leader and 1–2 additional experts plus technical reviewer
Staff profile	<ul style="list-style-type: none"> <li>Team could be all consultants (local and international) accompanied by MOH staff or mixed (both consultants and clients) along with MOH staff.</li> <li>Clients looking for an independent assessment or who are unable to commit staff time may prefer an all-external team who can work full time, ask probing questions, and provide objective recommendations.</li> </ul>	Senior experts who can dedicate time to HSA

Resources for travel	<p>1–3 visits: A minimum of one 2-week visit by core team that includes a multi-stakeholder workshop at the end of the visit to present and validate findings and preliminary recommendations.</p> <p>Up to 3 visits: 1. Plan/scope; 2. Data collection and (ideally) preliminary findings and recommendations; 3. Present final findings and recommendations, possibly linked to action planning.</p>	No travel
Data sources: Most low- and middle-income countries have a wealth of prior reports, studies, and secondary data (surveys, health information systems [HIS]) that have not been analyzed systematically.	<ul style="list-style-type: none"> <li>• Documents and secondary data.</li> <li>• HIS data.</li> <li>• In-person interviews, focus groups, workshops with key informants.</li> <li>• Visits to a few health facilities (not representative) for further guidance on subnational and facility visits.</li> <li>• Primary data collection is rarely part of the HSAA but has been done to meet client needs when there is adequate time and funds (e.g., facility survey, a political economy analysis).</li> </ul>	Documents and secondary data, key informant interviews (national-level only), follow-up communications (calls, emails).
Health system level: national, subnational, combination	<p>Most HSAs have been at the national level.</p> <p>A. A subnational-level assessment is appropriate in countries where: a) the public health sector is very decentralized (Nigeria, India)</p> <p>B. A national-level assessment has recently taken place, but subnational areas require further investigation</p> <p>C. The client prioritizes comparisons among subnational areas (e.g., health disparities).</p>	The rapid, low-resource HSA can be at any level, but the data sources will be more limited.
Engagement of local stakeholders in the HSA	<ul style="list-style-type: none"> <li>• Launch event to get buy-in before the assessment begins and involve stakeholders in the adaptation of the methodology.</li> <li>• Hold briefing meetings.</li> <li>• Conduct interviews and focus groups.</li> <li>• Hold one or more stakeholder workshops to fully share, discuss, and shape the findings and recommendations.</li> <li>• Hold one or more rounds of stakeholder review of the draft report.</li> <li>• Hold one or more dissemination events.</li> </ul>	<p>Communications via calls, emails.</p> <p>One round of report review.</p> <p>Rely on client for other stakeholder engagement.</p>
Final report	<ul style="list-style-type: none"> <li>• At least one technical review.</li> <li>• Reviews by client (if not direct solicitation by MOH), MOH, and possibly other stakeholders. Allow several weeks or months.</li> <li>• At least 100 pages.</li> <li>• Professionally copyedited and formatted (e.g., color graphics).</li> <li>• Translated into local language.</li> </ul>	One technical review, client review within one month, up to 100 pages, light copyedit and simple format, English only.



Based on these considerations, the team leader will estimate the overall timeframe and dates for implementation of all assessment steps and activities, including the team's preparations; and each individual team member's preparation, fieldwork, and writing assignments (See Step 2).

## Prepare Assessment Budget

The budget should be estimated early in the planning process in order to balance assessment priorities with budget realities. Table 2.1.2 provides a simple budget template to which additional lines and items can be added. A notional budget should be prepared during the scoping phase and then updated with actual rates once the team members are confirmed. The team leader should track all expenditures to ensure that the HSA is completed within budget.

**Table 2.1.2. Template Assessment Budget**

Line Item	Rate	Unit	Number of Days (Level of Effort)	Total = Rate x Units
<b>Labor</b>				
Team leader	\$	/day	35 days	\$
Team member	\$	/day	30 days	\$
Team member	\$	/day	30 days	\$
Team member	\$	/day	30 days	\$
Team coordinator	\$	/day	10 days	\$
In-country consultant/logistics coordinator	\$	/day	15 days	\$
Subtotal labor				\$ Subtotal
<b>Travel</b>				
Travel – airfare	\$	/trip	# trips	\$
Per diem	\$	/days	12 days	\$
Other costs – local travel	\$	/trip	# trips	\$
Other costs – visa	\$	/trip	# trips	\$
Other costs – miscellaneous	\$	/trip	# trips	\$
Subtotal travel				\$ Subtotal
<b>Subcontracts/outside services</b>				
Workshop venue	\$	/day	# days	\$
Workshop meals	\$	/person	# people	\$
Driver and car	\$	/day	# days	\$
Translators	\$	/day	# days	\$
Subtotal subcontracts				\$ Subtotal
<b>Other costs</b>				
Communications	\$			\$
Other	\$			\$
Subtotal other				\$ Subtotal
<b>Total Assessment Budget</b>				<b>\$ (Sum Subtotals)</b>

## 1.3. Promote Local Stakeholder Engagement

Stakeholder engagement from all sectors in the HSA process from start to finish is critical to assessment ownership, accuracy, and completeness as well as use of its findings and recommendations for decisionmaking and actions. Early on, the team, together with the client and MOH (if the client is other than the MOH), should decide on the approach to stakeholder engagement. A supplementary guide to stakeholder participation can be accessed at *Engaging Stakeholders in Health System Assessments: A Guide for HSA Teams*.

Ideally, HSA teams should engage local stakeholders prior to, during, and after the assessment to inform and solicit their support, participation, validation of findings, and support and ownership of recommendations. The team leader and client should agree on the number and type of stakeholder encounters and workshops that would be the most useful. The HSA approach recommends working with these stakeholders through four main types of stakeholder encounters, shown in Table 2.1.3.

**Table 2.1.3 Options for Stakeholder Workshops and Consultations**

Type of Engagement	Description	Who	When
Shaping the scope of work to ensure engagement	During this first step, reach agreement with the client on how stakeholders will be involved during the HSA process and document decisions in the SOW, the schedule of activities, and team composition.	HSA client	First step
HSA team	<ul style="list-style-type: none"> <li>Local expert(s) nominated and recruited as members of the HSA team.</li> <li>Work with the MOH to identify consultants and build the team together.</li> </ul>	<ul style="list-style-type: none"> <li>HSA client</li> <li>Senior stakeholders to vet names</li> </ul>	First step
Predata collection consultations	Conference calls or small meeting that serves to orient primary stakeholders and local team members, who have not been intimately involved in the preparation stages, to the assessment methodology, roles and responsibilities, in-country data collection process, and (in some cases) the technical content being discussed.	Primary stakeholders, local team members, and, potentially, individuals from the client organization who will be participating actively in the assessment	Before the fieldwork is conducted
Launch workshop	Larger workshop used to orient key stakeholders, who are external to the HSA team, to the approach and solicit input on important background information, secondary data, health system constraints and priorities, and ensure buy-in from local key informants.	Key stakeholders who are external to the HSA team.	At the outset of data collection fieldwork

Type of Engagement	Description	Who	When
Stakeholder consultation during data collection and analysis	<ul style="list-style-type: none"> <li>Series of sessions with key stakeholders.</li> <li>Sessions intended to leverage the knowledge and expertise of key stakeholders for greater understanding of the system and the actors that are important in the system.</li> <li>Interpretation of the data, the cross-cutting analysis, and validating conclusions.</li> <li>Input on potential recommendations to ensure they are actionable and feasible.</li> </ul>	<ul style="list-style-type: none"> <li>Either individually or with small groups of 3–5 key stakeholders.</li> <li>Meetings are facilitated by an HSA team member.</li> <li>Conference calls.</li> </ul>	During and after the HSA field work, before the report is completed
HSA validation and prioritization workshop	<ul style="list-style-type: none"> <li>Used to (1) validate findings and recommendations after the report has been written, reviewed by in-country counterparts, and revised for formal dissemination to external audiences and (2) prioritize the recommendations for action.</li> <li>Critical steps in moving assessment recommendations from suggestions to action.</li> <li>HSAs may include either a validation workshop alone or a prioritization workshop or both.</li> </ul>	Client and local stakeholders	Can happen before HSA team leaves the country or during a second trip.
Review of HSA report	<ul style="list-style-type: none"> <li>Agree with client (if not MOH) on the MOH review and approval process.</li> <li>Submit draft report to selected local stakeholders.</li> <li>To avoid delays, consider scheduling a conference call to discuss feedback.</li> </ul>	<ul style="list-style-type: none"> <li>Client</li> <li>Selected local reviewers</li> </ul>	Once draft HSA report is completed

## Who Are the Stakeholders?

The following provides a comprehensive list of stakeholder types by institution, including which stakeholders are important to engage for the purpose of the HSA; which ones to be included for data collection at a later date will depend on the focus of the assessment.

1. MOH and social security agencies: minister; key officials; and staff from planning, human resources, or other units.
2. Other ministries (e.g., local government, finance) or health-related bodies.
3. Local or regional authorities (e.g., county governments, district health officials).
4. Development partners' health team staff: World Bank and other international financing institutions; Global Fund to Fight AIDS, Tuberculosis, and Malaria; WHO and other U.N. agencies; bilateral partners such as U.S. government (USG) in-country health team staff (USAID and/or other agencies)

“As multi-donor trust funds are being set up and [the Social Health Protection] P4H networks are becoming more active in response to UHC, donors can help coordinate HSS investments by implementing an HSAA in advance of a project design.

—USAID

with significant and relevant investments in health and health systems), U.K. Department for International Development (DFID), among others.

5. Coordinating bodies (e.g., health sector coordinating committee, sectorwide approach, country coordinating mechanism).
6. Private sector commercial (for-profit) providers, multinationals, or national corporations involved in health as funders or employers.
7. Professional associations, councils, and unions (e.g., for doctors, nurses).
8. Licensing bodies and regulatory commissions.
9. Public service commission and regulatory agencies (e.g., for insurers, health professionals).
10. Nonprofit organizations, community groups, representatives of civil society, religious/faith-based organizations.
11. Private provider organizations.
12. Key implementing partners from development partner agencies and organizations.

General limitation to key informant interviews: During discussions with stakeholders, keep in mind that oftentimes stakeholders within the same organization are not always mutually aware of each other's activities and priorities and that interviewing one person from an agency does not necessarily provide the assessment team with the full picture. For example, if you are talking to the World Bank or African Development Bank, talk with technical officers in-country as well as those based in regional or headquarters offices. For USAID, talk with the country mission, the regional bureau, the Washington-based global health bureau. If you are talking with WHO, make sure to speak with various actors working in-country, including those who serve as resident advisors and those who perform short-term technical assistance. This is also true for interviewing staff at a few facilities and representatives of not-for-profits and commercial private subsectors (providers, insurers, large employers, suppliers). It is important to identify this limitation to the study and to realize that the study relies only on published documents, secondary data, and interviewing key informants, and this is a different exercise than carrying out a representative survey.

## 2. STEP 2—MOBILIZE THE ASSESSMENT TEAM

### 2.1. Assemble the Team

HSA team members should be identified as early in the assessment process as possible. This can be done while discussions are ongoing with the client to clarify the priorities and scope of the assessment. Members of the assessment team should possess skills and knowledge that reflect the priorities of the client and objectives of the HSA. While each team member might have specific expertise in one or more of the core health systems functions, all team members should have the ability to work and to think critically across the health system core functions. Table 2.1.2 summarizes the roles and responsibilities of assessment team members. It is recommended that, along with MOH focal points for the assessment, a team comprise:

- A team leader who understands HSS and the HSA approach and who can guide the team, facilitate analysis, and be responsible for the final report.
- Three technical experts (note: At least one of the four technical team members should have private health sector expertise).
- One assessment coordinator (who may be one of the technical experts).

- One local (in-country) logistics coordinator.

Once the team is assembled, the team leader assigns modules from Section 3 to each technical team member based on his/her expertise. The team leader then prepares an individual SOW for each team member so that the roles are clear; the SOW covers the responsibilities for data collection, analysis, and report writing for their modules, as well as participation in general team activities. Ideally, a role is also defined for any MOH focal point assigned to work with the team; otherwise the MOH staff would serve as liaison, and his or her role may vary depending upon the ability of the ministry to assign someone to

**TIP BOX: LOCAL LOGISTIC COORDINATOR**

Effective local (in-country) logistics coordinators play an important role in making an HSA successful. A good coordinator will save the team time in-country by allowing the technical leads to focus on the technical aspects of their assignments rather than on making appointments or arranging transportation. (See [Annex 2.1.C](#) for Sample Logistic Coordinator SOW.)

this task throughout the assessment.

**Table 2.2.1. Roles and Responsibilities of the Assessment Team**

	<b>Roles and Responsibilities</b>	<b>Tasks to Complete</b>
<b>Team leader</b>	<ul style="list-style-type: none"> <li>• Lead overall management of team activities with clear performance expectations.</li> <li>• Clarify the scope and timeline of HSA with client and team members.</li> <li>• Determine the context-appropriate level of stakeholder engagement and develop stakeholder engagement plan.</li> <li>• Ensure timely completion of the HSA within budget.</li> <li>• Conduct data collection, analysis, and write 1–2 chapters of the assessment report.</li> <li>• Lead team in synthesizing findings across modules.</li> <li>• Review report drafts from individual team members and provide overall quality assurance for full report.</li> <li>• Ensure external technical review of the report and address comments from client.</li> <li>• Deliver final report to client.</li> </ul>	<ul style="list-style-type: none"> <li>• Identify team members, assign technical responsibilities, and lead team planning meetings, including meetings while in-country.</li> <li>• Prepare SOW for the assessment.</li> <li>• Communicate regularly with client and key stakeholders regarding scope, timeline, and progress, including initial and final debriefings while in-country.</li> <li>• Establish protocols for interview note taking, sharing notes among team members, and report format before in-country trip.</li> <li>• Plan and conduct stakeholder engagement activities and workshop(s) with full team.</li> <li>• Work closely with assessment coordinator and with in-country consultants to ensure smooth logistics throughout the process.</li> <li>• Oversee production of report, including editing, translation (if necessary), and layout and design.</li> </ul>
<b>Technical team members (may include consultants and client or MOH staff with</b>	<ul style="list-style-type: none"> <li>• Conduct data collection, analysis, and write report section for 1–2 chapters within specified time.</li> <li>• Ensure consistency of analysis, findings, and recommendations with other building block chapters and for overall health systems context in the country.</li> <li>• Participate in all team meetings and stakeholder workshops.</li> </ul>	<ul style="list-style-type: none"> <li>• Review HSAA Manual: Sections 1 and 2, Section 3 Module 1: Overview, and all assigned technical modules in Section 3.</li> <li>• Prepare for data collection: Develop lists of documents, data needs, and potential interviewees for each chapter, based on information gaps.</li> <li>• Review secondary sources before country visit; conduct in-country data collection and</li> </ul>

	<b>Roles and Responsibilities</b>	<b>Tasks to Complete</b>
<b>relevant technical expertise)</b>	<ul style="list-style-type: none"> <li>• Support team leader as needed.</li> </ul>	<p>analysis, including travel within country as needed.</p> <ul style="list-style-type: none"> <li>• Prepare zero draft of report chapter(s) before country visit; complete report chapter(s) during and immediately after country visit.</li> <li>• Prepare the assessment logistics checklist and budget and ensure that the team is following this (see Annex 2.2.A for a sample logistics checklist).</li> </ul>
<b>Assessment team coordinator</b>	<ul style="list-style-type: none"> <li>• Support team leader in overall coordination of all team activities (as listed above).</li> <li>• Support has team to ensure timely completion of the HSA within budget.</li> <li>• Could also be one of the technical experts on the team.</li> <li>• Work closely with the local (in-country) coordinator.</li> </ul>	<ul style="list-style-type: none"> <li>• Contract consultants and make travel plans.</li> <li>• Work with team leader to arrange technical review (editing, translation [if necessary], and layout and design) of final report.</li> <li>• Organize, with assistance of local in-country coordinator, any in-country dissemination events or stakeholder workshop (if needed).</li> <li>• Obtain documents and secondary data for team to prepare before country visit.</li> </ul>
<b>Local (in-country) coordinator</b>	<ul style="list-style-type: none"> <li>• Support team leader in overall coordination of all team activities (as listed above).</li> <li>• Provide guidance to team on in-country protocols, including usual daily working hours (start, lunch, end), holidays, introductions, etc.</li> </ul>	<ul style="list-style-type: none"> <li>• Schedule key informant interviews as specified by team leader with assistance from client or in-country stakeholders.</li> <li>• Contract local translator(s) to work with the team (if needed).</li> <li>• Make all local arrangements and transport for all in-country data collection and interviews.</li> <li>• Make all local arrangements for stakeholder workshop(s), including invitations, venue, and meals.</li> <li>• Provide specific comments on the draft assessment report so that authors can improve the quality of the report.</li> </ul>
<b>Technical reviewer</b>	<ul style="list-style-type: none"> <li>• As a health systems expert, provide an independent objective review of the draft assessment report.</li> </ul>	<ul style="list-style-type: none"> <li>• Provide specific comments on the draft assessment report so that authors can improve the quality of the report.</li> </ul>

## 2.2. Customize the Logistics Checklist and Field Visit Calendar

A sample checklist of the preparatory tasks and logistical steps is presented in Annex 2.2.A. This checklist should be customized based on the priorities, resources, and time available for the assessment.

There may be only one field visit during which data are collected, the assessment findings are presented, and the report is drafted. Alternatively, there could be up to three field visits: a preassessment visit, the data collection visit, and, weeks later, a third visit to present and discuss the report findings at a validation and prioritization workshop. Before fieldwork begins, the team should consult with the client

and others to identify the geographic focus of the assessment (if there is one) and/or the best locations for travel to gather provincial-level data. Clients, other contacts, and country reports may also provide information on key informants for the assessment. See Table 2.2.2 for an illustrative field visit schedule.

**Table 2.2.2. Illustrative Schedule for the Field Data Collection (Including Validation Workshop during the current or a follow-up visit)**

Sat	Sun	Mon	Tues	Wed	Thurs	Fri
6 AM: Arrival Team meeting with local consultant 1–5 PM to review interview schedule, documents collected, USAID meeting; get other guidance from local consultant.	7 Full-day team meeting to review zero drafts of chapters; begin problem analysis and prepare for data collection and/or launch workshop.	8 AM: Meeting with client to review schedule and prepare for data collection and workshops. PM: National-level interviews AND/OR Launch workshop <sup>a</sup> . Evening: Team check-in and write-ups.	9 Send invitations for stakeholders' workshop. National-level interviews, including discussions with group of NGO representatives. Evening: Team check-in and write-ups.	10 National-level interviews including discussions with group of private-sector representatives. Evening: Team check-in and write-ups.	11 National-level interviews. Evening: Team check-in and write-ups	12 Meeting with client re: info gaps and logistics for next week. 2 team members do province visit and 2 team members continue national interviews. Write-ups.
13 Final drafts of each chapter by 5PM <sup>b</sup> . OR Team meeting to review SWOTs*, synthesize findings across modules, prepare for additional data collection.  *SWOTs = Strengths, Weaknesses, Opportunities, and Threats	14 Team meeting to synthesize findings across modules and distill conclusions and recommendations. Write up options. Send draft report to person doing quality review. OR Additional national-level key informant interviews.	15 Team members split to visit 2 more provinces. Evening: Team check-in and write-ups.	16 Conference call with person doing quality review to hear feedback on report. Return from provincial visits.	17 AM: Team meeting to share info from provincial visits, revisit findings and recommendations. Briefing for client on preliminary findings and recommendations for stakeholder validation workshop. OR Additional national-level interviews.	18 Prepare for stakeholder validation workshop. AND/OR Additional national-level interviews.	19 Stakeholder validation workshop. OR Full-day final team meeting to formulate recommendations and validate findings.
20 <ul style="list-style-type: none"> <li>Write up results of workshop.</li> <li>Send latest draft of report to the client within a week after departure.</li> </ul>				OR Finalize report after visit and return for validation and prioritization workshop.		

<sup>a</sup> See Section 1.4 and Table 2.1.3 for more information on the types of and variations to stakeholder workshops used in the assessment process. If the HSA team decides a launch workshop would be appropriate and/or beneficial, the workshop invitation should go out at least a week before the workshop and official data collection should begin after the workshop.

<sup>b</sup> The second week in-country will vary depending on client needs. Teams have typically either prepared and reviewed the first draft of the report to share with the client on the final day in-country or utilized the time to collect additional information and postponed validation for a second visit.

## 2.2 Schedule and Conduct Team Planning Meetings

At the outset of the assessment, the team should meet to review the purpose of the assessment, the systems thinking approach, and assign responsibilities. SOWs for each team member should be reviewed. The assessment approach and the client's objectives should be discussed to make sure all team members have the same understanding of how the assessment is to be conducted, what it means to use systems thinking, and the purpose of the end product. See Annex 2.2.B for a sample team planning meeting (TPM) agenda.

By the first TPM, all team members should have done some research on their assigned chapter and/or core health system functions (see Step 3). Each team member should assemble public documents and data that are available, identify documents/data that are still being sought, and make a preliminary list of key institutions (if not individuals) to schedule interviews during the field work. The team leader should share the report outline, including writing assignments, internal deadlines for drafts, and expectations for the field work.

A second TPM may be scheduled before fieldwork to review progress on writing the zero draft of each chapter, identification of information gaps, preliminary findings, and coordination of field work. All team members should share the zero draft of their sections of the HSA report to encourage overall understanding of the health system, identify common problems, and identify knowledge/information gaps to be filled as well as hypotheses to be tested. During this meeting, team members prepare for fieldwork logistics and (if planned) the stakeholder launch workshop to ensure that meetings, key informant interviews, and planning for field visits are well coordinated. See Annex 2.2.C for a sample report outline/table of report writing assignments. This is explained in greater detail in Step 3: Data Collection.

### PREDEPARTURE LESSONS LEARNED FROM PREVIOUS HSAs

- Team leader communicates regularly (emails, phone calls) with client to build relationship and get country support for the HSA process.
- Establish a clear point of contact at the MOH for engagement, updates, information, and approval.
- Absorb as much background research as possible—do not ask local stakeholders questions that have published answers.
- Forcing yourself to produce a zero draft of your sections and discussing it with your team will accelerate your understanding of the health system and sharpen the focus of your field work.
- Be careful to not underestimate the amount of level of effort required particularly for the team leader, as he or she is responsible for the report in its entirety and may have to step in to finish or produce missing sections.



## 3. STEP 3—COLLECT DATA

### 3.1 Compile and Review Documents; Create a Zero Draft

The HSA approach is an assessment based on review of secondary data combined with interviews and discussions with key stakeholders. Statements and conclusions in the HSA report should be referenced in the bibliography so that the information is verifiable.

#### Compile and Review Documents

As early as Step 1, when the scope of the HSA is being shaped, the assessment team should begin to compile background information on the country, in particular all general health system documents they can find. Each module in Section 3 suggests specific types of documents, and references in these documents will suggest still other relevant sources of information. New documents and data will be gathered during the field visit. See a Country Example of background documents in Annex 2.3.A.

Basic rules:

1. The team leader should establish a single location accessible to all team members to save all files/resources.
2. The team leader should communicate the citation format to all members.
3. Each technical team member is responsible for locating and reading documents relevant to his or her core health system function and compiling a bibliography of all documents consulted.
4. The team leader should coordinate requests to the client and in-country contacts for documents and data.
5. One team member must consolidate a single reference list for the final report.

During the desk research phase, it is essential that all prior assessments be reviewed in order to identify gaps and that all team members begin building zero drafts.

#### Create Zero Draft

A “zero draft” is an early draft of all sections of the report developed prior to the fieldwork. The zero draft can be an annotated outline, with initial information under each subheading, or a draft narrative with initial analysis of strengths, weaknesses, opportunities, and threats (SWOTs). The more extensive the effort to develop the zero draft and discuss it as a team, the more productive will be the field visit. The field work will focus more on validating conclusions and exploring recommendations, instead of gathering information that was already available in documents. With the specific HSA objectives in mind, HSA team members should begin building the zero draft:

- Describe succinctly how each health system function is currently performing, guided by the indicators in the module.
- Flag underlying causes of problems and the links with other health system functions.
- Flag issues that are mentioned repeatedly across data sources.
- Note previous and ongoing plans and efforts to address these problems.

- Follow, to the extent possible, the final report outline (example in Annex 2.1.A).

Each technical team member should submit a zero draft of his or her assigned chapters to the team leader, who will review and share with the whole team. Ideally, this happens before a pre-fieldwork team meeting where the team leader facilitates the whole team to use systems thinking to discuss preliminary findings, potential solutions, and the implications for the field work. A zero draft and a team meeting will serve to:

- Highlight potential SWOTs to be investigated during fieldwork.
- Accelerate the team’s collective understanding of health system problems and possible systems-level solutions and their ability to produce a high-quality report that truly adds value.
- Identify information gaps and the types of key informants who can fill those gaps in order to:
  - Refine the list of key informants.
  - Prepare interview questionnaires.
  - Begin scheduling meetings and interviews in a coordinated manner (many key informants will be sought by multiple team members).
- Provide the team leader an early opportunity to assist and/or correct the course of a team member who may not be producing the product that the team leader expects.
- Begin a preliminary stakeholder mapping and analysis (see box below for further information).
- Identify opportunities for stakeholder engagement to analyze a problem more deeply and/or explore potential solutions.

#### **STAKEHOLDER MAPPING AND ANALYSIS**

A thorough understanding of health system actors and their roles and influence as stakeholders to various health systems issues is very important in assessing the system and developing actionable recommendations. Stakeholder mapping and analysis techniques can help the assessment team be systematic about stakeholder identification. Some of the mapping and analysis steps can already be completed at the time of the document review. The following stakeholder mapping exercise is provided as an illustrative example; the assessment team can decide how far or how much more in depth it wishes to go.

Stakeholder mapping is a process by which a network map depicting key stakeholders is drawn. During the mapping process, the assessment team identifies the actors in any given system, how they are linked (i.e., what kind of information or resources they share), how influential they are, and what their goals are. This process is “low-tech” and often conducted using large sheets of paper, sticky notes, markers, and some small items to mark influence. Actor types, as well as relationship types, can be color coded. Arrows can be single- or bi-directional. The assessment team can undertake this exercise on its own and update the actors and relationships as data collection progresses.

For more information, please see:

- [The NetMap Toolbox](#)
- [USAID Stakeholder Mapping Worksheet](#)

## Develop Data Collection Guides

Based on the document review and zero draft, each assessment team member should draft data collection guides, which list the data, documents, and questions necessary to address the gaps, questions, and issues identified by the team’s analysis so far. There should be a draft guide for each health system function module. All guides should be reviewed by all team members in order to:

- Identify links, for example, the data collection guide for human resources will have questions about how providers are paid that overlap with health financing. The questions should be compared and consolidated and the data collection effort among the team members coordinated.
- Consolidate questions directed to the same person or organization to streamline interviews, for example, senior officials at the MOH.

The team will prepare:

- 1) Interview guides for specific key informants that consolidates questions for multiple modules.
- 2) Discussion guides for groups (e.g., a group of providers, NGOs, private companies that offer employee health benefits) to get information and engage in problem analysis, brainstorming, and problem solving.
- 3) Field visit guide for a facility and/or district health office.

## 3.2 Prepare Contact List and Plan Stakeholder Launch Workshop

### Prepare Contact List for Interviews

Based upon documentation examined during the initial review, each HSA team member should develop a contact list of key informants to speak with across levels of the health system and other key stakeholders and informants important to the assessment. For each contact, identify additional documentation that you may be missing and which they may be able to provide to you.

Central-level interviews focus on collecting information on the national health system. Subnational field visits allow the team to interview local officials and get a first-hand view of operations in the field.

The HSA team leader, together with the in-country coordinator, ensures that if multiple team members need to interview the same individuals, when possible, team members conduct the interview jointly to avoid duplication of their time.

### Plan Stakeholder Launch Workshop

This is the time to plan a stakeholder launch workshop to be held during the visit. A list of key workshop participants is derived from the contact list for interviews as well as other stakeholders external to the assessment. Workshop participants include those who may be key to issues related to policy, implementation, or financing of any of the six core health systems functions. It is intended to introduce the assessment approach to a larger group of health system stakeholders, solicit input on the health system constraints and priorities, and ensure buy-in from local key informants. A sample agenda for the launch workshop is included in Annex 2.3.C. Planning the workshop(s) is the responsibility of the team leader, who should have met with the client early on when designing the HSA approach and timeline. Ideally, the MOH focal point for the HSA will take a lead role organizing this workshop and inviting

participants. Details for the workshop, including review of workshop objectives, agenda, draft findings, participant list, and logistics, are the responsibility of the team leader in consultation with the client/MOH.

### 3.3 Collect Field Data

It is important to remember that the HSAA does not often include primary data collection, such as a large-scale survey or representative sample. Data collection in the field could include key informant interviews, group discussions, and a review of additional documentation.

It is important to ascertain the differences between how things are meant to work—often described in secondary source documents—and how things are really working.

#### Central-Level Key Informant Interviews

As part of pre-field visit interview planning, team members should identify and prioritize the questions and the relevant persons to interview. Consolidating all the needed interviews into a single list prior to the field visit will enable the HSA team to identify overlapping information (and therefore interview) needs and to schedule interviews so that multiple technical team members will be able to attend the same interview. Alternatively, if multiple team members need information from the same individual but scheduling conflicts prevent all of them from attending, one team member can collect information on behalf of the other(s) and report the information collected back to the team. In no case should the team expect a single interviewee to sit for multiple interview sessions.

#### Subnational Field Visits—Interviews and Observation Visits

Subnational-level field visits and interviews are intended to validate findings from the central level and to dig deeper in order to discover more information about the topic. Typical interviewees include local officials, facility staff, local NGOs, private providers, patient advisory groups, community representatives, and international health project staff. The local coordinator can help identify interviewees and schedule interviews or discussion groups. See Annex 2.3.D for a country example of subnational discussion guides.

Discussion guides for the subnational level are generally finalized after national-level key informant interviews take place (but prior to the site visits). This enables teams to identify key issues for further exploration. Discussion guides should be site specific. Annex 2.3.D contains, for example, data collection and discussion guides for interviews with a provincial or district health office and visits to health facilities.

##### DOING A SUBNATIONAL INTERVIEW

- Contact regional offices in advance of a site visit.
- Travel with a letter of authorization from the ministry.
- Plan the interview approach:
  - Team members could separate to conduct interviews at more facilities.
  - Interviews may be individual or group.
- Team members who travel to visit sites could, in some instances, collect data for the whole team.
- Diversify the type of facilities visited according to assessment priorities, such as: national, regional, and local; primary, secondary, and tertiary service providers; urban and rural; laboratories, pharmacies, medical facilities, etc.

The HSA team should consider the following factors when planning field visits:

1. Based on the HSA objectives and preliminary findings from the document review and national interviews, what are the priority questions that the team is looking to answer through the subnational interviews and field visits?
2. Which and how many subnational (state, province, or district) representatives should the team interview? Consider the size and geographic diversity of the country and the locus of power/authority in the health system (provincial, district, or municipal level). Subnational health authorities play a role in health system performance, even in the most centralized health systems.
3. Which and how many health facilities (for example, medical centers, retail and public pharmacies, warehouses, laboratories, and other places where health services or products are delivered or handled) should the team visit? Consider the diversity of the country's health service providers (e.g., use demographic and health survey data on source of services) to determine the mix of public and private (NGO, religious, or for-profit) health facilities to be visited. Note that the HSA methodology employs a qualitative approach to data collection through facility/site visits. If the client or country stakeholders want a representative facility survey in order to obtain data for a quantitative assessment, there are well-known survey methodologies for this purpose, such as the Service Provision Assessment.

While this HSA manual assumes that the assessment team members have field research experience and interviewing skills, following are tips from previous assessments.

#### **ADVICE FOR SUCCESSFUL INTERVIEWS**

1. Avoid asking “dumb” questions. Prepare for each interview by reviewing information already available in the person's area of expertise. Probe for information that is not publically available.
2. Validate any initial assumptions or conclusions that you (the team) are gravitating toward, based on available information—see your zero draft of the report.
3. Ask open-ended questions. What are his/her perspectives on the causes of observed problems? Why have previous efforts failed?
4. Explore possible HSS solutions that you and the team have been considering. Share experiences and evidence about these solutions. What does he/she think of these ideas?
5. When a respondent refers to a study, policy, law, report, or other document, ask for a copy or link so you can independently evaluate the contents and confirm the informant's interpretation. Do not leave the country without documents only available in-country. It is much easier to get them in person than through later emails.
6. Seek information from multiple perspectives. Different parties may perceive the same situation differently, and an individual informant may not perceive it accurately, for many reasons. For example, some informants may not be privy to what is actually happening or may only feel comfortable speaking about the ideal, or the way things should be. For this reason, it is important to verify the same “facts” in multiple interviews.
7. Document interview notes promptly (daily) to share with other team members so that all of you identify follow-up questions in future interviews. These notes are an important resource as the team prepares the final report.

## 4. STEP 4—ANALYZE FINDINGS AND DEVELOP RECOMMENDATIONS

### 4.1. Analysis to Add Value

Because the HSA approach is relatively quick (less than six months) and based largely on secondary data and key informant discussions, the biggest challenge is adding value to what local experts already know.

Beginning with the first team meeting prior to the country visit, the entire HSA team is simultaneously doing a deep analysis of his/her health system function(s) **and** a cross-system analysis looking at **all** of the functions. This cross-cutting analysis moves the team toward more sophisticated conclusions across the entire system and within each health system function. This analytical process is iterative and interactive, not linear. How the HSAA adds value:

- Team applies systems thinking approaches to make a fresh, holistic analysis of existing data across all six functions, meeting frequently (almost daily in-country) to share and critically discuss findings.
- Team members bring lessons and experiences from other countries and latest evidence from published literature.
- Team explores opportunities in the current context and near future (e.g., elections, new policy initiative, new external development partner project).
- Team process facilitates bringing stakeholders together to discuss underlying system weaknesses and possible solutions.

The team needs to analyze and integrate the quantitative and qualitative data from the desk review, key informant interviews, and discussions and observation visits. Step 4 outlines methods for analysis, summarizing findings, and developing recommendations. The team member should be able to present findings and conclusions for his or her modules, first to other members of the team and then in the assessment report (see Annex 2.1.A for a suggested outline for the report).

### 4.2. Review and Organize Data

Even as data collection is ongoing, organizing and/or categorizing of the data coming from the various sources mentioned above should begin, as it will help to make sense of the extensive amount of information collected (Lockyer 2004). Organizing and categorizing the data facilitates the retrieval and interpretation and facilitates the development of theories based on that interpretation. It is important that the assessment team triangulate findings from multiple data sources so that the overall findings are verified and outstanding questions addressed.

### What is Triangulation?

Triangulation is a “method of cross-checking data from multiple sources to search for regularities in the research data.” (O'Donoghue and Punch 2003:78).

Triangulation works because: “Just like multiple viewpoints allow for greater accuracy in geometry, (organizational) researchers can create more accurate hypotheses by examining relevant data from many different sources.” (Kohlbacker 2006).

As a first step, each individual HSA team member should take stock of the data that he or she has collected within the module in order to develop preliminary core health system function profiles. Section 3, which covers the country and health system overview and the six core health system functions, includes detailed instructions for what sources and types of information to include in these profiles. Then, through categorization, the team should narrow and group the findings into a SWOT analysis to identify what affects a health system core function’s ability to perform.

## Identify Strengths and Weaknesses by Each Core Functional Area (SWOT)

A SWOT analysis identifies strengths and weaknesses that are internal to a system and opportunities and threats from the external environment (Table 2.4.1).

**Table 2.4.1. SWOT Quadrants**

	<b>Strengths</b>	<b>Weaknesses</b>
<b>INTERNAL</b>	<ul style="list-style-type: none"> <li>Strengths are elements of the health system that work well, contributing to the achievement of system objectives and thereby to good system performance.</li> <li>Examples are the existence of training programs to improve human resource capacity or strong facility-level data collection and reporting capacity.</li> <li>Recommendations should build on the strengths of the system.</li> </ul>	<ul style="list-style-type: none"> <li>Weaknesses are attributes of the health system that prevent achievement of system objectives and hinder good system performance.</li> <li>Examples are lack of public health sector partnerships with the private sector, health worker dissatisfaction with salaries, or extensive staff turnover.</li> <li>Recommendations should suggest how to resolve system weaknesses.</li> </ul>
	<b>Opportunities</b>	<b>Threats</b>
<b>EXTERNAL</b>	<ul style="list-style-type: none"> <li>Opportunities are external to the health system function that can facilitate problem solving.</li> <li>Examples are elections, rising economic growth, a new policy initiative, or private health sector partnerships.</li> </ul>	<ul style="list-style-type: none"> <li>Threats are external conditions that can hinder achievement of health system objectives.</li> <li>Examples are inadequate budget allocations to health or a currency devaluation that will depress health worker income.</li> <li>Recommendations should suggest how to overcome these threats.</li> </ul>

The team should begin with **collectively** analyzing health outcome data (mortality, morbidity) and the strengths and weaknesses observed in service delivery, community health, and household practices (first core health system function). From the very beginning, each team member should seek the root causes of the problems found related to the other core health system function areas. For example: Despite a “free care” policy, public clinics are underutilized—why? What are the causes related to health workers and medicines? Despite a decade of external development partner-funded community health

projects, community health structures and practices are rarely sustained—why? What are the causes related to decentralization or lack of links to the local public health system?

Armed with a collective, initial analysis of health outcomes and the strengths and weaknesses in service delivery, community health, and household practices, team members do a SWOT and root cause analysis of their health system function(s). Team members should constantly be looking for links with other health system functions. For example: Despite adequate budget allocations and a multilateral agreement, the central procurement agency frequently delays importation of essential medicines—why? Investments in HIS have not yielded expected improvements in data use or quality—why? What are the incentives for data use? What are the consequences for generating poor-quality data?

Interviews also can be used to verify SWOT themes identified through triangulation. Interviewers should note different perspectives and attitudes that government, private sector, and civil society representatives may have about SWOT issues and probe the reasons for those differences. In addition, interview discussions may yield new SWOT points, especially around issues that often are not documented, such as informal payments, governance, and new or changing strategies. SWOT issues should be narrowed to those that local stakeholders feel strongly about or that seem to be having the most impact across all parts of the health sector. The example from St. Lucia (Figure 2.4.2) analyzes the country HIS and provides an illustration of applying SWOT to a single health system function.

**Table 2.4.2. Sample SWOT on Health Information Systems, St. Lucia 2012**

<b>Strengths</b>	<b>Weaknesses</b>
<ul style="list-style-type: none"> <li>• Electronic health management information system (HMIS) has been purchased.</li> <li>• Strong project management team leading efforts to roll out electronic HMIS.</li> <li>• Routine reporting taking place across public health facilities, generating data.</li> <li>• Good technical infrastructure in place across health facilities to support new HMIS.</li> </ul>	<ul style="list-style-type: none"> <li>• Limited staff to support needs of a nationally implemented electronic HMIS.</li> <li>• Absence of unique patient identifier nationally limits capacity of HIS to track patients.</li> <li>• Poor timeliness of data consolidation and dissemination limits effectiveness of data-driven decision policymaking.</li> <li>• Limited funding to complete all projected phases of HIS rollout.</li> </ul>
<b>Opportunities</b>	<b>Threats</b>
<ul style="list-style-type: none"> <li>• Leverage the E-GRIP work plans and team to move the dialogue on a national identifier forward.</li> <li>• Timely data from health facilities using the HIS increases the ability to drive demand for data.</li> <li>• Leveraging fledgling telemedicine efforts at Tapion hospital promotes broader health improvement (internal and external to Saint Lucia).</li> </ul>	<ul style="list-style-type: none"> <li>• Weak functional specifications process at early stages of HIS acquisition limits ability to match functions to needs.</li> <li>• Delayed focus on reporting capacity of the HIS may lead to further delays in consolidating data.</li> <li>• Unknown data quality may weaken value of HIS rollout.</li> <li>• Technical support requirements of the HIS will be beyond the manpower capacity of the HMIS unit.</li> </ul>

Source: Rodriguez et al. 2011.



## Root Cause Analysis

There are many techniques for doing root cause analysis. One technique is doing a “cause and effect” or “fishbone” diagram. At a minimum, team members should consider for each weakness, “Why does it exist,” and then for each reason, “Why does that situation exist?” Discuss and analyze potential implications of the final list of high-level problems. In particular, note any political sensitivity and think about how best to address these in the stakeholder workshop or other debriefings. The stakeholder consultations can be used to go through parts of the root cause analysis in a participatory way. In addition, the local consultant on the team should actively advise the team and guide in this regard.

A fishbone diagram (Figure 2.4.2) helps team members visually diagram a problem or condition's root causes, allowing them to truly diagnose the problem rather than focusing on symptoms. It allows team members to separate a problem's content from its history and allows for team consensus around the problem and its causes.

### TIP BOX

#### ROOT CAUSE ANALYSES

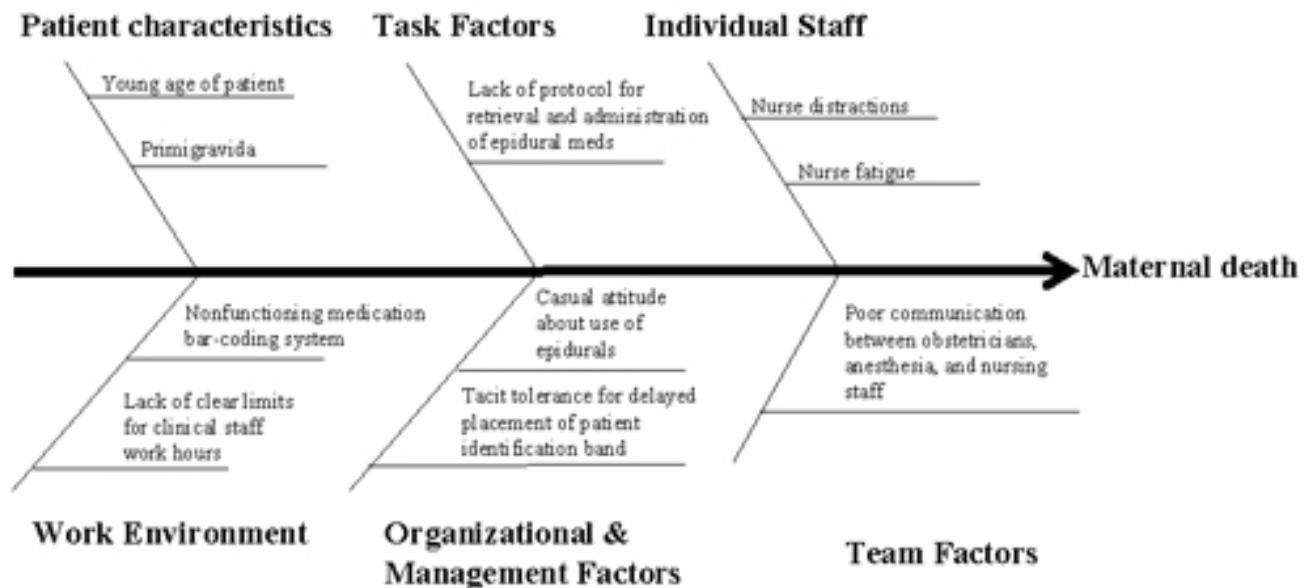
Start by examining the situation at the service delivery level.

- Are standards of care defined?
- Are medicines, equipment, and other materials available?
- Are staff available and motivated at the service delivery level to provide care?
- Is care accessible?

The next set of questions looks for deeper causes of problems identified.

- To what extent are human resources issues affecting quality and quantity of care?
- To what extent is financing affecting these areas?
- To what extent are stewardship (governance) issues and information availability affecting these areas?
- To what extent is the private sector overall contributing to service delivery?

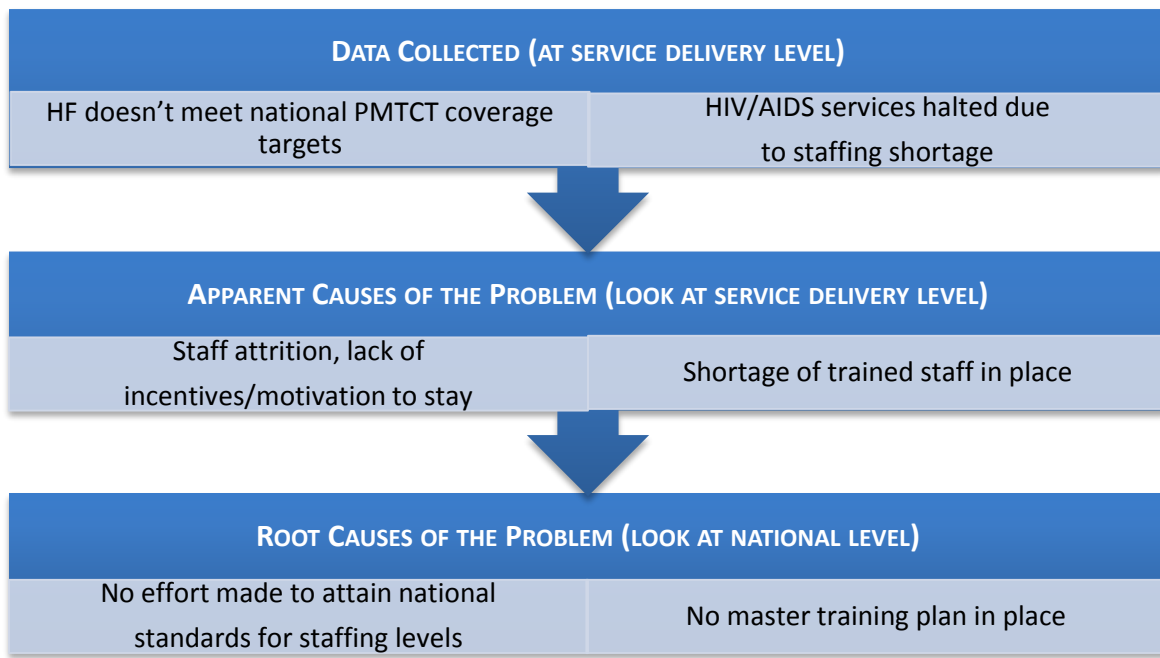
Figure 2.4.2. Root Cause Analysis Using a Fishbone Diagram



Source: Pil 2010.

Alternatively, a root cause analysis can also be configured as a causal ladder from problem up through levels of the health system. For example, the multilevel causal analysis depicted in Figure 2.4.3 shows a flowchart as an example of how a problem identified at the service delivery level can be traced back to its causes at other levels in the health system.

**Figure 2.4.3. Flowchart for Multilevel (Causal) Problem Analysis**



In the above example, by identifying a problem at one level of the system and following up on that same problem with individuals from different levels of the health system, the team member is able to examine how issues related to staffing, training, administrative actions, or policy ideas are (or are not) being followed through and implemented at the service delivery level. Likewise, this type of analysis will help to determine whether statements made at one level of the system are accurate or upheld at other levels of the system.

Similarly, once a gap or problem is identified in the health system (e.g., high attrition rates by personnel at the health facility level), a solution or intervention is found (creation of an incentive system for staff retention), and funding is found for this intervention, the success of implementation of this intervention can be analyzed through tracing of investments/inputs through outputs (incentive system designed and operationalized) to outcomes (lower attrition rates) to impact (reduced morbidity and mortality from malaria).

## 4.3. Identify Cross-Cutting Themes between Core Health System Functions

In addition to frequent meetings to share information, the team leader should organize and facilitate a half-day to a full-day HSA team meeting for a deeper discussion of findings, conclusions, and potential recommendations across the six core health systems functions. This meeting ideally occurs at the end of the first week of in-country visit. This leaves time to fill any new information gaps, verify and validate initial conclusions and recommendations with stakeholders, and receive feedback before leaving the country.

### Team Meeting: Identifying Cross-Cutting Themes

**Initial presentation**—Ideally, all team members have shared revised drafts of their sections of the HSA report the day before the team meeting. The meeting begins with each team member presenting for 10–15 minutes the following for each of his or her core health system function(s):

- Main findings regarding the current status of the health system function area(s), including 10–15 SWOT issues and their impact on health system functioning overall.
- Underlying causes, highlighting links with other health system functions.
- Initial thoughts on recommendations and their rationale.

**Identify Cross-Cutting Areas**—Based on the presentations, the team identifies and summarizes the cross-cutting areas with the other core health system functions to determine whether or how these problems may be connected and how they affect health systems performance. This task serves to compare issues and identify cross-cutting themes across the core functions. From this the team should be able to:

- Compile the most important findings obtained from each of the core function modules. Are there issues that are at the root of multiple problems?
- Identify additional findings unique to the individual core health system function modules.
- Synthesize conclusions in a way that can be communicated clearly to others.

Table 2.4.3 provides an example of how the 2010 Guyana HSA captured cross-cutting issues. The table identifies the issues by technical area and organizes them by where the challenge originates and intersects with other core health system functions. For example, in the governance component (first row), one issue is that regional health spending may not be aligned to the health budget. This is first a governance issue in that regional structures allow spending to be allocated away from health; because the issue manifests in health spending (or lack thereof), it intersects with health finance (second

#### TIP BOX

##### SYNTHESIZING CROSS-CUTTING ISSUES

Do not focus exclusively on your individual module. Engage with the whole team to analyze across the health system. Here's how:

- Hold daily debriefings among team members.
- Proactively identify links and cross-cutting issues.
- Share draft chapters early.
- Hold several team sessions to discuss issues and problems.

#### TIP BOX

##### TEAM ANALYSIS EXERCISE

Working as a team to fill out a blank version of [Table 2.4.3](#) can be a good exercise for organizing and examining cross-cutting health systems issues.

column). Annex 2.4.A offers options for additional ways for the team to synthesize findings, e.g., by health system performance criteria (equity, access, efficiency, quality, sustainability).

**Develop Preliminary Recommendations**—Based on the analysis across modules, the team will brainstorm recommendations. Some recommendations may apply to a single health system core function; others may cut across core functions. After brainstorming, the team should discuss the cross-cutting recommendations in terms of:

- Implementation considerations that reflect on social, cultural, political, and financial feasibility.
- Opportunities or mechanisms to ensure the actual use of the recommendation, possible champions, and sources of political support (and opposition).
- Links to national policy and governance with consideration of the potential political will for adopting and implementing.

**Table 2.4.3. Key Issues Effecting the Core Health System Functions from Guyana HSA 2010**

Source of Issues by Core Health System Function	Governance	Health Financing	Service Delivery	Human Resources for Health (HRH)	Medical Products, Vaccines, and Technologies	Health Info System
Governance		Spending on health in regions may not be fully aligned to the health budget and resources for health may be appropriated for other uses (4.3.1).	Service agreements do not always ensure accountability (8.2.1; 3.4.2).	Management capacity at the regional level is weak (5.4.5).	Lack of data on availability of medicines and medical products across facilities/regions affects informed planning (6.7).	Limited use of existing health surveillance data for planning and policymaking (7.12).
Health Financing	Limited coordination among key stakeholders affects resource allocation across regions and disease-specific programs (3.3.2).		Free services imply no revenues at facility level, making needs-based budgeting and financing important (8.5).	Lack of trained staff and management capacity means that budgets are not always based on needs analysis (4.3.1).	External development partner-supported medical products and medical supplies may require government resources for distribution (6.5).	Limited use of HIS in budgeting and financial planning (7.12).
Service Delivery	Relevant policies are in place but not fully implemented (3.6).	Significant funding for HIV/AIDS, relative to other disease priorities, supports improved service delivery. Little or no financial incentives at facility level to improve quality of service delivery (4.4).		HRH shortage hinders the full implementation of the PPGHS, particularly in rural areas and at the primary health care level (5.2.5).	Transportation and general infrastructure challenges limit access to supplies and medicines, particularly in rural and hinterland areas (6.6).	Limited availability of data to monitor quality, efficiency, and use of services (7.12; 8.5).

<b>Source of Issues by Core Health System Function</b>	<b>Governance</b>	<b>Health Financing</b>	<b>Service Delivery</b>	<b>Human Resources for Health (HRH)</b>	<b>Medical Products, Vaccines, and Technologies</b>	<b>Health Info System</b>
Human Resources for Health	Training, staff allocation, and hiring are inadequately coordinated across the range of stakeholders involved (3.3.2).	Little or no financial incentives for health workers to serve in-country after training or to serve in rural areas (4.4).	Worker motivation is adversely affected by working conditions, including poor incentives and infrastructure (5.2.2).			No comprehensive HRIS—limited use of data in planning for and allocating HRH (5.2.3).
Medical Products, Vaccines, and Technologies	Coordination among key stakeholders is needed to develop systems to effectively allocate medical supplies across regions and diseases (3.3.2).	Lack of needs-based budgeting and financing for drugs and medical supplies across regions and diseases (4.3.1).	Prescribing practices are not standardized and comprehensive standard treatment guidelines are not finalized (6.4; 8.7).	Shortage of pharmacists can lead to unqualified personnel dispensing medications (6.8).		Electronic records maintenance is weakened by a lack of computers at public facilities (7.9.1).
HIS	Lack of coordination among key stakeholders affects development of HIS structures (3.3.2).	Funding for HIS is insufficient, including for data collection and analysis, especially at regional levels (7.3).	Data capture is driven by vertical programs (8.4.5; 7.12).	Poor HRH capacity to collect, compile, and analyze data, particularly in rural and hinterland areas (7.12).	Data on supplies and availability of medicines and medical products is not consistently available from all levels (6.7).	

Source: Health Systems 20/20 and Guyana Ministry of Health (2011).

## 4.4. Formulate Final Recommendations

Before departing the country, the team leader should convene another half-or full-day team meeting to finalize the key cross-cutting recommendations. Ideally, the team identified and discussed preliminary recommendations at the mid-visit team meeting and has received input from local stakeholders. If not, then consider inviting a few key stakeholders or informants to the final meeting.

Keep the primary audience in mind; is it the MOH, an external development partner such as the USAID Mission, or a private commercial pharmaceutical company? If the MOH is the primary audience for the HSA, recommendations should be linked to objectives and strategies outlined in MOH policy documents. Consider the needs of the HSA target audience and how recommended investments or actions will impact both the country and the client.

Each recommendation should be assessed for:

- The rational—what problems will be solved?
- The expected effects on health system performance in terms of equity, access, quality, efficiency, and sustainability—what will change because of this intervention?
- The expected results in terms of health outcomes.
- Its feasibility.
- The speed with which it can be implemented—is this something that is a short-, medium -, or long-term action?
- A rough assessment of cost implications (low, medium, high).
- Whether it applies to the national or regional level.
- Where possible, provide an actionable example or two on how to implement the recommendation and link it with a potential actor or set of actors who can take action for implementing the recommendation as well as with a set of ideas for funding sources.
- Consider including action items delineated by specific actors (e.g., MOH departments and/or other stakeholders) to promote ownership of recommendations.

These recommendations should be organized in a summary document that can later be presented to stakeholders for validation. Once validation takes place, then any comments from stakeholders may be considered when finalizing the report.

Examples of recommendations can be found in each health system core function module (Section 3, Modules 2–7) in the table labeled “Illustrative Recommendations for Strengthening [specify core HS function].” Examples of actual impacts resulting from HSS country interventions are also listed in Annex 2.4.B, while Annex 2.4.C presents Illustrative system constraints and possible disease or service-specific system responses.

## 5. STEP 5—DRAFT, VALIDATE, AND FINALIZE ASSESSMENT REPORT

### 5.1. Draft the Full Assessment Report

The HSA team leader is ultimately responsible for the completion and quality of the report. He/she provides the team with the report outline, due dates for the zero draft (prior to the country visit), subsequent drafts, and critical feedback on drafts. It is important to ensure consistency in the structure of the core health system function modules. For example, including a SWOT analysis summary box and a short list of topic-specific recommendations at the end of each core health system function chapter is useful. Step 1 provides a sample report outline (see Annex 2.1.A) that details all the sections that the person compiling the report (generally the assessment coordinator) should be aware of.

Ideally, HSA teams will revise the zero drafts while in-country so that they can present preliminary findings at a stakeholder validation workshop immediately at the end of in-country visit (see below). Some teams use all the time in-country for data collection and revise their sections after the trip, in which case a representative of the team makes a second trip to the country to conduct the validation workshop. If the assessment team does not complete revisions while in-country, the team leader should ensure that all chapters are completed and submitted for review and compilation into the full report within two weeks of finishing data collection.

After the validation workshop, the team should hold a final team meeting to incorporate feedback from the workshop into the conclusions and recommendations.

**NOTE:** The assessment report is usually a public document. In the case of politically charged or sensitive findings, the language should be vetted with the client. If the client advises that important findings not be included in the report, the team leader can offer the option of preparing an internal memo that would not be public.

Once the first draft is completed, if resources allow, the HSA team should ask a technical reviewer external to the team to review the draft. This person may be from the same organization as the team or from another organization but should be a health systems expert who can do an independent, objective review. The external technical review (and author response) is done before the team shares the report with the MOH, the client (if different from the MOH), and other key stakeholders involved in review and approval. See Table 2.5.1 for an overview of the review process. The report can then be edited before its submission to the client for approval and dissemination.



## 5.2. Validate Findings and Recommendations with Local Stakeholders

Local stakeholders and experts must validate and critique the team’s findings and recommendations to ensure accuracy, broad ownership, and ultimately decisions and actions. It is recommended that teams hold a half-to-full day validation workshop with stakeholders, either at the end of data collection or during a post-assessment visit, depending on client needs, scope of the assessment, and budget. If a validation workshop is not possible at the end of the visit, then at a minimum hold a debriefing meeting with key stakeholders in the MOH to share findings and preliminary recommendations. Advise that a more formal report review process will take place later, either through a return visit or remotely. If a return trip is not possible, then validation can be done remotely by sending the draft report to stakeholders highlighting relevant areas for their review and feedback, although this is the least effective way to validate findings and discuss recommendations.

The specific objectives of the validation workshop are:

- Review the assessment findings and recommendations.
- Create opportunities for dialogue and collaboration among stakeholders from diverse sectors (both public and private).
- Further identify the synergies between recommendations across different core health system functions and between sectors.
- Revise and flesh out the recommendations based on feedback from stakeholders.

The target audience for the validation workshop should be public and private sector stakeholders who participated in the development of the assessment findings, stakeholders who will lead implementation of the recommendations, and development partners that are likely to fund recommended interventions. (Stakeholders are likely to come from the MOH, other ministries, the private sector, commercial entities, professional organizations, NGOs, and USAID and other external development partners.) Participants are asked to determine whether the recommendations are consistent with the findings and if any recommendations need to be revised or added.

There are two ways to do the validation workshop. The first is a half-to-full day meeting where the HSA team presents and facilitates small group discussions. The second is a longer multiday workshop that is more participatory, with small group exercises designed for stakeholders to work together to reach conclusions. Annex 2.5.A contains an illustrative multiday validation workshop agenda, which can be adapted as needed depending upon the stakeholders, managers, and policymakers participating.

There is a brief presentation of findings and recommendations at the beginning of the workshop via slides and handouts. Most of the workshop time is devoted to discussion of the recommendations. Typically, the draft report is not shared with workshop participants because their feedback is used to revise the report.

In addition to validating recommendations, stakeholders may be engaged to prioritize the recommendations. The benefits of a prioritization exercise are:

- An agreed-upon priority of recommended interventions developed by those who know the health environment best.
- Commitment and buy-in of key stakeholders on a process for moving forward.

The proposed prioritization method is based on key criteria that are practical in nature and include importance, feasibility, risk, affordability, duration, and impact of proposed interventions. The Private Sector Assessment Guide Assessment to Action is also an excellent resource for information on a participatory prioritization approach.

### 5.3. Finalize Report and Recommendations

The report finalization process varies from country to country depending on client and user needs. The report is finalized only after validation by local stakeholders, however the validation takes place (workshop at the end of the data collection visit, workshop during a second visit, just a briefing, or remotely). This ensures that their feedback can be incorporated. Generally, the MOH would like to review and approve the draft report before finalization. In addition, the report will benefit from an outside technical review prior to finalizing. Table 2.5.1 provides an overview of the recommended HSA report preparation and review process.

**Table 2.5.1. HSA Report Review and Revision Process**

<b>HSA Team Incorporates Relevant Findings and Reviewer Feedback to Create:</b>	<b>Due Date for Writers</b>	<b>Reviewer and Due Date</b>
Zero draft: core health system function chapters; chapter on cross-cutting findings	Pre-field assessment	Team leader prior to field visit
Draft 1: core health system function chapters; chapter on cross-cutting findings and recommendations	After first week of data collection; or immediately after data collection	Team leader before departure Stakeholder validation option 1: feedback during visit based on summary slides or handouts
Draft 2: core health system function chapters; chapter on cross-cutting findings; recommendations; executive summary	Approximately 2 weeks after data collection	Team leader 2–3 days after receipt Stakeholder validation option 2: feedback during 2nd visit or remotely
Draft 3: all sections drafted and organized, including front matter, references, and attachments	2 weeks after draft 2	Technical reviewer <sup>a</sup>
Draft 4: all sections consolidated	1 week after draft 3	Editor and team leader <sup>b</sup> (may include several rounds of editing/discussions/ Q&A)
Final Draft #1	1–2 weeks after draft 4	Client and local government stakeholders
Final Draft #2	To be determined	Editor and team leader (may include several rounds of editing/discussions/Q&A)
Final HSA Report - Complete	To be determined	

Note: Q&A = question and answer.

<sup>a</sup> The technical reviewer (and other team member) roles and responsibilities are described in Section 2, Module 1, Table 2.1.2.

<sup>b</sup> Individual assessment team members address and/or incorporate feedback and comments into their respective chapters. The assessment coordinator consolidates chapters into one draft report and provides support to the team members and leader throughout this process.

# ANNEX 2.1.A SUGGESTED OUTLINE FOR FINAL ASSESSMENT REPORT

Acronyms

Acknowledgments

Executive Summary (3–5 pages)

1. Background (1–2 pages)

Context—why was the assessment carried out and with what purpose?

2. Country and Health System Overview (3–5 pages)

The Country and Health System Overview chapter should be drafted in advance of trip and revised after data collection. See HSAA Manual Section 3 Module 1 for guidance on constructing this chapter.

3. Methodology (1–2 pages)

Framework for the Health System Assessment Approach (HSAA)

Description of tool and how it was used, including types of resources consulted, numbers and types of interviews conducted, dates of field work, regions/districts visited, types of facilities observed.

4. Summary of Findings (a.k.a. Core Health System Function Chapters) (7–12 pages for each chapter)

Service Delivery

Human Resources for Health

Medical Products, Vaccines and Technologies

Health Information Systems

Health financing

Governance

(See Section 3 Modules 2–7 of the HSA Manual for guidance on constructing these chapters.)

5. Cross-cutting Findings (5–10 pages); see HSAA Manual Section 2, Module 4.

6. Recommendations (8–10 pages); see HSAA Manual Section 2, Module 4.

Contains recommendations for strengthening the health system across modules and within each technical module. This subsection and recommended solutions tables from each health system core function module should propose areas that stakeholders might strengthen to address health system weaknesses. Each recommendation should discuss the relative time frame to accomplish each intervention.

Stakeholder views on the priority intervention areas should be included. This section may also discuss potential ways forward, based on stakeholder discussions.

Annex A. Contact list

Annex B. List of documents consulted and bibliography

Annex C. List of sites visited

\*Note: Assessment teams may choose to present a preliminary draft of recommendations for stakeholder validation. Therefore, this list may be shared and then revised to reflect stakeholder views and/or priorities discussed in validation and/or prioritization workshops.

## ANNEX 2.1.B COUNTRY EXAMPLE: HEALTH SYSTEM ASSESSMENT SCOPE OF WORK AND TIMELINE

A clear scope of work (SOW) (also called Terms of Reference) is a key document agreed upon between the Health System Assessment (HSA) client/MOH and the team leader to clarify the expectations and specific approach of that HSA and to inform the budget. A basic outline for an HSA SOW is the following:

1. Background—country context for this HSA, key issues that the HSA will likely address
2. Goal and Objectives of the Assessment
3. Activities and Methodology
4. Schedule
5. Deliverables
6. Team Members—name, role, short biographical sketch for each
7. Client Role

# HEALTH SYSTEMS ASSESSMENT SOW: ANGOLA 2010

## I. Background

In 2005, the USAID Partners for Health Reformplus project (PHRplus) conducted an HSA in Angola to inform USAID/Angola's health sector programming. Since then, numerous USG-funded health projects have been implemented. Other development partners such as UNICEF, WHO, the World Bank, and the EU have also worked closely with the Ministry of Health to carry out major health system strengthening activities in Angola. These efforts have generated new information on the state of Angola's health system, and likely produced some results. Currently the MOH is in the process of developing a national health policy and a national health strategic plan, and USG/Angola is consolidating and improving an integrated approach to its health programming in the country. This is an opportune time to update the 2005 assessment and expand the scope of the proposed 2010 assessment to identify the main advancements of USG interventions, to identify areas for future strengthening, and inform the MOH and USG/Angola's strategies moving forward.

## 2. Purpose

**The purpose of this assignment is to update the HSA done for Angola in 2005. In particular, the assessment will:**

- Review new sources of data that have become available since 2005.
- Identify areas of national progress since the 2005 HSA and successful strategies, including a comparison of USAID intervention provinces with non-USAID provinces to measure the impact of USAID's investment.
- Identify the continuing challenges to strengthening Angola's Health System, with particular attention to: human resources, health information systems (HIS), commodity security, external development partner coordination, and translating good planning into action.
- Develop recommendations to help inform the MOH's health strategy.
- Help inform USG/Angola's integrated health strategy.
- Identify strategies that seek to leverage the resources and capacity of private sector actors.
- Increase understanding of the role and possible contributions of private sector actors for health.

## 3. Activities/Methodology/Schedule

- Document Review and Client Consultations – January–March 2010  
Prior to arriving in-country and conducting field work, the team will review various documents and reports including but not limited to: the 2005 Angola HSA, health project reports and surveys (not limited to USG), preliminary NHA and MICS results, if available, national health strategy and population reports; Government and other monitoring data; USG strategy documents. The team will consult USG agencies/Angola and USG support staff based in the United States such as HIV/AIDS (PEPFAR), malaria (PMI), RH, TB, water and sanitation, democracy and governance. These consultations will refine this scope of work, the assessment methodology, and report outline.
- Team Planning Meeting in DC – February 2010  
A Team Planning Meeting (TPM) will be held, with the HSA team members only, prior to official onset of meetings and work with the client (USG agencies), the MOH and others.
- Preparation for Trip – February–March 2010

After the TPM, the team will begin to coordinate with USAID/Angola to select and contact the key informants that should be interviewed, determine how to present the HSA concept to obtain their buy-in, draft the field schedule and begin setting up appointments.

- **Arrival – Team Planning Meeting with USG Agencies/Angola – April 2010**  
Upon arrival the team will meet with USG agencies/Angola to: review the priorities for the assessment and assessment methodology; finalize the key research questions and examine the field schedule (in which appointments will USG agencies/Angola staff participate? schedule check-in meetings or calls); review logistics, protocol for communications with USAID/Angola, other external development partners and government contacts, and for interviews during the field visits; and plan for stakeholder workshop.
- **Field Visits/Key Informant Interviews – April 2010**  
Site visits will be critical to understand health system performance at the service delivery level. Interviews with the key informants will include but not be limited to MOH officials, USG agencies, Implementing Partners, other external development partners, private and commercial partners, and civil society organizations.
- **USG Agencies/Angola Debrief – April 2010**  
Prior to the stakeholder workshop, the team will debrief USG agencies/Angola and discuss preliminary findings and recommendations, outstanding questions, and review draft presentation (ppt) for the stakeholder workshop.
- **Stakeholder Workshop – April 2010**  
A half-day workshop will be held with USG agencies/Angola and other key stakeholders after the site visit work is completed and prior to the departure of the team from the country. The mission might consider co-hosting with the MOH and/or WHO. In this meeting, the assessment team will present findings for comment and validation, and facilitate group discussion of recommendations for national health system strengthening. USAID and the MOH will send out the invitations and Health Systems 20/20 will cover expenses for this meeting, including meeting space.
- **Preliminary Draft Report – April 2010**  
Based on all the information collected in country, including at the USG/Angola debrief and the Stakeholder Workshop, the team will submit a preliminary draft report including findings and recommendations upon completion of the field work and before the team departs Angola (April 17). The draft report will incorporate comments and feedback from the debriefings. This draft will include findings and recommendations for mission review. USG agencies/Angola will have two to three weeks to provide comments and suggestions to the assessment team, including comments from the MOH, which shall be addressed in the final report.
- **Final Report – May-June 2010**  
The team will submit a final report no later than one week after USG agencies/Angola provide written comments on the team preliminary draft report. Once the final report is approved, it will take an additional week to edit and format it. The report will be submitted in English electronically for dissemination among implementing partners and stakeholders. It will be subsequently translated into Portuguese.

## 4. Team Composition

The assessment team will consist of one Team Leader, one public health specialist, one USAID staff member (participant of the 2005 assessment), one international consultant, one local specialist, one staff from the MOH, and a Research Assistant. Collectively the team members should have strong backgrounds to comprehensively cover all six building block chapters: governance/stewardship, financing, service delivery, human resources, pharmaceuticals, and HIS.

Team Leader – name, affiliation

The Team Leader will be responsible for managing the team in conducting the assessment and in preparing and finalizing all deliverables. This individual will be responsible for achieving assignment objectives and will be the key liaison with USAID/Angola. The Team Leader is fluent in Portuguese and has more than 10 years of experience leading assessment teams. The Team Leader will:

- Finalize and negotiate the HSA work plan with client.
- Establish assignment roles, responsibilities, and tasks for each team member.
- Facilitate the TPM or work with a facilitator to set the agenda and other elements of the TPM.
- Take the lead on preparing, coordinating team member input, submitting, revising and finalizing the assignment report.
- Take the lead with producing one or two building block chapters of the assessment.
- Manage the process of report writing.
- Manage team coordination meetings in the field.
- Coordinate the workflow and tasks and ensure that team members are working to schedule.
- Ensure that team field logistics are arranged.

Public Health Specialist – name, affiliation

The Public Health Specialist will support the Team Leader in all of the above-mentioned tasks and will carry out one or two building block chapters of the assessment. The Public Health Specialist is a native Portuguese speaker and has five years of experience in public health programming, particularly reproductive health, HIV/AIDS and the private sector.

USAID Staff Member – name, affiliation

[Name] was part of the 2005 assessment team, is fluent in Portuguese and is a Quality Assurance expert. She will take the lead with producing two building block [Core health system function] chapters, Service Delivery and Human Resources.

International Consultant – name, affiliation

This consultant is an expert of Pharmaceutical Systems and will be responsible for the pharmaceuticals chapter.

Local Specialist – name, affiliation

The Local Specialist has a background in public health and is very familiar with the Angola health system and stakeholder community. She participated in the 2005 assessment and will play the same logistics support role in this HSA. She will also provide feedback on assessment findings and recommendations, and facilitate part of the Stakeholder Workshop.

Research Assistant – name, affiliation

Because of the substantial requirements for assembly of materials required for the assessment as well as logistical arrangements, the team includes a Research Assistant for approximately 10 days over the assignment period. She will be responsible for:

- Identifying, collecting, and cataloging for easy retrieval by the team members relevant documents, surveys and other related background and historical reference materials as requested by the team.
- Assisting with identification of key informants.
- Providing scheduling support as required.
- Producing a final bibliography of all sources utilized in the assessment.
- Providing additional research support to the Team Leader, as required.

## **5. Logistics/Role of Client**

The client (USAID/Angola) will assist with arranging:

Contact and meetings with key informants in-country.

Mid-assessment Meeting: mid-way through the team's field work the team and USG/Angola will discuss the findings to date and troubleshoot possible obstacles towards completing the assessment as planned.

USG Debrief Meeting to be held at the conclusion of the fieldwork but prior to the Stakeholder Workshop.

Invitations for the Stakeholder Workshop to be held at the conclusion of the fieldwork and following the USG debrief. Health Systems 20/20 will cover expenses for this meeting, including venue.

USAID/Angola will provide overall direction to the assessment team, identify key documents and assist in arranging and/or participate in meetings with key stakeholders as identified by USG prior to the initiation of field work.

USAID/Angola personnel shall be available to the team for consultations regarding sources and technical issues, before and during the assessment process.

The USAID Health Systems 20/20 Project assessment team is responsible for arranging other meetings as identified during the course of this assessment and advising USAID/Angola prior to each of those meetings. The assessment team is also responsible for arranging vehicle rental and drivers as needed for site visits.

## **6. Deliverables and Products**

Final SOW

USG Debrief



Stakeholder Workshop

Preliminary Draft Report

## **7. Cost Estimate US\$XXX**

Final Report

The USAID Health Systems 20/20 Project will be responsible for editing and formatting the final report, which takes up to one week after the final unedited content is approved by USG agencies.

## ANNEX 2.I.C ILLUSTRATIVE LOCAL LOGISTICS COORDINATOR SCOPE OF WORK

The sample scope of work (SOW) below includes logistical tasks. In reality, a local logistics coordinator/consultant may also have a more technical role and contribute substantively to data collection, meetings, analysis, and report writing. Yet, if resources allow, it is ideal to separate this out into a full-time administrative position, responsible for the logistical tasks. This position is needed regardless of whether the assessment team is comprised of international consultants or purely made up of local experts.

**1. Background** – Same as in main SOW.

### **2. Role of the Local Consultant**

The local, short-term consultant will work as a full member of the assessment team to identify (with guidance of other team members) relevant sources of data and key stakeholders, and obtain data and documents. Further, the consultant will assist the team with coordinating the program of visits, facilitating access to key informants (setting up interviews and meetings), participating in the data collection activities, and ensuring that local technical and logistic needs are met in a timely and effective way. The local consultant will be expected to help identify a professional translator if necessary.

### **3. Expected Specific Tasks [insert dates]**

#### **4. Prior to team arrival (level of effort or LOE: minimum 5 days)**

Participate in team conference calls with the clients and key stakeholders.

Work with technical team to obtain reports and other data in advance, and provide guidance on appropriate key informants.

Manage logistical preparations:

- a. Interface with [client] regarding logistics for the team.
- b. Assist with invitations and arrangements for a workshop to be held on/near the last day of the visit.
- c. In consultation with [organization], prepare the schedule of appointments for the team members (each team member will have independent meetings and team or group meetings). Provide other logistical support as needed.

If the external assessment team coordinates with and/or hires local interpreters/translator(s) to work with the team then translate from [language] to English. The number of translators will depend on team requirements. Translators will:

- a. Accompany team members on interviews to provide interpretation services.
- b. Review and translate documents as required.

Provide guidance on local protocol including regular working hours, holidays, introductions, and language.

Hire car and driver to provide transportation for the team during the two-week visit, including pick-up and drop-off at the airport.

## **5. During team visit (LOE: expected 15 days)**

Meet with team upon arrival and participate in team planning meeting.

Participate in initial briefing meeting with [client].

Participate in data collection, interviews, and facility visits.

Contribute to preparations, and participate in the stakeholder workshop. Confirm conference room arrangements (including availability of overhead digital projector, flipchart paper, markers, notepads and pens). Arrange for photocopies as requested by the team.

## **6. Post-team visit (LOE: expected 1.5 day)**

Assist with arranging any follow-up calls or data collection needed after the field work has concluded.

A more specific list of tasks with dates will be provided when the dates of the visit are confirmed. The team will work under the overall direction of the Team Leader. All team members will contribute to day-to-day problem solving, solutions to issues of data availability, technical questions, etc.

## **7. Consultant Profile**

Experience in evaluation and/or health systems research, preferably at national level.

Advanced command of [language] and advanced reading, writing, and speaking skills in English.

Ability to work in teams.

Helpful to have familiarity and contacts in the ministry of health, private sector, and/or external development partner community.

## **8. Outputs/Deliverables**

List of key informants and their contact information

Draft schedule of appointments

Deadlines will be specified when the assessment schedule is finalized.

## **9. Attachments**

Brief description of the assessment tool/approach

Health System Assessment scope of work for [country]

## ANNEX 2.2.A ILLUSTRATIVE HEALTH SYSTEM ASSESSMENT LOGISTICS AND TASK CHECKLIST

### Health System Assessment Logistics and Task Checklist

Indicate who will be responsible for completing the task, the expected due date, and when it was completed.

Task	Client	Team Lead	Coordinator	Local Consultant	Team Members	Date Due	Date Completed
<b>Preparatory work</b>							
<b>General Coordination</b>							
Identify scope of assessment and the extent of client/stakeholder engagement through discussions with the client							
Identify team composition							
Set dates for the assessment in coordination with the client—consider relevant holidays and events							
Prepare scopes of work (team and local consultant, as needed)							
Schedule and participate in team planning meeting(s) and discussions							
Schedule and arrange logistics for the HSA stakeholder workshop(s)							
Determine if in-country travel will be required							
<b>Health System Core Function chapter preparatory work</b>							
Prepare materials for first team meeting with country information, background materials, and other assessment information							
Assign core health system function chapters to team members							
Team members review assigned core health system function chapter(s) and prepare lists of documents needed and potential interviewees							

Task	Client	Team Lead	Coordinator	Local Consultant	Team Members	Date Due	Date Completed
Identify team member responsible for stakeholder engagement							
Assessment coordinator compiles needed documents and facilitates translation as needed							
Compile Country Overview chapter data (available online)							
Review background documents and initiate desk review							
Request organizational charts for central-level Ministry of Health and relevant departments; each team member should identify departments relevant to their chapter and provide the information to the assessment coordinator							
<b>Logistics/other preparations</b>							
Contract local consultant, if needed; assign responsibilities							
Prepare contact list							
Prepare interview schedule							
Make travel arrangements							
Identify local travel options—select location and date							
Identify participants for the launch workshop; set time and date and send invitations; reserve room; work with client to coordinate and set agenda							
Hire translators (if needed)							
Hire drivers (if needed)							
<b>Field work</b>							
Meet with team and participate in team planning meeting							
Conduct a small (8–15 people) workshop with key local stakeholders (if applicable)							
Conduct a launch workshop (if applicable)							

Task	Client	Team Lead	Coordinator	Local Consultant	Team Members	Date Due	Date Completed
Confirm or reschedule interviews							
Collect data, conduct interviews central level interviews							
Travel to one or two subnational areas, as discussed in the assessment preparation							
Daily: Team members review data collected and identify gaps; identify additional interviews required, if any, and schedule with consultant; document names/titles of all people interviewed							
Collect additional information needed to respond to client questions through document review and interviews							
Using SWOT (strengths, weaknesses, opportunities, threats) analysis and root cause analysis (in Section 3, Modules 2–7), map possible interventions/reforms to address weaknesses identified in assessment							
Prepare preliminary analyses and draft relevant sections for the country assessment report, including recommended potential activity areas and interventions							
Liaise with any in-country program personnel to share and discuss findings and arrange a pre-departure debrief, if requested							
Schedule and conduct a pre-departure stakeholder findings, recommendations and prioritization meeting or/and workshop (if applicable)							
<b>Post-field work</b>							

<b>Task</b>	<b>Client</b>	<b>Team Lead</b>	<b>Coordinator</b>	<b>Local Consultant</b>	<b>Team Members</b>	<b>Date Due</b>	<b>Date Completed</b>
Finalize relevant sections for the country assessment report, including recommendations, based on input from the stakeholder workshop and the client							
Request feedback from a designated reviewer on draft report							
Edit and format final report for approval by relevant client/stakeholders							
Disseminate report in some form (print/CD)							

# ANNEX 2.2.B ILLUSTRATIVE TEAM PLANNING MEETING MATERIALS AGENDA

**Date:**

**Participants:**

Name, HSA Coordinator/Researcher (Team member) Name, Team Leader

Name, Health Systems Specialist (Team member) Name, Health Finance Specialist (Team member)

Name, Senior Consultant (Team member) Name, Task Manager

Name, Ministry of Health HSA Focal Point

**Meeting Objectives and Output:**

- Review and agree on HSA objectives and methodology.
- Clarify team roles and responsibilities.
- Discuss level and types of coordination and involvement of the MOH.
- Agree on team roles and responsibilities in report preparation.
- Agree on tasks/roles while in field.
- How to work together.
- Draft HSA timeline, including schedule while in country.
- Hold a technical and planning discussion to share initial findings and data/information gaps across health system core function chapters.
- Identify action steps and outstanding questions for client, logistics coordinator and team members.
- Summary of Next Steps.
- Other as needed.



## ANNEX 2.2.C ILLUSTRATIVE OUTLINE AND REPORT WRITING ASSIGNMENTS

Chapter	Author(s)	Page Length	Due Dates
1. Executive summary	Team leader	5 pages	
2. Overview of country's health system	Assessment coordinator	5 pages	
3. Methodology	Assessment coordinator	1–2 pages	
4. Findings			
4.1. Service Delivery	Team leader	10 pages	
4.2. Human Resources for Health	Team member 1	10 pages	
4.3. Medical Products, Vaccines, and Technologies	Team member 2	10 pages	
4.4. Health Information Systems	Team member 3	5–10 pages	
4.5. Health Financing	Team member 3	10 pages	
4.6. Governance	Team member 2	5–10 pages	
5. Summary: Analysis (SWOT) and findings across health systems components	Team leader with team	5–10 pages	
6. Recommendations	Team leader with team	5–10 pages	
7. Conclusions/next steps	Team leader	1 page	
8. Bibliography	Assessment coordinator		
9. Contact list	Assessment coordinator with team input		
10. Stakeholder workshop agenda	Team leader with team		
11. Stakeholder workshop presentations	Team leader and team member inputs		

## ANNEX 2.3.A COUNTRY EXAMPLE: BACKGROUND DOCUMENTS

The desktop review for the *Kenya Health System Assessment 2010* compiled the following list of documents.

### General/Core

WHO Country Profile (2006)

The Kenya Health System-Analysis of the situation and enduring challenges (2009)

Overview of Kenya Health System, Chapter 2 of Kenya Service Provision Assessment (2004)

UNAIDS Situational Analysis (2008)

Kenya Health Policy Framework 1994–2010

Analysis of Performance, Health Situation Trends & Distribution: 1994–2010, and Projections for 2011–2030, Ministry of Public Health and Sanitation and Ministry of Medical Services

USAID/Kenya Five-Year Implementation Framework for the Health Sector (2010–2015)

National Health Sector Strategic Plan II (2005–2010)

National Health Sector Strategic Plan II Mid-term Report (November 2007)

Kenya Demographic and Health Survey Preliminary Report (2003)

Kenya Demographic and Health Survey (2003)

Launch of Kenya Demographic and Health Survey (2008)

Assessment of USAID/Kenya's Health Portfolio (APHIA II)

MSH. Health Systems Annual Report (2008)

PSP-One/USAID- Kenya Private Sector Assessment (August 2009)

Health Systems for Outcomes (HSO), The World Bank (2009) <http://hso.worldbank.org/hso/>

UNICEF Country Program: Kenya (2009–2010)

WHO Country Cooperation Strategy Brief May (2009)

WHO Country Cooperation Strategy (2008–2013)

WHO. Kenya Cooperation Strategy (2002–2005)

WHO. Assessment of health systems' performance report of the Scientific Peer Review Group (2002)

PEPFAR Public Health Evaluation: Care and Support – Phase 1 Kenya (2009) (includes assessments of 60 PEPFAR-funded HIV care and support facilities: care provided, human resources available, pharmacy review, analysis of routine assessment/patient forms, staff interviews, and patient focus group discussions)

Annual Operational Plan, Year 4 review, received April 2010

Presentation on the potential new HSS funding platform (Getting More Health for the Money:

Establishing a Health Systems Funding Platform in Kenya)

## Service Delivery

Norms and Standards for Health Service Delivery, Ministry of Health (June 2006)

Kenya Service Provision Assessment Survey (2004–2005)

National Policy on Injection Safety (2007)

Kenya Working Papers: *Decentralizing Kenya's Health Management System: An Evaluation*. January 2009

Kenya Working Papers: *Influence of Provider Training on Quality of Emergency Obstetric Care in Kenya*. January 2009

Using the 2004 Kenya SPA for Health Service Delivery Improvement. 2008 (attached, or go to Measure Evaluations Publications and search Kenya)

Community health worker strategy documents (strategy, training manual, reference guide)

## HRH

Health Worker Recruitment and Deployment Process in Kenya: An Emergency Hiring Program 2008. Ummuro Adano

The Kenya Emergency Hiring Plan-Results from a Rapid Workforce Expansion Strategy, Capacity Project Brief, (September 2009)

HIV and AIDS Policy in the Workplace (2005)

USAID/Quality Assurance Project: Kenya: assessment of health workforce competency and facility readiness to provide quality maternal health services (2008)

Human Resource Management Rapid Assessment Tool for Public and Private Sector Health Organizations: A Guide for Strengthening HRM Systems. MSH. (2005)

The World Health Report 2006. Working Together for Health. The World Health Organization  
Competency Gaps in Health Management—an explanation (2009)

Incentives for health worker retention in Kenya: An assessment of current practice (2008) David M Ndeti, Lincoln Khasakhala, Jacob O Omolo

Africa Mental Health Foundation (AMHF)

Institute of Policy Analysis and Research (IPAR), Kenya

Nursing Human Resources in Kenya: Case study; Developed by Chris Rakuom for the International Centre for Human Resources in Nursing International Council of Nurses and Florence Nightingale International Foundation (2010)

Distance Education Project Between Nursing Council of Kenya (NCK) and Africa Medical Research Foundation (AMREF), Commonwealth Regional Health Community for East, Central and Southern Africa (2006)

Kenya, South Africa, and Thailand: A Study to Improve Human Resource Policies. Health Exchange (2009)

Assessing Health Worker Performance of IMCI in Kenya. Quality Assurance Project (2000)

HR Mapping of the Health Sector in Kenya: The Foundation for Effective HR Management; James J, Muchiri S, HLSP Institute, Ministry of Health (2006)

Impact of HIV/AIDS on Public Health Sector Personnel in Kenya Commonwealth Regional Health Community for East, Central and Southern Africa (2003)

The Health Worker Recruitment and Deployment Process in Kenya: An Emergency Hiring Program, Ummuro Adano (2008)

Cost of Health Professionals' Brain Drain in Kenya (2006)

Extended Service Delivery Project: Best Practices Series Report #2: A Description of the Private Nurse Midwives Networks (Clusters) in Kenya (May 2007)

HR Crisis in Kenya: The Dilemma of FBOs; Mwenda S, HRH Global Resource Center, Interchurch Medical Assistance (2007). Description: This presentation was given as part of the Christian Health Association's Conference: CHAs at a Crossroad Towards Achieving Health Millennium behind this migration and how this problem is being addressed.

Kenya Nursing Workforce (a presentation); Commonwealth Regional Health Community for East, Central, and Southern Africa (2006)

Stepping Up Health Worker Capacity to Scale Up Services in Kenya; Partners for Health Reformplus, Ministry of Health, Kenya (2006)

Evaluation of DFID Country Programmes Brief: Kenya, 2000–2006 (2007)

Evaluation of DFID Country Programmes Country Study: Kenya Final Report 2000–2006 (published 2007)

Evaluation of a Rapid Workforce Expansion Strategy: The Kenya Emergency Hiring Plan. Capacity Project (2009)

Kenya's Health Care Crisis: Mobilizing the Workforce in a New Way, Capacity Project (November 2006).

Making an Impact: Transforming Service at a Remote Hospital in Kenya, Capacity Project, (May 2007)

Mid-Term Evaluation of the Kenya Emergency Hiring Plan, The Capacity Project (February 2008)

What About the Health Workers?: Improving the Work Climate at Rural Facilities in Kenya. The Capacity Project (January 2009)

Strengthening Professional Associations for Health Workers, The Capacity Project (September 2009)

Training Health Workers in Africa: Documenting Faith-Based Organizations' Contributions. The Capacity Project (November 2009)

The Capacity Project in Kenya Country Brief (November 2008)

Investing Wisely: Health Policy Initiative Helps Kenya Improve Health Financing Policies and Systems Kenya (September 2009)

Absenteeism of Teachers and Health Workers. The World Bank

## Medical Products, Vaccines, and Technologies

SPS in Kenya.

Improving Access to HIV/AIDS Pharmaceuticals in Kenya and Zambia. Management Sciences for Health (current project, no date on brief)

How to Develop and Implement a National Drug Policy. WHO (2003)

Drug Management for Successful Public Health Outcomes. MSH (2005)

## HIS

Health Sector Strategic Plan for Health Information Systems (2009–2014)

Health Metrics Network. Health Information Systems Assessment & Scores (2008)

Ministry of Medical Services and Ministry of Public Health and Sanitation: Master Facility List Implementation Guide. (February 2010)

Health Metrics Network. The Case for a National Health Information System Architecture: A Missing Link to Guiding National Development and Implementation

Health Metrics Network: Guidance for the Health Information Systems (HIS) Strategic Planning Process Steps, Tools and Templates for HIS Systems Design and Strategic Planning (March 2009)

Use of HIV/AIDS Information in Kenya. 2007 (attached, or go to the Measure Evaluations website publications and search Kenya)

Decision Maker Perceptions in Kenya: An Assessment of Data Use Constraints. (2005) (the attachment includes an assessment for Kenya and an assessment for Nigeria. the Kenya assessment can be found after the overall title, acknowledgements, and introduction pages at Measure Evaluations publications and search Kenya)

## Finance

Toward a Health Financing Strategy for Kenya, Ministry of Public Health and Sanitation (2009)

WHO. Health Financing Reform in Kenya: Assessing the Social Health Insurance Proposal (2007)

USAID/Health Policy Initiative (HPI). Investing Wisely Health Policy Initiative Helps Kenya Improve Health Financing Policies and Systems: Kenya (September 2009)

USAID/Health Systems 20/20. Kenya National Health Accounts (2005/2006)

## Governance

Decentralizing Kenya's Health Management, Republic of Kenya (2009)

HD Governance Assessment, World Bank Institute (2009)

Various health governing laws, regulations collected and referenced

## HIV/AIDS

Kenya National AIDS Strategic Plan (2006–2010)  
Kenya National AIDS Strategic Plan (2009/10-2013)  
HIV/AIDS Decentralization Guidelines (2009)  
National HIV/AIDS Testing and Counseling Guidelines (2009)  
Guidelines for PMTCT in Kenya (2010)  
Male Circumcision Policy (2009)  
Modes of Transmission Analysis (2009)  
Guidelines on Counseling and Testing (2007)  
Kenya AIDS Indicator Survey (2007)  
Guidelines for Field Implementation of NACC at the Decentralized Levels (2007)  
Socioeconomic Impact of AIDS (2006)  
National M&E Framework (2005)  
HIV/AIDS Research Strategy (2007)  
HIV and Nutrition Guidelines (2006)  
Assessment of Kenyan Sexual Networks (April 2009)  
AIDS Control and Prevention Act (2006)  
Home and Community Based Care in Kenya, NASCOP (2008)

## ANNEX 2.3.B COUNTRY EXAMPLE: CONTACT LIST/INTERVIEW SCHEDULE

The following table is an excerpt from the Guyana Health System Assessment, Health Systems 20/20 and Ministry of Health, 2011. The list of potential interviews in any one country is likely to be much longer.

### Options for Stakeholder Workshops

Contact (name and title)	Contact Information	Organization	Interview Date	Interviewers	Overview	Leadership and Governance	Health Financing	Service Delivery	HRH	Medical Products etc.	HIS
Director	(Email address, phone, street address)	Regional Health Services, MOH	Mon 9:00	Team Leader, SD, HIS		X	X	X			X
Director		Materials Management Unit, MOH	Wed 10:00	HF, Medical Products			X			X	
Dean		University of Guyana Medical School	Mon 14:00	HRH, team					X		
TBD		World Bank	Thurs	HF, Core	X		X				
Director		Guyana Human Rights Association	Tues	Governance		X					
Director		Private Medical Professionals' Association		Team Leader, SD	X	X		X	X		X

## ANNEX 2.3.C ILLUSTRATIVE HSA LAUNCH WORKSHOP AGENDA

This is an illustrative model for how to hold an HSA Launch Workshop. It does not need to be followed exactly as long as the objectives are met and it is done in a participatory manner.

### Launch Workshop Objectives

- To discuss the health system assessment (HSA) process and the health systems strengthening landscape.
- To provide input related to the strengths, weaknesses, and barriers within each HSA function/ building block chapter.
- To share expectations for the HSA process and implementation going forward.
- Set-up: Round tables, six people per table. Use pre-printed name tents on the tables to mix people from different organizations. Each table should have pens, notepads, markers, and a flipchart. Need PowerPoint (PPT) projector and screen.

### Launch Workshop Agenda

Time	Topic	Responsible	Materials
8:30	Coffee/registration	Logistics Coordinator	Registration sheet
9:00	Welcome	Client/MOH	
9:15	<ul style="list-style-type: none"> <li>• Introductions</li> <li>• Introductory activity where each person shares their name, organization, and role/concern with the health sector in [Country]</li> <li>• Overview of Objectives and HSA process</li> <li>• Concepts, Goals, and Landscape of Health Systems Strengthening</li> <li>• HSA Implementation Process and Data Collection (PPT Slide Presentation with Handout; and Structured Q&amp;A Discussion Task at Tables)</li> </ul>	Team Leader or Facilitator	Handout of agenda and objectives Guidelines (pre-prepared)
10:15	BREAK		
10:30	Stakeholder Input: Small Group Work (person responsible) — 45 minutes <ul style="list-style-type: none"> <li>• Participants self-select their group of choice by Health Systems Function/ building block chapter. To ensure enough people per group, ask participants to have a backup in case one area has too many people.</li> <li>• Need facilitator for each session – ideally MOH point person with Team Leader as backup. Will include handout for small group facilitation to ensure that these facilitators are moving the discussion forward and allowing participants to generate ideas.</li> </ul>	Team Members	Presentation(s) Handouts of slides, write-up of options



Time	Topic	Responsible	Materials
	<p>Exploration of strengths, weaknesses, barriers, and potential strategies – discussion questions related to:</p> <ul style="list-style-type: none"> <li>• Strengths and weaknesses of this area in [Country]</li> <li>• Cross-cutting linkages with other areas</li> <li>• Gaps in programming</li> <li>• Barriers to addressing gaps and recommendations</li> <li>• Who to interview and anything to note for site visits</li> <li>• Potential core health system function-specific questions</li> <li>• Report-outs (person responsible) 45 minutes</li> <li>• Option 1: Reporter from each group presents a three-minute overview of key areas for discussion, or two top areas for further investigation</li> <li>• Option 2: Gallery walk, where participants read flipcharts from other groups</li> </ul>		
12:00	<p>Stakeholder Engagement Going Forward:  Sharing of Hopes for Results of the HSA: Making it Meaningful  Sharing of Hopes for Involvement in the Process</p> <ul style="list-style-type: none"> <li>• Pair or trio task to discuss each question, quick responses from each pair.</li> <li>• If lack of time, can write on notecard and leave on the tables.</li> </ul>		Questions for discussion
12:30	Summary of Next Steps (person responsible)	Team	
1:00	Workshop Evaluation. Adjourn for Lunch		Evaluation form

## ANNEX 2.3.D COUNTRY EXAMPLE: DISCUSSION GUIDES FOR THE SUBNATIONAL LEVEL

The sample discussion guides below, adapted for this manual from the Health System Assessment (HSA) done in Kenya in 2010, are included here as a reference for future HSA teams working at the subnational level. The documents should be used to guide the discussion or interview, rather than as a structured questionnaire, and many of the questions should not be asked as written, but rather paraphrased. It is important to remember that each country HSA will have a different focus and set of priorities, so the discussion guides will reflect this. Some may focus more on Medical products, vaccines, and technologies core health system function, and less on Human Resources for Health while others may have a strong Health Financing focus and therefore more specific discussion in this area will take place at the subnational level.

## Discussion Guide for Provincial, County or District Health Teams

District/ Province: \_\_\_\_\_ Date: \_\_\_\_\_

### Respondent(s) Interviewed

Name	Designation

### Service Delivery

What is the total number of facilities that are private and public sector in the district? How do you interact with private/NGO/faith-based facilities? (These questions check knowledge about the private sector.)

What is the availability of telephones, transport, or other means of communication between levels of care?

Is there a district standard for the frequency of supervision visits to primary care facilities? What is the frequency of supervision visits?

To what degree is supervision integrated between programs (primary health, TB, HIV, malaria)? Do vertical programs such as HIV, malaria, and maternal health, have their own individual supervisors or do they share them? Do supervisory teams conduct supervisions using a single supervision tool?

What other processes assuring quality of care besides supervision are in place?

Is there a formal procedure for referrals and follow-ups between levels of health care facilities? If so, what data do the health system track to monitor referrals between facilities of different referral levels?

What types of specialist equipment exist at the facility? Are laboratory, ultrasound, x-ray, surgical facilities available?

## **Human Resources for Health**

Please tell us about the patterns of staff vacancies here: Over time, what % of established posts are vacant?

What can you tell us about the level of staff motivation and satisfaction? What factors affect motivation and satisfaction the most (in both good and bad ways)?

When is the last time staff members received training? What kind of training was it, and who sponsored it? (Probe for clinical vs. other, NGO/external development partner sponsored vs. MOH sponsored.)

How is supervision conducted, how often by whom and what type of follow up is there?

\* For private providers: How many clinicians are available at this facility? What are their specialties and/or area of practice? What is the scope of any support personnel at the facility?

\*Private Providers: Do clinicians, nurses, and/or support personnel at this facility have access to in-service and/or continuing education trainings?

\* What is the percentage of time clinicians at this facility devote to private or public practice (100%? 50%)? Are there any clinicians at this facility engaged in dual-practice?

## **HIS**

How is health information collected, by whom, where does it go, and is feedback received from the central level? Is feedback provided to the local level?

How are data used for planning; please explain.

How are disease surveillance data collected from the facility and community levels, what is done with that data?

How are data collected and what types of data are collected from private providers including NGOs, FBOs and commercial sector? Where does this data enter? Are these data included in your reporting?

Is health information data shared with stakeholders, and if so, how is this done?

\*Private Providers: What data are you required to report on, to whom, and how often?

## **Finance**

Are private providers contracted or reimbursed for providing government services in the district/province?

Is there an insurance scheme in place and how does it work?

Are NGOs/FBOs working in the districts/province disclosing funds available to the health sector during the annual planning? Are those funds finally disbursed for intended purposes?

Are AOPs (Annual Operational Plans) useful in mobilizing funds for health? If not what changes would you propose in the AOP preparation process?

Are you able to achieve the operational and investment funding needed to meet the service needs of this district? If not, why not? What would be needed for you to get the funding needed to offer the services promised/demanded?

## **Governance**

What mechanisms are in place to allow for your involvement in health policy development and planning (public or private)?

Do you think the Government and the Ministry of Health in particular ensure that there is availability of health information especially to the public?

Do you use data for resource planning, budget requests, program adjustments, quality control, etc.?

What mechanisms are in place for the public, especially the community, to provide feedback to health providers?

Are you aware of any recent changes in regulations or reforms that require you to change the way you work? Do you understand what is required and do you feel you have been given the proper training and resources to implement the regulations/programs?

Are clinicians in [country] members of any professional associations, councils, or unions? If so, what services do the associations provide to you? Do you feel they represent the interests of providers to government adequately?

Are there any penalties for health offices or clinicians who perform poorly or incentives for good performance?

### **Provincial Level ONLY**

Data within the FTP system [FTP = File Transfer Protocol—MOH system for reporting data from district to national level] should be available to the Provincial Health Office and/or Provincial Health Records and Information Officer, through aggregated, provincial-level data spreadsheets.

- a. Do you access provincial-level data spreadsheets through the FTP?
- b. If yes, how do you use this information?

### **District Level ONLY**

The FTP requires facilities to submit monthly service summary forms to the district level (via the District Health Records and Information Officer or DHIRO), and for the district level to submit aggregated summary data to the national level.

- a. In general, are facilities in your district able to fulfill this requirement? What are the major barriers?
- b. In general, do nongovernmental (private, NGO, faith-based, etc.) facilities adhere to this requirement? What are your thoughts on why or why not?

Does this district produce summary health service and status reports?

- a. If yes, please describe what is produced, frequency, and method of dissemination.

Does this district organize opportunities for stakeholders to share, review, and discuss district health service and status statistics/data?

- a. If yes, please give an example (from previous 12 months), including type and stakeholder groups represented.
- b. If yes, can you provide an example (within the previous 12 months) of a service delivery/health sector management decision that resulted from the multi-stakeholder review/discussion of district-level data?

## Medical Products, Vaccines, and Technologies

Have there been stock-outs of the following in the past three months?

Type of Commodity	Enter Y/N/NA	Comments (reason for stock-out and action taken)
Essential medicines		
Essential medical supplies		
Reproductive health/family planning commodities		
HIV/AIDS medicines		
TB/leprosy medicines		
Vaccines		
Laboratory supplies		
Dental supplies		
X-ray supplies		

Briefly comment on the following issues stating your achievement, challenges, and needs:

Infrastructure/Equipment/Materials Key Issues

Human Resource Capacity Key Issues

Record-Keeping Practices Key Issues

Availability and Use of Guidelines/ Rational Use Issues e.g., Medicine and Therapeutics

Committees Key Issues

Supplies (Essential Medicines and Medical Supplies) Key Issues

General Comments Specific Program Related Issues (Are there specific problems relevant to a group of commodities e.g., TB, ARV, RH, Laboratory etc.)

## Discussion Guide for Facility-Level Data Collection

Facility Name: \_\_\_\_\_ District: \_\_\_\_\_ Province: \_\_\_\_\_

Level of Care<sup>1</sup>: \_\_\_\_\_ Ownership<sup>2</sup>: \_\_\_\_\_

### Respondent(s) Interviewed at the Facility

Name	Designation

### Finance

Have you heard of the HSS Fund? Are committees in place to oversee implementation of this Fund?

How do you receive funds allocated to your facility by the GoK [Government of Kenya]?

Are the user fees charged compliant to the 10/20 Policy? If not, how do you determine the level of fees

to be charged? (If a private provider) what are the reporting requirements for revenue and/or costs related to service? Do you accept private insurance? Do you have contracts with private companies to provide services? What % of your revenue is from private out of pocket payment? Do you have to provide credit to your customers? Do you get credit from your suppliers of drugs (and how does this arrangement or lack of impact availability and stability of supplies)?

### HRH

Please tell us about the patterns of staff vacancies here: over time, what % of established posts are vacant?

What can you tell us about the level of staff motivation and satisfaction? What factors affect motivation and satisfaction the most (in both good and bad ways)?

When was the last time staff members received training? What kind of training was it, and by whom was it sponsored? (Probe for clinical vs. other, NGO/external development partner sponsored vs. MOH sponsored.)

### Governance

What mechanisms are in place to allow for your involvement in health policy development and planning?

---

<sup>1</sup> DH = District Hospital; SDH = Sub-District Hospital; HC = Health Center; D = Dispensary; C = Clinic; H = Hospital.

<sup>2</sup> GoK = Government; FBO = Faith-Based Organization; CBO = Community-Based Organization; NGO = Nongovernmental Organization; P = Private; O = Other (Specify).

Health information is important for planning, transparency, and accountability in the health sector. Do you think the GoK and the Ministry of Health in particular ensure that there is availability of health information especially to the public?

What mechanisms are in place for the public, especially the community, to provide feedback to health providers?

What would you recommend to achieve the goals of the health sector at both national and local levels?

## **HIS**

What is the referral process for services unavailable at this facility? That is, to hospital and/or private providers and/or for diagnostics unavailable at the facility?

Does this facility submit monthly service summary forms to the district level?

- a. If so, to whom is this facility reporting every month (i.e., to the DHIRO, to external development partners/funding mechanisms)?
- b. Who in your facility normally completes and submits monthly service summary forms (i.e., is it the nurse/service provider rather than a data/information clerk)?
- c. Does this facility / that person experience regular challenges/barriers to submitting summary forms on a monthly basis? If so, please describe.

Does this facility receive feedback, supervision, or training from the district or national level regarding the quality (including timeliness, completeness, accuracy) of data collected and submitted monthly?

- a. If yes, please provide an example (within previous 12 months).

Does this facility have access to district health service and status summary reports?

Does this facility (or a representative) participate in district-level stakeholder meetings to share, review, and discuss district health service and status statistics/data?

- a. If yes, please give an example of such a meeting/forum (from previous 12 months).

Does this facility review its monthly service summary forms to inform service delivery or management (budget, HRH, etc.) decisions?

- a. If so, please provide an example (from the previous 12 months) of a service delivery or management decision that this facility implemented as a result of review of service statistics.

## **Service Delivery**

Are outreach services available for remote communities? If so, what is the frequency of these outreach visits and which services are included?

What mechanisms are in place to ensure that eligible people access waivers and exemptions and that non-eligible people do not?

What is the number of supervision visits to health centers planned that were actually conducted?



How frequently does the district level come for supervision visits and, when they do come, do they come as a team/individual for multiple programs or do they pay separate visits for separate programs?

How does the community participate in assuring that health services offered by the public sector meet community needs?

Are there any community health units in your catchment area? If so, how do you interact with the Community Health Extension Workers (CHEWs)? Has the system better enabled you to plan for the communities' needs?

What is the scope of private facilities in the community? Are there private clinicians offering services?

**Medical Products, Vaccines, and Technologies:**

What is the source of your facility's health commodities? (Essential medicines, Reproductive Health/Family Planning medicines, HIV/AIDS meds, TB/Leprosy meds, vaccines, lab reagents, etc.)

Are there private laboratories and/or pharmacies?

Is there a functioning procurement committee?

Does the facility collect user fees for services rendered?

Are Financial Intermediate Funds (FIF) utilized to procure medicines/supplies?

Question (Answer Y/N)	Y/N	Comments
A. Is space sufficient (both bulk store and dispensing area)		
B. Is shelving sufficient?		
C. Is there a functional cold storage?		
Is the cold storage temperature monitored?		
Are physical stock counts done at least quarterly?		
Do staff use a quantification procedure for replenishment?		
Do all items have bin cards or stock control cards (SCC)?		
Are commodity reporting and requesting (replenishment) forms/order books available?		

Are there guidelines for the utilization of FIF funds?

<b>Are the Following Available to staff</b>		<b>Y/N/NA</b>	<b>Comments</b>
	Clinical Guidelines for Diagnosis and Treatment of Common Conditions in Kenya		
	National Guidelines for Diagnosis, Treatment and Prevention of Malaria for Health Workers in Kenya		
	Guidelines for Antiretroviral Therapy in Kenya		
	National Guidelines for Prevention of Mother-to-Child HIV Transmission		
	National TB/Leprosy Guidelines		
<b>Medicines and Therapeutic Committees</b>			
	Is there a functional Medicines and Therapeutics Committee?		
	How often does this committee meet?		

What proportion of FIF is utilized for procuring essential medicines and medical supplies?

#### **Out-of-Stock Items**

1. Which groups of health commodities or supplies are most commonly out of stock (e.g., general medicines, TB, malaria, laboratory reagents)?
2. Where do patients acquire out-of-stock items? What is done in the case of out-of-stock essential medications such as ART?
3. Infrastructure/ Equipment/storage
4. Answers to this checklist may be obtained through observation and staff interview. Y: Yes is a positive response, N: No is a negative response, N/A: Not applicable should be used if the response to a question does not apply.

#### **Program Specific Challenges**

5. Are there specific challenges/issues common to one group of commodities, e.g., RH/TB, ART? Describe.

## ANNEX 2.4.A OPTIONS FOR SYNTHESIZING FINDINGS

Three tables are presented below as options for presenting data in the final report. The team leader may opt to either use the suggested tables and format for synthesis presented in Section 2, Module 4 or use one of these options to analyze and present findings. Based on the needs of the client, the team leader should select which options to use, when possible, before data collection starts. This will ensure that all team members are collecting relevant data.

### OPTION I. PRESENTING INFORMATION ON SPECIFIC PRIORITY HEALTH ISSUES

When analyzing data, consider how the findings are relevant to various external development partners or disease-specific groups; this can help the team craft recommendations that appeal to specific groups. The following matrix can be used to summarize information for priority areas identified by the client/MOH. (The matrix can be modified to suit individual HSA needs.)

#### DIAGONAL HEALTH SYSTEMS STRENGTHENING MATRIX

	HIV/AIDS/TB	MNCH	Malaria	NTD	FP	Shared System Strengthening Activities
Service Delivery						
HRH						
Medical Products, Vaccines, Technologies						
HIS						
Health Finance						
Governance						

## OPTION 2: Country Example: SUMMARY OF KEY HEALTH SYSTEM FINDINGS BY PERFORMANCE CRITERIA

Another useful way to depict findings is by performance criteria, as shown in the following example from the 2010 Guyana HSA.

### ILLUSTRATIVE KEY HEALTH SYSTEM FINDINGS BY PERFORMANCE CRITERIA 2010 GUYANA HSA

Health System Core Function	Equity	Access	Efficiency	Quality	Sustainability
Governance	A few CSOs, particularly those focused on HIV/AIDS, have strong voices on health-related issues. Lesson learned can be transferred to non-HIV organizations.	The MOH has a good relationship with the media and uses them effectively to convey strong health promotion messages to the public.	Flexibility of GPHC and Region 6 to innovate, including task shifting and incentive programs, offers lessons for other regions.	Service agreements have the potential to improve accountability for service delivery and quality through performance-based targets and use of client satisfaction surveys.	There is strong political and senior-level ministerial leadership, including through the NHPC, on health systems issues.
Service Delivery	The PPGHS is currently being revised.	Outreach services, mobile clinics, and communication have improved in recent years.	The referral system has improved with increased communication.	Recent development of standard treatment guidelines holds promise for improved quality and consistency of services.	There is movement toward preventive care and increased advocacy and health promotion.
Health Financing	Provision of free services allows financial access for all; NIS mandates health insurance coverage for all employed, including self-employed.		Doubling of the government health budget over 2005-2009, with significant increase in external funding from development partners, should allow for increased efficiency in planning and providing health services.	Significant increase in capital investment to refurbish and renovate facilities in recent years makes it important to ensure that capital investment is not wasted and other needed inputs such as staff, drugs, and supplies are adequately available to improve overall quality.	There is growing external development partner support for HSS, opening opportunities for partners to help the MOH to address health system weaknesses as well as direct support for HSS.

<b>Health System Core Function</b>	<b>Equity</b>	<b>Access</b>	<b>Efficiency</b>	<b>Quality</b>	<b>Sustainability</b>
Medical Products, Vaccines and Technologies	Transportation and general infrastructure challenges could continue to limit rural access to supplies and medicines	Central-level procurement, with bulk purchasing would improve efficiency.	Significant positive steps are already being taken in the area of quality assurance, but lack of strong coordination between external development partners and key stakeholders could reduce the assurance of access to quality products.	The government has already taken responsibility for many of the activities and services previously supported and/ or provided by development partners.	
Human Resources for Health	Data and standards exist on the HRH necessary to meet the PPGHS; but the overall shortage of health workers, particularly nurses, affects adequate distribution of workers at various levels.	Numbers of doctors are increasing with training abroad and availability of foreign doctors; foreign doctors often have difficulty integrating into the Guyanese health system and communicating with clients and colleagues.	The HRIS has been developed and is housed in the MISU and could contribute to more informed planning; however, the HRIS is not capturing current health worker information, nor is it being used to analyze workforce data and trends.	The MDP is improving the quality of health managers.	PSM rules and regulations lead to lengthy and cumbersome hiring processes.
Health Information Systems	More data and information are available than ever before, which offers the opportunity to inform planning across the health sector.		Data collection and analysis in recent years has been streamlined with better information flow, but data collection is still weak, particularly in rural areas and the hinterlands.	Data quality is much more reliable due to advances and investment in technology and infrastructure but needs to be better used to improve quality of clinical care.	HIS personnel have developed uniquely Guyanese hardware and software systems. Steps are being taken to take greater ownership and responsibility for IT and HIS.

## ANNEX 2.4.B HOW SELECTED HSS INTERVENTIONS HAVE EFFECTED HEALTH SYSTEM PERFORMANCE

Examples of Successful HSS Interventions	Description of Intervention	Positive (A) or Negative (V) Effect on Health System Performance	Outcomes in Terms of Service Use or Health Impact
Bamako Initiative in West Africa (Ridde 2011)	Adopted by African ministers in 1987 with the support of UNICEF and the World Health Organization, the goal of the Bamako Initiative was to increase access to primary health care services and essential drugs in sub-Saharan Africa through community participation in the local management of health services, cost recovery of drugs, and community contributions to the financing of health services	<p><b>A Access:</b> Increased access to health services and wider geographic access to essential generic drugs (despite some stock shortages).</p> <p><b>V Quality:</b> Regional disparity in terms of access to health centers and drugs.</p> <p><b>V Equity:</b> Drug prices/user fees were never calculated according to capacity to pay, and the very poor were not given user fee exemptions.</p> <p><b>V Sustainability:</b> Low levels of cost recovery and community participation.</p>	<p>Access to antenatal care and use of generic, essential drugs have increased.</p> <p>Rates of immunization are higher.</p> <p>However, the poorest households perceived less value in the quality of health care than better-off households and were less likely to use the health services.</p>

Examples of Successful HSS Interventions	Description of Intervention	Positive (A) or Negative (V) Effect on Health System Performance	Outcomes in Terms of Service Use or Health Impact
<p>Manas and Manas Taalimi Health Reform Programs in Kyrgyzstan (Ibraimova et al. 2011)</p>	<p>Between 1990 and 1996, Kyrgyzstan's government spending on health decreased by 67%. In response to the funding crisis, the government implemented the Manas (1996–2006) and Manas Taalimi (2006–2010) reforms, which were linked to measurable health outcomes. The reforms led to the implementation of a basic benefits package, a shift from specialist-oriented care to family practice care, liberalization of the pharmaceutical market, and the introduction of a consolidated single-payer system.</p> <p>Kyrgyzstan has also benefited from an emerging civil society, a well-educated population (female literacy is almost 100%), and a more open political climate that has attracted international development partners.</p>	<p><b>A Access:</b> The family medicine model, introduced in 1997 and rolled out to the whole country in 2000, extended universal coverage of primary care. Reforms resulted in new processes, referral procedures, communication channels, and peer support.</p> <p><b>A Quality:</b> Continuity and transparency in policy and staffing as well as strong human resource capacity and accountability in the health sector and in government (both clinical and managerial) have improved the quality of health services.</p> <p><b>A Equity:</b> The health system in Kyrgyzstan combines taxation and mandatory health insurance, which has resulted in universal coverage and free essential services for vulnerable populations.</p> <p><b>A Efficiency:</b> The Mandatory Health Insurance Fund, which pools health funds and merges budget streams from insurance, has helped the government to address socioeconomic and health inequalities.</p> <p><b>V Sustainability:</b> Questions remain over Kyrgyzstan's ability to retain health workers due to growing internal and external immigration.</p>	<p>Improved contraceptive use has resulted in fewer unplanned pregnancies and longer intervals between births. Antenatal care coverage is only slightly less in rural than in urban areas, at 95.4 percentage points and 99 percentage points, respectively and childhood immunization coverage is high at 98–99 percentage points.</p> <p>The infant mortality rate has dropped from 66 deaths per 1000 live births in 1997 to 38 deaths per 1000 live births in 2006, while the under-5 mortality rate has fallen from 72 to 44 percentage points during the same period.</p>
<p>Health extension workers and task shifting of health care workers in Ethiopia to expand and modernize health workforce (Good Health at Low Cost 25 Years on) (Banteyerga et al. 2011)</p>	<p>The Health Extension Programme was launched in 2003. The program trains women who have completed at least ten years of formal education to be community health workers. To continue to modernize and expand the health workforce, Ethiopia has enabled nurses to perform tasks traditionally assigned to doctors and invested in health care professional training programs. There has also been investment in data monitoring and evaluation tools.</p>	<p><b>A Access:</b> Expansion of the work force has led to scaling up of treatment and prevention programs in areas where doctors are absent, particularly for maternal and child health, at a low-cost.</p> <p><b>A Quality:</b> Improved capacity of health workers and an investment in developing information systems to improve data gather for evaluation purposes.</p> <p><b>V Sustainability:</b> Development partners have provided considerable assistance to provide basic equipment and train health extension workers. Career progression of staff could also threaten sustainability.</p>	<p>In the five years following the introduction of the program, the percentage of births with a skilled attendant present doubled and the percentage of women receiving antenatal care and of infants receiving all immunizations increased by over 50 percentage points.</p> <p>Malaria-related deaths decreased significantly due to prevention education, use of malaria nets, and earlier diagnosis.</p> <p>There has also been significant progress in tackling the underlying determinants of health including access to water, sanitation, and nutrition.</p>

Examples of Successful HSS Interventions	Description of Intervention	Positive (A) or Negative (V) Effect on Health System Performance	Outcomes in Terms of Service Use or Health Impact
Mutuelle de Sante: Rwanda's community-based health insurance scheme (Innovations in Rwanda's Health System)(Logie et al. 2008)	Rwanda introduced its community based health insurance (CBHI) scheme in 1999 and has since expanded it throughout the country. The scheme is run by community members and managed as an autonomous organization to pool health risks at village and district levels. The central government provides funds up to US\$5,000 to be shared by the district and rural health facilities. The scheme provides basic services including family planning, antenatal care, deliveries, consultations, basic laboratory examinations, generic drugs, and hospital treatment for malaria. A central reserve fund can cover catastrophic health events. Each member of the scheme contributes 1000 Rwandan Francs (US\$2) per year and also pays a 10% fee for each illness episode.	<p><b>A Access:</b> The CBHI scheme mobilizes financial resources to pay for health services. As of 2006, 73% of the population was covered by the scheme.</p> <p><b>V Quality:</b> While the CBHI scheme gives the poor access to basic health services, their package of health services could be improved and include tertiary care if the scheme for civil servants and the military insurance scheme were pooled with the Mutuelle de Sante to spread the risk across the entire population.</p> <p><b>V Equality:</b> While some individuals' contributions to the health fund are subsidized by external development partners, an elected village committee decides who needs the subsidy (unless the individual has HIV/AIDs and is in a PEPFAR program, automatically excusing them from contributing to the fund). An estimate in 2005 suggested that 15–30% of the poorest subset of the population needed to have their fees waived, yet a 2004 study found that only 10% of the poorest received the subsidy.</p>	<p>Health seeking behavior has increased significantly from the time when most health care was completely funded by patients.</p> <p>Infant mortality, under-5 mortality, and maternal mortality rates have dropped.</p>
Oportunidades in Mexico (Barber and Gertler 2008)	Oportunidades was introduced in 1997 as a large-scale conditional cash transfer program that rewards households for taking actions to improve the education, health, and nutrition of their children. To improve birth outcomes through better maternal nutrition and use of prenatal care, the cash transfers are conditioned, in part, on pregnant women completing a prenatal care plan, taking nutritional supplements, and attending an educational program.	<p><b>A Access:</b> Increased access to services through decreased financial barriers.</p> <p><b>A Quality:</b> Improvements in the quality of health care received and nutritional value of food through access to higher levels of cash.</p> <p><b>V Sustainability:</b> Questions remain about the long- term sustainability of cash transfer programs.</p>	<p>Beneficiary status was associated with a higher birth weight among participating women and a 4.6 percentage point reduction in low birth weight.</p> <p>Children in participating households have a reduced probability of anemia and fewer illness episodes (25.3 percentage point reduction) as well as an increase in age-adjusted height by 1.1 cm.</p>



## ANNEX 2.4.C ILLUSTRATIVE HEALTH SYSTEM CONSTRAINTS, POSSIBLE DISEASE/SERVICE-SPECIFIC AND HEALTH SYSTEM RESPONSES

Constraint	Disease or Service-Specific Response	Health System Response(s)
Financial inaccessibility (inability to pay formal or informal fees)	Exemptions/reduced prices for focal diseases	<p>Develop risk-pooling strategies.</p> <p>Offer vouchers for specific health services (e.g. FP, RH, safe deliveries) that allow consumers to select provider of choice in public or private sectors.</p> <p>Public purchasing of privately provided services and offering providers incentives linked to services delivered.</p> <p>Leverage corporate funding for innovations and strategic problem solving.</p> <p>Publicly funded (or public-private co-funded) campaigns to inform consumers about health insurance market.</p>
Physical inaccessibility	Outreach for focal diseases	<p>Reconsideration of long-term plan for capital investment and siting of facilities.</p> <p>Contract FBO or NGOs to deliver services located in areas where MOH is not present.</p> <p>Improve coverage by offering providers incentives linked to coverage.</p> <p>Define scopes of work for health workers and generating more medical graduates.</p> <p>Leverage human resources in the private sector to deliver essential health services.</p> <p>Agreements or contracts with commercial drug marketers to market or distribute drugs, vaccines or other products to local markets.</p>
Inappropriately skilled staff	Continuous education/training to develop skills in focal diseases	<p>Review of basic medical and nursing training curricula to ensure that appropriate skills are included in basic and in-service training.</p> <p>Require CME for all health cadres in both public and private sectors.</p> <p>Address short-term skill shortages by subsidizing specialist services in the public sector.</p> <p>State mandate—through councils and/or boards—to define scopes of professional scopes of practice, pre-service or continuing medical education standards and facility licensing.</p>
Poorly motivated staff	Financial and nonfinancial incentives to reward delivery of particular priority services	<p>Institute proper performance review systems, creating greater clarity of roles and expectations as well as consequences regarding performance.</p> <p>Review salary structures and promotion procedures.</p> <p>Offer public subsidies for education and regulate charges.</p>
Weak planning and management	Continuous education/training workshops to develop skills in planning and management	<p>Restructure ministry of health.</p> <p>Recruit and develop cadre of dedicated managers.</p> <p>Create MOH capacity to engage and partner with the private sector.</p> <p>Develop new technologies to collect and manage health information, such as management contracts.</p> <p>Use privately developed cell phone/ information technologies to collect data, improve reporting of health information, prevent stock-outs (supply chain).</p>
Lack of inter-sectoral action and partnership	Creation of special disease-focused cross-sectoral committees and task forces at the national level	<p>Build local government capacity and structure to incorporate representatives from health, education, and agriculture, and promote accountability to the people.</p> <p>Create forum for dialogue between the public and private sector on health system issues of common interest.</p> <p>Policy forums and other processes (e.g., revise and update laws, strategic planning) that actively engage and consult private sector groups.</p> <p>Develop monitoring, accreditation, and regulation systems that encompasses both the public and private sector and enforces regulations fairly across sectors.</p>

<b>Constraint</b>	<b>Disease or Service-Specific Response</b>	<b>Health System Response(s)</b>
Poor quality care of care	Training providers in focus diseases or services	<p>Create and enforce standards for private medical education.</p> <p>State mandate to educate consumers, create a mechanism for addressing consumer complaints and advocate with private insurance companies.</p> <p>Provide supportive supervision through professional councils or associations.</p> <p>Contract with high quality private sector institutions for the provision of laboratory or diagnostic services.</p> <p>Invest in primary research to identify new vaccines or treatments (both public and private sector). This could include funding to set up research institutions.</p>

# ANNEX 2.5.A ILLUSTRATIVE VALIDATION WORKSHOP AGENDA

What follows below are some suggestions for how to carry out a validation workshop in-country. There is no one correct way to validate HSA findings and recommendations, however the team needs to work together with the client and MOH to decide what format makes the most sense for broad-based validation of the HSA results. For example, a validation workshop could be conducted either through a half day presentation and discussion with a more formal agenda and less focus on group discussion and exercises, or a longer more didactic and participatory approach involving one full day or over multiple days.

The agenda below is based on one used for a Health System Assessment (HSA) validation workshop in a sub-Saharan country and is a multiday participatory workshop. When designing the country validation workshop, the detailed description in this agenda need not be followed in it's entirely, rather it is important to ensure that the objectives listed below are met and that discussion is done in a participatory manner. This workshop could be done in one-full day or over multiple days. Given that the HSA typically covers all six health system core functions and that many findings and recommendations cut across core functions, the workshop in this country was designed to be highly participatory with small group exercises and discussions, a number of days may be necessary.

## Objectives

- Present the scope of the HSA and methodology
- Review the HSA findings and recommendations for each core health system function
- Revise the recommendations based on feedback from stakeholders from multiple sectors
- Identify recommendations that cut across more than one core health system function following a root-cause analysis process
- Prioritize recommendations

## Materials

1 box of markers per table  
2 rolls of masking tape to hang flipcharts on walls  
Name tents and name tags  
2 packs of 5x7 notecards  
Handouts

## Room Set-up

Ideally the room will have round tables that seat about 6–8 people each. Notepads and pens (one per person) are on the tables, as are note cards (15–20 per table). Instruct participants to sit with people they don't know or who are from different organizations. This can be done by hanging a flipchart sign and providing instructions to participants to sit accordingly. It's also ideal to have nametags for participants and name tents for speakers.

## AGENDA (FULL-DAY MEETING)

### 8:30 am Welcome and Overview of the Workshop

Welcome the participants. Have a senior MOH official welcome the participants. Have participants introduce themselves quickly.

Before reviewing the objectives, explain to the participants the overall process (PPT) for the workshop (whether it is a short half-day rapid presentation and discussion, a one-day more participatory workshop, or a multiday working discussion).

State that the overall purpose of the today's workshop shop is to validate the HSA recommendations with stakeholders. While the report may have been preliminarily accepted by the MOH, the recommendations have not been fully validated across all part of the MOH nor with a larger group of stakeholders. Explain that this is an essential step before beginning to prioritize the recommendations.

Review the objectives and agenda for the day.

Encourage active, focused participation (this is a working meeting and full engagement is required).

Create opportunities for participation across sectors (i.e., mixed discussion groups).

Focus on the benefit of the recommendation to the health system rather than focusing on the aspect of the health system you represent.

Ensure that everyone participates in the discussion.

Turn off cell phones during the session.

### 9:30 Presentation of Findings and Recommendations

Ask how many have read the HSA report, especially the chapter pertaining to their direct area of interest. Remind the group that the recommendations are presented in the report by core health system function:

Service delivery

HRH

Medical Products, Vaccines and Technologies

HIS

Financing

Governance

Ask for overall reactions to the findings and recommendations, that is, whether they seem on target, sufficiently specific, and actionable. (Do not let the discussion go to specific comments—that is the next step in the agenda.)

Capture any of these reactions on flipchart.

### 10:30 Break

### 10:45 Small Groups – Discussion of Findings and Recommendations by Core Health System Function

Say that the findings and recommendations will be discussed in six groups, each representing one of the health system core functions.

Designate six tables, one for each of the core functions. Ask for a show of hands of those interested in each building block to make sure that the groups are roughly equal in number. The number in each group doesn't have to be the same, but group size should not vary greatly—avoid having one group with 15 and another with three people, for example.

1. Ask everyone to take 10 minutes to review the findings and recommendations for their assigned core function.

2. Then, as a group, agree on your answers to the following questions:

- Are the recommendations consistent with the findings?
- Are there any recommendations that are not clear and need to be re-phrased?
- Should any recommendations be dropped?
- Should any recommendations be added?

After answering these questions, suggest revised wording for each recommendation the group feels needs to be changed.

Capture your revised recommendations on a flipchart or PPT.

Appoint a spokesperson to present your revised recommendations.

You have 90 minutes.

Explain clearly to participants that the purpose of the next activity is to make sure that the recommendations are on target and consistent with the findings of the HSA. The purpose is not to prioritize the recommendations, since that will be done later in the afternoon.

**12:30 Lunch**

**1:30 Report-outs**

Ask each group to report out in 5–7 minutes.

After each report-out, allow for 10 minutes of plenary discussion. This means each group will have about 15 minutes in total.

**3:00 Break**

**3:15 Plenary Discussion**

Say that now that we have examined the recommendations by core health system function, we want to spend some time looking at the entirety of the recommendations. Although the team has already spent some time working on root-cause or multi-causal analysis as described in Section 2, Module 4, it is important for the participants to also participate in the analysis process.

Discuss the two following questions in plenary.

Are there any overarching recommendations that are missing? These recommendations are not necessarily specific to a health system core function. Two examples are (1) the lack of a qualified office within the MOH that provides direction and leadership for HSS and (2) the lack of an interagency mechanism to coordinate work on interventions that go beyond the scope or capacity of any one national agency.

What synergies do you see between the recommendations? Which ones are dependent on recommendations in other core functions? An example is the financing needed to address HRH constraints and hire new health workers.

Capture the main points on flipchart.

**3:45 Summary and Next Steps**

Review the main points from the day's discussion and what was accomplished.

If the workshop is to continue for another day, review the process for the next day (or through the workshop conclusion)—revising the recommendations tomorrow, subgroup on prioritization the day after to narrow down the list, and full stakeholder group to further prioritize.

Hand out evaluation form that answers the following questions:

- What was most effective about the workshop today?
- What was less effective about the workshop?
- What is the single most important thing to you about today's workshop?

**4:30 Close**

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