Annex 2

Section 2
Conducting the Assessment

Annex 2.1.A Documented Use of the Health System Assessment Approach

The United States Agency for International Development (USAID) Health System Assessment (HSA) approach was developed and piloted in 2005-2007 through assessments in Angola and Benin. The tool has been used in 29 countries for a variety of reasons, ranging from USAID-driven internal assessments of bilateral programs to Ministry of Health (MOH)-driven assessments to inform health systems strengthening planning and health sector strategic and investment plans.

The table below lists the documented use of the tool. Health Systems 20/20 has participated in 23 HSAs, in Angola, Antigua, Benin, Cote d'Ivoire, Dominica, Ethiopia, Grenada, Guyana, Kenya, Lesotho, Mozambique, Namibia, Nigeria, St. Kitts and Nevis, St. Lucia, St. Vincent and the Grenadines, Senegal, South Sudan, Tanzania, Uganda, Ukraine, Vietnam, and Zimbabwe.

Documented Applications of the USAID HSA Tool (as of October 2011)

Country	Year	Audience	Objective
Angola	2005	USAID	Pilot to inform the design of an integrated health project
Azerbaijan	2005	USAID	Input into pharmaceutical management strategy. No formal report
Benin	2006	MOH	Pilot to inform for 5-year health strategy
Pakistan	2006	USAID	Inform health system activities. No formal report
Yemen	2006	MOH	Framework for health system review. No formal report
Malawi	2006	USAID	Input into bilateral design. No formal report
Ghana	2006	USAID	Input into assessment of insurance. No formal report
S. Sudan	2007	MOH	Input into GAVI Alliance HSS proposal
Vietnam	2008	PEPFAR,MOH	Assess 2 provinces and build local capacity for future province assessments
Namibia	2008	MOHSS	Adapted for use in health sector review, cited in successful Global Fund proposal. Country led process
Nigeria	2008	Sec PHC, PEPFAR	State performance assessment
Senegal	2008	MOH,USAID	Input for health strategy
West Bank	2008	MOH, USAID	Input for 5-year health strategy. Conducted by Chemonics
Vietnam	2009	MOH	Subnational assessment of 6 provinces. Used as a baseline for monitoring HSS. Informed Vietnam's Partnership Framework
Cote d'Ivoire	2009	PEPFAR	Input for country action plan
Lesotho	2010	PEPFAR, MOHSW	Input for USAID and PEPFAR planning and the MOHSW HSS plan
Zimbabwe	2010	PEPFAR, MOH	Input for National Investment Plan, USAID/PEPFAR COP planning
Angola	2010	MOH, USAID	Follow-up on progress since 2005 HSA, input for health sector planning
Kenya	2010	MOMS, MOPHS, USAID	Input for health planning and health policy reviews
Guyana	2010	MOH, USAID	Input for MOH and Global Fund HSS intervention planning
Tanzania	2010	MOH, donor groups	Input for health partner planning and health finance review
Uganda	2011	MOH, USAID	Develop a set of SMART indicators for measuring health system progress
Ukraine	2011	MOH, USAID	Inform MOH health reform agenda, HIV and TB planning, and Partnership Framework development
Mozambique	2011	TBD	Inform planning for next MOH 5 year strategic plan
Ethiopia	2011	TBD	Inform implementation of current MOH 5 year strategic plan
St. Kitts and Nevis	2011	MOH, USAID	Support implementation of the US-Caribbean Regional HIV and AIDS Partnership Framework
Antigua	2011	MOH, USAID	Support implementation of the US-Caribbean Regional HIV and AIDS Partnership Framework
St. Vincent and the Grenadines	2011	MOH, USAID	Support implementation of the US-Caribbean Regional HIV and AIDS Partnership Framework
Grenada	2011	MOH, USAID	Support implementation of the US-Caribbean Regional HIV and AIDS Partnership Framework
Dominica	2011	MOH, USAID	Support implementation of the US-Caribbean Regional HIV and AIDS Partnership Framework
St. Lucia	2011	MOH, USAID	Support implementation of the US-Caribbean Regional HIV and AIDS Partnership Framework
Benin	2011	MOH, USAID	TBD

Note: HSS=health system strengthening; PEPFAR=U.S. President's Emergency Plan for AIDS Relief; MOHSS=Ministry of Health and Social Services; PHC=Primary Health Care; MOHSW=Ministry of Health and Social Welfare; COP=Country Operating Plan; MOMS=Ministry of Medical Services; MOPHS=Ministry of Public Health and Sanitation

Annex 2.1.B Assessment Options for Kenya

Since 2004, USAID'S Health System Assessment (HSA) Approach has been applied in over 20 countries for a variety of audiences with varying objectives. The objective of the assessment determines how the methodology is applied in terms of the size and composition of the team, the number of trips to the country, the health system levels to be addressed (central, province, and district), and the manner and degree of local country counterpart participation.

Health Systems 20/20 prepared the following options for HSA coverage to fuel discussion of the most appropriate HSA approach for Kenya.

Options for Health Systems Assessment Coverage, Kenya

Proposed Options for Breadth of Health System Assessment, Kenya						
Type of Assessment	**# of Provinces**	**# of Districts**	**# of District Hospitals**	**# of Health Centers**	**Total # of Visits**	**Approximate Budget**
Option A – National	2	2	2	2	8	$XXX
Option B – Partial subnational	3	6	6	6	21	$XXX
Option C – All districts	8	16	16	2	42	$XXX
Option D – Provincial/ decentralization	2	18	18	36	74	$XXX

Option A: National Level for Strategic Planning

To inform national-level program planning for health system strengthening via the national health policy review and the strategic planning process for the 2011–2015 health strategy.

- Planning/preparation: HSA scope and schedule determined through communications with central Ministry of Health (MOH) and USAID mission via emails, conference calls, and discussions with HSA implementer. MOH and other stakeholders help determine priority questions and issues to be explored, key informants to be interviewed, other stakeholders to be involved, and sites to visit.
- In-country: One trip of 15–20 days with extensive MOH and stakeholder engagement to include:
  - Stakeholders/ consensus-building meeting in preparation for selected interviews and meetings at both the national and subnational levels (through select site visits).
  - National-level interviews: Health Systems 20/20 team and advisors spends approximately five days interviewing selected national-level health officials.
  - Subnational/facility-level data collection: team site visits to two provincial health offices, two district health management teams (DHMTs) and district hospitals, and two health facilities.
  - At the end of the trip, the team presents initial findings to the MOH, USAID mission, and local stakeholders.
- Post-trip: A first draft of the HSA report will be delivered within 4–6 weeks of the end of the field work for a detailed review by the MOH, USAID mission, and other stakeholders. Once all review comments are received, the report will be finalized in approximately four weeks, depending on the number of reviewers, the extent of changes requested, and how quickly editing and formatting can be completed.

- Local stakeholders' role: At a minimum, as partners, informants, and advisors to the assessment team to vet HSA findings and ensure consistency with country priorities. Select stakeholders could be actively involved as team members, participating in the assessment, data analysis, and writing, as time allows.
- Team of two project staff, 2–3 local consultants and collaborators, and 1–2 Kenyan MOH advisors. Total time estimated to be 2–4 months from planning to report.
- Approximate budget: $XXX

Option B: National and Subnational, Small Sample

To inform both national and subnational program planning for health system strengthening. Same as above except:

- Subnational/facility-level data collection: three provincial offices, six DHMTs and district hospitals, and six other facilities during 3-5 days of data collection
- Data collection team: 3-6 Health Systems 20/20 staff, consultants, and MOH advisors
- Approximate budget: $XXX

Option C: National and Subnational, 8 Provinces, 16 Districts

To inform subnational program planning for health system strengthening (larger subnational-level collection). Same as above, except:

- Subnational/ facility-level data collection: Eight provincial health offices, 16 district health offices and hospitals, and two other district facilities over 8–10 days
- Data collection team: Nine data collectors for 10 days
- Approximate budget: $XXX

Option D: National and Subnational, 2 Provinces, 18 Districts

To inform health system strengthening for decentralized functions (provincial/decentralization assessment). Same as Option A, except:

- Provincial-level data collection: Two provincial offices, 18 districts health offices and hospitals, plus 36 facilities within those districts during 8–10 days of data collection/facility-level interviews
- Data collection team: 15 data collectors for 10 days
- Approximate budget: $XXX

ANNEX 2.1.C 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 Overview (3–5 pages)

   The Country Overview chapter should be drafted in advance of trip and revised after data collection.

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. Building Block Chapters) (7–12 pages for each chapter)
   - Leadership and governance
   - Health financing
   - Service delivery
   - Human resources for health
   - Medicines, vaccines, and technologies
   - Health information systems

   See Section 3 of this HSAA Manual for guidance on constructing these chapters.

5. Cross-cutting Findings (5–10 pages)

   See HSAA Manual Module 2.4.5

6. Recommendations (8–10 pages)
   - Recommendations for strengthening the health system, based on the assessment
   - Drawing upon HSAA manual Section 2, Module 4, this subsection and recomended solutions tables from each building block module should propose areas that stakeholders might strengthen to address health system weaknesses. Each recommendation should discuss the relative time frame.

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

Annex A. Contact list

Annex B. List of documents consulted

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.D Health System Assessment Scope of Work

A clear scope of work (SOW) (also called Terms of Reference) is a key document agreed upon between the Health System Assessment (HSA) client 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*
4. *Schedule*
5. *Deliverables*
6. *Team Members – name, role, short biographical sketch for each*
7. *Client Role*

HEALTH SYSTEMS ASSESSMENT SOW: ANGOLA

1. Background

In 2005, the Partners for Health Reform*plus* project (PHR*plus*) conducted an HSA in Angola to inform USAID/Angola's health sector programming. Since then, numerous USG-funded health projects have been implemented. Other donors such as UNICEF, WHO, the World Bank and the EU have also carried out major activities in Angola with the Ministry of Health (MOH). 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 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, donor 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

- 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 US 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 USG agencies 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 donors 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 donors, 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 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

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 field work but prior to the Stakeholder Workshop
- Invitations for the Stakeholder Workshop to be held at the conclusion of the field work 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 Health Systems 20/20 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
- Final Report

Health Systems 20/20 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.

7. Cost Estimate

US$XXX

ANNEX 2.1.E. 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.

Background – Same as in main SOW.

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.

Expected Specific Tasks [insert dates]

Prior to team arrival (level of effort or LOE: minimum 5 days)

1. Participate in team conference calls with the clients and key stakeholders.
2. Work with technical team to obtain reports and other data in advance, and provide guidance on appropriate key informants.
3. 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.
4. Coordinate with and/or hire local interpreters/translator(s) to work with the team to 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.
5. Provide guidance on local protocol including regular working hours, holidays, introductions, and language.
6. Hire car and driver to provide transportation for the team during the two-week visit, including pick-up and drop-off at the airport.

During team visit (LOE: expected 15 days)

1. Meet with team upon arrival and participate in team planning meeting.
2. Participate in initial briefing meeting with [client].
3. Participate in data collection, interviews, and facility visits.

4. 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.

Post-team visit (LOE: expected 1.5 day)

5. 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.

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 donor community

Outputs/Deliverables

- List of key informants and their contact information
- Draft schedule of appointments

Deadlines will be specified when the assessment schedule is finalized.

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
Preparatory work							
General Coordination							
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							
Building block chapter prep work							
Prepare materials for first team meeting with country information, background materials, and other assessment information							
Assign building block chapters to team members							
Team members review assigned building block chapter(s) and prepare lists of documents needed and potential interviewees							
Identify team member responsible for stakeholder engagement							
Assessment coordinator compiles needed documents and facilitates translation as needed							
Compile Country Overview chapter data (available online)							
Complete Country Overview chapter							

Task	Client	Team Lead	Coordinator	Local Consultant	Team Members	Date Due	Date Completed
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							
Logistics/other preparations							
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)							
Materials for travel: memory sticks, flipcharts, markers, name tags, paper, portable printer							
Field work							
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)							
Confirm or re-schedule interviews							
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							

Task	Client	Team Lead	Coordinator	Local Consultant	Team Members	Date Due	Date Completed
Using SWOT (strengths, weaknesses, opportunities, threats) analysis and root cause analysis (in Chapter 3), 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							
Schedule and conduct follow-up interviews as needed							
Liaise with any in-country program personnel to share and discuss findings and arrange a pre-departure debrief, if requested							
Travel to one or two subnational areas, as discussed in the assessment preparation							
Schedule and conduct a pre-departure stakeholder workshop (if applicable)							
Post-field work							
Finalize relevant sections for the country assessment report, including recommendations, based on input from the stakeholder workshop and mission staff							
Request feedback from a designated reviewer on draft report							
Edit and format final report for approval by relevant client/ stakeholders							
Schedule and conduct a prioritization workshop (if applicable)							
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

Meeting Objectives:

1. Review and agree on HSA objectives and methodology
2. Clarify team roles and responsibilities
   - Agree on team roles and responsibilities in report preparation
   - Agree on tasks/roles while in field
   - How to work together
3. Draft HSA timeline, including schedule while in country
4. Hold a technical and planning discussion to share initial findings and data/information gaps across building block chapters
5. Identify action steps and outstanding questions for client and logistics coordinator

MEETING SCHEDULE

9:00 **Welcome and Introductions** (Team Leader)

Objectives and overview of team planning meeting

9:15 **Objectives of the HSA** (Team Leader)

- How will the HSA results be used?
- Priority issues among and within technical areas
- Client/stakeholder engagement
- Questions about the HSA modules?
  - Identify how to use the HSAA manual

10:00 **Overview of the HSA Timeline and Process** (Assessment Coordinator)

- Discussion and clarification of key steps
- Update on current status of activity
- Discussion of timelines for the draft and final reports
  - Expectations for zero draft
- Dates/agenda for 2nd team planning meeting
- Team member roles and responsibilities
- Expectations for how the team will work together

10:30 **BREAK**

10:45 **Continued Discussion of Timeline and Process** (Team Leader, Group)

- Expectations for field work – what are you looking forward to?
- Travel outside of the capital city – why/where?
- Draft field work agenda/schedule
- Developing and using interview protocols

11:30 **How to Use the HSA Manual/Q&A** (Team Leader, Group)

12:15 **Team Member Summaries** (5-10 mins/each):

- Key findings to date and key technical issues
- Gaps in information and potential sources for these
- Initial thoughts on cross-cutting issues (if any)
- Initial thoughts client priority issues (if any)

1:00 **GROUP LUNCH**

2:00 **Team Member Summaries** (5-10 mins/each) (Continued if necessary):

- Key findings to date and key technical issues
- Gaps in information and potential sources for these
- Initial thoughts on cross-cutting issues (if any)
- Initial thoughts client priority response issues (if any)

2:15 **Data Collection** (Team Leader, Group) (approx. 15 minutes per topic)

- Library review – prioritization of documents, how to rationalize review (Assessment coordinator, group)
- Key informant identification/initial thoughts on interviews needed
  - Brainstorm – health stakeholders to meet with in country (group)
- Focus groups – are they needed? Purpose and composition (team leader, group)
- Site visits (team leader, group)
- Interview logistics, tips, and etiquette (team leader, group)

3:30 **BREAK**

3:45 **Summary of Next Steps**

Questions for client:

Questions/issues for in-country logistics coordinator:

4:15 **END**

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. Governance	Team Leader	5-10 pages	
4.2. Health financing	Team member 1	10 pages	
4.3. Human resources for health	Team member 2	10 pages	
4.4. Service delivery	Team member 3	5-10 pages	
4.5. Medical products, vaccines, and technologies	Team member 3	5-10 pages	
4.6. Health information systems	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 & team member inputs		

TIP

Pre-departure Lessons Learned from Previous HSAs

- Communicate regularly (including 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 updates, information, and approval.
- Prepare as much background research as possible before reaching the country so that the team members arrive well-informed.
- Prepare a zero draft of the report. Zero drafts can help the team leader determine where the module leads are at in their preparation prior to departure. Sharing zero drafts among team members before departure encourages better overall understanding of the health system, understanding of knowledge/information gaps to be filled, as well as hypotheses to be tested, prior to arrival in country.
- Organize a team meeting four weeks in advance of field work for clarifying expectations and planning.
- Be careful to not underestimate the amount of LOE 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 produce missing pieces.

Annex 2.3.A. Illustrative 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) http://www.cpc.unc.edu/measure/news/pepfar-public-health-evaluations-published
- 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)

FINANCE

- Towards 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)

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. Jan 2009 http://www.measuredhs.com/pubs/pub_details.cfm?ID=878&srchTp=advanced
- Kenya Working Papers: Influence of Provider Training on Quality of Emergency Obstetric Care in Kenya. Jan 2009 http://www.measuredhs.com/pubs/pub_details.cfm?ID=882&srchTp=advanced
- Using the 2004 Kenya SPA for Health Service Delivery Improvement. 2008 (attached, or go to http://www.cpc.unc.edu/measure/publications and search Kenya)
- Community health worker strategy documents (strategy, training manual, reference guide)

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.

MEDICAL PRODUCTS, VACCINES, AND TECHNOLOGIES

- SPS in Kenya http://www.msh.org/projects/sps/Global-Focus/Kenya.cfm
- 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 http://www.cpc.unc.edu/measure/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.) http://www.cpc.unc.edu/measure/publications and search Kenya)

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 Ndetei, Lincoln Khasakhala, Jacob O Omolo
- Africa Mental Health Foundation (AMHF)
- Institute of PolicyAnalysis 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) http://www.biomedcentral.com/1472-6963/6/89
- 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 Development Goals. It outlines FBO health services in Kenya and sources of and financial support for them. It also discusses the exodus of health workers from church health facilities, the reasons

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)
- Evaulation 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 http://econ.worldbank.org/external/default/main?theSitePK=477916&contentMDK=20562060&menuPK=546432&pagePK=64168182&piPK=64168060

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)
- Socio-economic 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. ILLUSTRATIVE CONTACT LIST/ INTERVIEW SCHEDULE

The following table is excerpted 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. 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.

DISCUSSION GUIDE FOR PROVINCIAL OR DISTRICT HEALTH TEAMS

District/ Province:_____ Date:_____

RESPONDENT(S) INTERVIEWED

FINANCE

Name	Designation

1. Are private providers contracted or reimbursed for providing government services in the district/ province?
2. 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?
3. Are AOPs (Annual Operational Plans) useful in mobilizing funds for health? If not what changes would you propose in the AOP preparation process?
4. 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?

HUMAN RESOURCES

5. Please tell us about the patterns of staff vacancies here: over time, what % of established posts are vacant?
6. 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)?
7. When is 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/donor sponsored vs. MOH sponsored.)

   * **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?

HEALTH GOVERNANCE

8. What mechanisms are in place to allow for your involvement in health policy development and planning (public or private)?
9. Health information is important for planning, transparency, and accountability in the health sector. Do you think the Government and the Ministry of Health in particular ensure that there is availability of health information especially to the public?
10. What mechanisms are in place for the public, especially the community, to provide feedback to health providers?
11. What would you recommend to achieve the goals of the health sector at both national and local levels?
12. Are clinicians here members of any professional associations, councils, or unions?

SERVICE DELIVERY

13. 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.)
14. What is the availability of telephones, transport, or other means of communication between levels of care?
15. Is there a district standard for the frequency of supervision visits to primary care facilities? What is the frequency of supervision visits?
16. 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?
17. What other processes assuring quality of care besides supervision are in place?
18. 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?
19. What types of specialist equipment exist at the facility? Are laboratory, ultrasound, x-ray, surgical facilities available?

HIS

20. 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?

Provincial Level ONLY

21. 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

22. 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?
23. Does this district produce summary health service and status reports?
    a. If yes, please describe what is produced, frequency, and method of dissemination.
24. 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

a. 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)
1. Essential medicines		
2. Essential medical supplies		
3. Reproductive health/ family planning commodities		
4. HIV/AIDS medicines		
5. TB/leprosy medicines		
6. Vaccines		
7. Laboratory supplies		
8. Dental supplies		
9. 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[1]: Ownership[2]:

Respondent(s) Interviewed at the Facility

Name	Designation

FINANCE

2. Have you heard of the HSS Fund? Are committees in place to oversee implementation of this Fund?
3. How do you receive funds allocated to your facility by the GoK [government of Kenya]?
4. Are the user fees charged compliant to the 10/20 Policy? If not, how do you determine the level of fees to be charged?
5. (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

6. Please tell us about the patterns of staff vacancies here: over time, what % of established posts are vacant?
7. 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)?
8. 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/donor sponsored vs. MOH sponsored.)

[1] DH = District Hospital; SDH = Sub-District Hospital; HC = Health Center; D = Dispensary; C = Clinic; H = Hospital

[2] GoK = Government; FBO = Faith-Based Organization; CBO = Community-Based Organization; NGO = Nongovernmental Organization; P = Private; O = Other (Specify)

GOVERNANCE

9. What mechanisms are in place to allow for your involvement in health policy development and planning?
10. 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?
11. What mechanisms are in place for the public, especially the community, to provide feedback to health providers?
12. What would you recommend to achieve the goals of the health sector at both national and local levels?

HIS

13. 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 donors/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.
13. 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).
14. Does this facility have access to district health service and status summary reports?
15. 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).
16. 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

17. Are outreach services available for remote communities? If so, what is the frequency of these outreach visits and which services are included?
18. What mechanisms are in place to ensure that eligible people access waivers and exemptions and that non-eligible people do not?
19. What is the number of supervision visits to health centers planned that were actually conducted?
20. How frequently does the district level come for supervision vists and, when they do come, do they come as a team/individual for multiple programs or do they pay separate visits for separate programs?
21. How does the community participate in assuring that services offered meet community needs?

22. 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?

23. What is the scope of private facilities in the community? Are there private clinicians offering services? Private laboratories and/or pharmacies?

MEDICAL PRODUCTS, VACCINES, AND TECHNOLOGIES

24. 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.)

Health Commodity Management Structures and Systems

25. Is there a functioning procurement committee?

26. Does the facility collect user fees for services rendered?

27. Are FIF funds utilized to procure medicines/supplies?

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

28. Are there guidelines for the utilization of FIF funds?

Guidelines and Policy Documents

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

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

Out-of-Stock Items

30. Which groups of health commodities or supplies are most commonly out of stock (e.g. general medicines, TB, malaria, laboratory reagents)?

31. Where do patients acquire out-of-stock items? What is done in the case of out-of-stock essential medications such as ART?

Infrastructure/ Equipment/storage

32. 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

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

Annex 2.3.D. Interview Techniques and Etiquette

STARTING THE INTERVIEW

- Introduce yourself.
- Start the interview by thanking the interviewee for his or her time.
- Make sure you note the name, position, and organization of interviewee. (This information is added to the contacts list that is annexed to the final report.). The interviewee may have this information on a business card; if not, be sure to get the correct spelling of his or her name, title, and organization). You may also ask for email address and phone number and if you may contact him or her later if you have any follow-up questions.
- Introduce the Health System Assessment (HSA), especially if the interviewee did not attend the launch workshop or is not aware of the HSA.
- State the purpose of your visit (which topic area[s] you are collecting information for).
- Ask for interviewee assistance in providing information.
- State approximately how long the interview will take.
- Explain that you will only collect information relevant to the assessment.

CONFIDENTIALITY ISSUES

- Information provided will be used among the assessment team only and will be kept confidential–no direct quotes will be used in the final report, that is, neither interviewee name nor title will be tied to any findings, although the name will be included in the annexed contacts list of all interviewees.

INTERVIEWER PRESENTATION

- Be prepared with key questions before arriving but also be flexible in your interview dialogue–be prepared to probe further if a relevant issue is raised (see below).
- Show a positive attitude.
- Always keep eye contact.
- Do not spend your time looking down at your questions/notes–rather, try to keep the interviewee engaged, even as you take notes.
- Use body language to acknowledge the responses.
- Turn your cell phone off.

PROBING RESPONSES

- If the respondent gives an answer that seems to be incorrect, try the following:
  - Do NOT say it is wrong.
  - Act surprised and ask the same question differently.
  - Ask why this is different from previous years and why.
  - Ask to see reference materials such as registers where this information is recorded.
  - Take note to yourself to triangulate the information with other interviewees/data sources.
  - As a last resort, ask if they would prefer a colleague cover this topic area.

ANNEX 2.3.E. SAMPLE HSA LAUNCH WORKSHOP AGENDA

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		Registration sheet
9:00	Welcome	USAID/MOH	
9:15	• Introductions • Introductory activity where each person shares their name, organization, and role/concern with the health sector in [Country] • Overview of Objectives and HSA process • Concepts, Goals, and Landscape of Health Systems Strengthening • HSA Implementation Process and Data Collection (PPT Slide Presentation with Handout; and Structured Q&A Discussion Task at Tables)	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
	• 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.
	• Need facilitator for each session – ideally MOH point person with Health Systems 20/20 person 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.
	• Exploration of strengths, weaknesses, barriers, and potential strategies – discussion questions related to:
	  • Strengths and weaknesses of this area in [Country]
	  • Cross-cutting linkages with other areas
	  • Gaps in programming
	  • Barriers to addressing gaps and recommendations
	  • Who to interview and anything to note for site visits
	  • Potential building block chapter-specific questions
	• Report-outs (person responsible) 45 minutes
	  • Option 1: Reporter from each group presents a three-minute overview of key areas for discussion, or two top areas for further investigation
	  • Option 2: Gallery walk, where participants read flipcharts from other groups
		Team Members	Presentation(s) Handouts of slides, write-up of options

12:00	Stakeholder Engagement Going Forward: Sharing of Hopes for Results of the HSA: Making it Meaningful Sharing of Hopes for Involvement in the Process • Pair or trio task to discuss each question, quick responses from each pair. • If lack of time, can write on notecard and leave on the tables.		Questions for discussion
12:30	Summary of Next Steps (person responsible)	Team	
1:00	Workshop Evaluation. Adjourn for Lunch		Evaluation form

ANNEX 2.4.A. OPTIONS FOR SYNTHESIZING FINDINGS

Three tables are presented below as options for presenting data in the final report. Based on the needs of the client, the team leader should select which tables the team will use before data collection starts. This will ensure that all team members are collecting relevant data.

OPTION 1. PRESENTING INFORMATION ON SPECIFIC PRIORITY HEALTH ISSUES

When analyzing data, consider how the findings are relevant to various donors 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. (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
Governance							
Health finance							
Service delivery							
Human resources for health							
Medical products, vaccines, and technologies							
Health information systems							

OPTION 2: 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 (Health Systems 20/20 and Ministry of Health 2011).

Illustrative Key Health System Findings by Performance Criteria from the 2010 Guyana HSA

Health System Building Block	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 donor support for HSS, opening opportunities for partners to help the MOH to address health system weaknesses as well as direct support for HSS.
Medicines and Medical Products	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 donors 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 donors.	
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. EXAMPLES OF HOW SELECTED HSS INTERVENTIONS HAVE INFLUENCED THE USE OF PRIORITY SERVICES

Examples of Successful HSS Interventions	Description of Intervention	Positive (▲) or Negative (▼) 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.	▲**Access:** Increased access to health services and wider geographic access to essential generic drugs (despite some stock shortages). ▼ **Quality:** Regional disparity in terms of access to health centers and drugs. ▼ **Equity:** Drug prices/user fees were never calculated according to capacity to pay, and the very poor were not given user fee exemptions. ▼ **Sustainability:** Low levels of cost recovery and community participation.	Access to antenatal care and use of generic, essential drugs have increased. Rates of immunization are higher. 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.
Manas and Manas Taalimi Health Reform Programs in Kyrgyzstan (Ibraimova et al. 2011)	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. 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 donors.	▲ **Access:** 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. ▲ **Quality:** Continuity and transparency in policy and staffing as well as strong human resource capacity and accountibility in the health sector and in government (both clinical and managerial) have improved the quality of health services. ▲ **Equity:** The health system in Kyrgyzstan combines taxation and mandatory health insurance, which has resulted in universal coverage and free essential services for vulnerable populations. ▲**Efficiency:** 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. ▼ **Sustainability:** Questions remain over Kyrgyzstan's ability to retain health workers due to growing internal and external immigration.	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. 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.

Examples of Successful HSS Interventions	Description of Intervention	Positive (▲) or Negative (▼) Effect on Health System Performance	Outcomes in Terms of Service Use or Health Impact
Health extension workers and task shifting of health care workers in Ethiopia to expand and modernize health workforce (Banteyerga et al. 2011)	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.	▲ **Access:** 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. ▲ **Quality:** Improved capacity of health workers and an investment in developing information systems to improve data gather for evaluation purposes. ▼ **Sustainability:** Development partners have provided considerable assistance to provide basic equipment and train health extension workers. Career progression of staff could also threaten sustainability.	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. Malaria-related deaths decreased significantly due to prevention education, use of malaria nets, and earlier diagnosis. There has also been significant progress in tackling the underlying determinants of health including access to water, sanitation, and nutrition.
Mutuelle de Sante: Rwanda's community-based health insurance scheme (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.	▲ **Access:** The CBHI scheme mobilizes financial resources to pay for health services. As of 2006, 73% of the population was covered by the scheme. ▼ **Quality:** 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. ▼ **Equality:** While some individuals' contributions to the health fund are subsidized by donors, 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.	Health seeking behavior has increased significantly from the time when most health care was completely funded by patients. Infant mortaility, under-5 mortality, and maternal mortality rates have dropped.

Examples of Successful HSS Interventions	Description of Intervention	Positive (^) or Negative (▼) Effect on Health System Performance	Outcomes in Terms of Service Use or Health Impact
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 pre-natal care, the cash transfers are conditioned, in part, on pregnant women completing a pre-natal care plan, taking nutritional supplements, and attending an educational program.	▲ **Access:** Increased access to services through decreased financial barriers. ▲ **Quality:** Improvements in the quality of health care received and nutritional value of food through access to higher levels of cash. ▼ **Sustainability:** Questions remain about the long-term sustainability of cash transfer programs.	Beneficiary status was associated with a higher birthweight among participating women and a 4.6 percentage point reduction in low birthweight. 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.

Sources:

Banteyerga, H, Aklilu, K, Conteh, L, and McKee, M. 2011. Ethiopia: Placing Health at the Centre of Development, in D. Balabanova, M. McKee, and A. Mills: Good Health at Low Cost 25 Years On: What Makes a Successful Health System? London: London School of Hygiene and Tropical Medicine.

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Ibraimova, A, Akkazieva, B, Murzalieva, G, and Balabanova. 2011. Kyrgyzstan: A Regional Leader in Health System Reform, in D. Balabanova, M. McKee, and A. Mills: Good Health at Low Cost 25 Years On: What Makes a Successful Health System? London: London School of Hygiene and Tropical Medicine.

Logie, D, Rowson, M, Ndagije, F. 2008. Innovations in Rwanda's health system: Looking to the future. The Lancet 372: 256-261.

Ridde, V. 2011. Is the Bamako Initiative Still Relevant for West African Health Systems? International Journal of Health Services 41(1): 175-184.

Annex 2.4.C. Illustrative 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	• Develop risk-pooling strategies • 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 • Public purchasing of privately provided services and offering providers incentives linked to services delivered • Leverage corporate funding for innovations and strategic problem solving • Publicly funded (or public-private co-funded) campaigns to inform consumers about health insurance market
Physical inaccessibility	Outreach for focal diseases	• Reconsideration of long-term plan for capital investment and siting of facilities • Contract FBO or NGOs to deliver services located in areas where MOH is not present • Improve coverage by offering providers incentives linked to coverage • Define scopes of work for health workers and generating more medical graduates • Leverage human resources in the private sector to deliver essential health services • Agreements or contracts with commercial drug marketers to market or distribute drugs, vaccines or other products to local markets
Inappropriately skilled staff	Continuous education/ training to develop skills in focal diseases	• Review of basic medical and nursing training curricula to ensure that appropriate skills are included in basic and in-service training • Require CME for all health cadres in both public and private sectors • Address short-term skill shortages by subsidizing specialist services in the public sector • 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
Poorly motivated staff	Financial and non-financial incentives to reward delivery of particular priority services	• Institute proper performance review systems, creating greater clarity of roles and expectations as well as consequences regarding performance. • Review salary structures and promotion procedures • Offer public subsidies for education and regulate charges
Weak planning and management	Continuous education/ training workshops to develop skills in planning and management	• Restructure ministry of health • Recruit and develop cadre of dedicated managers • Create MOH capacity to engage and partner with the private sector • Develop new technologies to collect and manage health information, such as management contracts • Use privately developed cell phone/ information technologies to collect data, improve reporting of health information, prevent stock-outs (supplychain)

Constraint	Disease or Service-Specific Response	Health System Response(s)
Lack of intersectoral action and partnership	Creation of special disease-focused cross-sectoral committees and task forces at the national level	• Build local government capacity and structure to incorporate representatives from health, education, and agriculture, and promote accountability to the people • Create forum for dialogue between the public and private sector on health system issues of common interest • Policy forums and other processes (e.g., revise and update laws, strategic planning) that actively engage and consult private sector groups
Poor quality care of care	Training providers in focus diseases or services	• Develop monitoring, accreditation, and regulation systems that encompasses both the public and private sector and enforces regulations fairly across sectors • Create and enforce standards for private medical education • State mandate to educate consumers, create a mechanism for addressing consumer complaints and advocate with private insurance companies • Provide supportive supervision through professional councils or associations • Contract with high quality private sector institutions for the provision of laboratory or diagnostic services • Invest in primary research to identify new vaccines or treatments (both public and private sector). This could include funding to set up research institutions

ANNEX 2.5.A. ILLUSTRATIVE VALIDATION WORKSHOP AGENDA

This agenda is based on one used for a Health System Assessment (HSA) validation workshop in a sub-Saharan country. It focuses on the first day of the four-day process.

Objectives

- Review the HSA findings and recommendations
- Revise the recommendations based on feedback from stakeholders from multiple sectors
- Identify recommendations that are closely linked to other categories

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 each seat about 6-8 people. 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 instructing them to sit accordingly. It's also ideal to have name tags 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. "Please share" (PPT) slide

- Your name
- Organization
- Job title
- Number of years working the in the health sector in x country

Before reviewing the objectives, explain to the participants the overall process (PPT) for the week as follows:

- Full-day validation workshop (approximately 25-30 participants)
- Full-day prioritization workshop (25-30 participants)

Explain how these two events link together. Then say that the overall purpose of the today's workshop shop is to validate the HSA recommendations with stakeholders. While the report has been accepted by the MOH, the recommendations have not been fully validated with stakeholders. This is an essential step before we begin to prioritize the recommendations.

Review the objectives and agenda for today (PPTs).

Provide guidelines for today's workshop.

- 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 building block:

- Service delivery
- Financing
- Pharmaceutical management
- Governance
- Health information systems
- Human resources

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 Building Block

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

Designate six tables, one for each of the building blocks. 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.

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 week. Then give the following task on PPT:

Task

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

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 rephrased?
- 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.

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 building block, we want to spend some time looking at the entirety of the recommendations.

Discuss the two following questions in plenary.

- Are there any overarching recommendations that are missing? These recommendations are not necessarily specific to a building block. 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 building blocks? 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.

Review the process for the rest of the week – revising the recommendations tomorrow, sub-group on prioritization the day after to narrow down the list, and full stakeholder group on Friday to further prioritize.

Ask what advice the group has as we continue this process the rest of the week.

- 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

Notes