SECTION 1: INTRODUCTION TO THE HEALTH SYSTEM ASSESSMENT APPROACH AND MANUAL

1. HEALTH SYSTEM STRENGTHENING AND THE ASSESSMENT APPROACH

1.1. Background

Since its release in 2007, the HSA approach has been used to assess health systems and guide policymakers and program planners in more than 30 countries. Health system assessment (HSA) results have contributed to national strategic plans, PEPFAR partnership frameworks, grant applications, and numerous other health system strengthening (HSS) and programmatic activities. Examples of country applications, HSAA reports, and results can be found on the HSAA website (http://healthsystemassessment.org/).

Version 1.0 targeted USAID country missions and their partners seeking to develop programs that strengthened the health system. Version 2.0 added methods and guidance to build the capacity of country teams to conduct a health systems assessment. This new Version 3.0 is the result of a collaborative effort by USAID, several USAID health system technical projects, and WHO to broaden the audience and the use of the HSAA. This version accomplishes three objectives:

- Technical updates from subject experts including WHO;
- Assessing the health system's ability to effectively undertake core functions to achieve universal health coverage; and
- Adding more 'systems thinking' guidance and techniques.

The goal of the HSAA manual is to add value by assessing the interactions among the system functions, and the policies and regulations underpinning the functions to identify interventions that change the way the system works.

The HSA approach presented in this manual is a structured, indicator-based methodology for rapid, comprehensive assessment of a country's health system. The HSA approach synthesizes information – from document reviews, site visits, and in-country stakeholder interviews – to identify the strengths, weaknesses, opportunities, and threats (SWOT) of a wide range of health system components, and transform the findings into specific recommendations and strategies both across the health system as well as for individual "core health system functions", namely: Service Delivery, Human Resources for Health; Medical Products, Vaccines and Technologies; Health Information Systems, Health Finance, and Governance for action based on country priorities. In addition, the manual itself may serve as an educational and reference tool for health systems issues and health systems strengthening.

Table 1.1.1 lists the 34 countries which have completed an HSA as of April 2016.

Table 1.1.1 Health System Assessment Approach Countries 2007-2016

Country	Year	Audience	Objective/Impact
1. Angola	2005	USAID	Inform the design of an integrated health project
2. Azerbaijan	2005	USAID	Input into pharmaceutical management
3. Benin	2006	MOH	Input for 5 year health strategy
4. Pakistan	2006	USAID	Inform health system activities
5. Yemen	2006	MOH	Framework for health system review
6. Malawi	2006	USAID	Input into bilateral design
7. Ghana	2006	USAID	Input into assessment of insurance
8. South Sudan	2007	MOH	Input into GAVI health systems strengthening (HSS) proposal
9. Vietnam	2008	PEPFAR, MOH	Assess 2 provinces and build local capacity for future province assessments
10. Namibia	2008	MOHSS	Adapted for use in health sector review, cited in successful GF proposal
11. Nigeria	2008	Sec PHC, PEPFAR	State performance assessment
12. Senegal	2008	MOH, USAID	Input for health strategy
13. West Bank	2008	MOH, USAID	Input for 5 year health strategy
14. Vietnam	2009	MOH	Sub-national assessment of 6 provinces. Used as a baseline for monitoring HSS. Vietnam's Partnership Framework Implementation Plan refers to the HSA findings from the 8 provinces.
15. Cote d'Ivoire	2009	PEPFAR	Input for country action plan
16. Lesotho	2010	PEPFAR, MOHSW	Input for USAID and PEPFAR planning and the MOHSW HSS plan
17. Zimbabwe	2010	PEPFAR, MOH	Input for National Investment Plan, USAID/PEPFAR COP planning
18. Angola	2010	MOH, USAID	Follow-up on progress since 2005 HSA, input for health sector planning
19. Kenya	2010	MOMS, MOPHS, USAID	Input for health planning and health policy reviews
20. Guyana	2010	MOH, USAID	Input for MOH and Global Fund HSS intervention planning
21. Tanzania	2010	MOH, development partners	Input for health partner planning and health finance review
22. Uganda	2011	MOH, USAID	Develop a set of SMART indicators for measuring health system progress
23. Ukraine	2011	MOH, USAID	Inform MOH health reform agenda, HIV and TB planning, and Partnership Framework development
24. Ethiopia	2011-12	MOH	Inform implementation of current MOH 5 year strategic plan
25. St. Kitts and Nevis	2011	MOH, USAID	Support implementation of the US-Caribbean Regional HIV and AIDS Partnership Framework
26. Antigua	2011	MOH, USAID	Support implementation of the US-Caribbean Regional HIV and AIDS Partnership Framework
27. St. Vincent and the Grenadines	2011	MOH, USAID	Support implementation of the US-Caribbean Regional HIV and AIDS Partnership Framework
28. Grenada	2011	MOH, USAID	Support implementation of the US-Caribbean Regional HIV and AIDS Partnership Framework
29. Dominica	2011	MOH, USAID	Support implementation of the US-Caribbean Regional HIV and AIDS Partnership Framework

Country	Year	Audience	Objective/Impact
30. St. Lucia	2011	MOH, USAID	Support implementation of the US-Caribbean Regional HIV and AIDS Partnership Framework
31. Benin	2011	MOH, USAID	Inform MOH's universal coverage initiative
32. Guatemala	2015	MOH, USAID	Baseline diagnosis of the current health system to inform health sector reforms
33. Indonesia	2015	MOH, USG	Inform health systems strengthening technical assistance programming
34. Mali	2016	MOH	Inform strategy discussions and decisions within the MOH

1.2. Key Concepts Used in the Health System Assessment Approach

Defining a Health System and Health System Strengthening

The conceptual framework for the HSA approach draws from the efforts of the past two decades to define and understand health system functions and performance. Decades of international and domestic investments have measurably improved health outcomes in LMICs. However, the persistent gap in many countries to achieve sustained universal coverage of proven essential services drew attention to weak health systems. In 2000, the WHO defined a **health system** as consisting of "all organizations, people and actions whose primary intent is to promote, restore or maintain health." It is much broader than the public health service delivery system that is often the focus of public health officials. It includes the full range of stakeholders in a health sector, for example, private for-profit and not-for-profit service providers, health insurance organizations, community outreach workers, educators, researchers, patients, and consumers, communities, and households.

The goal of the HSAA is to support investments in health systems strengthening. WHO (2007) defined **health system strengthening** as "...improving [the] six health system building blocks [core health system functions] and managing their interactions in ways that achieve more equitable and sustained improvements across health services and health outcomes". In 2013, a useful distinction was proposed between health system support and strengthening: "Supporting the health system can include any activity that improves services, from distributing mosquito nets to procuring medicines. These activities improve outcomes primarily by increasing inputs. Strengthening the health system is accomplished by more comprehensive changes to performance drivers such as policies and regulations, organizational structures, and relationships across the health system to motivate changes in behavior and/or allow more effective use of resources to improve multiple health services.[1]"

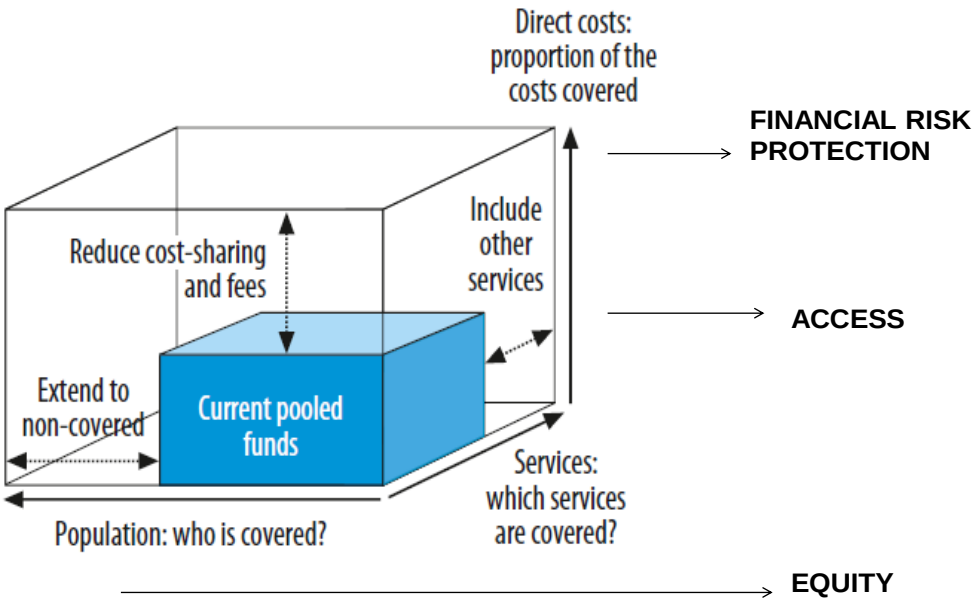
The holistic, "systems" approach in this HSAA manual responds to several aspects of the above definitions:

- **Equitable** improvement
- **Across health services** and public and private sectors, by
- Managing **interactions** and
- Leveraging all resources available – both public and private – **to sustain improvements.**

[1] Chee G, Pielemeier N, Lion A, Connor C. Why differentiating between health system support and health system strengthening is needed. Int J Health Plann Manage. 2013 Jan-Mar; 28(1):85-94.

With growing support from the international community, the WHO is leading a campaign to promote UHC in all its members states (WHO 2013a). In 2012, several high-level multinational events reinforced the growing movement for UHC (WHO 2013c). This support led to the inclusion of UHC into the post-2015 development agenda where it features prominently in the UN's Sustainable Development Goals (UN 2015a; UN 2015b).[2] In 2015, achievement of Universal Health Coverage by 2030 was adopted as United Nations Sustainable Development Goal 3. The objectives of UHC are typically defined by three dimensions: the population that is covered by pooled funds (Equity); the proportion of direct health costs covered by pooled funds (Financial risk protection); and the health services covered by those funds (Access). These have long been key indicators of health system performance and are illustrated in the UHC cube (Figure 1.1.1 below).

Figure 1.1.1 The UHC Cube



Source: WHO and Busse, Schreyogg & Gericke

8

UHC is a key concept for the HSAA and the manual includes several indicators for equity, access and financial protection. The HSAA process should generate system strengthening recommendations and actions that support country progress towards UHC. WHO notes that, "*Conceptual clarity is essential for a systematic approach to policy-making. Confusion and inefficiency arise when health system strengthening is defined as an objective and also when universal health coverage, health security or resilience are described as separate programmes to be implemented. So here is a simple guide: health system strengthening is what we do; universal health coverage, health security and resilience are what we want.*"[3]

[2] UHC supported by the G7: Ise Shima declaration 2016, and Germany's "Healthy Systems—Healthy Lives" roadmap.

[3] Joseph Kutzin & Susan P Sparkes. WHO 2016. Health systems strengthening, universal health coverage, health security and resilience. Bulletin of the World Health Organization 2016;94:2

The Health System Functions

As part of the HSS framework described above, WHO (2000) simplified the health system into six building blocks:

1. Leadership and governance
2. Health financing
3. Service delivery
4. Human resources for health (HRH)
5. Medical products, vaccines and technologies
6. Health information systems (HIS)

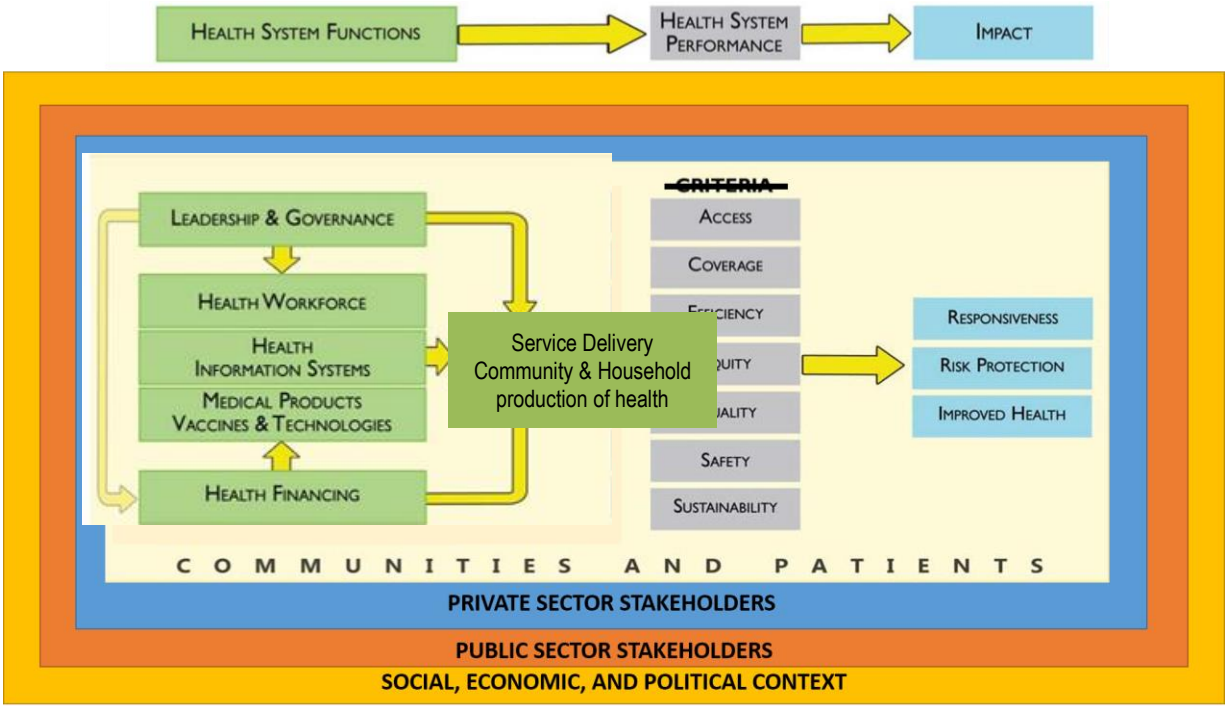
Other health system frameworks exist. The “control knob” framework presented by Roberts, Hsiao, Berman, and Reich (2004), describes five "control knobs' for influencing health sector performance: financing, payment, organization, regulation, and behavior. The HSAA manual version 3.0 draws from both of these frameworks and has re-ordered these functions in the HSA manual as: Service Delivery; Human Resources for Health (HRH); Medical Products, Vaccines and Technologies; Health Information System (HIS); Health Financing; and Leadership and Governance.

Introduced by WHO in 2007, but emphasized in more recent WHO publications, is the importance of “systems thinking” to understand the dynamic relationships among the six system functions to solve systemic problems and improve health system performance and ultimately health outcomes[4]. A systems-thinking lens is particularly important for solving systemic problems – which don’t have a clear solution and unfold in complex and adaptive systems: cause and effect are poorly understood; stakeholders interactions are poorly understood; and stakeholders cannot reach consensus due to diverse perspectives. Applying a systems thinking lens facilitates “seeing how things are connected to each other within some notion of a whole entity”[5]. The framework depicted below in Figure 1.1.2 illustrates the relationships among the six core health system functions.

[4] de Savigny and Adam, eds, 2009

[5] Peters DH. The application of systems thinking in health: why use systems thinking? Health Research Policy and Systems. 2014;12(1):1-6. doi:10.1186/1478-4505-12-51.

Figure 1.1.2 Health System Framework of Functions, Performance, and Impact



Performance Criteria

While a basic understanding of the health system can be gained by examining the health system core functions individually, a holistic view of the health system requires looking across the entire system, examining interrelationships and effects. One way of measuring overall system performance is by using the performance criteria suggested by WHO, listed in the text box and defined below.

Understanding the health policies of the national government, and its international partners, allows for informed development of advocacy for improved health care access, equity, and quality. The policies also affect the health workers' ability to deliver efficiently, thereby affecting the overall sustainability of the health system and its ability to function into the foreseeable future from a financial and organizational perspective. The overall outcomes of enhanced performance are improved health, responsiveness, and risk protection. Below are five performance criteria for assessing a health system:

Equity is a normative issue that refers to fairness in the allocation of resources or the treatment of outcomes among different individuals or groups. The two commonly used notions of equity are horizontal and vertical equity.

- **Horizontal equity** is commonly referred to as "equal treatment of equal need." For example, horizontal equity in access to health care means equal access to all services irrespective of provider for all individuals irrespective of factors such as location, ethnicity, or age.
- **Vertical equity** is concerned with the extent to which individuals with different characteristics should be treated differently. For example, the financing of health care through social health insurance may require that individuals with higher income pay a higher insurance contribution than individuals with lower income (similar to progressive taxation).

Efficiency refers to obtaining the best possible value for the resources from all stakeholders and sectors used (or using the least resources to obtain a certain outcome). The two commonly used notions of efficiency are allocative and technical efficiency.

- **Technical efficiency** means producing the maximum possible output from a given set of inputs. It can be thought of as minimizing waste within a given approach – wasted time, money, or other inputs – or using new methods or technologies to combine the set of inputs in a more productive way.
- **Allocative efficiency** means allocating resources to the most cost-effective approaches and interventions – looking within and across programs – in a way that achieves the maximum possible overall benefit.

Access is a measure of the extent to which a population can reach the health services it needs delivered by either the public or private sector. It relates to the presence (or absence) of economic, physical, cultural, or other barriers that people might face in using health services. Several types of access are considered in the field of health care, but the two types that are primarily investigated in this assessment are financial access and physical access.

- **Financial access** (also referred to as economic access) measures the extent to which people are able to pay for health services. Financial barriers that reduce access are related to the cost of seeking and receiving health care, relative to the user's income.
- **Physical access** (also referred to as geographic access) measures the extent to which health services are available and reachable. For example, not having a public or private health facility within a reasonable distance to a village is a physical access barrier to health care for those living in the village

Quality is the characteristic of a product or service that bears on its ability to satisfy stated or implied needs. Quality is defined as "that kind of care which is expected to maximize an inclusive measure of patients' welfare after one has taken account of the balance of expected gains and losses that attend the process of care in all of its parts" (Eisele, Hotchkiss, Bennett et al. 2003, citing Donabedian 1980).

Sustainability is the capacity of the system to continue its normal activities well into the future. The two commonly used notions of sustainability are financial and institutional sustainability.

- **Financial sustainability** is the capacity of the health system to maintain an adequate level of funding to continue its activities.
- **Institutional sustainability** refers to the capacity of the system, if suitably financed, to assemble and manage the necessary resources to successfully carry on its normal activities in the future.

Mixed Health Systems and Key Actors

The HSA approach recognizes that all health systems are mixed public-private systems. The HSAA also recognizes that health promotion and disease prevention are as important as the service delivery system for health outcomes, and therefore communities, households, and patients are critical health system actors. WHO acknowledged the growing trend in pluralistic financing and delivery of health services and products as governments seek to respond to "major modifications in the pattern of disease, in demographic profiles, in exposure to major risks and in the socioeconomic environment" (WHO 2003). Therefore, each core function module contains indicators needed to assess the roles of relevant stakeholders in improving system performance: the public sector, the private sector, and communities and patients.

Public Sector

As will be addressed in detail in the Governance Module, the public sector, also called the government sector, is a complex group of actors that is ultimately responsible for carrying out Essential Public Health Functions that embody health system stewardship.

Private Sector

In many developing countries, there is high utilization of private providers of essential health services, even by those individuals in the lowest wealth quintiles (IFC 2007). The private health sector is typically described as comprising "all providers who exist outside of the public sector, whether the aim is philanthropic or commercial, and whose aim is to treat illness or prevent disease" (Mills, Brugha, Hanson, et al. 2002). Dual employment is common in some countries where a health worker is employed in the public sector but also works privately.

The private sector includes:

- Larger companies, particularly those in mining, textiles, and agriculture, that offer health care through workplace clinics and collaborate in public health initiatives.
- Not-for-profit private sector, such as NGOS, FBOs, and CBOs play an important role in providing essential services, particularly for the underserved populations such as impoverished and rural populations.
- Private pharmacists and drug sellers are often the first-line providers in the formal health sector that serves people in poor and remote communities (WHO 2005a, IFC 2007). Often, the pharmaceutical market encompassing distributors, producers, and retailers is the largest subsector in the private health sector (O'Hanlon 2009).
- The informal health sector consists of traditional healers, traditional birth attendants, indigenous medical providers, and market drug sellers. The informal sector is a significant, albeit not well documented, source of health care, particularly for rural and poor populations.

The Service Delivery, Human Resources for Health, Pharmaceutical, and Health Information System modules address these aspects of the private health sector in-depth. The Leadership and Governance module looks at regulation of the private sector and the Health Financing module includes private financing (insurance and out-of-pocket spending). If the purpose of the HSA has a particular emphasis on the private health sector, the assessment team can use the Private Health Sector Assessment Tool (http://assessment-action.net/) to supplement or replace the HSAA.

Communities and Individuals

The Health Systems Framework (Figure 1.1.2) includes the demand side, (communities and patients) and recognizes community and household production of health. Community and patient inputs to the health system, their engagement with the service delivery system, and role in promoting health are examined in each of this manual's six core function modules. Indicators are included to assess whether the role of communities and patients is effectively contributing to the performance of that core function.

Communities and individuals can have roles as service providers (CHWs, peer educators) and as groups organized and empowered to hold providers accountable (community health committees, patient advisory groups, health facility board members, and so forth). For example, promoting engagement of health care workers with patient advisory and civil society groups can contribute to higher-quality care, increased productivity, and lower attrition rates (Wellins, Bernthal, and Phelps 2005).

For in-depth look at community health issues, there are many publications and resources, including:

- USAID's Community Health Framework and Toolkit http://mpoweringhealth.org/the-community-health-framework/
- Work Force Alliance's joint framework to guide efforts to scale-up the role of CHWs within health and development programs http://www.who.int/workforcealliance/knowledge/resources/Framework_partenrs_harmonised_support.pdf
- The CHW Program Assessment and Improvement Matrix (AIM), http://www.who.int/workforcealliance/knowledge/toolkit/50.pdf

2. USING THE MANUAL

The HSAA manual is intended for different audiences who may use the Manual in different ways. The HSAA manual can be used to:

- Enable users to assess a country's health system, possibly during development of a health program or sector plan. This assessment will diagnose the relative strengths and weaknesses of the health system among the different health actors, prioritize key areas for strengthening, and identify potential solutions or recommendations for interventions that build on the comparative advantages of both public and private health sectors.
- Inform all stakeholders – both public and private – about the basic elements and functions of health systems for all health systems stakeholders.
- Assist users to conceptualize key health systems challenges and to engage in a process for systematically gathering key information and engaging key stakeholders in order to identify solutions to priority problems.

The output of the assessment should be:

1. An assessment report presenting key findings for each core health system function, highlighting important strengths, critical cross-cutting health system weaknesses that limit performance, and recommendations for priority HSS interventions.

2. A set of actionable and specific HSS recommendations

3. As part of the process, the team will engage stakeholders in a variety of ways (interviews, focus groups, events), culminating with a stakeholder workshop for validating findings, identifying priorities, and discussing recommendations. Recommendations should reflect priorities and objectives of the client and key stakeholders, and should serve as the basis for an action plan for HSS.

2.1. Users of the HSA Manual

Government organizations/MOHs: MOH staff can use this manual as a reference for designing a health system assessment that meets their needs and produces the information and recommendations they are seeking. Section 2 Module 2 explains the HSA approach and how it can be adapted to unique country circumstances.

International donors: International donors have often funded health system assessments to inform their program planning. This manual is a guide to what to expect from an HSA, in terms of methods and outputs, and describes how an assessment can be tailored to meet the country and the funders' needs. Section 2 Modules 1 and 2 describe how to give direction to an HSA team, and the options available in the management and implementation of an assessment.

HSA team leaders: HSA team leaders should read Sections 1 and 2 of the manual thoroughly. Section 1 describes how to use the manual and Section 2 details the steps in the HSA approach process; with this knowledge team leaders can best direct their team members to collect, analyze, and find cross-cutting health system issues. In addition, team leaders should make use of templates, guides, draft schedules, and

guidance on issues to consider in planning and implementing the assessment, which are all found in Section 2 and in the annexes.

HSA team members: Team members should review all sections of the manual broadly to understand the HSA approach process and how the core health system functions are related to one another. Team members should focus on the core function modules in Section 3 in particular and understand how to use them for data collection, analysis, crosscutting analysis, and report writing. If team members are inexperienced with the analysis approach, then Section 2, Modules 4 and 5, are critical.

Others interested in health system strengthening: Anyone interested in HSS will find several helpful resources including the HSAA manual bibliographies at the end of each module; the indicator lists, references to other HSA tools, and HSS links found on the manual website (www.healthsystemassessment.org).

The HSA approach is flexible. Depending on how the client intends to use the findings of the assessment and what information is already available, an assessment may encompass all core function modules for a comprehensive view of the health care system, or focus on selected modules. The HSA approach developed here will be most useful in countries where one or more of the following conditions apply:

- *The MOH and other stakeholders such as private and/or civil society actors are beginning a strategic planning process.* The assessment findings could contribute to or inform the country strategic plan.
- *The country is applying for grants or other funding, or in discussions with donors about future assistance.* The assessment findings could contribute to or inform their project's design, work plan, or both.

The country has not recently completed an HSA or a similar assessment (within the past two years). If a country has conducted a similar study recently, the need for another assessment is unlikely.

2.2. Steps of the HSA Approach

The HSA approach includes a general description of the health system environment as a foundation, along with assessment of six health system core functions and general description of the private health sector using defined indicators and guiding questions. The HSA approach is summarized through five modules or steps in Figure 1.2.2: The five steps of the HSA approach are described in detail in Section 2.

1. Shape the Assessment
2. Mobilize and Operationalize the Team
3. Collect Data
4. Organize and Analyze Findings and Develop Conclusions
5. Formulate Recommendations and Prepare Report

Figure 1.2.2 Steps in the Health System Assessment Approach

[PENDING Figure 1.2.3]

Developing a Country and Health Systems' Overview (described in Section 3, Module 1) gives the assessment team an understanding of the country-specific contextual background; it should be completed before any work begins the remaining six technical chapters (described in Section 3, Modules 2 through 7). Each chapter is estimated to take three to four person-weeks to complete, depending on the information available for the assessment country. Multiple chapters can be completed simultaneously. The entire HSA can be accomplished in a concentrated period (10 weeks) or spread out over a longer period of more than six months.

It is important to involve in-country stakeholders in all steps of the assessment (see Figure 1.2.3 as well as Section 2) – from planning the work through conducting the assessment and disseminating and validating the findings and recommendations. A supplementary guide to stakeholder participation guide, *Engaging Stakeholders in Health System Assessments: A Guide for HSA Teams* (Schalk-Zaitsev 2011), can be downloaded at http://www.healthsystemassessment.org.)

A pre-assessment stakeholder meeting to define common objectives, identify specific areas of focus, and get input and guidance on the approach will maximize the use of the assessment outputs. Based on stakeholder interest, some core health system functions, or elements within some functions, may require more or less attention. Section 2, provides detailed guidelines for planning and conducting the assessment.

A development partner mapping exercise (see Section 3, Module 1.5 Table 3.16) to get an idea of the key external partners are in the health system.

2.3. Overview of HSA Chapters

The manual is organized according to the HSA approach process. There are four main sections:

1. Introduction to The Health System Assessment Approach and Manual: describes the HSA approach and how the manual is organized.
2. Conducting the Assessment: provides detailed description of each of the five steps in the assessment process. It offers guidance on working with the client to identify priorities, pulling together the assessment team, data collection, organization of findings and how to do a SWOT root cause analysis for each function, and exercises cutting across functions using a holistic, systems approach. Templates, country examples, lessons learned, and references to relevant tools, all of which can be adapted for use in future assessments, are included in each module and as annexes.
3. Guidance on Assessing the Health System discusses carrying out a country overview and an assessment of the core health system functions and presents selected indicators for each.
4. Annexes: gives bibliography and supplementary material organized according to manual sections and modules.

Implementing the HSA approach results in an assessment report, with chapters on each of the health system functions. Depending on the objectives of an individual assessment, all or some of the technical chapters may be used, although the overview chapter should always be used. The technical modules are sequenced to encourage root cause analysis. The assessment team begins with the country overview – what are the major causes of morbidity and mortality? The next most proximal function is service delivery – what are the deficiencies in service delivery? What are the underlying causes in terms of human resources and medical products? What are the underlying causes in terms of information systems, financing, and governance? A brief description of each chapter in Section 3 is provided here.

- The **Country Overview** chapter covers basic socio-demographic and economic information for and an overview of the health system and the general health situation of the assessment country. It covers the topic areas of political and macroeconomic environment, business environment and investment climate, top causes of mortality and morbidity, structure of the main government and private organizations involved in the health care system, decentralization, service delivery organization, external stakeholder mapping, and coordination.
- **Service Delivery** examines the factors that affect service delivery outputs and outcomes, including demand for services; development of service packages; organization of the provider network including public, private, and community-based providers; and management of health services including safety and quality, and the physical infrastructure and logistics of the system.
- **Human Resources for Health** covers systematic workforce planning, human resources policies and regulation, performance management, training/education, and incentives. This chapter also looks at the distribution of health personnel between the public and private sector and various subsectors.
- **Medical Products, Vaccines, and Technologies** reviews the interconnectedness between supply chain functions and explains each function. It assesses the health system's pharmaceutical policy, laws, and regulations; selection of pharmaceuticals; quantification and procurement of medical products; storage and distribution; appropriate use of pharmaceuticals across sectors; access to quality pharmaceutical products and services; financing mechanisms for pharmaceuticals; and logistics information systems and management support.
- **Health Information Systems** reviews the current operational HIS components; the resources, policies, and regulations supporting the HIS; data availability, collection, and quality; and analysis and use of health information for health systems management and policy making.
- **Health Financing** covers the collection of financial resources; the pooling and allocation of health funds, including government budget allocation and health insurance; and the process of purchasing and providing payments for health care.
- **Leadership and Governance** addresses the capacity of the government and other actors to formulate policies and provide oversight for the overall health system; stakeholder participation; and health system responsiveness, accountability, and regulation.
- **Private Sector**. The role of the private sector should be woven into all of the previous chapters. Yet, it may be convenient and useful to discuss the role of the private sector across health system core functions, including with a specific SWOT analysis, as a separate chapter so that users can access this information easily.

Technical Modules

Each technical module begins with a brief overview of that health system function that includes defining the functional responsibilities and key terminology describing the relative role of public and private stakeholders and implications of this core function for advancing towards UHC; and highlighting key issues and recent global developments. This overview is followed by a description of the indicators used to assess various topics related to that technical function. Each module concludes with guidance for analyzing the data in a systematic way to formulate health system strengthening recommendations that reflect the synergies and links across functions.

Indicators

Each technical chapter is divided into topical areas that begin with a brief discussion of the topic followed by details for each indicator. Several quantitative indicators are selected based on readily available, internationally comparable data. In addition, there will be qualitative indicators for which the information is collected through country-level document review and stakeholder interviews. Subsections within each chapter provide an overview by topical area, along with suggestions of data sources and stakeholders to interview. Indicator tables are organized by topical area and include detailed description of each indicator, as well as key issues and questions related to that indicator.

The assessment combines a desk-based assessment of documents with stakeholder interviews and observation visits to identify strengths and weaknesses in the technical area, validate findings, and explore HSS recommendations that link multiple functions.