

HEALTH SYSTEMS 20/20 ANNUAL REPORT, YEAR 5 OCTOBER 1, 2010 – SEPTEMBER 30, 2011



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HEALTH SYSTEMS 20/20 ANNUAL REPORT, YEAR 5

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ACRONYMS

ABA	American Bar Association
AFENET	African Field Epidemiology Network
ART	Antiretroviral Treatment
ARV	Antiretroviral (drugs)
CAPMAS	Central Agency for Public Mobilization and Statistics (Egypt)
CBHF	Community-based Health Financing
CBHI	Community-based Health Insurance
CESAG	Centre Africain d'Etudes Supérieures en Gestion (African Center for Higher Management Studies) (Senegal)
CHW	Community Health Worker
DFID	Department for International Development
DHS	Demographic and Health Survey
DivHIS	Division of Health Information Systems (Kenya)
DRC	Democratic Republic of Congo
DOP	Department of Planning (Egypt)
ECSA	Commonwealth Regional Health Community for East, Central and Southern Africa (Tanzania)
EMIS	Expenditure Management Information System
GDP	Gross Domestic Product
GIS	Geographic Information System
HAPSAT	HIV/AIDS Program Sustainability Analysis Tool
HCT	HIV Counseling and Testing
HEARD	Health Economics and HIV/AIDS Research Division
HIO	Health Insurance Organization (Egypt)
HIS	Health Information System/s
HMIS	Health Management Information System
HRH	Human Resources for Health
HS-STAR	Healthcare System Strengthening in Armenia
HSA	Health System Assessment
HSS	Health System Strengthening
ICAP	International Center for AIDS Care and Treatment Programs
IMIS	Immunization Management Information System
INFAS	Institute National de la Formation des Agents de Santé (National Institute of Health Worker Training) (Cote d'Ivoire)
IRDA	Insurance Regulatory and Development Authority (India)
ISID	Institut de Santé et Développement (Institute for Health and Development)
IT	Information Technology

KSPH	Kinshasa School of Public Health
M&E	Monitoring and Evaluation
MBB	Marginal Budgeting for Bottlenecks
MCH	Maternal and Child Health
MFL	Master Facilities List
MIS	Health Management Information System
MNCH	Maternal, Neonatal, and Child Health
MOH	Ministry of Health
MOHSS	Ministry of Health and Social Services ((Namibia)
MOHSW	Ministry of Health and Social Welfare (Liberia)
MoPH	Ministry of Public Health (Afghanistan)
MOHP	Ministry of Health and Population (Egypt)
MPH	Masters in Public Health
MSLS	Ministère de Santé et de la Lutte contre le SIDA (Ministry of Health and AIDS) (Cote d'Ivoire)
MSP	Ministry of Health and Prevention (Senegal)
NAC	National AIDS Commission (Liberia)
NACO	National AIDS Control Organization (India)
NASA	National AIDS Spending Assessment
NASCOP	National AIDS Program (Kenya)
NGO	Nongovernmental Organization
NHA	National Health Accounts
NHIS	National Health Insurance Scheme (Nigeria)
NHMIS	National Health Management Information System (Nigeria)
OVC	Orphans and Vulnerable Children
P4P	Pay for Performance
PBF	Performance-based Financing
PBI	Performance-based Incentives
PDA	Personal Data Assistant
PEMR	Public Expenditure Management Review
PEPFAR	President's Emergency Plan for AIDS Relief
PHC	Primary Health Care
PHSP	Private Health Sector Program (Ethiopia)
PLWHA	People Living With HIV/AIDS
PMTCT	Prevention of Mother-to-Child Transmission
PNLS	Programme National de Lutte contre le SIDA (National Program to Fight AIDS) (DRC)
QAPC	Quality Assurance Partnership Committee
RBF	Results-based Financing
SASED	Services d'Appui aux Services Exterieurs et a la Decentralisation (Support Service Unit for Foreign Assistance and Decentralization) (Cote d'Ivoire)
SHOPS	Strengthening Health Outcomes through the Private Sector
SLP	Senior Lawyer Project

SMT	Senior Management Team
STI	Sexually Transmitted Infections
TB	Tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
USAID	United States Agency for International Development
UNICEF	United Nations Children's Fund
USG	United States Government
UTM	Union de Technique de la Mutualité
VAAC	Vietnam Administration of HIV/AIDS Control
WHO	World Health Organization



Catherine Connor/Mozambique

I. INTRODUCTION

We are pleased to present the fifth annual report on the Health Systems 20/20 project. Now with more than 250 activities in over 50 countries, our focus is increasingly on country ownership. Over the past several years, we intentionally sought to build out each activity so that it not only clearly supported the health system but also truly strengthened it. Two years ago we instituted eight strategies in order to better plan, carry out, and document these efforts. This organizing structure has worked well, and we are now able to clearly demonstrate results in each of the eight strategy areas. It is satisfying to begin to see the strategies merge into each other, thus more deeply affecting the health system at the country level. For example, in project Year 3, we carried out numerous resource tracking exercises (National Health Accounts, or NHAs), costing and sustainability efforts using the HIV/AIDS Program Sustainability Analysis Tool studies (HAPSATs), and health systems assessments (HSAs). In Year 4, we perfected a more rigorous and consistent approach to local stakeholder involvement as we implemented these methodologies, resulting in more robust country ownership and clearer impact on policy. In Year 5, we have begun to transfer the ability to carry out these methodologies to six regional institutions in Africa, ensuring sustainability of the efforts once the project ends in 2012. The trajectory from carrying out an evidence producing effort, to ensuring local ownership and use of the evidence, to transferring the skill to produce evidence locally, has been our overall goal.

In Year 5, we also increased efforts to better link evidence generation for policy change. Our NHAs now have a clearer path to affecting the debate over national health budgets. Our HAPSATs are more clearly used for HIV funding scenario planning at the national level, for Global Fund and GAVI grants, as

well as for national strategic HIV/AIDS plans. Our HSAs are clearly guiding national planning and health systems investments. In addition to health care financing efforts, we have results where we have strengthened health information systems (HIS), merged vertical HIS systems into national systems, and built capacity to maintain and broaden the scope of the systems. We completed several seminal human resources for health (HRH) studies contributing to the HRH debate and policy decisions around financial and nonfinancial incentives and their relationship to productivity. All of these efforts and others are the front end of a pathway that leads to increased funding envelopes and system-wide interventions for better health care services.

This annual report summarizes results from key activities in each of the eight project strategies: Capacity Building, Costing and Sustainability, Financial Risk Protection, Governance, Human Resources for Health, Measuring and Monitoring Health System Performance, Performance-Based Incentives, and Resource Tracking. The field demand for this project is evidence of an increasing awareness of the need to build health systems to sustain USAID investments. In addition to the Health Systems 20/20 leader being fully funded for Year 6, and even turning down work as a result of the ceiling, we are also seeing USAID mission demand for project associate awards to be able to further carry out health systems strengthening (HSS) efforts over a longer period of time (descriptions of the Associate Awards are annexed to this report). We hope the reader senses both our enthusiasm for the results evolving from our work, as well as the shift in the uptake and commitment by the field to carry out our HSS work.



Health Systems 20/20/Egypt

2. PROJECT PROGRESS TOWARD RESULTS

2.1 CAPACITY BUILDING

Vision: Health Systems 20/20's vision is to strengthen key regional- and country-level organizations that are essential to supporting health systems in their respective countries and regions. The organizations assisted include NGOs, research institutions, networks, consulting firms, and key national government agencies. Health Systems 20/20 uses a “whole of system” approach by developing capacity in the full range of organizational competencies including leadership and management, management systems, resource mobilization, organizational governance, coordination, and technical expertise. The improvements in these organizations will be measurable and sustainable. The project draws from the best practices of organizational development, starting with an assessment to identify needs based on the core competencies and ending with an explicit plan to sustain the improvements.

Strategy: The strategy in Years 1–3 was to develop a conceptual approach and build a portfolio of organizational capacity-building activities focused on country and regional organizations that are essential to strengthening health systems. In Years 4–5, the focus has been on the implementation of these activities, integration of organizational capacity-building activities into the other project strategies, and initial efforts to document, capture, and disseminate lessons learned. This approach has resulted in 20

activities where organizational capacity building is the primary focus in addition to activities where it is just one component of a larger activity. Many of the activities are in Africa, reflecting the emphasis of USAID, and the vast majority of them have been multi-year in duration, a strong indicator of interest by the mission and client organization.

In Year 5, USAID’s focus on regional and country ownership continued to be a major theme for Health Systems 20/20’s institutional capacity-building activities. The theme underlies the project’s activity to institutionalize capacity to use three sophisticated HSS methodologies – HAPSAT, HSA, and NHA. The project identified and trained six African institutions to assist countries in their regions with conducting studies using the methodologies, to decrease reliance on international sources for technical assistance. Project staff also trained U.S. Government (USG) field staff and host-country government officials in HSS. Health Systems 20/20 continued strengthening the African Field Epidemiology Network (AFENET) as an institution, so it can better serve international and country clients. In Year 4, the project developed a concept paper on the application of organizational development approaches to HIS; in Year 5, it put the concepts into practice, in the establishment of an HIS Directorate in Namibia, and the design of a multi-year activity to develop a country-led effort to strengthen the national HIS in Nigeria.

Other Year 5 efforts aided specific organizations: the Kinshasa School of Public Health (KSPH) in the DRC, the National AIDS Commission (NAC) in Liberia, and a new Ministry of Health (MOH) Global Fund Unit in Mozambique.

INSTITUTIONALIZING HEALTH SYSTEMS STRENGTHENING METHODOLOGIES ACROSS AFRICA

Health Systems 20/20 is working with six regional institutions in Africa, empowering each to independently carry out one of the key HSS methodologies: HAPSAT, HSA, and NHA (Table 1). Three organizations are Anglophone and three Francophone, ensuring that each methodology can be implemented in two languages. By choosing regional institutions with a significant presence in Africa and the ability to mobilize staff for short-term assignments in other countries in their respective subregions, Health Systems 20/20 is enhancing the ability of regional organizations to carry out HSS work on a sustainable basis.

TABLE 1. REGIONAL INSTITUTIONS TRAINED ON HEALTH SYSTEMS STRENGTHENING METHODOLOGIES

	Anglophone	Francophone
HSA	School of Public Health, Makerere University	Institut Regional de Santé Publique
HAPSAT	Health Economics and Research Division, University of Kwazulu Natal	Institut de Santé et Développement
NHA	East Central and Southern African Health Community	Centre Africain d’Etudes Supérieures en Gestion

In Year 5, the London School of Economics selected the institutions using a mapping study conducted as the starting point. Three high-quality courses based on adult-learning principles and the experiential learning model were developed for each methodology; each consists of a four-day technical training course in the methodology and a one-day management course that addresses such aspects as budgeting, contracting, and marketing. Teams of two or three trainers then conducted training for each institution. Health Systems 20/20 has subcontracted or is in the process of subcontracting the institutions for a field application in Year 6 with project guidance and oversight.

TRAINING U.S. GOVERNMENT FIELD STAFF AND HOST-COUNTRY GOVERNMENT OFFICIALS IN HEALTH SYSTEMS STRENGTHENING

Health Systems 20/20, in conjunction with USAID, Centers for Disease Control and Prevention, and International Center for AIDS Care and Treatment Programs (ICAP)/Columbia University, is building the capacity of leaders in developing nations to analyze, prioritize, design, and oversee HSS programs. In Year 5, Health Systems 20/20 led development and delivery of a five-day HSS training to provide participants with sufficient knowledge and skills to respond effectively to the increased focus on HSS under PEPFAR 2 and the Global Health Initiative. Thirty-five participants including roughly equal numbers of USG field staff and country government officials from Barbados, Kenya, Namibia, South Africa, Uganda, Vietnam, and the Caribbean Region attended the training in Cape Town, South Africa in July. The training will be followed with six months of distance learning, led by ICAP/Columbia University.

Findings of a needs assessment including an online survey and key informant interviews informed the development of the training. This workshop provided a common language and conceptual framework for the analysis of health system bottlenecks and interactions, shared the growing evidence base regarding best practices in HSS, and emphasized the practical application of HSS knowledge to USG-supported programming. A standard set of materials was created, including a participant workbook and facilitator guide, to facilitate future delivery of this course with other PEPFAR-assisted countries.

In Year 6, Health Systems 20/20 will make revisions to the course materials based on feedback from Cape Town, and conduct additional deliveries of the course to new country teams. The project will continue to collaborate with ICAP/Columbia University to provide inputs to the Phase 2 training, in particular modules on financing, governance, and integration.

“By developing better understanding of health system strengthening, we realize that most interventions supporting the system stop at the level of inputs. We begin to understand that it is not until you stretch your fingers to the level of policies and to the level of all people affected by the system that you are able to deliver strengthening through these programs.”

– Dr. Alfred Dirwale, Health Policy Advisory Committee, Uganda

STRENGTHENING THE AFRICAN FIELD EPIDEMIOLOGY NETWORK TO OFFER REGION-BASED EPIDEMIOLOGICAL SERVICES

In Year 5, Health Systems 20/20 completed the fourth year of institutional strengthening assistance for AFENET. Established in 2005, AFENET currently has 10 institutional members that include some of the strongest schools of public health in Africa. Because of this competence, the increased appreciation of the importance of field epidemiology, and the desire to use African platforms, AFENET has become better known in the U.S. development community and in Africa more generally. The organization has grown rapidly – it now has an annual budget of \$10 million and a Secretariat with 29 full-time staff, up from \$750,000 and three staff members in 2007. As AFENET has expanded and developed, it has needed to strengthen its systems to keep up with the demands created by a larger organization that has more resources, more members, and a larger Secretariat.

Health Systems 20/20’s assistance has focused on providing AFENET with an organizational foundation to manage its rapid growth and ensure its effectiveness and sustainability over the long term. This assistance has included the following activities: 1) revised constitution that clarified membership, organizational structure, composition of the Board of Directors, and the roles, responsibilities, and authorities of the executive director and Secretariat; 2) strategic plan for 2010–2014 that has been

officially approved by the Board of Directors; 3) human resources plan that is consistent with the strategic plan and that details the staffing and skill needs of AFENET over the next five years; 4) resource mobilization plan that lays out a path for AFENET to grow; 5) strengthening of Secretariat management capacity including team-building and management training; 6) in-house financial management system that meets USG accounting standards and a justified indirect cost rate; and 7) enhanced understanding by the board on how to manage growth. In Year 6, Health Systems 20/20 will build the capacity of AFENET's resource mobilization unit and continue to strengthen the Secretariat's internal management.



AFENET

FROM THEORY TO USE: DEVELOPING COUNTRY-OWNED STRENGTHENING OF HEALTH INFORMATION SYSTEMS

Over the past two years, Health Systems 20/20 has been using organizational development approaches to develop country-owned programs to strengthen national HIS. In January 2010, it presented a concept note on the use of organizational development approaches in HIS strengthening at an international conference in Bangkok. The approach focused on the importance of having a high-level interagency body to lead the strengthening effort and oversee the implementation of national HIS strategic plans. Health Systems 20/20 has also put these ideas into practice.

NAMIBIA: CREATING A DIRECTORATE TO CONSOLIDATE HIS

Namibia's Ministry of Health and Social Services (MOHSS) previously had no centralized operating unit responsible for HIS. Health Systems 20/20 is assisting the ministry to establish an HIS Directorate that is accepted by stakeholders and to ensure an integrated national HIS. In Year 5, the project worked with the MOHSS to develop an organogram for the new directorate, and determine the list of positions and materials required for approval from the Public Service Commission. It used participatory methods such as team-building and role clarification processes to develop a tentative action plan and timeline for establishing the directorate and for initiating planning for integration of the various parallel HIS. Assistance will continue in Year 6.



Susna De/Namibia

NIGERIA: STRENGTHENING THE HEALTH MANAGEMENT INFORMATION SYSTEM

In Nigeria, Health Systems 20/20 led a six-person team to develop a country-led approach to strengthen the national health MIS (NHMIS). The outcome of the trip was an action plan that will be carried out in three phases. Phase I is the start-up period; Phase II is the following 12 months and consists of 11 activities aimed at creating a foundation for a country-driven HMIS strengthening process; Phase III is for

the ensuing three years. Core activities include the creation of a Coordination Secretariat within the federal MOH, establishment of a high-level interagency body through the Coordination Secretariat, strengthening the internal management and organizational capacity of the NHMIS Branch, and raising the profile of the NHMIS Branch and providing it with staff and resources to drive NHMIS implementation.

IMPROVING THE INSTITUTIONAL CAPACITY AND SUSTAINABILITY OF THE KINSHASA SCHOOL OF PUBLIC HEALTH

Health Systems 20/20 has completed the third year of a four-year institutional strengthening program for the Kinshasa School of Public Health (KSPH). KSPH is part of the University of Kinshasa and currently offers a regular one-year Masters in Public Health (MPH) program and a 15-month Masters in Health Economics. Health Systems 20/20's support to KSPH includes an institutional strengthening component and a scholarship component.

The institutional strengthening is valuable, as KSPH is increasingly called upon to implement studies for USAID and other donors. Health Systems 20/20 continues to strengthen KSPH management. A local audit firm is actively working to strengthen the financial management system and in Year 5 completed a number of tools for KSPH. A financial management procedures manual was finalized and staff trained in its use and an automated accounting system was installed. Also in Year 5, KSPH created a business development center aimed at supporting resource mobilization efforts and hired a part-time coordinator to establish the center. Finally, the American University of Beirut drafted a revised MPH curriculum including syllabi for the proposed courses. In Year 4, an indirect cost rate was established and KSPH is now collecting indirect costs from existing projects thereby improving its revenue base.

The scholarship program financially supported 23 MPH students in Year 5. In addition, Health Systems 20/20 provided funding for two students to prepare dissertation proposals for their PhD programs in Belgium.



Douglas Glandon/Democratic Republic of the Congo

STRENGTHENING THE MANAGEMENT AND COORDINATION CAPACITY OF THE MINISTRY OF HEALTH HIV/AIDS OFFICE IN THE DEMOCRATIC REPUBLIC OF THE CONGO

Health Systems 20/20 has completed the second year of a three-year activity to strengthen the management and coordination of the National AIDS Program (Programme National de Lutte contre le SIDA, or PNLS). As a line office within the MOH, PNLS is responsible for coordinating the programs of a range of implementing partners for prevention, care, and treatment of HIV/AIDS. With the increase of HIV/AIDS funding available in the Democratic Republic of the Congo (DRC), the demands on PNLS for management and coordination have increased significantly.

To address these needs, Health Systems 20/20 identified five areas of strengthening: 1) clarifying the role of PNLS within the health system, including its relationship with other offices in the MOH, 2) building the leadership and management skills of PNLS staff, 3) revising the organizational structure so it is aligned with the vision and mission of PNLS, 4) strengthening the capacity of PNLS to align the activities

of its implementing partners with national strategies and norms and standards and improving its planning capacity, and 5) enhancing the effectiveness of communication and coordination processes.

In Year 4, the focus was on the central level; in Year 5, it was extended to the provincial level. As a result of a team-building retreat, PNLs staff developed a common vision and values and identified ways to work together more effectively. All professional staff have improved their leadership and management skills as a result of Health Systems 20/20 training of 31 PNLs central office managers and 22 provincial coordinators from all 11 provinces. Provincial staff also received additional training in facilitation and communication skills. A steering committee has been established to improve communication and coordination with implementing partners. Job descriptions and competency requirements were established for all positions that provided the basis for a recommended new organizational structure and is under consideration by PNLs management.

Consistent with the strategic leadership role of PNLs, one of the most important accomplishments in Year 5 was the development of an annual operating plan with extensive involvement from provincial staff. This resulted not only in the plan itself but also in improved working relationships and teamwork between the central office and the provinces. In Year 6, the PNLs will institutionalize the planning process by developing better data collection tools and standardizing, documenting, and institutionalizing the planning processes.

Finally in Year 5, Health Systems 20/20 also contributed to the physical infrastructure of PNLs by completing the renovation of its meeting room and by assessing its IT needs, developing an IT improvement plan, and installing an upgraded IT infrastructure that will improve productivity. In Year 6, Health Systems 20/20 will provide funding to ensure the functioning of the IT system.

ESTABLISHING A SECRETARIAT FOR THE NATIONAL AIDS COMMISSION IN LIBERIA

Health Systems 20/20 assisted the Government of Liberia to establish a Secretariat for the NAC in Year 3. The Secretariat has a broad mandate: it is to coordinate activities of stakeholders especially civil society, local governments, and other ministries; review strategies of various stakeholders to ensure that they are aligned with the national strategic framework; advocate with national and international organizations; recommend improvements to the legislative framework; and develop and maintain a HMIS to monitor and evaluate the response to HIV/AIDS. Initially, none of these functions was being carried out in a coordinated or effective manner because of the absence of a staffed and functioning Secretariat.

As a result of Health Systems 20/20 assistance, the Secretariat is now up and running. The project first defined the essential functions of the NAC and then developed a staffing plan and position descriptions for eight full-time staff. Once staff were hired, Health Systems 20/20 conducted performance assessments and initial team building, provided management coaching, and assisted the Secretariat to develop its annual work plan and an operating budget that was the basis for securing funds from the Government of Liberia, Global Fund, and other donors.

The national law to create the NAC, passed by both houses of the legislature in Year 4, was signed by the President in Year 5, ensuring that the NAC is a regular line item in the national budget. Programmatic activities undertaken by the Secretariat have focused on mainstreaming HIV/AIDS into eight other line ministries, launching an Association of People Living with HIV/AIDS (PLWHA), and conducting county-level workshops to raise awareness of HIV/AIDS.

Health Systems 20/20 provided assistance in two other areas in Year 5. First, it provided a monitoring and evaluation (M&E) expert to build the capacity of the Secretariat's M&E coordinator and reduce the number of HIV/AIDS indicators from 55 to 12. Second, it initiated assistance to strengthen the financial

management capacity of the Secretariat by installing an automated accounting system, developing a financial procedures manual, and training Secretariat staff.

While the NAC Secretariat is still a young organization in need of assistance with limited funds for programmatic activities, it is fully functioning and carrying out activities consistent with its role and functions.

NEW GLOBAL FUND UNIT STREAMLINES GLOBAL FUND DISBURSEMENTS IN MOZAMBIQUE

Mozambique's MOH is the main principal recipient of substantial grant funding from the Global Fund to provide prevention and treatment services as well as procure drugs and supplies. However, as the government's dependency on the Global Fund has grown in recent years, the MOH has had difficulty managing, tracking, and reporting on the programs funded by the Global Fund, which led to uncertainty in financing many critical programs – a particular problem was delays in disbursement of Global Fund funding.

To improve MOH management and reporting of Global Fund grants, Health Systems 20/20 first helped create a Global Fund Unit within the ministry. The unit is responsible for managing and reporting on program and financial indicators and improving disbursements. The challenge then was to unplug the disbursements while at the same time build the capacity of unit staff to take over all key functions while ensuring no disruption in future disbursements.

Health Systems 20/20 has focused its support on the design and implementation of processes in four areas that track and report on Global Fund programs: 1) develop and implement the business processes that guide information sharing between the HIV/AIDS, Malaria and Tuberculosis (TB) programs and the Global Fund Unit, the MOH Finance and Administration Department, and the Central Medical Store; 2) develop and implement a financial management system that tracks and reports on Global Fund-funded activities on time and accurately; 3) develop an M&E system that tracks Global Fund program indicators; and 4) design and implement a procurement system that is compliant with Global Fund standards.

The Global Fund Unit has helped unplug a massive pipeline of disbursements dating back to 2002 and is meeting strict Global Fund deadlines for the first time, which is positively impacting the ministry's ability to fully utilize monies available from the Global Fund for improving the delivery of HIV/AIDS services.



Arturo Sanabria/Mozambique

2.2 COSTING AND SUSTAINABILITY

Vision: Health Systems 20/20's vision is to be the “go to” project for technical assistance in program costing, sustainability analysis, and determining value for money. The project will be recognized for bringing flexibility, rigor, and innovation to all its costing and sustainability work and considering process improvement (e.g., identifying efficiency solutions and problem solving), impact analysis, and effective capacity building to be an integral part of every costing/sustainability analysis activity. The project is particularly well suited to providing ready-to-use recommendations rather than producing only cost or financing gap estimates because it can leverage its broad range of HSS expertise in resource tracking, infectious diseases, maternal and child health (MCH), HMIS, HRH, and, in particular, health financing.

Strategy: Costing and Sustainability was made a stand-alone strategy based upon the significant number of requests that the project received in Years 1– 4 for costing analyses and the responses that the different teams have used to meet these requests. Health Systems 20/20 recognized not only the opportunity to both provide rigorous quantitative data that are in increasing demand in the current economic climate but also the need to focus engagement, taking into consideration the clients' needs and context. This enables the project to provide clear, appropriate, implementation-ready recommendations, and in addition, to focus on educating our country clients, to ensure that the limitations and uses of these data are clear and that costing data are linked where appropriate to specific issues such as understanding value for money and increasing effectiveness and efficiency. This focus on the entire process makes results more sustainable, as the analysis incorporates country needs and interest, local capacity to conduct costing and sustainability analyses grows, MOH technicians are more able to communicate with key decision makers, decision makers better understand the implications of study findings, and broader participation allows countries to take ownership of the process.

In Year 5, Health Systems 20/20 introduced the HAPSAT-Plus tool and worked with Guyana, Sierra Leone, South Sudan, and other countries to do HAPSAT analyses or to act on findings of studies begun in earlier years. HAPSAT also was used to help determine the most effective and affordable package of services that could be offered to orphans and vulnerable children (OVC) in post-earthquake Haiti. Also in Haiti, Health Systems 20/20 carried out a comprehensive costing of HIV services delivered across five USAID-funded health networks. Particular costing successes were the grants that countries such as Angola and Papua New Guinea won from the Global Fund, using HIV strategy costing data that the project helped them produce. Finally, Health Systems 20/20 produced costing tools to serve the needs of individual countries that will have application elsewhere.

HAPSAT-PLUS: UPDATING THE APPROACH TO ENCOURAGE COUNTRY OWNERSHIP

The HIV/AIDS Program Sustainability Analysis Tool-Plus (HAPSAT-Plus), released in Year 5, is a customizable tool for enhancing the sustainability of HIV/AIDS programs. The methodology examines the financial and human resources required for delivering major HIV/AIDS services such as antiretroviral treatment (ART), prevention of mother-to-child transmission of HIV (PMTCT), HIV counseling and testing (HCT), case management of sexually transmitted infections (STIs), behavioral prevention, and care and support for people living with HIV/AIDS (PLWHA) and OVC.

Like HAPSAT 1.0, the updated tool can be utilized to estimate the amount and sources of financing, the number and cost of HIV/AIDS services delivered, and the financial and human resources required to maintain the current or future volume of HIV/AIDS services. It is more flexible, to meet the specific needs of countries. Findings from the analysis inform the development of national strategies, operational plans, and funding proposals. The methodology uses an intensive stakeholder engagement process to analyze and compare the feasibility of various policy scenarios for an HIV program as well as address

program sustainability concerns. Specifically, the HAPSAT-Plus strategy incorporates four lessons learned from the success of HAPSAT Kenya:

- **Results to policy:** In contrast to early HAPSATs, which focused on gap analysis of financial and human resources, HAPSAT-Plus makes gap analysis only one of several deliverables. It also focuses on the stakeholder process in designing the research questions of the sustainability analysis of the examined HIV program, deliberating its findings, and addressing the HAPSAT’s recommendations. The new HAPSAT approach makes stakeholders aware they own the analysis, its findings, and its recommendations. While stakeholder engagement is not new in public health – it is used, for example, for developing strategies and policies – in pure analytical assignments it is less common.
- **Standardizing HAPSATs:** Standardization ensures that the USAID client receives a similar product across countries and that HAPSAT activities stay within budget, despite their expanded scope.
- **Enhanced features:** The HAPSAT software was modified to simplify the structure and make it more user-friendly. Programmatic targets are being set based on different scale-up scenarios and it is possible to compare the funding and human resources required for each scenario. As mentioned above, the methodology does enhanced costing of HIV services, and it is harmonized with other tools to facilitate exchange of data.
- **Leveraging the HAPSAT experience:** Lessons learned from HAPSAT are being analyzed and compiled into documents addressing sustainability issues. They will be published in Year 6.

Since Health System 20/20 built HAPSAT in 2007, HAPSAT studies have been done or are planned in 14 countries (Figure 1).

FIGURE 1. COUNTRIES WHERE HAPSAT STUDIES HAVE BEEN DONE OR ARE PLANNED



Year 5 results from Guyana, Sierra Leone, and South Sudan show the utility of the HAPSAT-Plus approach.

USING HAPSAT TO MAXIMIZE HRH IN GUYANA

HAPSAT Guyana has shown that the human resources capacity can be addressed by efficiency measures rather than by recruitment of additional staff. Faced with severe HRH shortages, Guyana’s national HIV program is using HAPSAT findings to guide strategies to best utilize the health workers it does have to provide HIV/AIDS services. For example, HAPSAT findings are being used to review the number, distribution, and tasks of HIV counselors. Also based on the HAPSAT findings, the Guyana government is developing plans to ensure clinics are open eight hours a day, in order to make full use of available

staff. In addition, the greater country ownership has enabled stakeholders to understand, discuss, and address the sustainability issues arising from the substantial decline in donor funding for HIV.

MOBILIZING RESOURCES FOR HIV/AIDS PROGRAMS IN SIERRA LEONE

In Sierra Leone the HAPSAT provided a platform for stakeholders to set targets for their interventions, as well as address the sustainability issues of the program's M&E and human resource components.

USING HAPSAT DATA TO GENERATE DONOR FUNDING IN SOUTH SUDAN

In South Sudan the HAPSAT team assisted in formulating the key interventions for which donor funding could be requested, taking into account that competition on Global Fund money is more competitive than ever. As such, the services for which funding is requested need to show value for money, with modest unit costs; need to be integrated with other health and social services; and need to be aligned with the funding of the government and other donors.

BUILDING REGIONAL CAPACITY OF HAPSAT

To ensure that the HAPSAT-Plus methodology will continue to be used beyond the life of the project by countries in Africa, Health Systems 20/20 has been working with regional research organizations there to build capacity in HAPSAT data collection, analysis, and use. As described in the Capacity Building section and elsewhere in this annual report, in Year 5, Health Systems 20/20 trained two regional research organizations, one (Institut de Santé et Développement) in Francophone Africa and one (Health Economics and HIV/AIDS Research Division) in Anglophone Africa, on the use of HAPSAT, so that they can help countries in their respective regions carry out HAPSAT analyses that will contribute to the efficiency, sustainability, and country ownership of HIV programs. In Year 6, these organizations will help Benin, Lesotho, and Swaziland, to conduct HAPSAT analyses, with the oversight of Health Systems 20/20.

USING HAPSAT ANALYSIS TO PLAN A SUSTAINABLE OVC SERVICE PACKAGE FOR HAITI

In Haiti, the impact of HIV worsens the already challenged circumstances faced by many children and exacerbated by the devastating 2010 earthquake. To assist in estimating HIV program costs and resources for OVC, Health Systems 20/20 conducted a HAPSAT analysis of PEPFAR-funded OVC programs in Haiti to:

- Improve the understanding of the inputs and costs of providing well-defined services
- Identify gaps in the M&E framework of OVC programs
- Provide vital data to support a quality improvement process being rolled out in 2011

The study analyzed the range of interventions being delivered by four partners. The HAPSAT model then was used to determine the cost of delivering this package to all eligible OVC. Given the substantial costs of such a program in light of the number of OVC who could be classified as being 'in need,' a second, smaller package with lower target levels of coverage was also costed and the gaps between needs and targets highlighted.

The results can assist in the planning and expansion of current programs in a sustainable manner in several ways. By describing a clear and consistent package of care, funding partners will be able to agree on a more specific set of targets, and define indicators to monitor and evaluate progress toward the targets that truly improve the well-being of OVC (impact) rather than merely deliver services (process).

A costed package provides valuable information to funding partners wishing to leverage their efforts by working together. Detailed costing may encourage partnerships by removing the possibility of partner funding ‘disappearing’ into a program and making it easier for partners to report their own individual efforts in impact terms rather than monetary terms. Finally, as partners increase efforts to strengthen Haiti’s public sector, any effort at costing programs is potentially useful information for the many ministries that ought to be involved in providing OVC care.

COMPARING HIV SERVICE COSTS AMONG PEPFAR PARTNERS IN HAITI

At the request of USAID, Health Systems 20/20 conducted a comprehensive costing of HIV services delivered across five USAID-supported health networks in Haiti, to provide a comprehensive understanding of the specific package of services provided to HIV patients. Specifically, this research looked to understand three different areas of enquiry:

- Is there a difference in the packages of HIV services that patients receive?
- Is there a difference in the costs of HIV service packages?
- Is there an association between patient outcomes and costs?

Cost data were collected from 15 health facilities in the five health networks between October 2010 and April 2011. The data collection teams also surveyed facility medical records to glean information on the types of care facilities give their HIV-positive patients. Specific information gathered was on the number of patient visits per year, the quantity of support services delivered per year (i.e., nutritional, cash transfers, transportation fees or the value) and the quantity and type of labs, and antiretroviral (ARV) drugs and non-ARV drugs dispensed.

Results show that there is a difference between HIV service packages, both clinical and nonclinical, on visits by patients per year. Specifically, the study found a difference between the package of care that the providers say they give to HIV-positive patients and what the records show that they receive.

Furthermore, there was a great cost range in service packages, from \$220 to \$429 per ART patient per year. At the individual level, there were very few associations between costs and outcomes, though this could be due to limited outcome data available due to the low number of CD4 counts that were conducted.



COSTING OF NATIONAL HIV/AIDS PLANS HELPS COUNTRIES WIN \$119 MILLION IN GLOBAL FUND GRANTS

As a part of a Global Fund application, a country must provide transparent and detailed cost estimates for reaching coverage targets for the prevention, care, and treatment services for the national HIV/AIDS strategic plan. Using Health System 20/20’s costing of HIV/AIDS strategies in their countries, Papua New Guinea and Angola earned Global Fund approval of their Round 10 proposals for \$50 million and \$69 million, respectively.

Although Health Systems 20/20 was not originally asked to work on the Global Fund Round 10 grant, Papua New Guinea used the project's costing work in its grant application to define how it would spend the funds. The grant was approved for a potential \$50 million over five years to finance part of the country's five-year strategy.

Angola's Global Fund Round 10 proposal was aligned with the National Strategic Plan and focused on PMTCT. In the proposal, the high maternal mortality rate (1,400/100,000) and low contraceptive use (18 percent of which only 6 percent is condom) are described as "the most pressing and urgent health needs in Angola."

MAKING PEPFAR FUNDING TRANSPARENT AND EFFECTIVE: THE HEALTH SYSTEMS 20/20 RWANDA BUDGETING TOOL

USAID/Rwanda and the Centers for Disease Control and Prevention/Rwanda are both using the PEPFAR/Rwanda Budgeting Tool developed by Health Systems 20/20 to prepare their fiscal 2012 Country Operating Plan budgets. The budgeting tool was developed in response to PEPFAR and USAID/Rwanda's desire to establish a more evidence-based system of determining funding levels for HIV clinical services delivered by their implementing partners, the Rwandan and international donor organizations that PEPFAR funds to provide services. Use of the tool will allow the USG agencies to better link the funding they give to partners to results they expect of them, thus improving transparency and accountability.



Susna De/Rwanda

In the past, funding was not rigorously tied to outputs, such as the number of people put on ART in a year, or the expected costs of service delivery. Now, PEPFAR can specify the output and award the level of funding it expects to cover cost of the output, based on the calculations of the budgeting tool.

Tool developers used a "bottom-up" or "ingredients costing" approach in designing the tool. All the inputs needed to provide a specific service were established and costs applied to determine a unit cost per patient per year of that service. Developers followed a decision-tree process to identify all the different patient types and the services received by each. Inputs into each service were determined from the Rwanda HIV treatment protocols.

All clinical services for which PEPFAR provides funding to its implementing partners were included in the costing in order to provide a comprehensive picture of what it costs for a partner to provide those services in a 12-month period. The tool provides a summary of all unit costs but the budgeting part of it only includes those costs for which partners require funding – for example, it excludes the cost of drugs, because these are already paid for centrally and partners do not have to purchase them.

2.3 FINANCIAL RISK PROTECTION

Vision: Health Systems 20/20's vision for financial risk protection in health is to move countries along a transparent and responsible path toward universal health insurance coverage/financial risk protection in a sustainable manner, so that individual people are not denied care for their lack of financial resources.

Strategy: Health Systems 20/20's work to expand financial risk protection comprises both global/regional efforts and country-specific work. For example, it provides targeted technical assistance to countries working to eliminate health care user fees and/or develop health insurance programs. This assistance includes increasing understanding among policymakers and implementers of the challenges as well as benefits of financial risk protection approaches using evidence from studies, discussion and feedback from regional workshops, and practical technical materials. More broadly, it continues to play a role as a global leader in the field; its collaboration relationship with international development agencies accelerates and expands the project's technical impact, enhances project and USAID credibility, and leverages funds.



Marty Makinen/Egypt

Building on the solid foundation of experience and information from Years 1– 4 in areas such as insurance, vouchers, and other financial risk protection activities, in Year 5 Health Systems 20/20 worked with international, country, and subnational entities to establish or strengthen social health insurance programs, community-based prepayment schemes, voucher programs, conditional cash transfers, and other financial risk protection mechanisms that make health care more affordable.

As described below, the project's health insurance handbook, developed for two regional health insurance workshops in Africa in Year 4, is being re-published by the World Bank. The achievements of several countries that moved their health insurance programs forward after attending the workshops are featured. Other country-specific progress was made in Liberia, where a nascent democracy is developing an initial health finance policy and strategy. Health Systems 20/20 also helped India to integrate coverage of PLWHA into insurance plans.

WORLD BANK TO PUBLISH THE HEALTH SYSTEMS 20/20 HEALTH INSURANCE HANDBOOK

In Year 4, Health Systems 20/20 led two health insurance workshops, for countries from Anglophone and Francophone Africa, with participation of the World Bank, World Health Organization (WHO), African Development Bank, and Ministerial Leadership Initiative. During the workshops, the country teams developed a blueprint – realistic, concrete action plans – for moving their health systems toward universal coverage, using Health Systems 20/20's step-by-step *Health Insurance Handbook: How To Make It Work* (<http://www.healthsystems2020.org/content/resource/detail/2697/>).

In Year 5, the World Bank agreed to publish the handbook as part of its Working Paper series. This comes at a crucial time, as many countries are considering and promoting health insurance as the major financing mechanism to improve financial access to health services, as well as to provide financial risk protection. In Africa, several countries have already spent scarce time, money, and effort on health insurance initiatives. However, many of these schemes, both public and private, fail to anticipate

significant challenges: a majority of the population operate in the informal and rural sectors, which are the most difficult to insure; large informal economies, which are difficult to tax; removal of user fees, which eliminates a classic incentive for a person to enroll in health insurance; and limited technical capacity in insurance design and operations. As a result, the schemes still cover only a small proportion of the population, with the poor less likely to be covered. In fact, unless carefully designed to be pro-poor, health insurance can widen inequity as higher-income groups are more likely to be insured and therefore to use health care services.

The handbook is intended to help developing countries think through such issues as they are strengthening and scaling up existing health insurance schemes, or even are just beginning to discuss health insurance. The handbook provides policymakers and health insurance designers with practical, action-oriented steps to deepen their understanding of health insurance concepts, and help them identify design and implementation challenges, consider various options and perspectives, and define realistic steps for the development and scaling up of equitable, efficient, and sustainable health insurance schemes. It includes a map to help stakeholders collectively make decisions that serve the larger interest.

In addition to Health Systems 20/20 and the World Bank, the handbook is used by international donors such as the Japanese International Cooperation Agency, which uses the English version as a primary reference on health insurance in training of Anglophone African experts in Japan. The Africa Region/Healthy Systems for Outcomes office is interested in printing the handbook in French.

YEAR 4 HEALTH INSURANCE WORKSHOPS PRODUCE YEAR 5 RESULTS: EXPANSION OF HEALTH INSURANCE IN AFRICA

As noted in the preceding story, in Year 4, Health Systems 20/20 led two health insurance workshops in Africa with the participation of other donor partners. Many of the 15 countries that attended the workshops have used the blueprints they developed there to move forward their country insurance plans, some with assistance from Health Systems 20/20; others – as intended – have secured support from other donors. Progress in two countries that were already working on health insurance, Mali and Nigeria, are described individually in this section.

Another USAID-supported country, Senegal, is also of note: The health insurance team that attended the workshop returned home with new skills that allowed it to successfully advocate for expansion of CBHI in Senegal. In January 2012, the government will implement a one-year CBHI pilot in three districts (45 local government units, or counties), with support from a USAID bilateral agreement, WHO, and Belgian Cooperation. The MOH has drafted a law to create a “solidarity fund” to subsidize the CBHI premiums. The pilot is significant because it is the first time that the government has tried a coordinated district-level pilot – previously only isolated CBHI schemes existed. If successful, the one-year pilot is envisioned to expand to 21 districts in the two ensuing years.

Other countries are in earlier stages of work on health insurance. Among them, Benin has held various stakeholder workshops, drafted an action plan and budget that has been approved by the President and Board of Ministries. In addition, the government has decided to create a health insurance agency and appointed a senior MOH staff member to direct it.

GOVERNMENT OF MALI APPROVES HEALTH INSURANCE PREMIUM SUBSIDIES – POTENTIAL COVERAGE FOR 1.2 MILLION PEOPLE

Three years of Health Systems 20/20 assistance to expand community-based health insurance (CBHI) coverage in Mali reached an important milestone in Year 5, when in February the President and the Board of Ministries officially adopted the CBHI policy, described as “a national strategy to extend health insurance coverage through mutual health organizations,” and the program One District – One Mutual Health Organization. Adoption of the policy marks the first time the Malian government will subsidize CBHI premiums, making it only the second country in West Africa to do so.

This success was preceded by three years of individual capacity building and institutional strengthening in CBHI policymaking, planning, and budgeting. Health Systems 20/20 and its partners, the Ministry of Health and Social Welfare (MOHSW), World Bank, and Ministerial Leadership Initiative, worked to create a steering committee and a technical committee composed of MOHSW staff and representatives from civil society organizations. To inform policy development, several members of the committees were sponsored for a study tour in Rwanda, where 85 percent of the population is covered by CBHI schemes. In Year 4, a country team of national and local government and NGO representatives attended the Health Systems 20/20-led health insurance workshops, where they developed a CBHI operational plan and budget and honed their advocacy skills.

The MOHSW will begin implementing the CBHI policy with a three-year pilot of schemes in three regions (21 districts) for an expected 1.2 million people, 40 percent of the population in the pilot areas. Lessons learned from the pilot will inform a nationwide scale-up. Health Systems 20/20 helped develop the pilot strategy in Year 5, and in Year 6 will help the government develop the institutional infrastructure to implement the pilots.

In a letter to the USAID Mission, the Malian Minister of Health and Social Welfare praised the project’s technical and financial support of the CBHI initiative. The new policy will bolster current CBHI schemes in Mali, which currently cover only 2 percent of the population. Data suggest that CBHI may help equalize access to health care among different socio-economic levels since CBHI utilization rates among members remained constant across different income levels.

HEALTH INSURANCE SCHEMES: SHARING LESSONS FROM NIGERIA

Nigeria is yet another country that benefitted from the Health Systems 20/20 African Regional Health Insurance Workshop in Year 4. At the workshop, Health Systems 20/20 identified Nigeria as one of several countries that could benefit from follow-up technical engagement, which happened through the Partnership for Transforming Health Systems 2 (PATHS2) project of the Department for International Development (DFID).

In Year 5, a Nigeria team presented on the successes and lessons learned by the country’s National Health Insurance Scheme (NHIS) at the Joint Learning Network for Universal Health Coverage workshop entitled “Expanding Coverage to the Informal Sector,” held in Mombasa, Kenya. Health Systems 20/20 sponsored the team’s attendance.



Ugo Amanyiwe/Nigeria

The NHIS provides free primary services to children under five and free primary and secondary services to pregnant women. In addition to expanding coverage, the NHIS is a means for tackling the Millennium Development Goals for MCH. The insurance scheme aimed to cover 1.1 million pregnant women and children under five in 12 provinces. By March 2011, the team had exceeded that goal, reaching 1.5 million people. An independent USAID study reported that the project “produced significant benefits to its target population and the communities in which they live” and estimated that the NHIS received a 640 percent return on investment. Other achievements of the NHIS project include improved facility infrastructure and quality of services delivery, a strengthened referral system, and elimination of financial burden for enrollees to access maternal and child health services.

The NHIS team also described setbacks. One was having insufficient information for project planning and M&E. The team overcame this by carrying out a baseline survey, which is currently being analyzed to better understand regional health care needs. “It’s often by responding to challenges that we develop innovative solutions,” said Dr. Hong Wang, former Health Systems 20/20 health economist who worked with the team.

REMOVING USER FEES FOR CAESAREANS IN MALI: HAS IT IMPROVED ACCESS?

Women in Mali face a 1 in 15 lifetime risk of maternal death (the corresponding figure in industrialized countries is 1 in 2,800) in part because access to caesareans and other lifesaving obstetric care is extremely low. Caesarean rates in 2005 were below 1 percent of live births. In 2005, the Government of Mali removed user fees for caesarean sections in all public sector facilities. By eliminating the financial barrier to life-saving emergency obstetric care it intended to reduce maternal and neonatal mortality rates throughout the country. Health Systems 20/20 and USAID’s ATN Plus bilateral program worked with Mali’s MOH to evaluate the effects of the policy on access to caesareans and identify remaining barriers. The study, begun in Year 4, published its findings in the April 2011 report, *Improving Access to Life Saving Maternal Health Services: The Effects of Removing User Fees for Caesareans in Mali* (<http://www.healthsystems2020.org/content/resource/detail/2837/>).



Health Systems 20/20/Mali

Findings showed an increase in caesarean rates across all regions of Mali between 2005 and 2009, and a decline in maternal and neonatal deaths after caesareans from 2006 to 2009. However, an analysis of the socioeconomic status of women who underwent caesarean sections in 2010 shows that the policy disproportionately benefits wealthier women. Community-based funds that finance the transport of women from community health centers to district health centers do not always function, and communication links between facilities remain weak. Other obstacles include a shortage of blood in facilities performing caesareans, problems with the state-provided caesarean kits, and skepticism among health providers about the sustainability of the fee exemption policy.

Study recommendations include establishing an affordable and reliable transport system between villages and the community health centers, reviewing the content of the caesarean kits, establishing sufficient blood banks and a policy for blood collection, and developing a long-term strategy to address the

sustainability of the policy. The MOH has begun working on programmatic changes based on the recommendations and will continue to use the findings to improve policy implementation.

The study has received wide interest and reaction in various venues. In March 2011, the Reproductive Health Division/ National Health Directorate presented the findings at the MOH/ National Health Directorate conference on user fee exemption policies; held in Bamako, the conference was well attended by representatives from government ministries, agencies, and directorates, health facilities at various levels, civil society organizations, and international partners including USAID, Médecins Sans Frontières, Ministerial Leadership Initiative, UNICEF, and the West African Health Organization. Health Systems 20/20 presented the study at the 38th Annual International Conference on Global Health in Washington, DC, and at the 8th World Congress on Health Economics in Toronto, sponsored by the International Health Economics Association. It also was circulated among the African Community of Practice, a virtual community with over 1,400 members from 87 countries that works to build capacity to manage development results through sharing experiences and networking between practitioners in Africa and around the world.

SUPPORTING LIBERIA'S FIRST HEALTH FINANCING POLICY AND STRATEGIC PLAN

Liberia is emerging from more than 15 years of conflict and its health system faces critical post-conflict financing issues. Donors finance 50 percent of total health expenditures, households 35 percent. About 80 percent of the health services are provided by NGOs. Due to the high level of poverty (GDP per capita is US\$130 compared to \$879 for sub-Saharan Africa and \$373 for low-income countries), Liberia's MOHSW has suspended the administration of user fees at the primary health care level. Despite this policy of free care for all, out-of-pocket health expenditures are high. Liberia also faces the reduction of donor funding. Consequently, the MOHSW is in the process of identifying other methods to increase the adequacy and sustainability of health revenues.



Ellen Offner/Liberia

In Year 5, Health Systems 20/20 helped the MOHSW make rapid, visible progress in health financing in terms of equity, accountability, and impact on health (measured by use of essential services). Specifically, it worked with the ministry to develop the first Health Financing Policy and Strategy to support the National Health and Social Welfare Financing Policy, 2011–2020.

To inform these documents, Health Systems 20/20 did a situational analysis of current health financing in Liberia. Its primary conclusion was that “Liberia should move away from across-the-board free health care towards some targeting mechanisms for the poor and vulnerable coupled with alternative financing mechanisms.” Specific recommendations included the following:

- **Translate vision into the government position:** Begin building high-level political support for making this vision the official government position on health care financing. Government leadership and commitment do not guarantee success, but without them there will certainly be no progress.

- **Clearly delineate services to be fully subsidized and services to be provided on a cost-sharing basis:** Public subsidies should be redefined in a way that is affordable and realistic. Lack of clear delineation will crowd out financing methods such as CBHI, a voluntary mechanism that will not succeed while health services are provided for free.
- **Provide financial risk protection:** Existing means of solidarity and risk pooling need to be further explored as entry points for CBHI. Pilots need to be undertaken to better understand how community financing can be set up and then scaled up in the large informal sector.
- **Strengthen performance-based financing:** Ensuring that mobilized resources are used in an efficient manner goes beyond delineating services for resource allocation – it needs to be accompanied by a payment mechanism that encourages efficiency. Therefore, ongoing efforts in the area of performance-based financing need to be harmonized and scaled up.

Based on the Health Systems 20/20 data, the MOHSW developed its first Health Financing Policy and Strategic Plan. In addition, Health Systems 20/20 in collaboration with World Bank provided quality assurance to plan development and in fact redrafted the document. The document is undergoing a final review by MOHSW senior management and a committee drawn from different ministry departments. It will be circulated to stakeholders outside the ministry for a final round of comments, after which it will be submitted to the Cabinet.

The Deputy Minister of Planning used the Health Systems 20/20 data, along with project technical assistance, to develop a presentation, "Is Free Care Truly Free and Equitable? The Case of Liberia," for the annual African Health Economics Association conference in March 2011. The presentation explored the policy's financial ramifications on households, as well as the lessons learned. It shared Liberia's experiences with a regional audience that included countries finding themselves in the midst of similar health financing debates.

INTEGRATING PLWHA INTO SOCIAL PROTECTION BENEFITS IN INDIA

India ranks third in the world in terms of greatest number of PLWHA. Approximately 2.27 million Indians are living with the disease¹. With a population of more than 1 billion, a mere 0.1 percent increase in HIV prevalence would increase the estimated number of PLWHA by more than half a million. Currently, HIV/AIDS is the fifth most common cause for life-years lost and the eighth most common cause of mortality in India. The relatively high mortality due to HIV/AIDS is indicative of poor access to care and treatment services. However, despite the obvious need and demand for health insurance, PLWHA are typically excluded from traditional health insurance policies in India, regardless of ability to pay or health or employment status. No HIV-related services are offered under employer-based schemes and PLWHA employees are excluded from such schemes solely on the basis of disease status.

The Government of India is now exploring options to sustain HIV/AIDS services and better integrate PLWHA into social protection benefits, including insurance. To help the government do this, in Year 5 Health Systems 20/20 published *Risky Business? Financial Protection for People Living with HIV/AIDS, A Review of International Experiences* (<http://www.healthsystems2020.org/content/resource/detail/2800/>).

¹UNAIDS, WHO, and UNICEF. 2008. Epidemiological Fact Sheet on HIV and AIDS: Core data on epidemiology and response.

The report describes aspects of incorporating HIV coverage into health insurance schemes such as policy and regulatory environments, financing and cost experiences, and benefit packages. It diminishes the prevailing misconceptions in India about the costs/implications of HIV, demonstrates that it is possible to mainstream HIV/AIDS into health insurance, and recommends ways for India to better mainstream HIV into the insurance sector. For example, the largest gap to India mainstreaming HIV is the paucity of data to do actuarial analysis; limited data on health care utilization and costs for PLWHA make it difficult or impossible to appropriately cost a benefit package inclusive of HIV-related services. Furthermore, mainstreaming HIV will require multi-stakeholder buy-in from the Insurance Regulatory and Development Authority (IRDA), insurance companies, employers, Ministry of Labor, MOH, National AIDS Control Organization (NACO), beneficiaries, and others. Despite the challenges noted, Health Systems 20/20 finds that India has a strong foundation upon which to build a solvent insurance industry for PLWHA.



Alison Comfort/India

Report findings were presented at the “Mainstreaming HIV/AIDS: Role of the Insurance Sector Conference,” co-sponsored by Health Systems 20/20, Population Services International (PSI), NACO, and IRDA. The conference was a huge success, with over 200 participants, buy-in from government agencies including NACO, IRDA, the ministries of Health and Finance, and interest from several donors (World Bank, UNICEF, UNAIDS, DFID).

2.4 GOVERNANCE

Vision: Health Systems 20/20's vision for health governance is that, in project-assisted countries, health ministries provide leadership and regulatory oversight for improved health policies, programs, and practices; increase transparency and efficiency in policy and resource allocation/management processes; pursue dialogue and consultation with elected officials and communities on plans and performance; and strengthen anti-corruption and accountability systems. Civil society and the private sector will participate to a greater degree than before in service delivery, oversight, and advocacy regarding policy, planning, and resource allocation to increase the effectiveness, transparency, accountability, and equity of health systems.

Strategy: Health Systems 20/20's focus in Years 1–3 was building knowledge and understanding of health governance concepts, approaches, and tools among health system actors and the international health community and identifying governance demonstration activities. In Years 4 and 5, emphasis has shifted to documenting the results of field demonstrations, clarifying governance-related activities already undertaken, and embedding governance more explicitly in ongoing activities. This approach has led to a greater recognition of the health governance implications of Health Systems 20/20's work. The project put together for USAID a review of how health governance is integrated into 29 ongoing activities (see full report at <http://www.healthsystems2020.org/content/resource/detail/2845/>). For example, within Resource Tracking, policy communication tools have been developed to improve how mid-level managers communicate NHA findings to policymakers, improving the link between policy and resource allocation procedures. Within Capacity Building, the institutionalization of HSS methodologies in regional institutions in Africa increases private and non-profit sector involvement in health systems oversight and analysis and the likelihood that decision makers in countries in the region will seek out and use the methodologies. In addition, developing and documenting a stakeholder engagement process for HSAs, found under Measuring Health System Performance, has led to increased civil society engagement with health systems such as Guyana's.

While integrating governance approaches has led to many successes, several stand-alone Year 5 Governance activities contributed to the strengthening of linkages between citizens, health providers, and government. Health Systems 20/20 published a process guide for countries and groups interested in using Quality Assurance Partnership Committees (QAPCs) to provide a mechanism by which providers, citizens, and local politicians collaborate to find ways to improve and expand use of health services. Country-specific activities included developing a tool to streamline the financial management of NGO health services in Afghanistan, assisting the Liberian MOH to write health care legislation, and assessing how Nigerian government agencies incorporate HIV services into the workplace.

THE QUALITY ASSURANCE PARTNERSHIP COMMITTEE PROCESS GUIDE: IMPROVING HEALTH CARE SERVICES THROUGH GOVERNMENT/HEALTH FACILITY/CITIZEN INTERACTION

In Years 3 and 4, Health Systems 20/20, in cooperation with USAID/Philippines, conducted a pilot demonstration of citizen participation in health governance. In three sites in Mindanao, Health Systems 20/20 supported the establishment of QAPCs, facility-based governance committees of local leaders and government officials, health service providers, civil society, and community representatives that addressed issues related to access, availability, and quality of maternal and child health related services in local facilities. Anecdotal evidence suggested that community participation via the QAPCs contributed to client-focused and responsive MCH service delivery, expanded outreach from the facility to MCH service users, and increased MCH service utilization, and that facility responsiveness to community needs and preferences increased.

In Year 5, Health Systems 20/20 published the *QAPC Process Guide* based on the framework developed for the Mindanao QAPC demonstration project design and management, field experiences, and lessons learned. The guide provides steps and suggested actions for how to set up, operate, and sustain a QAPC to enhance ongoing quality assurance programs. While the demonstration project focused on MCH-related services, the QAPC mechanism can also be used for other service areas. The intended audience for the guide includes local government health officials, regional MOH staff, and facility managers interested in reinforcing a customer focus in service delivery through increased community participation (<http://www.healthsystems2020.org/content/resource/detail/3007/>).

USING TECHNOLOGY TO STRENGTHEN NGO PROGRAMMATIC AND FISCAL ACCOUNTABILITY IN AFGHANISTAN

A Health Systems 20/20 NGO financial management assessment in Afghanistan in early 2011 documented the need for a technology solution to streamline current redundant, manual – and therefore time-consuming and costly – NGO reporting to the Ministry of Public Health (MoPH), NHA team, and international donors. Using technology to automate the reporting process would benefit NGOs, the MoPH, and donors.

- NGOs would spend less time preparing myriad reports, thus reducing their indirect costs and allowing them to spend more time and money on service delivery.
- The MoPH task of transferring financial reports to donors would be less cumbersome, and data for NHA would be more accurate.
- Donors would receive more accurate and timely reports, allowing them to spend more on direct costs and service delivery.

The Expenditure Management Information System (EMIS) was identified as the software solution to harmonize NGO reporting to the MoPH and donors. Health Systems 20/20 and the MoPH are currently coordinating EMIS technical development and pilot implementation within the ministry and with NGOs. In June, MoPH and project representatives traveled to New Delhi, India, to work with the EMIS developer to incorporate linkages with the MoPH information systems and stakeholder needs.

EMIS has evolved from a software solution for generating accurate and timely financial reports for the MoPH, NHA team, and donors to a more robust system that also provides:

- Double-entry accounting functionality
- Financial data analysis functionality
- Internal controls for user access and manipulation of financial data

EMIS also has a customized chart of accounts to include line items required for USAID, World Bank, and European Union financial reports and NHA reports.

In August, a Beta EMIS was introduced to the MoPH Health Economics Financing Directorate, Finance team, Grants Management Unit, and NGOs to engage them in the development process. Based on feedback, developers made system enhancements. In September, 19 NGOs in various provinces



Health Systems 20/20/Afghanistan

throughout Afghanistan began a pilot test of the EMIS. Health Systems 20/20 and the MoPH will hold EMIS workshops in the pilot areas.

OVERHAULING PUBLIC HEALTH LEGISLATION IN LIBERIA

Very little of Liberia’s legal infrastructure governing the delivery of health care survived the country’s 14-year civil war. In addition, most of the law and regulations still in place dated back to 1976 and need to be adapted to current health trends. The Liberian MOHSW has deemed building a transparent legal and regulatory foundation for the health sector a necessary precondition for the successful implementation of the National Health Policy and National Health Plan.

Health Systems 20/20, in conjunction with the Senior Lawyer Project (SLP) and the American Bar Association (ABA), has been working with the MOHSW and the Office of General Counsel to build governance and regulatory structures and systems by revising health and pharmaceutical laws, treaties, policies, and/or regulations. Throughout Year 5, SLP and ABA worked to untangle unclear health care financing rules in order to implement Liberia’s health financing policy, also anti-corruption measures; overlapping institutional mandates; licensing of health care professionals, hospitals, and medical schools; and policies affecting orphanages and the adoption process. Also in Year 5, they helped draft a law creating the Liberian Medicines and Health Products Regulatory Agency; the law – which was passed recently – will give Liberians better access to essential medicines.

In Year 6, SLP will continue to work with the MOHSW to develop regulations to implement the law, develop legislative reform strategies and build consensus to adopt and implement comprehensive mental health legislation, and establish an independent pharmacy board and a general counsel that will draft future legislation and contracts.

TAKING STOCK OF PROGRESS ON “MAINSTREAMING” HIV/AIDS ACTIVITIES IN NIGERIA

“Mainstreaming” HIV refers to adapting the policies, programs, and workplaces of public and private sector institutions to ensure they address the underlying causes of vulnerability to HIV infection and the consequences of HIV – how the policies and practices of each sector contribute to the spread of HIV, how the epidemic is likely to affect goals and productivity, and how each sector can respond to HIV.

In Nigeria, nearly 3 million people currently live with HIV, and adult prevalence is 4 percent. To strengthen its stewardship of HIV prevention and mitigation efforts, the Nigerian government asked its ministries, departments, and agencies (MDAs) to identify sector-specific factors that increase HIV vulnerability, and how the sectors mainstream HIV-related policies and services. For example, do workplaces have programs to educate workers about HIV transmission? Do they have policies to prevent discrimination against HIV-positive employees? Do they pay for employee counseling and testing, and treatment? Do their other policies – such as mining camps prohibiting workers’ families



Ugo Amanyiwe/Nigeria

from residing there – have unintended consequences, such as men visiting sex workers, thereby exacerbating the spread of HIV?

In Year 5, Health System 20/20 completed a study for the National Agency for the Control of AIDS (NACA) that found that Nigeria MDAs have made impressive strides in implementing HIV mainstreaming activities. All interviewed MDAs had conducted HIV prevention training with their staff, nine had already implemented workplace policies, and another six are currently developing workplace policies. In addition, 12 MDAs have implemented sector-specific activities, such as creating educational modules on HIV or youth mentoring programs.

Nevertheless, there are still challenges to HIV mainstreaming that need to be addressed. Many MDAs lack line item budgets for HIV mainstreaming activities. Many policymakers, both within MDAs and the National Assembly, feel that NACA should fund the activities with external donor funds. Furthering HIV mainstreaming activities will require NACA to clarify its role with MDAs, train MDAs on how to advocate for HIV activities, and identify strong champions at the senior management level to advocate for HIV mainstreaming at the National Assembly.

IDENTIFYING WAYS TO STRENGTHEN PUBLIC HEALTH EXPENDITURE MANAGEMENT SYSTEMS IN NIGERIA

Resource allocation and the effective use of resources have been major problems in Nigeria, particularly in the health sector. A 2008 HSA conducted by Health Systems 20/20 found significant weaknesses in health resource tracking across government levels. The HSA recommended a more detailed review and analysis of the country's public health financing mechanisms so that government agencies could improve their systems in a way that would ensure efficient and effective allocation and use of their health resources.

In Year 5, Health Systems 20/20 initiated a Public Expenditure Management Review (PEMR) in three Nigerian States (Cross River, Nasarawa, Sokoto), complementing a similar exercise run by the DFID-supported PATHS2 project in four other states (Enugu, Jigawa, Kaduna, and Kano). The PEMR examines the flow of funds from the central government down to decentralized levels and to service providers, as well as the overall governance environment of public expenditure management.

Preliminary results of the PEMR show a widespread lack of accurate financial record keeping and reporting, especially at lower levels. Weak budget execution undermines the credibility of the budget and planning process at the state and local levels. There is evidence of a weak link between resources spent and facility conditions, suggesting that resources are not effectively utilized. The PEMR reports (forthcoming in Year 6) will highlight major system weaknesses and gaps and provide concrete recommendations for the state and local governments on how to improve their expenditure systems for better resource management.

2.5 HUMAN RESOURCES FOR HEALTH

Vision: Health Systems 20/20's vision is for regional and country-level institutions to have in place comprehensive HRH systems that include the necessary organizational structures, tools and processes, and human capacity to plan, develop, deploy, and support the health workforce to meet the needs of the population.

Strategy: As one of the six health system building blocks, HRH is a critical component of Health Systems 20/20's overall work in that HRH systems-strengthening initiatives help in-country counterparts to effectively implement health care priority activities. Health Systems 20/20 plays an important role in the area of HRH by complementing and contributing to the body of knowledge of other projects and organizations, including the WHO Global Health Workforce Alliance, the World Bank, and CapacityPlus. The strategy is to provide countries and health ministries with decision-making information, tools, and skills that enable them to make fiscally sound strategic choices in HRH strengthening.

Year 5 was highlighted by specific attention to providing evidence for policymakers and program managers to take priority actions that strengthen HRH. These interventions included documenting lessons learned in pre-service medical and nursing education initiatives supported by USAID over many years; testing financial and nonfinancial incentive systems to improve health workforce retention, performance, and productivity; and assessing differences in performance, retention, and motivation between faith-based organizations and public sector providers.

EVALUATING PRE-SERVICE EDUCATION TO IMPROVE HEALTH WORKER PERFORMANCE

Since the early 1980s, USAID has led the global donor community in supporting more than 788 pre-service education programs in Africa, Asia, and Latin America. The programs have focused on a broad array of pre-service education issues: medical, nursing, and midwifery curriculum development; skills development; supervision; provision of tools, assessment and evaluation instruments, and training materials; strengthening of community-service delivery linkages; quality of care; and expanded access to care.

Although USAID-supported activities in the recent past have moved health workforce development forward and produced measurable results, to date, there has been no comprehensive synthesis of lessons learned in the pre-service arena. In Year 5, Health Systems 20/20 collected and synthesized pre-service education lessons learned over the past decades to better inform future program design and decision-making.

To do this, Health Systems 20/20 conducted content analysis of documents and curricula used for pre-service education programs for physicians, nurses, and midwives in the past 25 years, and in-depth interviews with people designing, implementing, and monitoring the impact of pre-service education activities. This culminated in the development of a comprehensive report that makes recommendations about how to shape future pre-service education activities and agendas to respond to HRH challenges.



Christine Ortiz/Zambia

Some of the recommendations for future pre-service education programs include the need to prioritize faculty and students, by building research capabilities and supervision skills, and creating a career ladder for tutors. Access to IT and knowledge on how to use it is critical. Furthermore, it is important for pre-service education programs to initiate clinical practice early and sustain a high volume of practice over time to establish and maintain competencies.

STRENGTHENING, EXPANDING, AND REDISTRIBUTING THE HEALTH WORKFORCE IN COTE D'IVOIRE

In Year 5, Health Systems 20/20 continued strengthening HRH in Cote d'Ivoire through a multi-pronged approach of PBI, pre-service training, and building local management capacity. Although a disputed presidential election led to a political crisis that first slowed, then suspended work for more than half a year (October 2010 to May 2011), the incentive scheme for retention of HRH in hardship posts was expanded, institutional support was provided to pre-service training schools, and management capacity at decentralized levels continues to be supported.

In Year 5, Health Systems 20/20 began the close-out and final evaluation of a scaled-up PBI pilot to test incentives intended to re-staff health facilities in underserved areas. Human resource assessments conducted in 2005 and 2006 found that HRH in Cote d'Ivoire were geographically maldistributed, with 60 percent based in and around the country's commercial capital of Abidjan, leaving many rural areas underserved. In response, Health Systems 20/20 worked with the Ministry of Health and the Fight Against AIDS (Ministère de la Santé et de la Lutte contre le SIDA, or MSLS) and District Medical Offices to pilot a PBI scheme in Ferkessedougou District. The incentive program offered three possible types of incentives: a monthly 10 percent salary top-up, a quarterly pay-for-performance bonus, and a quarterly performance bonus to facilities participating in the pilot. The incentive pilot began in six facilities in 2009; when the first phase showed promising results – such as 94 percent of staff being retained in the first 12 months of the pilot, six new graduates (three nurses, two midwives, and one lab technician) agreeing to serve in the pilot facilities, and availability and access to HIV and other priority health services increasing – the pilot was scaled up to 11 facilities before it concluded late in Year 5.

Health Systems 20/20 also continued financial and training support to INFAS, Cote d'Ivoire's leading nurse training institution. Financial support since 2007 has covered the emergency hiring of 35 (20 new and 15 retired) instructors to strengthen the school's practical and theoretical training at four INFAS campuses (Abidjan, Aboisso, Bouake, and Korhogo). This produced a more adequate student-to-teacher ratio about 1:28 (vs. 1:39 without supplemental hiring); improved student attendance, mentoring, and oversight; and a strengthened INFAS management team, which realigned the curriculum to match local needs. In Year 5, Health Systems 20/20 phased out salary support and focused on strengthening INFAS organizational capacity and training curricula. Earlier project efforts to strengthen the INFAS library led in Year 5 to requests to do the same for the library at the training institution for social work; Health Systems 20/20 provided equipment, reference materials, Internet connectivity, and upgrading of staff skills.

Health Systems 20/20 also continued its support of MSLS institutional capacity building. For several years, the project has been helping to strengthen the MSLS unit in charge of decentralization (Services d'Appui aux Services Exterieurs et a la Decentralisation, or SASSED); it worked with the MSLS to update the physical infrastructure of the SASSED offices, including installation of basic IT systems allowing for staff to monitor decentralization activities. In Year 5 it did training of trainers on the implications of decentralization and helped SASSED develop a framework for accountability and collaboration for decentralization. This included starting a technical working group with members of the MSLS, Ministry of Interior, Union of Towns and Communes of Cote d'Ivoire, and Assembly of Districts and Departments

of Cote d'Ivoire that will become active in Year 6. It has also begun an assessment of an earlier training of MSLS regional and district managers on management and leadership, to be published in Year 6.

IMPROVING WORKFORCE PLANNING IN EGYPT

Workforce planning is a strategic objective of the health sector reform program in Egypt. Health Systems 20/20, in conjunction with the Egyptian Ministry of Health and Population (MOHP), has been developing a strategic MOHP workforce plan and building capacity within the MOHP to predict and fill Egypt's HRH needs. To help build capacity for workforce planning in Egypt, Health Systems 20/20 has worked on multiple projects utilizing technology, assessing select governorates for HRH needs, and developing protocols for the MOHP.

To help project current and future HRH needs, Health Systems 20/20 has created an Access-based software program that allows the estimation of gaps between current and required workforce. This system will be useful in projecting needs of specific health facilities and allow for more even distribution of the workforce.

To further help understand HRH needs and distribution, Health Systems 20/20 performed a Hospital Workforce Assessment Pilot in a hospital located in the Gharbia Governorate. This pilot was then scaled up to do 30 more hospital workforce assessment reports covering all MOHP general and district hospitals in the Assiut, Gharbia, and Luxor governorates. The workforce assessment findings from the three governorates were well received by the MOHP and further scale-up efforts are being discussed.

Finally, an effective, valid workforce planning model was developed for the Egyptian context. The model quantified the magnitude of staff imbalances by governorate, specialty, and staff category. But policies are needed to close the gaps observed between the need for and supply of health workers for all levels of service provision.

To address the findings of the assessments, both from the computer system and the Hospital Workforce Assessment Pilot, Health Systems 20/20 created staff productivity and workload standard protocols for hospitals. Representatives from the MOHP hospitals believe that these protocols, which stakeholders believe should be adopted by the MOHP, could be the motivating force to pave the way to health insurance being introduced to different health facilities in Egypt, since using the contracting system will necessitate accurate estimation of the required workforce.



Marty Makinen/Egypt

USING NONFINANCIAL INCENTIVES TO IMPROVE PERFORMANCE AND RETENTION AMONG HEALTH WORKERS IN SWAZILAND

Swaziland's HIV/AIDS prevalence rate among adults is among the highest in the world. A shortage of trained health personnel and suboptimal productivity within the existing workforce are key impediments to scaling up HIV/AIDS prevention and treatment. In 2009, Health Systems 20/20 began pilot-testing a 12-month operational research study to assess the effect of a nonmonetary incentive scheme aimed at increasing the performance of public health workers in providing HCT, and measure the effects on provider retention.

All government facilities offering HCT services were randomly assigned to equal-sized treatment and control groups. Based on the initial assessment and consultation with the MOH and other key stakeholders, the HCT target rate was set at 7 percent of a facility's quarterly clinic patient load. Facilities that achieved their targets were eligible for a nonmonetary incentive, which they could select from a pre-set menu that included laptop computers, additional training, infrastructure upgrades, and extra HCT equipment. The study employed a baseline and endline job satisfaction surveys of health workers and head nurses. Additionally, qualitative research was conducted in the treatment facilities to better understand how the incentive program affected health worker productivity, facility operations, and retention of staff.

Results from the quantitative survey published in Year 5 show that the program had a modest impact on HCT performance and no impact on job satisfaction. The qualitative analysis undertaken revealed that the incentive stimulated performance by creating a competitive spirit, greater teamwork, and improved access to testing services. Treatment facilities that failed to increase HCT performance sufficiently to receive the incentive cited unrealistically high targets and logistical impediments to increasing tests given as their main challenges. An unintended but positive consequence of the study was an improvement of data collection systems for tracking HCT performance at public facilities.



Marc Luoma/Swaziland

HOW TO INCREASE HEALTH WORKER PRODUCTIVITY IN ZAMBIA

Zambia, with an adult HIV prevalence of 15.2 percent, has a great need to increase its HRH. The country faces an acute shortage of health care professionals and needs to find ways to increase productivity of the HRH who are available. Health Systems 20/20, in collaboration with the Health Services and Systems Program and the Zambian MOH, implemented a demonstration project to explore the effectiveness of a stakeholder-driven participatory productivity improvement process.

Results show that most cadres of health care providers spent the majority of their days engaged in productive activity, but not necessarily in direct patient care (see Table 2). Health workers also reported that equipment and supply shortages impacted the quality of service and that to improve patient care there is a need to increase on-the-job training. Furthermore, lack of resources and time are two key obstacles in increasing productivity, while staff resistance to the interventions was minimal.

TABLE 2. MEAN DISTRIBUTION OF TIME SPENT IN DIRECT PRODUCTIVE PATIENT CARE

Cadre	Control Group	Intervention Group
Physicians	40%	28%
Nurses	36%	50%
Clinical officers	36%	33%
Midwives	31%	47%

The participatory productivity improvement process had effects on multiple levels in the intervention facilities. At the individual level, staff showed reduced absenteeism and tardiness and developed new skill sets and increased motivation and accountability. At the facility level, there were more organized workplaces, enhanced human resource management, increased utilization of staff time on patient care, and maximization of staff skill across units. And finally, on the community level, there were fewer patient complaints and increased use of health facility services.

HOW DO MOTIVATION AND PERFORMANCE FACTORS COMPARE IN FAITH-BASED AND PUBLIC FACILITIES IN UGANDA AND MALAWI?

Many believe that faith-based health facilities in sub-Saharan Africa are more efficient in service delivery than public facilities and that faith-based health facility workers are more satisfied with their jobs, leading to better job retention, than are public sector health facility workers. This popular belief stems from the idea that faith-based health facilities have better cohesion and working environments, which have been proven to influence job satisfaction and retention. However, this theory has not undergone critical scientific analysis.

To address this information gap, Health Systems 20/20 conducted research in Uganda and Malawi to gain a better understanding. In Uganda, researchers interviewed 311 health workers from 91 health facilities, both public and faith-based, from 20 districts; in Malawi, they interviewed 602 health workers from 163 health facilities from every district in Malawi. In Malawi, they also conducted interviews with 612 clients. Both qualitative and quantitative data were collected in a baseline and endline study.

Results from the two countries show that when comparing faith-based health facilities with public sector facilities, religiosity is an important driver for motivation, but it exists at the individual and workplace level in the public as well as faith-based facility. Intrinsic motivation levels are largely not associated with satisfaction about compensation packages; rather, the drivers of intrinsic motivation are professional development and promotional opportunities and overall a sense of fairness of compensation.

2.6 MEASURING AND MONITORING HEALTH SYSTEM PERFORMANCE

Vision: As HIV/AIDS, TB, and malaria services transition to a focus on sustainability and integration, it is vital to understand the state of the health systems in which these services are being delivered. Strong health systems will deliver effective, safe, quality health services, with as much efficiency as possible. Health Systems 20/20's vision is to empower countries and development partners to achieve such health systems by providing for the countries and partners innovative tools to produce high-quality data to measure and monitor health system performance, as well as by building their capacity in analyzing data for decision-making.

Strategy: A central Health Systems 20/20 strategy is to enhance global resources for measuring health system performance and to enable stakeholders to use the data to inform national strategies. Specifically, the Health Systems 20/20 strategy entails: 1) creating web-based databases and dashboards that compile and analyze country data, allowing health managers to quickly access assessments of specific health issues and benchmark performance against peer groups; 2) conducting HSAs to provide a comprehensive overview of key system functions organized around the WHO health system building blocks: governance, health financing, service delivery, HRH, pharmaceutical management, and HIS. HSAs serve as the basis for national health strategic plans, recommendations for targeted technical assistance, and inputs to international funding requests; and 3) promoting strengthened geographic and health information systems, which efficiently produce routine information necessary for health sector decision making.



In Year 5, Health Systems 20/20 further updated the Health Systems Database using the most recent WHO, World Bank, DHS, and other data sources; Google Maps and Data in Motion were incorporated to allow users to create more dynamic presentations of data. The project modified the HSA approach – and accompanying manual – based on field experience from more than 20 countries to enhance the stakeholder engagement process and ensure country ownership, update the component indicators, and strengthen the incorporation of the private sector. It helped six Eastern Caribbean nations and Ukraine to do their first HSAs and issued preliminary results. In Kenya, the Master Facilities List (MFL) on which the project has been working with the country's health ministries was formally launched and the country's AIDS program helped to improve its M&E framework, to better coordinate HIV/AIDS services.

HEALTH SYSTEMS 20/20 DATABASE GETS ADDITIONAL FEATURES

In Year 3 (September 2009) Health Systems 20/20 launched the Health System Database, (<http://healthsystems2020.healthsystemsdatabase.org/>) a web-based tool that allows users to analyze and compile standardized country data from internationally comparable sources such as the WHO, World Bank, and country DHS. The database provides stakeholders with a broader understanding of their country's health system and helps them to benchmark performance against other countries or regions, and monitor progress toward achieving goals. The Health Systems Database accompanies the *Health Systems Assessment Approach: A How-To Manual* and closely mirrors the framework and quantitative analysis presented in the manual.

Since its launch, the database has undergone continuous improvements to maintain its high level of quality and ensure user satisfaction. In Year 4, new data sources were added and the database introduced the customizable "My Health Dashboard" page, which allows users to construct a user-specified dashboard, selecting indicators of interest and constructing and displaying customized data

tables, maps, charts, and graphs. The original dashboard was for the health system. In Year 5, dashboards were created for priority health areas: MCH, family planning and reproductive health, TB, malaria, and HIV/AIDS.

Another addition is the Sub-national Data Display, which presents selected indicators from the DHS and displays them on Google Maps for different regions within a country. The indicator values are color coded to indicate whether they are above or below the national average.

ADDITIONAL COUNTRIES DO HEALTH SYSTEM ASSESSMENTS – AND USE THE FINDINGS

The USAID Health System Assessment tool was developed and piloted in 2005-2007 in assessments in Angola and Benin. Since then, the tool has been used in 29 countries with a variety of objectives, ranging from USAID-driven internal assessments of bilateral programs to MOH-driven assessments to inform HSS planning and health sector strategic and investment plans. A few countries have done multiple HSAs; Vietnam has done multiple subnational assessments.

Table 3 lists the documented use of the tool, by year. Health Systems 20/20 has participated in 23 assessments: 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.

In Year 5, Health Systems 20/20 helped conduct HSAs in six Eastern Caribbean nations and Ukraine.

TABLE 3. DOCUMENTED USES OF HSA, SEPTEMBER 30, 2011

Country	Year	Requested by	Objective
Angola	2005	USAID	Inform the design of an integrated health project
Azerbaijan	2005	USAID	Input into pharmaceutical management
Benin	2006	MOH	Input for 5-year health strategy
Pakistan	2006	USAID	Inform health system activities
Yemen	2006	MOH	Framework for health system review
Malawi	2006	USAID	Input into bilateral design
Ghana	2006	USAID	Input into assessment of insurance
South Sudan	2007	MOH	Input into GAVI health systems strengthening (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 GF proposal
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
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 8 provinces
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

Country	Year	Requested by	Objective
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	Inform GHI HSS strategy and national health strategy

EASTERN CARIBBEAN: USING HSA TO DETERMINE TECHNICAL ASSISTANCE NEEDS FOR HIV/AIDS

Health Systems 20/20 branched out into a new region in Year 5 – the Eastern Caribbean – doing HSAs in six countries. The HSAs also took on a new attribute, as they were done in tandem with a private health sector assessment by the USAID Strengthening Health Outcomes through the Private Sector (SHOPS) project. The assessments were to assist the efforts of the U.S.-Caribbean Regional HIV and AIDS Partnership Framework 2010-2014, which comprises 12 Caribbean countries and seeks to promote results in HIV prevention, strategic information, laboratory strengthening, human capacity development, and sustainability. The USAID/Barbados and Eastern Caribbean Mission oversees both HSS and private sector engagement – key to sustaining HIV/AIDS programming – and tasked Health Systems 20/20 and SHOPS with providing technical assistance on these topics.

After an initial literature review on health systems and the role of the private sector in all 12 Partnership Framework countries identified knowledge gaps, USAID and the two projects identified six of the 12 countries for assessments: Antigua and Barbuda, Dominica, Grenada, St. Kitts and Nevis, St. Lucia, and St. Vincent and the Grenadines. Aiming as always to ensure an inclusive, country-owned approach, the assessment teams hosted a regional stakeholder engagement meeting in Barbados (attended by 62 participants representing 10 countries in the Partnership Framework) and six country-level meetings to identify local health systems priorities and build consensus around the assessment process. Team members then conducted in-depth interviews with up to 110 key stakeholders in each country. Preliminary findings and recommendations were presented to key stakeholders and senior officials, including some of the Ministers of Health, at debriefing meetings held the last day of each assessment week. Experts from the International Training & Education Center for Health (I-TECH, funded by the U.S. Health Resources and Services Administration), the Caribbean HIV/AIDS Regional Training

Network (CHART), the Pan American Health Organization (PAHO), and regional consultants participated in the assessments.

Overall, country stakeholders expressed enthusiasm for the assessment process and preliminary recommendations, as well as opportunities for technical assistance in Year 6: Findings confirmed the human resource shortages in the region and underscored the challenges local health systems face in trying to address these shortages. There is significant interest in developing national health insurance schemes throughout the region; however, there is a lack of data on health sector costs and utilization, both of which are essential for developing efficient, sustainable insurance schemes. There is also a need to conduct an NHA estimation in order to better measure health expenditures in each country, especially private sector spending. Weak HIS impede the use and analysis of available information for rational health sector planning.



*Abby Vogus / Lauren Lumkin Thomas,
Caribbean Association of Pharmacists*

Reports will be validated by stakeholders during country dissemination meetings in Year 6, and country priorities will be translated into specific work plans for USAID-funded support.

UKRAINE HSA: INFORMING REFORM, ENGAGING NEW STAKEHOLDERS, ENHANCING THE UKRAINE/USAID RELATIONSHIP

Ukraine is one of the few post-Soviet Union countries to have not significantly reformed its health system – until now. Looking to turn around the deteriorating system of health care, the country’s health leaders welcomed the Health Systems 20/20-led HSA as a way to inform the government’s ambitious health sector reform plan, to open the door to greater public involvement and support of reform, and to expand the Ukraine/USAID partnership framework.

As with all HSAs, this one examined Ukraine’s health system according to the six WHO health system building blocks, identifying strengths and opportunities as well as weaknesses in each; it also looked at issues that cut across the building blocks. Major recommendations included reforming health financing to give facilities more budget and contracting autonomy; reorienting service delivery from the inpatient/specialist model to a primary care-focused one; and enhancing leadership and governance – strengthening the MOH, informing and soliciting input from a greater range of actors, and allowing institutional changes such as risk pooling, decentralization, and public-private partnerships.

Unlike other HSAs, during the course of the in-country phase the assessment team was asked to review the government’s health reform agenda, part of the President’s Economic Reform Plan 2010, and four draft laws, and provide feedback and recommendations. This review was submitted to USAID and the Government of Ukraine under separate cover from the HSA.

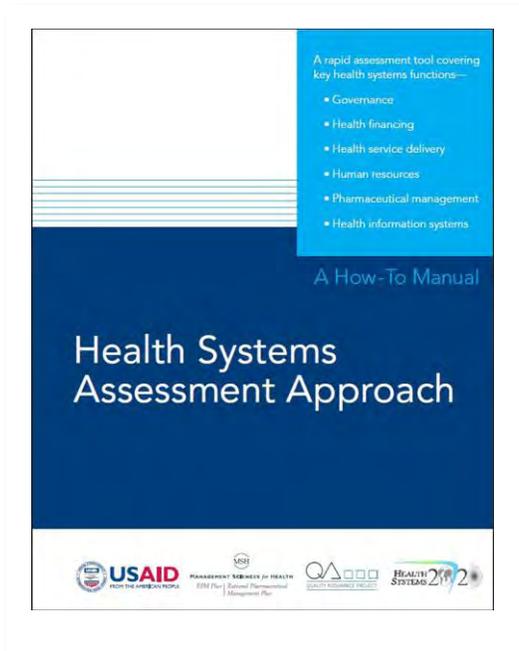
While the Year 5 assessment has not been finalized – a prioritization conference at which stakeholders discuss and prioritize study recommendations will be held once the assessment report has been translated and disseminated – the government has expressed interest in using the HSA as a focal point on which to bring the reform agenda into better public awareness and to push the reform process along.

HEALTH SYSTEMS 20/20 UPDATES HEALTH SYSTEMS ASSESSMENT APPROACH MANUAL

The *Health Systems Assessment Approach: A How-To Manual* (www.hs2020.org/hsa) was developed in 2006 at the request of USAID through a collaboration of three of USAID's development partners: Health Systems 20/20, the Quality Assurance Project, and Rational Pharmaceutical Management Plus. It was designed to allow clients to assess a country's health system, possibly during development of a health program or sector plan; the assessment diagnoses the relative strengths and weaknesses of the health system, prioritizes key weakness areas, and identifies potential solutions or recommendations for interventions.

With Health Systems 20/20's extensive experience in conducting HSAs, the project was selected to lead the effort to update and revise both the technical and methodological content of the manual, in partnership with USAID and other implementing partners. The revised manual, forthcoming in Year 6, targets a broader audience, includes technical revisions from experts at the top of their fields, and documents lessons learned from past HSA applications in more than 20 countries. Its web-based interface will allow users around the globe to download manual content as well as additional process guidance on enhancing stakeholder engagement throughout the assessment to increase local ownership; build consensus through validation and prioritization of HSA results; and vary data analysis to help customize the tool to client needs and priorities. The inputs will enable more systematic assessments of health systems in developing countries.

As an accompaniment to the manual, in Year 5 the project published *Engaging Stakeholders in Health System Assessments: A Guide for HSA Teams*. This document helps HSA teams to effectively engage a variety of stakeholders in the HSA, a critical aspect of the process from start to finish (<http://www.healthsystems2020.org/content/resource/detail/82437/>).



MOVING TOWARD A COMPREHENSIVE AND INTEGRATED NATIONAL HIS IN KENYA

Year 5 saw the official nationwide deployment of Kenya's MFL, a multi-year effort of the country's health ministries, in particular the Division of Health Information Systems (DivHIS), and Health Systems 20/20 (with collaboration from ICFMacro). The web-based MFL is a stand-alone database that assigns a unique identifier code to all public and private health facilities operating in Kenya (more than 7,500) and captures pre-defined information regarding services available at each facility, as well as basic contact and administrative information. Geocodes provide for the mapping of facilities. Based at the central level, the MFL promotes ownership at the individual district level where quality and timeliness of the data are maintained. The system also provides a user-level portal via the web (<http://ehealth.or.ke>) that allows users access to the entire database.

In addition to developing the MFL database, Health Systems 20/20 produced training materials and trained district teams how to use and update the software. Trainings took place in all districts in Kenya,

more than 280. The project also worked with DivHIS to create a “help desk” within the division to supply ongoing support to users and monitor the quality of the MFL data.

As the MFL developed, senior levels in the health ministries became increasingly aware of its importance in creating a national, integrated HIS. They took ownership of the activity and made it a priority within the government’s Rapid Results Initiative. Even before its official launch the MFL was receiving close to 8,000 hits per month from around the world. In July 2011, a national-level, multi-sectoral forum on the initiative introduced the MFL to the public and recognized the Health Systems 20/20-DivHIS achievement in meeting the target date. The MFL has become the official listing of Kenyan health facilities, adopted by all systems within the Kenyan HIS. It also has been linked directly to the current facility-based service delivery reporting software (DHIS2).

In short, as the MOH put it, the MFL is the “glue” that will allow for a comprehensive and integrated national HIS that will link service delivery, disease program, human resource, financial, and other HIS systems together to provide for integrated analysis and presentation of health sector data – as well as to obviate the time and expense of running multiple data reporting and decision support systems. Further evidence of its value is its use as a foundation for the World Bank’s Open Data Initiative in Kenya. This paves the way for increased information availability and utilization within the health sector.

REVISING THE MONITORING AND EVALUATION AND REPORTING FRAMEWORK TO PROVIDE BETTER HIV/AIDS SERVICES IN KENYA

Over the past year, Health Systems 20/20 has provided extensive technical and financial support to the Kenyan National AIDS program (NASCO) to revise its M&E framework. The existing framework’s indicators did not adequately reflect changes in program delivery strategies, program monitoring and management, or reporting requirements (including PEPFAR Next Generation Indicators as provided by USAID). This, of course, was an impediment to NASCO’s ability to provide defined services to target populations.

Through a process of highly collaborative consultation with program officials and stakeholders, Health Systems 20/20 carried out a review of the existing indicators, and a new set of indicators that better reflect NASCO needs were defined and agreed upon. The project then worked with NASCO to modify the various tools (patient cards, clinic registers, data summary sheets and reporting forms) to allow for the collection of defined data elements necessary to calculate and report on the agreed-upon indicators. It developed training materials to guide service providers in the correct use of these tools and forms. The new tools and training materials went through a final revision by NASCO and stakeholders before a national-level training plan was developed for Kenya’s 280-plus districts. Health Systems 20/20 supported a series of training-of-trainers workshops to build the capacity of NASCO, provincial staff, and other stakeholders to correctly use the training materials to train district staff, who will in turn train facility-level service providers in use of the tools and forms.

At the same time, Health Systems 20/20 worked with the DivHIS to adapt the web-based facility-level service delivery software (DHIS2) to accommodate the new reporting tools and the information they contain. The government and health ministries adopted the tools as the official documents for use in all Kenyan health facilities. Sufficient quantities of the tools were printed to supply all health facilities, enabling them to begin collecting required data and reporting on the new indicator set.

This effort has built the capacity and ownership of counterpart institutions to improve the quality and relevance of data collected and information available at all levels. Counterparts have praised Health Systems 20/20 for the collaborative and effective support it provided. USAID has also recognized the project for its role in operationalizing the new M&E framework for HIV/AIDS services in Kenya.

2.7 PERFORMANCE-BASED INCENTIVES

Vision: Health System 20/20's vision for PBI (also called pay for performance, or P4P, and performance-based financing, PBF) is to help countries move along a transparent and responsible path toward P4P.

P4P initiatives transfer money or material goods to either providers or recipients of health services if they take actions to improve health or increase utilization or quality of health services in a sustainable manner. The project provides global leadership that stimulates donors, technical assistance providers, and country policy leaders to support effective PBI approaches, increasing global access to information, tools, and evidence; enhancing global capacity to support PBI programs; and providing direct country technical assistance.

Strategy: Health Systems 20/20 is establishing a PBI legacy by building and sharing knowledge about PBI, enhancing global capacity to design and implement PBI programs, and providing technical assistance to such programs. It synthesizes and shares what is happening in PBI globally, filling a knowledge gap that will contribute to building appreciation of PBI as a strategy to strengthen health systems and improve key public health outcomes. We share lessons in global fora with a variety of audiences (for example, those concerned with maternal health, HIV/AIDS, malaria, and child health) so they understand the importance of addressing dysfunctional incentives, how PBI works, and the existing evidence that it works. To address the shortage of PBI practitioners who can provide assistance or directly implement PBI programs, we build access to tools and learning opportunities.

In Year 5, Health Systems 20/20 continued its global leadership and knowledge sharing of PBI and provided direct technical assistance: the project is working closely with USAID field missions and governments in Afghanistan, DRC, Mozambique, and Senegal to design, implement, and/or evaluate PBI schemes.

GLOBAL LEADERSHIP, GLOBAL LEARNING ON PERFORMANCE-BASED INCENTIVES

In Year 5, Health Systems 20/20 continued its global leadership in PBI through participation on the Inter-Agency Working Group on Results-Based Financing, presentations at international events such as the International Health Economics Association (iHEA) and the Centre d'Etudes et de Recherches sur le Développement International (CERDI), participation on the GAVI Alliance task team to develop a new PBI approach for all of GAVI's cash-based support, and contributions to the PBF community of practice.

The project contributed to building the capacity of USAID partners in a workshop for the Support for International Family Planning Organizations (SIFPO) project in Nairobi, support to TRAction, and contributions to a DELIVER conference on incentives to motivate supply chain workers and to strengthen supply chain system performance. The project also provided support to the newly formed USAID PBI Interest Group. Health Systems 20/20 has been asked to provide training on PBI to USAID Missions from the Latin America and Caribbean region through the SOTA trainings and has trained a multiagency PEPFAR team on PBI and HSS.



Lisa Nichols/Mali

Also in the past year, the PBI team enhanced the *Paying for Performance in Health: Guide to Developing the Blueprint* (<http://www.healthsystems2020.org/content/resource/detail/2088/>), with country examples to illustrate each step. This guide has been used in six workshops (five in Africa, one in Asia), and trained teams from up to 35 countries.

EXPANDING USE OF MATERNAL AND CHILD SERVICES IN AFGHANISTAN THROUGH CONDITIONAL CASH TRANSFERS

Despite notable improvements over the past decade, Afghanistan's health sector continues to face challenges. Significant resources have been put towards removing barriers to priority services, but demand for key MCH services remains low: less than 15 percent of households deliver at a health care facility, and only one in three children under the age of five are fully vaccinated. The maternal mortality ratio and infant mortality rate are among the highest in the world – at 1,600 deaths per 100,000 live births and 209 deaths per 1,000 live births, respectively.

Research shows that when resources are available and quality of care sound, increase in service utilization is associated with decrease in maternal and child mortality. Therefore, to stimulate demand, the MoPH in collaboration with the GAVI Alliance launched a conditional cash transfer project (CCT) in 2009 to provide families with monetary incentives for institutional delivery and DPT3 vaccination. While evidence in favor of CCTs for middle-income countries is growing, little is known about the effect of CCTs in post-conflict settings where resources are stretched, service provision limited, and security tenuous. Furthermore, challenges abound in implementing, monitoring, and evaluating CCT programs in these settings.

The CCT pilot project employs a quasi-experimental pre-post design and includes four arms: In the control arm, no incentives are provided; in the community health workers (CHW) arm, cash incentives are provided to CHWs for completed referrals; in the household arm, cash incentives are offered to households for utilization of services; and in the combined arm, cash incentives are offered to both CHWs and households for institutional delivery and DPT3 vaccination.

In Year 5, Health Systems 20/20 began an impact and process evaluation of the CCT pilot program to determine its effectiveness in encouraging mothers to utilize institutional delivery and obtain DPT3 vaccinations for their children. A sequential mixed methods design is being used.

The first phase of the study analyzed facility-based data collected through the HMIS and an endline household survey that captured responses from 6,318 women who reside in the pilot districts. Preliminary results suggest that CCT is an effective tool to stimulate demand for MCH service utilization in Afghanistan, with the most significant effect on rates of institutional delivery. Compared to the control districts where no incentives were provided, women who reside in the "combined" districts, where incentives are offered to both CHWs and households, are more likely to deliver at a government institution.

A second phase of the study, to be completed in Year 6, will be a qualitative assessment to better understand operational factors – program management, level of awareness among families and communities, and the effect of cash incentives on CHW motivation to provide better service to families and so forth – that make certain districts more successful at implementing CCT, as well as identify common challenges.

SCALING UP THE RESULTS-BASED FINANCING APPROACH IN DEMOCRATIC REPUBLIC OF THE CONGO

DRC has some of the earliest and most significant PBF initiatives in sub-Saharan Africa, covering approximately a third of the total population, in 153 out of 515 health zones. However, the initiatives are not harmonized, with many donors implementing their own initiatives in different parts of the country. Until recently, there was little coordination among the stakeholders to support effective RBF, but with the help of Health Systems 20/20 the MOH is now taking the lead in scaling up the RBF approach to address this issue.

In June 2010, the MOH requested a review of RBF schemes in DRC to serve as a basis for improving the stakeholder's understanding of the principles and challenges of implementing RBF. At the request of USAID/DRC, Health Systems 20/20 reviewed RBF schemes and captured the results in the Year 5 technical report, *Review of Results-Based Financing Experiences in DRC*. The process of collecting information and writing the review was participatory. In particular, the workshop held in October 2010 by the MOH and the Health Systems 20/20 team was extremely productive for arriving at a consensus on the basic guidelines and common principles shared by the MOH and its technical and financial partners. This consensus was incorporated into the drafting and approval of an important national policy on RBF.

Having the government and the partners approve RBF national policy in the National Steering Committee (CNP)-SS Technical Coordination Committee was a major step toward harmonizing the projects that are underway, as well as those that will be implemented in the future, and provides an important foundation for scaling up the RBF approach in the DRC at the national level. Based on Health Systems 20/20's recommendations, the MOH also created an RBF unit within the ministry that will coordinate the implementation of the RBF national policy.

Following the dissemination of the report, USAID/DRC, at the government's behest, asked Health Systems 20/20 to extend its support to develop a plan for the government-led, Global Fund-financed, RBF scheme that will be implemented in 256 health zones as well as at the provincial and central level. The project worked with an MOH team to design the scheme, which was finalized and presented to the government and partners in December 2010. Health Systems 20/20 also developed a training manual for RBF implementation. In Year 6, the project will continue to support the design and launch phase of the RBF scheme.

USING PERFORMANCE-BASED INCENTIVES TO EXPAND AND IMPROVE PRIORITY HEALTH SERVICES IN MOZAMBIQUE

In Year 5, Health Systems 20/20 began assisting USG, donor, and country stakeholders in Mozambique to explore the introduction of PBI into the country's health system, in an effort to introduce innovative mechanisms to improve access to and use of priority health services. The team completed a situational analysis for PBI that took care to provide a balanced, objective view of opportunities and risks of PBI (see report at <http://www.healthsystems2020.org/content/resource/detail/2799/>).

The major conclusions were that PBI is legally and culturally feasible, and already there are several examples of supply-side and one of demand-side incentive arrangements in Mozambique. However, given the low level of health spending (\$20 per capita), the limited population coverage (40 percent), and estimates of unmet need in the country, PBI should be designed to improve system efficiency but not be expected to reduce spending in absolute terms. Finally, local stakeholders were open to the PBI concept, but some authorities and health worker staff expressed concerns about sustainability and equity of paying for performance. The study identified three areas that PBI could help address:

- Increase the delivery of quality priority HIV and primary care services in collaboration with USAID’s bilateral project CHASS-SMT, which works in the provinces of Sofala, Manica, and Tete.
- Expand population coverage in collaboration with USAID’s CapacityPlus project and the MOH’s community health worker strategy (“APE”s).
- Increase the availability of essential medicines in collaboration with USAID’s Supply Chain Management System and Deliver projects and the central medical store (“CMAM”).

Findings of the situational analysis were already producing change by the end of Year 5:

- Provincial health authorities in Manica and CHASS SMT staff began to design a pilot of performance-based grants in three districts with a total population of 600,000. Indicators include institutional deliveries, HIV/AIDS care, and prevention of malaria and STIs. Manica and CHASS have benefited from the lessons learned by the Elizabeth Glazer Pediatric AIDS Foundation, which has operated PBI grants in Nampula and Gaza provinces since January 2011.
- The CHW strategy will integrate an incentive payment for the district coordinators in 50 districts who are launching the first groups of CHWs. Indicators are linked to start-up activities and submission of monthly reports by health workers.
- The MOH appointed its Directorate of Human Resources as the focal point for all PBI activities in the Mozambican health system.
- Health System 20/20’s PBI Blueprint Guide was translated into Portuguese through a collaboration with the World Bank. (<http://www.healthsystems2020.org/content/resource/detail/2088/>)

PAY FOR PERFORMANCE TAKES OFF IN SENEGAL

Despite investments in the health sector, and reforms such as decentralization and health insurance for the poor, many health indicators remain poor in Senegal. In an attempt to improve quantity and quality of services, motivate health workers, and build the capacity of district health teams, the Ministry of Health and Prevention (MSP) has decided to experiment with P4P. Unlike some countries in sub-Saharan Africa, interest in P4P came from within the government itself. “Beyond what one can read [about P4P], beyond the literature, there was this experience of Rwanda,” says Dr. Lakh, head of the Primary Health Care Division within the MSP. “After seeing it, they felt that they should also try to implement P4P...but adapt it to the Senegalese context.”

Since December 2010, Health Systems 20/20 has been providing technical assistance to the P4P technical working group, formed to design and oversee implementation of a P4P pilot. Once a provisional design was developed, the working group held national and then regional meetings, which brought together all the stakeholders, including the Ministry of Finance and the country’s powerful trade unions, to solicit feedback about the program. The pilot is slated to launch shortly in three districts. Though there will be challenges ahead, and while the design is still being refined and finalized, it is clear that Senegal is off to a good start. Many countries will be watching, keen for lessons about how to successfully navigate the politics and planning involved in what is a major health system reform.

2.8 RESOURCE TRACKING

Vision: A fundamental part of strengthening the financing function of health systems in developing countries is increasing the availability and use of timely, high-quality health expenditure data. A clear understanding of how money flows through the system from sources all the way to service provision enables governments and development partners to make more informed funding decisions, monitor health system performance, generate useful and responsive policies, and improve overall stewardship of the sector. To this end, Health Systems 20/20 supports global and country-level efforts to implement and sustain systems and approaches that facilitate the collection, analysis, and use of health expenditure data as one essential ingredient in effective health policy and planning.

Strategy: Health Systems 20/20 works to ensure that sustainable resource tracking mechanisms fit into the fabric of national financial resource planning, maximizing the quality and availability of data to improve health policy and outcomes. The project strategy is to help countries carry out and institutionalize resource tracking by: 1) building regional and country capacity to produce and institutionalize NHA, 2) building tools and skills that facilitate the production and use of NHA data, 3) harmonizing different resource tracking methodologies, and 4) helping individual countries to do NHA production and then use findings and institutionalize the methodology.



Health Systems 20/20/Ghana

In Year 5, the project made considerable headway in developing data collection mechanisms and IT solutions for making the production and use of NHA easier. As part of its effort to improve the mechanisms for accountability and transparency, Health Systems 20/20 worked closely with WHO/Geneva to create the NHA Global Access Database, the first central, web-based repository of all NHA country-level data that will allow for conducting cross-country comparisons, developing or evaluating health policy, and looking at historical trends within a country. Other new tools are the Health Resource Tracker, which harmonizes and streamlines data collection and reporting expenditure data, and the NHA Production Tool, which facilitates doing NHA estimations, thereby making the methodology more accessible to developing countries in terms of production and expense.

Also in Year 5, Health Systems 20/20 continued to build regional and country capacity for NHA production, use, and institutionalization. The project supported two regional institutions in Africa to become institutional homes for NHA expertise and providers of technical assistance for NHA estimations conducted in their respective regions. It also invested heavily in building local and regional capacity for NHA training, working with stakeholders in Kenya and Rwanda to incorporate an NHA course into university public health curriculum.

Health Systems 20/20 encourages harmonization of NHA with other data collection and policy planning tools. For example, the above-mentioned Health Resource Tracker integrates multiple health resource tracking systems into a single web-based platform for reporting and analysis. As seen in the stories below, the project is encouraging countries and institutions to learn about and use health finance methodologies in tandem for a better picture of their health expenditure: NHA and Marginal Budgeting for Bottlenecks (MBB) in a course Kenya, NHA and Expenditure Tracking System in Egypt, and NHA

and HAPSAT in Vietnam. In Year 5, the project continued working with implementers of the DHS to add health expenditure questions to the survey, to obviate the need for a country to do a separate – and costly – household health expenditure survey specifically for the NHA exercise. Health Systems 20/20 also continued to work with UNAIDS to harmonize data collection for NHA and the National AIDS Spending Assessment (NASA), most recently in Namibia, Rwanda, and Vietnam.

Finally, the project has helped individual countries with production of NHA rounds, and with institutionalization of the methodology.

BUILDING DATA SYSTEMS TOOLS FOR HEALTH RESOURCE TRACKING

GLOBAL HEALTH EXPENDITURE DATABASE: INCREASING ACCESS TO RESOURCE TRACKING DATA

While NHA findings are public, and over 100 countries have conducted NHA assessments over the past 15 years, there has been no central location where country NHA tables and reports are easily accessible and usable for analysis. Each organization that assisted developing countries in conducting NHA assessments has different methods for tracking and publishing results. Some governments and programs do not post results to their websites – NHA matrices exist only on MOH or consultant hard drives, or are buried in the annexes of NHA reports. All this means that NHA data were not being accessed and used to their full potential. Increasing public access to NHA data, findings, and reports is critical for making past, present, and future NHA data more policy-relevant and for augmenting its use as a health system monitoring tool. This will in turn increase the demand for and use of health expenditure information by a broad set of stakeholders, including donors, NGOs, international organizations, and host governments.

To deal with these issues, Health Systems 20/20 collaborated with WHO and the software development firm Prognoz Corporation to develop the Global Health Expenditure Database, with the broad objective of creating worldwide access to country NHA data to increase use of health financing information by all health stakeholders: donors, country governments, civil society, and other groups. The database allows users to interactively view, compare, and manipulate NHA data alongside other health systems indicators. Essentially, the database is a warehouse for NHA data across countries with the ability to support:

- Downloading country-produced data into ready-to-analyze formats
- Interactively presenting data and presenting innovative ways to view country data and cross-country comparisons
- Generating health system indicators (per-capita spending, spending relative to disease burden, etc.) that are of high value to health systems strengthening
- Hosting both time-series indicators and country-supported NHA data

HP Health Providers	HF.1.1.1 - Ministry of Health	HF.1.1.2 - Other ministries and government institutions	HF.1.1.3 - Local/municipal government	HF.1.2 - Social security funds
HP1.1.1.1 - General hospitals owned by Ministry of Health	1,786,016,490.13		875,995,772.73	
HP1.1.1.2 - Other public hospitals (military etc)	2,050,495,044.00			3,035,016.85
HP1.1.2.1 - Private-owned for profit general hospitals	87,188,937.41		268,454,558.83	2,142,364.84
HP1.1.2.2 - Private-owned not for profit general hospitals	29,675,269.70		97,260,392.19	892,652.01
HP1.2 - Mental health and substance abuse hospitals	134,159,895.00			
HP3.1 - Offices of physicians				
HP3.3.1 - Community health agents	4,485,321,000.00			
HP3.4.5.1 - Public outpatient health centers	2,195,968,822.65		389,041,568.74	3,570,608.06
HP3.4.5.2 - Private outpatient health centers	91,908,914.01		252,877,019.68	2,320,895.24
HP3.5 - Medical and diagnostic laboratories	51,046,766.99			
HP3.6 - Providers of home-based health care services	1,382,582,578.54			
HP3.9.2 - Blood and organ banks	1,499,733,751.00			
HP4.1 - Dispensing chemists				
HP6 - Provision and administration of public health programmes	19,765,392,090.03			
HP8 - General health administration and insurance	13,560,268,145.85		5,184,342,796.98	
HP8.1 - Research institutions	2,848,184,712.14			
HP8.2 - Education and training institutions			847,931,983.00	
HP9 - Rest of the world				
HPnak - Providers non-specified by type	47,022,388.63			65,222,485.00

The database launched on the WHO website in May 2011, WHO displayed the database at a side session of the World Health Assembly, and Health Systems 20/20 presented on the significance of the database in improving the availability and policy use of NHA data at the NHA Symposium that preceded the 2011 International Health Economic Association conference.

(<http://apps.who.int/nha/database/ChoiceDataExplorerRegime.aspx>).

HEALTH RESOURCE TRACKER: STREAMLINING DATA COLLECTION

Rwanda pioneered the Health Resource Tracker (HRT) to address systemic problems in the process of collecting expenditure information from donors and NGOs. This effort to implement a harmonized system for collecting and using resource tracking data was supported by Health Systems 20/20 and partners. Health Systems 20/20 is also providing support to the Kenyan MOH, to develop a comparable resource tracking platform support.

In countries that lack a common data collection platform for recording and aggregating expenditure data from key health sector stakeholders, organizations typically have to respond to multiple separate, often redundant, surveys, creating issues of inefficiency, respondent fatigue, and human error in survey response and data entry. For example, the Rwandan MOH has done five NHA estimations and conducted NASAs and Public Expenditure Reviews (PER), and it regularly carries out a variety of planning exercises such as the Joint Annual Work Plan and others for the National AIDS Commission and Ministry of Finance, each study with its own data collection.

To reduce this excess of reports and systems, Health Systems 20/20 worked with the Rwandan government, NGOs, and donors throughout Years 4 and 5 to develop an integrated health resource tracking system that harmonizes the multiple existing systems into a single web-based platform for reporting and analysis. The HRT systemizes the expenditure data collection process in an accessible way. It also increases the quality of the data, and makes them available to a wider range of stakeholders. Its accessible interface and automated programs allow managers within the government, NHA team members, and data contributors to avoid some of the more complex, non-intuitive aspects of using Excel-based systems.

The HRT also provides the space for linking the production of resource tracking information to reporting, analysis, and dissemination. Even HRT users without high levels of expertise can analyze variables together and produce clear and intelligible charts and graphs for dissemination. For example, a government agency might want to compare several donors on projected expenditures over the last five years, or health expenditures across regions; the HRT analysis tool can facilitate both tasks. Also, because the HRT collects data regularly, government agencies can check expenditure information more regularly than the NHA is produced, usually every 3–5 years; this feature can also help government officials doing yearly budgeting reviews and it makes the HRT relevant for other resource tracking efforts. Thus, though the main purpose of the HRT is to streamline data collection, its other features broaden the relevance of the tool within the overall process of NHA institutionalization and within resource tracking more generally.

Rwanda HAVE AN ACCOUNT? [SIGN IN](#)

HEALTH RESOURCE TRACKER

≈ IMPROVING LIVES THROUGH BETTER HEALTH POLICY ≈

**Better Information.
Better Decisions.**

≈ The Health Resource Tracker tracks resource flows in the health sector from their many sources to the ultimate health function they serve. Information about health spending, both planned and realized, are essential for evidence-based budgeting, planning and policy-making.

≈ This system was created under the stewardship of the Resource Tracking Steering Committee, chaired by the Ministry of Health, with extensive input from CNLS. It was implemented by Health Systems 20/20, a global project funded by USAID, aided by many development partners, especially USAID, UNAIDS and CHAI.

This project is supported by:

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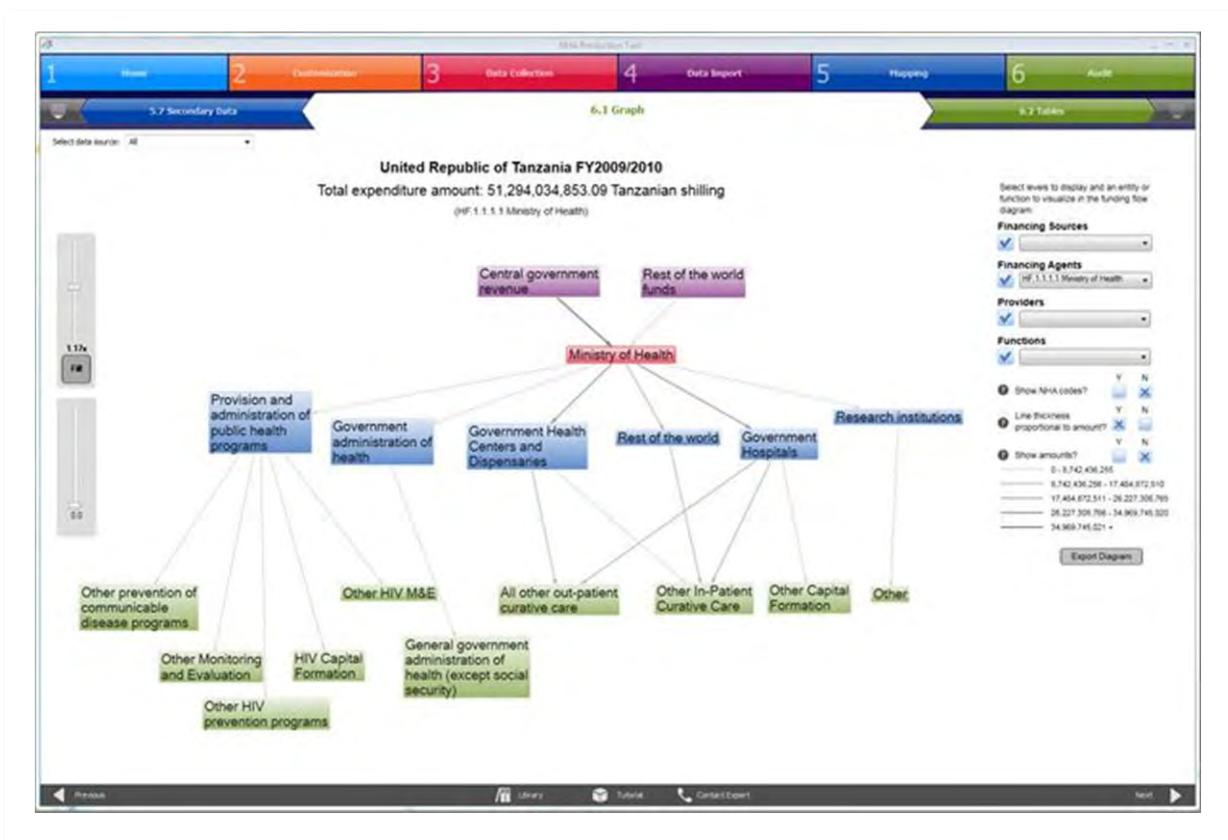
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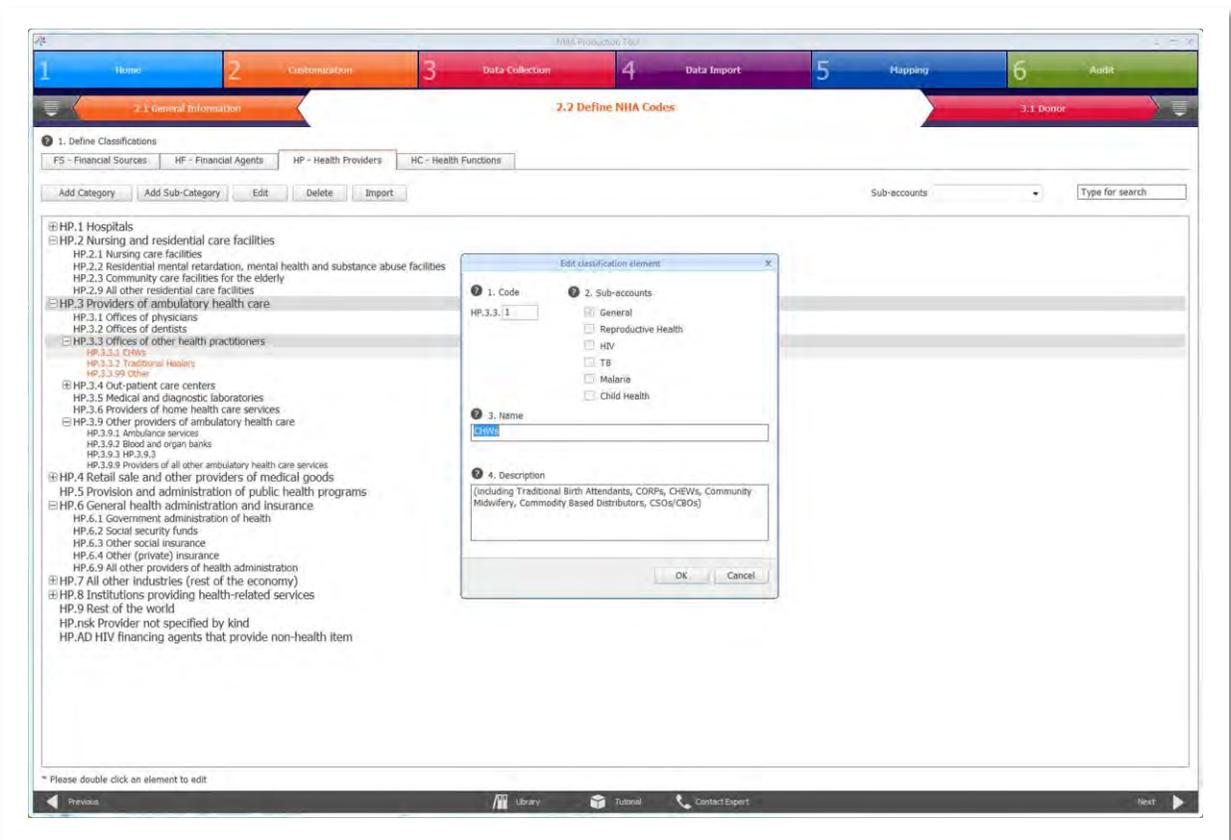
THE NHA PRODUCTION TOOL: SIMPLIFYING THE PROCESS

While the HRT streamlines the process of collecting expenditure data from financing sources and agents, the NHA Production Tool focuses on problems arising during the NHA estimation process. During this stage, discrete expenditures from surveys are assigned a set of codes according to the specific NHA categories. In the traditional way of analyzing NHA data, this process is quite time intensive and requires a high level of skill in the use of Microsoft Excel. The Production Tool lessens the complexity of the NHA exercise through step-by-step guidance through the analysis, built-in validation features, and automated population of the NHA output tables.

Key functions of the tool include:

- Step-by-step directions to help guide country teams through the NHA methodology
- Platform to manage complex datasets and reduce the burden of data management
- Survey creator and an import function to streamline the data-collection and data-analysis process
- Built-in auditing function to facilitate review, and correction for possible double-counting
- Report generator for simplified NHA table creation
- Interactive diagram feature to help NHA teams visualize and critically analyze the flow of funding through the health sector





The Production Tool has several important benefits. First, it significantly reduces the need for international technical assistance, thus bringing down the cost of producing NHA as local staff manage more of the estimation process. Second, it makes local NHA teams more independent thereby building country ownership over the NHA process. Finally, data quality will improve and become more standardized across countries, making international comparisons more powerful.

At the same time, the Production Tool will not solve all of the challenges of NHA. While the Production Tool will eventually bring about savings in time and money and simplify the estimation process, at first the novelty of the system may intimidate new users who might be accustomed to other methods. It is important to note that the Production Tool is primarily aimed at countries with low capacity for NHA production and low levels of NHA institutionalization. Where the general NHA is routinely conducted every few years, the Production Tool might not be an appropriate resource. And while it lessens the need for technical assistance, it does not completely eliminate it all together.

BUILDING CAPACITY OF REGIONAL INSTITUTIONS TO CONDUCT AND MANAGE NHA ESTIMATIONS

As the Capacity Building strategy described, part of Health Systems 20/20's vision is to strengthen technical institutions with health financing expertise in developing countries so they can take on the role that Health Systems 20/20 and its predecessor projects have played. In Year 5, Health Systems 20/20 helped two African institutions become 'regional hubs' for NHA by increasing their capacity to successfully conduct NHA estimations, not just as technicians, but also as consultants who can manage the whole NHA process, including planning and budgeting, stakeholder engagement, data collection and analysis, and translating results into policy impact.

The African Center for Higher Management Studies (CESAG) in Senegal was selected as the institutional home for NHA in Francophone West Africa; the Commonwealth Regional Health Community for East, Central and Southern Africa (ECSA) in Tanzania was selected as the home in Anglophone East Africa. Both institutions, founded in the 1970s and introduced to NHA in the late 1990s, were chosen for their regional presence and experience with NHA and health economics in general. They had already become involved in and committed to doing NHA estimations and institutionalization. ECSA, for example, actively advocates for NHA production with member countries during the annual conference of health ministers. These networks also provide technical experts in the region a forum for discussion of best practices in NHA production.

In Year 5, Health Systems 20/20 focused on addressing the problems limiting the effectiveness of these organizations as technical assistance providers. Health Systems 20/20 designed and implemented two workshop-style courses: a four-day course on conducting NHA estimations, and a one-day course on managing NHA production as a consultant. Specific workshop topics included best practice and technical issues in NHA production, teaching and consulting, and post-production issues.

Health Systems 20/20 first conducted the workshops for CESAG. Afterward, a CESAG technical expert commented that “we are now better prepared to conduct NHAs in the region following best practices presented during the workshop.” CESAG’s management and administrative staff also expressed satisfaction with the management course: “We are now more familiar with the management and operational requirements for conducting NHA as well as how to prepare, position, and market [our] institution as a major technical resource in the region for conducting NHA estimations.” Feedback from the CESAG workshop was used to revise the courses for the ECSA workshop.

In Year 6, Health Systems 20/20 will include workshop participants in NHA estimations done in their respective regions and assist the participants in applying workshop materials in real-world situations.

DEVELOPING LOCAL CHAMPIONS: INCORPORATING NATIONAL HEALTH ACCOUNTS INTO COUNTRY HEALTH CURRICULA

As part of Health Systems 20/20’s objective to help countries institutionalize the NHA methodology, the project has worked with stakeholders in Kenya and Rwanda to incorporate NHA content into university public health curricula – training local experts will facilitate national ownership of NHA, build domestic support for doing NHA estimations and using their findings, and reduce countries’ reliance on costly international NHA consultants.

KENYA: MASTERS PROGRAM DEVELOPS AN NHA MODULE

Kenya’s years-long collaboration with Health Systems 20/20 and predecessor projects to do NHA estimations has built substantial capacity in the country’s two health ministries: the Ministry of Medical Services and the Ministry of Public Health and Sanitation. This has significantly improved the efficiency of data collection – Kenya completed its third NHA estimation (for 2009/10) in six months, whereas most estimations take more than a year.

Ministry staff change over time, however, so to build sustainable local capacity to understand, produce, and use NHA data, Health Systems 20/20, together with the two health ministries, developed a course with an NHA module for the University of Nairobi’s Master’s program in Health Economics, the first program of its kind not only in Kenya but also in East Africa.

In addition to the NHA module, the new course will have a module on Marginal Budgeting for Bottlenecks (MBB), a well-established costing tool. Combining NHA and MBB within one course should foster an intuition for the complementarity of expenditure and costing data in health financing analysis,

which will have positive implications for institutionalization when program graduates enter the workforce.

The semester-long course is scheduled to start in January 2012. Stakeholders in Kenya view this as the first step toward their long-term vision of the MOH Department of Planning subcontracting NHA production to the University of Nairobi. More generally, the course will build local capacity for routine production of NHA and reduce reliance on international technical assistance.

RWANDA: INSTITUTIONALIZING NHA THROUGH THE SCHOOL OF PUBLIC HEALTH

Like Kenya, Rwanda has carried out multiple rounds of NHA, and the Health Resource Tracker, described earlier in this section, grew out of the country's need to harmonize its myriad health information reporting systems. To generate interest in and thereby sustain use of the NHA methodology and the tracking system, Health Systems 20/20 is building capacity at the School of Public Health, assisting the school to develop a course on NHA data collection and analysis and developing courses on resource tracking. In Year 5, the project did training in the application of the NHA methodology and worked with the Rwandan NHA team, which comprises school faculty and staff, MOH officials, and representatives from development partners, to undertake an NHA estimation for 2009/10. The School of Public Health led a training exercise for data collectors for primary data collection. Once the faculty masters NHA themselves, they will adapt the materials for their courses. By teaching students about the NHA and involving them in data collection, the school aims to generate interest and technical expertise in NHA, which would expand the school's pool of technical staff for conducting future estimations.

AFGHANISTAN'S FIRST NHA: MOVING TOWARD DEVELOPING SOUND HEALTH CARE POLICIES

Afghanistan's MoPH and Health Systems 20/20 collaborated on the country's first NHA estimation. In addition to enhancing local understanding and awareness of the NHA methodology, the partnership developed mechanisms to improve data collection and analysis, useful beyond NHA. In April 2011, Afghanistan released NHA results at an event attended by nearly 100 attendees who included the minister of public health, USAID deputy mission director, representatives from the WHO, World Bank, and the larger donor community, hospital directors, and academics. National and international media covered the event.

The NHA results demonstrated that health spending in Afghanistan is unsustainable and identified several areas of concern. For example, the country spends over US\$1 billion (close to 10 percent of GDP) on health care with almost 60 percent directed toward curative services. Three-quarters of this health spending comes from households, about 20 percent from donors – and only 6 percent from government. This statistic is alarming when compared with Organization for Economic Co-operation and Development countries, where the government contribution is over 72 percent, and it represents the fragility and unsustainability of Afghanistan's current health system.



Health Systems 20/20/Afghanistan

The policy implications of the NHA findings are substantial and have initiated nationwide discussion. There were immediate calls for reducing the household burden through some form of prepayment system such as CBHI schemes, limited social insurance programs, or a combination, to increase access to treatment. In addition, promoting behavioral change and rationalized medicine use will be critical to a society that frequently oversubscribes to pharmaceuticals.

“This first National Health Accounts represents a major step forward in the development of a complete picture of health expenditures in Afghanistan and helps us develop sound health care policies that would decrease the financial burden of health care on families,” said Acting Minister Dalil. He also stated that the “NHA will guide future decisions on financing the health system.”

Going forward, Health Systems 20/20 and the MoPH are taking steps to institutionalize the NHA process: developing a stronger environment and governance structure; strengthening human and financial resources; improving data collection, management, and quality; and encouraging the dissemination and use of NHA data. Health Systems 20/20 has trained two Afghan advisors, currently based at the MoPH, who will form the core of the country’s NHA technical team. The Central Statistics Organization will house the team, and compile needed data. Household health expenditure data will be collected through inclusion of health expenditure questions in the biannual National Risk and Vulnerability Assessment survey, which will allow for NHA to be carried out biannually. Finally, Health Systems 20/20 has already started expanding support to the MoPH in line with NHA policy implications, in the areas of capacity building, revenue generation, and financial risk protection.

NHA IN EGYPT: LATEST ROUND PROMPTS DIALOGUE ON HEALTH FINANCING SOLUTIONS

In Year 5, Health Systems 20/20, in collaboration with Egypt’s Ministry of Health and Population’s (MOHP) Department of Planning (DOP), completed the country’s fourth round of NHA, for 2008/09. Health Systems 20/20 provided technical assistance to the DOP to continue developing and rolling out the Expenditure Tracking System, which tracks health program expenditures at the central/national, governorate, district, and facility level. The information from these two resource tracking exercises allowed for direct comparison between budgeted and actual expenditures.

NHA results were released at a June 2011 meeting of nearly 150 attendees who included the MOHP minister, USAID mission director, and deputy minister of finance, as well as Egyptian government planners, hospital managers, private sector representatives, journalists, and donors. The findings revealed the reality of health care spending in Egypt – including that Egyptian households bear nearly 72 percent of health care spending, up from 62 percent in 2001/02, while the government pays less than 25 percent. This and other findings engendered an unprecedented dialogue among stakeholders seeking health financing solutions. An MOHP official said, “the NHA findings provide powerful evidence to advocate for an expansion in insurance coverage and public spending on health.” Local hospital managers voiced concerns about lack of funding and called for greater budget authority at the local level. Participants in general pointed to the need for evidence-based



health care planning and budgeting. Dr. Faten Ghazi, Chief of Cabinet for the MOHP underscored that, saying, “budgeting has to be part of our culture.”

In addition to NHA production, Egypt is taking steps toward NHA institutionalization. The minister has proposed creation of a Health Economics Unit to provide regular briefings on expenditures, benefits, and potential savings; the USAID mission supports creation of such a unit. Health Systems 20/20 has developed a subcontractual partnership with the Central Agency for Public Mobilization and Statistics (CAPMAS), which will promote Egypt’s ability to replicate future NHA estimations. In Year 5, a CAPMAS survey of 12,000 households provided information on the type and frequency of health services used, the level and distribution of out-of-pocket spending on health care, and the factors that influence the use of and expenditures on health care. Health Systems 20/20 also contracted CAPMAS to survey health expenditures of NGOs and firms, which clarified their role as sources, financing agents, and providers of health services, information used in the NHA estimation.

NHA AND HAPSAT JOIN FORCES TO STRENGTHEN POLICY PLANNING IN VIETNAM

While Vietnam has made substantial gains in recent years in increasing availability and coverage of HIV/AIDS services, foreign assistance paid for much of the increase –73 percent of HIV/AIDS spending in Vietnam comes from international donors. With Vietnam’s rise to middle-income status, foreign aid will decrease and the country will need to transition away from reliance on international donors for public health funding. Thus, financing and sustaining HIV/AIDS services is at the forefront of the agenda as the Government of Vietnam prepares the National Strategy on HIV/AIDS Prevention and Control, for 2011–2015.

To move forward the planning phase, the government requested an analysis of the total health expenditure for HIV-related activities and a projection of financial resources needed to implement the National HIV Strategic Plan. To this end, Health Systems 20/20 and the Vietnam Administration for HIV/AIDS Control (VAAC), in coordination with the MOH Department of Planning and Finance (DPF) and in partnership with the Health Policy Initiative/Vietnam, carried out two analyses: an NHA HIV/AIDS subaccount estimation to track resource flows through the HIV sector, and the HAPSAT to project financial resource gaps to inform strategic policymaking. This approach made Vietnam the first country to do a joint NHA/HAPSAT analysis, harmonizing data collection and use.

As the NHA/HAPSAT activity began, the MOH and Health Systems 20/20 learned that UNAIDS and VAAC would carry out a NASA, the UNAIDS framework for tracking HIV/AIDS expenditures. To further the NHA/HAPSAT emphasis on harmonization, coordination with the NASA became a priority. Activities needing in-country stakeholder participation and data collection were done jointly – making Vietnam one of the few countries to have accomplished such a collaboration – and NHA subaccounts were produced from NASA using the ‘crosswalk’ document developed by Health Systems 20/20, UNAIDS, and WHO in 2009. The resultant savings, in both cost and time, convinced the MOH and VAAC of the value of collaboration, and they wish to continue this approach in the future.

In May 2011, Health Systems 20/20 organized an event that presented NHA/HAPSAT findings and a five-year projection of HIV program sustainability in Vietnam. Attendees included the head of the National Assembly’s Committee on Social Affairs and vice-minister of health. The analysis’ comparisons of actual spending and budgets, and anticipated domestic funding increases and donor decreases led to the projection of an annual funding gap of approximately US\$132.3 million in 2015. Health Systems 20/20’s NHA/HAPSAT team and the Health Policy Initiative will help the MOH put the data to use in its development of the HIV/AIDS strategic plan and to find ways to enable the ministry to make the HIV subaccount a regular part of the NHA estimation.



3. MANAGEMENT

As our number of activities soared to 250 and countries to over 50, the Senior Management Team (SMT) continued to fine-tune project operations to achieve the best possible results. We increased our staffing to ensure all project systems are as efficient as possible. We ensured our team leads are all senior managers, experienced in field management and working with tight budgets and short timelines. In addition, our country focal points have taken on greater responsibility to ensure country clients are pleased with our work, to increase responsiveness to their needs, and to coordinate a growing constellation of activities within each country. Finally, our eight strategy leads are now responsible for overseeing the technical cohesion of the activities within each strategy and ensuring strategy indicators are met and results documented in a timely manner.

The SMT continues to meet each week with clear agendas and action items, especially regarding finance issues. In particular, the SMT now meets regularly to monitor the pipeline for each activity. SMT point persons have been identified to monitor possible problem areas. Our Finance and Operations Team monitors and shares a pipeline analysis on a monthly basis with all staff, especially team leads. Each activity has a task manager, who is responsible for monitoring the activity budgets, processing subcontracts and consultants, and assisting the activity team with technical work. As we have grown quickly, we are also holding regular training for new staff on the project and Abt systems. Minutes of all SMT meetings are shared across the full project.

Because there had not been a mid-term evaluation of the project, in Year 5 we hired a former USAID mission director to perform an assessment of the project. Her recommendations resulted in several key changes, particularly with regards to our strategies. Specifically, we re-organized our strategies to highlight Measuring and Monitoring Health System Performance and to better capture our Costing and Sustainability work. We also made several internal changes as a result of the stakeholder feedback she shared with us.

We continue to have monthly meetings with our AOTR team, and biweekly smaller meetings on specific areas. The project benefits greatly from the bi-weekly "The AOTR is In" sessions, where any staff member can sign up for a 30-minute meeting with the AOTR. This access has increased the overall understanding of our activities and team and it has also clarified how USAID leadership works and what its expectations are. We feel this meeting is a "best practice" for any USAID project and recommend it highly. In addition, this year we have seen a closer coordination among our key USAID clients (HIDN and OHA), resulting in more streamlined programming and stronger communication.

Finally, Health Systems 20/20 uses subcontracts and subgrants to build capacity of local organizations to conduct project activities and to encourage sustainability of the work beyond the life of the project. This approach leverages existing in-country capacity and is a vehicle for transferring new skills and knowledge in HSS. We also collaborate and learn with a number of other international partners. Table 4 lists Year 5 non-US subcontractor/subrecipient/grantee partners.

Year 5 has been a fulfilling and exciting year from many angles, the management one included. Our expanded team and recalibration of Health Systems 20/20 has set the stage for a strong finish in Year 6.



Itamar Katz/South Sudan

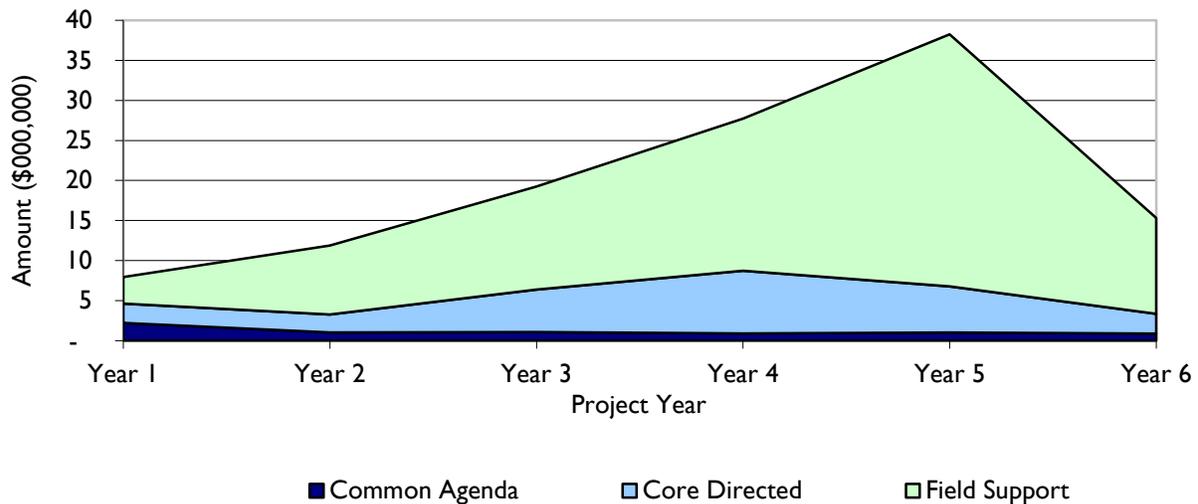
**TABLE 4. HEATH SYSTEMS 20/20 NON-US SUBCONTRACTORS/
SUBRECIPIENTS /GRANTEES, YEAR 5**

Subcontractor	Country
American University of Beirut	Lebanon
Austral-COWI, Lda	Mozambique
Avid Database Solutions, Inc.	United States
Bitran Y Asociados	Chile
Brandeis University	United States
Broad Branch Associates LLC	United States
Center for Community Health Research and Development (CCRD)	Vietnam
Central Agency for Public Mobilization and Statistics (CAPMAS)	Egypt
Centre Africain d'Etudes Superieures en Gestion (CESAG)	Senegal
Centre d' Appui de la Reserche et a la Formation (CARE-F)	Mali
Coach Africa Limited	Uganda
Coordinating Assembly of Non-Governmental Organisations (Cango)	Swaziland
Deloitte Consulting LLP	United States
Emory University	United States
Federal University of Technology (FUT)	Nigeria
Forum One Communications	United States
Health Economics and HIV/AIDS Research Division of the University of KwaZulu Natal (HEARD)	South Africa
Health Systems Action Network	United States
HLFPPT	India
Institut de Sante et Developpement (ISED)	Senegal
Institute for Development Management (IDM)	Swaziland
International Senior Lawyers Project (ISLP)	United States
Kinshasa School of Public Health (KSPH)	Democratic Republic of Congo
Knowing Ltd	Kenya
Liberia National AIDS Commission	Liberia
Maer Associates	Kenya
Makerere University School of Public Health	Uganda
Management International	Malawi
Miz-Hasab Research Center	Ethiopia
Mullan & Associates (Pty) Ltd	Botswana
Offner Consulting LLC	United States
Performeks LLC	United States
PROGNOZ	Russia
PS Consulting	United States
Qualitas	Cote d'Ivoire
Research Triangle Institute	United States
School of Public Health at National University of Rwanda	Rwanda
Siyelo Software	South Africa
Strong NKV	Democratic Republic of Congo
Summit Consulting Group	Malawi
Swasth India	India
Training Resources Group	United States
Tulane University	United States
Union Technique de la Mutualite	Mali
Zaria Institute National Tuberculosis and Leprosy Training Center	Nigeria

4. PROJECT FUNDING (YEAR 5)

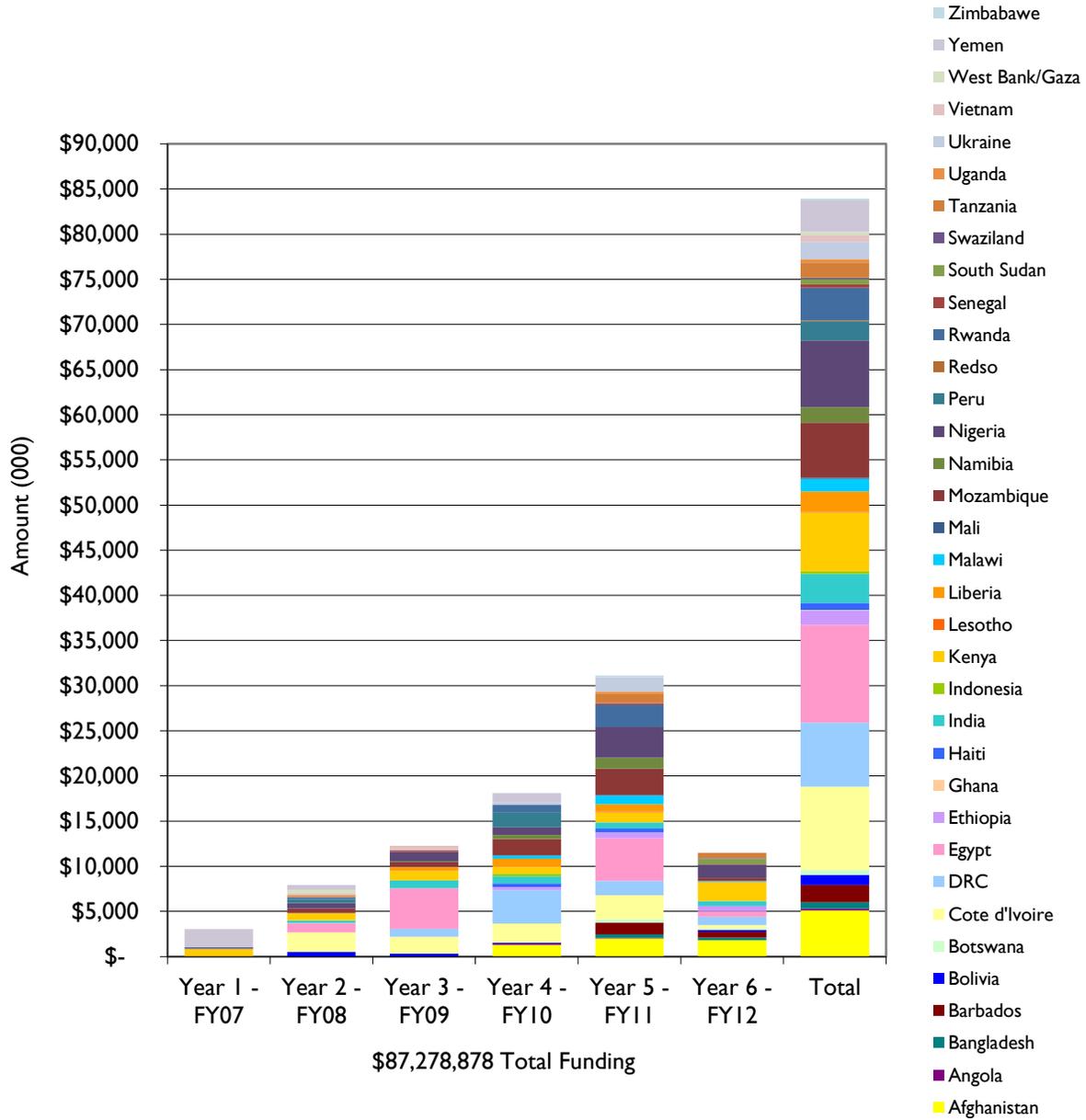
Health Systems 20/20 can receive funding from all USG foreign assistance programs – all USAID operating units, PEPFAR, and the President’s Malaria Initiative. Project funding consists of field support funds from USAID’s missions and bureaus, plus core funds from USAID/Washington. Core funds comprise “core-directed” funding to address specific constraints to the focus of the USAID Global “element” teams, and “common agenda” funding to address cross-cutting issues (Figure 2). In Year 5, 17.7 percent of the project’s funds (total \$38,528,322) came from core funding and 82.3 percent came from field support. Over the life of the project, this breakdown is 25 percent core funding and 75 percent field support.

FIGURE 2. FUNDING OF HEALTH SYSTEMS 20/20 PROJECT



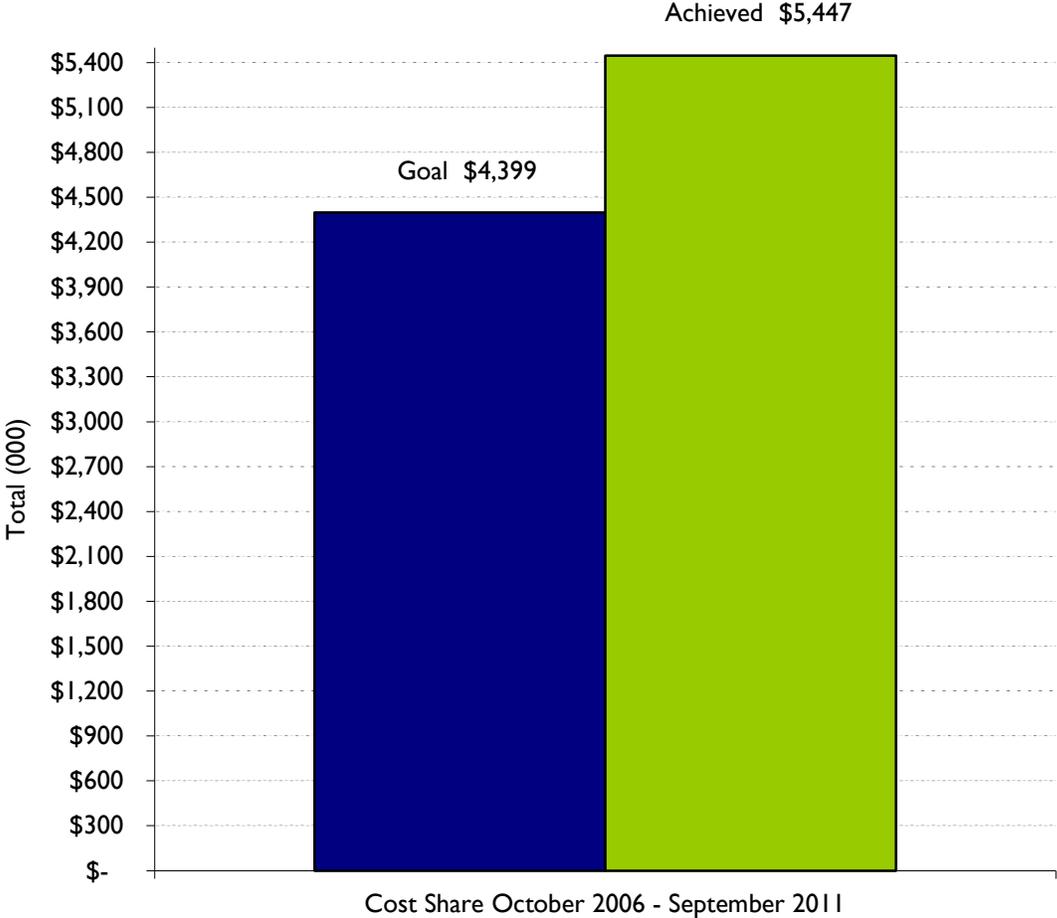
As has been noted, the number of countries in which Health Systems 20/20 has activities has increased dramatically over the life of the project, from five countries in Year 1, to 20 in Years 2 and 3, to 28 in Year 4, 32 in Year 5, and to over 50 countries in Year 6. Figure 3 breaks down funding by project year and country.

FIGURE 3. HEALTH SYSTEMS 20/20 FIELD SUPPORT FUNDING



It should be noted that the Health Systems 20/20 cooperative agreement includes a 5 percent cost-share requirement for the recipient team to contribute through direct and third-party contributions. In Year 1, the project established rigorous cost-share guidelines and reporting forms. As of the end of Year 5, the project had successfully achieved 124 percent of its cost-share goal (Figure 4). We expect to revise the cost-share percentage upward once accrued Year 5 contributions from several field activities are documented. These include HSS activities carried out under the U.K. DFID-funded Paths II project in Nigeria and national data collection activities in DRC in conjunction with UNAIDS and UNICEF.

FIGURE 4. COST-SHARE ACHIEVEMENT 124% OF GOAL, PROJECT YEARS 1-5

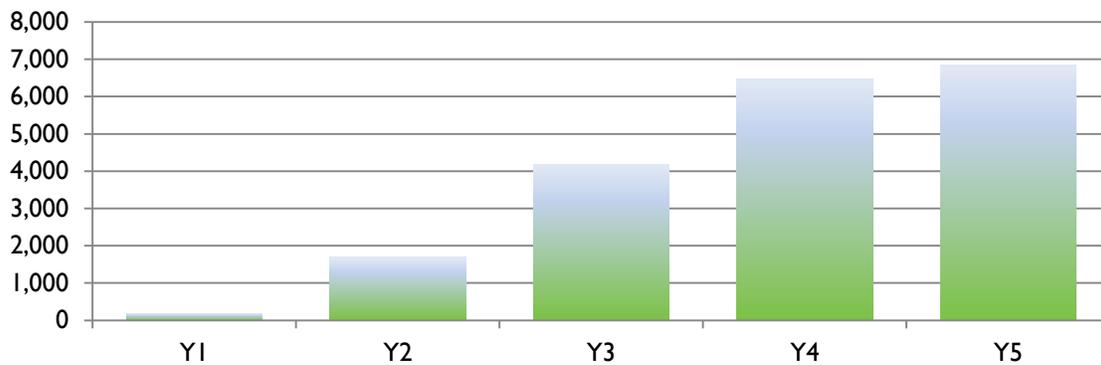


5. WEB SITE AND SOCIAL MEDIA STATISTICS

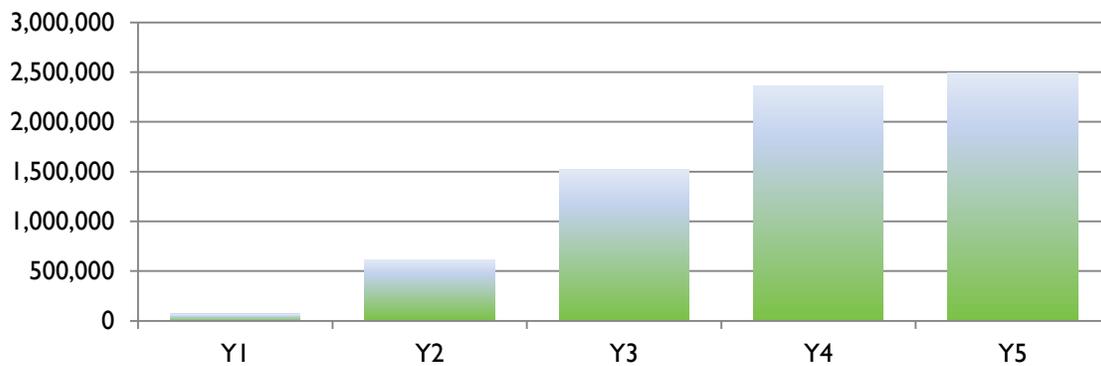
Health Systems 20/20's Year 5 web site statistics show a continuing upward trend. The project disseminated 20 e-announcements, and increased the list of subscribers by 19 percent to 3,539 contacts. Users from 229 countries accessed the site. Page views surged in the month of September to an all-time high of over 300,000 page views. Figure 5 illustrates the exponential growth of web site usage from Year 1 to Year 5 of the project.

FIGURE 5. GROWTH IN WEB SITE VISITS TO HEALTH SYSTEMS 20/20, YEARS 1-5

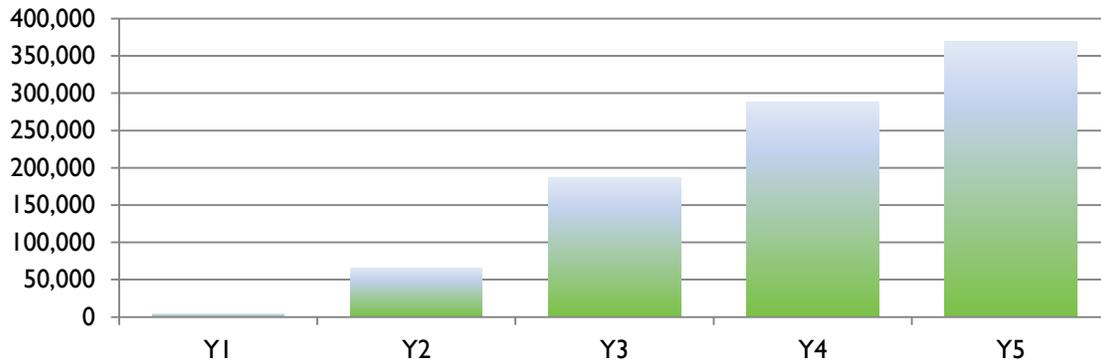
Health Systems 20/20 Web Site Average Daily Page Views, Year 1 - Year 5



Health Systems 20/20 Web Site Total Page Views, Year 1 - Year 5



Health Systems 20/20 Web Site Resource Downloads, Year 1 - Year 5



Note: Page views: Requests from a visitor's browser for a displayable web page, a single user can rack up many page views.
Downloads: The number of times files are requested for download from the web site.

FACEBOOK

The number of new subscribers/fans on the Health Systems 20/20 Facebook page increased by more than 40 percent to a total of 516 in Year 5. The project's Facebook page received nearly 72,000 post views (number of times fans and non-fans have viewed a newsfeed story posted by the page) in the year. As the Health Systems 20/20 audience grows, user activity continues to increase. The number of monthly active users (a 30-day count of people who have viewed or interacted with the Facebook page) increased by nearly fivefold to 355 in September 2011. User feedback (likes and comments on the Health Systems 20/20 page) increased by 37 percent over the past year. Facebook has more than 800 million active users. In May 2010, Facebook surpassed Google in daily page views and in August 2011, Facebook became the first web site to receive 1 trillion monthly page views.

TWITTER

The Health Systems 20/20 Twitter page currently has 381 followers. Our average retweet (i.e., publicly posted by other individuals and organizations on their Twitter page) rate has increased by tenfold from last year. Twitter has been at the center of many news-breaking stories over the past year and we are pleased to have a strong presence in this medium. According to the web analytics firm ComScore, 32.8 million unique visitors used Twitter in July 2011.

Social media continues to be an effective, low-cost method for sharing success stories and documents produced by the project.



Christine Ortiz/El Salvador

ANNEX: ASSOCIATE AWARDS

HEALTHCARE SYSTEM STRENGTHENING IN ARMENIA

The three-year Healthcare System Strengthening in Armenia (HS-STAR) project began implementation in February 2011. The goal of HS-STAR is to address key constraints in health financing, leadership and governance, human resources, and information systems that impede access to and delivery of quality health services. The project relies on an approach that simultaneously aims to strengthen the health system while improving the quality of care and increasing population knowledge in priority service areas, including MCH, reproductive health and family planning, TB, non-communicable diseases and emergency medicine.

With an eye on sustainability, HS-STAR aims to significantly enhance local capacity to design, implement, and monitor reform through technical assistance in four areas:

- **Health financing and governance:** Develop and sustain government capacity to properly manage available resources to meet existing health needs of the population.
- **Quality improvement:** Increase government capacity to establish a system of sustainable quality improvement processes in priority service areas.
- **Tuberculosis:** Build the capacity of the National Tuberculosis Program to implement priority activities that improve infection control measures and improve prevention, diagnosis, and treatment for multi-drug resistant TB cases.

- **Civil society engagement:** Empower individuals and communities to exercise their health rights and responsibilities in an informed way and institutionalize these efforts through increased government ownership and innovative public-private partnerships.

Though still in its first year, HS-STAR has already made significant achievements. As part of quality improvement efforts, the project conducted a rapid assessment of stakeholder perceptions of barriers and improvement opportunities for institutionalization and sustainability of the quality of care processes that previous projects introduced at different levels of the health care system. It also assessed emergency care and ambulance services throughout Armenia and developed a realistic improvement strategy. To optimize the country's allocation of health workers, the project designed a health workforce planning model using data on enrolled population, medical graduates, health service utilization, and primary health care (PHC) physician workload. Linking quality improvement with health financing, HS-STAR supported implementation of the new performance-based provider payment system by analyzing PHC performance data; the project also developed a tool to help the MOH and facilities calculate performance-based bonus payments for PHC doctors and nurses. Working closely with the National Tuberculosis Program, the project introduced a scoring system for choosing the patients for treatment from the Multi-Drug Resistant-TB waiting list. Lastly, to encourage the population's use of health care services, the project developed radio public service announcements on pre-conception care and family planning topics.

PRIMARY HEALTH CARE STRENGTHENING PROJECT IN AZERBAIJAN

The USAID Primary Health Care Strengthening (PHCS) Project in Azerbaijan works closely with the MOH to improve the country's PHC system. The project provides technical assistance to the Government of Azerbaijan to strengthen health policies, initiate improvements in HIS and health care financing, establish a foundation for improvements in quality of care, promote personal responsibility for health, and improve services for TB, PHC, and maternal, neonatal and child health (MNCH).

In 2011, the project continued to provide technical assistance to the MOH in six areas:

- **Health financing**—PHCS supported the MOH in implementing the Action Plan of the Concept for National Health Financing Reform 2008-2012, designing new payment systems for hospitals and PHC, and piloting new provider payment systems. The project also concentrated efforts on strengthening hospital HIS, an integral part of any case-based hospital payment system, and expanded the number of hospitals where a computerized database on discharge patients was introduced.
- **Health policy**—PHCS supported a study tour for parliamentarians to Turkey to inform efforts to strengthen the legislative and regulatory base for family medicine. The project also supported the piloting of a simple software system to monitor receipt and disbursement of pharmaceuticals in order to inform improvements in the management of drugs. Finally, the project conducted a Reproductive Health Situational Analysis and made recommendations to address ongoing barriers to access to and demand for contraceptives.
- **Quality improvement**—PHCS significantly contributed to the development of six clinical practice guidelines and built the capacity of PHC providers to provide clinical care according to approved guidelines. The project continued to support district monitoring teams with the continuous quality improvement process at PHC facilities in five pilot districts.
- **Health communication**—PHCS conducted trainings for journalists on blood diseases, TB, and malaria and supported the development of TV shows on TB and MNCH. The project also supported the development of patient education materials on rational antibiotics use, diabetes, nodular goiter, and sputum collection. To support improvements in the quality of health services, the project conducted trainings on provider-patient communications for medical doctors.
- **TB**—PHCS supported the development of several TB-related regulations and policies: the National TB Strategy for 2011-2015, recommendations to improve TB laboratory services, and the draft Action Plan for TB Strategy 2011-2015 Implementation. The project supported a TB KAP (knowledge, attitude, and practice) study regarding reasons for treatment default among TB patients to inform TB policy decisions. In the service delivery area, PHCS trained nearly 50 TB specialists in drug-resistant TB treatment. To improve the country's TB recording and report system, the project supported the introduction of e-TB Manager, a comprehensive electronic TB registration and monitoring system, in the prison system and the National Reference Laboratory.
- **MNCH**—PHCS provided multifaceted technical assistance to the MOH to implement the National Perinatal Program by developing proposals for a new referral system, standards of care, a list of essential equipment, and maternal/neonatal transport systems. The project conducted trainings on new MNCH standards of care for more than 300 gynecologists, obstetricians, neonatologists, midwives, and PHC providers in selected regions. To ascertain the knowledge and attitudes of health providers towards Active Management of the Third Stage of Labor (AMTSL), PHCS conducted an assessment in health care facilities where maternal mortality cases were registered. Finally, PHCS supported the development of four evidence-based MNCH clinical practice guidelines.

DJIBOUTI GOOD GOVERNANCE IN THE HEALTH SECTOR

The Djibouti Good Governance in the Health Sector associate award is providing the MOH with technical assistance, equipment, and training to manage the delivery of quality essential services. The project is working with the MOH to ensure that strengthened health governance activities are integrated into the MOH Action Plan (PNDS). Activities take place under two main areas, the HMIS and financial management, part of governance; both include extensive training to ensure country ownership and sustainability.

Health management information system: The lack of reliable data is a major handicap for health decision-making in Djibouti. Prior to this award, USAID assisted the MOH to establish a functional and routine HMIS, which operates at both the district and national management levels and is used to enter and analyze monthly summary report data. Further assistance is needed so that the HMIS can fully respond to the needs of the MOH and international partners. For example, the HIV/AIDS program and others are requesting expansion of the HMIS to include newly established reporting requirements. Linkages to demographic and other databases are needed so that the system can include population-based indicators.

Health Systems 20/20 is working with the MOH to refine pre-defined reports so that the HMIS Unit can better manage and utilize data from health centers and hospitals. The project will build the unit's capacity to improve data management, security, and dissemination. Eventually it will help develop and implement a plan for the use of health information for decision-making at all levels of the system.

In Year 5, 105 health care workers were trained to correctly fill out the monthly report (RAM). All district focal points and doctors, hospital managers, and supervising doctors, were trained to use the HMIS software and update the database with the RAMs submitted by each health post.

While the training was designed to address the most common problems the HMIS team found in the incoming RAM tables, working with the health care workers allowed the trainers to identify improvements needed in the RAM and recognize that some common "mistakes" were due to service delivery rather than reporting errors, a finding that was promptly reported to the MOH and responsible parties.

The HMIS Unit is currently making improvements to the RAM expected to be in service in January 2012. The HMIS is also currently transitioning to new database software, again to be launched in January after appropriate training. Additional funding for the HMIS project was secured from UNICEF and the work plan is under review for a no-cost extension to accommodate these additional funds.

Financial management: Health Systems 20/20 is working closely with the MOH financial management and inspection offices to reinforce ministry coordination, control, and M&E of financial management at different levels of the health system. Based on extensive organizational analysis, the project recommended organization changes to increase ministry responsiveness and accountability. Additionally, it conducted internal audit training with 12 MOH inspectors and affiliated department directors. Immediately following the training there was a guided practice in which recently trained inspectors conducted two internal audits with oversight and feedback from the internal audit trainer. The training produced a Djibouti-specific *Manual of Procedures for Internal Audits* that the MOH will use to sustain the audit process. Large procurements of furniture and IT equipment were made to support the financial management improvements at the ministry.

PROGRAMA SISTEMAS DE SALUD 20/20 IN EL SALVADOR

The Health Systems 20/20 Associate Award to the government of El Salvador (2009-2012) supports the health sector by addressing challenges in strategic planning, health finance, governance, and operations. The program builds on the successes of the previous TASC2 award in both health financing and procurement supply management. Under the award, there are four functions designed to support El Salvador's health system:

- Strengthening the governance function
- Strengthening the financing and financial management function
- Strengthening the availability of the MOH's human resources
- Strengthening availability of drugs, medical supplies, and contraceptives

Strengthening governance: The project assists the government of El Salvador in the development of a long-term strategic plan to help the sector implement basic organizational and processes restructuring, including human resource management, performance monitoring, managing and using reliable information, and also budget, disbursement and tracking. These tasks include: formulating annual operational plans and indicators to follow-up, monitor, and evaluate the annual operational plans; developing MOH Planning Directorate capacities to draft policies and monitor and evaluate results; and validating the methodology to link the goals in the annual operational plans and financial resources.

Strengthening health care financing: The program developed a methodology that links the formulation of the annual operational plan with the formulation of the budget. The ministry is developing the primary phase, which consists of introducing criteria of efficiency for the estimation and evaluation of the needs of different resources, especially human resources and drugs and medical supplies, which represent approximately 95% of health facilities operating budget inputs. This methodology is being used to develop the budget for draft of the MOH 2012 plan of action. Over the past year, project staff have worked closely with district level hospitals to introduced performance-based budgeting to replace historical budgeting.

Improving human resources capacity: The program provided training to 762 Ministry of Health officials at the central level, hospitals, and health care units on drafting and evaluating annual operations plans. Training was provided to 22 employees of the Higher Council for Public Health on strategic management of quality health care, and to 9 trainees from the Emergency Committee on risk management fundamentals. Furthermore, an HRH strategy document was developed in conjunction with the MOH to operationalize the new community-based health teams for primary care.

Increasing availability of drugs, medical supplies, and contraceptives: The program developed software, trained staff, and purchased computers and other supplies needed to implement the supply information system, which supports every step of the pharmaceutical procurement process. The pharmaceutical supply information system is being used at the MOH in 30 hospitals and five regional health centers that supply drugs to 377 health units and 149 health posts. Patients benefit from the tighter, centralized monitoring system because pharmacies receive medicines faster and are less vulnerable to stock-outs. Furthermore, the system allows pharmacies to check the availability of drugs at nearby facilities in the event of a drug shortage.



Christine Ortiz/El Salvador

PRIVATE HEALTH SECTOR PROGRAM IN ETHIOPIA

The Private Health Sector Program (PHSP) in Ethiopia, a five-year program funded by USAID/Ethiopia, is working to strengthen linkages between the public and private health sectors as important elements of the national health system. The program's implementation strategy includes consensus building with all stakeholders and capacity building, especially of private providers to deliver targeted services, in particular for TB/HIV, mobile HCT for most-at-risk population groups, and family planning. It also fosters creation of an enabling policy environment to ensure the full participation of the private health sector and ensures skills and knowledge transfer to the Federal Ministry of Health/Regional Health Bureaus, and Town Health Offices to guarantee sustainability. PHSP current works with 254 private facilities.

Although the program has just finished its second year of implementation, it has some impressive achievements, as the numbers below show:

TB/HIV services: PHSP is currently supporting 197 private health facilities in five major regions (Amhara, Harari, Oromia, Southern Nations, Nationalities and Peoples [SNNP], Tigray) and two city administrations (Addis Ababa and Dire Dawa) to provide TB services. These private facilities can now correctly diagnose a significant number of TB cases and correctly refer them to health facilities close to their homes for treatment and follow up. Between April and June 2011, 3,681 (75.4 percent) patients who came in for testing were diagnosed with TB and referred from the private health facilities to public health and hospital facilities for follow up treatment.

PHSP also supports TB/HIV services in 10 workplace health facilities in Oromia, Amhara, and Addis Ababa. The sites enrolled 108 TB patients, 15.2 percent more than the target set for April–June 2011; 86 (79.6 percent) of them also received HCT services during the first three months of TB treatment. Of those tested, only 37 (17.3 percent) were HIV positive. Overall, 1,636 clients (49.0 percent female) were tested for HIV. The HIV-positive rate was 2.8 percent (3.7 percent among females and 1.8 percent among males).

PHSP has introduced the process of joint supportive supervision in the private facilities it supports. It conducts supervision visits jointly with the Town/Woreda Health Offices and Sub-city Health Office TB/HIV focal persons. The process includes discussions with facilities on major TB/HIV-related activities, challenges, and possible actions to resolve the challenges. Corrective measures and feedback are provided on identified problems and at the end of each visit, an agreed action plan is developed and discussed with facility staff for follow-up. To facilitate supportive supervision, PHSP introduced a new mobile electronic tool, the PDA Version 3.4.

Mobile HIV counseling and testing: Under a program agreement with two private health facilities, PHSP implements mobile HCT in 21 towns located along four major transport routes in Oromia, SNNPR, and Tigray. The mobile HCT program has focused on creating access to and demand for HCT services among populations most-at-risk of HIV infection. The mobile units also offer family planning services. By the end of June, MCT services had been provided for a total of 18,024 clients (male 9,950 and female 8,074). Out of the total tested, 479 (2.7 percent) were HIV positive.

Strengthening the federal level to promote sustainability: PHSP supports the Federal Ministry of Health at the national level, and seconded to the ministry a staff member who has provided input and support for development of Ethiopia's five-year implementation strategy on the Global Health Initiative and drafted the implementation guideline for the Gene Xpert Mycobacterium tuberculosis (MTB) and resistance to rifampicin (RIF) technique. PHSP also took part in finalizing and field testing the national comprehensive TB, leprosy, and TB/HIV training material for health workers.

4TH SECTOR HEALTH PROJECT IN LATIN AMERICA AND THE CARIBBEAN

The 4th Sector Health Project, led by Abt Associates in collaboration with RTI International and Forum One Communications, contributes to improved health outcomes in Latin America and the Caribbean by developing partnerships and strengthening local capacity. Now in its fourth year, 4th Sector Health uses USAID funding to leverage private sector funding for public health programs in areas such as HIV/AIDS, TB, malaria, MCH, and reproductive health.

4th Sector Health has two main objectives: building public-private alliances in health and facilitating South-to-South exchange activities of best practices throughout the region. Through the first component, 4th Sector Health assists in brokering and convening regional alliances. The project strives to identify new sources of funding from the corporate sector for health programming for priority health needs in the region, and in exchange offers partnership with USAID and funding to leverage corporate contributions to health activities. The target is to leverage funding at a 3-to-1 corporate partner-to-USAID ratio. Implementing organizations that receive funding from alliance partners build their capacity to work with the private sector, so that in the future they are able to successfully expand their base of potential donors to work on health activities.

4th Sector Health has sought alliances that promise some degree of sustainability and far greater impact than its own investment alone would allow for. More than 28,520 individuals in seven countries have been reached with the efforts of alliance activities. The range of alliance activities includes the following:

- Seed-funding the expansion of a reproductive health program for vulnerable youth in Mexico with Johnson & Johnson
- Supporting the development of innovative tools with Project HOPE and Bristol Myers Squibb to screen pregnant women for gestational diabetes
- Adding an essential health component to a regional food security project in Green Mountain Coffee Roaster's supply chain
- Increasing regional access to a new pediatric Chagas drug with DNDi
- Working with Procter & Gamble to ensure that life-saving clean water products are available after disasters
- Funding innovations in information and communications technologies for health with telecoms Ericsson and Claro

In addition, in the past year, 4th Sector Health's South-to-South exchanges have taken place between health professionals in Ecuador, Dominican Republic, Mexico, and Costa Rica. The exchanges fund activities to promote increased sharing of best practices among health program practitioners in the region. The project funds both interpersonal and Internet-based exchanges.

