



# ANNUAL PERFORMANCE MONITORING REPORT

OCTOBER 1, 2014 – SEPTEMBER 30, 2015

November 2015

This publication was produced for review by the United States Agency for International Development.  
It was prepared by the Health Finance and Governance Project.

## The Health Finance and Governance Project

USAID's Health Finance and Governance (HFG) project will help to improve health in developing countries by expanding people's access to health care. Led by Abt Associates, the project team will work with partner countries to increase their domestic resources for health, manage those precious resources more effectively, and make wise purchasing decisions. As a result, this five-year, \$209 million global project will increase the use of both primary and priority health services, including HIV/AIDS, tuberculosis, malaria, and reproductive health services. Designed to fundamentally strengthen health systems, HFG will support countries as they navigate the economic transitions needed to achieve universal health care.

**November 2015**

**Cooperative Agreement No:** AID-OAA-A-12-00080

**Submitted to:** Scott Stewart, AOR  
Office of Health Systems  
Bureau for Global Health  
United States Agency for International Development

**Recommended Citation:** Health Finance and Governance project. November 2015. *Annual Performance Monitoring Report October 1, 2014 – September 30, 2015*. Bethesda, MD: Health Finance and Governance project, Abt Associates Inc.



Abt Associates Inc. | 4550 Montgomery Avenue, Suite 800 North | Bethesda, Maryland 20814  
T: 301.347.5000 | F: 301.652.3916 | [www.abtassociates.com](http://www.abtassociates.com)

Avenir Health | Broad Branch Associates | Development Alternatives, Inc. (DAI)  
| Johns Hopkins Bloomberg School of Public Health (JHSPH) | Results for Development Institute (R4D)  
| RTI International | Training Resources Group, Inc. (TRG)



# **HEALTH FINANCE AND GOVERNANCE PROJECT ANNUAL PERFORMANCE MONITORING REPORT**

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## **DISCLAIMER**

The author's views expressed in this publication do not necessarily reflect the views of the United States Agency for International Development (USAID) or the United States Government.



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# ACRONYMS

<b>AFD</b>	<i>Agence Française de Développement</i> (French Development Agency)
<b>AfHEA</b>	African Health Economics Association
<b>AFR/SD</b>	Africa Bureau Office of Sustainable Development
<b>AIDS</b>	Acquired Immune Deficiency Syndrome
<b>ANAM</b>	<i>Agence National d'Assurance Maladie</i> (National Agency for Health Insurance)
<b>ANHSS</b>	Asia Network for Capacity Building in Health Systems Strengthening
<b>AO</b>	Agreement Officer
<b>AOR</b>	Agreement Officer Representative
<b>APPF</b>	Asia Public Policy Forum
<b>APTS</b>	Auditable Pharmacy Transaction and Services
<b>ART</b>	Antiretroviral Therapy
<b>ASTMH</b>	American Society of Tropical Medicine and Hygiene
<b>AYUSH</b>	Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homoeopathy
<b>BNHA</b>	Bangladesh National Health Account
<b>BoFED</b>	Bureau of Finance and Economic Development
<b>BPR</b>	Business Process Reengineering
<b>BSC</b>	Balanced Score Card
<b>CARICOM</b>	Caribbean Community
<b>CASH</b>	Clean and Safe Hospitals
<b>CASN</b>	Canadian Association of Schools of Nursing
<b>CBHI</b>	Community-based Health Insurance
<b>CDC</b>	Centers for Disease Control and Prevention
<b>CDC-CRED</b>	Competencies Development Centers for Children's Growth and Development Control
<b>CFC</b>	Child-Friendly Court
<b>CGD</b>	Center for Global Development
<b>CHAG</b>	Christian Health Association of Ghana
<b>CHAI</b>	Clinton Health Access Initiative
<b>CHPM</b>	Center for Health Policy and Management
<b>CHPS</b>	Community-based Health Planning and Services Initiative
<b>CHW</b>	Community Health Worker
<b>CIDRZ</b>	Centre for Infectious Disease Research in Zambia
<b>CIH</b>	Commission on Investing in Health
<b>CMAM</b>	<i>Central de Medicamentos e Artigos Médicos</i> (Central Medical Store, Mozambique)
<b>CONSAMUS</b>	<i>Le Conseil National des Structures d'Appui aux Mutuelles de Santé</i>
<b>COP</b>	Chief of Party
<b>COP</b>	Country Operational Plan
<b>CPHL</b>	Central Public Health Laboratory
<b>CPWA</b>	Child Protection and Welfare Act

<b>CSI-FBP</b>	Interdepartmental Scientific Committee for the Implementation of the National Performance-Based Financing Strategy
<b>CSO</b>	Civil Society Organization
<b>CWFD</b>	Concerned Women for Family Development
<b>DAB</b>	<i>Direction de l'Administration et du Budget</i> (Department of Administration and Budget)
<b>DAF</b>	<i>Direction des Affaires Financieres</i> (Directorate of Financial Affairs)
<b>DAI</b>	Development Alternatives, Inc.
<b>DALY</b>	Disability-Adjusted Life Year
<b>DCE</b>	Discrete Choice Experiment
<b>DFID</b>	Department for International Development
<b>DFPSS</b>	<i>Direction de la Formation et de Perfectionnement en Sciences de la Santé</i>
<b>DG</b>	<i>Directeur Generale</i> (Director General)
<b>DGHS</b>	Directorate General Health Services
<b>DHI</b>	Department of Health Insurance
<b>DHMT</b>	District Health Management Team
<b>DHS</b>	Demographic and Health Survey
<b>DOGS</b>	<i>Direction de l'Organisation et de Gestion des Services des Soins de Santé</i> (Directorate of the Organization and Management of Health Services)
<b>DOH</b>	Department of Health
<b>DOSS</b>	<i>Direction d'Organisation des Services de Santé</i> (Directorate of the Organization of Health Services)
<b>DPF</b>	Department of Planning and Finance
<b>DPS</b>	Provincial Health Division
<b>DPSS</b>	<i>Direction de la Prospective, de la Planification et des Stratégies</i> (Department of Planning and Statistics)
<b>DQA</b>	Data Quality Assessment
<b>DRC</b>	Democratic Republic of Congo
<b>DRG</b>	Center of Excellence on Democracy, Rights and Governance
<b>DRG</b>	Diagnosis-Related Group
<b>DRH</b>	<i>Direction des Ressources Humaines</i> (Department of Human Resources)
<b>DSCMP</b>	<i>Direction de la Santé Communautaire et de la Médecine de Proximité</i>
<b>DSGRH</b>	<i>Direction des Ressources Humaines</i> (Directorate of General Services and Human Resources)
<b>DSIM</b>	<i>Direction des Soins Infirmiers et Maternels</i>
<b>DSO</b>	<i>Department de Santé de l'Ouest</i>
<b>DSW</b>	Department of Social Welfare
<b>E&amp;E</b>	Eastern Europe and Eurasia
<b>E2Pi</b>	Evidence to Policy Initiative
<b>EAHF</b>	East Africa Health Federation
<b>eCMS</b>	Electronic Case Management System
<b>EFY</b>	Ethiopian Fiscal Year
<b>EGPAF</b>	Elisabeth Glaser Pediatric AIDS Foundation
<b>EHAC</b>	Ethiopian Hospital Alliance for Quality
<b>EHIA</b>	Ethiopian Health Insurance Agency
<b>EHRIG</b>	Ethiopian Hospital Reform Implementation Guideline
<b>EID</b>	Early Infant Diagnosis

<b>eMTCT</b>	Elimination of Mother-to-Child Transmission
<b>ENAP</b>	Every Newborn Action Plan
<b>EOI</b>	Expression of Interest
<b>EPCMD</b>	Ending Preventable Child and Maternal Deaths
<b>EPHS</b>	Essential Package of Health Services
<b>EPM</b>	Entry Point Mapping
<b>EVD</b>	Ebola Viral Disease
<b>F&amp;A</b>	Finance and Administration
<b>FARA</b>	Fixed Amount Reimbursement Agreement
<b>FMOF</b>	Federal Ministry of Finance
<b>FMOH</b>	Federal Ministry of Health
<b>FP2020</b>	Family Planning 2020
<b>FP/RH</b>	Family Planning/Reproductive Health
<b>GDP</b>	Gross Domestic Product
<b>GEPE</b>	<i>Gabinete de Estudios, Planeamiento e Estadística</i> Department of Research, Planning and Statistics
<b>GHB</b>	Global Health Bureau
<b>GHI</b>	Global Health Initiative
<b>GHS</b>	Ghana Health Service
<b>GIS</b>	Geographic Information System
<b>GOP</b>	Government of Peru
<b>GRN</b>	Government of the Republic of Namibia
<b>GTT</b>	<i>Groupe Technique de Travail</i> (Technical Working Group)
<b>HA</b>	Health Accounts
<b>HAAT</b>	Health Accounts Analysis Tool
<b>HAPT</b>	Health Accounts Production Tool
<b>HC</b>	Health Center
<b>HCF</b>	Health Care Financing
<b>HCFRTF</b>	Health Care Financing Resource Task Force
<b>HCFS</b>	Health Care Financing Strategy
<b>HCM-II</b>	Healthy Communities and Municipalities II
<b>HEU</b>	Health Economics Unit
<b>HF</b>	Health Facility
<b>HFG</b>	Health Finance and Governance
<b>HFS-IP</b>	Health Financing Strategy Implementation Plan
<b>HHA</b>	Harmonizing Health in Africa
<b>HIDN</b>	Office of Health, Infectious Diseases, and Nutrition
<b>HIS</b>	Health Information Systems
<b>HIV</b>	Human Immunodeficiency Syndrome
<b>HMIS</b>	Health Management Information Systems
<b>HP</b>	Health Policy Reform
<b>HPMI</b>	Hospital Performance Monitoring and Improvement
<b>HPNSDP</b>	Health, Population, and Nutrition Sector Development Program
<b>HPP</b>	Health Policy Project
<b>HRAA</b>	Human Resources Alliance for Africa
<b>HRH</b>	Human Resources for Health
<b>HRHMC</b>	Human Resources Management Committee
<b>HRHTWG</b>	Human Resources for Health Technical Working Group

<b>HRIS</b>	Human Resources Information System
<b>HRU</b>	Human Resources Unit
<b>HSA</b>	Health Services Assessment
<b>HSDA</b>	Health Services Delivery and Administration
<b>HSDP</b>	Health Sector Development Program
<b>HSFR</b>	Health Sector Finance Reform
<b>HSG</b>	Health Systems Global
<b>HSHRC</b>	Haryana State Health Resource Center
<b>HSR</b>	Health System Research
<b>HSS</b>	Health Systems Strengthening
<b>HSSP</b>	Health Sector Strategic Plan
<b>HTC</b>	HIV testing and counseling
<b>HUM</b>	Hôpital Universitaire de Mirebalais
<b>IDI</b>	Infectious Disease Institute
<b>IDU</b>	Injecting Drug Users
<b>IGSLS</b>	Inspector General for Health and the Fight Against AIDS
<b>iHEA</b>	International Health Economics Association
<b>IHME</b>	Institute of Health Metrics and Evaluation
<b>IHP</b>	Institute for Health Policy
<b>IMCI</b>	Integrated Management of Childhood Illness
<b>INFAS</b>	<i>Institute National de Formation des Agents de Santé</i> (National Institute of Health Worker Training)
<b>INFS</b>	<i>Institut National de Formation Sociale</i> I(National Institute of Social Worker Training)
<b>IPPF</b>	International Planned Parenthood Federation
<b>IR</b>	Intermediate Result
<b>IR</b>	Implementation Research
<b>IRB</b>	Institutional Review Board
<b>IRS</b>	Indoor Residual Spraying
<b>ISS</b>	Integrated Supportive Supervision
<b>IT</b>	Information Technology
<b>JHPN</b>	<i>Journal of Health, Population and Nutrition</i>
<b>JHSPH</b>	Johns Hopkins School of Public Health
<b>JICA</b>	Japan International Cooperation Agency
<b>JKN</b>	<i>Jaminan Kesehatan Nasional</i>
<b>JLN</b>	Joint Learning Network
<b>JPGSPH</b>	James P Grant School of Public Health, BRAC University
<b>JSI</b>	John Snow, Inc.
<b>KEMRI</b>	Kenya Medical Research Institute
<b>KPI</b>	Key Performance Indicator
<b>KSPH</b>	Kinshasa School of Public Health
<b>L3M</b>	Level 3 Monitoring
<b>LAC</b>	Latin America and the Caribbean
<b>LLIN</b>	Long-Lasting Insecticide-Treated Net
<b>LMD</b>	License, Master, Doctorate
<b>LMG</b>	Leadership, Management and Governance Project
<b>LMIC</b>	Low-and Middle-Income Countries
<b>LOA</b>	Letter of Agreement
<b>LOE</b>	Level of Effort

<b>LSMS</b>	Living Standards Measurement Survey
<b>M&amp;E</b>	Monitoring and Evaluation
<b>MaHTAS</b>	Malaysian Health Technology Assessment Section
<b>MARP</b>	Most At-Risk Population
<b>MCDMCH</b>	Ministry of Community Development, Maternal and Child Health
<b>MCH</b>	Maternal and Child Health
<b>MCPR</b>	Modern Contraceptive Prevalence Rate
<b>MCTS</b>	Mother and Child Tracking System
<b>MDA</b>	Ministries, Departments, and Strategies
<b>MDG</b>	Millennium Development Goal
<b>MDR</b>	Multidrug Resistant
<b>MDTF</b>	Multi-Donor Trust Fund
<b>MEF</b>	<i>Ministère de l'économie et des Finances</i> (Ministry of Economics and Finance)
<b>MHE</b>	Ministry of Higher Education
<b>MHIF</b>	Mandatory Health Insurance Fund
<b>MINSA</b>	<i>Ministerio da Saúde</i> (Ministry of Health)
<b>MIS</b>	Management Information Systems
<b>MMT</b>	Methadone Maintenance Treatment
<b>MNCH</b>	Maternal, Neonatal, and Child Health
<b>MOE</b>	Ministry of Education
<b>MOF</b>	Ministry of Finance
<b>MOFED</b>	Ministry of Finance and Economic Development
<b>MOH</b>	Ministry of Health
<b>MOHFW</b>	Ministry of Health and Family Welfare
<b>MOHSS</b>	Ministry of Health and Social Services
<b>MOHSW</b>	Ministry of Health and Social Welfare
<b>MOPS</b>	Ministry of Public Service
<b>MoWCA</b>	Ministry of Women's and Children's Affairs
<b>MPCE</b>	Ministry of Planning and Donor Coordination
<b>MSD</b>	Medical Services Directorate
<b>MSF</b>	<i>Médecins Sans Frontières</i> (Doctors Without Borders)
<b>MSH</b>	Management Sciences for Health
<b>MSLS</b>	<i>Ministère de la Santé et de la Lutte contre le SIDA</i> (Ministry of Health and Fight Against AIDS)
<b>MSM</b>	Men Who Have Sex with Men
<b>MSP</b>	<i>Ministère de la Santé Publique</i> (Ministry of Public Health)
<b>MSPLS</b>	Ministry of Health and Fight Against HIV/AIDS
<b>MSPP</b>	<i>Ministère de la Santé Publique et de la Population</i> (Ministry of Public Health and Population)
<b>MTR</b>	Mid-Term Review
<b>NACA</b>	National Agency for the Control of AIDS
<b>NCHADS</b>	National Center for HIV/AIDS, Dermatology and STD
<b>NGO</b>	Nongovernmental Organization
<b>NHA</b>	National Health Accounts
<b>NHIA</b>	National Health Insurance Authority

<b>NHIA</b>	National Health Insurance Administration
<b>NHIS</b>	National Health Insurance Scheme
<b>NMCC</b>	National Malaria Control Centre
<b>NRM</b>	National Health Mission (formerly National Rural Health Mission (NRHM))
<b>NHSDP</b>	NGO Health Services Delivery Project
<b>NHSSPII</b>	National Health Sector Strategic Plan II
<b>NICE</b>	National Institute for Health and Clinical Excellence
<b>NT</b>	National Treasury
<b>NTBLCP</b>	National Tuberculosis and Leprosy Control Program
<b>OECD</b>	Organization for Economic Co-operation and Development
<b>OECS</b>	Organization of Eastern Caribbean States
<b>OGAC</b>	Office of the Global AIDS Coordinator
<b>OGEI</b>	Office of Statistics and Informatics
<b>OHA</b>	Office of HIV/AIDS
<b>OHS</b>	Office of Health Systems
<b>OHT</b>	OneHealth Tool
<b>OMRH</b>	<i>Office de Management et des Ressources Humaines</i> (Office of Management and Human Resources)
<b>OOP</b>	Out-of-Pocket
<b>OP</b>	Operational Plan
<b>OR</b>	Operations Research
<b>ORAS</b>	<i>Organismo Regional Andino de Salud</i> (Andean Health Agency)
<b>ORT</b>	Other Recurrent Transactions
<b>OSM</b>	Office of Strategic Management
<b>P4H</b>	Providing for Health
<b>PANCAP</b>	Pan Caribbean Partnership Against HIV-AIDS
<b>PATHS2</b>	Partnership for Transforming Health Systems, Phase Two
<b>PBF</b>	Performance-Based Financing
<b>PBI</b>	Performance-Based Incentives
<b>PCRPP</b>	President's 2013 Comprehensive Response Plan
<b>PDS</b>	<i>Plan Directeur de Santé</i>
<b>PE</b>	Personnel Emoluments
<b>PEPFAR</b>	President's Emergency Plan for AIDS Relief
<b>PER</b>	Public Expenditure Review
<b>PF</b>	Partnership Framework
<b>PFIP</b>	Partnership Framework Implementation Plan
<b>PFM</b>	Public Financial Management
<b>PFPA</b>	Procurement, Finance, and Property Administration
<b>PHC</b>	Primary Health Care
<b>PHER</b>	Public Health Expenditure Review
<b>PHFI</b>	Public Health Foundation of India
<b>PHR</b>	Partners for Health Reform
<b>PIO</b>	Public International Organization
<b>PLHIV</b>	People Living with HIV
<b>PMI</b>	President's Malaria Initiative
<b>PMP</b>	Performance Monitoring Plan
<b>PMTCT</b>	Prevention of Mother-to-Child Transmission

<b>PNDS</b>	<i>Plan National de Développement Sanitaire</i> (National Plan for Health Development)
<b>PNDS</b>	<i>Plano Nacional de Desenvolvimento Sanitário</i> (National Health Development Plan)
<b>PNLS</b>	<i>Programme National de Lutte contre le SIDA</i> (National Program for the Fight Against AIDS)
<b>PNS</b>	<i>Politique Nationale de Sante</i> (National Health Policy)
<b>POC</b>	Point-of-care
<b>PPJK</b>	Center for Health Financing and Insurance
<b>PPP</b>	Public-Private Partnership
<b>PPPN</b>	Preferred Primary Care Provider Network
<b>PRB</b>	Population Reference Bureau
<b>PRH</b>	Population and Reproductive Health
<b>PRODESS</b>	Procedures Manual for the Health Sector Development Plan
<b>PS</b>	Permanent Secretary
<b>PSS</b>	Provincial Social Security
<b>PSSP</b>	<i>Plateforme du Secteur Sanitaire Privé</i> (Private Health Sector Platform)
<b>QA</b>	Quality Advisor
<b>QHC</b>	Quality Healthcare
<b>R4D</b>	Results for Development
<b>RAMU</b>	<i>Régime d'Assurance Maladie Universelle</i> (Universal Health Insurance Scheme)
<b>RBF</b>	Results-based Financing
<b>RBM</b>	Results-Based Management
<b>RCM</b>	Regional Coordinating Mechanism
<b>RDQA</b>	Routine Data Quality Audit
<b>RFA</b>	Request for Applications
<b>RGa</b>	Request for Application
<b>RHB</b>	Regional Health Bureau
<b>RMD</b>	Resource Mobilization Department
<b>RMG</b>	Ready-made Garment
<b>RMNCH+A</b>	Reproductive, Maternal, Newborn, Child, and Adolescent Health
<b>RMS</b>	Resource Mobilization Strategy
<b>RRU</b>	Revenue Retention and Utilization
<b>SACA</b>	State Agency for the Control of AIDS
<b>SADC</b>	Southern African Development Community
<b>SAMBA</b>	Simple Amplification-based Assay
<b>SCTF</b>	Single Donor Trust Fund
<b>SEGAL</b>	Secretary General's Office
<b>SFI</b>	Sustainable Financing Initiative
<b>SGBP</b>	State Guaranteed Benefit Package
<b>SHA</b>	System of Health Accounts
<b>SHI</b>	Social Health Insurance
<b>SHOPS</b>	Strengthening Health Outcomes through the Private Sector
<b>SIFPO</b>	Support for International Family Planning Organizations
<b>SIGRH</b>	<i>Système d'Information et de Gestion des Ressources Humaines</i> (Human Resource Information Management System)
<b>SIHFW</b>	State Institute of Health and Family Welfare

<b>SIS</b>	<i>Sistema Integral de Salud</i> (Integrated Health System)
<b>SLA</b>	Service-Level Agreement
<b>SLHA</b>	State-Level Health Accounts
<b>SMC</b>	Seasonal Malaria Chemoprevention
<b>SMT</b>	Senior Management Team
<b>SMT-RHD</b>	Regional Health Directorate in San Martin
<b>SNC</b>	Swaziland Nursing Council
<b>SOTA</b>	State of the Art
<b>SOW</b>	Scope of Work
<b>SSC</b>	Social Security Commission
<b>SNNP</b>	Southern Nations, Nationalities, and Peoples Region
<b>SRM</b>	Sustainability Road Map
<b>SSA</b>	Sub-Saharan Africa
<b>SVG</b>	St. Vincent and the Grenadines
<b>SW</b>	Social Welfare
<b>TACAIDS</b>	Tanzania Commission for AIDS
<b>TASC</b>	Technical Assistance and Support Contract
<b>TAG</b>	Technical Advisory Group
<b>TB</b>	Tuberculosis
<b>TBSS</b>	Tuberculosis Supportive Supervision
<b>TDY</b>	Temporary Duty Yonder
<b>TOR</b>	Terms of Reference
<b>TOT</b>	Training of Trainers
<b>TWG</b>	Technical Working Group
<b>UADS</b>	<i>Unité d'Appui à la Décentralization Sanitaire</i> (Decentralization Unit)
<b>UEMOA</b>	<i>Union Economique de Monetaire Ouest Africaine</i> (West African Economic and Monetary Union)
<b>UEP</b>	<i>Unité d'Evaluation et de Programmation</i> (Evaluation and Planning Unit)
<b>UFR-SM</b>	<i>Unité de Formation et de Recherches des Sciences Médicales</i> (Training and Research Unit/School of Medicine)
<b>UHC</b>	Universal Health Coverage
<b>UHCAN</b>	Universal Health Care Advisory Committee for Namibia
<b>UN</b>	United Nations
<b>UNAIDS</b>	Joint United Nations Programme on HIV/AIDS
<b>UNDP</b>	United Nations Development Program
<b>UNFPA</b>	United Nations Population Fund
<b>UNICEF</b>	United Nations International Children's Fund
<b>UNMSM</b>	University of San Marcos
<b>UoPH</b>	Yangon University of Public Health
<b>UPE</b>	<i>Unité de Programmation et d'Evaluation</i> (Planning and Evaluation Unit)
<b>US</b>	Under Secretary
<b>USAID</b>	United States Agency for International Development
<b>USG</b>	United States Government
<b>UWI</b>	University of the West Indies
<b>VAAC</b>	Vietnam Administration of HIV/AIDS Control
<b>VCT</b>	Voluntary Counseling and Testing

<b>VL</b>	Viral Load
<b>VSS</b>	Vietnam Social Security
<b>WBI</b>	World Bank Institute
<b>WHO</b>	World Health Organization
<b>WoFED</b>	Woreda Office of Finance and Economic Development
<b>WorHO</b>	Woreda Health Office
<b>ZHD</b>	Zone Health Department
<b>ZISSP</b>	Zambia Integrated Systems Strengthening Project
<b>ZPCT-II</b>	Zambia Prevention, Care, and Treatment Project



# I. INTRODUCTION

Countries need strong health systems that are well-managed and country-financed if they are to increase the use of life-saving health services, especially by women and children, poor, and rural populations. USAID's Global Health Bureau launched the Health Finance and Governance (HFG) project to support countries in their quest for stronger health systems that deliver the life-saving services their citizens need, when and where they can access them, and at affordable prices.

To achieve this goal, domestic financing for health will need to grow in many countries. At the same time, policymakers and donors know that strong health governance at all levels is necessary to ensure that resources are devoted to the health sector achieve their intended results. HFG integrates governance into country programs to improve government stewardship, civil society voice, transparency, and accountability.

HFG's strategy is to deliver country-responsive technical assistance and interventions that reduce system bottlenecks in order to increase the use of priority health services, including for tuberculosis, HIV/AIDS, malaria, maternal and child health, and reproductive health. HFG collaborates with other USAID projects and other donors to ensure harmonized and efficient progress. HFG partners with local institutions and builds their capacity to sustain the impact of project interventions.

HFG's four Intermediate Results (IRs; Figure 1) work in concert to move countries towards self-sufficient health system financing and governance, and to advance global learning and consensus:

IR1: Improved financing by mobilizing domestic resources, reducing financial barriers, expanding health insurance, and implementing provider payment systems

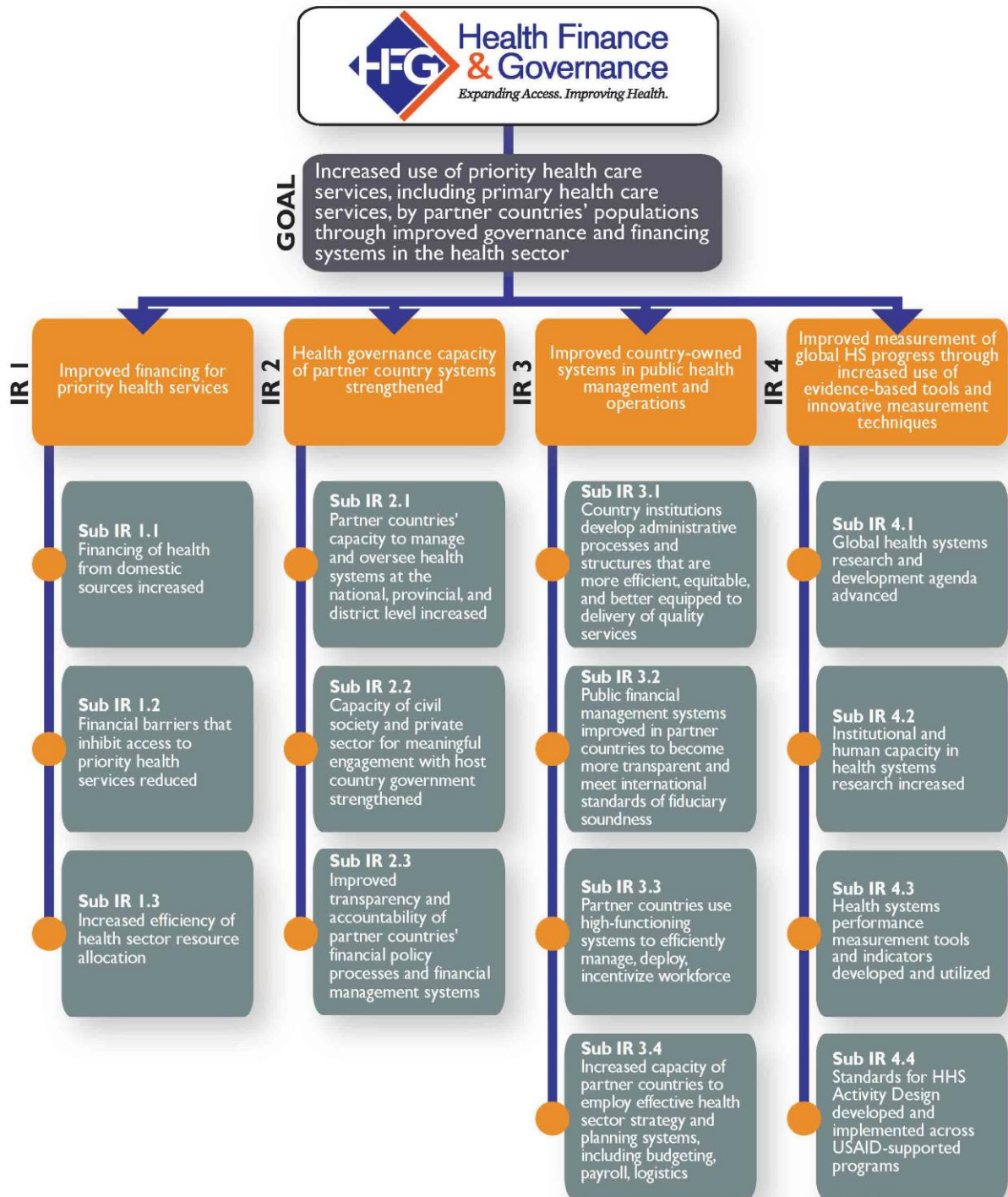
IR2: Strengthened governance for better health system management and greater accountability and transparency

IR3: Improved country-owned health management and operations systems to improve the delivery and effectiveness of health care, for example, through mobile money and public financial management

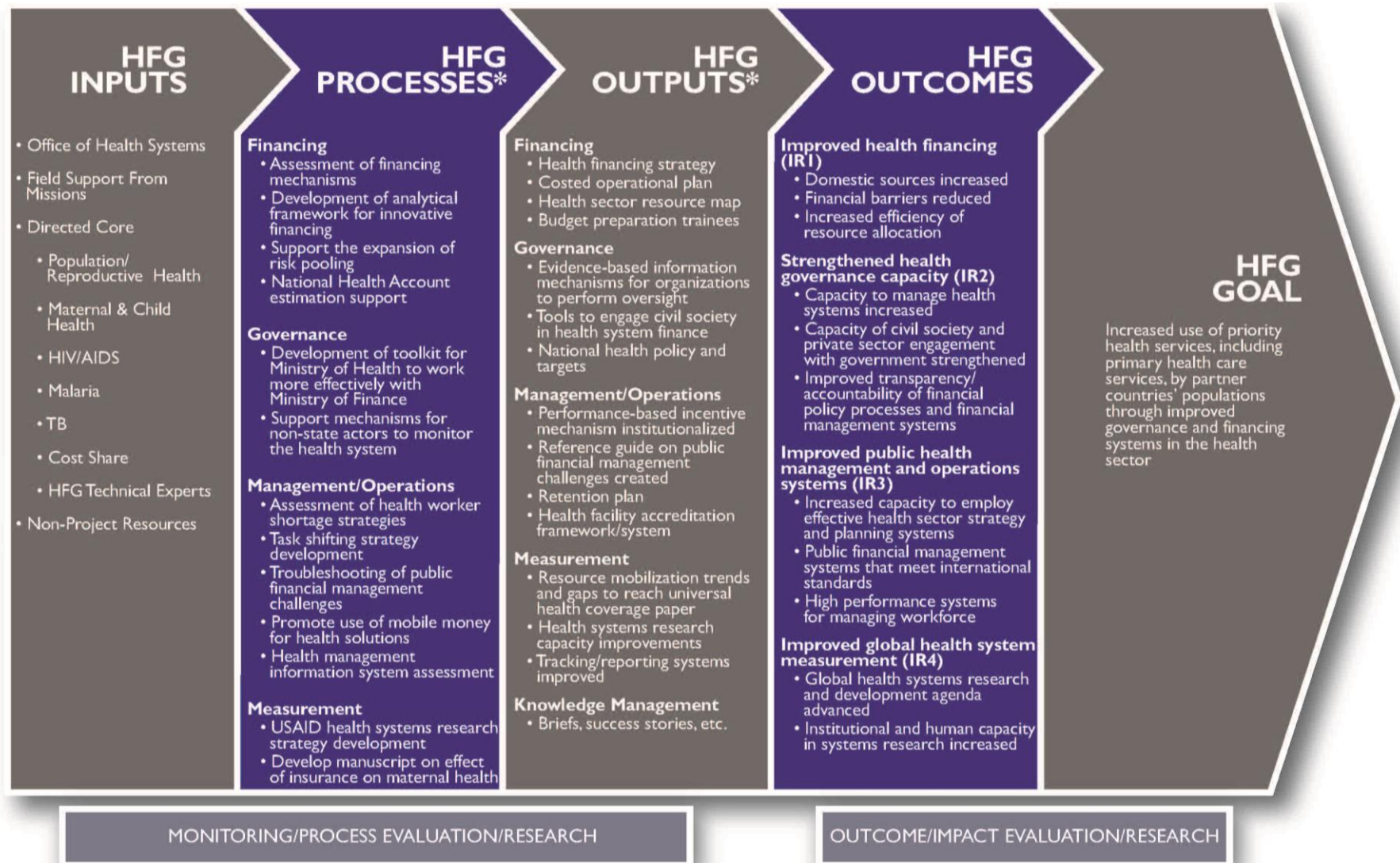
IR4: Improved techniques to measure progress in health systems performance, especially around universal health coverage

The project's monitoring and evaluation (M&E) framework (Figure 2) maps the causal pathway from project inputs to outcomes. This annual report summarizes the inputs, processes, outputs, and outcomes of more than 200 activities implemented across all project programs: 23 countries, four regional bureaus, five health offices (directed core), and the Office of Health Systems' cross-bureau program.

**FIGURE 1: HFG RESULTS FRAMEWORK**



**FIGURE 2: HFG M&E FRAMEWORK**





## 2. HIGHLIGHTS

### *IR 1: Improved Financing for Priority Health Services*

#### Burundi's Health Accounts Data Underline Need for Health Financing Reforms

Faced with a double burden of disease, Burundi's government is grappling with how to address growing demand for health care. At the same time, the government is working to balance financial constraints, rising costs, and limited resources. Policymakers need access to reliable data to make well-informed decisions to raise sufficient funds for the health sector, allocate them according to need, and manage the burden of health costs on households.

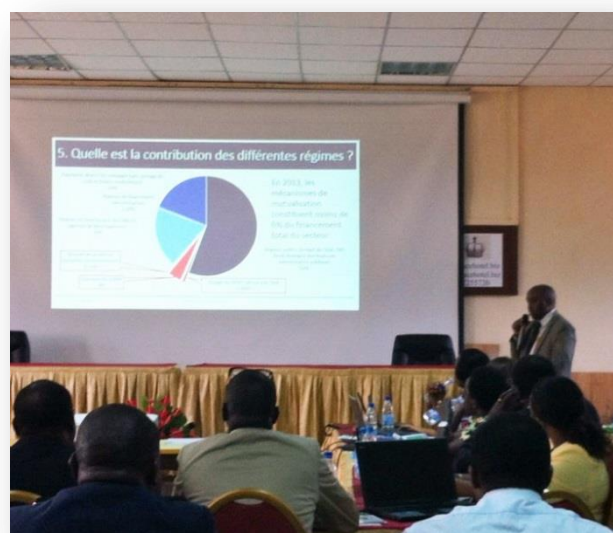
Health accounts (HA) can help. They are constructed using an internationally recognized framework known as the System of Health Accounts 2011 (SHA 2011) to measure the amount of funds spent on health in a given year and how those funds are allocated. In particular, Health Accounts reveal:

- ▶ who receives funding for health;
- ▶ who spends the received funds and through which types of providers;
- ▶ what goods and services are purchased with the funds; and
- ▶ which diseases or health conditions receive the most health spending.

For more than a year, HFG has worked closely with Burundi's HA team to build their capacity to use HA and the SHA 2011 framework. The team is housed in the Planning Unit of the MSPLS. As a result, the MSPLS now has the expertise to produce HAs going forward with minimal external assistance.

As the Director of the Planning and M&E Department of MSPLS, Mr. Sublime Nkindi, observed, "Health accounts are an important tool to understand the financing available for health as Burundi introduces reforms to achieve universal health coverage. Health accounts should be promoted at the highest political levels to help inform national strategies."

This spring, MSPLS completed a new round of HA (2012/2013) and presented the results at the Annual Health Sector Review. Over 100 participants, including Burundi's Minister of Health, nongovernmental organizations, and civil society organizations engaged in lively discussions about the results and their implications for Burundi's health sector.



Dr. Longin Gashubije, former Director General of Planning in the Ministry of Health and Fight Against HIV/AIDS (MSPLS), presents the results of the 2012/2013 Health Accounts.

While the government has demonstrated its commitment to health by increasing contributions to health since 2007, the new data highlight several challenges. The Total Health Expenditure per capita is below the World Health Organization (WHO) norm of USD \$44. Also, the percentage of the government budget allocated to health is lower than the 15 percent recommended by the 2001 Abuja Declaration.

In addition, the percentage of Total Health Expenditure financed out-of-pocket (OOP) is higher than WHO's recommendation of 15–20 percent. According to the HA, the average household OOP spending was US \$29 in 2013. A recent survey of agricultural workers showed that more than 80 percent of the

rural population could not afford to pay more than U.S. \$16 per year. As a result of these findings, many participants called for greater reforms to ensure more-affordable health care.

The new HA provide Burundi's government with critical health spending information, and give policymakers much-needed evidence to ensure that the country's upcoming Health Financing Strategy responds to the challenges highlighted by the data.



Participants at Burundi's Annual Health Sector Review in April 2015 listen to the findings of the 2012 and 2013 HA.

## Championing Sustainability, Namibia Funds Health Accounts

In Namibia, donor funding for health dropped by 47 percent between 2009 and 2013. This sharp decline could have broad implications for the health sector—particularly Namibia's HIV and AIDS response, which relies heavily on donor resources. In light of declining donor resources for health, the Government of Namibia (GRN) is positioning itself to sustain health sector progress to date, through investing in HA.

HA—an internationally standardized methodology that allows a country to understand the source, magnitude, and flow of funds through its health sector—is a key tool to better understand a country's health financing landscape. Since 1998, the GRN has completed four rounds of HA. Previously, the exercises were conducted only when funds were allocated by donors or implementing agencies—typically every few years. Conducting an annual HA exercise is far more valuable in providing a full picture of health financing trends. USAID assistance, through HFG and its predecessor, Health Systems 20/20, has supported the past three rounds of HA, which have helped the GRN recognize the importance of HA for informing health policy decisions in the country. This year, the GRN committed funds to the exercise, championing HA as an important tool for making evidence-based health policy decisions.

With the support of HFG, the GRN completed its fourth round of HA, covering the 2012/13 fiscal year. For the first time, the GRN committed funds in addition to its historical allocation of staff time to conduct the exercise. The additional \$1,000,000 Namibian Dollars (US\$80,000) from the GRN's annual budget helped fund the local costs associated with data collection and analysis.

### Building Capacity to Inform the Future -

In most countries, institutionalization, or the routine production and use, of health accounts data is a challenge, and Namibia is no exception. Through training on the SHA 2011 methodology, technical assistance, and additional support, HFG helped the GRN build in-country capacity to produce HA on a regular basis. HFG and the Ministry of Health and Social Services HA team also explored other mechanisms to ensure regular production of HA in the future.

The finalization of the current HA results has garnered excitement and momentum in Namibia. The Minister of Health and Social Services, Dr. Benhard Haufiku, disseminated the HA results at a launch event in Windhoek in July 2015.



HFG team members and the Ministry's HA leads at the dissemination of the 2012/13 results.

Dr. Haufiku emphasized the importance of the exercise, stating: “National HA ... provides critical information required for strategic and informed decision-making at various levels of the Ministry and by other relevant stakeholders.” He also expressed enthusiasm and commitment to regularizing HA: “We look forward to conducting HA exercises on a regular basis and institutionalizing the process within [the Ministry] so that we can continue to track health financing progress and continue to make data-driven and evidence-based decisions.”

The Ministry's HA team is eager to begin the next round covering the 2014/15 financial year. The team is proactively identifying more-efficient data collection processes, and securing greater involvement of key stakeholders in order to produce improved results in a shorter time frame. These are important steps towards country ownership of the HA process and ensuring that results are produced and used on a regular basis.

Namibia's continued investment in HA bodes well for the sustainability of the country's health system. The additional domestic funding for the fourth round of HA signals recognition of the importance of collecting the data and using it to inform national health care decisions. As donor funding declines further, it is imperative that countries step up with domestic resources to fund these crucial exercises.

### Paving the Way for Universal Health Coverage in Perú

Since implementing health sector reform in 1998, Peru has reached 80 percent of its population with health services, putting the country well on the path toward achieving universal health coverage (UHC). This progress is significant for the country of 30 million, characterized by diverse cultures and rugged geography.

The expansion of health coverage to the current level of 80 percent has had a positive impact on maternal and child health and survival, achieving two Millennium Development Goals ahead of schedule:

- ▶ The number of women delivering in health facilities increased from 57 percent in 2000 to 89 percent in 2014—and the corresponding percentages for women in rural areas were from 24 to 72 percent.
- ▶ Between 1990 and 2013, the maternal mortality rate dropped from 250 to 89 deaths per 100,000 live births, and the infant mortality rate dropped from 80 to 17 deaths per 1,000 live births.

Over the past two decades, USAID's health projects in Peru have also had a significant impact on reducing malnutrition. The implementation of a nutritional program, in partnership with the Regional Government of San Martín, reduced chronic child malnutrition from a baseline level of 29 percent in 2010 to 15 percent by the end of 2013.

In addition to the significant progress in maternal and child health and nutrition, Peru has also improved its health system. Public insurance has been financed and expanded to reach the poor. Legislation passed in 2013 looks promising for improving the health system as a whole by strengthening regulation while also bringing in larger participation from the private sector.

Despite this progress, Peru's health system faces formidable challenges in reaching the remaining, mostly rural, 20 percent of the population. To support Peru's final push to achieve universal health coverage, HFG is consolidating and documenting over 20 years of learning and knowledge generated by a series of USAID-funded health systems projects.

### **Documenting Best Practices to Inform Future Efforts**

- Although there is no single path towards UHC, Peru's success follows a formula that consists of sound planning and consensus-building, inclusive participation by the public and private health sectors, and the consolidation of legislative reforms.

Representing the culmination of several USAID projects supporting health system reform in Peru, HFG is documenting and compiling the various tools and methodologies developed under USAID's tenure with the Peruvian Ministry of Health. In 1998, the Partners for Health Reform (PHR) Project supported the modernization of hospital financial management in public hospitals.

Subsequently, PHRPlus (2000–2006) and the Technical Assistance and Support Contract

(TASC) 2 Peru—Promoviendo Alianzas y Estrategias (PRAES; 2007–2009)—supported policy dialogue and consensus around health sector reform, encompassing issues such as the decentralization of the health system and designing a universal health insurance reform. The Millennium Challenge Corporation Immunization projects (2008–2011) strengthened information communication and the supply of childhood immunization. In 2009, the Health Systems 20/20 project worked with Peru to strengthen its health system and start the implementation of health insurance reform. From 2010 to 2014, the TASC 3 Health Policy Reform Project focused on finance and governance activities to increase the capacity of the Peruvian Ministry of Health, alongside regional and local entities.

USAID projects have produced a legacy of achievements in Peru starting with the decentralization process, to designing a financial platform for comprehensive health insurance—Seguro Integral de Salud (SIS)—and later, providing inputs for a package of legislative health reforms. HFG's documentation process includes lessons about the factors driving progress at the three levels of the health system: macro (where policies are made), meso (where policies are operationalized), and micro (where policies are implemented).

HFG is preparing a suite of 20 tools covering the areas of health financing, costing, priority setting, planning and deployment of human resources, information systems, costing and forecasting medicines,



Workshop in Cusco.

electronic clinical records, and managing health networks. This legacy of tools, capacity building, manuals, and policies involving measurable outcomes will be available on the HFG website in late 2015.

**Legacy of USAID Work Paying Dividends** - In particular, the private sector has played a key role in the expansion of publicly financed health services. Peru's SIS contracts with private providers to deliver health services. A benefits package designed by USAID and partners, Plan Esencial de Aseguramiento en Salud, outlines the provision of health care by both private and public entities, and covers 65 percent of the disease burden.

Finally, a package of 20 legislative decrees (Legislative Decrees 1165–1175) written with input and technical assistance from several USAID-funded projects was approved by the Peruvian Congress in 2013. The package of decrees contains provisions to consolidate health sector reform and move toward UHC, including:

- ▶ Enlarging the pool of pharmacies to serve SIS beneficiaries
- ▶ Implementing networks of primary health care, with a flexible mix of public and private providers;
- ▶ Creating the Management Institute for Health Services to improve strategic planning, results-based budgeting, and administrative processes
- ▶ Launching an infrastructure investment multi-annual program that involves close coordination between regional governments and other institutions of the health sector (e.g., social security, army health services, among others)
- ▶ Reducing the segmentation of the Peruvian health system by implementing fully operational exchanges of the provision of services among the different public health provision agencies
- ▶ Implementing a compensation policy and economic incentives for public sector health staff as part of a comprehensive health workforce policy reform

## Dr. Ariel Pablos-Mendez Praises Ethiopia's CBHI Program

Earlier this summer, Dr. Ariel Pablos-Mendez, Assistant Administrator for Global Health, and Dr. Kebede Worku, State Minister of the Ethiopian Federal Ministry of Health, visited one of Ethiopia's first community-based health insurance (CBHI) schemes. Since its establishment, the Gimbichu CBHI scheme has registered remarkable results, and it is considered among the most high-performing schemes in terms of membership uptake, renewal, and financial sustainability. The current enrollment ratio stands at 58 percent of the total eligible households in the district, which has an estimated population of 108,255.

In his welcoming speech, Dr. Kebede Worku described the efforts made by the Government of Ethiopia to initiate CBHI in the four most populous regions of the country: Tigray, Amhara, Oromia and Southern Nations, Nationalities and People. "We introduced CBHI in 13 districts at a pilot level four years ago," said Dr. Kebede. "By evaluating and monitoring our strengths and weaknesses, we have taken the lessons from this pilot to expand CBHI to 185 additional



Dr. Ariel Pablos-Mendez arrives at the CBHI Scheme in Gimbichu District, Ethiopia..

districts. Based on this good experience, the Ethiopian government's vision is to establish CBHI schemes in each of its 900-plus districts by 2020, and to provide coverage for 70 percent of the population in the agricultural and informal sectors."

Dr. Kebede also recognized the government and people of the United States for their continued technical and financial support to health insurance initiatives. He said that "on behalf of the Ethiopian Government I would like to take this opportunity to specially recognize and thank the American people and government for the continued support in initiation and implementation of Ethiopia's CBHI initiative."

Dr. Pablos-Mendez addressed the gathering by reminding the audience of his visit to Ethiopia four years ago. He said that as a public health professional, he appreciates the progress the Ethiopian Government has made in health care financing reform and implementation of health insurance. Health insurance was a new concept for the country during his first visit. He said the government's efforts to introduce insurance had produced significant achievements.

Dr. Pablos-Mendez also had the opportunity to hear from local beneficiaries about the changes they have witnessed since the establishment of CBHI in their villages, and its impact on their lives.

Mrs. Kumele Cherenet, a community member with three children, told the visitors about her experience with the new insurance scheme. "Before implementation of CBHI in our village, we used to borrow up to 1,000 birr when we got sick and had to repay double the amount of this loan. Now, by contributing an affordable amount, we are getting quality health services both at the health center and the hospital. Women in our villages have witnessed many positive changes since the introduction of CBHI."

Mr. Chalchisa Megersa, a farmer, said that "among the villagers here, the benefit of being CBHI member is that at least one of us has sold our cattle to solve our health-related problems. But now, thanks to CBHI, each household can get comprehensive health care services without the need to pay at the time of seeking these services."

Dr. Pablos-Mendez highlighted Ethiopia as one of the success stories, having reached an important milestone by achieving its target for Millennium Development Goal #4, reducing child mortality. The success of Gimbichu's CBHI pilot scheme demonstrates that Ethiopia will be a model country in health insurance, and is moving towards achieving universal health coverage.

With regard to testimonies of CBHI member community representatives, Dr. Pablos-Mendez reflected that residents of Gimbichu are not only beneficiaries of CBHI, but also part of the change that the world



Dr. Kebede Worku, State Minister of Health.



strives to see: equity in health by achieving universal health coverage. He also reassured the gathering that the American people and government will be by their side to ensure this change.

The visit was a big event for communities in Gimbichu, and the public gathering was attended by more than 400 people including community representatives and federal, regional, zonal and district governmental officials. A large number of CBHI beneficiaries attended the event to welcome Dr. Pablos-Mendez. Community leaders thanked the visitors for their continued support and for visiting their CBHI scheme. They then presented Dr. Pablos-Mendez and other guests with gifts of traditional costumes as a gesture of gratitude and respect.

The dignitaries were accompanied on the visit by senior officials and experts from the Federal Ministry of Health, the Oromia Regional Health Bureau, the Ethiopian Health Insurance Agency, and USAID Ethiopia.

## **IR 2: Health governance capacity of partner country systems strengthened**

### **Remedying Urgent Health Worker Challenges in Haryana, India**

Late last year, several employees of the Haryana Health Department filed a legal challenge as a result of receiving transfer orders to work at different health facilities. The plaintiffs claimed they had been wrongly transferred due to record-keeping mistakes. A subsequent judicial review uncovered numerous clerical errors in the state's 25,000 employee records, including employees with identical names being misidentified.

To avoid future litigation, the high court ordered in February that each employee must receive a unique identification number within the next six months. Before this legal challenge, however, the Haryana Government, with technical support from HFG, had already been working on a solution: implementing a new Human Resources Information System (HRIS) to give all of its doctors, nurses, and other health care staff unique identification numbers.

**Paper Records Lead to Errors** - Before the HRIS was developed, Haryana's health worker personnel records were kept on paper. The logistical challenge of maintaining thousands of paper records likely contributed to the clerical errors cited in the lawsuit. The paper-based system also made it difficult for state officials to make evidence-based decisions on human resources for health policy and management. Haryana first established the online HRIS system with assistance from USAID's CapacityPlus Project and has moved forward with support from HFG. The HRIS should give administrators the data they need to manage their large health workforce.

The effort to tackle a project of such a large scope—designing and launching the software, as well as entering and validating the data—has been a multi-partner, multi-year task. Last year, HFG accompanied a state-level technical working group to conduct a system requirements study, which recommended that the state map the entire health workforce using the HRIS. The workforce is composed of approximately 17,000 regular workers and 3,000 contractual workers.

**New System to Identify "Ghost Workers"** - The new system will allow better management of a workforce of more than 30,000 health workers, and improve processes related to recruitment and retirement planning and overall management of contract and regular staff. In the longer term, it is likely that a well-functioning HRIS will yield additional benefits for Haryana. For example, data validation may lead to the identification of "ghost workers," employees who are absent from their posts or non-existent, which could result in significant cost savings for the state. Confirmation of vacancies could also allow the state to hire or transfer employees to facilities in need of additional staff. Whatever the

state's health system goals in the future, an effective HRIS will empower its decision-makers to take evidence-based actions to optimize the use of its human resources.

## HFG Participates in Launch of India's Campaign to Improve Girls' Lives

On July 21, 2015, HFG was invited to share its achievements at a "call to action" launch event for the Indian government's Beti Bachao, Beti Padhao ("save the girl, educate the girl") campaign. Beti Bachao, Beti Padhao is a national effort launched by Indian Prime Minister Shri Narendra Modi that seeks to prevent sex-selective abortion, promote the health of girls under five, and empower girls through access to education.

The launch took place in Haryana State, where HFG is working with the state government to strengthen human resource management and health information systems. HFG is helping to improve the lives of girls in Haryana by incentivizing local health workers to increase access to-and quality of-family planning, reproductive services, and infant and child care.

Stakeholders in attendance included Haryana state's chief executive, The Honorable Manohar Lal; U.S. Ambassador to India Mr. Richard Verma; Haryana's Minister for Women and Child Development, Kavita Jain; and representatives from local and international organizations, nongovernmental organizations, and businesses. Ambassador Verma referenced HFG's work as an example of how the U.S. government is aiding the initiative: "In Haryana, we've supported the Health Management Information System (HMIS), which monitors reproductive, maternal, and child health indicators, and helps reduce gender disparities in health coverage across the state. Based on its success here, the initiative is now being scaled up in other states."

HFG's work in assessing health data quality to inform the HMIS will help to ensure that health authorities in Haryana State have accurate information on girls' health and access to services, and areas for improvement. The project will also work with the Indian government to assess health system data nationwide, thus allowing health officials at the national level to monitor-and improve-access to health services throughout India.

## IR3: Improved Country-Owned Systems in Public Health Management and Operations

### Organization of Eastern Caribbean States Successful in Global Fund Bid

The Organization of Eastern Caribbean States (OECS) Regional Coordinating Mechanism (RCM) for HIV/AIDS was successful in its Global Fund bid on behalf of six Eastern Caribbean nations. The \$5.3 million grant is earmarked for outreach, prevention, care, and treatment for key populations, with a focus on human rights.

In an article on the Global Fund award, OECS RCM Chair and St. Lucia Minister of Health Alvina Reynolds commented, "It's been hard work . . . Today we got the good news that we have been awarded the amount of US\$5.3 million to deal with the issues of HIV/AIDS in the region. We must continue to be strategic in using the funds where [they are] most needed, to save lives and reduce HIV and AIDS infections in the region." This award is particularly good news given that donor support for HIV in the OESC has declined in recent years.

HFG supported the Global Fund application, with additional support from the Strengthening Health Outcomes through the Private Sector (SHOPS) project. HFG:

- ▶ Developed HIV Investment Briefs and analyses for each of the six countries, outlining country commitments to the HIV response and possible impact of investments

- ▶ Developed a regional approach for the OECS RCM, expressing funding requirements, gaps, and expected contributions from donors and other related inputs for the application
- ▶ Facilitated and provided technical support to the country-based dialogue meetings with government, private sector, and civil society stakeholders
- ▶ Participated in several regional meetings with the RCM and development partners in support of the application

The six OECS countries receiving the grant include: St. Lucia, St. Kitts and Nevis, St. Vincent and the Grenadines, Grenada, Antigua and Barbuda, and Dominica.

## ***IR 4: Improved Measurement of Global Health Systems Progress through Increased Use of Evidence-based Tools and Innovative Measurement Techniques***

### **"Groundbreaking" Report Links Health Systems Strengthening Interventions to Health Outcomes**

On July 28, 2015, USAID's Office of Health Systems (OHS) released a major new report, which for the first time presents a significant body of evidence linking health systems strengthening interventions to measurable impacts on health outcomes. The report identifies 13 types of health systems strengthening (HSS) interventions with quantifiable effects.

Ariel Pablos-Mendez, Assistant Administrator for Global Health, Child and Maternal Survival Coordinator, opened today's event. "We all agree on the importance of building sustainable health systems, but it's harder to appreciate the importance of HSS investments at the country level. This exercise is allowing us to share the first wave of the impact of health systems strengthening interventions. This is paramount and it is an important step for us," he said.

The report, which was prepared by a team from the HFG, presents evidence on how to strengthen health system performance to achieve sustainable health improvements at scale, particularly toward ending preventable child and maternal deaths, fostering an AIDS-Free Generation, and protecting communities against infectious diseases. Many of the interventions straddle several health system functions, and often overlap or are implemented in combination.

"This groundbreaking report marks a milestone in our path towards identifying concrete evidence of the capacity of health systems strengthening interventions to save lives," said Karen Cavanaugh, Director of OHS, at the launch.

The report draws on evidence identified in 66 systematic reviews, which together cover more than 1,500 individual peer-reviewed studies, on the effects of HSS interventions on health status and outcomes.

The interventions were found to be associated with reductions in mortality at different stages in the life cycle as well as reductions in morbidity for a range of conditions—acute and chronic, infectious and non-infectious, including diarrhea, malnutrition, low birth weight, and diabetes. HSS interventions are also associated with improvements in service utilization, financial protection, and quality service provision, all important outcomes on the pathway to improved health. The authors caution, however, that these interventions should not be perceived as "best buys."

## Botswana Costing Study: Outsourcing Adds Value, Boosts Quality

To deliver better-quality services at a lower cost, the Government of Botswana has been pursuing a strategy of outsourcing nonclinical hospital services, such as laundry, cleaning, and security, to private vendors since 2011. In theory, outsourcing these services should save hospitals money that could then be used to buy more medical supplies, and to pay nurses and doctors. But hospital managers have been signing outsourcing contracts without knowing whether outsourcing really offers them a better deal than their current systems.

"I'm paying Botswana pulas 80,000 (\$8,000) a month for cleaning, but I don't know how much I was



paying previously—is this better or worse? There is no way of comparing," said a contracts officer at a government hospital that is outsourcing nonclinical services.

USAID, through the HFG project, recently conducted a study at five government hospitals to determine the "benchmark" costs of providing nonclinical services in-house. HFG also completed a case study of the costs and benefits of outsourcing cleaning services at one of the hospitals, the Mahalapye Hospital in the Central District. The findings should help hospital managers make more-informed decisions regarding whether or not to outsource services.

The first study found that considering both the costs and the benefits at Mahalapye Hospital, outsourcing provides greater value for money in terms of "cleanliness per pula spent" than providing cleaning services in-house. While outsourcing was more expensive than paying hospital staff to clean, the cleanliness of the hospital improved dramatically after the cleaning services were outsourced to a private company.

"There is much improvement in terms of level of cleanliness," remarked the infection control officer at Mahalapye Hospital. The hospital paid approximately BWP 219 (\$24) per square meter per year to contract out cleaning services compared to its own cost of BWP 173 (\$19).

In essence, Mahalapye Hospital is getting cleaner hallways and patient rooms, more-effective waste removal, and safer storage of cleaning chemicals for only about \$5 more per square meter of hospital area. The results suggest that by paying a private company to clean the hospital, Mahalapye would gain the equivalent of BWP 1.7 million (\$182,000) worth of "additional cleanliness" over five years.

While the case study focused on Mahalapye Hospital, other hospitals reported a similar improvement in the quality of nonclinical services after outsourcing. In a survey of nurses at the seven hospitals that are currently outsourcing, 61 percent said the quality of cleaning services has improved, 75 percent claimed that laundry services have improved, and 50 percent felt that security services are better since outsourcing.

The benchmark costing exercise provided other important information for hospital managers, such as that the price of providing services in house varies greatly among different hospitals. For example, the price of cleaning ranged from BWP 175 (\$19) per square meter cleaned to BWP 1,350 (\$145) per square meter. The cost of laundry was between BWP 1.65 (\$0.18) and BWP 14 (\$1.50) per kilogram of linens. The study also found that the cost of supplies, such as soap, cleaning solutions, and laundry detergent, made up the majority (53 percent) of the costs of nonclinical services, followed by human resources.

HFG's study offers hospital managers valuable guidance about how to think about the costs and benefits of outsourcing, and what sort of data they should collect to make informed decisions. Key lessons learned from the analysis include:

- ▶ Costs are only half of the equation. When deciding whether or not to outsource, hospital managers should consider whether improved quality of the services would justify a higher price.
- ▶ Managers of hospitals that are already outsourcing should regularly monitor the vendor's performance to ensure they deliver the quality of the services that was promised.
- ▶ Hospital managers need to know the production units of the services they wish to outsource, such as the floor area that needs to be cleaned (in square meters) and the quantity of linens to be laundered (in kilograms), to evaluate bids from private vendors.
- ▶ Outsourcing should get cheaper, and the quality of services should improve, as vendors and hospitals gain more experience working together.
- ▶ Armed with new knowledge and evidence, Botswana's public hospitals are better positioned to reap the benefits of the country's outsourcing strategy.

## Essential Package of Health Services Country Snapshot Series

A new series of country profiles analyzes the governance dimensions of Essential Packages of Health Services (EPHS) in the 24 Ending Preventable Child and Maternal Deaths (EPCMD) priority countries. An EPHS can be defined as the package of services that the government is providing or is aspiring to provide to its citizens in an equitable manner. Essential packages are often expected to achieve multiple goals: improved efficiency, equity, political empowerment, accountability, and altogether more-effective care.

The user-friendly snapshots explore several important dimensions of the EPHS in each country, such as how government policies contribute to the service coverage, population coverage, and financial coverage of the package. There is no universal EPHS that applies to every country in the world, nor is it expected that all health expenditures in any given country be directed toward provision of that package. Countries vary with respect to disease burden, level of poverty and inequality, moral code, social preferences, operational challenges, financial challenges, and more, and a country's EPHS should reflect those factors.

Each country snapshot includes annexes that contain further information about the EPHS. When available, this includes the country's most recently published package; a comparison of the country's package to the list of priority reproductive, maternal, newborn and child health interventions developed by the Partnership for Maternal, Newborn and Child Health in 2011; and a profile of health equity in the country.



### 3. CROSS-BUREAU ACTIVITIES

#### ACTIVITY 1

#### *Develop Analytical Framework for Domestic Innovative Financing*

**Activity Objectives** - The objective of this activity is to outline a framework for innovative or alternative health financing approaches for USAID missions, countries, and health sector development partners, drawing upon a review of practical country experiences from the published literature.

**Year 3 Progress** - During the Y3Q1 the team worked with Dr. Jack Langenbrunner, former senior World Bank economist and fiscal health expert, to finalize the report, Domestic Innovative Financing for Health. This work included:

- ▶ Careful documentation of the report's bibliography, with 229 published and gray literature entries, reviewed as part of the report analysis and writing
- ▶ Simplification of the language of the report so as to better target the intended audience of public and private health professionals in low- and middle-income countries who are involved in designing and implementing health programs and in developing health sector strategy
- ▶ Final round of internal quality reviews and substantiation of several passages with additional research, based on quality review feedback

During Y3Q2, HFG completed and published the final report, now titled "Domestic Innovative Financing for Health: Learning From Country Experience." A short technical brief was also developed and published online in Q3 to accompany dissemination.

In Q4, the team agreed to reprogram the small remaining balance of funds towards the Year 4 activity on domestic resource mobilization, "Domestic Resource Mobilization: Getting Health's Slice of the Pie."

**Q4 Additional Information** - Activity is complete.

#### ACTIVITY 2

#### *Support Universal Health Coverage Measurement at Country Level*

**Activity Objectives** - Universal health coverage (UHC) as a goal of health policy has gained wide acceptance at country and global levels since the publication of the World Health Report 2010, and has been included in the Sustainable Development Goals as a part of the post-2015 development agenda. For this to be feasible, however, policymakers must first be able to define, measure, and monitor UHC.

This activity flexibly supports strategic steps in building and testing affordable data collection processes, guidance, and tools for UHC measurement. The project will continue efforts to find feasible indicators that Ending Preventable Child and Maternal Deaths (EPCMD) and AIDS Free Generation (AFG) priority countries can adapt and use to measure country-led UHC progress.

Specific objectives include:

- ▶ The development of UHC communication materials geared towards raising USAID Missions' awareness and knowledge of UHC and how it fits with USAID's programs
- ▶ Providing technical assistance to one or more countries in the area of UHC measurement, including the measurement of service coverage, financial protection, and equity

**Year 3 Progress** - In Q2, HFG met with the Agreement Officer Representative (AOR) team to refine the scope of this activity. In Q3, it was agreed that HFG would prepare a PowerPoint presentation and technical brief explaining UHC, to assist the Office of Health Systems in engaging and educating USAID mission staff on the topic of universal health coverage and its measurement. HFG drafted the presentation in Q4 and submitted the document to USAID for review. Several options were also identified to complement the PowerPoint file, such as a "frequently asked questions" handout and an annotated bibliography of UHC resources. The materials being developed are intended to collectively function as a "UHC kit" that will assist the Office of Health Systems in engaging USAID mission staff and educating them about UHC. In addition, it was agreed in Q3 that HFG would identify potential technical assistance activities in one country. Ethiopia and Ghana were identified as potential countries, because they are undertaking ambitious UHC reforms and they are both EPCMD priority countries. HFG began discussion with its country teams in each country to further refine the scope and identify potential areas of assistance.

To launch this process, in Q4 HFG prepared a one-page concept note describing the proposed activity for Ethiopia or Ghana. In Ethiopia, the note was shared with HFG's in-country Chief of Party to in turn discuss with his counterpart at the Ethiopian Insurance Agency under the Ministry of Health. We expect there to be interest and engagement from Ethiopia to proceed, but we have not yet received approval or been able to detail a specific scope of work. HFG is in a similar stage of planning with Ghana. Focal persons at the Ministry of Health and the National Health Insurance Agency were identified and a separate telephone conversation was held with each. Our counterparts shared general areas of interest for potential technical assistance in UHC measurement. These include service coverage, with focus on one or more primary care indicators, and improved access to clinical data, and also improved measurement of financial risk protection. Subsequently, the National Health Insurance Authority (NHIA) focal person requested that HFG confirm with the NHIA Chief Executive Officer that he supports engagement by NHIA in this activity before further efforts are made. We are presently awaiting this confirmation.

HFG met with the AOR team in Q4 to discuss whether/how mission colleagues might be able to encourage their counterparts in the Ministries of Health to commit to this activity.

**Q4 Challenges** - Efforts to engage the possible countries of interest, Ethiopia and Ghana, for in-country technical assistance have been unsuccessful so far. Although we believe the topic of UHC measurement is of interest to both countries, it may be that the limited amount of funds is insufficient to trigger active engagement in the midst of other priorities. We may also need to agree on a timeline for falling back on alternatives, such as seeking another country partner for this activity.

**Q4 Additional Information** - During Q4, the AOR team advised HFG to pursue technical assistance in UHC measurement in two countries (both Ethiopia and Ghana), rather than one as originally proposed. Additional Year 4 resources will be allocated to support the second country, creating a pool of approximately \$120,000 for technical support of two countries.

Table I provides additional activity-specific updates.

**TABLE I. CROSS-BUREAU ACTIVITY 2 DETAIL**

Year 3 Q4 Planned Tasks	Year 3 Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
Determine and refine scope of the activity in consultation with the AOR team.	HFG prepared a one-page concept note describing the proposed activity for Ethiopia and Ghana. HFG's local project teams in both countries have continued to follow up with their Ministry of Health (MOH) counterparts.	Efforts to engage the two countries of interest, Ethiopia and Ghana, for in-country technical assistance have been unsuccessful thus far. HFG met with the AOR team to discuss whether/how mission colleagues might be able to encourage their counterparts in the Ministries of Health to commit to this activity. We may also need to agree on a timeline for falling back on alternatives, such as seeking another country partner for this activity.
Develop UHC materials.	HFG drafted a PowerPoint presentation about UHC, and submitted the document to USAID for review.	



## **Health Accounts for Improved Resource Allocation to Priority Services**

**Activity Objectives** - Standardized, internationally consistent methodologies for tracking health expenditures are key to keeping countries and donors accountable for their financial commitments. USAID has been a leader in health resource tracking in collaboration with the World Health Organization (WHO), World Bank, and Organization for Economic Cooperation and Development (OECD). This mutual accountability is a key element of USAID's initiatives, including both the EPCMD and AIDS-Free Generation initiatives.

The Year 3 objectives of this activity are as follows:

- ▶ Institutionalize tools to support country-led resource tracking in collaboration with the WHO, such as an updated Health Accounts Production Tool (HAPT) and the National Health Accounts (NHA)-Satellite Accounts brief.
- ▶ Increase country capacity to use the Systems of Health Accounts (SHA) 2011 framework through training and awareness-raising activities.
- ▶ Reduce the cost and streamline the production of health expenditure data by embedding expenditure questions into the Living Standards Measurement Survey (LSMS), and updating the HAPT to reflect the SHA 2011 framework.

**Year 3 Progress** - As an ongoing activity in Year 3, HFG will continue to test the HAPT and relay suggested updates to WHO for incorporation into the HAPT.

In Q1:

- ▶ HFG received edits from WHO on the draft HAPT software user guide. All of WHO's edits were incorporated into the user guide, and the guide was finalized and submitted to the WHO team for incorporation into the next iteration of the HAPT software.

- ▶ The NHA Policy Primer, which was originally developed for SHA 1.0 under the Partners for Health Reformplus project, was updated to reflect the SHA 2011 methodology. After several rounds of internal review the policy primer was finalized and disseminated.
- ▶ The revised and simplified Nongovernmental Organization (NGO) survey was piloted in two Caribbean countries that conducted Health Accounts (HA) estimations, Barbados and St. Vincent and the Grenadines. Feedback from the pilot is being incorporated into the survey, and the revised survey file is being adjusted so that it can be uploaded directly into the HAPT software to avoid manual data entry.
- ▶ Discussions took place around a more streamlined format of the HA report. In the two Caribbean estimations, HFG tested a condensed report format consisting of: 1) a short "executive summary" style report; 2) an accompanying methodological note; and 3) the metadata from the HAPT.
- ▶ The Resource Tracking team has been working on writing and recording video tutorials to be embedded into the HAPT software. HFG resolved software compatibility issues between the HAPT software and the video recording software, which had delayed the activity. HFG and WHO refined the video script, and video recording will resume in Q2.

In Q2:

- ▶ In March 2015, HFG built the capacity of countries to use health accounts data to inform policy and planning. A four-day workshop was held in Pretoria, South Africa, entitled "Value for Money, Sustainability and Accountability in Social Sector," bringing together 15 country participants from the Southern African Development Community (SADC) region. The workshop was organized by African Development Bank, and participants were drawn from Ministries of Health, Finance, and Education and community service organizations. HFG co-facilitated two sessions on efficient transfers and resource tracking. A key objective of the workshop was to build the capacity of participants to be able to understand and explain how to use data from resource tracking exercises like HA, Public Expenditure Reviews, Public Expenditure Tracking Surveys, and other sources to improve the efficiency and effectiveness of health financing.
- ▶ In March 2015 WHO and HFG contributed to a five-day training in Geneva on disease-specific expenditure tracking. The goal of the training was to standardize the methods used in tracking expenditures by diseases (with particular reference to data-poor settings), and to increase comparability of results across countries. Over 20 resource tracking experts from 18 countries and 15 partner organizations participated in the training. The workshop themes were analysis of spending earmarked for specific diseases, calculating "distribution keys" to allocate un-earmarked spending, and using the HAPT and Health Accounts Analysis Tool. HFG presented a session on analyzing disease-earmarked spending in government data. On the final day of the training, WHO representatives provided guidance on converting previous SHA 1.0 analyses to SHA 2011 categories, and shared recommendations on estimating spending for years when National Accounts were not produced. The WHO will be publishing a guide for calculating disease distributions in the coming year (2015), to which HFG is contributing two chapters (on family planning and maternal health). Overall, there was agreement among the participating HA practitioners on the approach for calculating disease distributions, notwithstanding some variations between countries on the methodologies used. At the end of the workshop, the WHO team presented their vision for HA post-2015, which includes:
  - Produce HA in a timely manner to facilitate their use-accounts should be completed in second quarter after close of previous fiscal year.
  - Collect budgets and external resource estimates for the forthcoming year at the same time as HA; governments can better plan if they know how much donors will be financing. WHO will work with the Clinton Health Access Initiative (CHAI) to produce an integrated instrument.

- Disaggregate more health spending by gender and by geographical area.
  - End reliance on dedicated HA surveys, instead using Health Management Information Systems (HMIS) for government data, International Health Partnership reporting for donors and NGOs, regular reporting for social and private health insurance, accreditation/licensing for private provider data, and piggy-backing on existing regular household surveys for out-of-pocket spending.
  - Transition WHO's role from technical assistance provider to quality control.
- ▶ Nine HAPT software video tutorials were recorded and edited. The videos were submitted to WHO for incorporation into the next version of the HAPT. A few videos still need to be recorded; WHO has asked the team to wait until the next release of HAPT to record the final set of videos, as the next version will contain updates that may affect the video scripts.
  - ▶ The finalized Health Accounts Policy Primer was posted to the HFG website <https://www.hfgproject.org/understanding-health-accounts-a-primer-for-policymakers/>
  - ▶ The finalized HAPT user guide has been submitted to WHO for posting on their health accounts website and in the HAPT library.

#### In Q3:

- ▶ Revisions and updates to the SHA 2011 training materials continued. The team continued to update the training manual, participant manual, and PowerPoint presentations used during SHA 2011 trainings.
- ▶ Refinement of the HAPT survey instruments is an ongoing activity. The team continued to update the survey instruments to contain new classifications that were added to the latest version of the HAPT software.
- ▶ HFG prepared an initial draft of definitions of all of the SHA 2011 classification elements. The definitions, once refined, will be incorporated into the HAPT as pop-up "bubbles" to help the user understand the content and boundaries of each classification.
- ▶ The team started developing new text and refining existing text for the "help bubbles" that exist to guide users throughout the HAPT. An updated version of the HAPT was released in late June, so the next round of edits will be based on the latest version of the tool.
- ▶ Comments were received from WHO on the nine initial HAPT software video tutorials, and incorporated into the existing videos. HFG waited to receive the latest version of the HAPT, which was released in late June, before recording the final round of videos, to ensure that the videos would incorporate the latest HAPT features. The team is currently updating the video script for those final videos to include the latest HAPT features before starting the recording.

#### In Q4:

- ▶ WHO uploaded HFG's completed user guide to the EZCollab sharing site, so that it is accessible to all HA practitioners.
- ▶ The SHA 2011 training manual and PowerPoint presentations are undergoing final revisions, and will be shared with WHO, USAID, and other stakeholders through the HFG website within the coming quarter.
- ▶ HFG prepared definitions of all of the SHA 2011 classification elements and sent these to WHO for their review.
- ▶ HFG finalized the HAPT video script based on the latest version of the HAPT software and began recording the remaining seven videos.

**Q4 Challenges** - Several Year 3 activities (NHA Database, International Health Economics Association (iHEA), Health Accounts Symposium, and LSMS survey updates) need to be reprogrammed. The HFG team discussed these options with the AOR team during the October 2015 quarterly progress meeting.

**Q4 Additional Information** - During the quarterly meeting in October, HFG proposed re-scoping these two Y3 activities as follows.

1. **Reallocate funds for the NHA database activity to cover recent WHO requests for assistance:** Given the grant of USAID to WHO to work on the health expenditure database, HFG proposes supporting three priority activities requested by WHO:
  - Develop guidance around how to approach the Disease/Priority Area dimension within the SHA 2011 framework. HFG would help draft additional chapters of the WHO's guidance document, addressing specific priority health areas.
  - Develop a short manual for the Health Accounts Analysis Tool (HAAT) and in the process work with the WHO team to develop an analytical page that will highlight and summarize spending on EPCMD-related services.
  - Produce an Introduction to HA video to post on websites and use for large meetings.
2. **Reallocate funds for the 2015 iHEA Health Accounts Symposium and LSMS activities:** Given that WHO decided not to host an HA event at IHEA, and that other groups are taking on the task of harmonizing household survey instruments such as the LSMS, we propose re-scoping the two activities into organizing a peer learning event for HA practitioners from developing countries. The event would bring together practitioners to share findings and lessons learned related to the production and use of HA data. The information and lessons learned from the event could be captured and disseminated to the wider HA audience to further facilitate roll-out.

Table 2 provides additional activity-specific updates.

**TABLE 2. CROSS-BUREAU ACTIVITY 3 DETAIL**

Year 3 Q4 Planned Tasks	Year 3 Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
<b>Production Tool Support to WHO</b>		
Update training materials: training manual, participant manual, and PowerPoint presentations.	Training materials revised and currently undergoing final edits and formatting for dissemination.	
Further refine HAPT survey instruments.	Supported WHO in developing simplified instruments for NGO and donor expenditure data collection. Simplified survey instruments for donors and NGOs were circulated by WHO to health accounts practitioners for final review prior to uploading them into the production tool.	
Improve the HAPT software (including updated help bubbles, classification definitions, updated voice guidance, and an updated user guide)	Prepared definitions of all of the SHA 2011 classification elements and submitted them to WHO. Continued developing new text and refining existing text for the “help bubbles” that exist to guide users throughout the HAPT. The nine initial HAPT video tutorials have been finalized. The team updated the video	Once WHO approves the SHA 2011 classification definitions they will be translated into French and Spanish and uploaded into the HAPT.

Year 3 Q4 Planned Tasks	Year 3 Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
	script for the remaining videos to include the latest HAPT features, and has begun the final round of video recording.	
<b>Trainings</b>		
Co-organize an HA Symposium at the 2015 iHEA.	This activity is being re-scoped, pending AOR approval.	

## ACTIVITY 4

### *Universal Health Coverage Pathways: The Role of Evidence in Shaping Benefits Packages*

**Activity Objectives** - Countries have pursued alternative pathways to UHC and have realized different results. As countries work to expand coverage, they have requested guidance on how to do so. Policy choices made in the early phases of UHC strategy development can have long-lasting effects on the success and pace of country efforts to expand population coverage.

One decision facing many countries has been how to allocate limited resources across primary, preventive, and hospital care—and at the same time, promote broad access to quality services, without creating individual financial hardship. This new activity will use a cross-cutting case study approach, including desk reviews and key informant interviews, to document experiences of several countries to design a benefits package. The overall objective will be to draw cross-cutting lessons for countries to effectively use evidence to share benefit packages.

#### **Year 3 Progress -**

**Q1:** The activity team finalized a framework to select a meaningful, representative set of countries that have experience grappling with benefits package design, have lessons relevant for EPCMD countries, and whose representatives the activity team has access to or for which there is literature. The team identified relevant criteria, which were applied uniformly to all countries in the world, to derive a final list of 30 countries most likely to produce sufficient information through in-person interviews and/or a literature review. Using three initial screening criteria (population size, political stability, stage of UHC design), 99 of 214 countries were excluded due to population size under 4 million, extreme political instability, and no/very limited commitment to UHC. Next, a quick search of known resources (e.g., UNICO, Giedion et al.) and key websites (e.g., World Bank, WHO, and Joint Learning Network (JLN)) was performed to identify those countries for which there is publicly available relevant content; this narrowed the field to 46 countries. Further review of several primary sources (UNICO, WHO) allowed the team to prioritize a list of 30 countries, felt to be representative, diverse, and also within the scope of our work plan.

HFG traveled to Kuala Lumpur, Malaysia in December for a workshop on incorporating primary health care (PHC) services into UHC reforms, convened by the JLN. Participants represented Malaysia, Ghana, India, Indonesia, Nigeria, the Philippines, and Vietnam. Interviews were held in and around this workshop, primarily with Malaysian representatives, to gain insight into use of evidence in a country that has made progress towards UHC through implicit rationing rather than an explicit benefit package. Discussions were held with representatives of the Malaysian MOH, specifically the Malaysian Health Technology Assessment Section (MaHTAS), the Unit for Health Financing, and the Traditional and Complementary Medicine Division. Additional interviews were held with a representative of the PHC

benefit team of the Philippine Health Insurance Corporation (PhilHealth), and the head of Indonesia's Tangerang District Health Office.

The team also progressed in the literature review. With 30 countries identified, the team developed a template in Excel to record key findings and resources. The team extracted data for one-third of the countries; and substantiated interview notes for several countries including Ghana, India, Malaysia, and the Philippines. Additionally, the team has scheduled further interviews with key informants for Vietnam, Namibia, and Mexico. If possible we will conduct a telephone interview with a representative of Kenya.

**Q2:** The team synthesized the information from the literature review and interviews to produce a PowerPoint presentation with preliminary results and their implications. The team held an internal analysis meeting to discuss the findings and identify next steps for the analysis. The team then shared the PowerPoint with interviewees in order to validate the country-level findings and gather feedback on the broader analysis. The team also planned for other ways to solicit feedback from experts, and was able to schedule an event at the Center for Global Development (CGD) for the third quarter of Year 3 (April 30, 2015). The team began preparing the zero-draft of the 30-page report that will be shared with participants in advance of this event.

**Q3:** The team finished preparing the draft report and circulated it in advance of the roundtable discussion hosted at CGD on April 30. At this roundtable, HFG presented, and received feedback from about 20 people, including official discussants Amanda Glassman, Jesse Bump (Georgetown), and Kalipso Chalkidou (National Institute for Health and Clinical Excellence (NICE)), all of whom are members of CGD's Technical Working Group on priority setting. Other participants included Robert Hecht (R4D), Amanda Folsom (R4D), Daniel Cotlear (World Bank), and Diana Pinto (International Development Bank-IDB). Some comments from discussants and other participants were very practical; others sparked discussion and ideas for additional activities. A selection of these comments is listed below. After this meeting, HFG prepared a revised version of the product that responded to this feedback and better targeted the intended audience of practitioners. This draft was circulated for HFG internal review and also circulated among the JLN members who participated in the study as key informants. The product was finalized at the end of Q3. Early in the Q4, the product will be presented at a UHC conference in Bellagio, Italy.

**Q4:** This activity is complete: the project presented the study at the Bellagio event in July 2015. (See "Global Health 2035" activity.)

Table 3 provides additional activity-specific updates.

**TABLE 3. CROSS-BUREAU ACTIVITY 4 DETAIL**

Year 3 Q4 Planned Tasks	Year 3 Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
Draft and finalize product covering examples as well as policy implications and recommendations.	This activity is complete. The product was presented at a UHC conference in Bellagio, Italy in July 2015 (see "Global Health 2035" activity).	



## ACTIVITY 5

### Ministries of Health Effectively Engage Ministries of Finance

**Activity Objectives** - The importance of an MOH working effectively with a Ministry of Finance (MOF) is often viewed through the lens of resource capture. The more effectively an MOH can work with its MOF, the more appropriate resource allocation the health sector will likely receive. The HFG toolkit consists of four tools: 1) Guided Self-Assessment of Public Financial Management Performance; 2) Self-Assessment of Internal Control Health Sector; 3) Developing Key Performance Indicators; and 4) Data for Efficiency: A Tool for Assessing Health Systems' Resource Use Efficiency. The toolkit offers Ministries of Health a set of resources to better understand how efficiently and effectively they are spending resources. An MOH can use the outputs of these tools to guide future decisions on allocations and expenditure and demonstrate that additional investments in health will be well spent.

HFG efforts in Year 3 will focus on broad dissemination of the toolkit and the development of a new tool.

**Year 3 Progress** - This activity builds off of the toolkit that was developed and approved in Years 1-2 to help MOHs engage better with MOFs. The approved toolkit is now posted on the HFG website (<https://www.hfgproject.org/new-toolkit-ministries-health-work-effectively-ministries-finance/>).

During Y3Q3 and Y3Q4, the tools were applied in two countries:

- ▶ **Angola:** Through field support, HFG is supporting the Angolan Ministry of Health in developing a plan to monitor and evaluate the execution of the health sector strategy. As part of this process, the HFG team used the Developing and Implementing Key Performance Indicators for Health tool to guide work with ministry staff on defining key performance indicators for the monitoring and evaluation plan.
- ▶ **Jordan:** Through a USAID bilateral fiscal reform program, the Collecting Data for Efficiency tool was used to conduct a fiscal assessment of the health sector budget. The findings of the assessment were presented at a conference in Amman, Jordan in mid-June to an audience of MOH and MOF participants.

In Quarter 4, the Self-Assessment on Internal Control tool was included in the Haiti Year 4 work plan. In addition, a concept note for an additional tool to address revenue transparency was developed and will be shared with the AOR team in Y4Q1.

Table 4 provides additional activity-specific updates.

**TABLE 4. CROSS-BUREAU ACTIVITY 5 DETAIL**

Year 3 Q4 Planned Tasks	Year 3 Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
Dissemination of approved toolkit	Self-Assessment for Internal Control included in Haiti Year 4 work plan.	
New tool developed.	Concept note for revenue transparency tool developed to share with AOR team.	Concept note will be shared with the AOR team after vetting by HFG country managers. Any new tool will have a confirmed country for application.

## **ACTIVITY 6**

### ***Advancing Civil Society Engagement to Promote EPCMD***

**Activity Objectives** - The objective of the activity is to provide civil society organizations (CSOs) in at least one EPCMD priority country with the skills necessary to identify strategic advocacy entry points and use them to pursue an advocacy strategy. This activity builds off of HFG work in Years 1 and 2 to develop tools to assist civil society organizations to engage in health finance and governance. HFG developed a suite of tools, including 1) Engaging Civil Society in Health Finance and Governance: A Guide for Practitioners; 2) Entry Point Mapping: A Tool to Promote Civil Society Engagement on Health Finance and Governance; 3) Where Are Our Budgets? Public Expenditure Tracking Surveys as Tools for Engaging with Civil Society; and 4) Health Finance and Governance Media Briefing Kit.

In Year 3, HFG will conduct training specifically on the HFG Entry Point Mapping (EPM) tool for MCH-oriented CSOs in two EPCMD countries, with a preference for HFG field support countries. The training will address two issues:

1. How CSOs can use the EPM tool to identify and strategically target officials and institutions, to address their EPCMD advocacy priorities?
2. Hands-on advice on developing and refining their organization's strategy to pursue EPCMD advocacy.

As a result of the training, participating CSOs will have a map of the EPCMD entry points and an advocacy plan that targets the most strategic entry points. HFG will track and document the progress of CSOs that participate in the training.

Also in Year 3, HFG will adapt the Entry Point Mapping tool to focus specifically on promoting civil society engagement on domestic resource allocation.

**Year 3 Progress** - On April 15, HFG presented the Entry Point Mapping Tool at the Core Group Annual Meeting as part of their New Ideas Circuit. The Core Group includes NGO representatives from the 24 EPCMD countries. The feedback on the tool was positive and fills a need for organizations interested in pursuing advocacy objectives.

After feedback from the AOR team, the Engaging Civil Society in Health Finance and Governance: A Guide for Practitioners and the Entry Point Mapping Tool were reformatted. These two resources were re-submitted on June 19, 2015 and posted on the HFG website (<https://www.hfgproject.org/tools-civil-society-health-governance/>).

On August 3, HFG received helpful comments from the AOR team on the Health Finance and Governance Media Briefing Kit. The Briefing Kit is now receiving final formatting and will be finished in early October 2015.

**Q4 Challenges** - The revision of the Entry Point Mapping to address domestic resource mobilization issues is dependent upon field application. The tool was included in the HFG Nigeria work plan to assist civil society organizations to increase demand for additional public investments in HIV/AIDS. The Nigeria work continues to evolve and the entry point mapping work has not started

Table 5 provides additional activity-specific updates.

**TABLE 5. CROSS-BUREAU ACTIVITY 6 DETAIL**

Year 3 Q4 Planned Tasks	Year 3 Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
Finalize Media Toolkit	HFG received comments from AOR team on the Media Briefing Kit, which is receiving final formatting for completion.	

## **ACTIVITY 7**

### **Governance of Benefits Packages to Achieve EPCMD**

**Activity Objectives** - USAID is interested in understanding whether EPCMD priority services are included in the benefits packages defined by the 24 EPCMD countries and whether these services are actually available. Specifying and communicating benefit package contents makes entitlements transparent to the population, and can serve to increase access to information that enables the public to hold their governments accountable. Countries would appreciate guidance on how to determine benefits package contents in the near term, and a process to update the contents of benefits packages as economies develop, the burden of disease changes, capacity increases to deliver services, and the ability to finance health services grows. Governments would benefit from the opportunity to learn about effective approaches to communicating benefits packages contents to their population. Citizens and civil society groups should know the benefits package they are entitled to receive from their government, and have the opportunity to monitor whether these benefits are truly available.

HFG will implement this activity, which can be built upon in future years, through four steps. Note that only steps 1 and 2 have been approved by the AOR team.

**Step 1: Develop Frameworks for Landscape Analysis and Governance Process** - HFG will develop frameworks for reviewing benefit packages and the process by which they are developed and implemented. Specifically, HFG will:

- ▶ Develop a taxonomy of "benefit package" to define boundaries and reflect the reality of multiple service delivery schemes/arrangements in many countries that cover different packages. This will ensure consistent data collection and categorization.
- ▶ Develop a framework of the governance aspects of benefits package development, delivery, and maintenance. Examples include accountability to beneficiaries, managing the risk of interest groups' (providers', beneficiaries') rent-seeking behavior, and the cost of providing the benefit package vs. total health expenditure.

**Step 2: Conduct a Landscape Analysis of EPCMD Country Benefit Packages** - HFG will assess the current landscape of the benefit packages in EPCMD countries from publicly available data. The assessment will include the following:

1. What is included in essential benefit packages in the 24 A Promised Renewed countries?
2. To what extent are EPCMD USAID priority services (USAID/Global Health Bureau (GHB)/health elements) included in the benefit packages of the EPCMD countries?
3. To the degree possible, are these services actually available?

**Step 3: Assess How Countries Govern Their Benefit Packages** - HFG will conduct a targeted assessment of how countries govern their benefit packages, including both the definition of services to be included in the list and how the package is implemented. Using a sample based on HFG's network within EPCMD and non-EPCMD countries, we will design and conduct a qualitative survey seeking to explore issues such as:

- ▶ How countries use transparent and inclusive processes for defining what is in benefit packages
- ▶ How countries communicate what is in the benefit package(s) to the MOH, health providers, and citizens
- ▶ How countries oversee benefit package implementation and what mechanisms they have for appeals and complaints

To deepen understanding, we will identify up to three countries where we will leverage HFG field activities and/or HFG partner programs to conduct field research on: the contents of essential packages as specified in policy; whether officials in Ministries of Health are aware of the benefits package policy; the process the countries follow to arrive at and update these contents; how information about essential packages is communicated to the population; whether these services are consistently available; and whether civil society groups monitor access and employ strategies to hold their governments accountable.

**Step 4: Develop Benefit Package Governance Guidelines** - Based on our targeted survey and field research, HFG will determine specific aspects of benefit package governance (definition, communication, oversight, transparency, etc.) where guidance is most needed. HFG will develop a set of practical guidelines for countries as they develop and refine their benefit packages.

**Year 3 Progress** - After completing a lengthy review of secondary literature, on May 18, 2015, HFG presented the findings of the landscape analysis of essential packages of health services (EPHS) in the 24 EPCMD countries to an audience of USAID Bureau of Global Health officers. The presentation provided an overview of the assessment methodology, key findings, and specific emphasis on the governance dimensions of EPHS. The landscape analysis also included an evaluation of whether 60 priority Reproductive, Maternal, Newborn, and Child Health interventions are included (explicitly or implicitly) or excluded (explicitly or implicitly) in the country EPHS.

Some of the key findings include:

- ▶ In 10 of 23 countries, some services included in the EPHS are legally exempt from user fees on a national scale; in another 6 countries, all services from the EPHS are exempt.
- ▶ 14 of 23 countries specify strategies to target adolescents.
- ▶ 15 of 23 countries specify strategies to target the indigent.
- ▶ 22 of 23 countries specify strategies to target rural residents.
- ▶ 23 of 23 countries specify strategies to target women.

On August 21, the 24 country snapshots were posted on the HFG website <https://www.hfgproject.org/ephs-epcmd-country-snapshots-series/>.

**Q4 Challenges** - On June 30, 2015, HFG submitted to the AOR team several scenarios for follow-up tasks to the EPHS landscape analysis. On July 1, 2015, the AOR team requested that HFG temporarily stop work on the activity until the Office of Health Systems (OHS) had completed internal planning on Year 4 activities.

## ACTIVITY 8

### *Generating Evidence for Governance Contributions to Improved Health Outcomes*

**Activity Objectives** - HFG will seek to build the evidence for the impact of good governance on key intermediate health outcomes through two key efforts: 1) facilitating dialogue to develop a shared learning agenda among stakeholders inside and outside USAID; and 2) generating evidence based on HFG governance activities.

1. **Facilitate dialogue to develop a shared learning agenda:** In Year 3, HFG will build on the successful workshop held in July 2014 that presented the state of research on the impact of good governance on health and identified the evidence gaps. HFG will continue to work with other USAID implementing partners, including the Leadership, Management and Governance (LMG) project and the Health Policy Project (HPP), to develop and coordinate evidence generation efforts.
2. **Contribute to the evidence base for health impact on intermediate outcomes for health:** HFG will seek to address evidence gaps identified in the workshop. These efforts, which will be initiated in coordination with USAID, might include the following:
  - i. Building upon ongoing HFG research in Ethiopian facility governance boards
  - ii. Building upon ongoing HFG research on tax administration and health revenues
  - iii. Developing a set of governance indicators for a specific set of health intermediate outcomes
  - iv. Building upon ongoing PFM field-based research
  - v. Case study of how oversight institutions and CSOs can work collaboratively to promote accountability and contribute to improved health outcomes and quality and access to care
  - vi. Contributions and collaboration with LMG and HPP on evidence generating activities

**Year 3 Progress** - The Year 3 work was launched on May 7, when HFG joined representatives from the AOR team and USAID Center of Excellence on Democracy Rights and Governance to coordinate different evidence generation agendas. The meeting provided clarity on the HFG role and areas of focus. HFG is preparing proposals for evidence generation research including with a focus on Ethiopia Governing Boards, and the link between governance inputs and health outcomes at the state level in Nigeria.

On August 6, 2015, HFG met with the representatives from AOR, OHS and the Center of Excellence on Democracy, Rights and Governance (DRG) to discuss ideas for an evidence summit around governance contributions to health outcomes. Following the discussion, HFG sent a concept note to USAID for this event and a smaller event to organize implementing partners' contributions.

During Q4, HFG sent notes to six regional partner organizations regarding ongoing research activities they might be engaged in that relate to generating evidence for governance contributions to health outcomes. HFG will assess the response to determine how HFG can provide small support to expand the scope or more broadly disseminate findings.

Table 6 provides additional activity-specific updates.

**TABLE 6. CROSS-BUREAU ACTIVITY 8 DETAIL**

Year 3 Q4 Planned Tasks	Year 3 Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
Develop strategy for evidence generation through HFG.	HFG reviewed several options for generating evidence through HFG activities, including in Ethiopia and Nigeria. None were deemed appropriate for the scope of this activity.	HFG reached out to regional partners to assess whether ongoing research activities might align with the HFG objectives—or could, with small additional support.
Implement evidence generation strategy.	HFG reached out to regional partners to assess whether ongoing research activities might align with the HFG objectives—or could, with small additional support. HFG is now reviewing the ideas being submitted.	
Conduct evidence generation workshop	HFG presented a concept note for two events—an initial evidence generation workshop to organize USAID and implementing partner contributions to an evidence summit, and for the evidence summit itself.	

## **ACTIVITY 9**

### ***Tax Administration Reform and Resource Mobilization for Health***

**Activity Objectives** - Increase domestic financing of health from improved tax revenue mobilization by examining and documenting the experience in a second country case study.

**Year 3 Progress** - In Year 2, the team completed a report on an analytical framework that uses country examples and regression analysis to evaluate the relationship between tax administration reforms and government health expenditures. The report found that changes in tax revenues are not associated with changes in government health expenditures relative to other sources of government funding. However, there are proven strategies in some countries that can facilitate the use of tax revenues for health purposes, such as prioritizing health within the government budget, decentralizing spending, and earmarking tax revenues toward health. In Year 3, the team received comments from USAID on the paper; it has been integrating them into a revised version. One of two case studies (El Salvador) was drafted in Year 2 and revised in Year 3 based on feedback from the Quality Advisor (QA). In Year 3, Rwanda was selected as a second country case, and the case study has been drafted, revised based on feedback from the QA, and submitted to Abt for editing and formatting.

Table 7 provides additional activity-specific updates.

**TABLE 7. CROSS-BUREAU ACTIVITY 9 DETAIL**

Year 3 Q4 Planned Tasks	Year 3 Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
Develop annotated outline based on landscaping to guide quantitative analysis and qualitative interviews for each case study for review by the QA.	An outline was completed for the second country case (Rwanda) and has been reviewed by QA.	
Identify and select country.	The team switched from focusing the second country case study on Mali, for which it was challenging to find adequate data and evidence, to Rwanda, at the advice of QA.	
Obtain approval of country selection from QA and HFG project team, and vet with USAID Mission.	Rwanda was selected and approved by QA and HFG.	
Conduct qualitative interviews with key experts.	Documents were consulted and an interview with key expert Claude Sekabaraga, former Director of Planning, Policy and Capacity Building in Rwanda, was conducted to better understand the conditions that facilitated resource allocations to health in Rwanda.	
First draft of case studies written and submitted for review by QA.	First draft was written and submitted for review by QA; comments were received.	
Second draft finalized and edits incorporated.	Feedback from QA was integrated into a second draft of the Rwanda case study, which was submitted to Abt.  Second draft of the El Salvador case study was developed based on feedback from QA and the team is currently doing a final review before submission to Abt.  Made revisions to main paper addressing USAID comments.	El Salvador case study expected to be submitted to Abt in early Y4Q1.  Main paper expected to be finalized in early Y4Q1.
Third draft final Abt editing and formatting.	The final draft of the Rwanda case study was completed. It was submitted to Abt for any needed final editing and formatting.	
Finalized case study completed and sent to USAID.		Final versions of case studies and main paper expected to be shared with USAID in Y4Q1.



## ACTIVITY 10

### *Mobile Money for Health*

**Activity Objectives** - The overall objective of Year 3 activities is to generate evidence (through targeted in-country technical support) for mobile money as a tool to expand reach of health services to underserved populations and improve the efficiency, transparency, and accountability of financial transactions in the health sector, and build knowledge about mobile money solutions for UHC through a regional convening, and follow-up activities.

**Year 3 Progress** - HFG was invited by USAID to support the design and implementation of a regional meeting May 12–15, 2015 in Lilongwe entitled “Digital Health for Overcoming Barriers to Ending Preventable Child and Maternal Deaths and Achieving Universal Health Coverage.” USAID’s Africa Bureau hosted the event with co-sponsorship from the UN Foundation. HFG was also asked to provide financial support for a delegation from the Kenyan Ministry of Health to attend the meeting, as global leaders in applications of mobile money for health.

On the technical side, HFG was tasked with shaping content and identifying participants for special two-day follow-up sessions representing private sector digital solution initiatives; these sessions followed the first two-day country team format. HFG assumed responsibility to lead the design and execution of innovative sessions including an interactive group exercise to define partner needs and a matchmaking session.

The meeting was attended by 150 participants, and had active involvement from major private companies including Orange, Qualcomm, BD Technologies, MicroEnsure, and GSMA, who had not participated in previous Africa mHealth meetings. Examples of programs reaching scale and opportunities to expand and form new Public-Private Partnerships (PPPs) were highlighted. Additionally, participants were able to explore opportunities to expand and form new PPPs for mHealth initiatives.

The linkages of mHealth and mMoney solutions to UHC were an explicit element of the meeting agenda, a new emphasis. For example, WHO noted that digital tools facilitate accountability to achieve UHC, and that emerging standards for open source national health digital information are enablers. MicroEnsure, Changamka and PharmAccess presented examples of large-scale insurance partnerships with mobile companies that address key barriers to insurance uptake, including consumer awareness and enrollment efficiency.

USAID’s Africa Bureau has requested a follow-up concept note from HFG for a broader Digital Health Africa Summit. This proposed meeting will replace the USAID Africa Bureau’s regional mHealth meeting, and additional African and other sponsors will be invited to it to support a global exchange anchored in Africa.

USAID’s Africa Bureau, Office of Health Systems, Office of Population, Global Development Lab, and other internal stakeholders are exploring a variety of options for building on momentum from the Malawi meeting to plan a digital health meeting in Africa in 2016.

**Q4 Challenges** - Uncertainty among USAID decisionmakers about the scope, partners, timing and purpose of proposed 2016 Digital Health Meeting.

Delays in the field work in Senegal

Table 8 provides additional activity-specific updates.

**TABLE 8. CROSS-BUREAU ACTIVITY 10 DETAIL**

Year 3 Q4 Planned Tasks	Year 3 Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
Provide technical support to 2-4 missions or governments.	The assessment of mobile money for strengthening the results-based financing pilot in Senegal is under way. A consultant has been contracted by R4D and will travel to Senegal the week of October 5–16 to conduct the assessment. The study methodology and protocols are being finalized and local stakeholders are engaged and supportive of the assessment.	The study had initially been scheduled for the week of September 14. The Ministry of Health of Senegal requested that the study be postponed to October 5 to accommodate the availability of their program staff.
Build on and update Year 1 efforts to gather and disseminate existing evidence and best practices from case studies on mobile money for health.	The team continues to conduct interviews with stakeholders to learn more about mobile money and health applications and develop case studies featuring these applications. A compendium of case studies featuring 14 mobile money use cases in health has been produced and will be disseminated in October 2015.	
Facilitate public-private partnerships at the global and regional level.	HFG continues to provide guidance to stakeholders involved in shaping the concept and agenda for a possible African Digital Health meeting in 2016, which would be intended to facilitate mHealth PPPs. HFG participates in weekly calls to discuss options for private sector sponsors, meeting themes, and structure, especially on digital finance and UHC. Reviewed several draft agendas prepared by HealthEnabled (African mHealth organization).	There is continued uncertainty about timing and funding of 2016 Africa digital health meeting; several options are still under consideration.
Convene a regional experts and practitioners meeting, bringing together the health, finance, insurance, mobile, and IT sectors for knowledge exchange. This is expected to accelerate concrete applications of mobile money.	HFG provided follow-up communications (report editing, newsletter contributions) for materials distributed about the May 2015 Digital Health Meeting.	

## ACTIVITY II

### Support to USAID Leadership in Health Systems Research

**Activity Objectives** - HFG will support USAID's leadership role in health systems programming, intending to gain a solid understanding of the kind of health systems evidence that is needed to determine future health systems research (HSR) priorities. HFG will collaborate with USAID and partners on identifying HSR priority topics, propose HSR initiatives, and advance best practices in HSR. HFG will also explore various mechanisms through which HSR is implemented to help guide USAID's investments in HSR, including the identification of capacity-building needs. This work will contribute to achieving USAID's HSR goals and to the agency's broader global health strategy.

**Year 3 Progress** - The stock-taking workshop held in Year 2 (September 2014) with USAID revealed a reluctance among mission staff and USAID/Washington offices to dictate a single HSR strategy given the variety of research priorities across the agency. Consequently, Year 3 activities are focused on identifying potential opportunities to generate additional HSR evidence to help fill overall evidence needs for USAID.

In Q1, members of the HFG team met with USAID stakeholders (Estelle Quain, Diana Frymus, Natalia Lane, Joe Naimoli) vested in health workforce issues to identify potential areas for research/work activities to take place. Based on these conversations, HFG developed a concept note to be shared with USAID stakeholders for feedback and finalization. Also during Q1, the final notes from the stock-taking workshop from late Year 2 were finalized for internal distributions within USAID.

During Q2, members of the HFG team met with USAID stakeholders vested in health workforce issues to identify potential areas for research/work activities to take place. Based on these conversations, HFG finalized the concept note to be shared with USAID missions.

During Q3, the AOR team shared the concept note with relevant missions to assess interest, and begin proceeding with activities. Several missions have expressed interest, and HFG has had follow-on conversations with Nigeria and Haiti, with Cote d'Ivoire pending. A country-specific concept note was developed for and shared with the Nigeria mission in Q3.

**Q4 Challenges** - The HRH case study activity was suspended by instruction of the AOR team. Remaining funds for this activity were redistributed across other HFG activities.

Table 9 provides additional activity-specific updates.

**TABLE 9. CROSS-BUREAU ACTIVITY II DETAIL**

Year 3 Q4 Planned Tasks	Year 3 Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
<b>4: HRH Scoping</b>		
Overarching concept note for HRH research	During Q4 this activity was suspended by instruction of the AOR team.	
Develop concept notes for HRH research studies with mission officers.	This activity was suspended on instruction of the AOR team.	



## ACTIVITY 12

## Support to Health Systems Global

**Activity Objectives** – The overall purpose of this activity is to organizationally strengthen Health Systems Global (HSG), a professional society established in 2012 whose aim is to strengthen the field of HSR and thereby contribute to improving the evidence base needed for health systems strengthening (HSS).

The objectives in Year 3 were:

- ▶ Support the transition from the current Secretariat to the new one.
- ▶ Participate in the newly launched HSG Thematic Work Group (TWG) on Evidence Translation aimed at sharing best practices and lessons learned.

**Year 3 Progress** - Because Health Systems Global selected a new Secretariat, HFG was asked to delay its organizational development support until the new Secretariat was on board and HFG could discuss directly with the new Secretariat Director and new Board Chair. Curatio International Foundation was selected as the new Secretariat in February, and in March HFG held discussions with the Board Chair and the new Executive Director to outline HFG assistance in Y3. A Scope of Work (SOW) for HFG institutional strengthening assistance was prepared, with three main activities that are described in the table below.

Q3 was extremely active. The SOW was finalized and work was initiated in all three activities. Interviews were conducted with all board members for the governance assessment, and a presentation prepared for HSG board members in a late June board meeting. Data collection was also completed for the assessment of TWG functioning, and a presentation prepared at the same meeting. These two presentations were well received by the Secretariat and the board.

In Q4 the reports on the governance assessment and the assessment of the TWGs were finalized and disseminated by the HSG Secretariat. The governance assessment resulted in a series of proposals that is being sent to all board members. HFG will conduct follow-up interviews with board members to obtain their reactions to the proposed changes. The TWG report was sent to all nine TWGs and will be discussed at a TWG retreat in London in November 2015. In addition, HFG has developed a tool for assessing board performance and is currently developing a 360 degree assessment to assess the performance of the HSG Executive Director. These various products have been well received by HSG in further developing its organizational foundation.

In addition, HFG participates actively in the Evidence Translation Thematic Working Group. The TWG is currently defining its two- to three-year work plan, which will include hosting webinars on knowledge translation topics, maintaining active communication/discussion through the group's LinkedIn page, and collaborating with the SHAPES TWG to develop a Global Baseline Inventory/Assessment of knowledge translation materials. This assessment would serve as a "hub" to collect and share knowledge translation materials among the TWGs and beyond.

**Q4:** The Translating Evidence into Action TWG hosted its first webinar on July 22, 2015. The webinar was a big success; over 55 participants joined the webinar and participants were intensely engaged in asking questions and tweeting about the event. The webinar focused on a discussion of Chile's use of evidence in the design of their Universal Access with Explicit Guarantees health benefit plan, and provided a reflection on the factors that can facilitate and hinder the process of making evidence-based decisions in the design of a health benefit plan. HFG met with Chris Atim, Director of the African Health Economists Association (AfHEA), to plan a second webinar for sometime late fall.

In collaboration with the Social Science Approaches for Research and Engagement in Health Policy & Systems TWG, the Evidence to Action TWG is beginning work to develop a Global Baseline Inventory/Assessment of knowledge translation materials.

The TWG filmed a short video to post to the LinkedIn site (and TWG webpage) to succinctly explain the goals of the TWG and generate more traffic and participation. Overall, the TWG awaits guidance from the new HSG Secretariat on new platforms that may better serve its communication needs.

HFG hosted a call with several TWG members on September 2 to update them and discuss the upcoming HSG Board meeting. Elaine Baruwa will represent the TWG at the HSG Board Meeting in November 2015 and contribute to defining the TWG roles in HSG's new five-year strategy.

Table 10 provides additional activity-specific updates.

**TABLE 10. CROSS-BUREAU ACTIVITY 12 DETAIL**

Year 3 Q4 Planned Tasks	Year 3 Q4 Progress	Critical Assumptions/ Problems Encountered/ Follow-up Steps
<b>I: Organizational Development Support to HSG</b>		
Continue support to develop governance structures and processes.	This task was folded into the governance assessment discussed below.	
Form fundraising committee and develop fundraising strategy.	This task was not included in the HFG SOW.	
Assess the success of the TWGs.	The TWG assessment report was finalized this quarter. The findings will be discussed at a retreat for TWG leaders in November in London.	No further work is anticipated on the TWG assessment.
Conduct review of HSG governance.	The report on the governance assessment was finalized in this quarter and has been distributed to all board members. Based on the assessment findings, HSG has developed proposals to strengthen HSG governance.	
Develop a process for monitoring Board and Secretariat performance.	A tool to monitor board performance was developed during this quarter. HFG has initiated the development of a 360 degree assessment for the HSG Secretariat Executive Director.	No further work is anticipated on the board assessment tool. The 360 degree tool will be finalized in Y4Q1.
Assist in transition to new Secretariat.	This task was not included in HFG's Y3 SOW.	
Plan and conduct retreat.	This task was not included in HFG's SOW.	

Year 3 Q4 Planned Tasks	Year 3 Q4 Progress	Critical Assumptions/ Problems Encountered/ Follow-up Steps
<b>2: Support to Evidence Translation TWG</b>		
Design and implement at least two webinars on knowledge translation and related topics.	The TWG hosted its first webinar on July 22, 2015. The webinar was attended by over 55 participants and focused on Chile's use of evidence in the design of their Universal Access with Explicit Guarantees health benefit plan. The webinar provided a reflection on the factors that can facilitate and hinder the process of making evidence-based decisions in the design of a health benefit plan.	A second webinar, hosted in collaboration with AfHEA, is currently being planned for late fall.
Establish and maintain routine communication channels for TWG members (e.g., maintain LinkedIn group page, other listservs, etc.).	The TWG filmed a short video to post to the LinkedIn site (and TWG webpage) to succinctly explain the goals of the TWG and generate more traffic and participation.	Despite the group's attempt to foster dialogue via LinkedIn, the activity on the site remains low. The TWG awaits guidance from the new HSG Secretariat on new platforms that may better serve its communication needs.
Implement additional priority activities as identified in TWG work plan.	In collaboration with the SHAPES TWG, the Evidence to Action TWG is beginning work to develop a Global Baseline Inventory/Assessment of knowledge translation materials.	
Engage with HSG Secretariat on TWG efforts.	The Secretariat will continue to be informed and involved in the group's activities and progress.	A representative of the TWG will participate in the HSG Board Meeting in November 2015 to contribute to defining the TWG roles in HSG's new five-year strategy.



### ACTIVITY 13

## **Stimulate USAID Field Research into Advancing Universal Health Coverage and Results-based Financing**

**Activity Objectives** - USAID missions and country counterparts will gain a deeper understanding of the value of research to advancing UHC and RBF and of how to integrate research in this context. This will be done by producing a series of technical briefs to share lessons from specific implementation research for UHC initiatives in Myanmar and Indonesia that is being funded by the Asia Regional Bureau. The briefs will document the experiences in these two countries to test implementation research (IR) methodologies. The series will include the following three technical briefs: 1) Getting Started, 2) Defining and Designing the IR, and 3) Implementing IR: First Cycle Lessons Learned. HFG will disseminate lessons globally through publication on the HFG website and through other channels.

**Year 3 Progress** - The first of three technical briefs on Implementation Research for UHC in Practice: A Series of Technical Briefs Based on Lessons Learned from the Field in Myanmar and Indonesia has been drafted and is currently under review with USAID's Office of Health Systems and Asia Bureau.

Table 11 provides additional activity-specific updates.

**TABLE 11. CROSS-BUREAU ACTIVITY 13 DETAIL**

Year 3 Q4 Planned Tasks	Year 3 Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
Produce first brief.	The first of three technical briefs on Implementation Research for UHC in Practice: A series of Technical Briefs Based on Lessons Learned from the Field in Myanmar and Indonesia has been drafted and is currently under review with USAID's Office of Health Systems and Asia Bureau.	Upon approval and finalization, the brief will be disseminated on the HFG website and through relevant websites, professional organizations, and working groups.  One challenge in developing technical briefs based on our experiences with current IR activities is to provide specific and relevant information to readers without revealing information that in-country stakeholders deem sensitive. Another challenge is that the timing of these briefs has been negatively affected by internal delays in the IR for UHC activities in Indonesia and Myanmar.
Produce second brief.	Planned for Y4Q2	Assuming that the IR for UHC activities in Myanmar and Indonesia proceeds as planned.
Produce a third brief.	Planned for Y4Q3	Assuming that the IR for UHC activities in Myanmar and Indonesia proceeds as planned.

## **ACTIVITY 14** *M&E of Country Transitions*

**Activity Objectives** - HFG will build upon recent and ongoing efforts related to transition and sustainability planning to generate a better understanding of how countries approach transition (particularly transitional financing for health), of the types of metrics that are required to monitor and evaluate the path toward transition, and of the transition process itself. A clear understanding of what transition means and what a "successful" transition looks like are critical to the development of any framework on how countries might approach transition and transitional financing.

Through this activity, HFG will achieve the following objectives:

1. Improved understanding of how countries approach transition and sustainability planning, with a focus on the Global Health Initiative (GHI) principle of country ownership
2. Improved approaches to measuring country ownership, with a focus on transitional financing and sustainability, including benchmarks and metrics linked to transition
3. Increased interest in field research into monitoring and evaluating the pathway toward transition and the process

**Year 3 Progress** - HFG developed a conceptual framework and guiding documentation for approach transition and its monitoring and evaluation. The framework and guiding document were revised based on AOR feedback and submitted. These were also shared within HFG to team members working with the Eastern Europe and Eurasia (E&E) bureau to assess interest in piloting the guide.

JHU team members have submitted a manuscript to the journal Global Health Science and Practice based on the M&E guide, and has been accepted for review. Revisions were requested and the article was resubmitted in late September.

**Q4 Additional Information** - JHU team members have submitted a manuscript to the journal Global Health Science and Practice based on the M&E guide; it has been accepted for review. Revisions were requested and the article was resubmitted in late September. Additional edits to the manuscript will be performed as needed.

Table 12 provides additional activity-specific updates.

**TABLE 12. CROSS-BUREAU ACTIVITY 14 DETAIL**

Year 3 Q4 Planned Tasks	Year 3 Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
Develop concept note for pilot testing metrics in select country.	A phone conversation was held with the Armenia mission in June to discuss the upcoming transition in country. HFG drafted a Terms of Reference document in mid-July, describing the potential approach to assessing the Armenia transition, and shared it with the Armenia missions and E&E Bureau contact. No response has been received.	HFG to follow up with the Armenia mission once the new E&E Bureau officer is in place. HFG to discuss potential of employing M&E guide in the Caribbean region.
Dissemination workshop at USAID	This task is to be determined.	Waiting for confirmation from the AOR team.
Launch country pilot in at least one country (to be determined, pending funding availability).	This task is to be determined.	

## **ACTIVITY 15**

### **Synthesis of Available Evidence on Health Systems Strengthening Impact on Health**

**Activity Objectives** - Evidence is scarce, scattered, and not widely disseminated on how interventions to strengthen and sustain improved health system performance contribute to sustained improvements in health status, particularly to ending preventable child and maternal deaths and fostering an AIDS-free generation. Without this evidence, decisionmakers lack a robust basis for investing scarce health funds in HSS interventions in an environment of competing investment options. This evidence gap hinders support from the U.S. Congress, PEPFAR, USAID GH element fund stewards, mission health officers, counterpart governments, and other stakeholders. HFG will conduct a rapid review of the literature on the contribution of HSS interventions to improved health outcomes, which may include proxies of improved health status, such as positive changes in coverage and behavior. HFG will then draft a Policy Brief modelled on PHR Plus's "Investments in Health Contribute to Economic Development." HFG will also write a short brief of the technical report.

**Year 3 Progress** - With AOR approval, this activity began in July 2014 and progressed quickly, thanks to excellent support from HFG technical leads and Abt colleagues. A team of 15 people assisted with completing the foundational tasks:

- ▶ Prepare concept note outlining approach to rapid literature review.
- ▶ Conduct rapid literature review and develop a list of relevant literature to serve as evidence base of brief.
- ▶ Divide the literature into six buckets and ask technical experts to review and extract key findings.
- ▶ Develop an outline and finalize with USAID input.
- ▶ Draft the technical report and brief for HFG and USAID review, and comment.
- ▶ Finish and submit complete first draft to USAID for review.

In October 2014, HFG submitted the first complete draft of the HSS Impact Technical Report to Scott Stewart and Joe Naimoli for their review. USAID shared comments and feedback with the lead authors (Laurel Hatt, Ben Johns, Catherine Connor, and Megan Meline) a few weeks later. HFG then revised the document based on their comments and suggestions, and submitted a second version for review in late November. At the same time, Megan Meline worked with the team to draft a four-page brief of the report, which she submitted to USAID for review in mid-December.

As of Q2, the technical report, *The Effects of Health Systems Strengthening Interventions on Health Status and Outcome Measures: A Review of the Evidence*, is in its sixth version. Laurel Hatt, Catherine Connor, Ben Johns and Megan Meline incorporated several additional rounds of comments from the client to ready the report for internal USAID review by staff outside the OHS. As of late March, Joe Naimoli had secured seven USAID technical reviewers. Comments and feedback are expected in early April. In addition, HFG prepared two versions of a short brief on the report for Karen Cavanaugh, Director of OHS.

The original budget for this activity was \$150,000, and as of March 30, 2015, roughly \$16,000 remains. The client is aware of the remaining funds. To successfully bring the four products to completion (technically finalized, copyedited, formatted, and disseminated, perhaps at a BBL or other launch event) will likely cost more than \$16,000. HFG would like to discuss options in the near future.

During Q3, HFG completed the ninth round of revisions to the HSS technical report (official title, *The Effects of Health Systems Strengthening Interventions on Health Status and Outcome Measures: A Rapid Review of Systematic Reviews*). During this round, the authors responded to all of the USAID reviewers' comments and queries, and resolved all final issues. The final document was formatted and submitted to USAID on June 29, 2015.

Q4: In July, HFG completed revisions of the report, working closely with OHS. On July 28, USAID's Office of Health Systems released the report, *Impact of Health Systems Strengthening on Health at an event held at USAID's offices*. Ariel Pablos-Mendez, Assistant Administrator for Global Health, Child and Maternal Survival Coordinator, opened this event. "We all agree on the importance of building sustainable health systems, but it's harder to appreciate the importance of HSS investments at the country level," he said. "This exercise is allowing us to share the first wave of the impact of health systems strengthening interventions. This is paramount and it is an important step for us."

"This groundbreaking report marks a milestone in our path towards identifying concrete evidence of the capacity of health systems strengthening interventions to save lives," said Karen Cavanaugh, Director of OHS, at the launch.

Since its launch, the report has been downloaded more than 1,900 times.

During this quarter, HFG completed the ninth round of revisions to the HSS technical report (now officially entitled *The Effects of Health Systems Strengthening Interventions on Health Status and Outcome Measures: A Rapid Review of Systematic Reviews*). During this round, the authors responded to all of the USAID reviewers' comments and queries, and resolved all final issues. The final document was formatted and submitted to USAID on June 29, 2015.

Table 13 provides additional activity-specific updates.

**TABLE 13. CROSS-BUREAU ACTIVITY 15 DETAIL**

Year 3 Q4 Planned Tasks	Year 3 Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
Draft a four-page brief of the technical report and submit to USAID.	This was done, revised, and approved by USAID. It is called a synopsis.	Since being launched in July, it has been downloaded more than 1,900 times.



## ***Complete Health Systems Strengthening e-Learning Course***

**Activity Objectives** - The activity objectives changed from a focus on the development and dissemination of knowledge created by HFG activities to finalizing an e-learning course on HSS.

**Year 3 Progress** - HFG completed all revisions to the course. Substantive revisions were made to two modules based on technical reviewer feedback—Health Information Systems (HIS) and Service Delivery—and the file size was compressed to make modules more easily accessible. As a result of discussions with Knowledge 4 Health, it was determined that the USAID University website was a more appropriate venue to make the HSS e-learning course publicly available. All modules were made 508 compliant, tested, finalized and posted on the HFG website. HFG also prepared the documentation needed to post the course on the USAID University website. Final approval is needed from the HFG AOR on these documents before they can be posted on the USAID University site, first for pilot-testing and then to the permanent site. Wide dissemination of the course is also pending the AOR team's review.

Table 14 provides additional activity-specific updates.

**TABLE 14. CROSS-BUREAU ACTIVITY 16 DETAIL**

Year 3 Q4 Planned Tasks	Year 3 Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
Post course online.	Course has been posted on the HFG website.	Wide dissemination and posting on USAID University is pending review by USAID.

The graphic for Activity 17 features a blue rectangular background with a white chevron pointing to the right. The text "ACTIVITY 17" is written in white, bold, uppercase letters.

## ***Global Health 2035: Progressive Pathways to Universal Health Coverage and Health Systems Strengthening***

**Activity Objectives** - Revised objectives of this activity as of January 2015 are to:

1. Support a review of country experience to date on achieving universal health coverage, and which elaborates next steps to implement UHC
2. Participate in, and provide additional support of key contributors to conduct, a high-level meeting, hosted by Rockefeller Foundation in July 2015, that will result in an implementation guidance document targeting high-level government leaders, in particular Ministers of Health working to achieve UHC
3. Disseminate findings from an HFG activity on identifying cross-cutting lessons based on experience of countries in the use of evidence in developing benefits plans

### **Year 3 Progress -**

**Q1:** The HFG team initiated discussions with the Joint Learning Network for UHC to secure preliminary commitment to the evidence-sharing conference. The JLN would be able to contribute up to approximately 50 percent of the funds made available by USAID, so additional partners or funding would need to be identified.

**Q2:** In January 2015, the opportunity for HFG to collaborate with the UCSF Global Health Group's Evidence to Policy Initiative (E2Pi) was identified. E2Pi has been supporting work launched by the Lancet Commission on Investing in Health (CIH). After discussions with HFG and E2Pi representatives and HFG's AOR, Scott Stewart, it was agreed that resources previously programmed under this activity to organize a conference on evidence sharing would be applied to support Phase 3 activities under E2Pi.

Specifically, HFG funds would be applied to co-sponsor a meeting on this topic on July 6–10 2015. The meeting would be hosted by Rockefeller Foundation at its Bellagio Center in Italy, and chaired by CIH Commissioner David Evans. Its purpose would be to review country experience to date, and elaborate on next steps to implement UHC. An outcome of the meeting would be an implementation guidance document targeting high-level government leaders, in particular Ministers of Health. HFG would have the opportunity to present relevant findings from research being done to identify cross-cutting lessons on the use of evidence in shaping the design of health benefit plans.

**Q3:** Preparation for the Global Health 2035 conference in Bellagio, Italy continued. With support from HFG, consultant Alix Beith finalized the logistics and agenda for the Bellagio meeting. Ms. Beith produced a draft background paper on the state of global progress in UHC design and implementation to inform discussions at the meeting. HFG provided detailed written comments on this draft. A consulting agreement was finalized for the lead facilitator of the meeting and contributor to the background paper, Dr. David Evans. Travel arrangements for two travelers, Ms. Neelam Sekhri Feachem, and Dr. Kalipso Chalkidou, to the conference were completed as planned. The process for recording meeting attendance and reimbursing meeting participants for airport transportation to/from their home countries was reviewed for compliance with USAID regulations. An additional traveler, global health expert Ms. Helen Saxenian from Results for Development Institute, was approved and her arrangements are in progress. (This addition is budget-neutral, made possible by reducing days committed to in the consulting contract with Ms. Beith.)

**Q4:** On July 7–9, 2015 a diverse international group of 21 practitioners and academics convened at the Rockefeller Foundation's Bellagio Center for a three-day workshop. The meeting was chaired by Dr. David Evans, former Director of Health Systems Governance and Financing at WHO and now affiliated

with the Swiss Tropical and Public Health Institute. Dr. Gavin Yamey, Lead for the Evidence to Policy Initiative, was the rapporteur. Dr. Ariel Pablo-Mendez represented USAID and Ms. Jeanna Holtz represented HFG. Ms. Holtz presented findings from HFG's research on the use of evidence in the design of benefit plans.

Following the meeting, The Bellagio Statement on Implementing Pro-Poor Universal Health Coverage was drafted and underwent revision based on comments from participants. The statement was submitted to the Lancet Global Health journal for publication.

Additionally, HFG continued its facilitation of components of the logistical support of the event. This included arranging for payment for travel of participants to and from the venue and Milan, and organizing travel from home countries to Milan for several participants.

Table 15 provides additional activity-specific updates.

**TABLE 15. CROSS-BUREAU ACTIVITY 17 DETAIL**

Year 3 Q4 Planned Tasks	Year 3 Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
Manage meeting preparation and logistics.	Completed.	
Produce working paper and policy briefs.	The meeting rapporteur, Dr. Gavin Yamey, drafted the Bellagio Statement on Implementing Pro-Poor Universal Health Coverage. The draft was circulated and underwent revision based on comments from participants; it was then submitted to the <i>Lancet Global Health</i> journal. Additionally, a draft report of the workshop (upon which the Statement is based) was distributed for comment.	It is hoped that the Bellagio Statement on Implementing Pro-Poor Universal Health Coverage will be accepted and published by a relevant professional journal.  Ms. Beith and Dr. Yamey will prepare two 1–2 page “practice briefs” from the implementation report and the literature review, drawing out key messages for practice.
Participate in meeting.	Completed. Dr. Ariel Pablo-Mendez represented USAID and Ms. Jeanna Holtz represented HFG at the workshop.	
Conduct dissemination event.	A dissemination event, possibly linked to Universal Health Coverage Day in December, will be planned.	

## **ACTIVITY 18**

### **Promoting Effective Parliamentary Standing Committee Oversight of Responses to Priority Health Challenges**

**Activity Objectives** - The objective of the activity is to provide parliamentary standing committees with information about EPCMD priorities and the mechanisms they can use to conduct robust, sustained oversight on government performance in improving child and maternal survival rates. Parliamentary standing committees will use the HFG guidelines to conduct oversight hearings and ask focused questions on government performance, and review budget allocations and expenditures on EPCMD. Greater parliamentary oversight on efforts to end preventable child and maternal deaths leads to improved performance and increased budgetary allocations.

Improving oversight of maternal and child survival programs will include care and treatment services in EPCMD countries where HIV/AIDS is a major health challenge.

**Year 3 Progress** - HFG work on this activity was launched on May 7 when HFG joined representatives from the AOR team and USAID Center of Excellence on Democracy Rights and Governance to discuss the objectives, content, and proposed piloting of the HFG guidelines. This meeting brought together key stakeholders and served as the launch of the activity. Work on the guidelines is currently ongoing.

The activity team met to review outlines and a draft is expected for internal and external review in October 2015.

Table 16 provides additional activity-specific updates.

**TABLE 16. CROSS-BUREAU ACTIVITY 18 DETAIL**

Year 3 Q4 Planned Tasks	Year 3 Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
Development of guidelines	Work is ongoing.	
Pilot of guidelines	Potential pilot sites are being assessed.	

## **ACTIVITY 19**

### ***Defining Experiences and Success Factors in Institutional Roles and Relationships in the Governance of the Health Sector to Ensure Quality***

**Activity Objectives** - As countries move toward UHC, it is important to consider quality and the governance that ensures quality of health services. Access to quality services is a key factor in EPCMD. The objective is to assess and document global experience in institutional relationships that govern quality in the health sector, and provide practical and action-oriented guidance to countries on success factors in structuring institutional roles, responsibilities, and relationships. HFG would aim for WHO endorsement and dissemination of activity deliverables.

Countries seeking to develop new governance structures or to improve existing structures would have a ready guide, based on the results of documented country experiences, to successful approaches and lessons learned in structuring institutional roles, responsibilities, and relationships to improve and ensure ongoing quality. At least one country will commit to change or adapt existing institutional roles, responsibilities, or relationships according to the guidance, to improve health (likely long-term evidence, after dissemination of the product.).

Relative to the Aids Free Generation, some of the countries to be studied have concentrated epidemic profiles, and lessons will be drawn for their institutional governance and how the challenge of access to quality counselling, care, and treatment has been addressed in the nature of the institutions that govern HIV services roles, responsibility, and relationships.

**Year 3 Progress** - The activity was approved in November 2014. In Year 3, multiple stakeholders, including WHO, USAID's ASSIST project, the Institute for Healthcare Improvement, and the Joint Learning Network, came together to implement this activity, looking to define best and promising practices in countries when governing quality improvement and assurance for health services. Multiple tasks were accomplished in Year 3 including: work planning, stakeholder engagement, defining the functions for governing quality, and selecting countries for the literature review and Joint Learning Network stakeholder engagement. In Y3Q4 the team finalized the countries for the literature review and began the review in earnest. The team also supplemented the literature review with semi-

structured interviews of a subset of 10 countries, and began the engagement process with the JLN countries who responded to the Expression of Interest soliciting interest in learning from and collaborating in the activity.

**Q4 Challenges** - Working with the multiple stakeholders contributes immense value to the product, yet in practice this technique of product development is challenging logistically and technically. However, the team is moving rapidly now after much consultation to complete the literature review, semi-structured interviews, and engagement process leading up to the Y4Q1 consultative meeting.

**Q4 Additional Information** - In Y3Q4 the Technical Program Officer changed from Alexandra Hulme to Kelley Laird

Table 17 provides additional activity-specific updates.

**TABLE 17. CROSS-BUREAU ACTIVITY 19 DETAIL**

Year 3 Q4 Planned Tasks	Year 3 Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
Literature review, landscaping	Countries for the literature review have been systematically selected. The literature review team has been on-boarded and the literature review is well under way. The team hopes to complete the literature review and landscaping in Y4Q1. Simultaneously, the information from the literature review will be augmented by semi-structured interviews currently under way by the ASSIST project and WHO.	Establishing countries using a methodical and systematic approach (and collaborative decisionmaking with WHO, ASSIST, JLN, etc.) took more time than we had initially expected.
Case development	The team has initiated engagement with JLN countries interested in engaging in and learning from this Governing Quality activity. We expect a few of these countries to work in greater depth with the team, and identify and analyze case studies in their countries to improve governing quality.	Currently beginning.
Publication and dissemination of final product guide	Not yet started.	



## ACTIVITY 20

## Strengthening People-centered Services Through Improved Accountability

**Activity Objectives** - To generate evidence of the impact of good governance, and enhance understanding of how efforts to improve citizen voice affect accountability relationships in the health system. This work will contribute to the knowledge base on what works to improve health system responsiveness to communities.

**Year 3 Progress** - The study team held preliminary conversations with partners implementing community accountability projects in Tanzania, Indonesia (R4D), and India (Sahaj), as well as with HFG governance advisor Jeremy Kanthor. The team identified civil society-supported (community score card)

accountability projects focused on maternal health in the tribal districts of Gujarat, and established government linkages through the National Health Systems Resource Center in India.

The team prepared a full SOW based on the maternal health project in Gujarat along with a budget, and mobilized doctoral candidates at the Johns Hopkins School of Public Health (JHSPH) who can undertake the data collection and analysis. Briefing in person with Jodi Charles garnered feedback emphasizing the value of the project in terms of being able to document increases in access for marginalized populations, having quantitative data sources, and combining demand and supply elements of monitoring for improved accountability.

The team undertook an initial trip in April 2015 to Baroda to further plan the study (see trip report). The team subsequently finalized a research plan and obtained IRB approvals at JHSPH (May), Abt, and IIHMR (local Indian IRB) (June). Data collection was slightly delayed to ensure that all IRB approvals are secured. Follow-up permissions were sought from state-level authorities to access village-level data on pregnant and lactating women. The team developed a sampling frame to select appropriate comparison groups. Interview guides were successfully piloted and a respondent list was finalized.

Data collection started during the week of June 29 and ended the week of July 27. A total of 55 qualitative interviews were undertaken with multiple stakeholders at community, block, district, and state level. The sampling frame for quantitative analysis was completed, and a proposal was developed for HMIS data abstraction and analysis, subject to further funding and permissions. A report outline was developed and a timeline for completion was agreed upon.

**Q4 Challenges** - Low levels of literacy made conducting in-depth interviews challenging. Triangulation of data sources and types of respondents has helped counter some of these challenges. A work plan has been developed with clear deliverables outlined for finalizing the report. The plan to collect HMIS data was delayed but is progressing; permissions from government to access their routine data may still be challenging.

Table 18 provides additional activity-specific updates.

**TABLE 18. CROSS-BUREAU ACTIVITY 21 DETAIL**

Year 3 Q4 Planned Tasks	Year 3 Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
Ongoing data collection and analysis	Completed qualitative data collection. A proposal for HMIS data abstraction and analysis was developed, subject to further funding and permissions.	
Research reports, dissemination, manuscripts to be completed during Year 4	To be completed in Y4Q1	

## **ACTIVITY 21**

### *Developing indicators database*

**Activity Objectives** - The OHS is keeping track of the indicators of health systems outcomes and building blocks for low- and middle-income countries. These indicators reflect the maternal, neonatal, child, family planning, and HIV/AIDS services and resources. The information is collected on an ad hoc basis and kept in different formats, making it difficult to conduct various kinds of analyses or create a holistic picture of the health system performance. There is a need to standardize a process and create a

database of indicators that is easily accessible and amenable to provide answers to emerging policy and programmatic questions. HFG will create a new database that will include data from 2000 to the present for the various indicators of interest. The database will be dynamic and relational, allowing for new indicators and the option to link and display them on a dashboard for descriptive analysis, and visualization of the data in various formats.

**Year 3 Progress** - The phases of collecting and organizing the indicators from existing sources, and incorporating built-in data analytics and visualization, are now completed. The database presently includes several modules and a built-in capacity to perform a variety of functions including timeline analysis, cross-tabulations according to health system function groupings with benchmarks, and producing an executive summary snapshot visual for a country.

**Q4 Challenges** - Incorporating the entirety of crosstabulation functions and built-in clustering capabilities involves further scoping out and planning, and is contemplated for the next phase of this work.

**Q4 Additional Information** -Year 4 scoping has begun, but has not finished yet.

Table 19 provides additional activity-specific updates.

**TABLE 19. CROSS-BUREAU ACTIVITY 2I DETAIL**

Year 3 Q4 Planned Tasks	Year 3 Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
Develop analysis and visualization tool.	The second phase, focusing on developing built-in data analytics and visualization, started at the end of Q2, and is completed. There are several modules that include a built-in capacity to analyze timeline information for each indicator according to health system function groupings, and all indicators for selected countries; as well as the capability to conduct cross-tabulation analysis controlling for income and region, benchmarking against parameters of the mean, fixed value, median, and standard deviation of indicator values; and the capability to produce a summary snapshot visual for a country.	Country and central teams should find this tool helpful for planning. Preparations are under way in scoping the next stage and subsequent phases of the project. This is proposed to contain modules for enhanced cross-tabulation features, clustering (Kmean and Kmedian), and improved front-end instructions for users.
Collect and manage data.	Completed phase one data collection and integration into the tool.	Additional indicators and refreshed data will likely be added in Year 4.



## 4. DIRECTED CORE ACTIVITIES

This section presents a summary of progress made in the five directed core areas – HIV/AIDS, Malaria, MCH, Population and Reproductive Health (PRH) and TB.

### 4.1 HIV and AIDS

**Program Objectives** - HFG activities support countries in achieving and sustaining PEPFAR's goal of epidemic control through data-driven approaches that target key populations and focus on specific geographic areas. HFG activities contribute to this by producing strategic and scientifically sound data to guide investments. For example, HFG is generating data to guide scale-up of innovations to improve efficiency, such as point-of-care (POC) diagnostics (viral load (VL)), and service integration. HFG began Year 3 with the following program objectives:

- ▶ **Expand sustainable financing options for HIV response.** Building on activities of the previous year, HFG will continue to support 1-2 countries in examining key factors associated with expanding fiscal resources. This will include: 1) support to government (national AIDS committees, etc.) planning and budgetary allocation processes; and 2) strengthening of country capacity to plan and direct HIV resources more efficiently, through improved resource projections, allocation, tracking, and management. This effort will include at least Botswana as one of the focus countries.
- ▶ **Build the evidence to support efficiencies in integration in service delivery.** HFG will complete its integration efficiencies study in Zambia and Tanzania. The proposed service delivery platforms being studied are the HIV care and treatment and family planning/reproductive health (FP/RH) platforms, with a focus on HIV antiretroviral (ART) and Prevention of Mother-to-Child Transmission (PMTCT) services. HFG will develop an Efficiencies Measurement Framework, to be used to study the efficiencies of health service integration in existing delivery systems and define key indicators. This activity may also include assessing different models for integration with a focus on expanding comprehensive HIV treatment and care services for people living with HIV (PLHIV), pregnant women living with HIV, children, and other key populations. The activity will be conducted in partnership with USAID implementing partners that are funded with mission resources to implement integrated health and HIV programs.
- ▶ **Market analysis to determine the optimal price points for novel HIV nucleic acid test POC technologies.** This activity is a continuation of the previous year's work to expand the use of virologic monitoring to measure ART effectiveness and link treatment efforts with reduced transmission at a population level. HFG will compare different monitoring treatment technologies using data from the POC VL Simple AMplification-Based Assay (SAMBA) technology. The models developed will assess at what price point the POC VL technology would increase value for money as compared with current monitoring methods. The results of this activity will support PEPFAR's goal of moving country programs to the use of viral suppressions as an indicator of the effectiveness of HIV treatment programs.
- ▶ **Increase support for Global Fund activities.** Countries need to address the challenges of HIV program sustainability. To understand the resources they will need in the future, countries need to strengthen their strategic and operational plans and funding proposals with concrete timelines and responsibilities for addressing sustainability issues. HFG will support countries as they prepare grant applications to the Global Fund under the New Funding Model.

- **Review of Partnership Frameworks.** This review will examine the effectiveness of the PEPFAR Partnership Frameworks (PFs) and Partnership Framework Implementation Plans (PFIPs) in supporting country ownership and sustainability planning of HIV programs. This activity will develop and pilot an assessment protocol to gather lessons learned from countries where PFs have ended or will soon end, to inform the next phase of the PEPFAR sustainability planning.

### **Year 3 Activities**

#### **Activity 1-Assessing Resource Allocation of HIV Services and Improving Efficiency of ART**

**Provision at the District Level in Botswana:** HFG will conduct an analysis and track the allocation of resources for HIV programs in Botswana, comparing health expenditure data and normative costs. The activity will collect financial data related to facility characteristics and programmatic activities for ART services delivery. A final report will be drafted and include a cost variation analysis, data envelopment analysis, lessons learned, challenges, and opportunities to improve efficiency in ART provision.

#### **Activity 2-Financing Strategies to Support PEPFAR Transition to Domestic Funding of the**

**National HIV Response:** This activity will support PEPFAR country teams' work with national stakeholders in transitioning donor-funded activities to country-owned entities. HFG will conduct analyses of resource flows, programmatic activities, services delivered, and accountability arrangements. Key informant interviews will be conducted in two African countries, and HFG will support the dialogue and process of transitioning in two countries by conducting stakeholder and consensus meetings. Country reports on financing strategies, scenario analysis with a particular focus on PEPFAR transition strategies, assessment of challenges and bottlenecks, and recommendations to overcome these will be drafted. Additionally, a framework to address sustainable financing, lessons learned, challenges, and opportunities will be developed.

#### **Activity 3-Costing and Planning Tools to Support Rational Strategies to Scale Up VL Monitoring**

**within ART Programs:** This activity contributes directly to the current PEPFAR mandate, as described under the Impact Action Agenda, on ensuring effective treatment through viral load testing. The study explores costing, budgeting, and planning for the scale-up of VL monitoring to sustain ART programs. This activity seeks to determine the test characteristics of POC VL technologies that influence the feasibility of adoption of these technologies in low-income or middle-income settings on a sustainable basis. Building on progress in Y2, HFG will complete the costing of POC VL and early-infant diagnosis (EID) platforms for conventional laboratories in Uganda, and conduct cost-effectiveness analyses. Using data collected from Médecins Sans Frontières (MSF) and their implementation of the SAMBA technology, the analyses will ascertain the cost per VL and EID test in Uganda. In addition, through examination of inappropriate antiretroviral (ARV) drug switches, development of resistance, and different monitoring protocols in Uganda, models developed will assess the price at which the POC VL technology would save money, comparing (1) current monitoring methods (given values for other parameters) and (2) specific thresholds (e.g., gross domestic product (GDP) per life-year). In addition to the production of costing data, HFG will support the development of strategic costed plans for the expansion and placement of VL platforms in additional country contexts; proposed countries include Kenya, Nigeria, Mozambique, Malawi, and Haiti. Final determination of new focus countries will be made in consultation with the OHA Treatment Lead. HFG will support pilot country teams in planning the transition toward viral load monitoring, so they can implement the monitoring in a deliberate and phased manner over the next several years. It is anticipated that these pilot cost-impact models will be converted into forecasting tools that can be shared across countries to further catalyze VL transition even after the conclusion of this activity.

#### **Activity 4-Evaluating Efficiency of Integrated HIV and AIDS and Family Planning Services:**

This activity aims to provide a quantitative approach and baseline analysis for integration efficiency gains in service delivery, exploring factors at both at the system and facility level. In Y2, Tanzania and Zambia were selected as the two countries for the Integration Efficiencies study. In Tanzania, HFG is working

with EngenderHealth, a recipient of PEPFAR FP/HIV Acceleration Funds, to conduct an operations research activity. Their main objective is to compare different models of integration (service-based integration vs. unit-based integration) to describe strengths and weaknesses of each approach in the delivery of quality integrated services within typical health center settings in Tanzania. In Y3, HFG plans to design the methodology to measure efficiency gains, while EngenderHealth will support integration interventions using the FP/ART service delivery platform. Pending approval of the protocol by USAID/Tanzania, HFG will coordinate with EngenderHealth to develop schedules, timelines, and specific deliverables for respective implementing partners. In Zambia, HFG is collaborating with the FHI360-led Zambia Prevention, Care, & Treatment (ZPCT-II) Project, Society for Family Health, and the Centre for Infectious Disease Research in Zambia (CIDRZ). During Y3, HFG will work closely with each implementing partner, conduct a data collection trip to collect cost-related and qualitative data from facilities supported by the various implementing partners in order to inform the analysis, and complete the analyses and case studies.

Expected results include:

1. An Efficiency Measurement Framework and related indicators. Future integration programs can use these resources as a reference for the design and implementation of activities.
2. Improved understanding of potential efficiency gains in integrated programs, as well as documentation of missed opportunities.
3. Key recommendations for FP/HIV service integration on production process, including where efficiency gains are fully realized and improvements that could be implemented in order to maximize those gains.

***Activity 5-Financial Management and Costing Support to Global Fund Applicants and Recipients:***

In Y3, HFG will continue to provide support to countries under the new Global Fund funding model. HFG will use its technical expertise and flexibility to respond quickly to short- and medium-term technical assistance requests from countries, with the option of longer-term capacity-building, in areas that include costing of national HIV and AIDS strategic plans and financial management. HFG received a request from USAID/Cambodia to support the costing of the National Strategic Plan for HIV and AIDS and the national harm reduction plan, as this information is required for the country to complete their Global Fund concept note (anticipated submission in 2015). In Y3Q1, HFG will develop a methodology for the work, including adaptation of an existing tool (the OneHealth Tool), and develop purpose-built spreadsheets for data collection and aggregation. Trip(s) to Cambodia will be undertaken in the conduct of tasks to be implemented in collaboration with local counterparts.

***Activity 6-Lessons Learned from Partnership Frameworks and Related Implementation Plans for HIV Sustainability Planning:***

To understand the lessons learned from the PF and PFIP, HFG will conduct a rapid and systematic assessment of PFs and PFIPs and their implications for country ownership and program sustainability. The work will involve a two-tiered approach: 1. a broad document analysis of all countries that developed PF agreements, and 2. in-depth country case studies of a small number of countries to be selected in conjunction with USG. Specific activities include a PF/PFIP desk review, development of assessment protocols, data compilation and analysis, in-depth case studies, and drafting a synthesis report that summarizes conclusions and proposes recommendations.

**Year 3 Progress Against Objectives**

**Activity 1:** The study received approval from the Botswana MOH Internal Institutional Review Board (IRB) Committee in Q4. Following approval, the HFG team began defining the sample parameters and determining the facility sample. The data collection training and data collection are expected to take place in Y4Q1. Following consultations with USAID, the scope of this activity was refined to examine only the efficiency of ART service delivery.

**Activity 2:** At the request of the AOR team, this activity has been re-scoped to support the USAID Sustainable Financing Initiative, "Bold Vision." HFG will conduct a baseline measurement of health financing in two Nigerian states, to be determined by USAID.

**Activity 3:** The countries of focus for this activity have evolved, based on client inputs and mission availability/interest. Kenya was selected as a second country of focus, and in Q2 HFG traveled to Kisumu to meet with counterparts at the Kenya Medical Research Institute (KEMRI)/ Centers for Disease Control and Prevention (CDC) regarding the iteration of the study in country. HFG would contribute the costing/cost-effectiveness component to KEMRI's broader study on POC VL and EID technologies. HFG developed a scope of work and shared it with KEMRI for inclusion into the study protocol with the requisite IRB approvals, and also adapted the costing methodology and data collection tools to the Kenyan context. During this trip (February 2015), HFG piloted and finalized the data collection tools. The team also conducted a cost-effectiveness analysis training for selected KEMRI/CDC staff.

In Q3, HFG finalized the data collection tools, and was prepared to start data collection with KEMRI when the team encountered funding challenges for the data collection. Under HFG's original partnership agreement, KEMRI was to fund the data collection as part of the broader study. However, when the broader study on POC VL and EID technologies was cancelled, HFG was asked to fund the data collection. The funding was later approved by the Agreement Officer Representative (AOR) team, and data collection would proceed as planned despite the delays experienced during the process.

In Q4, data collection by the KEMRI team started. Preliminary data from all sample sites was received and reviewed by HFG staff, and further guidance on cleaning and finalizing the data was provided to KEMRI. Upon finalization of the data in Y4Q1, the HFG team will begin analysis.

Based on ongoing conversations with USAID/Washington activity manager Tom Minior, HFG continues to explore options to complete collection of the outstanding data for the Uganda component of this activity. One option under consideration is to perform another trip that would be linked with a costing/cost-effectiveness workshop for key stakeholders in Uganda. These would include officials from MSF, the Central Public Health Laboratory, and the VL laboratory (CDC), which are the primary institutions for the data collection exercise. This could potentially facilitate collection of utilization and costing data, which is required to complete the model and determine the cost of the diagnostics VL and EID.

**Activity 4:** In Y3Q1, HFG focused on launching the integration efficiencies study in Zambia. Key accomplishments included the development and finalization of data collection tools, hiring of a local research coordinator, and approval from both Abt's IRB and the local research and ethics committee in Zambia. The first quarter was rounded out by a trip conducted by Health Economists Ben Johns and Sophie Faye. In collaboration with the local research coordinator, they conducted stakeholder meetings with the implementing partners, piloted the data collection tools, and finalized study sites and tools for data collection. Despite initial delays in obtaining local IRB approval, data collection began in earnest under the leadership and coordination of the local research coordinator in Q2, with support from the U.S.-based team. From early January to mid-February 2015, the local research team visited 10 clinics across three different provinces to obtain both quantitative and qualitative data on integrated FP-HIV activities. At the end of Q3, the team had received the majority of the data from the field and had begun initial data preparation. In Q4, data analysis was conducted and the draft report was shared with the mission as well as OHA colleagues. The analysis indicated that, among the indicators of efficiency assessed, there was no statistical difference between the results obtained using the internal referral (IR) and one-stop-shop (OSS) models of integration. The cost analysis results suggest that there are small efficiency gains from the OSS as opposed to having women obtain FP at a referral clinic. Providing a more comprehensive package of care to HIV-positive women and increasing their access to FP services costs relatively little regardless of which integration model is used; in the IR model it is an additional \$8 and in the OSS model it is an additional \$3. It is important to note that the societal benefit for the

women of not having to make an additional clinic visit for FP services could be important, but was not assessed in this study. At the end of the quarter, the team had received comments from USAID/Zambia and was awaiting OHA's comments in order to finalize the report.

In Tanzania, HFG began Y3 by contributing to the latest version of the concept note, led by Engender Health's RESPOND project. This activity is also supported by the Population Council. In Q2, the USAID/Tanzania mission approved the joint concept note, combining the scopes of three agencies- Engender Health, the Population Council, and HFG-to undertake this integration activity. At the end of Q2, Engender Health invited HFG to participate in a week-long partner meeting in mid-April to coordinate partners, and to develop the research protocol for the study and relevant tools based on the approved concept note. In Q3, HFG participated in a joint planning event in Tanzania with Engender Health and the Population Council in April 2015. The final concept note and the research protocol were fully approved by the USAID Mission in Tanzania, and the specific scope for HFG was defined. In Q4 the three partner groups submitted and obtained IRB approval from their internal IRBs (including Abt's) and from the Tanzanian local IRB. A 20 site-facility inventory was conducted by Engender Health, and HFG is using the results to plan for the baseline data collection, which is scheduled for Y4Q1.

**Activity 5:** The overall purpose of the activity is to provide technical assistance to Global Fund proposals and activities as determined by the USAID Global Fund Liaison team. In Q1 HFG was requested to support the costing of Cambodia's strategic plan for HIV/AIDS, STI Prevention and Control. Cost data were collected from key Cambodian stakeholders over a four-month period and continuously validated. This process required three Temporary Duty Yonders (TDYs) to Cambodia. The first was conducted in October 2014, and included introduction of the methodology and preliminary data collection to local counterparts, and hiring of a local consultant. A follow-up visit took place in December, and included a presentation of preliminary results and continued data collection. The third visit entailed collecting outstanding data, presenting final results, and training key stakeholders on the OneHealth Tool. Since their last visit in January 2015, the team has completed and submitted a draft of its costing report, titled A Cost Analysis of Cambodia's Strategic Plan for HIV and AIDS and STI Prevention and Control in the Health Sector 2015-2020. The report was founded upon a rigorous costing analysis that was modelled through the OneHealth Tool. In addition to the strategic plan's costs, the report also models the impact of the strategic plan on outcomes such as HIV prevalence in Cambodia, HIV incidence rates, and AIDS-related mortality rates. The report provides recommendations from these findings for policymakers, and key next steps to implement, monitor, and evaluate the strategic plan. The report was reviewed by Cambodia's national AIDS coordination body, the National Center for HIV/AIDS, Dermatology and STD (NCHADS/MOH) and USAID, and was well received by key stakeholders and the USAID mission. This is the first successful costing analysis of an HIV and AIDS strategic plan that has been completed for NCHADS. In Q3, there were no requests for technical assistance from Global Fund countries.

In Q4 HFG received a request to support Global Fund activity in Jamaica. HFG conducted a recruitment process and identified an ideal candidate with both financial management and Global Fund experience. The candidate was interviewed by the OHA client (USAID Washington). Following a series of coordination meetings and discussions with the Global Fund Portfolio Manager for Jamaica based in Geneva and the Jamaican Ministry of Health (MOH), the scope of work was finalized. HFG will support the in-country presence of the Global Fund consultant, who will work with the MOH team in country over the first quarter of Y4 (Oct-Dec 2015).

**Activity 6:** HFG made progress in completing the initial phase of the activity, which focused on review of Partnership Frameworks, Implementation Plans and other documents. This included developing tools to extract, organize and present data; conducting data extraction of host country PFIPs; and a review of relevant national resource documents to prepare 15 country profiles. HFG drafted the initial synthesis report summarizing the findings, and submitted the draft to OHA. OHA provided detailed comments

and requested substantial revisions to the report. HFG undertook a second rewrite of the entire report, which was finalized and shared with the client in Q4. HFG is awaiting feedback from USAID on this latest iteration of the report. USAID has requested that the final report include the findings from the case studies, whenever those will be completed.

The current proposal is to have key findings shared with USAID/OGAC through a brown-bag event slated for the next quarter. In addition, HFG completed the case study instruments and identified technical assistance resources to support in-depth country case study activities. Both the organizations represented on HFG for this activity, Abt and Johns Hopkins University, have submitted the IRB request, and the study is exempt because it does not include human subjects research. While it was anticipated that field visits would be conducted in the first quarter, these were later postponed to the summer due to the busy Country Operational Plan season (Feb-April 2015). This timeline has been pushed forward even further, to Y4Q1. USAID has tentatively gotten interest from Kenya as a potential case study country. HFG has updated the study instruments and the protocol, which have been shared with the client at USAID Washington. HFG is planning to conduct the case study in Y4Q1 pending approval of dates and Scope of Work by the in-country team/mission in Kenya.

HFG continues to participate in meetings with representatives from USAID and the Sustainability team from OGAC on the sustainability planning framework, which is guiding this work. Coordination meetings were also conducted with other implementing partners, in particular MSH, which is working on a similar activity.

Table 20 provides additional activity-specific updates.

**TABLE 20. OFFICE OF HIV/AIDS ACTIVITY DETAIL**

Year 3 Q4 Planned Tasks	Year 3 Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
<b>Activity 3: Costing and planning tools to support rational strategies to scale up viral load monitoring within ART programs</b>		
Conduct costing field work in Kenya.	Data collection by KEMRI staff started in Q4. Preliminary results were received and reviewed. HFG provided guidance to KEMRI to clean and finalize the data.	
Develop a planning tool.	A preliminary Excel-based Planning/Costing Tool was developed and reviewed. Data collected from the Kenya study (pending finalization) will be used to further refine the tool. Work on the Excel tool is currently on hold, pending finalization of the Kenya data.	
<b>Activity 4: Evaluating efficiency of integrated HIV and AIDS and family planning services</b>		
<b>Dissemination</b>		
Draft report outline.	This will be done once the Tanzania study is completed. The idea behind this report is to have a summary of the findings from the two countries to better inform implementation of integration of FP and HIV services.	

Year 3 Q4 Planned Tasks	Year 3 Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
Develop final report on the potential indicators used to measure efficiency of integrated family planning and HIV service programs.	Same as above	
Report dissemination	Same as above	
<b>Tanzania</b>		
Program baseline data collection in Tanzania	Due to IRB delays (local approval was expected in August but was received in September), baseline data collection is now scheduled for Y4Q1.	Local IRB approval was slightly delayed but has been received now. Data collection will begin in Y4Q1.
Collect relevant baseline costs in Tanzania.		Data collection will begin in October (Y4Q1).
<b>Zambia</b>		
Collect relevant quantitative (costing) and qualitative data in Zambia.	The remaining data were collected and verified last quarter. Analysis continued this quarter. The indicators proposed for assessing the efficiency of Internal Referral (IR) versus One-Stop Shop (OSS) were: percentage of missed opportunities in the ART clinic, provider time per patient provided with FP services in the ART clinic, and unit cost per patient provided with FP services in the ART clinic. For all of these indicators, no statistical difference was found between the IR and OSS models. Percentage of missed opportunities ranged from 8 to 88%, the average time difference between a visit with and without FP counselling was low (2 minutes) and as expected, the cost analysis results suggest that there are small efficiency gains from the OSS as opposed to obtaining FP at a referral clinic. A more appropriate way to view these results would be to say that providing a more comprehensive package of care to HIV-positive women, and increasing their access to FP services, costs relatively little regardless of which integration model is used; in the IR model it is an additional \$8 and in the OSS model it is an additional \$3. From this point of view, it is important to note that the societal benefit for the women of not having to make an additional clinic visit for FP services could be important, but was not assessed in this study.	At the end of Q4, the team was awaiting feedback from OHA in order to finalize the report.

Year 3 Q4 Planned Tasks	Year 3 Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
Complete Zambia case study.	The report has been drafted and shared with OHA; key findings are highlighted above.	See above.
<b>Activity 5: Financial management and costing support to Global Fund applicants and recipients</b>		
Identify countries requiring support for Global Fund proposals and develop SOWs.	This is demand-driven. HFG responds to requests as they are received from the client. In Q4 HFG received requests for technical assistance on Global Fund work in Jamaica. Global Fund has completed the recruitment process, and this work will start in Y4Q1.	
Costing of Cambodia HIV Health Sector Strategic Plan	Completed	
PFM Support to Jamaica Global Fund Grant	HFG hired a consultant with Global Fund and financial management experience to travel to Jamaica in Y4Q1. Upon arrival in country in October, the consultant will work with the MOH (PR of the Global Fund Grant) to conduct a quick assessment of the situation and further refine his work plan for Y4Q1 (Oct–Dec 2015).	
Provide support to countries in public financial management of Global Fund grants.	Demand-driven: HFG has been informed by the client of upcoming work during Y4, focusing on FM support for countries in Sub-Saharan Africa (SSA). The full scope of work has not been shared.	
<b>Activity 6: Lessons learned from partnership frameworks and related implementation plans for HIV sustainability planning</b>		
Identify and plan for case study countries.	HFG has completed the review of the study instruments and the protocol to guide the case studies. USAID is leading the process of contacting in country missions to get buy-in for the case studies. Kenya has shown some interest and HFG is waiting for approval before we can travel to the country.	
Develop synthesis report.	The second reiteration of the report has been completed and shared with the client. USAID is reviewing the report and will be sharing comments/feedback.	
Finalize report following USAID inputs and feedback.	Report currently under review by the client.	
<b>Activity 7: Sustainable Financing Initiative</b>		
Develop baseline report.	This activity is covered under the respective country descriptions for Nigeria and Vietnam.	

## 4.2 Malaria

**Program Objectives** - USAID/PMI recognizes the critical importance of operations research (OR) and other types of studies to respond to the changing epidemiology of malaria. These studies help identify cost efficient ways to improve uptake and scale-up of interventions, measure the impact of interventions on reducing malaria, and improve the broader health system. In Year 3, HFG has been working with PMI on four activities:

Evaluate the microeconomic impact of malaria prevention, diagnosis, and treatment interventions at the household level (ongoing).

Estimate the cost-effectiveness of using different insecticide classes for indoor residual spraying (IRS). (Concept note prepared, but study discontinued after further discussion with PMI due to lack of time to fully compare IRS interventions.)

Assess the cost-effectiveness of different malaria prevention, diagnosis, and treatment strategies implemented in areas with seasonal malaria transmission (ongoing).

Develop and implement a dissemination strategy for all HFG/malaria activities (ongoing).

### Year 3 Activities

During Year 3, HFG implemented a study to identify the effect of malaria control scale-up on economic outcomes at the household level, using retrospective data from Zambia. In addition, HFG initiated the design of two new studies, discussed these with PMI country staff, and moved forward on implementation of the second study, as discussed with PMI. The first study looked at assessing the cost-effectiveness of adopting organophosphates for IRS, a more expensive insecticide class but a potentially more effective one due to growing resistance to carbamates and pyrethroids and the longer residual efficacy of organophosphates. However, HFG and PMI were not able to identify a suitable country to engage in the study, primarily due to the limited time available to effectively compare interventions, so PMI and HFG decided not to pursue that study's concept note. The second new study investigates the cost-effectiveness of different malaria prevention, diagnosis, and treatment strategies, focusing on the use of seasonal malaria chemoprevention (SMC), in countries that aim to achieve pre-elimination. This second study will focus on Senegal and potentially one other West African country. In Year 3, HFG also developed a dissemination strategy with PMI with the objective of sharing research results on the economic impact of malaria control widely to implementers, researchers, and other stakeholders. This strategy will be carried out in Years 4 and 5.

### Year 3 Progress Against Objectives

In Y3Q4, HFG continued to move forward on developing and implementing the approved studies.

After receiving final approval of the concept note for the Zambia microeconomic impact study from PMI's Operations Research Review Committee in November 2014, HFG developed a comprehensive research protocol shared with PMI in January 2015. Abt's IRB granted HFG an exemption from a full IRB review due to the low-risk nature of the study. The team subsequently received IRB approval from the Zambian entity ERES Converge, and made requests for study approval and secondary data from the Central Statistical Office, as well as the Ministry of Health (MOH) and Ministry of Community Development, Maternal and Child Health (MCDMCH). Supported by the team's two local consultants, HFG's Sharon Nakhimovsky traveled to Zambia at the end of Q2 to conduct data collection. She successfully gathered the majority of the data requested as well as gaining important insight into the context for malaria control in Zambia. The team worked closely with USAID/Zambia and key local stakeholders at the MOH, MCDMCH, and National Malaria Control Centre (NMCC) throughout the quarter. The team continued in Y3Q3 to liaise with consultants and contacts in Zambia to finish gathering the remaining data needed for the study. Unfortunately, not all of the data HFG originally

sought could be obtained, particularly agricultural production data for the baseline. The team then cleaned and matched the data across sources to prepare a dataset for analysis.

In Y3Q4, the team inputted missing values for the Health Management Information Systems (HMIS) data on malaria outpatient cases and finalized the analysis dataset. This dataset was employed to complete the generalized propensity score matching analysis as specified in the study protocol. These results were shared with PMI. Unfortunately, the results of this analysis were inconclusive in linking malaria control efforts to microeconomic outcomes. The confidence intervals for estimates were large and made it impossible to identify whether the association was positive, negative, or zero. The team assessed the limitations of the study design and the available data that may explain these inconclusive results, and suggested potential means to strengthen the results in a memo to PMI. The draft article presenting the study and its results is currently on hold pending further discussions with PMI. In Y4Q1, the team will discuss their assessment and suggested next steps with PMI and make decisions about future programming. The team will also present a poster on the analysis methods, data, results, and avenues for further analysis at the American Society for Tropical Medicine and Hygiene (ASTMH) Annual Meeting in October 2015.

As a result of the decision to not go forward with the Long-Lasting Insecticide-Treated Net (LLIN) costing study in Q1, HFG provided the concept note to Vectorworks to inform their future study. HFG subsequently met with PMI in December to discuss ideas for two new activities.

The first activity proposed was a cost-effectiveness analysis of using organophosphates for IRS. HFG developed a draft concept note for this research activity in Y3Q3 to be discussed with the broader PMI team for country selection. After the team explored in great depth with PMI the viability of the two countries proposed for the potential research activity, neither proved feasible for different reasons. Primarily because HFG's contract ends in FY 2017, there was not enough time for more than one IRS intervention to take place and the related cost data to be gathered for a reliable comparison. After this decision the HFG research team worked with PMI to explore alternative countries and research topics that are viable and useful to further systems research in malaria programming.

The second proposed activity is a cost-effectiveness analysis of targeted malaria prevention, diagnosis, and treatment intervention packages, including potentially IRS, LLIN distribution, seasonal malaria chemoprevention, active case detection and treatment, etc., in countries where the opportunity to attain pre-elimination exists. As a result of discussions with PMI, Senegal and Zimbabwe were originally selected as the focus countries for this study. In Y3Q4, HFG began conducting landscape analyses for both countries to understand the financial and programmatic content of the malaria programs. Through a desk review, HFG collected available information from existing literature and country-planning documents, and identified gaps to be filled during in-country assessments. Based on the findings of the analysis and following discussions with PMI, it was determined that Zimbabwe will not be a suitable context for this study, due to the limited number of interventions in country. However, the HFG team will be working with PMI to propose an alternative country, in West Africa.

Lastly, in Y3Q2 HFG initiated the development of a dissemination plan for the malaria activities as part of HFG's scope of work with PMI for Year 3. In Y3Q3, HFG determined the best dissemination tactics to employ for the two studies, with the goal of finalizing the plan to share with USAID at the end of Y3Q3. HFG prepared an abstract for the ASTMH 2015 Annual Meeting to present the anticipated results of the Zambia microeconomic study. In Y3Q4, HFG received feedback and approval of the dissemination plan from PMI. HFG worked with PMI to organize a consultative technical meeting as a side event during the annual meeting in October 2015 to encourage technical discussion and exchange on recent research on the economic impact of malaria control.

**Q4 Challenges** - The microeconomics of malaria study team encountered several key challenges during the data analysis. These challenges included limited sample size, high variance in outcome measures, and limited number of variables available at baseline (e.g., agricultural production of maize and other crops, which the Central Statistical Office was unable to provide for us). Because of these challenges, the results of the analysis are inconclusive. To address these challenges, the team has presented several potential solutions and discussed further steps with PMI. In Year 4, the team will continue to discuss possible next steps with PMI and make a plan for ensuring value from the investment made in this analysis.

**Q4 Additional Information** - Health Economist Sophie Faye, PhD, joined the Seasonal Malaria study team due to the need to have a qualified French-speaking research expert for data collection and analysis in Senegal.

Table 21 provides additional activity-specific updates.

**TABLE 21. MALARIA ACTIVITY DETAIL**

Year 3 Q4 Planned Tasks	Year 3 Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
<b>Activity 1: Microeconomic impact of scaled-up malaria control</b>		
Data analysis	The team imputed missing values for the HMIS data on malaria outpatient cases and finalized the analysis dataset. This dataset was employed to complete the generalized propensity score matching analysis as specified in the study protocol.	Analysis results were inconclusive in linking malaria control efforts to microeconomic outcomes. The team assessed the limitations of the study design and the available data that may explain these inconclusive results, and suggested potential means to strengthen the results in a memo to PMI on September 15, 2015. The team will continue dialogue with PMI to ensure greater value from the investment made into this analysis.
Prepare manuscript for journal submission.	The team drafted the introduction and methods sections of the manuscript; the team will wait to proceed until there have been further discussions about next steps with PMI.	
<b>Activity 2: Cost-effectiveness of IRS using organophosphates (cancelled)</b>		
Draft concept note.	Draft prepared and discussed with PMI and PMI country teams.	Discontinued due to lack of sufficient time to compare IRS interventions.
Draft budget for study protocol.	Draft prepared.	Discontinued.
<b>Activity 3: Cost-effectiveness of malaria prevention, diagnosis, and treatment in areas with seasonal transmission</b>		
Draft concept note.	Concept note was drafted and shared with PMI in Y3Q3. Zimbabwe and Senegal were selected. Further discussion on Zimbabwe with PMI country team indicated a lack of seasonal malaria activities.	Upon completion of a desk review and following discussions with PMI, it was determined that Zimbabwe is an unsuitable context for the purpose of this study due to the limited number of malaria prevention interventions. HFG will attempt to identify another country, in addition to Senegal, where the study can be conducted.

Year 3 Q4 Planned Tasks	Year 3 Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
Develop methodology.	A detailed cost-effectiveness study methodology was developed and included in the landscape analysis report for each country. The methodology, outlining country- and intervention-specific data needs and potential sources, was presented to PMI.	
<b>Activity 4: Dissemination</b>		
Dissemination Plan	Draft completed in Y3Q3. Reviewed by PMI in Y3Q4 and finalized in Q4. Moving to operationalize the approved plan.	No problems.
Economic Impact of Malaria Control, a consultative meeting at ASTMH Annual Meeting	Logistics well under way in Y3Q4 for this event in Y4Q1, including lining up venue, inviting speakers and informing participants, organizing refreshments, and addressing AV needs.	No problems.

## 4.3 Maternal and Child Health

**Program Objectives** - As the end of 2015 approaches, the international community is dedicated to ending preventable maternal and child deaths, and helping countries meet Millennium Development Goal (MDG) 4 (Reduce Child Mortality) and 5 (Reduce Maternal Mortality). While substantial progress has been made in the last several years, only half of women in developing countries receive the recommended health care during pregnancy, and more than six million children worldwide die before their fifth birthday. In June 2012, the United States Government (USG), along with the United Nations Children's Fund (UNICEF) and the governments of Ethiopia and India, launched the Child Survival Call to Action, and challenged the world to reduce child mortality to 20 deaths or less per 1,000 births in every country by 2035. Harnessing the momentum from the Call to Action and its subsequent initiative, A Promise Renewed, USAID invigorated its efforts to improve maternal and child survival in the five countries that account for over half of global child deaths: Ethiopia, Democratic Republic of Congo, India, Nigeria, and Pakistan. Early in 2014 USAID once again renewed its commitment to ending preventable child and maternal deaths, and pledged a reduction in under-five mortality by 4 deaths per 1,000 live births in 24 priority countries by 2015 (as compared to a 2013 baseline). The three-year anniversary of the Call to Action in June 2015 added to the momentum, serving as an interim milestone and an acute reminder of the progress yet to be realized. The USAID MCH office and HFG recognize that without the proper policies in place and the country-level capacity to provide MCH services, as well as reduced financial barriers to access these services, the goals set by these initiatives are unlikely to be met.

HFG's MCH portfolio supports the following intermediate objectives, each of which links to MDGs 4 and 5 and aims to end preventable child and maternal deaths:

- ▶ Develop and promote analytic and planning tools to support evidence-based MCH planning and budgeting by policymakers.
- ▶ Improve capacity of countries to apply health financing mechanisms to stimulate uptake of essential MCH services, enhance provision and quality of such services, and improve supply chains for MCH commodities.
- ▶ Contribute to the evidence base on the effectiveness and cost-effectiveness of various health financing and governance interventions for MCH service use.
- ▶ Strengthen global partnerships on key MCH-related initiatives to leverage resources and advance the knowledge and practice of MCH programs.

### Year 3 Activities

The project continued implementing four activities carried over from Year 2:

- ▶ **Evaluation of a health microinsurance pilot program in Lagos, Nigeria.** HFG conducted a baseline evaluation of an insurance scheme for informal sector workers in Lagos State, Nigeria. The insurance program was based on a partnership between a Nigerian health insurance company (Health Care International) and a microfinance bank (Infinity) in Lagos; the partnership and development of the insurance product have been supported over the past several years by the Abt-led Partnership for Transforming Health Systems, Phase Two (PATHS2) program, funded by the UK Department for International Development (DFID). Since lower- and middle-income women of reproductive age constitute the bulk of the clients of the microfinance bank, providing access to otherwise unavailable health insurance coverage is expected to increase their access to high-quality health care, including essential MCH services. HFG's evaluation contributed to the evidence base on the effectiveness of health financing interventions for MCH service use.

- ▶ A study of **lessons learned from the Nigeria micro health insurance scheme** using key informant interviews to distill broader implications for practitioners and policymakers.
- ▶ **Resource tracking for MCH.** In the context of the global economic transition, in which middle-income countries are increasingly able to finance health care with domestic resources, tracking how much countries and donors are spending on priority MCH services is more critical than ever. The updated National Health Accounts methodology, known as the System of Health Accounts (SHA) 2011, aims to track overall health spending across a spectrum of program- and disease-specific categories-beyond what used to be tracked for selected priority areas like the Reproductive Health and Child Health subaccounts. The new methodology will ultimately provide opportunities for more-granular analysis of MCH spending, but countries also need guidance to meet the increased information requirements it entails. To this end, HFG has supported the following three activities:
  - **Develop practical guidance materials on MCH resource tracking for countries applying the updated SHA 2011 methodology.** To ensure that MCH-related spending is consistently and accurately measured using the new framework, countries need support and guidance. Similar to the guidance that is being developed for tracking spending on tuberculosis and family planning expenditures, the aim is to integrate the MCH guidance into the broader guidance that the World Health Organization (WHO) is developing; HFG has worked in close collaboration with WHO on this activity.
  - **Support development of policy advocacy and communications tools to enhance uptake and use of findings by government officials and civil society organizations.** HFG created a summary brief analyzing existing MCH resource tracking data across several countries, showcasing how this information can be interpreted and used. The project is creating basic templates for policy-relevant communication of MCH resource tracking results. These tools will demonstrate how MCH expenditure information can be used to improve national strategic planning, domestic resource mobilization, and resource allocation for MCH programs.
  - **Pilot MCH guidance in a USAID-identified priority country that is conducting an SHA 2011 estimation.** This experience will be used to improve and finalize the guide. HFG identified Zambia as a possible context for this support.
- ▶ **Modeling the effects of health systems strengthening on coverage and lives saved.** Health systems provide the basic inputs for the delivery of health services, yet it has historically been difficult to quantify contributions of health systems strengthening inputs and their importance for improving MCH outcomes and reducing mortality. As a result, policymakers, health planners, and donors find it challenging to demonstrate the importance of investing in activities to strengthen health systems. HFG built an Excel-based projection model that incorporated available evidence on the effects of health systems strengthening on health outcomes, in order to support strategic planning, prioritization, and advocacy efforts worldwide.

In Y3Q4, the project initiated several new activities, as follows.

- ▶ Preparing a **manuscript summarizing lessons learned from the Nigeria micro health insurance scheme**, for submission to the journal *Health Policy and Planning*.
- ▶ Contributing financing inputs to the **synthesis paper for a Lancet Maternal Health Series to be published in 2016**.
- ▶ **Using provider payment to improve quality of maternal health services:** Countries are increasingly recognizing the importance of good -quality care for achieving health targets, and several are exploring ways in which financial payments and incentives to health care providers can not only improve access to services, but also improve the quality of those services. However, there is little information available on how to design provider payments for improving maternal health in

Low?And Middle?Income Countries (LMICs), and little information on how such payment arrangements are working to improve quality of maternal care. HFG will review and document country examples of arrangements that link financial payments to providers (including salaries, reimbursements, capitation payments, and various performance-based financial incentives) with the quality of maternal health care, and analyze the mechanisms through which these incentives are influencing provider behavior. The aim is to derive practical lessons that would guide other countries to design and implement similar schemes.

- ▶ **Supporting OneHealth Tool capacity-building and technical assistance:** The OneHealth Tool (OHT) is a comprehensive tool used to analyze and estimate the costs of health systems investments needed to achieve maternal, newborn and child health goals. Many countries in Southeast Asia have drafted their Every Newborn Action Plans (ENAP), but most of these were developed with limited information of anticipated costs and the impact of the proposed plans. Therefore, targets may not be consistent with available funds, and countries do not know whether their plans will put them on track to reach global and country targets for mortality reductions. In collaboration with the WHO/SEARO, the HFG project (through its partner Avenir Health) will support additional capacity-building on the OHT in two countries, Bangladesh and Indonesia.

### **Y3 Progress Against Objectives**

**Evaluation of a health micro insurance program in Lagos, Nigeria:** The baseline report was completed and this activity is now complete.

**Lessons learned from Nigeria micro health insurance evaluation:** To assess qualitative lessons learned from the Nigeria insurance pilot, HFG contracted a qualitative research consultant with skills to effectively communicate with a range a key stakeholders while understanding cultural boundaries. The consultant traveled to Lagos, Nigeria in mid-October 2014 to spend two weeks conducting key informant interviews with 25 stakeholders. The HFG team finalized a technical brief incorporating findings from these interviews. This activity is now complete.

**Prepare journal manuscript on Nigeria microinsurance intervention:** The USAID/MCH team agreed to support HFG in preparing a manuscript documenting lessons learned (both positive and negative) from the Nigeria microinsurance partnership experience. HFG's lead author prepared a first draft of the manuscript and the team is now reviewing and revising it. HFG plans to submit the manuscript to the journal Health Policy and Planning.

**MCH resource tracking activities:** The HFG Health Accounts team received feedback on the maternal health resource-tracking guidance from the WHO Health Accounts team and incorporated the feedback into the latest draft. This will be shared with a wider group for consultation. Given limited response from the Zambia Health Accounts team and delays with their process, HFG is exploring other countries in which the guide could be piloted. Ethiopia and Botswana are being explored. The team finalized, formatted, and submitted the MCH Policy brief.

**Modeling the effects of health systems strengthening on coverage and lives saved:** In Y2Q3 HFG developed a concept note to illustrate how the HFG team planned to model the influence that health system strengthening (HSS) inputs can have on coverage, and how this ultimately impacts lives saved. In Y3Q1 the team began a literature review to document the effects of HSS interventions on coverage. A preliminary search of the effect of HSS inputs on health coverage using the McMaster University Health System Evidence database by health system domain was conducted, and the team reviewed all 400 outputs related to the "human resources" and "finance" pillars. The team continued to go through the initial output from the McMaster Health Systems Evidence database for all pillars through the end of January 2015. Concurrently, a literature search using other online databases to search for similar coverage effects was completed, and the literature review framework was revised to conform with the USAID HSS functions.

In Q2, USAID asked HFG to draft a detailed activity implementation plan for development of the HSS Impact Tool, and instructed HFG to proceed with tool development. By the end of Q2, the literature review was near completion, the HFG team continued to work on the impact matrix developed from the literature review, and a mockup of the calculation sequence had been built for preliminary internal review and consistency testing. USAID also began liaising with UNICEF regarding its similar work with the EQUIST tool. At the end of Q2, HFG convened a virtual Advisory Group meeting to solicit expert input on the conceptual framework for the HSS modeling tool. Opening remarks at the meeting were made by Dr. Ariel Pablos-Méndez, USAID Assistant Administrator for Global Health.

In Q3, the literature review was completed. A beta model of the tool in Excel was built, default data on the effects of HSS activities on bottlenecks were entered into the tool, and the beta tool was submitted to USAID. HFG also participated in ongoing discussions between UNICEF and USAID about the relationship between this tool and UNICEF's EQUIST tool and how to proceed given possible duplication of efforts.

In Y3Q4, HFG demonstrated the HSS Impact Tool for USAID's Office of Health Systems staff. The beta tool was very positively received. However, USAID expressed continued concern about the development of two parallel tools. It was determined that, going forward, HFG should collaborate with UNICEF to further develop and vet the HSS impact matrix, with the intent that the common, expert-reviewed impact matrix would eventually be incorporated into UNICEF's EQUIST tool. Therefore, in Q4, HFG made final improvements to the beta Excel version of the tool to ensure that it was fully functional and to improve the user experience. In Y4Q1, HFG plans to develop a joint work plan with UNICEF, which will determine next steps for the activity.

**Contribute to maternal health Lancet Series:** HFG is contributing to a series being prepared for Lancet publication in 2016 on the future of maternal health, focusing on financing challenges. HFG prepared an outline and then a draft of the financing section for the Lancet synthesis paper and shared this with co-authors. Next steps will be discussed at a workshop after the Mexico City Maternal, Neonatal, and Child Health (MNCH) conference in October 2015, during which peer reviewers will provide preliminary feedback on the draft.

**Using provider payment to improve quality of maternal health services:** In Y3Q4, HFG prepared a draft conceptual framework that links maternal health care quality with provider payment systems, and circulated it internally for review. HFG will next solicit input from USAID and other experts. HFG also started a literature review to analyze how LMICs are developing links between quality measurement and provider payments.

**OneHealth Tool capacity-building and technical assistance:** In collaboration with Lily Kak (USAID/HIDN), HFG developed a tentative scope with the WHO/SEARO, and reached out to USAID missions in Indonesia and Bangladesh. The Indonesia mission is in the midst of preparing its work plan with the MOH, and is unlikely to commit to this activity at the moment. HFG is currently in communication with the Bangladesh mission to determine a scope.

## **Q4 Challenges**

### **Modeling the effects of health systems strengthening on coverage and lives saved:**

Coordination among USAID leadership, UNICEF leadership, and HFG project staff for the purposes of joint work planning has been somewhat difficult due to competing schedules and other ongoing priorities. Managing the collaboration going forward will require concerted effort on the part of all three parties.

## Q4 Additional Information

Modeling the effects of health systems strengthening on coverage and lives saved: Through Year 3, this activity was co-implemented with both MCH and Cross Bureau funds. In Q4, MCH funds were fully expended. From Y4Q1 onward, the activity will be funded by and reported through Cross Bureau.

Table 22 provides additional activity-specific updates.

**TABLE 22. MATERNAL AND CHILD HEALTH ACTIVITY DETAIL**

Year 3 Q4 Planned Tasks	Year 3 Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
<b>Activity 2: Develop practical guidance materials on MCH resource tracking for countries applying the updated SHA 2011 methodology.</b>		
Circulate second draft of chapters with WHO and partners for external review.	Following WHO's changes to the outline of the disease guidance document, HFG has now agreed on a new outline with WHO that combines HFG recommendations with WHO's preferences. A draft of the maternal health chapter using this new outline was completed, which will be shared with for consultation in the next quarter.	
Finalize chapters and share with WHO for inclusion in global guidance.	Not yet started.	
<b>Activity 3: Support development of policy advocacy and communications tools to enhance uptake and use of findings by government officials and civil society organizations.</b>		
Develop template for policy-relevant communications.	A policy-relevant communication template has been drafted and is undergoing internal review before being finalized.	A final policy communication template will be available in early October 2015.
<b>Activity 4: Pilot MCH guidance in a USAID-identified priority country that is conducting SHA 2011 estimation.</b>		
Pilot the MCH guidance in Zambia.	Given limited response from the Zambia Health Accounts team and continued delays with their process, HFG began exploring other countries in which the guide could be piloted. Ethiopia and Botswana are being explored.	It appears that support to Zambia may not be feasible.
<b>Activity 5: Lessons learned from Nigeria micro health insurance scheme</b>		
Write technical brief.	The draft brief was completed.	This activity is now complete.

Year 3 Q4 Planned Tasks	Year 3 Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
<b>Activity 7: Modeling the effects of health systems strengthening on coverage and lives saved</b>		
Development of methodology to convert literature review data into impact matrix	<p>USAID, UNICEF, and HFG agreed to convene an expert panel in Year 4 to vet and review HFG's draft impact matrix, with the hope that the common, vetted impact matrix would be incorporated into UNICEF's EQUIST tool.</p> <p>In preparation for an expert review process, HFG identified additional data (baseline values, etc.) needed from specific studies included in the impact matrix. Coverage indicators for some of the bottlenecks (particularly effective coverage, initial utilization, and continuous coverage) were reviewed to ensure that they are included in the appropriate bottleneck being reduced; and key questions related to each bottleneck matrix to address with the expert panel were identified.</p>	A meeting with USAID, UNICEF, and HFG will be held in October 2015 to discuss specifics of the collaboration, including next steps in convening the expert panel.
Conduct literature review.	<p>In Q4, the team merged all of the literature reviewed to date into one, consolidated spreadsheet. (That is, output from McMaster Health Systems Evidence database, Dr. Alex Rowe's systematic review, HFG's initial literature documenting quantitative bottleneck reductions, and the final list of activities/strategies that were included in the HSS Impact Tool relating to MCH.)</p> <p>In addition, HFG completed a draft document detailing the literature review methodology, noting why certain choices were made, and identifying issues for future discussion.</p>	Task completed.
Develop Excel version of tool, and link to LiST in Excel.	<p>The beta Excel version of the HSS Impact Tool was completed in Q3. In Q4, HFG presented the beta version to USAID/OHS stakeholders. The tool was separately presented to UNICEF's technical team.</p> <p>With feedback from the AOR team, the team revised the Excel model and produced a stand-alone functional tool. Updates to the tool included: (1) the facility-based delivery levels were standardized so that they feed correctly into LiST; (2) final needed changes were made to ensure all model links work; and (3) improvements were made to the user interface (e.g., color coding for easier navigation and a simple dashboard feature</p>	The HSS Impact Tool beta version is now complete.

Year 3 Q4 Planned Tasks	Year 3 Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
	were added).	
Pilot test in country	Not yet started.	This task is on hold pending further discussions between USAID and UNICEF.
<b>Activity: Contribute to <i>Lancet</i> maternal health synthesis paper.</b>		
Prepare first and final draft of financing section for submission to <i>Lancet</i> .	HFG prepared first and second drafts of the financing section for the <i>Lancet</i> synthesis paper and shared this with co-authors. The team incorporated preliminary feedback from co-authors.	Next steps will be discussed at a workshop after the October 2015 Mexico City MNCH conference, during which external peer reviewers will provide preliminary feedback on the draft. Additional revisions will then be made before submission to the <i>Lancet</i> in January 2016. The publication is expected to be released in May 2016 at the Women Deliver conference.
Draft outline for financing section	After discussions with Dr. Marge Koblinsky and Dr. Nandakumar, HFG prepared an outline for the financing section of the <i>Lancet</i> maternal health series synthesis paper.	
<b>Activity: OneHealth Tool capacity-building and technical assistance to support cost analysis of every newborn action plans</b>		
Provide additional technical assistance on costing using OneHealth.	Not yet started.	
Conduct training workshops	Not yet started.	
<b>Activity: Using provider payment to improve the quality of maternal health services.</b>		
Development of a conceptual framework	HFG prepared a draft conceptual framework and circulated it internally for review.	The draft will be sent to USAID and additional experts for comments.
Conduct literature review.	HFG started the literature review.	
Conduct field-based case studies in two contexts.	Not yet started.	

## 4.4 Population and Reproductive Health

**Program Objectives** - HFG will support USAID's commitment to meeting the goal of 100 million additional users of modern family planning methods by 2015, and USAID's contribution to meeting the global goal of 120 million additional family planning users by 2020, which was established during the London Summit on Promise Renewed, and resulted in the global initiative Family Planning 2020 (FP2020).

**Y3 Activities** - In Year 3, HFG will continue to support the development of resource tracking methods that focus on sources and uses of funding for family planning; it will provide technical support to Track 20, the resource tracking component of FP2020, to implement these methods in FP2020 countries. We will continue our collaboration with John Snow Inc. (JSI) and the DELIVER project on performance-based incentives (PBI) for strengthening country supply chains to procure, store, and deliver family planning commodities. We will join DELIVER to disseminate the supply chain experience from Mozambique, and will develop opportunities to provide technical assistance. HFG will provide technical assistance to the USAID-supported Support for International Family Planning Organizations (SIFPO) project awarded to International Planned Parenthood Federation (IPPF) to help them strengthen their approach to rewarding affiliates for results. We will engage with the global family planning technical community through participation on the Rights and Empowerment working group of FP2020.

**Y3 Progress Against Objectives** - In Year 3, HFG leveraged other support provided for resource tracking in the Caribbean to highlight issues around tracking resources for family planning, and tested a draft guide. Through consultations with country Health Accounts teams and WHO, HFG completed guidance material for tracking family planning spending using the System of Health Accounts 2011 framework. Together with JSI DELIVER, we disseminated the results of the evaluation of the performance-based incentives in the supply chain program in Mozambique, engaged in technical assistance design in Tanzania, and began disseminating what we have learned from Mozambique about the potential application of performance incentives to strengthen the performance of supply systems.

HFG continued collaboration with JSI DELIVER to disseminate results and lessons from the experience of implementing results-based financing in the supply chain in Mozambique. A paper was submitted to the GHPP Journal and revised. HFG submitted an abstract for a preformed panel on results-based financing (RBF) in the supply chain to the International FP Conference, which was accepted. HFG also presented on the Mozambique RBF in supply chain experience at the HSS working group of the Reproductive Health Supplies Coalition Meeting in October 2015.

HFG began providing support to the International Planned Parenthood Federation, through collaboration with USAID's SIFPO project, on their Performance-Based Funding Model. Structured interview instruments were developed, and interviews were conducted with key informants in the London Central Office of IPPF and with the regional offices covering the Western Hemisphere, Africa, and South Asia.

Two meetings were held with the subgroup of the FP2020 Rights and Empowerment Working Group to discuss potential entry points to educate donors and planners about RBF and FP. The subgroup is in the process of developing a concept notes that will outline next steps.

**Q4 Additional Information** - HFG is providing technical support to the International Planned Parenthood Federation on their Performance-Based Funding model. In Q4 we developed structured interview instruments, and interviewed key informants at the IPPF Central Office in London and at the IPPF regional offices in the Western Hemisphere region, South Asia region, and the Africa region. Next steps are to develop an online survey that will be sent to member associations and follow up with interviews with some of these associations. After this process of data collection is complete and data

have been analyzed we will provide feedback from the field and recommendations to IPPF to strengthen their PBF model.

Table 23 provides activity-specific updates.

**TABLE 23. POPULATION AND REPRODUCTIVE HEALTH ACTIVITY DETAIL**

Year 3 Q4 Planned Tasks	Year 3 Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
<b>Activity 1: Technical Assistance to FP2020 Working Groups on Expenditure Tracking</b>		
Draft guide to support countries in collecting accurate family planning data and calculating the disease distribution	<p>The guidance document for FP has been reorganized to align with WHO's revised outline for the disease chapters. The remainder of the disease chapters in WHO's disease guidance is not yet ready. For the time being, the FP guide will be shared upon request until the WHO document is published (estimated December 2015).</p> <p>The FP guidance will be showcased in the forthcoming International Family Planning Conference in November 2015.</p>	The completion of WHO's guidance document risks being pushed back because it would appear that WHO will not be able to draft the document itself—e.g., HFG has been approached to also draft the malaria and TB chapters.
<b>Activity 3: Innovations to strengthen supply chain performance</b>		
Dissemination plan for Mozambique case study and dissemination activities	<p>HFG submitted an abstract for a preformed panel on RBF to strengthen supply chain performance for the International Family Planning Conference that will be held in Indonesia in November 2015. The panel was accepted and will feature Mozambique.</p> <p>HFG will participate in the Reproductive Health Supplies Coalition Meeting in Oslo, Norway in October, 2015, where HFG will host a table in an information marketplace that will feature RBF in the supply chain and the experience of Mozambique.</p>	

## 4.5 Tuberculosis

Program Objectives - In accordance with the Lantos-Hyde USG Tuberculosis Strategy, HFG works toward improving overall health systems including health purchasing/provider payment systems as an important part of the effort to improve TB control. Current provider payment practices waste millions of dollars on unnecessary hospitalization in Central Asia and lead to early termination of treatment in East and South Asia. HFG is introducing new payment systems to improve TB services and patient outcomes.

### Y3 Activities

#### Kyrgyzstan:

- ▶ Design and develop new TB hospital payment system that will target health budget funding to priority services and will structure payment to vary based on relative weight or cost of the TB case; this will be an incentive to end the expensive and unsafe practice of extended inpatient stays, and instead encourage treating and reducing the spread of Multi-drug Resistant-TB.
- ▶ Support implementation of the new TB hospital payment system.
- ▶ Collaborate with the Global Fund to develop a strategy in the context of the National Health Reform Program 2012–2016 (locally known as Den Sooluk Health Sector Strategy, being implemented through a Sector-Wide Approach (SWAp)) to improve quality and further integrate TB services into primary health care (PHC) by improving the relationship between health financing and service delivery; to increase sustainability, the latter should cover both the new TB hospital payment system and PHC per capita payment system.
- ▶ Limited activities in Kazakhstan and Tajikistan are included in the Kyrgyzstan activity including disseminating Kyrgyzstan's new TB hospital payment system and building the capacity of Kazak and Tajik partners to adapt the system and implement it.

#### Ukraine:

- ▶ Develop products to enable Ukraine to develop a strategy for integration of TB services into the general health system, including linkages with health financing reform such as the new TB hospital payment system.
- ▶ Disseminate Kyrgyzstan's new TB hospital payment system and build capacity of Ukrainian partners to adapt the system and implement it.

#### Asia:

- ▶ Assess four to six Asian country public health financing and public finance management (PFM) systems and recommend how to better target public funds to TB services delivered by private providers.
- ▶ Design and develop at least one specific technical methodology to enable an Asian country to better target public funds to TB services delivered by private providers (e.g., new provider payment system, improved budget formation process, improved funds flow, removal of PFM barrier, support of system improvement, operational policies and procedures).

### Y3 Progress Against Objectives

Kyrgyzstan: During Y3Q1, data collection and initial analysis of both clinical and cost accounting data was completed. The analytical tool was created to develop TB clinical groups and relative payment weights for the case-based hospital payment system, and initial work was done to develop a simulation model to portray the impact of implementing the new TB case-based hospital payment system.

During Y3Q2, iterative work took place to develop TB group relative weights from the clinical perspective, adjust the groups from the financial perspective, and make policy adjustments. From the clinical perspective, TB groups are based on WHO classification, and a hierarchy was developed with 37 groups. From the financial/statistical perspective, relative payment weights were calculated and similar or unstable groups were combined, including those with too few cases, resulting in aggregation to 13 groups. On policy adjustments, the relative payment rates were adjusted to increase the differential between sensitive and resistant TB—to stimulate shift to TB outpatient services for sensitive TB and pay appropriately for resistant TB, and decrease the relative payment weight for clinically diagnosed cases to incentivize bacteriological confirmation.

In sum, the HFG team has worked with national partners to undertake four steps:

- ▶ Collecting and analyzing clinical and cost accounting data
- ▶ Specifying 37 clinically cohesive TB groups (or sub-categories of TB disease)
- ▶ Aggregating the groups into 13 groups for financial/statistical cohesiveness including group stability and payment of average cost
- ▶ Making policy adjustments to relative payment weights, to further differentiate drug-sensitive and drug-resistant cases to incentivize rapid shift of non-multidrug-resistant (MDR) TB cases to outpatient TB services, and also stimulate bacteriological confirmation rather than clinical diagnosis

During Y3Q3, HFG engaged in dialogue with and conducted a workshop for the Mandatory Health Insurance Fund (MHIF) to finalize TB clinical groups and relative payment rates for the new TB case-based hospital system. Based on the recommendations of the MHIF, the number of TB clinical groups in the diagnosis-related group (DRG) was reduced from a proposed 13, to 10. The reasoning for this change was that the DRGs do not have separate categories for co-morbidities for any other disease categories, so the MHIF preferred not to have separate categories for TB with co-morbidities either.

During Y3Q4, the Mandatory Health Insurance Fund began to pay TB hospitals using the new TB hospital payment system/DRG system developed under the HFG project. Effective September 1, payments to TB hospitals are made according to the new DRG system. HFG worked closely with the USAID Bilateral Defeat TB project in Kyrgyzstan to ensure smooth implementation, with the bilateral project both supporting database improvements to allow for implementation of the new system, and providing technical assistance to hospitals in entering data according to the DRGs. HFG will analyze results against the baseline data (types of cases hospitalized in each facility, total expenditures of TB hospitals) over Year 4 of the project.

Ukraine: In September 2014, HFG staff undertook a trip to Ukraine to engage in dialogue with key country stakeholders and generate a provisional scope of work for introducing TB strategic purchasing, including new provider payment systems. Following an HFG TDY in September 2014, USAID/Ukraine asked HFG to write a Concept Note for additional TB strategic purchasing funding. This Concept Note was developed and submitted. The objective of this TB strategic purchasing project in Ukraine is to “construct a platform for oblast level TB global budget (a global budget is, at its simplest, an overall spending limit or target) based on actual TB services that would provide for more flexibility in achieving efficiency gains and matching fixed and semi-fixed resources to TB clinical needs and internationally accepted treatment.”

The HFG TB Strategic Purchasing Team visited Ukraine in March to meet with USAID, the MOH, and other partners, and discuss how to move forward. There is significant interest and potential in implementing DRGs for TB hospital payment in Ukraine. In Kyrgyzstan the general health sector underwent financing reforms first, and now HFG is helping TB to catch up. Ukraine still pays for inputs across the public health system. It is possible that financing reform in TB will serve as an example for the broader health sector reform.

A follow-up visit in April focused on an investigation of what step-down costing methodologies had been used in Ukraine that may be compatible with DRG formation. In fact, a step-down cost-allocation program used by the Project Consultant, Sergey Dyachenko, was presented to team members and Poltava-based counterparts. It was determined after detailed review that the presented methodology was fully consistent with the criteria and approaches that the HFG TB Strategic Purchasing Activity has used in other countries, and allows obtaining all the necessary data to calculate economic parameters of the DRG system. During the visit to Poltava Oblast, the team discovered that this step-down costing methodology was familiar to oblast economists, as it had been used to some extent in non-TB hospitals in the region.

A number of opportunities arose during this trip to begin making linkages between improving purchasing of TB services in Poltava Oblast and the broader national health financing reforms currently being considered in Ukraine. USAID/HFG meetings with WHO resulted in consensus on the principles of broad health financing reform later discussed directly with the minister. USAID/HFG and the World Bank discussed specifics of the planned DRG implementation in Ukraine. It is critical for this dialogue and collaboration to continue, as the case-based hospital payment system, or DRG clinical groups and relative payment weights, that HFG has started to develop in Poltava Oblast will have to fit within the broader national DRG payment system developed for all illnesses/conditions.

A second opportunity to begin making linkages between improving purchasing of TB services in Poltava Oblast and the broader national health financing reforms currently being considered in Ukraine came in the USAID-facilitated dialogue with Minister of Health Alexander Kvitashvili. Clearly, the minister is attempting to move rapidly on health reform, including health financing, with his planned first step being increasing the autonomy of providers. The USAID, World Bank and WHO technical meetings and collaboration described above resulted in consensus on basic health financing reform principles in a meeting with the minister. Consensus on basic health financing reform principles is described below:

- ▶ Establishment of a purchaser-provider split in Ukraine.
- ▶ Implementation sequencing consisting of movement in parallel to improve health purchasing and increase provider autonomy (rather than a linear approach with work on either improving health purchasing or increasing provider autonomy coming first, and then subsequently leading to either purchasing improvement or provider autonomy).
- ▶ The oblast level is the most appropriate level to establish a health purchaser and pool funds in Ukraine.
- ▶ A shift from input- to output-based provider payment systems (e.g., case-based or DRGs for hospitals, capitated rate for PHC) will enable creating the purchaser-provider split, reinvestment of savings, restructuring of hospital sector and efficiency gains, and desired service delivery improvements.
- ▶ Legal/organizational changes and increased autonomy for public providers is a priority.

USAID/Ukraine has made \$750,000 of mission funding available to HFG, to complement the global funds available for the HFG TB strategic purchasing work in the country. The mission has committed this money, and USAID/Washington is expected to obligate these funds early in Y3Q4.

During Y3Q4 (with funding from USAID/Ukraine), HFG continued its collaboration with the Poltava Oblast Health Department to gather the necessary data to allow design of the TB DRGs. The project brought on two additional local consultants with expertise in cost accounting and health information systems, to support collection of the TB cost accounting data and development of the discharged patient database. HFG technical expert Olga Zues and international consultant Alexander Katsaga traveled to Ukraine in September to work with the country-level consulting team to provide technical expertise and methodological support in cost accounting and discharged patients analysis. During August 2015 local

consultants worked with the economists from TB hospitals in Poltava to introduce the cost-accounting concept, provide data collection templates, and start data collection. Budget and statistical data for 2014 were collected in eight hospitals. In September, the HFG team reviewed the dataset, defined gaps, and agreed on specific principles for cost accounting analysis (cost centers taking into account TB specific, distribution formula, etc.). The team also agreed on a detailed plan for the next quarter for data collection and data analysis. The country consultants' team will clean the dataset for costing based on agreed parameters in October 2015, and the HFG team will conduct analysis early in Year 4.

HFG has installed Form 66 software in all TB hospitals in Poltava. The TB hospitals have started using the system for discharged patients in 2015, and also entered data retrospectively for 2013-14. During a meeting in September, the team reviewed initial data and agreed to add a few specific rules into the system algorithm, such as an additional field for TB resistance categories (Mono, Poly, MDR and XDR), and allowing only full ICD coding (four symbols). The country consultants will incorporate changes and update software in all hospitals by October 15.

During the reporting period, the HFG team continued to collaborate with counterparts, and participated in policy dialogue at the national level aimed at ensuring linkages between the TB financing reforms and the country's overall health financing reforms. In September, the HFG team had meetings (funded by USAID) with Dr. Ninel Kadyrova, Health Policy Advisor for MOH, to update Dr. Kadyrova on HFG program activities and discuss current health policy development in Ukraine. The team reached an agreement, and incorporated HFG-supported development and implementation of a new TB hospitals system into the National Plan, as a specific TB module of the national general DRG system; this is under development now with support from the WB health project. The HFG team also met with the WB program leader for Ukraine to discuss collaboration within development of new provider payments systems, particularly those involving DRGs. The HFG team's next trip to Ukraine is planned preliminarily for December 2015.

Asia/other global: At the request of USAID/Office of Infectious Disease, HFG carried out preliminary assessment work to collect information on TB public financing and PFM systems in four to six additional countries. Essentially, USAID/Office of Infectious Disease has asked that HFG expand its role to include examining what public finance management changes can be made in country in order to improve the effectiveness and efficiency of the TB Continuum of Care. The HFG team also discussed with the USAID/Washington Infectious Disease division the launch of a new sub-activity under the HFG Strategic Purchasing activity: the collection of global health financing indicators, with these indicators having a significant relationship with TB service delivery indicators.

During Y3Q3, the HFG team made its first visit to Malawi, as the first site visit under the "Other Asia/Global" sub-activity. The assessment and recommendations revealed substantial potential to fill gaps in the TB continuum of care by small changes in health purchasing/provider payment systems and reduction of PFM barriers.

Malawi's strength in the TB continuum of care is treatment, with 85 percent+ treatment completion rates. (While we recognize that this official data on completion rates may not be accurate, the extremely low levels of MDR TB both in official statistics and in anecdotal evidence relayed to us by health care facilities seem to support these rates.) Substantial amounts of funding are invested in treatment, through Global Fund grants and the country general revenue health budget allocated to the National TB Program (NTP). Malawi's weakness in the TB continuum of care is case-finding. Early results from a recent prevalence study showing prevalence rate underestimated by about three times (study showing approximately 300/100,000, with previous estimates approximately 100/100,000). Due to budget formation and execution regulations, there is limited flexibility in district-/facility-level funding for needed monies to improve case finding.

Malawi's PFM system includes three major budget line items: personnel emoluments (PE), other recurrent transactions (ORT), and capital. ORT contains sub-budget line items including supplies, fuel, drugs, and food. PE and capital expenditures are largely determined at the national level, while ORT is decentralized to the district level for budget formation and expenditure. Current PFM or Treasury procedure is to place expenditure caps on ORT sub-budget line items following approval of the budget. This constrains the ability of health centers on the front lines of patient care in allocating budget to the right mix of inputs to produce TB case-finding outputs. For example, funding could remain in the supplies sub-budget line item for sputum collection cups, but the fuel sub-budget line item may have hit the expenditure cap, constraining the health center in transporting sputum samples to the lab for microscopy. This facility-level management autonomy is even more critical in a world of extreme underfunding, uncertainty in budget execution, and inflation continuously increasing input prices.

The major recommendation of the HFG-TB Malawi assessment is to move the ORT expenditure cap from the sub-budget line item level to the budget line item level, granting district health offices and health centers the autonomy they need to efficiently allocate resources to fill gaps in the TB continuum of care. PFM systems and processes are needed for good financial management and expenditure control, but they can be realigned and even strengthened at the ORT budget line item level. In addition to serving as a shorter-term step to increase efficiency and fill TB continuum of care gaps, moving the ORT expenditure cap to the budget line item level can also be a first step in Malawi's longer-term public service and health reforms. In fact, moving the ORT expenditure cap can be a first step in shifting to output-based provider payment systems or unified pooling and purchasing arrangements for priority health services or the minimum benefit package. Next steps will include finalization of a technical report on Malawi; discussion of the Malawi findings with USAID; and planned visits to additional countries, to potentially include a short list for next visits, to Tanzania, Philippines, Cambodia, and Indonesia.

During Y3Q4, based on the country assessment visit to Malawi, HFG continued development of its country assessment process. Planning with USAID for Malawi follow-up work is in process. The next country assessment visit is planned for the Philippines in January 2016, and preparations were initiated for it.

HFG-TB coordinated with the DFID-funded program, the World Bank, and WHO in Nigeria on dialogue with the Federal Ministry of Health (FMOH) related to development of the National Health Financing Strategy and implementation of the Health Act. Coordination revealed that the current Nigeria health financing strategy direction is consistent with the desired TB purchasing/provider payment improvements, and HFG's next step will be documenting synergies and further activity planning.

Under the TB Strategic Purchasing Activity, during Y3Q3, HFG has also begun work on a Global Indicator activity. Through this activity, HFG will collect data on health systems indicators that can affect TB outcomes. A list of 23 draft indicators was submitted to USAID for review. These indicators cover Financial Protection and Equity in Financial Burden; Health Governance; and Efficiency, Quality, Transparency, and Utilization, as connected to health financing. The indicators will be discussed and agreed upon with USAID in Q4, and data collection will begin for the USAID TB priority countries.

During Y3Q4, HFG finalized the indicator framework and tables for the Global Indicator Activity, and began data collection for the seven of the Activity's Phase I countries: Kyrgyzstan and Kazakhstan in Central Asia; Malawi, Tanzania, and Nigeria in Africa; and the Philippines and Cambodia in Asia. The first round of indicator data will be completed and undergo an internal review process, and will be submitted to USAID in October 2015. During Year 4, the project will collect indicator data from the additional USAID priority TB countries, for a total of 23 countries.

**Q4 Additional Information** - In Y3Q4, all Ukraine activities were carried out using the Ukraine Mission funding for TB activities in the country. Effective in Year 4, HFG will report on Ukraine activities under the Ukraine country section of this report, rather than under the TB section. Given that the switch in

funding source took place near the end of the year, this annual report keeps Ukraine TB activities all in one place, under the TB heading.

Table 24 provides activity-specific updates.

**TABLE 24. TB ACTIVITY DETAIL**

Year 3 Q4 Planned Tasks	Year 3 Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
<b>Activity 1: Develop TB hospital payment system for Kyrgyzstan and redirect savings to support outpatient TB.</b>		
Develop and have approved relevant indicators and Performance Monitoring Plan (PMP) Process.	Initial indicators were submitted to USAID in July 2014. However, with the expanded scope of the HFG TB activity, new indicators need to be developed. This will take place in October 2015, to align with the Year 4 work plan.	
<b>Develop case classification or grouper for new TB hospital payment system (groups into which TB cases are classified for payment using relative weights based on type and severity of case).</b>		
Further analysis and refine TB group hierarchy.	Completed.	
<b>Develop simulation model and combine clinical and cost data to iterate case groups and relative weights.</b>		
Expenditure tracking, monitoring, or operations research studies	Implementation began on September 1, 2015. Baseline data were collected from each hospital on expenditures in Year 3.	Analysis of changes in hospitalization and spending will be carried out in Year 4.
Develop plans for implementation with MHIF.	Implementation plans developed during workshop in Y3Q3. Implementation began in Y3Q4 (September 1, 2015).	
Develop plans for expenditure tracking, monitoring, or operations research studies on TB hospital payment system implementation.	Expenditure tracking was done for baseline period, before implementation of the new TB hospital payment system. Now that the new TB payment system is being used (effective September 1, 2015), the MHIF database will include this information.	HFG will analyze the information during Year 4.
Finalize TB hospital payment system (HPS) design, including TB groups and relative weights.	System was finalized in Q3.	
Develop written product, including TB HPS design methodology.	Written product on TB health payment system design methodology, to be used in the near term for dissemination to Kazakhstan and Tajikistan, is in process, and will be finalized in Y4Q1.	
Begin and support implementation.	Implementation began on September 1. Support for implementation was handed over largely to the USAID bilateral Defeat TB project in Kyrgyzstan.	HFG will make a trip to Kyrgyzstan in November to support the MHIF with any obstacles to implementation.

Year 3 Q4 Planned Tasks	Year 3 Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
Begin monitoring implementation.	HFG is in regular contact with the USAID Bilateral TB project, which is supporting the MHIF and TB hospitals in implementation.	HFG will make a visit to Kyrgyzstan in November to monitor and support implementation.
Implementation of new TB hospital payment system	System was implemented effective September 1, 2015.	Implementation was delayed one quarter, as the national database system used by the Mandatory Health Insurance Fund was outdated, and required some updating in order to accommodate the addition of the new TB hospital payment system. After discussion with HFG and national partners, the USAID bilateral Defeat TB project in Kyrgyzstan stepped up to support updating of this database.

#### **Dissemination of TB hospital payment system methodology to Kazakhstan and Tajikistan**

Develop plans to disseminate TB hospital payment system methodology to Kazakhstan and Tajikistan.	The HFG team has reviewed the current health financing situation in Kazakhstan and Tajikistan and identified a strong consultant with experience in both countries to support dissemination activities. Dissemination will take place in Year 4.	
Begin implementing dissemination plans.	Dissemination plans will be implemented in Year 4.	

#### **Activity 2: Engage in policy dialogue in Ukraine to improve TB financing within context of any broad provider payment reforms.**

##### **I. Country dialogue to develop strategies and plans**

Engage in dialogue with Ukrainian partners as opportunities arise.	The team has engaged in dialogue with the MOH and Poltava Oblast Health Department, and has arranged to carry out a TB hospital payment system in Poltava Oblast.	
Coordinate with USAID/Washington, USAID/Ukraine, and other development partners to continuously assess situation and envision openings or opportunities to develop strategies and plans.	Through effective engagement with the Ukraine Mission and USAID/Washington, the HFG project was awarded \$750,000 of Ukraine Mission funding. This funding was obligated in September 2015.	Moving forward, the project will report Ukraine activities separately, under Ukraine country funding.

Year 3 Q4 Planned Tasks	Year 3 Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
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## 2. Begin development of Ukrainian TB strategic purchasing products including adaptation of Kyrgyzstan TB hospital payment system.

Based on dialogue, envision potential products or methodologies to support introduction of Ukraine TB strategic purchasing	HFG has begun activities to collect cost accounting and discharged patient data from TB hospitals, toward development of a new TB payment system in Poltava Oblast. During Y3Q4, HFG installed Form 66 software in all TB hospitals in Poltava. The TB hospitals have started using the system for discharged patients in 2015, and also entered data retrospectively for 2013–14. During a meeting in September, the team reviewed initial data and agreed to add a few specific rules into the system algorithm, such as an additional field for TB resistance categories (Mono, Poly, MDR and XDR) and allowing only full ICD coding (4 symbols).	
Begin process of adapting Kyrgyzstan TB hospital payment system to Ukraine.	Collection of discharged patient data and cost accounting data is key to adapting the DRG system/hospital payment system developed for Kyrgyzstan to Ukraine. This process was begun in Y3Q4.	

## Activity 3: Identification of small steps improving TB strategic purchasing for public funds in private providers to improve the TB continuum of care

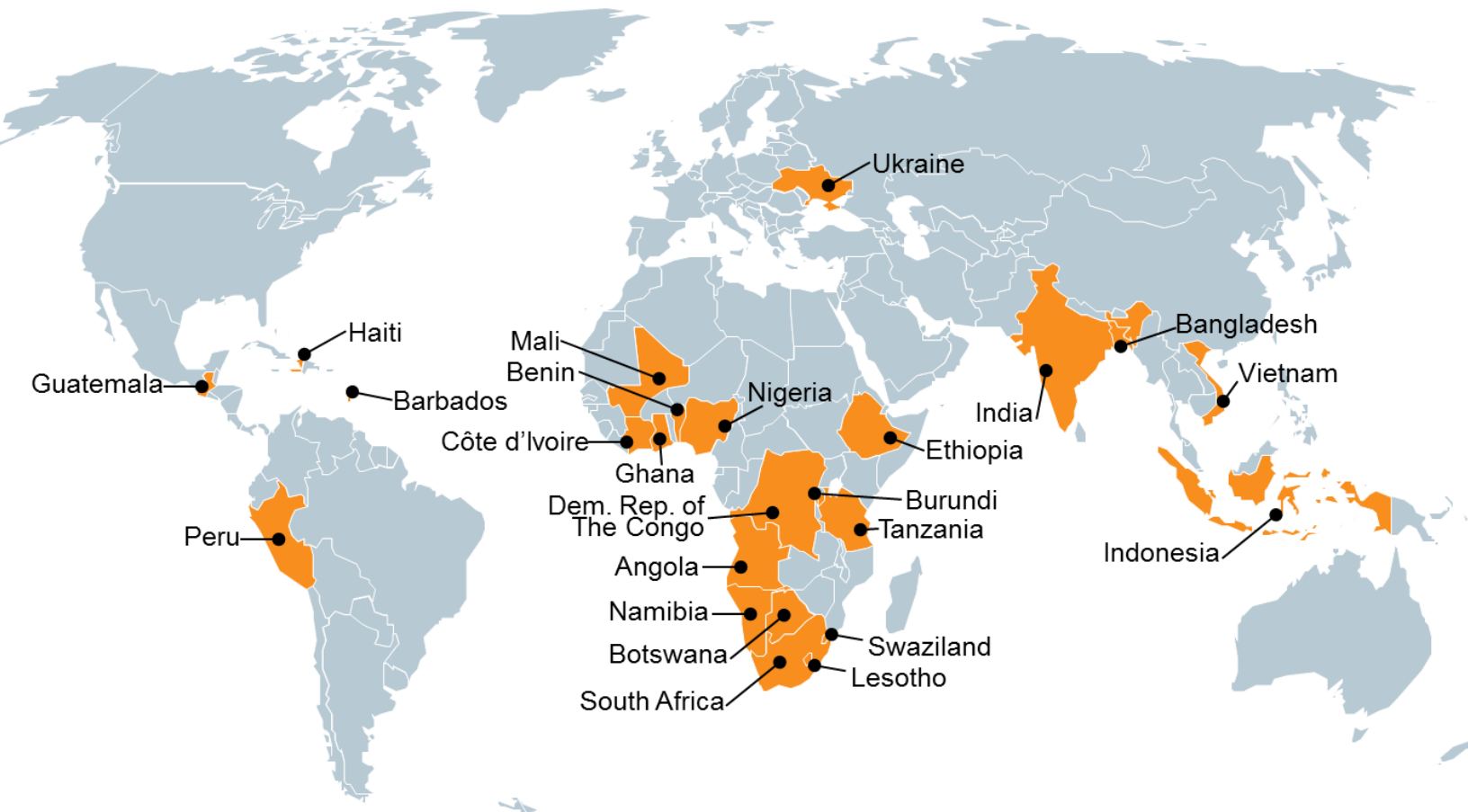
### I. Complete Asia country assessments and identify small steps to improve TB strategic purchasing using public funds for services delivered by private providers.

Finalize initial group of Asian countries for assessment.	This activity has been geographically rescoped upon agreement with USAID, to include both Asia and Africa. The initial countries to be assessed include Malawi, Tanzania, and Nigeria in Africa; and the Philippines and Cambodia in Asia.	
Travel to countries in Asia for assessing potential inclusion.	Malawi trip completed in Y3Q3. Preliminary desk review has begun for other Asia and Africa Phase I countries, as listed above.	Additional travel delayed due to staffing transitions on the HFG TB team.
Development of first phase of country assessment visit reports, including recommendations on how to better target public funds to TB services in private providers	Malawi report completed in Y3Q3. Other reports expected in Year 4.	

Year 3 Q4 Planned Tasks	Year 3 Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
<b>2. Begin design and development of at least one specific technical methodology to enable an Asian country to better target public funds to TB services in private providers.</b>		
Consolidate country assessment visit reports and recommendations into first steps and/or categorization, and develop a written product together with detailed country-level plans for design and development of at least one specific technical methodology.	This activity has been delayed until Year 4, after further country visits have taken place. In the meantime, the indicator data collection process for the Phase I countries has provided an overview of the health purchasing/PFM situation in several countries, including the Philippines, with a primarily private health care delivery system.	

## 5. FIELD SUPPORT ACTIVITIES

The section provides a summary of progress made on activities in the 19 countries and with the four regional USAID bureaus (Africa, Asia, Eastern Europe and Eurasia, Latin America and Caribbean) with which HFG works.



## 5.1 Africa

### 5.1.1 Africa Bureau

**Program Objectives - Africa** To build on HFG progress in Year 2, the following five areas were identified for project work in Year 3 to support the USAID Africa Regional Bureau's Office of Sustainable Development's (AFR/SD's) overall objective of strengthening country commitment and capacity to implement health financing reforms to end preventable maternal and child deaths and contain infectious diseases: (1) build the capacity of the sub-Saharan Africa region to design and implement health financing and governance reforms to achieve universal health coverage (UHC) through peer learning and practical, action-oriented learning methods; (2) achieve better understanding of the domestic allocation of resources to the social sectors; (3) develop key lessons learned and best practices across the series of Community-Based Health Insurance (CBHI) linkages to a national health financing framework (based on the Year 1 case studies); (4) identify potential benefits of mhealth and mobile money tools/initiatives in cost savings to improve resource tracking in health finance (Intermediate Result 1), and strengthening of public system operations (Intermediate Result 3); (5) enhance the bureau's understanding of family planning priorities for assessment and project planning.

#### **Year 3 Activities -**

1. Domestic Allocation Study: Collaborate with AFR/SD on a study to better understand the domestic allocation of resources to the social sectors to determine the efficiency in allocation and utilization of resources by a small sample of countries with high rates of economic growth and at varying stages of fiscal devolution. The analysis will provide policy and program options for the countries to transition to self-sustaining growth in the social sectors.
2. Health Care Financing Capacity Building Workshop follow-on training(s): Build the capacity of the sub-Saharan Africa region to design and implement health financing and governance reforms to achieve UHC through peer learning and practical, action-oriented learning methods
3. Case Study Synthesis Paper: Produce a synthesis paper based on the three CBHI case studies completed in Year 2 to highlight key lessons learned and best practices on CBHI linkages to a national health financing framework.
4. mHealth Cost Analysis : Conduct two activities aimed at promoting the use of promising mobile money and mhealth applications: 1) do a cost-effectiveness study of an mhealth application, including a framework and study protocol, to contribute needed evidence of cost-effectiveness of mobile applications within health systems, and 2) review existing grey literature and conduct stakeholder interviews to prepare a white paper on mobile money's potential in the health sector that highlights innovations, trends, and opportunities.
5. Analytical Support to AFR/SD for assessment and strategic planning: Demographic analysis to enhance the Africa Bureau's understanding of family planning priorities for assessment and project planning.

**Year 3 Progress Against Objectives -** Based on discussions of the concept note developed by the USAID AFR/SD team (Health, Education, and D/G), HFG reworked and finalized the SOW for the study on the efficient allocation and utilization of domestic resources in Q1 and Q2. A Request for Application (RFA) was released in Ghana in early Q2 (March 2015). HFG has completed the evaluation and selection process. The Sub-award Approval Request (MoN) and proposed sub-award were sent for HFG AOR approval in late June 2015 and approved immediately. In Q4, the Center for Democratic Development (CDD) Ghana completed a comprehensive literature review on the resource allocation and mobilization for the education and health sectors in Ghana. HFG is working with CDD Ghana to revise the study protocol including the data collection tools and the district/interview selection process.

In Q1, HFG facilitated AFR/SD's second workshop on Healthcare Financing Capacity Building in Abuja, Nigeria. Thanks to a collaborative team made up of AFR/SD, HFG, Nigeria's Federal Ministry of Health (FMOH), University of Nigeria, PharmAccess, and the Joint Learning Network, the workshop was well-organized, well-attended, and highly successful. Overall, 42 federal- and state-level health officials dealing with health systems and disease-specific programs participated. The workshop built upon and incorporated the curriculum and materials from the regional health financing training that HFG piloted for 10 sub-Saharan African countries in June 2014 in Tanzania. The focus was on communicating the basics of health economics and finance and applying these concepts to financing UHC and EPCMD services on a sustainable basis. Key topics covered include risk pooling, revenue generation, fiscal space, and benefits package design. Group work engaged Nigerian officials to debate the suitability and feasibility of possible options to improve performance in the Nigerian context.

Between Q2 and Q4, discussions were conducted with Africa Bureau and USAID/Ghana mission on organizing a peer-learning workshop in Ghana (early 2016) that builds on the trainings in Tanzania and Nigeria and provides an opportunity to disseminate the experiences and lessons learned in expanding and ensuring sustainable health insurance coverage. The concept note for the Ghana workshop was revised based on these discussions. Further discussions are underway about whether to conduct the workshop in both English and French to which end the concept note has been translated into French for AFR/SD's use with the potentially participating francophone countries.

In Q2, the synthesis of the three CBHI case studies developed by HFG was completed and submitted to the client and posted on the HFG website for wider dissemination in Q3. It highlighted key lessons learned and best practices on CBHI linkages to a national health financing framework. HFG plans to use this synthesis paper as a resource tool for follow-on UHC and health financing training(s) and workshop(s). As part of the project's mhealth activities, HFG finalized its cost-effectiveness analysis of D-Tree's IMCI phone-based decision support application in Malawi to improve the health worker standard of care for management of childhood illness. The study involved collaboration with D-Tree, the developer of the mhealth tool, and Catholic Relief Services (CRS), the implementer of the IMCI program. Promising results from the evaluation included findings that the mobile decision support tool led to more follow-up questions with clients, which are important for more complex diagnoses and correct dosage for treatments. No impact was found on general treatment decisions. Cost per percent improvement was high given that initial investments were spread over a small pilot. Due to limitations of the data set provided for the analysis, the study does not project impact on health outcomes such as DALYs or lives saved. When projected at scale, costs per percent improvement achieved were low to modest value for money for the application studied. The report provides a template useful for conducting mhealth cost effectiveness studies.

HFG presented the results of the study to the AFR/SD. The client was very pleased, as this study is the first of its kind to document a mhealth tool's cost effectiveness and impact. HFG is incorporating final revisions into report based on feedback from Africa Bureau and an internal brownbag presentation. The final report is to be completed in October 2015.

In Y3 Q3, HFG through Avenir Health worked with the Africa Bureau client to update and analyze the results of population projections of the poorest and wealthiest quintiles in Kenya and Rwanda – two of four case study countries that are the focus of USAID/AFR's ongoing review of repositioning family planning efforts in sub-Saharan Africa countries. They prepared DemProj and FamPlan projections of the poorest and richest quintiles in the remaining sub-Saharan Africa countries covered in the USAID/AFR Review and assembled and reviewed international studies regarding the demographic dividend and the key role of accelerated MCPR increase. In Q4, Avenir with the Africa Bureau submitted an abstract "Inequity, Fertility and Economic Opportunity: Access to Family Planning Makes a Difference" to the 2015 International Conference on Family Planning in Nusa Dua, Indonesia in November 2015. The

abstract has been accepted by conference organizers for oral presentation. Planning is underway for presentation of the key results projections during the conference.

**Q4 Additional Information** - In Q4, Africa Bureau requested support in helping with the facilitation of the Health Financing session in the upcoming SOTA. Preparation of materials for the session has commenced.

Table 25 provides activity-specific updates.

**TABLE 25. AFRICA BUREAU ACTIVITY DETAIL**

Year 3 Q4 Planned Tasks	Year 3 Q4 Progress	Critical Assumptions/ Problems Encountered/ Follow-up Steps
<b>Activity 1: Study on allocation and utilization of domestic financial resources across sectors in selected countries</b>		
Desk review of relevant documents from country and global literature	CDD Ghana completed a comprehensive literature review report. The review presents some interesting questions and conclusions that can be drawn from the literature regarding resource allocation and mobilization for the education and health sectors in Ghana. These conclusions are grouped under three broad areas: 1) <i>Understanding factors that influence resource allocation decisions</i> , 2) <i>Understanding some of the key factors that can help improve the status quo</i> , 3) <i>Questions for Further Exploration</i> .	This report was shared with the entire USAID team.
Prepare study protocol, including a. Detailed approach, b. Country assessment plan, c. Mapping of research questions with data sources and analysis methods, d. Data collection tools (interview guides by type of informant, comparison tools)	Draft study protocol was submitted by CDD Ghana in mid-Sept 2015. HFG has been working with CDD to review the protocol and incorporate necessary revisions to the district selection process, interview guides, and overall design.	Revised study protocol to be shared with USAID team after HFG Q/A process.
<b>Activity 2: Regional capacity-building workshop on health finance and UHC</b>		
Follow-on HCF training(s) in Nigeria	Building on the trainings in Tanzania and Nigeria, further discussions were conducted on organizing a peer-learning workshop in Ghana (early 2016) to disseminate the experiences and lessons learned in expanding and ensuring sustainable health insurance coverage. A revised concept note for the workshop was developed and shared with the client and mission. Discussions are underway to make the workshop bilingual (English and French). Concept Note was translated into French and shared with client and potential missions.	

Year 3 Q4 Planned Tasks	Year 3 Q4 Progress	Critical Assumptions/ Problems Encountered/ Follow-up Steps
<b>Activity 4: Mhealth cost-effectiveness analysis</b>		
Complete research paper	HFG is incorporating final revisions into report based on feedback from presentation to Africa Bureau and HFG Brownbag Session. The final report is to be completed and shared in early October 2015.	Plans are being developed for dissemination of report.
<b>Activity 5: Analytical support to the AFR/SD for assessment and strategic planning</b>		
Provide analytical support to the AFR/SD for assessment and project planning (funding for Futures Institute)	<p>Accessed the most recently released DHS Final/Preliminary reports of sub-Saharan Africa countries in order to update population projections of the poorest and richest wealth quintiles using Avenir Health's DemProj and assuming slow vis-à-vis rapid fertility decline.</p> <p>Used Avenir Health's FamPlan software to estimate family planning requirements corresponding to assumed Total Fertility Rates in the poorest and richest wealth quintiles.</p> <p>Prepared tables summarizing fertility, family planning, and age structure indicators for use in Africa Bureau's review of sub-Saharan Africa countries focusing on inequality, fertility and family planning changes, and economic opportunity.</p> <p>Initiated planning for the oral presentation of the key results of the projections during the International Conference on Family Planning in Indonesia on Nov. 9-12.</p>	

## 5.1.2 Angola

### Program Objectives –

#### **Activity 1: National Plan for Health Development (PNDS) Monitoring and Evaluation (M&E)**

**Plan:** The Ministry of Health (MINSA) must be able to demonstrate the effectiveness of the PNDS to a variety of stakeholders, many of whom are outside the health sector, in order to secure government financing for the PNDS. A strong operational plan for monitoring and evaluating both the programmatic and financial implementation of the plan is critical to ensuring that MINSA can manage PNDS implementation and make the case for continued public investments in the health sector.

**Expected Results:** The output of this technical assistance is a plan to monitor and evaluate the PNDS, both programmatically and financially. The plan will be practical, with clearly outlined steps for how it can be operationalized. The M&E plan will strengthen accountability for program performance and budget execution for PNDS at the central, provincial, and district levels.

**Activity 2: Support Implementation of Health Accounts (HA):** There is an urgent need to increase MINSA's capacity to monitor government financing of the PNDS and make informed decisions based on reliable information on the quantity of financial resources used for health, their sources, and the way they are used. Health expenditure tracking is internationally recognized as critical information for developing countries such as Angola to improve efficiency, equity, and financial sustainability in the health sector as well as understanding resource allocation across priority health programs.

Angola has so far undertaken resource tracking exercises such as: public expenditure review (2007), assessing the magnitude and flow of public spending; and household surveys to provide insight into household health seeking behavior and spending on health (Living conditions and household survey - 1995, Survey of households income and expenditure - 2000/01, and Multiple Indicators and Cluster Sampling surveys - 2000/01). While these resource tracking exercises provided policymakers with critical information about the respective resource flows, they have not provided them with the full picture to understand the full magnitude and flow of resources in the health sector. Additionally, the available data are not current and do not serve as a baseline for the country's strategic plan "PNDS 2012-2025."

#### **Expected Results:**

- ▶ Improved HA team capacity to lead and implement an HA exercise, including the use of the updated System of Health Accounts (SHA) 2011 methodology and the Health Accounts Production Tool (HAPT), leading to institutionalization of Angola HA exercises.
- ▶ HA data to monitor government financing of the PNDS, inform policy decisions, including increased understanding of the magnitude and resource flows to priority areas such as HIV/AIDS, maternal and child health, and family planning.
- ▶ Strengthened collaboration and coordination of organizations involved in resource tracking efforts, including MINSA, Ministry of Finance, and donors.

**Year 3 Activities - HFG** Angola received approval for two activities in February 2015 for Year 3 work.

**Activity 1: PNDS M&E Plan:** The technical assistance will enable MINSA to measure and share the progress achieved through the PNDS. This will be important for securing the sustained levels of government investment in health needed to finance the PNDS. In addition, a plan for clearly linking health expenditures with PNDS objectives will assist MINSA in prioritizing and targeting spending. The plan could also incorporate indicators of interest to stakeholders outside MINSA, for example the Vice President, Ministries of Planning, Finance, and Labor, and regional entities such as the Southern Africa Development Community (SADC).

HFG will collaborate closely with the PNDS M&E Working Group to include representatives from across MINSA, especially GEPE (Gabinete de Estudos, Planeamento e Estatística) and Finance Departments. Through a review of international best practices of how countries monitor and evaluate performance of health sector strategies, HFG will coordinate with the PNDS M&E Working Group to define the best way forward for Angola.

The work will be conducted in three phases.

**Phase 1:** HFG will work with the MINSA technical team and the Gabinete de Estudos, Planeamento e Estatística (GEPE) to review a set of international best practices related to monitoring performance of sector strategies. This phase will also include an evaluation of the indicators in the PNDS and determine Key Performance Indicators (KPIs) for the central, provincial, and district level. The identification of KPIs will include an assessment of the existing system for collecting and analyzing health sector M&E information.

**Phase 2:** HFG will focus on evaluating the MINSA procedures and budgetary parameters and how they align with the State Budget (OGE) of the Government of Angola, the current system of collecting and managing financial reporting, and implementation of the Integrated Financial Management Information System (SIGFE).

HFG will conduct the evaluations in partnership with their counterparts from MINSA, working to develop shared goals and joint review of the results. The review will involve consultation with the MINSA, Ministry of Finance, EU PASS II, and other donor programs.

**Phase 3:** Based on the results of the identification of the KPIs and budget system evaluation, HFG will provide specific assistance to develop a detailed plan for monitoring the implementation of the PNDS. The plan will be developed in collaboration with the PNDS M&E Working Group to ensure their understanding and ownership of the final product.

**Activity 2: Support Implementation of Health Accounts:** HFG will provide technical assistance and guidance to the Angola MINSA HA team to undertake its first HA exercise using SHA 2011. The exercise will be adapted to the Angolan context (through the classifications and the distribution keys) and utilize the existing Portuguese version of the tool.

In the process the technical assistance will help develop the capacity of the HA team to gradually institutionalize the exercise and use the data to monitor the progress of the PNDS.

The project will work on building the HA technical team capacity on the updated framework and the use of the HAPT, a software application developed by WHO and HFG to help streamline the HA data collection and analysis. HFG will also provide technical guidance and backstopping to the country HA team during the key stages of the exercise, specifically during the analysis and generation of key expenditure tables. Finally, the project will backstop the team in interpreting the results and developing a brief report to inform the country's policy and plan as well as disseminate the key results to stakeholders.

To facilitate the institutionalization of HA, the project will work with the health accounts technical team to identify and, where relevant, recommend for implementation mechanisms to enable routine (regular) data collection from the different data sources for health spending (e.g., government, donors, NGOs, private and public insurance).

### **Year 3 Progress Against Objectives -**

**PNDS M&E Activity:** HFG conducted an initial visit to Luanda April 26-May 9, 2015. The objectives were to meet instrumental members of MINSA and partners, perform an evaluation of the PNDS health indicators and extract KPIs which will be used to inform the development of an overall M&E framework.

HFG team members secured a meeting with the Minister and Deputy Minister to present international health and M&E best practices, which facilitated the formation of an M&E Working Group.

An evaluation of over 420 PNDS indicators was performed, extracting KPIs for the central, provincial, and district levels, and prioritizing the 58 PNDS projects. The identification of KPIs included an assessment of the existing system for collecting and analyzing health sector M&E information. With feedback received from this evaluation, a proposal of key and essential indicators was presented to the Working Group by the HFG Technical Team Leader, which included a review of data collection and data reporting techniques. Agreement was reached within the Working Group of what indicators should be included in the overall M&E plan which was then presented for mass buy-in from the 58 PNDS projects through independent meeting consultations. The Director of PNDS Coordination for MINSA committed to performing the remaining two consultations within this set of projects and organizing a weekly check-in meeting with the HFG Technical Team Leader in preparation for a planned second visit in July 2015. Due to visa issues, however, the July 2015 trip did not take place. HFG is now planning the follow-up trip for October 2015.

**NHA Activity:** Work began on the HA activity in Q3, but due to visa issues, Andre Zida could not travel to Angola until late in June. Given the challenges explained below, HFG is readjusting the timeline for the activity and aiming for data collection in January 2016 at the suggestion of the Minister of Health. In Q4, the HFG team continued to reach out to contacts at the Mission and at the MINSA, but the activity is still on hold until January 2016.

**Q4 Challenges** - Due to visa issues, the July trip for the PNDS M&E Activity did not take place. The M&E Team Leader accepted a full-time position with another organization. Though she continues to work pro-bono completing the indicators, a new Team Leader was recruited.

Table 26 provides activity-specific updates.

**TABLE 26. ANGOLA ACTIVITY DETAIL**

Year 3 Q4 Planned Tasks	Year 3 Q4 Progress	Critical Assumptions/ Problems Encountered/ Follow-up Steps
<b>Activity 1: PNDS Monitoring and Evaluation Plan</b>		
Develop PNDS KPIs	Draft KPIs have been developed for 38 programs. The remainder will be completed in advance of the October trip.	
Investigate programmatic data availability at national, provincial, and district level	Data forms were collected during the April / May trip and a short field trip was completed.	MINSA has requested that HFG focus on the M&E plan and not issues of data availability. No further trips to the field to review data will take place.

### 5.1.3 Benin

**Program Objectives** - HFG supports the Government of Benin's priority of investing in Universal Health Coverage (UHC) to serve its poorest and most vulnerable populations, especially women and girls. In Year 3, HFG continues to coordinate closely with other partners in Benin to assist the USAID/Benin Mission in achieving its objectives.

As the U.S. Government's (USG's) overarching health strategy in Benin, the Global Health Initiative (GHI) has designated USAID as the lead agency responsible for planning, implementation, and monitoring and evaluation (M&E) of GHI activities. The strategy places emphasis on women, girls, and gender equality in support of the A Promise Renewed initiative and USAID's Ending Preventable Child and Maternal Deaths (EPCMD) strategy. Furthermore, GHI continues to support health systems strengthening at various levels in order to provide sustainable, quality care health services in both the private and public sectors at the decentralized level. There is a particular emphasis on improving the performance of the private sector as an integral part of the national health system.

The Government of Benin's priorities, as laid out in the national health sector strategy, are to achieve universal access to health care and improve service quality, which will lead to significant and lasting reductions in infant, child, and maternal mortality. The roll-out of UHC is meant to promote greater access to health services by vulnerable populations and facilitate the scale-up of health interventions through reducing financial barriers and promoting equity. This initiative is called the Universal Health Insurance Scheme (Regime d'Assurance Maladie Universelle, RAMU). Reducing financial barriers to accessing quality health services in a timely manner is an effective method of increasing the demand for health care among the poor and underserved, especially women and children, and is a recognized contribution to A Promise Renewed and EPCMD. The HFG activities in support of this initiative all support HFG's Intermediate Result 1, improving financing for priority health services.

**Year 3 Activities** - The Government of Benin's vision for national UHC roll-out relies on mutuelles to reach the informal and rural sector. During Year 2 of the project, HFG Benin supported the Conseil National des Structures d'Appui à la Mutualité Sociale (CONSAMUS) in stimulating three regional mutuelle networks in Borgou Alibori, Zou/Collines and Atlantique/Littoral. These new organizations require institutional strengthening to ensure their sustainability. Three training courses will be developed/adapted including management topics and adhering to West African Economic and Monetary Union (UEMOA) regulations. The training courses developed will be useful to the Government of Benin and the Ministry of Health in rolling out regional networks in other areas of the country. Furthermore, as set out in the plan for professionalization (road map) and as a first step in supporting the development of a national federation of mutuelles, a workshop will be organized in Benin, with the objective of improving coordination between the actors involved. The Resident Activity Manager will continue to support the RAMU Technical Working Group (TWG-RAMU), and contribute to their deliberations. HFG Benin will also support the development of an analytic report to advocate how mutuelles could be increasingly integrated into RAMU (dossier technique), and proceed with the documentation of the current status of the resolutions made by the different national decision makers in 2013-2014 (état des lieux RAMU).

#### **Year 3 Progress Against Objectives -**

##### **Supporting mutuelles -**

- ▶ **Strengthen the advocacy capacity of stakeholders on RAMU law improvements:** At the request of CONSAMUS, HFG has provided technical assistance to the mutuelle stakeholders in their understanding of the RAMU law. HFG prepared and presented on the law at the 5th edition of Mutuelle Day in Bembèrèkè (JMB), specifically on the theme: "The place and role of mutuelles and local organizations in the universal health coverage process," held February 11-14, 2015. The

meeting was attended by 91 people representing the Board of Directors of the National Federation of Mutuelles of Benin (FENAMUS), the Departmental Mutuelle Councils (CDMS), CONSAMUS, mutuelle support structures, the community health service, the national health insurance agency (Agence National d'Assurance Maladies, ANAM), and some mayors of municipalities where mutuelles have been developed. This presentation on the bill informed the participants about its structure and content as well as aspects of the legislation which could be improved. Following the presentation, a group of participants conducted a synthesis of the areas for improvement that was presented and approved in plenary. CONSAMUS will use this synthesis to advocate for improvements.

- ▶ **Support the development of the Manual on the Professionalization of Mutuelles:** The Manual on the Professionalization of Mutuelles will initiate the process of harmonizing and complying with UEMOA directives on the management of mutuelles. During Q4, HFG worked with CONSAMUS to develop and validate the terms of reference for both the manual and the consultant hired to develop the manual, and the consultant completed this manual. The manual will be disseminated during Q1 of FY16.

#### **Strengthening the organization of the private sector -**

- ▶ **PSSP three-year strategic plan:** HFG has provided technical assistance to the Private Sector Health Platform (Plateforme du secteur sanitaire privé, PSSP) to develop and validate their strategic plan. Technical support was provided to PSSP stakeholders to develop the draft strategic plan. This document was submitted to 17 PSSP members on January 16, 2015 (three members attending this session were women).
- ▶ **Study on public-private collaboration:** Similarly, on February 27, 2015, HFG facilitated a meeting with the MOH and 11 members and PSSP stakeholders (1 woman) as an opportunity for them to comment on the draft terms of reference for a study regarding public-private collaboration in Benin. During Q4, a consultant was identified and has started the study, and the public-private partnership (PPP) typology has been defined. The study will be completed, validated, and disseminated during the Q1 of FY 16.
- ▶ **Participation in East Africa Health Federation:** Furthermore, to allow PSSP officials to learn from the example of umbrella organizations of private sector health care providers, HFG supported a PSSP-Benin delegation to attend the East Africa Health Federation's (EAHF) meeting May 17-19 in Kigali, Rwanda. The meeting focused on "the role of the private sector in sustainable financing of the health system."

#### **National Health Accounts -**

- ▶ Between March 7-22, 2015, Andre Zida traveled to Benin to support the government in the finalization of their National Health Accounts and to train the MOH team in using the One Health Tool. During this trip Mr. Zida worked with the Ministry team to complete the mapping of the 2013 accounts. He also began processing the data from the 2010 and 2011 health accounts. With regard to the OneHealth Training, 10 MOH planners and statisticians were trained in its use, and the Minister has indicated their intention to use the tool to update costs.

**Q4 Challenges -** The formal recognition of the PSSP was blocked due to a conflict within the PSSP President's organization. This was resolved when the Presidency was changed through an extraordinary meeting, and the recognition process restarted.

Table 27 provides activity-specific updates.

**TABLE 27. BENIN ACTIVITY DETAIL**

Year 3 Q4 Planned Tasks	Year 3 Q4 Progress	Critical Assumptions/ Problems Encountered/ Follow-up Steps
<b>Activity 1: Support to UHC</b>		
Support the role and involvement of community-based health insurance actors (mutuelles) via (CONSAMUS)	HFG prepared and presented on the law at the 5th edition of Mutuelle Day in Bembèrèkè (JMB), specifically on the theme: "The place and role of mutuelles and local organizations in the universal health coverage process," held February 11-14, 2015. The meeting was attended by 91 people representing the Board of Directors of the National Federation of Mutuelles of Benin (FENAMUS), the Departmental Mutuelle Councils (CDMS), CONSAMUS, mutuelle support structures, the community health service, ANAM, and some mayors of municipalities where mutuelles have been developed.	
Provide technical assistance to the GTT in its efforts related to RAMU	In close collaboration with WHO, contributed to the GTT meeting on April 7-9, 2015, at which the National Health Financing Strategy (SNFS) was finalized.	
Support the implementation of the administrative authority of mutuality according to UEMOA regulations	Developed the Manual on the Professionalization of Mutuelles.	
Strengthen three regional mutuelle networks	Ongoing	
Assist in the organization of a national federation of mutuelles	Developed the Manual on the Professionalization of Mutuelles.	Plan to assist in the dissemination of the manual.
<b>Activity 2: Private sector</b>		
Develop the three-year strategic work plan	Draft strategic plan developed.	Move to Year 3 action plan based on strategic plan.
Support the formal administrative recognition process for the platform	HFG continues to monitor the official recognition of the Platform filing.	Make a record of the administrative follow-up.
Study on public-private collaboration	Study planned and implementation begun.	Study will be completed and results disseminated in Y4 Q1.
Support monthly PSSP meetings/deliberations	Continuing to support the PSSP.	
Participation of PSSP leaders in East Africa Health Federation's annual meeting		Follow up to ensure implementation of road map.

Year 3 Q4 Planned Tasks	Year 3 Q4 Progress	Critical Assumptions/ Problems Encountered/ Follow-up Steps
<b>Activity 3: Resource tracking</b>		
OneHealth training and application	10 individuals from the MOH trained to use the OneHealth tool.	The MOH team has asked Pascal Soglohoun to support them in organizing in Cotonou another meeting for a pilot costing.
Zida Andre may support the MOH in doing their new three-year PNDS costing with the OneHealth tool if the strategic plan is ready by December 2015.		
Sustainability strengthening for NHA	Benin NHA team developed the first draft report for 2013 and 2014 HA. The remaining steps for the report will be additional reading and validation by an external person.	

## 5.1.4 Botswana

**Program Objectives** - During Year 2, HFG contributed to four specific areas of technical support. These included:

1. Strengthening management to improve outsourcing practices in public hospitals;
2. Building capacity of hospital managers in outsourcing;
3. Benchmarking the cost of outsourced services; and
4. Thoroughly documenting the government of Botswana's ongoing process of institutionalizing public-private partnerships (PPPs) and outsourcing nonclinical and clinical services at hospitals.

Technical support for the first two areas above was completed in Year 2; the other two were completed in Year 3.

**Year 3 Activities** - The Ministry of Health (MOH), through the Office of Strategic Management (OSM), designed and implemented a number of outsourcing agreements for private provision of nonclinical services at seven major hospitals. The MOH five-year outsourcing plan included extending access to outsourcing mechanisms to health facilities around the country and eventually expanding outsourcing to clinical services as well. The pressing reasons for MOH promotion of the outsourcing plan included aligning with government of Botswana efforts at strengthening the private economy and improving quality of nonclinical services provided in hospital settings.

The MOH is currently facing the following challenges with its ongoing outsourcing initiatives:

- ▶ Even while the main outsourcing initiatives are continuing, the MOH recognizes the need to strengthen the hospitals' capacity to manage the contracts and evaluate the performance and quality of the contract deliverables; related to this and with an eye to improve governance, the MOH anticipates the need to introduce performance-based service level agreements (SLAs) as the contractual mechanism to manage the next wave of outsourcing in hospitals.
- ▶ A dedicated PPP unit will be set up within the OSM to support the hospital contract management. It is imperative that the new unit is effectively and rapidly integrated with the existing OSM Project Management and Performance Improvement units according to good organizational and institutional practice.
- ▶ To strengthen its negotiating power with providers and its ability to successfully advocate for continued outsourcing of services, the MOH recognizes the need for a cost benchmarking study and a cost-benefit analysis of outsourcing as compared to business as usual.
- ▶ The MOH needs to capture the experience of past and current outsourcing efforts, and to continue such capture in the future, as a continuous learning effort needed to ensure the sustainability of the outsourcing program well beyond the initial period of HFG support.

To respond to these challenges, the MOH requested the support of the USAID mission in Botswana, which in turn tasked HFG with responding to the MOH's request. HFG proposed to support all the challenges above as they all align with HFG's mandate, specifically as described in IR3.

In Y3Q2, the Botswana Mission requested HFG's support during Year 4 to develop a comprehensive health financing strategy; implement and institutionalize an HA exercise; and conduct an actuarial analysis to effectively finance a sustainable Essential Health Services Package. In developing the health financing strategy, HFG will analyze and present plausible scenarios on the most equitable, affordable, and sustainable mechanisms to finance health insurance. This collaboration will build confidence in the government's ownership of a comprehensive health financing strategy and the accompanying processes of building consensus and incorporating stakeholder input at every step. The Year 4 scope of work for

these new health financing activities has been approved by the USAID mission and the Botswana MOH in Y3Q4.

### **Year 3 Progress Against Objectives -**

#### ***In Q1:***

**Activities 1 and 2: Strengthening management to improve outsourcing practices in public hospitals and Building capacity of hospital managers in outsourcing,** are now completed. As part of Activity 1 and as a follow-up to a capacity-building trip conducted in Y2Q4, HFG's hospital outsourcing consultant reviewed a set of three draft SLAs. The SLAs were initially developed during a July 2014 workshop as a starting point to help hospitals develop their own SLAs. Since July, the draft SLAs have continued to be edited and customized by hospital administrators and MOH staff. Final drafts of catering, cleaning, and laundry SLAs were shared with HFG's consultant for her final comments and input. Comments were shared with the MOH PPP Unit.

**Activity 3 Benchmarking costs for outsourcing nonclinical services:** In collaboration with Peter Stegman, data collection on the cost of non-clinical services was conducted and data were validated and remaining data gaps were filled from each facility. We also conducted service quality assessments in both facilities that outsourced and those that did not.

**Activity 4 Documentation of challenges and opportunities of outsourcing services for Botswana public hospitals:** A literature review on both clinical and non-clinical outsourcing in Africa and other regions was conducted to inform and contribute to the documentation process. Information, materials, and lessons learned from the other three activities were compiled into the final documentation report.

#### ***In Q2:***

**Activities 1 and 2:** Completed.

**Activity 3 Benchmarking costs for outsourcing nonclinical services:** The remaining data gaps, which were largely indirect costs, were filled in Q2. A first draft of the final report was also completed. In Q3 the report was reviewed, revised, and finalized for submission in April 2015.

**Activity 4 Documentation of challenges and opportunities of outsourcing services for Botswana public hospitals:** A literature review on both clinical and non-clinical outsourcing in Africa was finalized and incorporated into the documentation. In March 2015, the HFG team visited the seven hospitals in Botswana that initiated outsourcing of non-clinical services and conducted service quality assessment interviews with key hospital staff at those facilities. During each visit, the team:

- I. Distributed a short questionnaire to a sample of nurses on duty at each hospital to assess perceived quality of three services (security, laundry, and housekeeping services) before and after outsourcing.
- I. Conducted structured interviews of the Head Nurse and the Hospital Manager and/or Hospital Superintendent related to implementation of the outsourcing policy, progress in incorporating SLAs into outsourced contracts, methods by which hospitals are managing outsourced contracts, changes in service quality as a result of outsourcing, identification of outsourcing challenges/successes, and gender considerations in outsourcing.

The results from the trip have informed the documentation and cost-benefit analysis.

**Activities 5-7 (new) Support the development of a comprehensive Health Financing Strategy:**

Initial conversations around the scope of the health financing support have taken place with the mission. HFG conducted a scoping trip in April 2015 that was submitted to the mission.

**In Q3:**

**Activities 1 and 2:** Completed.

**Activity 3 Benchmarking costs for outsourcing nonclinical services:** This activity was completed. The benchmark costing report for outsourcing nonclinical services, along with an accompanying Excel-based costing tool, was finalized and shared with the Botswana USAID Mission and MOH.

**Activity 4 Documentation of challenges and opportunities of outsourcing services for Botswana public hospitals:** This activity was completed. The full documentation report, along with an accompanying brief, was completed and shared with the Botswana USAID Mission and the MOH. In addition, a cost-benefit analysis of outsourcing cleaning services at a hospital in Botswana was finalized and shared with the USAID Mission.

**Activities 5-7 (new) Support the development of a comprehensive Health Financing Strategy:**

Between April 30 and May 5, 2015, Carlos Avila travelled to Gaborone, Botswana to meet with key stakeholders and conduct scoping around upcoming areas for HFG technical assistance in Botswana. The objectives of this trip were (1) meet with USAID representatives and brief them on the progress of the current HFG outsourcing activities and discuss potential new areas of technical assistance under the current fiscal year budget; (2) meet with MOH officials to discuss technical assistance activities in the area of health financing; (3) meet with development partners, mainly WHO and UNAIDS, to make sure that further technical assistance is aligned and build up on previous work; and (4) meet with colleagues of other USAID projects to ensure coordination.

Following the scoping trip, HFG drafted a work plan for three new health financing support activities. HFG has reviewed the work plan with the Botswana USAID Mission, incorporated their comments and had it approved in Q3.

**In Q4:**

**Activities 1-4:** Completed.

**Activity 5 (new) Support the development of a comprehensive Health Financing Strategy:** HFG received work plan approval from the Botswana USAID Mission for the three new health financing support activities. The team also received approval from the MOH and will begin drafting a working document based on key informant interviews and relevant documents. The first presentation of the draft strategy will take place in December 2015 after the completed landscape analysis occurs in October.

**Activity 6 (new) Support Implementation and Institutionalization of Health Accounts Using the Updated SHA 2011 Framework:** A work plan and data plan have been developed, and the Health Accounts Production Tool (HAPT) has been customized to Botswana. HFG provided guidance to the MOH as they developed their sampling frame and sampling pool for for-profit entities, and customized survey instruments have been distributed to all entities for primary data collection. The MOH has agreed that the data analysis workshop will be combined with the SHA 2011 training in January 2016.

**Activity 7 (new) Support the development of an Actuarial Model:** HFG will conduct a scoping exercise in October 2015 to identify key questions that the MOH would like to use the actuarial model to inform. Technical assistance to support the health financing technical working group will take place after the actuarial firm has been recruited to build the actuarial model.

Table 28 provides activity-specific updates.

**TABLE 28. BOTSWANA ACTIVITY DETAIL**

Year 3 Q4 Planned Tasks	Year 3 Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
<b>Activity 5: Support the development of a comprehensive Health Financing Strategy</b>		
Presentation of draft strategy and relevant materials to share with and facilitate stakeholders' consultation	Tentative dates for the presentation of the draft strategy and consultation workshops were decided on and documented in the scope of work.	The first presentation will take place after the landscape analysis is completed and the Health Financing TWG will participate fully throughout the process.
Comprehensive Health Financing Strategy and explicit financing mechanisms for HIV programs and services	During Y3Q4 the HFG team drafted a detailed SOW outlining the five major tasks for the health financing strategy activity: 1) conducting a landscape analysis, 2) creating policy options for improving risk pooling, 3) conducting consultations with the Health Financing TWG and capacity-building workshops with ministries of health and of finance officials, 4) drafting a final health financing strategy document, and 5) disseminating the findings of the document.	
The SOW has been approved by the USAID mission and the Botswana MOH.	The next step is to conduct the landscape analysis, which will include desk research and a scoping trip to Gaborone in October 2015.	
Draft working document based on key informant interviews and relevant documents	An outline of the draft working document was included in the SOW. The SOW also lists the inputs that will feed into the health financing strategy document.	Work on the first input for the draft working document, the landscape analysis, will commence in October 2015.
<b>Activity 6: Support implementation and institutionalization of Health Accounts using the updated SHA 2011 Framework</b>		
Detailed data plan, work plan, and customized Health Accounts Production Tool	A detailed work plan and data plan has been developed and discussed in collaboration with the MOH. The HAPT has been customized to Botswana.	
Capacity building on the production of health accounts by providing training, manuals, and tools covering the SHA 2011 methodology and the HAPT	Since data collection was already under way when HFG joined the Health Accounts team, the MOH agreed that it would make most sense to combine the SHA 2011 training with the data analysis workshop. This is anticipated to take place in late January 2016.	
Customized survey instruments, sample frame and sampling pool for primary data collection	HFG provided guidance to the MOH as they developed their sampling frame and sampling pool for for-profit entities. Customized survey instruments have been distributed to all entities for primary data collection.	
Ministry of Health team fully trained on the SHA 2011	The SHA 2011 training combined with the data analysis workshop is anticipated to take	

Year 3 Q4 Planned Tasks	Year 3 Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
methodology and HIV resource tracking	place in late January 2016.	
Health Accounts report and policy brief	Pending completion of data collection and data analysis.	
<b>Activity 7: Support the development of an Actuarial Model to effectively finance an Essential Health Services Package that is sustainable</b>		
Detailed terms of reference and customized actuarial analysis plan	To develop a detailed TOR for an actuarial firm, HFG must first conduct a scoping exercise to identify key questions that the Botswana MOH would like to use the actuarial model to inform. HFG will conduct this scoping exercise in October 2015.	This scoping exercise will inform the type of functional requirements that the actuarial model will require. Furthermore, the scoping exercise will identify the data available for the actuarial firm to use in constructing the model. After this information is collected, the TOR for an actuarial firm will be finalized and HFG will build the model.
Technical assistance to support the health financing TWG to understand the methods and interpretation of the actuarial model	No progress to date. Depends on first recruiting actuarial firm.	This will follow after the actuarial firm has been recruited to build the actuarial model.
Full Actuarial Model report	No progress to date. Depends on recruiting the actuarial firm and conducting the full analysis.	This will take place after the actuarial firm has been recruited to build the actuarial model. This will serve as a deliverable for the actuarial firm.

## 5.1.5 Burundi

### Program Objectives -

- ▶ Strengthen the organizational capacity of the National HIV/AIDS Programme (Programme de Lutte Contre le SIDA et les Infections Sexuellement Transmissibles, PNLS) to carry out its core functions and, as a result, improve the delivery of HIV/AIDS programs and services.
- ▶ Provide up-to-date and accurate financial information to the HIV/AIDS sector in Burundi to support decisions on mobilizing resources for HIV/AIDS, pooling resources for HIV to minimize risk, and to allocate resources in an effective way.

**Year 3 Activities** - In Years 1 and 2, HFG implemented an intervention planned focused on building capacity of PNLS in nine areas including leadership and management skills, project management, monitoring and evaluation, planning and budgeting, and stakeholder engagement. Year 1 was aimed mostly at strengthening internal management and Year 2 at strengthening capacity to carry out core functions such as operational planning, supervision, training, and coordination. In Year 3, the objective was for PNLS to consolidate the work done to date and focus on application of skills to strengthen key functions. HFG's focus was to work with PNLS to ensure that staff apply these skills to their routine activities. Specifically, HFG aimed to:

2. Continue to develop leadership and management skills of PNLS staff.
3. Develop PNLS capacity to implement their first annual operational plan and monitor and evaluate their progress
4. Implement the newly developed Supervision Strategy to provide technical supervision at the provincial and district levels.
5. Continue to build PNLS capacity to carry out its training function by conducting training of trainer workshops
6. Support PNLS in securing funding to implement the technical training plan
7. Implement the communication plan to increase the visibility of PNLS.
8. Continue to improve working conditions at PNLS through the procurement of basic office equipment and furniture and improvement to the office itself.

**Health Financing** - In Year 3, HFG supported the completion of the 2012 and 2013 National Health Accounts (NHA). The NHA provides detailed breakdowns of overall health, and HIV, spending in order to highlight the sources of financing, allocation of spending by type of provider and by type of activity. This data helps the MOH to answer key questions such as: is spending on HIV sufficient; what are the sources of financing for HIV and are they sustainable; who are the providers of HIV good and services, and to what activities does HIV spending go.

### Year 3 Progress Against Objectives -

**PNLS organizational capacity building** - Following a mid-term review of the capacity-building program at the beginning of Year 3, HFG developed a work plan for Year 3. The work plan focused on the application of skills to carry out core functions such as operational planning, coordination, training, and supervision. HFG also assisted PNLS in developing its first-ever operational plan.

HFG continued to provide ongoing coaching to the senior management team, including the five heads of departments. Three TOT sessions to build a cadre of qualified trainers were carried out. Action plans have been developed for each unit of PNLS to ensure that their activities contribute to the overall

HIV/AIDS operational plan. The technical supervision strategy and the communication strategy are being implemented through the oversight of two technical committees composed of PNLS staff.

HFG assisted in the transition of the new PNLS Director by organizing an all-staff retreat that resulted in a revised vision and values and the identification of strategic priorities for PNLS in the coming year. HFG also financed the procurement of minor goods and services to improve the work conditions of the PNLS, including equipment for office partitioning, painting of the interior of the PNLS office, and purchasing equipment for the meeting room, which is now in full use.

**In health financing**, HFG supported the NHA team to complete the analysis and dissemination of health accounts data for 2012 and 2013 with a special focus on HIV and AIDS. The results, which were presented at the Annual Health Sector Review, attended by over 100 national and international participants, will feed into the design of the upcoming Health Financing Strategy.

**Q4 Challenges** - Because of civil unrest in Burundi, no external consultants were able to travel to Burundi from May to August. In mid August, USAID/Burundi said the situation was sufficiently calm for an external consultant to travel to Burundi.

In Quarter 4, HFG was informed that it will not be receiving PEPFAR funding for Year 4. This is due to a refocus of PEPFAR financing toward facility-based care and treatment. This is a decision that has affected all PEPFAR-funded projects in Burundi, not only HFG. Despite this, HFG has significantly improved the organizational capacity of PNLS over the past three years. PNLS now possesses the skills and knowledge to better oversee the implementation of the national HIV and AIDS Strategy, including the improvement of facility-based care and treatment. HFG intends to complete its remaining organizational capacity activities and close out by March 2016.

HFG's organizational capacity-building expert could not travel to Burundi in late August as originally planned, due to unforeseen changes to immigration rules that no longer permit the issue of visas on arrival in Bujumbura. His trip is now scheduled for early October.

**Q4 Additional Information** - For the first time, through the support of HFG, PNLS was invited to be part of the Burundi delegation that is negotiating funding with the Global Fund for the next grant round. PNLS could either be a major sub-recipient or a Principal Recipient for the new HIV/AIDS grant in Burundi, subject to confirmation from the Global Fund.

Table 29 provides activity-specific updates.

**TABLE 29. BURUNDI ACTIVITY DETAIL**

Year 3 Q4 Planned Tasks	Year 3 Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
<b>Activity I: PNLS organizational capacity building</b>		
Strengthen PNLS capacity in technical supervision	The Technical Supervision Strategy will be monitored under the umbrella of the Coordination Mechanism that is being established and is discussed below.	
Continue to develop leadership and management skills of PNLS staff	HFG will conduct a three-day leadership and management training program in October for all new staff who have joined in the past two years so that all staff are familiar with basic leadership and management concepts. The training was originally conducted in the first year of HFG's assistance.	
HFG will also conduct one-day team building retreats in October for all five divisions, focusing on decision making and conflict management.	Conduct leadership and management training program.	
Develop PNLS capacity in operational planning	Terms of Reference have been developed for the Coordination Mechanism. Based on the TORs, the coordination committee has been established and will be launched in October with HFG support. The mechanism will be used to monitor to monitor implementation of the Operational Plan and the Supervision Strategy.	Hold first formal meeting of newly established coordination mechanism in October.
Build PNLS capacity in designing and delivering training	HFG will conduct a two-day refresher TOT workshop for the 10 PNLS staff who have participated in previous TOTs. This workshop is aimed at consolidating skills learned in previous training programs.	Conduct refresher training of trainers.
Develop annual operational plan and M&E plan to track progress	The operational plan serves as the basis for the coordination of PNLS's partners and will be a prime topic during coordination meetings.	
Support implementation of stakeholder engagement strategy	PNLS has begun to actively fulfill its coordination function. To date PNLS has held one meeting of all its partners and a second one for PEPFAR implementing partners in July. These meetings have been held in PNLS's rehabilitated conference room and completely planned and conducted by PNLS staff. Since these meetings, the PNLS Director has made follow-up visits with each partner individually to enhance their engagement	

Year 3 Q4 Planned Tasks	Year 3 Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
	and to begin negotiations for financing the Operational Plan.	
Support implementation of communication plan to increase the visibility of PNLS	In Q 4, communications materials were purchased for dissemination to increase the visibility of PNLS with external stakeholders and with the population. A distribution plan to disseminate t-shirts, caps, leaflets, business cards and posters is being followed.	Complete implementation of communication plan.
Support PNLS in the implementation of strategy to provide technical supervision at the provincial and district levels	Measure Evaluation, through the request of the USAID mission, is supporting PNLS's M&E department to conduct technical supervision of the provinces. As a first step, they are supporting PNLS to develop supervision tools and a draft supervision framework. The coordination committee will continue to monitor the progress of this activity.	
<b>Activity 2: HIV/AIDS costing and financing</b>		
Provide technical assistance to NHA team on an ongoing basis	In Q4, the 2012 and 2013 health accounts report was completed, printed, and disseminated.	

## 5.1.6 Côte d'Ivoire

**Program Objectives** - USAID/Côte d'Ivoire has asked HFG to address two major areas in FY 2015: (1) human resources for health (HRH), including an assessment of the pre-service training institutions for health personnel and (2) health financing. Côte d'Ivoire activities are entirely funded by PEPFAR and as such contribute to achieving AIDS-Free Generation goals, and are in line with the PEPFAR Blueprint, which includes health systems strengthening (HSS) under the pillar "Smart Investment."

### Year 3 Activities -

- ▶ Developing the national HRH Strategic Plan
- ▶ Developing an HRH Performance Management System
- ▶ Strengthening Pre-Service Training for HIV Care and Treatment
- ▶ Promoting the integration of HIV/AIDS services in performance-based financing (PBF) implementation to improve the effectiveness of HIV care and treatment
- ▶ Improving the capacity of the Ministry of Health and of the Fight against HIV/AIDS (Ministère de la Santé et de la Lutte contre le SIDA, MSLS) to advocate for increasing domestic financial resources for HIV/AIDS
- ▶ Supporting adoption of a policy or legal framework and implementation of task sharing and pre-service training for Option B+

### Year 3 Progress Against Objectives -

**Development and dissemination of HRH Strategic Plan:** In Q1, HFG supported the MSLS in finalizing the HRH Strategic Plan for 2014/2015, which includes an M&E plan. The HRH Plan was the result of a participatory process with donors and partners, such as WHO, that are involved in national HRH policy development. The HRH Strategic Plan focuses on improving capacities and competencies of midwives and nurses to directly address the challenges related to achieving Millennium Development Goals 4 and 5. These midwives and nurses also play a critical role in the care and treatment of people living with HIV/AIDS (PLHIV), and the HRH strategy will help the MSLS to expand access to quality care.

In Q2, HFG supported the MSLS Human Resources Department (*Direction des Ressources Humaines*, DRH) in editing, printing, and disseminating 250 copies of the 2014-2015 HRH Plan. In accordance with USAID recommendations for HFG to focus on activities directly linked to HIV care and treatment, and in light of implementation delays and the short time remaining in the current HRH plan, HFG and DRH agreed to let other organizations such as the French Development Agency (*Agence Française de Développement*, AFD), the Japan International Cooperation Agency (JICA), and WHO implement and conduct activities that previously had been in the HFG work plan.

In Q3, HFG supported the DRH in engaging those entities in the former HFG activities. The Côte d'Ivoire team will document the contribution to HFG's cost share by AFD and JICA when possible. The DRH decided to use a quarterly meeting format for donor coordination to implement the first phase of the HRH strategic plan and achieve its milestones. HFG helped the DRH to organize the meetings.

During Q4, HFG has participated, along with the DRH and other HRH key actors and partners in a one-day workshop on August 14, 2015, which focused on the definition of HRH's retention strategies in rural areas. This activity, co-funded by the WHO and the World Bank, aimed to carry out a longitudinal evaluation of HRH preferences in Côte d'Ivoire. In Y4Q1, HFG will support the DRH to evaluate the HRH Strategic Plan 2014/2015 and develop the 2016-2020 plan, which will be aligned with the new National Plan for Health Development (*Plan National de Développement Sanitaire*, PNDs).

**Development of an HRH Performance Management System:** In Q1, HFG assisted the DRH in finalizing compilation of the health worker job description and skills into one reference document. Importantly, HFG is now using this document to support advocacy efforts to integrate community health worker (CHW) and data manager positions into the national health workforce (civil service) for the first time. These positions have been funded by PEPFAR and are key to reaching the country's HIV care and treatment goals. If they are incorporated into the civil service, their funding and management will transition from PEPFAR and NGO implementers to the MSLS.

As part of assisting the Department of Planning and Statistics (*Direction de la Prospective, de la Planification et des Stratégies*, DPPS) with the National Health Reform initiative, HFG was asked to develop a pool of trainers on the performance management tools for health facilities. HFG is still waiting for USAID local team approval to launch this activity.

Draft TORs were developed for use in HFG hiring of three local consultants (Statistician, Health Economist, and Sociologist) who will help the DRH conduct an assessment of incentive strategies (including post-differential payments and non-financial incentives) for health care workers (including those involved in HIV care and treatment). The consultants will support the DRH in developing and validating the assessment protocol, conducting the assessment, and producing the report.

Concerning the health worker career profiles, after the assessment, data and information collected from the survey was computerized and analyzed (October 1-5, 2014). A workshop to validate the profile document was held October 6-10, 2014 with 40 participants from health worker unions and associations. As a next step, HFG will support DRH in organizing a one-day workshop to present the health workers' career profiles. Ultimately these revised career profiles aim to have newer graduates trained in higher-level health centers and incentivize more experienced health workers to practice in more remote areas to improve access and quality of care. Currently, just the opposite happens - recent graduates are posted in rural and remote areas, while more experienced practitioners are concentrated in urban areas.

In Q2, HFG continued assisting the DRH to integrate CHW and Data Manager positions into the civil service. These positions have been funded by PEPFAR and are highly relevant to reaching the country's HIV care and treatment goals. If these positions are incorporated into the civil service, their funding and management will migrate from PEPFAR and NGO implementers to the MSLS. To help ensure that integration is done effectively, HFG worked with the Health Community Branch, which is in charge of CHWs, and the DRH on advocacy strategies to address the integration issues.

HFG will develop and validate advocacy documents before organizing advocacy workshops.

HFG supported DPPEIS in training a pool of trainers on drafting of facility business plans highlighting HIV/AIDS care and treatment activities (as part of hospital reform). This now includes a health financing component to make a comprehensive package for supporting the implementation of PBF strategies.

With HFG technical assistance, the DRH completed the first draft of the career profile document. In Q3, HFG held a workshop for review, discussion, and validation of this first draft and a one-day meeting to present the final document. To evaluate the implementation of HRH performance management tools, HFG will support the DRH in organizing a tool implementation mission to the health facilities in Yamoussoukro Health Region.

A delay in receipt of funds forced the postponement to Q3 of the activity "Support MSLS in hosting a stakeholder review with the Performance Management Multi-Sectoral Subcommittee," which will validate the proposed incentive policy for HRH, specifically those involved in HIV care and treatment. Meeting attendees will include staff from the Ministry of Public Service and Employment, the Ministry of Planning, health care workers, and other stakeholders.

In Q3, HFG continued assisting the DRH in evaluating the pilot of performance management tools. However, due to the DRH's need to address more imminent challenges, this activity was postponed until Q4. HFG will support the DRH in its valuation of the performance management tools piloted at several health facilities in the Yamoussoukro Health Region.

HFG supported the DRH and health worker unions to finalize the HRH career profiles begun in Q2 during a workshop on May 4-9, 2015, with 43 participants (including 9 women). A technical team of 10 members (2 women) from workshop participants met on May 15 to review and adopt the final document. The next step is to organize a one-day meeting to present the final career profile project document to the MSLS leadership.

HFG has been working with the MSLS to integrate community health workers (CHWs) and data managers into the national health workforce (civil service). Currently these positions are funded by PEPFAR through implementing partners. HFG assisted the Direction de la Santé Communautaire et de la Médecine de Proximité (DSCMP) to finalize the CHW advocacy document (supported by ICAP) and attended the CHW TGW on June 17, 2015. Due to limited financial support from the IMF and World Bank for the integration of new cadres into the civil service, the government of Côte d'Ivoire has prioritized a salary increase for existing civil servants and the recognition of specialization in the medical field. Integration of CHWs and data managers remained under discussion. One pathway proposed would be to support CHW roles through the addition of community-level indicators to PBF. As a next step, HFG will support the MSLS to develop and validate advocacy documents before organizing advocacy workshops.

As a result of recommendations from USAID, the activity entitled "Support MSLS to host a stakeholder review with the Performance Management Multi-Sectoral Subcommittee" was replaced by "Mapping of HRH involved in care and treatment within 39 health districts with high and medium levels of morbidity linked to HIV/AIDS in Côte d'Ivoire." HFG supported the DRH and members of the DPPEIS team (total of 8 members including 3 women) to draft and validate the tools and protocol during a working session (June 24, 25, and 30, 2015). In Q4, HFG worked with the DRH to develop and validate the mapping protocol and data collection tools, collect field data, and produce a report.

In Q4, the evaluation of the performance management tools pilot in several health facilities in Yamoussoukro, already postponed from Q3, was again postponed, to Year 4. However, this activity has been postponed for next FY because Yamoussoukro is one of the 15 Health Districts where USAID/PEPFAR planned to implement its strategy for scale-up to saturation. Therefore, in Y4Q1, HFG will support the DRH with the pilot evaluation and then, incorporating evaluation findings, pilot these tools in the 14 other health districts identified by USAID/PEPFAR.

Also in Q4, the final HRH career profile project document was presented to key members of the MSLS during a one-day meeting on August 18. This document was submitted to the Ministry of Civil Service for adoption and application. During Y4Q1, HFG will support the DRH with their advocacy strategy around the new HRH career profile and position descriptions that will be presented to key stakeholders during several sessions.

To achieve the 90/90/90 approach, USAID/PEPFAR has developed a strategy of scale-up to saturation in the health districts that make up 42 percent of the country's total disease burden from HIV/AIDS. Fifteen high-priority health districts were identified for this strategy. HFG in collaboration with the DRH has undertaken an HRH mapping exercise to identify and address the shortage of health care providers (nurses, midwives, and medical doctors) in these health districts. After developing survey tools, a training session for 18 investigators (including 3 women) was held on July 24, 2015. From July 27 to August 27, HFG supported the DRH by organizing an HRH mapping survey in the 15 scale-up to saturation health districts[1] and in 24 other (medium priority) health districts (with 32 percent of the total disease burden due to HIV/AIDS) where the strategy for scale-up is developed. In the meantime,

the DRH has administered the survey in 43 low-priority health districts. In Y4Q1, HFG will work with the DRH to finalize the data entry and develop an HRH mapping report to help advocate for the adequate allocation of HRH in the scale-up to saturation health districts.

**Strengthen pre-service training for HIV care and treatment:** In Q1, HFG provided support to the National Health Worker Training School (*Institut National de Formation des Agents de Santé*, INFAS) by developing a first draft of a capacity assessment report. That draft was shared with INFAS key actors before a workshop (December 15-19, 2014, with 35 participants from different INFAS sites) to validate assessment results and develop a capacity-building plan. HFG then supported the production of the final assessment report including a capacity-building plan and a one-day workshop to validate the report.

In Q2, after validating assessment results and developing the capacity-building plan, HFG provided technical assistance to INFAS to finalize those documents. However, this activity was delayed by competing priorities at INFAS, such as matriculation. For the next step, HFG will support the production of the final assessment report including a capacity-building plan and will organize a one-day workshop to validate the report.

HFG concluded its License, Master, and Doctorate (LMD) activities, which will elevate nursing and social work degrees to the university level. The last of these activities was to help INFAS's LMD committee to organize a workshop (January 12-16, 2015) to consolidate and finalize INFAS License courses; 37 people attended the workshop. Future HFG support of LMD will be limited to the License level and advocacy with other donors to continue curriculum development at the Master and Doctorate levels. The next step for HFG will be to report on its LMD activities.

In Q3, INFAS was to have completed the LMD capacity-building plan report. In the end, the teachers did not have time to help finalize the document for the License program.

In Q4, the LMD document was again postponed until the internal review of the consultants' contracts was complete. In the meantime, HFG participated in the development of HIV care and treatment courses for nurses and midwives in pre-service (August 5-6, 2015) and in the validation of these courses (September 16-17, 2015) through workshops supported by ICAP. HFG also supported the local INFAS management team of Daloa on August 28-29 2015, in the organization of two activities:

- ▶ Delivering ARV drugs by nurses and midwives in the context of task shifting (presented by the PNLS), on August 28.
- ▶ White coat ceremony for new students, nurses, and midwives. Total participation was 233 students: 163 nurses (including 52 women) and 70 midwives (all women) who had completed their training. To mark this occasion, HFG donated a computer kit in support of the task-shifting program including a desktop (1), laptop (1), video projector (1), printer, (1) and inverter. During the next quarter, HFG will support the INFAS sites of Daloa and Aboisso to design a training model for clinical supervision of students in task shifting.

**Support adoption of a policy or legal framework and implementation of task sharing and pre-service training for Option B+:** During Q2, HFG worked with the General Directorate of Health (Direction Generale de la Santé, DGS) and PNLS in adopting a policy or legal framework to implement task sharing and pre-service training for Option B+. Due to the delay in receipt of funds, activities in this component are planned for Q3.

In Q3, the bulk of activities in this component were again postponed, to Q4. Nevertheless, sites visits were made April 13-17, 2015. Discussions were held with the INFAS local management teams and other local actors involved in HIV service delivery. The in-country team met 15 members (6 women) of INFAS site (Aboisso and Daloa) management teams. There were additional meetings with 16 clinicians (5 women) involved in HIV service delivery.

Additionally in Q3, HFG supported PNLS in organizing two task-shifting TWG meetings (April 15, 2015 and June 19, 2015 with 10 and 9 participants, respectively, including 2 women). In order to move the activity forward despite delays, informal discussions were held with the DRH Management Team (June 11) on adapting the training strategy. A concept paper with the new strategy is completed and will be shared with the DRH, the local USAID team, and INFAS management team for comment and implementation.

During Q4, HFG supported the PNLS in organizing TWG meetings with 17 participants (including 2 women) to review the module on the treatment and biology of undetectable viral load (on August 14, 2015). Another TWG meeting was held by the PNLS with HFG's support on August 17-19: it reviewed presentations on the task-shifting training manual. Eight persons, including 2 women, participated. HFG also helped the DRH, INFAS, Inspector General for Health and the Fight Against AIDS (IGSLS) and other key actors in holding a workshop (August 20-21, 2015) on how to train new civil servants (nurses and midwives) on task-shifting matters in HIV care and treatment. A total of 27 participants (5 women), participated. As a next step, HFG helped with the development and validation of a training program for nurses and midwives in the context of task shifting. As part of this work, HFG supported INFAS to facilitate a workshop (September 1-4, 2015) for 22 of its teachers (4 women), to discuss different strategies. In Y4Q1, HFG will support INFAS, DRH, and PNLS to organize a theoretical training session on task shifting in HIV care and treatment for 1,691 nurses and midwives.

**Accountability:** In Q1, HFG supported the MSLS to develop a set of training modules to address accountability weaknesses identified through the self-assessment. Two workshops were organized for the development of the modules with broad participation by the MSLS, other Côte d'Ivoire government institutions, donors, and NGOs. Participants included: USAID, the Elisabeth Glaser Pediatric AIDS Foundation (EGPAF), World Health Organization (WHO), United Nations Development Program (UNDP), Management Sciences for Health/Leadership, Management and Governance Project (MSH/LMG), Terre des Hommes (TDH), Programme Pays de Renforcement des Capacités (PPRC), Ministry of Economy and Finance, Ministry of Higher Education and Scientific Research (MOHE), INFAS, National Secretary of Governance and Capacity Building, MSLS General Health Unit (*Direction Generale de la Santé*, DGS), MSLS Inspector General's Office, MSLS Legal Services, MSLS Training and Research Directorate, MSLS Directorate of Financial Affairs, MSLS DRH, MSLS Infrastructure, Equipment and Maintenance unit, MSLS Information, Planning and Evaluation unit, national public health pharmacy, National Institute of Public Health, University of Bouaké, University of Abidjan, and civil society organizations (CSOs).

In addition, HFG supported the MSLS in organizing TOT sessions on the health governance/accountability modules. These sessions were conducted by national experts from the MSLS and the 100 participants came from all levels of the health system (central, regional, and district).

HFG also supported the MSLS in organizing feedback sessions based on the assessment findings in key regions. These feedback sessions, led by the MSLS Inspector General's Office, took place in the regions of Cavally-Guemon, Tonkpi, Gôh, and Marahoué in October 2014 and continued in the regions of Poro-Tchologo-Bagoué, Hambol, Worodougou-Béré, and Kabadougou-Bafing-Folon in November 2014.

In Q2, having trained 100 health actors in accountability practices in December 2014, HFG continued its support to the MSLS in organizing feedback sessions based on the health accountability assessment's findings in the four remaining health regions. These feedback sessions, led by the MSLS Inspector General's Office, took place in the regions of Sud Comoe, Abidjan 2, Lôh Djiboua, and Abidjan I Grands Ponts in January 2015.

These feedback sessions covered all 20 health regions and allowed local health systems actors to understand the gaps in governance in the health sector. Participants committed to improve health

governance in their various regions. The IGSLs will do inspections and audits to strengthen governance in the different health regions.

The next steps will include supporting the IGSLs in disseminating the accountability assessment's findings and organizing audit missions in health regions.

In Q3, per PEPFAR's new vision and the Côte d'Ivoire Mission guidelines and priorities, interventions were categorized into core activities, near-core activities and non-core activities. The accountability component was deemed no longer relevant and so its activities were cancelled.

**Health financing:** In Q1, a platform for discussion and advocacy on the important institutional arrangements to consider for implementation of the national PBF strategy in Côte d'Ivoire was created for the Ministry of Finance and MSLS. The Direction Generale du Tresor, the Direction Generale de l'Economie, the DPPS, and the DGS, and a representative of HFG participated in this platform, named the Interdepartmental Scientific Committee for the Implementation of the National Performance-Based Financing Strategy in Côte d'Ivoire (CSI-FBP).

The first meeting was organized by the DGS (which is in charge of the Committee) and held on October 31, 2014 for reading of the draft "Advocacy document for institutional arrangements for the implementation of the national Performance Based Financing Strategy in Côte d'Ivoire" prepared by HFG. The participants approved the following decisions: extend the CSI-FBP to the Ministry of Budget, the Ministry of Planning, and MSLS Legal Services and formalize the CSI-FBP through a ministerial decree.

A second meeting was planned for January, to review the latest version of the advocacy document, finalized in December by HFG.

In addition, working sessions were held with DPPS to plan HFG's interventions with the DPPS in Year 3. HFG expected the formal request of the DPPS to prepare a road map for the implementation of the PBF pilot, the development of the manual of procedures, the development of a contracting strategy, and guidelines for contracting of health facilities.

In Q2, HFG received the request to support the implementation of the national PBF scheme. HFG drafted the road map for the pilot; it was discussed and validated at the second meeting of the CSI-FBP.

In accordance with the road map, the CSI-FBP planned a workshop on institutional arrangements negotiation for April and another to validate national PBF indicators for May. HFG worked closely with DPPEIS to prepare for these workshops by drafting scopes of work and other supporting documents.

In Q3, HFG held a training workshop on the OneHealth tool and several one-day work sessions to plan and cost the national HIV strategy and next PNDS as a part of the MSLS advocacy approach to increase domestic funding for the fight against HIV/AIDS.

In Q3, the HFG project supported the MSLS on the development of institutional arrangements to facilitate the implementation of the PBF scheme. A workshop was held on May 4-6, and on May 18-23, HFG Advisor Andre Zida provided a training on the OneHealth Tool for 20 MSLS key stakeholders. This training and Andre's ongoing support will help the MSLS advocate for increased domestic resources dedicated to HIV/AIDS.

In addition, HFG participated in four PBF TWG meetings (June 10, 17, 23, and 25, 2015) related to the definition of financial management procedures for primary health care facilities involved in the PBF scheme. These PBF TWG meetings, led by the DPPEIS, were attended by partners including USAID, the World Bank, the Global Fund, UNICEF, and UNFPA. HFG also participated in a June 24 work session related to a review of the HIV/AIDS program for the development of the National HIV Strategic Plan (2016-2020). This work session, coordinated by the PNLS, was attended by partners such as USAID, CDC, WHO, UNDP, the World Bank, the Global Fund, UNICEF, UNFPA, and UNAIDS.

In Q4, HFG continued its assistance to MSLS to develop consistent tools for PBF implementation through four activities:

- ▶ A workshop to design procedures for managing health facilities under the PBF scheme (July 1-3). 17 key actors including 7 women from the MSLS and Ministry of Finance attended this workshop.
- ▶ A workshop to formulate the PBF's manual procedures including indicators (July 20-25). There were 42 attendees including 8 women from the MSLS and Ministry of Finance.
- ▶ Two work sessions to reach consensus on the PBF national indicators (July 28-29) with 14 participants including 3 women from the MSLS and Ministry of Finance.
- ▶ A workshop to design and write sample contracts for the PBF's pilot project actors (September 2-4) with 21 attendees including 3 women from the MSLS and Ministry of Finance.

HFG also provided support to the DGS and the PNLS to write an advocacy note to increase the HIV budget in 2016 from 4 billion to 10 billion FCFA. This note was endorsed by the Minister of Health and presented to the Prime Minister by the U.S. Ambassador.

In addition, in order to support the MSLS in advocating more effectively to increase the HIV budget for 2016-2020, HFG worked together with the PNLS, other health programs, central key actors and the DPPEIS to formulate orientations for the coming PND. A workshop was held with 34 attendees for that purpose September 8-11. The participants came from the MSLS, Ministry of Finance, Ministry of Planning, and partners such as UNICEF, EGPAF, and PARSSI/EU.

### **Y3 Challenges –**

- ▶ In Q1, the HFG Chief of Party (COP) for Côte d'Ivoire, Dr. Desire Boko, was accepted for the position of HFG COP for Haiti, an international position to start January 1, 2015. The HFG Finance and Administration director took an international position in the region with another organization and left HFG in mid-December. During the transition period, Dr. Noel Nahounou was acting COP and Diane Ake acting Finance and Administrative Director.
- ▶ In Q2, delays in receiving funds slowed the pace of implementation this quarter. Dr. Noel Nahounou was approved as COP and Diane Ake as Finance and Administrative Director.
- ▶ During Q3, delays in receiving funds for task shifting and Country Operational Plan (COP) 2014 remaining funds, combined with urgent priorities outside of HFG for MSLS units, such as the DRH and INFAS faculty, slowed the pace of implementation. Campaign activities for the upcoming presidential elections in Côte d'Ivoire, scheduled for October, will also slow decision making and activity implementation, so it was critical to accelerate activities in Q4 to the extent possible. Due to campaign activities and elections scheduled for October 2015, the team is expecting delays in the implementation of upcoming activities.

### **Y3 Additional Information –**

- ▶ Based on the Côte d'Ivoire mission guidelines and PEPFAR priorities, interventions were assigned to PEPFAR categories of core, near-core, and non-core activities. The decentralization activity was cancelled in accordance with the mission's priorities. However, related activities were undertaken to hand over the decentralization work to the MSLS. In Q1, HFG assisted the TWG on the decentralization process. HFG supported the MSLS in the development of the Regional Health Development Plans for Guémon, Haut Sassandra, Belier, and Marahoué based on the results-based management approach and in organizing (in November 2014) sessions to finalize the four Regional Health Development Plans.
- ▶ Ms. Kate Greene traveled to Côte d'Ivoire in late September to discuss the FY15 work plan and budget, finalize the FY15 Ebola work plans (addressing USAID and INHP comments) and follow-up

on the new office search. She has also met with government partners, and the USAID PEPFAR/HSS team (new activity manager as of Y3Q3) to discuss COPI5 activities (HRH, health financing, task-shifting, and the Ebola proposed work).

Table 30 provides activity-specific updates.

**TABLE 30. CÔTE D'IVOIRE ACTIVITY DETAIL**

Year 3 Q4 Planned Tasks	Year 3 Q4 Progress	Critical Assumptions/ Problems Encountered/ Follow-up Steps
<b>Activity I: Support MSLS to elaborate the national HRH strategic plan</b>		
Continue the implementation of HRH Plan 2014-2015	HFG participated with DRH and other HRH key actors and partners in a one-day workshop (August 14, 2015) on the definition of HRH preferences for retention in rural areas.	Next Steps: <ul style="list-style-type: none"> <li>• Evaluate HRH Strategic Plan (2014-2015)</li> <li>• Produce HRH Strategic Plan (2014-2015) Report</li> <li>•</li> </ul>
Develop HRH Strategic Plan (2016-2020)	Postponed to Y4Q1	Next Steps <ul style="list-style-type: none"> <li>• Conduct a joint rapid assessment with MSLS/DRH and other stakeholders to determine changes in human resources needs and production using existing data sources from MSLS and implementing partners.</li> <li>• Generate a list of HRH strategies and activities for 2016-2020 Strategic Plan, including documentation and stakeholder input.</li> <li>• Conduct structured stakeholder workshops to determine strategic priorities and activities for the upcoming five years (2016-2020).</li> <li>• Draft the strategic plan to reflect the priorities selected through the stakeholder prioritization process.</li> </ul>

Year 3 Q4 Planned Tasks	Year 3 Q4 Progress	Critical Assumptions/ Problems Encountered/ Follow-up Steps
<b>Activity 2: Developing an HRH performance management system</b>		
Revise the career profiles and evaluation criteria to reflect updated MSLS position descriptions	HRH career profile project document was presented on August 18 to the key members of MSLS during a one-day meeting.	Next Step: <ul style="list-style-type: none"> <li>Support DRH in advocacy sessions with key stakeholders concerning new HRH career profiles and position descriptions.</li> </ul>
Evaluate implementation of HRH performance management tools	Postponed to Y4Q1	Next Steps: <ul style="list-style-type: none"> <li>Support the DRH in its evaluation of the performance management tools piloted at several health facilities in the Yamoussoukro Health Region.</li> <li>Support the DRH to administer performance management tools in the 14 health districts identified by USAID/PEPFAR as districts to implement the "scale-up to saturation" strategy (design scale-up policy for HRH performance management tools, develop plan for scale-up of HRH performance management tools).</li> </ul>
Support DRH in the mapping of HRH involved in care and treatment within 39 health districts with high and middle morbidity linked to HIV/AIDS in Côte d'Ivoire	<ul style="list-style-type: none"> <li>A training session was organized for 18 investigators (3 women included) on July 24, 2015.</li> <li>For a full month, HFG supported the DRH by administering a survey for HRH mapping in 15 health districts<sup>1</sup> (scale-up to saturation) and in 24 other health districts (scale-up)</li> </ul>	Next Steps: <ul style="list-style-type: none"> <li>Finalize survey data entry in the database.</li> <li>Produce HRH mapping report.</li> <li>Conduct advocacy session to allocate HRH in the scale-up to saturation health districts.</li> </ul>
Develop a proposed incentive policy, including post-differential payments and nonfinancial incentives, using data gathered from the performance motivators' rapid assessment and best practices from other countries	These activities are now led by the World Bank and WHO	These activities are now led by the World Bank and WHO.
Prepare the incentive strategy and framework for costing and resource mobilization in the subsequent program year	These activities are now led by the World Bank and WHO	These activities are now led by the World Bank and WHO.

<sup>1</sup> [The 15 priority health districts are: Koumassi-Port Bouet-Vridi, Adjamé-Plateau- Attécoubé, Soubré, Yopougon Ouest-Songon, Yopougon Est, Abobo Est, San-Pedro, Cocody-Bingerville, Abobo-Ouest, Treichville-Marcory, Daloa, Korhogo, Yamoussoukro, Divo, Adzopé

Year 3 Q4 Planned Tasks	Year 3 Q4 Progress	Critical Assumptions/ Problems Encountered/ Follow-up Steps
<b>Activity 3: Strengthen pre-service training for HIV care and treatment</b>		
Support INFAS, INFS, and UFR-SMA in the implementation of the LMD policy.	Postponed until Y4Q1	Activities concerning "Complete LMD document for license courses" were suspended until internal review process is completed.
Support the MSLS, MOHE, and MSA to obtain stakeholder buy-in from pre-service training institutions for the institutional capacity assessment, and pilot the assessment tools with one institution	These activities were canceled.	These activities were canceled.
Evaluate the data collection and information application tools	These activities were canceled.	These activities were canceled.
Support UFR-SM, INFAS, and INFS capacities to address HIV care and treatment issues	<ul style="list-style-type: none"> <li>• First ceremony on delivering ARV drugs by nurses and midwives in the context of task shifting.</li> <li>• White coat ceremony</li> <li>• HFG has offered a computer kit with a desktop (1), laptop (1), video projector (1), printer (1), and inverter (UPS)</li> </ul>	
<b>Activity 4: Promote the integration of HIV/AIDS services in PBF implementation to improve the effectiveness of HIV care and treatment</b>		
Complete the work undertaken to support MSLS to advocate for special conditions for PBF pilot implementation	<ul style="list-style-type: none"> <li>• Two workshops were held on the PBF manual of procedures; they covered topics such as indicators and sample contracts for PBF key actors.</li> <li>• Two work sessions to reach consensus on the PBF national indicators.</li> </ul>	<p>Next step:</p> <ul style="list-style-type: none"> <li>• Assist DPPEIS to obtain regulatory clause from the government through signed legal texts for the PBF implementation</li> </ul>
Participation in meetings, exchanges, and other fora on health finance, collaboration with MSLS and other donors around PBF and other reforms (UHC), and debriefing of USAID/PEPFAR, as requested	HFG participated in a workshop on hospital reform policy design (September 16-19, 2015).	<p>Next step:</p> <ul style="list-style-type: none"> <li>• Assist DPPEIS to link more effectively PBF mechanism and Hospital reform policy.</li> </ul>
Support MSLS to strengthen administrative and financial management of health facilities (develop the regulatory texts governing the administrative and financial management of health facilities and training modules, etc.)	HFG supported the organization of a workshop related to PBF management at health facilities.	<p>Next steps:</p> <ul style="list-style-type: none"> <li>• Develop administrative and financial management tools for health facilities under PBF.</li> <li>• Develop training modules for health facilities.</li> </ul>

Year 3 Q4 Planned Tasks	Year 3 Q4 Progress	Critical Assumptions/ Problems Encountered/ Follow-up Steps
Support central-level TOT (DPPS, DAF, IGSLs, etc.) on PBF tools and Standard Operating Procedures (SOPs). These trainers will train and support managers of health facilities	Postponed until Y4Q1	Postponed to Year 4 due to delays in PBF pilot implementation by MSLS.
Support the development of tools, SOPs for PBF implementation reporting tools that facilitate M&E of HIV/AIDS activities (prevention, treatment and care, retention in care, etc.)	Postponed until Y4Q1	Postponed to Year 4 due to delays in PBF pilot implementation by MSLS.
Contribute to designing a PBF pilot evaluation approach and tools on the perspective of PBF scale-up	Postponed until Y4Q1	Postponed to Year 4 due to delays in PBF pilot implementation by MSLS.
Complete PBF implementation regulatory framework	Postponed until Y4Q1	Postponed to Year 4 due to delays in PBF pilot implementation by MSLS.
Give specific technical assistance to DPPS during PBF implementation	Postponed until Y4Q1	Postponed to Year 4 due to delays in PBF pilot implementation by MSLS.
Assist MSLS in PBF strategy pilot implementation through health care services' purchase (including HIV/AIDS)	Postponed until Y4Q1	Postponed to Year 4 due to delays in PBF pilot implementation by MSLS
<b>Activity 5: Improve the capacity of MSLS to advocate for increased domestic financial resources for HIV/AIDS</b>		
Support MSLS to train stakeholders to use OneHealth tool for advocacy	HFG supported the training of 20 key actors from MSLS on OneHealth tool in the previous quarter (May, 18-23, 2015)	Activity completed.
Support PNLS in costing HIV/AIDS strategy for the future through the OneHealth tool	HFG supported the MSLS through DPPEIS to organize a workshop on orientations to the coming PNDS (September 8-11) for 34 attendees (26 men-8 women).	Next step: <ul style="list-style-type: none"> <li>Assist DPPEIS to plan, program, and cost next PNDS.</li> </ul>
Assist MSLS to advocate to Ministry of Economy and Finance for increased HIV/AIDS domestic resources	A technical note to increase the HIV budget to 10 billion CFA was prepared by HFG, endorsed by MSLS, and transmitted to the Prime Minister.	Next steps: <ul style="list-style-type: none"> <li>Assist PNLS to plan, program, and cost next HIV strategic plan.</li> <li>Assist PNLS and DAF to write a technical note on HIV budget increase.</li> </ul>

Year 3 Q4 Planned Tasks	Year 3 Q4 Progress	Critical Assumptions/ Problems Encountered/ Follow-up Steps
<b>Activity 6: Support adoption of a policy or legal framework and implementation of task sharing and pre-service training for Option B+</b>		
Support DGS and PNLS to develop a circular note for the supervision of the implementation of task shifting in Côte d'Ivoire	Postponed until Y4Q1	
Support DGS and PNLS to develop the legal framework of medical practice for nurses and midwives to promote and facilitate the adoption of the task-sharing policy for HIV care and treatment health financing priorities	Postponed until Y4Q1	Next Step: <ul style="list-style-type: none"> <li>Support Dept. of Nursing and Midwife Care and nurses' and midwives' unions to develop a legal framework for the medical practice for nurses and midwives to promote and facilitate adoption of task-sharing policy for HIV care and treatment.</li> </ul>
Support DGS and PNLS to organize 12 meetings with 15 members of task-shifting TWG	<ul style="list-style-type: none"> <li>Review of the Biology and Treatment of Undetectable Viral Load module</li> <li>TWG meeting was organized by PNLS with HFG support to review task-shifting training manual presentations</li> </ul>	Next Step: <ul style="list-style-type: none"> <li>Support DGS and PNLS to organize TWG in task shifting.</li> </ul>
Support DGS and PNLS in advocating for the generalization of task shifting through workshops with the TWG, HRH unions, and stakeholders	Postponed until Y4Q2	
Assist DGS and PNLS to develop a task-shifting operational plan	Postponed until Y4Q2	
Assist DGS and PNLS in implementing the task-shifting operational plan	Postponed until Y4Q2	
Assist DGS and PNLS in advocating for a working (policy) document to support implementation of Option B+	Postponed until Y4Q2	
Contribute to advocacy TWG to support the government's development and adoption of joint ART/PMTCT/PEDS guidelines that are in line with the combined 2013 guidelines	Postponed until Y4Q2	
Support DGS and PNLS in M&E activities of in-service training at supported Option B+	Postponed until Y4Q2	

Year 3 Q4 Planned Tasks	Year 3 Q4 Progress	Critical Assumptions/ Problems Encountered/ Follow-up Steps
Support INFAS management team to develop training modules theme as part of task shifting in HIV care and treatment on behalf of third-year nurses and midwives	Postponed until Y4Q2	
Support INFAS management team to train clinical teachers and develop task shifting in HIV care and treatment program tools with training materials	Postponed until Y4Q2	
Support INFAS management team to organize technical meetings which involve local clinical partners involved in HIV care and treatment in each site	Postponed until Y4Q2	
Support INFAS management team to provide informatics kits to task shifting in HIV care and treatment program management	Postponed until Y4Q2	
Disseminate the policy	Postponed until Y4Q2	
Support the training session for 364 nurses and midwives from INFAS sites of Daloa and Aboisso in task shifting in HIV care and treatment	Postponed until Y4Q2	This activity has changed in approach: "Support a training session for theoretical aspects of task shifting in HIV care and treatment for 1,691 nurses and midwives."
Support a training session in theoretical aspects of task shifting in HIV care and treatment for 1,691 nurses and midwives	<ul style="list-style-type: none"> <li>• HFG supported DRH, INFAS, IGSLs, and other key actors in holding a two-day workshop (August 20-21, 2015) on how to train new civil servants (nurses and midwives) on task shifting in HIV care and treatment.</li> <li>• HFG supported INFAS by organizing a follow-up workshop</li> </ul>	<p>Next Step:</p> <ul style="list-style-type: none"> <li>• Support INFAS, DRH and PNLS to organize a training session in theoretical aspects of task shifting in HIV care and treatment for 1,691 nurses and midwives.</li> </ul>
Support PNLS, DGS, and PNLS to complete the training of at least 200 nurses and midwives in clinical training in task shifting for HIV care and treatment	Postponed until Y4Q1	<p>Next Steps:</p> <ul style="list-style-type: none"> <li>• Complete the clinical training of a least of 200 nurses and midwives in task shifting in HIV care and treatment.</li> <li>• Develop tools to monitor new nurses and midwives in task shifting in HIV care and treatment.</li> </ul>
Assist DGS and PNLS in evaluation of task-shifting operational plan	Postponed until Y4Q2	

## 5.1.7 Democratic Republic of the Congo

**Program Objectives** – The HFG project works on two distinct activities in the Democratic Republic of Congo (DRC). The first is assisting the Ministry of Public Health (Ministère de la Santé Publique, or MSP) to implement the reform process. HFG assistance is divided into three broad streams of work: support to the Secretary General’s office in coordinating the reform process, institutional strengthening of three key central directorates, and establishment of two new provincial health divisions. The second activity is to prepare the Kinshasa School of Public Health (KSPH) to qualify for direct USAID funding.

The following activity results are expected with HFG support:

9. Constituency built within MSP that supports and facilitates the MSP reform process; this will facilitate MSP efforts to improve coordination of stakeholders within the ministry.
10. Key central MSP Directorates with improved capacity to function under the decentralized system.
11. Two provincial health divisions (Divisions Provinciales de la Santé, DPS) assume new roles under the reform process.
12. KSPH with a financial management system that qualifies for direct USAID funding.

With regard to KSPH, HFG is building on the work that was done under the Health Systems 20/20 project and addressing the recommendations that were made at the end of that project including the use of an automated accounting system, the need for regular financial reporting, and increased staff capacity in the Finance Department. HFG is completing the final steps needed to bring KSPH financial management capacity into compliance with USAID requirements to receive funding directly from USAID.

**Year 3 Activities** - In Year 3, HFG initiated work on both components – support to the MSP in the reform that is currently taking place and strengthening of financial management capacity of KSPH to prepare it to be a direct recipient of USAID funding. The summaries of these activities are as follows:

**Support to MSP Reform:** The DRC has traditionally operated in a highly centralized manner with limited authorities delegated to the subnational levels. Decisions have been made exclusively by the central government authorities with provincial and local authorities primarily in the role of carrying out those decisions<sup>2</sup> with limited support from the central level. The February 18, 2006 Constitution revised in November 2011 made several profound institutional reforms including an administrative and territorial reform, based on the principles of decentralization.

13. The number of provinces increased from 11 to 25 provinces plus the city of Kinshasa, which now has provincial status.
14. The Constitution authorized the provinces greater political, administrative, financial, and economic autonomy to the subnational level.

In the health sector, this reform has significant implications. Authorities newly assigned to the provinces include hiring and management of the health workforce; development, support, and supervision of health programs consistent with the national development health plan; management of hospital, laboratory, and pharmaceutical services; promotion of primary health care services at facility and community levels; and dissemination and enforcement of health laws and regulations. Under the reform, the central MSP’s role will be concentrated on setting norms and standards, oversight, leadership, national-level planning, coordination of partners, and management of the reform process itself. These reforms are aimed at

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<sup>2</sup> La décentralisation en bref. Ministère de l’intérieur, sécurité, décentralisation et affaires coutumières.

improving access and quality of services by moving responsibility closer to the level at which these services are delivered.

In spite of limited progress toward decentralization in other sectors, MSP has been progressively moving toward establishing the new health DPS, consolidating the number of central directorates from 13 to 7, and downsizing the number of staff from 1,012 to 598.<sup>3</sup> While much conceptual work on the reform has been accomplished, much remains to be done to implement the reform, especially in the area of institutional strengthening. A number of key decisions, such as a reassignment of human resources corresponding to the needs of the new structures, are still pending. MSP is looking to engage with technical and financial partners to provide assistance in implementing the reform, building support for the reform, and developing the institutional capacity at the central and provincial levels to make the reform successful.

USAID identified three key central directorates to support in the reform process and proposed that technical assistance be provided to establish and operationalize these offices. The three directorates are the Directorate of General Services and Human Resources (*Direction des Ressources Humaines*, DSGRH), Directorate of Financial Affairs (*Direction des Affaires Financières*, DAF), and the Directorate of the Organization and Management of Health Services (*Direction de l'Organisation et de Gestion des Services des Soins de Santé*, DOGS). Although the basic attributes of these offices have been established in the “Cadre Organique,”<sup>4</sup> the operationalization of these selected offices (as well as others within the MSP) and the details of their interactions with the provincial structures have not yet been fully defined.

**Strengthening KSPH's Financial Management** – KSPH is the premier public health research institution in the DRC for training of public health professionals, many of whom become the public health leaders in the country. The core of the school is its master's programs in public health. A wide range of donors and implementing partners seek to work with KSPH in their activities, often engaging KSPH as a sub-awardee on specific projects. In addition, for many years, USAID has provided funding for scholarships to KSPH through a variety of contractual mechanisms including Health Systems 20/20, the predecessor project to HFG, and African Strategies for Health (ASH). Consistent with the objectives of USAID Forward, USAID/DRC would like to strengthen KSPH financial management capacity so that USAID can provide direct funding for scholarships to KSPH and potentially for other activities in the future. This will require strengthening KSPH's grants and financial management systems so that it meets generally accepted accounting standards and ensuring the organizational commitment by the Management Committee to strengthen its financial management systems. Health Systems 20/20 provided assistance in the area of financial management, but concluded at the end of its activity that more remained to be done in this area for KSPH to become a direct recipient of USAID funding.

**Year 3 Progress Against Objectives** - In Q2, the site office became fully functional with three staff members on board. A detailed implementation plan was developed in full consultation with USAID and MSP. These consultations resulted in repositioning some activities. A highlight of the quarter was an awareness-raising workshop for approximately 100 MSP staff to increase understanding of the reform process and build support for its implementation and a web-based survey to determine the current level and understanding of the reform process and establish a baseline against which to determine of a constituency within the MSP has been built. Despite a relatively low response rate, the survey showed a lack of understanding of the reform due in large measure to a lack of information about the reform process. Plans were also developed to conduct initial visits to the two DPS that HFG will be supporting.

In Q3, the highlights were the selection of the two DPS (Haut Katanga and Lualaba) that HFG will support and oversight of the development of Annual Operational Plans in each DPS. The operational

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<sup>3</sup> *Plan social de mise en œuvre et de la réforme administrative et managériale dans le secteur de la santé. Ministère de la santé publique.*

<sup>4</sup> *Cadre et Structures Organiques, Aout 2012, Ministère de santé publique.*

plans were a major undertaking involving 27 health zones in Haut Katanga and 14 zones in Lualaba. The plans were posted online. HFG collaborated with the Integrated Health Project (IHP or PROSANI in French), a USAID bilateral, in this activity. Another highlight was the organizational assessment of the DSGRH. In Q3, the data collection phase was completed consisting of a web-based survey, individual interviews, and focus groups.

In Q4, HFG continued work at both the central and provincial levels. At the central level, the consultants completed the assessment report of DSGRH and developed an institutional strengthening plan. The report was then sent to DSGRH for review and approval. In the interim, the plan was reviewed with DSGRH and the first intervention, a six-day combined leadership and management and team-building workshop for 25 DSGRH staff, was successfully completed. Work has not yet begun with DAF because the legal framework is not yet in place nor with the DOGS where HFG will coordinate with the French Agency for Cooperation. At the provincial level HFG organized a major effort to conduct a situation analysis in both the Lualaba and Haut-Katanga DPS, using templates approved by the central MOH. HFG funded two central MOH staff and mobilized a large local team to visit all 41 zones in the two DPS to do a SWOT analysis, collect information needed to clarify the roles of the DPS and Provincial Health Inspectorates (IPS), and lay the foundation for the development of zonal and provincial health development plans that will feed into the next National Health Development Plan.

It is important to note that HFG's assistance to the two DPS is completely in line with the processes that the MSP has developed. The involvement of central MSP and DPS staff and the use of centrally developed templates have ensured that these efforts are integrated into the overall process. Deliverables<sup>5</sup> related to the situation analysis are of paramount importance in the development of the PND 2016-2020 and as such, represents an important contribution of HFG to the strategic planning of the MSP.

Regarding KSPH, following the initial financial management assessment and the development of a detailed work plan for KSPH in Q2, HFG completed the revision of the KSPH financial management procedures manual, which is now awaiting validation by the KSPH Management Committee. HFG also conducted two workshops focused on updating the chart of accounts and harmonizing accounting support across KSPH's research projects. Eleven QuickBooks licenses were procured and financial personnel were trained in its use. The TOR for the new senior accounting manager was drafted and validated by the Management Committee and recruitment initiated. The senior accounting manager will be hired in Q1 of FY 16. An internal auditor position has also been agreed upon and will be hired by KSPH in FY 16.

Finally, in Q4, HFG enhanced its local site office staff capacity by hiring a program coordinator and initiating recruitment for an administrative assistance to support the Finance and Administration function.

**Q4 Challenges** - As HFG intensifies its work with the two DPS, it will be important to coordinate closely with other financial and technical partners to ensure maximum synergy.

Neither DPS has completed its staffing so it is not yet possible to carry out a full-fledged organizational development analysis. Only the head of the DPS and his office manager have been recruited. Vacant positions are for technical support, resource management, health information, health and safety, teaching health sciences, inspection, and control.

Low access to Internet and equipment in many DPS offices makes it difficult for HFG to provide adequate technical support, particularly during the development of the operational action plans (PAO) and online access.

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<sup>5</sup> *Rapport des états des lieux des Zones de Santé et des DPS ainsi que les Plans Provinciaux de Développement Sanitaire, PPDS des deux DPS.*

KSPH hiring of the Senior Accounting Manager was delayed due to KSPH concerns on how to pay for the new staff member. The school needed to determine how to finance the new position. The agreed upon solution is to hire a civil servant from the Ministry of Higher Education and supplement the salary with school funds.

Table 31 provides activity-specific updates.

**TABLE 31. DEMOCRATIC REPUBLIC OF CONGO ACTIVITY DETAIL**

Year 3 Q4 Planned Tasks	Year 3 Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
<b>Activity 1: Support MSP reform</b>		
<b>I: Support to Secretary General's Office</b>		
Development of detailed implementation plan	This was completed in Q2.	
Build a constituency within MSP for the reform process	The survey report was sent to the Secretary General for review.	As yet, there is no clear agreement on how to build a constituency for the reform. Most efforts to involve MSP staff occur when there is a specific issue to address such as the standardization of key structures across all ministries such as the DAF. As part of the FY 16 work planning process, HFG will follow up with the Secretary General on the recommendations on how best to keep MSP staff informed about the reform process on a regular basis.
Establish a formal coordination mechanism between MSP and the provincial ministers of health	In Q4 HFG offered advice and support to Governance and Human Resources Commissions that operate under the umbrella of the CNP-SS. HFG's contributed to the finalization of the directives for the establishment of the DPS and the IPS.	HFG will continue to offer its support through participation in the two Commissions.
Provide specific support to the implementation of the road map for the MSP reform	The CNP-SS has the lead responsibility for the implementation of the road map so this task is no longer a priority for HFG.	
Revitalize the Technical Secretariat under the umbrella of the National Steering Committee	WHO provides direct support to the Technical Secretariat. HFG's support of the Secretariat is provided through two commissions in which it participates and through specific requests. In Q4, the Secretariat requested HFG to present on coaching skills at a workshop, held in Kisantu, to train national-level coaches who will support all the DPS. HFG made this presentation and was subsequently asked to deliver a three-day workshop on coaching skills. This has yet to be scheduled.	HFG will continue to discuss with WHO and the DEP Director, who chairs the Technical Secretariat, on ways the project can support the overall reform process at the national level.

Year 3 Q4 Planned Tasks	Year 3 Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
Update the mapping of the technical and financial partners' contribution to the reform process	This task was dropped in Q3 at the request of USAID.	
<b>2: Institutional capacity building of directorates</b>		
Assess organizational capacity of DSGRH, DAF, and DOGS	The assessment was completed in Q4. The assessment team completed the draft assessment report, which HFG sent to the DSGRH Director for review and approval. The capacity-building plan recommends seven activities to be carried out by HFG: development of a DSGRH strategic plan including development of vision and values, team-building, leadership and management strengthening, assistance in putting in place the new organizational structure, training in coaching to assist the DPS in assuming the HRH role, provision of IT equipment, and training of trainers to be able to train provincial staff.	The remaining task to complete the DSGRH assessment is to finalize and disseminate the report after receiving feedback from the DSGRH Director. Pending discussions with the AFD on the respective scopes of work, HFG plans to conduct an organizational assessment of the DOGS in FY16 Q1. The organizational assessment of the DAF will depend on the final organizational framework and discussions with the World Bank, EU, and Belgian Cooperation to ensure harmonization. This could well be delayed beyond Q1
Develop plans to strengthen the institutional capacity of DRH, DAF, and DOGS	The DSGRH capacity-building plan recommends seven activities to be carried out by HFG: development of a DSGRH strategic plan including its vision and values, team-building, leadership and management strengthening, assistance in putting in place the new organizational structure, training in coaching to assist the DPS in assuming the HRH role, provision of IT equipment, and training of trainers to be able to train provincial staff.	The plan will be finalized after receiving final comments from the DSGRH. However, the plan was reviewed in outline form with the Director and is awaiting final approval.
Support the implementation of the new organizational structures of key directorates in collaboration with the Technical and Financial Partners that are involved	Two of the interventions in the DSGRH capacity-building plan were carried out in Q 4. During a six-day workshop, two Congolese consultants conducted a combined team building and leadership and management workshop for 25 DSGRH managers and supervisors. The rest of the plan will be implemented in FY 16 and be included in HFG's FY 16 work plan.	Include the rest of the interventions in the FY 16 work plan and implement them.
Strengthen management capacity of the key directorates' agents by training	See above for management training conducted in this quarter.	

Year 3 Q4 Planned Tasks	Year 3 Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
<b>Activity 2: Creation of Provincial Health Divisions (DPS)</b>		
Select the two DPS that HFG will support	The two DPS were selected in Q2.	
Develop operational plans for each DPS	<p>In Q3, HFG led the process for developing annual operating plans for both DPS (Haut-Katanga and Lualaba). At the provincial level, HFG organized a major effort to conduct a situation analysis in both the Lualaba and Haut-Katanga DPS, using templates approved by the central MOH. These plans still have to be validated by the Provincial Health Steering Committees.</p> <p>In Q4, in support of the process to develop a five-year National Health Development Plan (PNDS), HFG funded two central MOH staff and mobilized a large local team to visit all 41 zones in the two DPS to do a SWOT analysis. HFG has collected enough data that will be helpful to clarify the roles of the DPS and IPS, and lay the foundation for the development of zonal and provincial health development plans that will feed into the next PNDS.</p>	<p>The reports from the situation analysis will be finalized in FY 16 Q1. To date these two DPS are ahead of the process to design the new PNDS. Thus they will have time to polish, review, and validate the operational plans accordingly.</p>
Define roles and responsibilities of DPS and IPS in each directorate	As part of the situation analysis in the two DPS, HFG developed a questionnaire aimed at eliciting the expectations from the health zones of the respective roles and responsibilities of the DPS and IPS. This information is being analyzed and based on the findings, HFG will recommend next step in Q1.	Implement the recommendations aimed at clarifying the roles and responsibilities.
Provide organizational strengthening to each DPS	An initial organizational analysis has been conducted and data are being analyzed.	This task is constrained by the fact that a full complement of DPS staff is not yet in place.
Assist each DPS to develop start-up plans	Both DPS have insufficient staff and start-up plan cannot be initiated until this problem is resolved.	
Support the DPS in other targeted activities	Additional support will be defined in FY 16 once a full staff is in place.	HFG organizational support to the DPS is dependent on a transparent recruitment process without interference by local and provincial political leaders.

Year 3 Q4 Planned Tasks	Year 3 Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
<b>Activity 3: Strengthening Kinshasa School of Public Health (KSPH) financial management</b>		
Update the KSPH accounting and financial manual of procedures	Procedures manual was completed.	Validation by the management committee and presentation to partners (organizations that have programs/activities with KSPH).
Ensure proper accounting and financial management using an accounting software	Quickbook software was purchased and staff trained.	Upload financial data in the software and generate initial consolidated accounts.
8. Strengthen capacity of KSPH financial management team	Hiring process was initiated for the senior accounting manager.	Look for qualified candidates at the Ministry of Higher Education.
9. Monitor and evaluate the action plan	Action plan is updated on an ongoing basis.	The HFG international financial management advisor is scheduled to visit KSPH in November to take stock of progress.

## 5.1.8 Ethiopia

**Program Objectives** - With technical support from a series of USAID bilateral projects, the government of Ethiopia has been implementing a wide range of health care financing (HCF) reforms for more than a decade. The most recent project, Health Sector Financing Reform (HSFR), ended in July 2013. The project mid-term evaluation conducted in 2012 concluded that project performance in all major components was outstanding. USAID is continuing its technical support of HCF reforms in Ethiopia through HFG.

The overall objective of HSFR/HFG “bridge” support in Ethiopia is “Increased utilization of health services.” It also has the following four specific objectives:

- ▶ Improved quality health services,
- ▶ Improved access to health services,
- ▶ Improved governance of health insurance and health services, and
- ▶ Improved program learning.

HFG will continue supporting the Federal Ministry of Health (FMOH), Regional Health Bureaus (RHBs), Woreda Health Offices (WorHOs), health facilities (HFs), and other stakeholders in consolidating and expanding a wide range of first-generation HCF reforms. These include revenue retention and use (RRU) at the HF level, systematizing fee waiver and exemption systems, strengthening HF governance, establishing private wings in government hospitals, and outsourcing nonclinical services. The project also continues supporting the Ethiopia Health Insurance Agency (EHIA) on introduction of health insurance (social health insurance (SHI) for formal sector employees and community-based health insurance (CBHI) for the citizens who work in the informal sector).

The project will support expansion of these first-generation HCF reforms to new regions (Afar and Somali) and to additional HFs in Ethiopia’s other seven regions (Amhara, Benishangul-Gumuz, Gambella, Harari, Oromia, Southern Nations, Nationalities and Peoples (SNNP), and Tigray) and the two city administrations (Addis Ababa and Dire Dawa). It will also continue supporting the government at various levels in consolidating these reforms in the regions and in HFs that have been implementing these reforms, and in building the required capacity and institutionalizing these reforms in the new reform regions.

With regard to health insurance, the project will continue supporting the FMOH, the EHIA, and RHBs in initiation and implementation of SHI, covering civil servants this year and eventually all other formal sector workers. The project will continue supporting implementation of 13 pilot CBHI schemes that have been operating in the four largest regions (Amhara, Oromia, SNNP, and Tigray). A local contractor has begun an evaluation of these pilot community-based health insurance (CBHI) schemes and will identify lessons learned for scale-up. Expansion of the CBHI pilot to an additional 161 woredas in the same four regions is progressing well.

**Year 3 Activities** - In Year 2, the HFG project undertook start-up activities to generate evidence on the performance of HF governing boards for policy making, strengthening the EHIA, and building capacity of government institutions to implement HCF reforms.

In Year 3, HSFR/HFG is continuing support of the government in the four objectives specified above. A wide range of specific activities and sub-activities, described below, are planned.

**Year 3 Progress Against Objectives** - HSFR/HFG supports the government of Ethiopia in implementing a wide range of HCF reforms. Support includes consolidating gains in the implementation of first generation reforms in seven regions and two city administrations as well as expansion of the reforms to Afar and Somali regions. HSFR/HFG supports the government in successfully piloting and

evaluation of CBHI in 13 woredas and expansion of the scheme to 185 additional woredas to provide financial risk protection to citizens in the informal sector, all in the largest four regions (Amhara, Oromia, SNNP, and Tigray). The project has also supported the government's preparation towards launching of the social health insurance (SHI) program for formal sector employees and their dependents.

HFG Year 3 (HSFR Year 2) is the first year that the bilateral HSFR project fully transitioned to the HFG Project. HFG continued providing technical support to the government of Ethiopia at different levels for consolidating and expanding the first-generation HCF reforms as well as implementation of SHI and piloting of CBHI.

In HFG Year 3 (HSFR Year 2), HSFR/HFG planned to expand its technical support of the scale-up of CBHI program and preparations for SHI implementation. It intended to carry out various activities to consolidate first generation reforms in regions and health facilities; expand reform in the remaining regions (Afar and Somali); disseminate the CBHI pilot evaluation report and support development of a CBHI scale-up strategy; and carry out routine monitoring and evaluation (M&E) activities. Major project activities and accomplishments are described in the sections below, organized by project objective and sub-objective.

Major planned activities for Q4 included: Organizing basic and/or refresher training on HCF reform implementation and financial management and providing technical support on the establishment and operation of private wings in federal referral, teaching, and regional/zonal hospitals; Facilitating the endorsement of a tool/selection criteria to identify best performing health facilities (hospitals and health centers) in the CBHI pilot and pilot expansion woredas; Supporting/facilitating systematic graduation of first generation health facilities in all zones; Supporting/providing orientation/training for selected regional, zonal, and woreda cabinet members; Supporting/providing training for health providers in hospitals serving CBHI beneficiaries; Facilitating the dissemination of HCF reform and CBHI best practices through different communication channels (TV, radio, and print); Providing technical support for establishment of health facility governing boards; Providing training for the governing boards/bodies; Conducting regular consultation with the Ethiopia Health Insurance Agency (EHIA) technical and managerial staff on progress of SHI implementation; Providing technical support for the EHIA in its implementation of health insurance initiatives in the country; and conducting regular supportive supervision in health facilities (all regions) and CBHI schemes (pilot regions). Major accomplishments by objective are as follows:

**Objective I: Improved Quality of Health Services:** Advocated for the approval of structure and recruitment of critical finance staff for new health centers (Amhara, Benishangul-Gumuz, and Gambella);

- ▶ Provided in-service training for 148 health care workers (on HCF reform);
- ▶ Facilitated the endorsement of a tool/selection criteria/ to identify best performing health facilities in the CBHI pilot expansion woredas; and
- ▶ Compiled health facilities Revenue Retention and Utilization plan and facilitated approval from woreda offices and regional bureau of Finance and Economic Development (WoFED/BoFED).

**Objective II: Improved Access to Health Services**

- ▶ Facilitated the visit of Dr. Ariel Pablos-Méndez, USAID's Assistant Administrator for Global Health, to the CBHI scheme in Gimbichu woreda (Oromia region);
- ▶ Facilitated the selection of 44 additional woredas for CBHI scale-up (Amhara);
- ▶ Facilitated the approval of the structure and recruitment of CBHI executive staffs for these woredas;
- ▶ Provided technical assistance to the implementation of CBHI program (Benishangul-Gumuz);
- ▶ Provided training on CBHI program implementation for different stakeholders (SNNP); and
- ▶ Trained 81 health providers (53 men and 28 women) in Oromia region.
- ▶ The report from CBHI implementing regions indicates that 1,458,726 households (1,113,436 paying and 345,290 non-paying) enrolled in the schemes both in pilot and expansion woredas. The overall enrollment rate is 24.7 percent (44.8 percent in pilot<sup>6</sup> and 23.3 percent in expansion woredas) of eligible households. The schemes generated 197,723,050.63 Birr (42,324,974.83 in pilot and 155,398,075.80 Birr in expansion woredas) from members' contributions (i.e., excluding general and targeted subsidies). In pilot woredas, 1,454,987 visits were made in health facilities (1,256,342 in health centers and 198,645 in hospitals) from April 2011 through June 2015; and schemes reimbursed 52,474,442.29 Birr to health facilities. While in the expansion woredas, a total of 1,293,074 visits were made in health facilities (1,201,353 in health centers and 91,721 in hospitals) up to end of June 2015 and schemes reimbursed 50,660,433.36 Birr to health facilities. Though there is variation among regions, 89.4 percent of total visits both in pilot and expansion woredas were made to health centers, 10.6 percent to hospitals.

**Objective III: Improved Governance of Health Services**

- ▶ Facilitated experience sharing visit both on HCF reform implementation to USAID guests in Bishoftu hospital, organized inter-regional experience sharing visit on CBHI program;
  - ▶ Participated in the CBHI regional review meeting; and
  - ▶ Provided technical support to the EHIA in the preparation of its five-year strategic plan.
- Objective IV: Improved Program Learning**
- ▶ Supported the institutionalization of NHA VI;
  - ▶ Carried out various preparatory activities to undertake NHA VI;
  - ▶ Supported the Ethiopian Hospital Alliance for Quality (EHAQ) assessment and validation with the steering committee; and

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<sup>6</sup> [1] Fogera, South Achefer and Tehuledere (Amhara); Deder, Gimbichu, Kuyu and Limmu Kossa (Oromia); Damboya, Damot Woyde and Yirgalem (SNNP) and Ahferom, Kilte Awlalelo and Tahitay Adiabo (Tigray).

- ▶ Supported the ongoing systematic revision of user fees for teaching hospitals among others.

#### **Q4 Additional Information -**

##### ***Additional activities conducted in Q4 (not included in work plan):***

*Facilitated visit of Dr. Ariel Pablos-Méndez, USAID's Assistant Administrator for Global Health, to the CBHI scheme in Gimbichu woreda, Oromia region:* The project supported the Gimbichu woreda administration and WorHO in their preparations to showcase the achievements of their CBHI program. The project team provided technical assistance to the woreda administration and WorHO in preparing a PowerPoint presentation on the process of CBHI implementation, achievements as well as challenges. The presentation was followed by discussions on the progress of scheme, major achievements, and challenges. A photo exhibition and graphic display on major project activities and results was also opened for participants. The visit to the CBHI scheme in Gimbichu woreda took place on July 12, 2015 where H.E Dr. Kebede Worku, FMOH State Minister; Dr. Areal Pablos Mendez, USAID's Assistant Administrator for Global Health; Dr. Zelalem Habtamu, Deputy Head of Oromia RHB; Mr. Eshete Yilma, COTR at USAID Ethiopia; zone and woreda cabinet members; CBHI scheme executive staff; and community representatives drawn from all kebeles in this woreda among others participated. Dr. Zelalem pointed out that the achievements of the CBHI scheme in this woreda are remarkable and the scheme could be a model for other woredas in the region. Dr. Pablos-Mendez also made remarks, stating that the CBHI initiative is historic and it will be better when very eligible households join the scheme. He added that the scheme's achievement is unprecedented and promised that USAID will continue supporting the wider government CBHI scale-up strategy.

*Participated in the rapid external diagnostic assessment of Black Lion Comprehensive Specialized Hospital:* The Office of the State Minister at the FMOH formed a high-level leadership and technical team to conduct a rapid external diagnostic assessment in the Black Lion Teaching and Specialized Hospital and affiliated College of Health Science. The main areas of the assessment included reviewing:

- ▶ Leadership and management functions, principles, and governance structures, to document current practices and challenges and put forward recommendations.
- ▶ Components of quality of health services and factors critical to meeting national-and-beyond health care standards and implementing quality assurance and improvement systems.
- ▶ Human resource management policies and procedures and factors critical to meeting national-and-beyond management standards and implementing human resource motivation, performance appraisal, and improvement systems.
- ▶ Operations and financial management policies and procedures and factors critical to meeting national-and-beyond operational standards, finance auditing policies, standards, and practices related to operations and finance management.
- ▶ Existing infrastructure and premises in view of the national standards and expected functions of a service deliver institution, research institution, and teaching institution.

The HSFR/HFG team participated in leadership and management, and operations and finance functions. Key areas explored under leadership and management were: clarity of mission (vision) of hospital among employees, faculty and operation, organizational structure, application of leadership roles, communication strategies and mechanisms, accountability and other management principles, barriers for change management, information technology, performance M&E, policies and procedures other than those included under human resource management; and operations and financial management focused on logistics, procurement, and supply chain management. The assessment started in August 2015 and is in progress; it is expected to deliver problem-solving recommendations to upgrade quality of services rendered in Black Lion hospital.

*Provided technical support to the RHB in the preparation of second annual regional health festival in Amhara:* The Amhara RHB organized its second annual health festival. The project team served as a member of the festival organizing committee and presented the achievements of HCF reform and the CBHI program in the last five years. High-level federal and regional government officials, including Mr. Demeke Mekonnen, Vice Prime Minister, and officials from the FMOH, party leaders from all zones, woredas, and selected health facilities in the region, and other invited partners attended the festival. Achievements of the CBHI program was a particularly important discussion point; the HSFR/HFG project was awarded a certificate of recognition by the speaker of the Regional Council, H.E. Yalew Abate. The project was recognized for its active role and contribution to the successful achievement of the first GTP and meeting Millennium Development Goals regional targets. The RHB covered all the costs and more than 3000 participants attended the event.

*Participated in the RHB Health Sector GTP Performance Review Meeting in Gambella:* The project cluster office participated in two-day meeting (July 13-14, 2015) organized by the Regional Council. The objective of the meeting was to assess the performance of the first Growth and Transformation Plan (GTP1) and discuss major activities planned in the second plan (GTP2). Participants discussed the major bottlenecks observed in GTP1, their effect on the intended target, and mechanism to tackle them in GTP2. Increasing health services coverage in the region was a top priority in GTP2; strengthening the health system in general and HCF reform in particular will play a paramount role in achieving the target.

*Attended the woreda-based Planning and Core Facilitators training in Addis Ababa and SNNP:* The project team participated in the woreda-based planning organized by the Addis Ababa City Administration Health Bureau. The city administration prepared woreda-based planning for 2008 EFY in coordination with heads of the health bureau and staffs, heads of sub-city health offices and staff, medical directors of HCs, and head of core processes. The project team worked with the health bureau medical services team in identifying SWOT, bottlenecks, indicators, and major planned activities of HCF reform and health insurance (CBHI) initiatives. In **SNNP**: The project staff participated in the five-day (August 3-7) training organized by the RHB for core facilitators of five-year woreda-based annual and strategic plan, and held in the RHB meeting hall. The training was aimed at orienting core facilitators on the components of planning tools, building consensus among the parties and ensuring standardization and uniformity in the planning process, and introducing new initiatives. Participants were drawn from ZHDs and WorHOs of special woredas; the woreda-based health sector planning was expected to start in August 11, 2015.

*Supported the RHB in adopting hospital and HC linkage guidelines, Amhara:* The project team provided technical support to the Amhara RHB in adopting the hospital and HC linkage guideline, which directs hospitals on how to support HCs located in their areas both in technical and administrative issues. The draft guideline was finalized and submitted to the RHB management for endorsement.

*Participated on health sector reform program evaluation, Amhara:* The USAID/Ethiopia and the Ethiopian Economic Association organized a health sector financing reform evaluation program August 17-18, 2015 at the association's meeting hall in Addis Ababa. The project staff from Dessie and Assosa cluster offices attended the HSFR program evaluation training, which focused on HCF reform, the status of CBHI program implementation, and issues regarding CBHI scale-up.

*Provided technical support to Lalibella hospital and Lalibella HC, Amhara:* Lalibella is one of the major tourist sites in Ethiopia; travelers may be interested in learning the progress of health sector financing reform in Lalibella hospital and Lalibella HC. The project team provided technical assistance to these health facilities in preparing wall charts on HCF reform to display for visitors.

*Discussed with Assosa hospital finance staff proper documentation and utilization of retained revenue in Benishangul-Gumuz:* The project team discussed with Assosa hospital finance staff the proper documentation and utilization of retained revenue in the hospital including the management of retained

revenue in the private wing. During the discussion, the project team learned that the hospital had not done a bank reconciliation and financial audit from EFY 2003 (2010/11) though 2006 (2013/14). A financial performance audit was done only for 2007 (2014/15) and revealed inconsistencies in the figures in the ledger and bank statement. Accordingly, the team advised hospital management to do an additional financial audit for the remaining years and report the issue to the regional BoFED for action. In contrast, based on earlier discussions with hospital management, management of retained revenue for private wings/rooms was found to be on track.

*Hosted the EHIA Deputy General Director visit, and experience-sharing visit of delegates from Addis Ababa City Administration, Amhara:* Right after his participation in the second health festival held in Bahir Dar town, the Deputy General Director of the EHIA visited the regional project office and held a half-day discussion with the heads of four EHIA branch offices and project staff. The discussion focused on the performance of the CBHI program, the observed challenges, and opportunities for future improvement. The Deputy General Director suggested the project develop a concept note for him to review and submit to the Minister of Health and send back to the regional project office to facilitate its submission to regional president. The project team developed the concept note with simple explanations of the basics of CBHI indicating the performance so far with detailed areas of support needed both from federal and regional actors, and submitted it to EHIA Deputy General Director. The team also facilitated the experience-sharing visit of delegates from Addis Ababa City Administration in Kutaber (expansion woreda) and Tehuledere (pilot woreda) in South Wollo zone. During the visit, guests learned the success stories as well as program implementation challenges.

*Participated in Health Sector Partners' Forum, SNNP:* The project team attended a one-day health sector partner's forum organized by Kembata Tembaro ZHD on July 14, 2015, held in the zonal administration council conference hall. The meeting aimed at assessing ZHD performance, strengthening collaboration with different partners, minimizing duplication of efforts among partners, identifying strengths and weaknesses of the ZHD, and creating common understanding with partners. HSFR/HFG, Integrated Family Health Program (IFHP), Kembatti Mentti Gezzima-Tope (KMG), Engender Health, and World Vision were major partner organizations that attended the forum. The forum ended after electing technical team members – head of ZHD, planning and M&E process owner, KMG, and IFHP – who will meet on a quarterly or biannual basis to attain the stated objectives. A total of 25 persons (24 men and 1 woman) from the ZHD and implementing partners attended the meeting.

*Participated on EHRIG Joint Integrated Support Supervision (JISS), SNNP:* The project staff participated in the JISS and validation visit on the status of EHRIG and the Hospitals Performance Monitoring Initiative (HPMI) framework held in Adare hospital, Hawassa town, August 5-7, 2015. A team of experts from the RHB medical services core work process, HSFR/HFG project, Clinton Health Access Initiative, ICAP, IFHP, and RHBs participated in the visit. The objective of the visit was to ensure whether the hospital Key Performance Indicators and other performance data reported to the RHB were accurate and acceptable. Furthermore, the JISS aimed to identify, recognize, and learn best practices to replicate in other hospitals in the region; identify gaps, provide guidance and technical assistance to improve hospital performance; check and validate progress of HDA implementation; and identify areas where additional support from the RHB or other partners is required. The team confirmed that Adare hospital has been properly implementing EHRIG and HPMI, identified gaps, and provided technical support in areas that need improvement. It also identified strengths and weakness of the hospital in other cross-cutting issues, HDA, staff involvement and internal monitoring system, and CASH. Finally, the team presented its findings and overall feedback to hospital senior management.

*Organized a one-day consultative meeting on 2008 EFY work plan alignment:* The project team organized a consultative meeting on 2008 EFY work plan alignment on August 31, 2015 in the project regional office. The meeting aimed to create awareness on planned activities, identify priority areas, avoid duplication of effort, and reach a consensus on the approach for the implementation of planned

activities. The meeting opened with a brief presentation by the regional project director highlighting the project priority areas, cost sharing, and areas of collaboration – review meetings and supportive supervision. This was followed by discussions on the timeline of planned activities, logistics, reporting, and feedback mechanisms. The issue of cost sharing, though supported by the EHIA branch manager, was the major concern as it affects planned activities. Finally, participants reached a consensus on these issues. Two officers from the RHB MSD core process, EHIA Hawassa branch office, and the regional project director and other technical staffs attended the meeting.

*Participated in supportive supervision visit held in health facilities in Gambella:* The project cluster office participated in a one-day (September 15) supportive supervision visit organized by the RHB in Gambella hospital and Gambella HC. The supervision team assessed health facilities' 2008 EFY budget preparation, and provided technical support in identifying priority areas that should be considered during the planning process. The Gambella hospital CEO stated that the planned budget (36,296,251.00 Birr) for 2008 EFY is appropriated (32,000,000.00 Birr from government treasury and remaining 4,296,251.00 ETB from retained revenue). Preparation of the Gambella HC budget was still in progress and figures on planned and appropriated budget were not available. The team identified an excess in some budget codes and thus the need to shift some budget to priority areas so as to improve health service provision. The hospital senior management accepted the recommendation to reallocate budget for higher-priority activities and promised to start the revision soon. The team also urged Gambella HC to finalize budget preparations and submit the budget to the town administration WoFED office for approval.

Table 32 provides activity-specific updates.

**TABLE 32. ETHIOPIA ACTIVITY DETAIL**

Year 3 Q4 Planned Tasks	Year 3 Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
<b>Activity 1: Improve quality of health services</b>		
Provide training on HCF reform implementation	<b>Oromia:</b> The project team in collaboration with the Oromia RHB provided basic training on HCF reform implementation on September 2-3, 2015 in Bishoftu Town. Trainees were drawn from four newly functional hospitals – Gundo Meskel (North Shoa), Kakie (Kelem Wellega), Bele Gesgar (Arsi), and Darimu (Ilubabara) – and respective ZHDs. The training topics included: basic health reforms such as HCF, Business Processing Reengineering (BPR), Balanced Score Card (BSC), and Health Development Army (HDA); 148 persons (142 men and 6 women) – hospital CEOs, hospitals department staff, and ZHD staff – attended the training. The project staff made presentation on basic concepts of HCF reform, six components of reform and progress to date. This was followed by discussions on the presentation and observed implementation challenges. The RHB and other stakeholders covered the training costs.	

Year 3 Q4 Planned Tasks	Year 3 Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
Support RRU planning and budgeting process	<p><b>Amhara:</b> Ongoing from the previous quarter, the project team provided technical assistance to the RHB and BoFED on the preparation and submission of health facilities' RRU plans and their appropriation by the regional council. Currently, the regional council endorses facilities' RRU plans.</p> <p>The team also discussed with the RHB curative process staff the 2008 EFY indicative plan for HCF-related activities and the RHB staff agreed to find a supplementary budget for these activities from other alternative sources.</p> <p><b>Benishangul-Gumuz:</b> The project team discussed with BoFED the need to allocate a government budget for new health facilities expected to begin HCF reform implementation in 2008 EFY. Accordingly, the regional BoFED allocated a budget to the RHB to facilitate the implementation of HCF reform, and facilitated the appropriation of 30,071,113 Birr from retained revenue for 2008 EFY. The team also discussed proper utilization of health facilities' retained revenue with the regional BoFED and RHB. The two bureaus promised to release an official letter to the WorHOs and health facilities to encourage utilization of retained revenue without violating HCF reform implementation directives.</p>	<p>At the beginning of each fiscal year, BoFED and WoFED offices used to appropriate a budget for health facilities (hospitals and HCs). Now, however, these offices need data on planned RRU from each facility. The project team facilitated collection and submission of the data to the respective BoFED, WoFED, and ZoFED office. Accordingly, the project team facilitated the appropriation of planned RRU in Amhara and Benishangul-Gumuz regions.</p>

#### Objective 1.1: Increased availability of operational budget at the point of service delivery

Advocate for the approval of structure and recruitment of critical finance staff	<p>Project central and regional teams did advocacy on various issues to government officials at the regional, zonal, and woreda levels. These included identifying and providing the names and number of health facilities intending to kick off reform during 2015/16, which in turn helped to determine the desired number and type of key financial staff for facilities initiating the reform.</p> <p><b>Amhara:</b> The project team carried out various advocacy activities to government officials at all levels (region, zone, and woreda) on the approval of structure and recruitment of critical finance staff for new health facilities implementing HCF reform. High turnover of trained facility staff is reported as one of the major challenges of HCF reform implementation. Zonal health departments (ZHDs), woreda health offices (WorHOs) and health facilities made frequent telephone calls to the regional project office seeking clarification on HCF reform components such as RRU. Most health facilities made calls as the reporting period was a planning time for Ethiopia fiscal year (EFY) 2008 (2015/16). The project staff provided technical guidance to the health facilities on proper planning and utilization of retained revenue. It also provided technical support to ZHDs and WorHOs by telephone on budget allocation and recruitment of key finance</p>	
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Year 3 Q4 Planned Tasks	Year 3 Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
	<p>staff to the new HCs implementing HCF reform. It is expected that 15 new HCs will start implementation of HCF reform in the region.</p> <p><b>Benishangul-Gumuz:</b> Ongoing from the previous quarter, the project team provided technical support to WorHOs and health facilities on the need to allocate a budget for new HCs, and fill vacant key finance staff positions at the new HCs. The team made presentations during woreda-based planning held from July 23-August 7, 2015 at the Assosa Red Cross Association meeting hall highlighting issues related to RRU as well as quality of health service provision that were critical in the planning and budgeting process.</p> <p>Gambella: The project cluster office held a half-day meeting with RHB on July 20, 2015 and discussed the implementation of HCF reform in the region. All the RHB management staff and technical team from the FMOH participated in the discussion. The RHB commended the role of the HSFR/HFG project for its technical support. The RHB's curative and rehabilitative core process owner promised to strengthen full-fledged implementation of HCF reform so as to improve quality of health care services in the region.</p>	
<b>Activity 2: Improve access to health services</b>		
Follow up on CBHI orientation/training of health care providers at HC level	<p><b>Oromia:</b> The project team in collaboration with East Shoa ZHD and Dugda WorHO provided an orientation for health providers from Batu Hospital on September 4, 2015. The orientation aimed to create awareness of CBHI program implementation for hospital staff and enable them to understand their responsibilities in providing quality health services for CBHI beneficiaries. The orientation covered basic concepts of CBHI, CBHI Financial and Administrative Management System (FAMS), and reporting procedures. The presentation was followed by discussion on the way forward. A total of 81 health providers (53 men and 28 women) attended the orientation.</p>	
Support institutionalization of transparent financial management in CBHI schemes through auditing of CBHI scheme	<p><b>Amhara:</b> The project team in collaboration with the RHB facilitated closing of CBHI scheme accounts and auditing of schemes. In order to see the financial health of the scheme, all accounts must be closed at the end of each budget year. Since July 2014, 30 out of 67 schemes (44.8 percent) have closed their accounts and the remaining 37 schemes (55.2 percent) are in the process of doing so.</p> <p>WoFED auditors have been auditing CBHI schemes and the project team has provided orientations to CBHI FAMS. Six schemes (Antsokia Gemiza, Mida</p>	

Year 3 Q4 Planned Tasks	Year 3 Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
	<p>Woremo, Kelela, Wadla, Hulet Eju Enessie, and Mecha) have already been audited and five (Guangua, Borena, Alefa, Farta, and Kombolcha town) are in the process of doing so. The audit findings are submitted to the general assembly for approval and to schemes and woreda administrations for follow-up action. Schemes that received the audit report are trying to enforce the woreda administration facilitating back payment of misused money from kebele cashiers.</p> <p><b>SNNP:</b> The project team facilitated the finalization of the financial audit of Damot Woyde woreda pilot scheme. Though it took a long time, the audit was successfully completed and the audit report was submitted to woreda administration and other stakeholders. A total of five WoFED auditors were involved in the financial audit of the scheme and kebeles and covered 25 kebele/CBHI sections. The project's technical support consisted of an orientation of the auditors to overall CBHI activities and close follow-up of the audit process until its finalization. It also provided financial support, covering a portion of the auditors' per diem.</p> <p>In addition, the project produced summary findings of the financial audit of pilot woredas and submitted the report to the RHB for follow-up. It also facilitated the issuance of a letter by the RHB to the woreda/ town administration encouraging them to take proper action to rectify the observed discrepancies.</p>	
<p>Provide training on CBHI financial, administration and management systems; and M&amp;E to CBHI executive staff in the scale-up woredas</p>	<p><b>Oromia:</b> The Oromia regional government planned to scale up the CBHI program in one urban setting, Batu town. The project team in collaboration with the RHB provided an orientation to eight town cabinet members on August 14, 2015. It covered basic concepts of CBHI, design parameters, and the CBHI legal framework. The participants thoroughly discussed the concepts of CBHI and implementation procedures. At the end of the discussion, a consensus was reached to undertake necessary preparatory activities so as to commence CBHI program implementation in the current (2008) EFY.</p> <p><b>Benishangul-Gumuz:</b> In response to the RHB request, the project team provided technical support to initiate CBHI in the region. The team advised the RHB to wait for the approval of the CBHI scale-up strategy. The project discussed with the head of RHB selection criteria of CBHI pilot woredas in the region, and status of health facilities in the selected woredas. The RHB selected three woredas for implementing the CBHI program; however, the project team advised them to reduce the number of woredas to two due to management issues (resource mobilization and low quality of health care service provision) in one woreda.</p>	

Year 3 Q4 Planned Tasks	Year 3 Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
	<p>The project team agreed to facilitate the finalization and submission of CBHI implementation directive for approval by regional council.</p> <p><b>SNNP:</b> HSFR/HFG in collaboration with the RHB and EHIA provided two-day training on CBHI program implementation to different stakeholders in the region. The objective of the training was to impart knowledge on basic concepts of health insurance in general and CBHI program in particular, the regional CBHI directive, and the CBHI financial management system. The training program was held in Butajira, Yirgalem, Mizan Aman, and Wolayta towns. Trainees were from zonal and woreda administrations, ZHDs, WorHOs, HCs, and CBHI schemes. A total of 710 persons (637 men and 73 women) attended the training. While the project office provided technical support by presenting the trainings, the associated training cost was fully covered by EHIA branch offices.</p>	
Provide training for kebele executive positions in the CBHI expansion woredas		The exact number of additional woredas implementing the CBHI program in the upcoming fiscal year is not yet decided; however, the project has been facilitating the approval of structure and recruitment of CBHI executive staff for expansion woredas by the regional Civil Service Bureau. The request was submitted and the approval process is progress.
<b>Objective 2.1: Coverage of CBHI and SHI increased</b>		
Support and follow up the establishment of CBHI schemes	<p><b>Amhara:</b> The RHB requested zones to prepare and submit a list of additional woredas intending to implement the CBHI program in 2008 EFY. Accordingly, many zones submitted the list of additional woredas. However, the project office advised the RHB to not further increase the number of woredas for several reasons: First, eight of the new woredas are town administrations – with very small risk pooling and greater challenge for the success of CBHI program. Second, eastern parts of Amhara region (Wag Himra, North Wollo, Oromo, South Wollo, and North Shoa zones) are in a severe drought. Finally, the endorsement of CBHI scale-up strategy should be done first. Of the proposed new woredas to implement the CBHI program, only one (Berehet, North Shoa zone) officially reported postponing the implementation of the CBHI program. Currently, 44 new woredas are intending to implement CBHI; however, the number of new CBHI woredas is expected to be less than this ambitious list because of different practical challenges.</p>	

Year 3 Q4 Planned Tasks	Year 3 Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
	<p><b>SNNP:</b> During the reporting quarter, the project team closely followed the performance of all 47 CBHI pilot expansion woredas in the region. The team collected data on members' registration, contribution collection, ID card preparation, and allocation of targeted subsidy from each woreda. It also provided technical support in these areas and other preparatory activities to expansion woredas. Scheme performance varied among woredas and zones. Furthermore, only few woredas met the required minimum enrollment rate (30 percent); others are working hard to attain the minimum requirement. The prevalence of drought has contributed to the low level of CBHI enrollment rate in some woredas.</p>	
<p>Enrollment and premium collection in the CBHI pilot woredas</p>	<p>A total of 174,638 HHs (145,168 paying and 29,240 non-paying HHs) have joined pilot schemes so far (from April 2011 through Sept 2015). Of these, 99,940 HHs renewed membership from April 2011–September 2015. During the reporting quarter, 3,713 HHs (2,670 in Damot Woyde; 388 in Yirgalem, 326 in Damboya, 318 Tahitay Adiabo, and 11 in Ahferom) renewed their membership; only 52 HHs (44 in Tahitay Adiabo and 8 in Ahferom) joined the schemes for the first time. The schemes have generated 42,324,974.83 Birr from member contributions so far; of this, 493,489.14 Birr was generated during the reporting quarter. The average HHs enrollment rate in the reporting quarter declined from 45.9 percent to 44.8 percent after an adjustment was made in the number of eligible HHs based on July 2015 population estimates. The highest enrollment rate is still reported in Tehuledere (83.4 percent) followed by Gimbichu (61.8 percent), Kilte Awlaelo (64.7 percent) and Tahitay Adiabo (52.9 percent).</p> <p><b>Amhara:</b> The schemes enrolled 52,930 HHs (46,471 paying and 6,459 non-paying) from April 2011 through June 2015. The schemes didn't report new HHs enrollments and membership renewals for the reporting quarter. As a result, they didn't generate funds from members' contribution. The average enrollment rate in the region is 47.5 percent, the highest being in Tehuledere (83.4 percent) and the lowest in Fogera (31.2 percent).</p> <p><b>Oromia:</b> As in the Amhara region, the schemes didn't report new HHs enrollment and membership renewal during the reporting quarter. Through the end of June 2015, the pilot schemes have enrolled 56,835 HHs (43,900 paying and 12,935 non-paying) and generated 13,038,311.00 Birr. The regional enrollment rate is 39.7 percent of eligible HHs, the highest being 61.8 percent in Gimbichu.</p> <p><b>SNNP:</b> The pilot schemes in this region enrolled</p>	<p>Enrollment of new HHs as well as membership renewal in all pilot woredas is insignificant as recruitment of new members and revitalization of existing members took place after the harvest season (December–February each year). Only few schemes (in SNNP and Tigray) generate funds from newly enrolled HHs and membership renewal; however, this figure is not that high.</p>

Year 3 Q4 Planned Tasks	Year 3 Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
	<p>21,667 HHs (20,252 paying and 1,425 non-paying) and generated 5,043,795.51 Birr from April 2011 through June 2015. A total of 3,384 HHs (2,670 in Damot Woyde, 388 in Yirgalem, and 326 in Damboya) renewed membership; and generated 443,197.14 Birr during the reporting quarter. The overall HH enrollment rate in the region is 43.2 percent, the highest being in Damboya (43.8 percent).</p> <p>Tigray: Fifty-two new HHs (44 in Tahitay Adiabo and 8 in Ahferom) enrolled in the schemes, and 329 HHs (318 in Tahitay Adiabo and 11 in Ahferom) renewed membership. The schemes generated 50,292 Birr from newly enrolled HHs and membership renewal. In total, the schemes mobilized 7,583,990.00 Birr from April 2011 through September 2015. The total HH enrollment rate in the region is 50.7 percent, the highest being recorded in Kilte Awlalelo (64.7 percent).</p>	
Provision of health care services in the pilot woredas	<p>From April 2011 through September 2015, 1,454,987 visits (1,256,332 in HCs and 198,655 in hospitals) were made in health facilities that signed a contract agreement with pilot woredas. Of these, 114,114 visits were made April–June 2015. Nearly 86 percent of the visits (103,676) were made to HCs and 14 percent (10,438) were made to hospitals (Table 8). The schemes have reimbursed 52,474,442.29 Birr to the health facilities since April 2011; of this amount, 4,978,758.56 Birr were reimbursed in April–June 2015.</p> <p><b>Amhara:</b> CBHI beneficiaries in the pilot woredas have made a total of 675,883 visits to contracted health facilities (628,538 in HCs and 47,345 in hospitals) so far (April 2011 through September 2015). Of these, 75,772 visits (72,467 in HCs and 3,305 in hospitals) were made during the reporting quarter. The schemes have reimbursed 23,160,641.28 Birr so far, 2,957,524.43 Birr during the reporting quarter.</p> <p><b>Oromia:</b> In the reporting quarter, a total of 12,662 visits were made to health facilities (10,983 in HCs and 1,679 in hospitals) and schemes reimbursed 587,017.25 Birr to the facilities. Since the CBHI schemes started providing protection in April 2011, 229,701 visits have been made (144,314 in HCs and 85,387 in hospitals) and contracted health facilities have been reimbursed 9,383,388.25 Birr.</p> <p><b>SNNP:</b> From July through September 2015, 6,992 visits (4,522 in HCs and 2,470 in hospitals) were made to health facilities, and 2,372,496.60 Birr was reimbursed. Overall, 292,961 visits (260,649 in HCs and 32,312 in hospitals) have been made to health facilities since April 2011 and 8,360,808.86 Birr have been reimbursed.</p> <p>Tigray: In the reporting quarter, 18,688 visits were</p>	

Year 3 Q4 Planned Tasks	Year 3 Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
	made to health facilities (15,704 in HCs and 2,984 in hospitals). Facilities received a reimbursement of 1,061,722.28 Birr from the three pilot schemes during the reporting quarter. From April 2011 through September 2015, a total of 256,432 visits were made in health facilities (222,831 in HCs and 33,601 in hospitals) and schemes reimbursed 11,569,603.90 Birr for services provided.	
Enrolled households in the CBHI schemes in the expansion woredas	<p><b>Amhara:</b> Currently 49 woredas (76.6 percent) of expansion woredas have established scheme; the remaining 15 woredas are in the process of doing so. The number of eligible HHs in Amhara's 64 expansion woredas increased from 1,177,325 to 2,026,501. Of these, 658,540 (32.5 percent) are enrolled in the CBHI schemes. The highest enrollment rate was reported in South Wollo (43.6 percent) and Oromia zones (41.2 percent each) followed by West Gojjam (37.4 percent) and East Gojjam (34.5 percent). A total of 2,729 new HHs (1,626 in North Gondar, 449 in South Wollo, 290 in Wag Himra, 288 in North Wollo, 53 in Oromia, and 23 in Awi) joined the schemes during the reporting quarter. Only 969 HHs (48 in Sekota town, 757 in Raya Kobo, and 164 in Dangila) renewed membership in the quarter. The schemes have generated 95,366,303 Birr since beginning of Year I and of this 455,297 Birr were generated during the reporting quarter.</p> <p><b>Oromia:</b> The 59 expansion schemes (those officially established and in process) enrolled 418,580 HHs<sup>[1]</sup> (235,224 paying and 183,356 non-paying HHs) for a total HHs enrollment rate in the region of 22.6 percent. The schemes have generated 44,417,353.00 Birr from paying HHs. So far, 26<sup>[2]</sup> officially established CBHI schemes. However, all 59 schemes reported the number of paying and non-paying households. The total HHs enrollment rate was reported as 22.6 percent; North Shoa (41.7 percent), Finfine Special zone (32.7 percent), and West Arsi (24.3 percent) showed the highest enrollment rate. As in other regions, upward adjustment of the number of CBHI-eligible HHs – in pilot and expansion woredas based on updated population projection/estimates has decreased the HHs enrollment rate.</p> <p><b>SNNP:</b> All 47 expansion woredas, located in seven zones and one special woreda, established schemes last year. The schemes reported that 153,260 HHs (131,578 paying and 21,682 non-paying) joined a scheme in their woreda for an average HHs enrollment rate of 12.5 percent. However, HHs enrollment rate showed variation among the CBHI expansion woredas. The highest average rate was reported in Siltie zone (24.2 percent) followed by Guraghie (21.3 percent) and</p>	Towards the end of each fiscal year, regional and woreda governments prepare a work plan for the coming year; for this year's exercise, they used projected population figures updated in July 2015. The HSFR/HFG project also used the population projections to revise the estimated number of CBHI-eligible households (HHs), which impacted HH enrollment figures.

Year 3 Q4 Planned Tasks	Year 3 Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
	<p>Wolayta (16.1 percent). In terms of specific woredas, the highest enrollment rate was reported in Alcho Wurriro (53 percent), Siltie zone; followed by Halaba special woreda (40.3 percent); and Mareko (31 percent), Guraghie zone. The schemes generated 12,818,211.80 Birr from registration fee and contribution.</p> <p>Tigray: Though the number of HHs enrolled in the schemes varied by woreda, all 15 expansion woredas started registration and premium collection. The highest average enrollment rate was reported in West Tigray zone (28 percent) followed by South Tigray zone (24.7 percent) and N.W Tigray zone (17.2 percent)—the regional average being 13.5 percent. This is below the minimum enrollment rate (40 percent) determined by the regional government. With the exception of Naeder Adet and Tahtay Maychew (<b>Central</b> Tigray), the remaining expansion woredas (13) selected indigents and processed allocation of the targeted subsidy for this segment of the population. The expansion schemes have enrolled 53,760 HHs (27,233 paying and 26,527 non-paying) and generated 2,796,208 Birr. As the numbers indicate, the number of paying and non-paying HHs enrolled in the schemes are about the same; this shows there is a need to conduct strong community sensitization and awareness creation to increase the number of paying HHs and make the scheme financially sustainable.</p> <p>[1] Due to the observed double counting and reporting by schemes, the figures (# HHs enrolled and amount of contribution collected) in this report are much lower than figures reported in the annual report.</p> <p>[2] Twelve schemes during fourth quarter of EFY 2006 (2013/14) and the remaining 14 schemes during first quarter of 2007 (2014/15)</p>	
Health service utilization by CBHI expansion schemes beneficiaries	<p><b>Amhara:</b> Forty-nine schemes in the region reported that beneficiaries have made a total of 1,108,518 visits (1,026,174 in HCs and 82,344 in hospitals percent) since April 2014 and the schemes have reimbursed the facilities 45,360,725.50 Birr up to end of June 2015. Fourteen of the 49 schemes started covering health care services for members between April and June 2015; and forty-nine schemes reimbursed 13,521,837.42 Birr to the health facilities in the last quarter (April—June 2015).</p> <p><b>Oromia:</b> In the 59 CBHI expansion woredas, 34 schemes have been providing benefits to their members. So far, a total of 184,556 visits have been made in health facilities (175,179 in HCs and 9,377 in hospitals). Of these, 103,285 visits (100,023 in HCs and</p>	

Year 3 Q4 Planned Tasks	Year 3 Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
	3,262 in hospitals) were made in April-June 2015; and reimbursed (5,299,709 Birr) to the health facilities through the end of June 2015. Of this amount, only 15 schemes reported as they reimbursed 1,610,293 Birr in the reporting quarter.	
<b>Objective 2.3: Resource mobilization for the health insurance scheme increased</b>		
Follow up the transfer of targeted subsidy both for the existing pilot and expansion woredas	<p><b>Amhara:</b> The RHB disbursed the general subsidy released from the EHIA to CBHI implementing woredas. Fifty-six woredas received 11,867,251 Birr as general subsidy, while 11 (Mirab Armachiho, Tach Armachiho, Dembia, Gondar Zuria, Takusa, Ebinat, Sekota Zuria, Kombolcha town, Bati, Mehal Saynt, and Minjar Shenkora) didn't receive the general subsidy due to late commencement of health service provision.</p> <p><b>SNNP:</b> The project team facilitated the release of general subsidy (344,954.00 Birr) to the three pilot woredas. The scheme in Yirgalem received 48,451.00 Birr, Damboya 138,650.00 Birr, and Damot Woyde 157,852.00 Birr.</p>	
<b>Objective 2.4: Communication and mass media coverage on health insurance enhanced</b>		
Facilitate the dissemination of HCF reform and CBHI best practices through communication channels (TV, radio, etc.)	<p><b>Central:</b> The central communication team provided technical support to the EHIA and Organization for Social Science Research in Eastern and Southern Africa (OSSREA) in the production of a documentary film on the CBHI program. The project team provided technical support in the film's preparation: interviewing beneficiaries and key informants, selecting areas for filming, directing, and writing scripts. Footage was taken in four CBHI woredas: Adea, an expansion woreda in Oromia; Damboya, a pilot woreda in SNNP; Dawa Chefa, an expansion woreda in Amhara; and Kilte Awlalelo, a pilot woreda in Tigray. The documentary has been completed and is ready for review and comment by appropriate bodies. The production of the documentary was financed by OSSREA, and the broadcasting cost will be covered by the EHIA.</p>	
<b>Objective 2.5: Management of exempted programs expanded</b>		
<b>Activity 3: Improve governance of health services and health insurance</b>		
Conduct experience sharing and review meeting among CBHI schemes and with HFs, and facilitate visits to CBHI pilot woredas	<p><b>Oromia:</b> As per the request from the USAID/Ethiopia office, the project regional and central teams facilitated the visit of USAID guests to Bishoftu hospital. The visit aimed to design a curriculum on HCF reform for MBA graduate students. The guests – Mr. Petros Faltamo, ATOR at USAID Ethiopia; Ziv Katalan, Managing Director of Global Initiatives, Operations and Information Management Department at Wharton University of Pennsylvania; Nicole Schiegg, Senior Vice President of Social Change Communications at</p>	

Year 3 Q4 Planned Tasks	Year 3 Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
	FENTON in Washington, DC – made the visit on August 19, 2015. They visited each department in the hospital, and discussed the implementation of HCF reform with hospital officials and experts. The project team provided technical support to Bishoftu hospital in compiling a data set on the status of HCF reform (RRU, fee waivers, private wing/room) from 1998 to 2007 EFY and preparing a PowerPoint presentation on the progress of the reform. At the end of the visit, it was announced that 40 MBA students from the United States will visit Ethiopia in March 2016 to share best experiences with Bishoftu hospital.	

### Objective 3.2: Networking of health insurance schemes and facility boards increased

Support_organize regional-level CBHI annual review meeting_networking in collaboration with the RHBs	<p><b>Amhara:</b> The Amhara RHB organized a one-day CBHI regional performance review meeting in Bahir Dar town in July 2015. The meeting aimed to assess annual performance of CBHI schemes in terms of strengths and problems. Participants were zonal curative and rehabilitative core process officers and zonal and woreda CBHI executive staff, and health facilities that had signed contracts with schemes. The head of the Office of the Regional President and the deputy head of the RHB participated in the meeting. The RHB head and a curative and rehabilitative core process owner led the meeting. The project regional team presented its annual performance report. Subsequently, two schemes – one weak and one best performing – presented their annual performance reports. This was followed by discussion that brought to the attention of decision makers CBHI-related issues such as limited ownership of the program by political leaders and health sector, the need to revise career structure for CBHI executive staff, professional development opportunities, absence of an operational budget for CBHI schemes, and poor quality of health care. The officials acknowledged the problems and promised to regularly monitor the performance of schemes. Senior staff from the RHB and President's Office promised to work to improve the career structure CBHI executive staff so as to reduce staff turnover. Other issues, such as the need to cover transport cost of kebele cashiers, await endorsement of the CBHI scale up strategy. The officials also pointed out that zone and woreda administrative and health structures need to strengthen their own reporting channels. The head of the RHB promised to take delays and CBHI-related fraud incidents to the Justice Bureau in an attempt to get the contributions back to the schemes. A total of 108 persons (92 men and 17 women) attended the meeting; and the RHB covered the meeting costs. Subsequently, the RHB released letters to the Justice Bureau to get legal support to facilitate repayment of</p>	
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Year 3 Q4 Planned Tasks	Year 3 Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
	contribution by kebeles to schemes and to zone administrations to schedule membership renewal and new enrollment from December to January each year.	
Organize interregional experience-sharing visit	<p><b>Central:</b> The central health insurance team in collaboration with Amhara and SNNP regional project offices organized an inter-regional experience sharing visit to the Addis Ababa City Administration technical working group (TWG) established to facilitate implementation of the city's CBHI program. The objective of the visit was to enable visitors to share best practices, learn implementation challenges from pilot and expansion schemes, and identify issues that might apply in implementing CBHI in the city administration. Prior to the visit, the project health insurance team organized a half-day training for the TWG members to give awareness on concepts, principles, and basic features of CBHI; provisions of the directive; progress to date; and current status of implementation. At the end of the training, participants raised a number of issues and the project team provided explanations. The TWG was composed of officials from Addis Ababa Health Bureau, Addis Ababa Finance Bureau, Addis Ababa Mayor's Office, and Addis Ababa Civil Service Bureau. The Addis Ababa EHIA branch manager, EHIA Provider Affairs Directorate Director, experts from the Health Bureau, and project staff also participated in the visit. Visitors were divided into two groups. The first group travelled to Gimbichu, a pilot woreda in Oromia, and Yirgalem, a pilot woreda in SNNP, while the second group went to Kuta Ber, an expansion woreda, and Tehuledere, a pilot woreda, both in Amhara. Gimbichu, Kuta Ber, and Tehuledere woredas were selected for their exemplary performance, Yirgalem for its urban setting and similarity to Addis Ababa City Administration. The scheme coordinators presented the performance and challenge of their respective schemes including issues such as CBHI structure and staff size. During the field visits the TWG members had discussions with scheme executive staffs, kebele administrators, health service providers, and beneficiaries about the impact of CBHI program. At the end of visit, TWG members forwarded comments and suggestion and reflected that the training helped them to understand more about CBHI activities during the visit. The HSFR/HFG project covered per diem and lodging costs of the TWG members.</p>	
<b>Objective 3.3: Capacity of health insurance agency improved</b>		
Conduct regular consultation with the EHIA technical and	<p><b>Central:</b> Provided day-to-day technical support to the EHIA through its seconded staff and its central health insurance staff. It also provided technical support to</p>	

Year 3 Q4 Planned Tasks	Year 3 Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
managerial staff on progress of SHI implementation	the EHIA during the agency's annual review meeting, held in Adama town on August 15-16, 2015; there, agency staff reviewed the 2014/15 annual performance report and 2015/16 annual work plan. The project team provided explanations for issues raised during the discussion, and provided feedback and inputs on both the performance report and work plan. The team also took care of the printing and distribution of communication materials and supported the EHIA in the production of a health insurance brochure targeted to non-governmental organizations, and the EHIA quarterly newsletter.	
Supported the EHIA in preparing periodic reports to parliament, MOFED, FMOH, and Board	<p><b>Central:</b> The project through its seconded staff supported the EHIA in the consolidation of its 2014/15 annual report, in both narrative and BSC formats, for submission to the parliament and FMOH. It also supported the agency in the preparation of its 2015/16 program budget, action plan, and annual plan using BSC as a tool.</p> <p><b>Central:</b> Through its seconded staff, the project supported the EHIA in drafting a five-year strategic plan. The planning team was composed of eight people, four from the EHIA and four from HSFR/HFG, who spent one week (August 25-September 1, 2015) preparing the draft. Initially, the planning team discussed and agreed on the areas to be covered in the plan and identified major areas using the BSC tool. The draft strategic plan was presented to EHIA management, which provided overall guidance, for comments and suggestions. The strategic plan document has four chapters: <i>introduction</i> (discusses health financing in general and health insurance legal frameworks, including the status of SHI and CBHI implementation, in particular); <i>situational analysis</i> (SWOT analysis, stakeholders analysis, mission, vision, and core values); <i>health insurance strategy</i> (customer value propositions, strategic theme and results, and strategic perspectives); and <i>health insurance strategic goals</i> (objective commentary, strategic map, costing, and financing and implementation arrangements). In addition to preparing a detailed five-year strategic plan, the team projected SHI and CBHI revenue and expenditure for the next five years, figures that will be incorporated into the FMOH Health Sector Transformation Plan (HSTP) and financial requirements of the EHIA over the next five years. The projections took into consideration the proposed CBHI and SHI phased scale-up plans under different scenarios. The EHIA also facilitated orientation training on costing procedures of the strategic plan. The project provided working space, and covered costs for refreshments and meal of EHIA staff. Currently, the five-year strategic</p>	

Year 3 Q4 Planned Tasks	Year 3 Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
	plan is with the EHIA.	
<b>Activity 4: Improve program learning</b>		
Conduct Assessment on the Progress of Pilot CBHI Implementation in Expansion Woredas of Oromia	<p><b>Oromia:</b> Ongoing from the previous quarter, the project team in collaboration with the RHB conducted a quick assessment of the capitation payment mechanism in Adea woreda, one of the expansion woredas in the region. The quick assessment aimed to examine whether the proportion of scheme revenue allocated to HCs through the capitation mechanism (30 percent) is adequate to provide services for CBHI beneficiaries, and generate information that serves as an input to revise the CBHI regional directive. Accordingly, the assessment team conducted data collection August 18-21, 2015, in both pilot and expansion woredas. The data on health services utilization and reimbursement generated from the pilot woredas of Gimbichu and Limmu Kossa was used to compare the proportion of patients served in HCs and hospitals as well as the cost per CBHI beneficiary both in the pilot and expansion woredas. The findings indicate that 98 and 46 percent of CBHI beneficiaries were served in HCs in Gimbichu and Limmu Kossa, respectively, for an average 66 percent of beneficiaries served in HCs; the remaining 34 percent were served in hospitals in the pilot woredas. The capitation amount for expansion woredas is calculated as the number of beneficiaries multiplied by the average cost per person per year (10.69 Birr). The average expenditure per person per year at the contracted HC in Adea woreda (37.39 Birr) is higher than in Gimbichu (29.02 Birr) and Limmu Kossa ((24.81 Birr). Similarly, the average expenditure per person per year at the contracted hospital for Adea woreda (645.55 Birr) is much higher than in the hospital for Gimbichu (268.24 Birr). Hence, the proportional allocation of scheme revenue to the hospitals and HCs in expansion woredas (70:30) seems to favor hospitals and there is a need to increase the proportional allocation of scheme revenue to HCs in expansion woredas to a minimum threshold.</p>	
<b>Conduct study on performance of HFgoverning boards</b>		
<b>Objective 4.1: Availability of evidence for decision making including routine financial and beneficiary data improved</b>		
Compile, analyze and report data on the status of HCF reform implementation in health facilities	<p><b>Addis Ababa:</b> The project team collected data on the status of HCF reform implementation from hospitals and sub-cities; prepared report on the status of HCF reform implementation in hospitals; and encoded data on the status of HCF reform in HCs. Of 10 sub-cities, three (30 percent) did not submit the required data during the reporting quarter.</p>	

Year 3 Q4 Planned Tasks	Year 3 Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
<b>Objective 4.2: National health accounts and other surveys conducted</b>		
Support the FMOH in producing Health Accounts	<p>Supported the institutionalization of NHA: <b>Central:</b> The HSFR/HFG project prepared and submitted the NHA institutionalization to the Federal Ministry of Health (FMOH). The latter drafted a terms of reference (TOR) to establish a Health Economics-Finance Case Team under the FMOH Resource Mobilization Directorate. The project team commented on the TOR; the draft was further refined, and then circulated to the NHA VI TWG.</p> <p>Prepared concept note for conducting NHA VI: <b>Central:</b> Ongoing from last quarter, the NHA VI TWG discussed the draft concept note, incorporated comments as appropriate, and submitted the note to the Joint Core Coordinating Committee through the Resource Mobilization Directorate.</p> <p>Identified National Technical Working Group and established Steering Committee for NHA VI: The project team provided technical support to the FMOH Resource Mobilization Directorate to identify institutions whose staff could serve as members of National TWG for the NHA VI exercise. The FMOH, HSFR/HFG, Federal HIV/AIDS Prevention and Control Office (FHAPCO), UNICEF, and the World Health Organization (WHO) were selected. The NHA VI TWG has 12 members: six from the FMOH, three from HSFR/HFG, and one each from FHAPCO, UNICEF, and WHO.</p> <p>Carried out preparatory activities for conducting NHA VI: The FMOH prepared draft TOR for the NHA VI TWG and circulated the document among NHA VI TWG members for comments. Since its establishment, the NHA VI TWG has met twice and discussed various issues related to NHA VI preparation. Major agenda items include: TOR for the NHA VI TWG, soliciting funds to conduct NHA VI Institutional and HH surveys, and the NHA VI launch workshop. The TWG discussed TOR and enriched the document using comments given by members. The FMOH distributed the NHA VI Concept Note to a few donors to solicit funding; securing funds for both the general HH and PLHIV surveys is the responsibility of the FMOH. The project's Research and Knowledge Management senior advisor prepared and submitted major cost elements to the FMOH Resource Mobilization Directorate to give them a rough estimation of survey costs for the HH and PLHIV surveys. The Abt home office secured funding for the institutional survey from the Bill and Melinda Gates Foundation (BMGF); the funding will also cover costs of the NHA team training and NHA VI launch workshop. The NHA VI TWG scheduled the</p>	

Year 3 Q4 Planned Tasks	Year 3 Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
	training for October 5-9 and the workshop for October 10, 2015.	

**Objective 4.3: Updated policy and strategy documents, success stories, and other documentation improved**

Support systematic revision of user fees	<p><b>Central:</b> Ongoing from the previous quarter, the TWG incorporated valuable comments and suggestions of health professionals from various teaching university hospitals. Comments included:</p> <p>The need to assess or pilot test user fees to see if the community can afford them; some of the user fees could conceivably have a catastrophic effect on the tertiary service user.</p> <p>As the hospital services expand, new types of services will emerge and the FMOH needs to build hospitals capacity – through SCAT training – on user fee setting.</p> <p>The user fees should avoid extra costs – medical students need to supply their own gloves, etc., – just not to overcharge patients for supplies to which the hospital should otherwise allocate a budget.</p> <p>Grouping the services that have similar user fees is not acceptable, as the procedures may fall in different sub-specialty groups. It would be advisable for the grouping exercise to consider whether services have more or less similar inputs (costs), and fall in the same sub-specialty group.</p> <p>The TWG assessed the list of services and supplies to avoid or at least minimize omissions and unreasonable mergers. It also independently categorized nursing services as per comments of health professionals and collected the local market prices of the supplies, which were entered into the user fee template.</p>	
Support EHAQ assessment and validation with audit and steering committee established by FMOH	<p><b>Central:</b> The Medical Services Directorate (MSD) of the FMOH arranged five groups of qualified professionals to conduct supportive supervision and provide comprehensive and intensive technical support for selected lead and member hospitals organized under the EHAQ initiative. The supportive supervision teams were staff from the MSD, departments, professional associations, and HSFR/HFG, as well as health professionals from health facilities. The HSFR/HFG staff participated in one group, which was assigned to undertake supportive supervision June 18-July 9, 2015 in Amhara (Debre Markos and Debre Tabor) and Tigray (Axum, Mekelle, and Lemlem Karle) regions. Supervision emphasizes quality improvements in antenatal care, labor and delivery services, pediatric and neonatal care, the Clean and Safe Hospital (CASH) initiative, and the overall activities of the cluster. In addition to the observational visit, the supervision team compiled information gleaned from document</p>	

Year 3 Q4 Planned Tasks	Year 3 Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
	review (medical records) and interviews with facility staff and mothers/attendants. From admission through discharge, 10 core areas of services were measured using scores 0 or 1.	
Participate in the review and finalization of the EHCRIG	<p><b>Central:</b> Ongoing from the last quarter, the project HCF and health insurance teams participated in the workshop, held July 23-25, 2015 in Adama. Project staff were assigned to two groups, Finance and Asset Management and Leadership and Governance, to lead the revision of operational standards and guidelines for finance and asset management (including outsourcing of clinical and non-clinical services in public hospital), public-private partnerships, health insurance, financial management, and auditing. Hospitals will play a pivotal role in the execution of health insurance initiatives in general and provision of health care services for insurance beneficiaries in particular. Accordingly, the concepts, design parameters, and implementation procedures of health insurance are incorporated under financing. The two teams were entirely composed of HSFR/HFG project staff. While other team members were drawn MSD and other stakeholders. Each team presented their draft to the plenary and participants forwarded their comments and suggestions on each topic covered in the EHRIG. The teams have developed operational standards, operational guidelines, and proposed additional indicators in areas of health insurance that should be incorporated into the revised zero draft EHRIG document.</p> <p><b>SNRP:</b> The RHB held a GTP evaluation program on July 20-22, 2015 in the Hawassa Management Institute hall. The evaluation focused on readiness of health facilities in expansion woredas to provide quality services to CBHI beneficiaries. The HSFR/HFG project attended the program, in which over 700 HC heads participated. RHB-led EHCRIG training immediately followed the program, on July 22-25, also in Hawassa town HSFR/HFG trained the 700-plus HC heads on HCF reform and CBHI program implementation.</p>	
Support the promotion of health insurance initiatives	<p><b>Central:</b> Ongoing from the previous quarter, the TWG incorporated valuable comments and suggestions of health professionals from various teaching university hospitals. Comments included:</p> <p>The need to assess or pilot test user fees to see if the community can afford them; some of the user fees could conceivably have a catastrophic effect on the tertiary service user.</p> <p>As the hospital services expand, new types of services will emerge and the FMOH needs to build hospitals capacity – through SCAT training – on user fee setting.</p> <p>The user fees should avoid extra costs – medical</p>	

Year 3 Q4 Planned Tasks	Year 3 Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
	<p>students need to supply their own gloves, etc., – just not to overcharge patients for supplies to which the hospital should otherwise allocate a budget.</p> <p>Grouping the services that have similar user fees is not acceptable, as the procedures may fall in different sub-specialty groups. It would be advisable for the grouping exercise to consider whether services have more or less similar inputs (costs), and fall in the same sub-specialty group.</p> <p>The TWG assessed the list of services and supplies to avoid or at least minimize omissions and unreasonable mergers. It also independently categorized nursing services as per comments of health professionals and collected the local market prices of the supplies, which were entered into the user fee template.</p>	
<b>Objective 4.4: Efficient M&amp;E system established</b>		
Produce supportive supervision synthesis report	<p><b>Central:</b> Compiled and analyzed the HSFR/HFG Year I (July 1, 2013-June 30, 2014) supportive supervision dataset received from Addis Ababa, Amhara, Benishangul-Gumuz, Oromia, Harari, Dire Dawa, SNNP, and Gambella regions; preparation of a synthesis report is in progress.</p>	

### 5.1.9 Ghana

**Program Objectives** - In Year 1 of the Ghana program (HFG Year 2), HFG and the USAID Mission agreed on the funding level, on the strategic approach, and on the concentration of program activities in three work streams related to strengthening National Health Insurance Authority (NHIA) purchasing, systems, and operations. In consultation with the Government of Ghana it was agreed that support for the NHIA is to be carried out to improve the functioning of the National Health Insurance Scheme (NHIS) as an effective tool in moving toward universal health coverage (UHC). Expected improvements include increasing NHIS efficiency and obtaining desired service delivery improvements in malaria, maternal and child health and family planning. The initial three USAID/HFG work streams to support NHIA were: 1) development of a sustainability road map (SRM); 2) design and preparation for scale-up of capitation for primary health care (PHC) services; and 3) NHIA as an evidence-based health purchaser. In addition to achieving the objectives of each work stream, the strategy intended to create synergies between the work streams for greater impact on NHIS development and long-term sustainability.

**HFG-Ghana Project Strategy Evolution** -In Year 2 of the Ghana program (HFG Year 3), dialogue among the HFG team, USAID, and NHIA resulted in the conclusion that the first-year strategy should evolve in two ways: the first two work streams (SRM and PHC Capitation Scale-Up Design), their work largely completed, should be merged into a single work stream entitled Strategic Health Purchasing and the relationship between the two remaining work streams should evolve as described below.

With the completion of the SRM and its integration into the MOH Health Financing Strategy Implementation Plan, the broad NHIS strategic planning exercise supported by HFG-Ghana will evolve to more targeted policy dialogue and planning on major health financing and governance issues (e.g., benefits package). With PHC capitation scale-up design activities largely complete, technical support will both widen and deepen in the new Strategic Health Purchasing work stream. It will widen to encompass all aspects of health purchasing including all types of provider payment systems and operating/information systems and cost accounting for the payment systems. It will deepen to support continued development and preparation and then implementation of PHC capitation scale-up in the pilot Ashanti region and the three scale-up regions of Upper East, Upper West, and Volta. A particularly important focal point is the intersection of health purchasing and service delivery.

The second aspect of strategy evolution is the nature of the relationship between the two work streams. There is now a circular relationship or synergy: policy dialogue and implementation of technical health purchasing interventions improve development and use of information and evidence which in turn feeds back into policy dialogue and further refinement of health purchasing mechanisms. In this way, the impact on NHIS development and long-term sustainability is magnified.

The following additional specifics of HFG-Ghana strategy evolution were agreed with NHIA:

1. Focused technical assistance to NHIA will continue.
2. PHC capitation scale-up will include implementation support in three regions.
3. Policy dialogue started with the SRM and MOH Health Financing Strategy will address key policy issues and work to remove barriers to NHIS financial sustainability.
4. Use of “evidence-based” approaches will be expanded and increasingly linked to strategic purchasing goals.
5. There will be an emphasis on governance, linked to service delivery improvement (e.g., in malaria and family planning programs).

**Year 3 Activities** - Taking into account the HFG-Ghana strategy evolution described above and based on dialogue with USAID and NHIA, agreement was reached on the following HFG Ghana Year 3 (second year of Ghana program) work plan activities:

1. **Strategic Health Purchasing Activity Workstream:** Aligning across all NHIS provider payment systems (capitation, Ghana diagnosis-related groups (G-DRGs), fee-for-service drug payment) and harmonizing with other health sector provider payment systems (line-item budget, PBF, other donor mechanisms). Includes policy dialogue and collaborations, and operating/information systems and cost accounting supporting provider payment. Four sub-activities are expected to continue for the life of the HFG-Ghana:
  - PHC capitation scale-up and formation of preferred PHC provider networks
  - Refinement of G-DRGs with corresponding service delivery improvements
  - Claims management and information system improvement and development of national unified cost reporting system
  - Ongoing policy and strategy dialogue and collaborations
2. **NHIA as Evidence-Based Health Purchaser Activity Workstream:** Scaling-up NHIA's generation and use of evidence in the short, medium, and long term. Its four sub-activities are:
  - Replicate/scale-up dashboards development and use
  - Support the development and roll-out of an organization-wide M&E policy
  - Systematize, improve, and augment NHIA operations research (OR) for strategic purchasing and improved service delivery
  - Foster knowledge exchange and study tour with Taiwan's NHIA

**Year 3 Progress Against Objectives** - HFG Ghana, USAID Ghana, and the NHIA agreed on the overall Year 2 and Year 3 Ghana country work plan strategy, specific activities, and in-country staffing and program. Implementation of planned activities in the two programmatic work streams is described below.

**1. Strategic Health Purchasing Workstream: PHC Capitation** – HFG Ghana contributed technical expertise to policy dialogue and all aspects of design of the refined PHC capitation payment system for scale-up to three additional regions (e.g., benefits or capitation basket, payment system specifications, contracting, operational mechanisms, early warning monitoring system). Refinement was based on lessons learned in the Ashanti pilot including that purchasing PHC services encompasses both the payment system itself and contracting with PHC providers capable of delivering the PHC services contained in the benefits package (i.e., contract with PHC providers rather than tertiary hospitals for PHC services). Therefore, an emphasis of HFG Ghana technical assistance has been supporting NHIA, MOH, Ghana Health Service (GHS), and other stakeholders to assess PHC provider capacity to help ensure that NHIA contracted with individual providers or networks able to deliver the desired PHC services.

To prepare for PHC capitation scale-up including selecting PHC facilities or forming networks able to provide the contracted PHC services, a provider mapping was completed. It contained detailed information on the clinical capacity, location, and population served of all 917 public, Christian Health Association of Ghana (CHAG), and private providers in the three capitation scale-up regions (Upper East, Upper West, and Volta). The results were analyzed, showed a surprising lack of providers or provider scope of services, and were used to inform options for Preferred Primary Provider Networks (PPPN), which will serve as contracting entities for the capitation payment system. Provider mapping

reports have been developed and are currently being reviewed and finalized by Ghana partners before their release.

HFG-Ghana work to assist NHIS/NHIA in PHC capitation scale-up design is largely complete and the project has shifted to Phase II implementation support for PHC capitation scale-up in Upper East, Upper West, and Volta. Based on NHIA and HFG-Ghana detailed planning session, HFG-Ghana will support three activities in the implementation of PHC capitation scale-up:

- ▶ Definition of the Capitation Basket and PPPN Formation and Development
- ▶ Develop “Early Warning System” to Manage Capitation Implementation
- ▶ Implementation Support through NHIA and Provider Staff Capacity Building and Other Related Interventions

In February 2015, a preliminary PHC capitation scale-up early warning system was developed intended to oversee implementation by continuously answering the following four questions through monitoring the nine indicators in parenthesis: 1) Is package of services being delivered? (e.g., % of enrolled members who made at least one visit to their preferred PHC provider, # of capitation visits per enrolled member, % of claims in capitation basket with diagnosis of malaria); 2) Are there inappropriate referrals or over-use of medicines? (e.g.% of OPD cases outside of capitation basket, value of claims for medicines per capitation encounter, # of medicines per capitation basket encounter); 3) What is the preferred PHC provider enrollment rate? (e.g.% of active enrolled with preferred PHC provider); and 4) Are non-capitation claims increasing? (e.g.% of total claims for G-DRG claims, % of claims for medicines).

NHIA provided HFG Ghana with 6,800 manual claims in January-June of 2014 for use in assessing claims data to determine whether the PHC capitation early warning system indicators could be monitored. None of the early warning system indicators could be monitored by analyzing claims data in its current format; five of the nine can largely be monitored if data are extensively cleaned and reorganized as done for the 6,800 claims or the new standardized provider claims summary form is implemented; and all nine indicators can be monitored if standardized provider claims summary form and enrollment data are merged into an analytical data set. Exemplary charts and graphs portraying data and provider benchmarking were presented at the June 2015 Claims Data Analytics Workshop (see claims management section below). During the workshop, it was determined that improvements in the provider summary claims form submitted with all claims data are needed to routinely collect and analyze PHC capitation scale-up early warning system data. This improvement subsequently became an HFG Ghana priority. Dialogue and provision of technical assistance on the early warning system continued during and after the workshop. The set of indicators to be included in the Capitation Early Warning System were validated and there was agreement on the following next steps:

1. Finalize definitions of early warning indicators
2. Begin merging enrollment with utilization data to construct indicators for test-case districts
3. Develop the data visualization and quarterly monitoring report structure
4. Program “one-button” reports

HFG facilitated the participation of four representatives from Ghana’s NHIA to participate in a five-day Joint Learning Network (JLN) learning exchange on Data Analytics for Monitoring Provider Payment Systems in Manila, Philippines. The NHIA representatives shared the progress on the capitation early warning system with a group of 48 policymakers and practitioners from nine countries. They received feedback and benefited from the experience and lessons learned contributed by the participating countries, which will further strengthen the development of the capitation early warning system.

*Analysis for G-DRG refinement* - The initial analysis expected to eventually lead to G-DRG refinement began with development of an exemplary DRG simulation model. NHIA is very interested in developing a Ghana version of the exemplary DRG simulation model presented by HFG-Ghana. In addition, the sub-activity was expanded to include not only analysis for G-DRG refinement but also a broad assessment of whether objectives of G-DRGs are being met and provision of training and capacity building on technical aspects of DRGs.

In June 2015, the Claims Data Analytics Workshop included a session on DRGs, which encompassed international experience, development of simulation model, and the difference between Ghana's current DRGs, which are set tariffs and formula-based DRG systems. The 6,800 claims in January-June of 2014 were used to simulate or compare Ghana's set tariffs vs. formula-based DRG system and show that both systems can result in the same payments to providers but the formula-based system has the advantage of enabling budget neutrality and having more policy levers to adjust. The DRG relative payment weights calibrated around 1.0 and the base rate in the formula-based DRGs can be tied to budget each year thus helping remain within budget or be budget neutral.

Workshop consensus was that it is time to consider moving to formula-based DRGs to be more budget neutral or help ensure that payment on claims stays within budget for sustainability. Agreed next steps include: 1) provide more explanation of the DRG simulation model and international experience in general; 2) develop a more extensive analytical database for the simulation model; and 3) begin to consider G-DRG refinement options using the simulation model.

*Claims Management and Information System Improvement* - In June 2015, HFG-Ghana conducted a two-day Claims Data Analytics Workshop intended to improve NHIS claims management operating and information systems and also ensure data are available for the three analytical products of PHC capitation early warning system, G-DRG refinement simulation model, and dashboard. Over 25 key NHIA staff (including 6 women) from all departments attended the workshop. To prepare for the workshop, HFG-Ghana technical specialists analyzed 6,800 claims in January-June of 2014 and created an analytical database. This extensive claims analysis identified a number of issues that were presented and discussed during the workshop. The issues relate to both basic data entry problems (e.g., errors, using different codes in different places) and the inability to aggregate manual claims data due to use of different structure and formats in the provider claims summary form. Workshop dialogue led to consensus that key issues with manual claims can be categorized into structure, format, and linkability challenges, and that these challenges with claims data limit opportunities for data analysis.

As an immediate high-impact solution, Claims Data Analytics Workshop participants agreed that the provider claims summary form already submitted by all providers could be easily standardized to provide higher-quality individual-level utilization data that can be linked and analyzed across the entire NHIS. In addition, a road map for claims and data management improvements was developed including immediate manual claims refinement through new provider claims summary form, transition to eClaims, and a future vision of unification and integration of all health management information systems.

In Q4, the HFG team worked with the NHIA Claims Directorate to create a first draft of an automated standard claims summary form containing a number of improvements including drop-down menus to remove errors and standardize data, and creation of a "flat file" that enables aggregation of data and data analysis. Planned next steps included: 1) joint work of NHIA and HFG-Ghana team to finalize structure, format and data contained in standard automated provider claims summary form; 2) pilot test for approximately one month; and 3) national roll-out to all provider through all NHIA claims processing centers.

*Development of National Unified Costing System* - A top-down and bottom-up strategy was developed for creation of the National Unified Costing System to generate cost information for capitation and G-DRG rate-setting, internal health facility management (including new PPP networks), and other joint objectives

of the MOH, NHIA, and GHS. Top-down activities will include supporting the National Costing Working Group (formed with HFG support at the first Costing Workshop in June 2014) to continue to develop the national health services costing system based on the JLN Costing Manual (to which Ghana was a major contributor), including solidifying objectives, technical elements, national working group, and location of data, while at the same time supporting bottom-up activities by initiating cost accounting in a selected hospital and linking with the USAID-funded MCSP and Systems for Health projects on costing of CHPS compounds.

*Sustainability Road Map* - HFG Ghana worked with NHIA staff to develop a SRM for NHIS with steps including an all-staff NHIA “brainstorming” on key elements and factors particularly related to strategic purchasing, followed by drafting and review of SRM. Subsequently, it was decided that the NHIA SRM and MOH Health Financing Strategy (HFS) should be directly linked and HFG Ghana helped coordinate the incorporate of NHIS SRM into MOH HFS. Continuation of MOH, NHIA, USAID, and WHO collaboration and cost share resulted in the final draft of the NHIS SRM, which was then integrated into the final draft of the MOH Health Financing Strategy Implementation Plan (see also collaborations below).

*Stakeholder Dialogue on NHIS Benefits Package* - The HFG Ghana team supported the NHIA in facilitating a highly successful stakeholder dialogue meeting on the NHIS benefits package. The meeting, in Accra on October 23-24, 2014, was the first held to review “An Equitable and Sustainable Benefits Package Based on Evidence.” More than 50 stakeholders, including health workers, academics, and private insurers, attended.

Akua Kwateng-Addo, Director, Health, Population and Nutrition Office, USAID/Ghana, participated in the opening of the meeting. HFG technical experts participated in plenary sessions, which included: the Development of Standard Treatment Protocols; Overview of Ghana’s NHIS Benefit Package; International Experience on Benefit Package Design; Evidence as a Basis for Design: the Role of Health Technology Assessment; and Effective Monitoring and Evaluation.

Afterwards, Mr. Nat Otoo, NHIA’s Deputy Chief Executive for Operations, expressed his appreciation for HFG’s support. “I wish to personally thank you for the clarity you brought about the way forward with the technical assistance project, which was greatly appreciated by our team, as well as for your responsiveness, technical inputs and personal presence, which all contributed to the success of the stakeholder dialogue on benefits package. I look forward to the next steps on the project and the outcome of the stakeholder dialogue.” As a result of this dialogue, NHIA will convene a national taskforce to begin developing an appropriate package of health services based on input from the stakeholders.

*Ongoing Strategy and Policy Development* - As opportunities arise, HFG Ghana engages in ongoing strategy and policy dialogue and development with NHIA and other stakeholders. This dialogue can encompass any topic related to improving NHIS purchasing, efficiency gains, and sustainability. An example that continuously emerges is dialogue, planning, developing options and analysis in preparation for refining drug payment with corresponding drug supply management improvements.

In the context of recent NHIS/NHIA financial issues, HFG-Ghana began engaging in dialogue with NHIA on a “shared responsibility” solution to sustainability, in which the government increases revenue, NHIA introduces more strategic and budget neutral health purchasing, and providers accept payment rates and better manage costs. The key points of the discussion were raised at an internal NHIA senior management meeting during the June 2015 TDY and it was agreed that a two-pronged response was needed to “close the hole” or increase NHIS financial sustainability – reduce fraud and abuse and increase strategic health purchasing/provider payment systems to improve expenditure management and increase efficiency.

*Collaborations* – HFG Ghana has prioritized developing and nurturing collaborations with other USAID projects and other development partners to coordinate, integrate, leverage, and increase sustainability of USAID investments. Examples of collaborations are as follows:

- ▶ USAID, WHO, and DFID cost-shared and collaborated on the development of NHIS SRM and MOH HFS. This collaboration continues as MOH moves to begin implementation of HFS. Particularly important aspects are recognition of the need to improve NHIS purchasing, obtain efficiency gains, and close the gap between MOH services/vertical programs and NHIS benefits package. This includes better coordinating and integrating services provided by Community-based Health Planning and Services Initiative (CHPS) which directly links to PHC capitation scale-up and formation of PPPN.
- ▶ HFG, other USAID projects, and the World Bank are collaborating with a multitude of Ghana partners on supporting and incentivizing the formation of PPPN. The June 2015 meeting of the Working Group on Capitation/Performance-Based Financing (PBF) Alignment including World Bank project activities led to consensus across the MOH, GHS, and NHIA to pilot the formation of PPPN in capitation regions, using PBF for start-up grants and incentive-based payment to CHPS for prevention activities. Given the gaps in provider capacity identified in the provider mapping exercise supported by HFG, the group agreed that PPPN are a necessary step to ensure access to basic PHC for the population of Ghana, and also to make capitation payment more fair and effective. The mapping also confirmed very weak clinical capacity at the PHC level and these results facilitated dialogue of USAID and other international partners to harmonize support for strengthening PHC capacity. In particular, the partners agreed that the PBF activities planned by USAID and the World Bank should be used as a catalyst for the formation of provider networks to close access gaps and to facilitate the role of CHPS providers in the networks to expand preventive services. The USAID HFG and Systems for Health teams agreed to continue to jointly support the working group as it finalizes the concept and design for the PPPN/PBF pilot.
- ▶ USAID HFG Project, USAID MCSP and Systems for Health Projects, and the JLN are collaborating to support MOH and NHIA on development of a national unified costing system, costing of CHPS services, and cost accounting to enable improving provider payment system rate-setting. In July 2015, HFG facilitated the participation of several representatives of Ghana's MOH and GHS in a training-of-trainers course on costing of health services based on the JLN Costing Manual, which is being used as the basis for Ghana's national unified costing system.
- ▶ Periodic discussions have occurred with USAID/Ghana about collaborations on drug payment and drug supply management and this dialogue is expected to continue.

## **2. NHIA as an Evidence-Based Health Purchaser Activity Workstream:**

*Replicate/scale-up dashboards development and use* – In July 2014, the NHIA's management information systems (MIS) team and HFG found that the MIS staff lacked the technical skills required to link the NHIA's numerous databases (National Claims Register, e-Claims database, membership database, and finance database) into a single consolidated platform that NHIA's senior management could easily access. To address this gap, the NHIA requested a series of courses to develop the MIS staff's skills using SharePoint, a Microsoft web application and platform that is able to access data from NHIA's various data sources and can create visualizations with that data. HFG executed a purchase order agreement with Axxend Corp., a business technology consulting firm based in Accra. Over three weeks in November 2014, Axxend delivered these trainings, which focused on core and advanced solutions and business intelligence using SharePoint. Taking the training were nine members of the MIS directorate and other relevant staff persons selected by the NHIA, who gave the course positive evaluations. The next steps for the dashboard activity will be to use the skills gained to produce the beta version of the dashboard for senior management.

In April, the beta version of the dashboard was launched and presented to senior-level NHIA management by the MIS team. The dashboard was well received by the NHIA leadership and HFG was encouraged to hear how enthusiastic they were to both implement the dashboard and identify data and next steps to roll out claims and clinical audit-focused dashboards. The June 2015 Claims Data Analytics Workshop provided consensus on the next steps for the dashboard. It was agreed that the National Claims Registry would be used to produce the next set of claims-focused indicators for the Dashboard.

*Support the development and roll-out of an organization-wide M&E policy* – In May 2014, following the dashboard development workshop, HFG was asked to provide similar collaborative support to the NHIA Planning, Monitoring and Evaluation directorate. The directorate requested assistance in building the capacity of senior staff managers across NHIA directorates in the practical implementation of M&E frameworks for health insurance. After building the knowledge of key staff, HFG is assisting the NHIA in writing and institutionalizing a new M&E organization-wide policy. A training and workshop was hosted February 16-27, 2015 in Sogakope, Ghana, and focused on the fundamentals of developing an M&E strategy for a large health purchasing organization, including budgeting for M&E activities, development of an M&E framework, and M&E specific to the core functions within NHIA.

HFG delivered the M&E course to 26 directors, deputy directors, and senior managers of the NHIA. The course was designed to build skills to analyze data, develop M&E plans, and create and use relevant management indicators. Insurance-specific topics such as capitation (health care provider payment), biometric identification cards, and membership management were emphasized. A video of the course's key messages can be viewed [here](#).

This past quarter was spent working with the NHIA to review drafts of the new policy framework, assisting the NHIA in completing evaluations resulting from the workshop and strategizing ways that HFG can further support the national roll-out of the policy.

The M&E policy, supported by the NHIA's new community of practice, will guide the NHIA to manage initiatives related to provider payment systems, member identification tools, and claims processing that aim to improve access to health care and improve efficiency of the scheme. The M&E policy is currently undergoing final rounds of editing and the HFG team awaits revisions from the NHIA. The NHIA has secured funding from DFID to finance the scale-up of the HFG M&E training nationally to all NHIA M&E officers located in the districts. In addition to the M&E policy draft, HFG has helped review an internal evaluation developed by the NHIA that resulted from the M&E training. The internal evaluation investigated the organization's capacity to record and account for premium payments. The study identified the 25 best and worst performing district offices in terms of capacity to correctly estimate and collect revenues derived from member premiums. The NHIA management is now reviewing this study to identify best practices that may be learned from high performing districts.

HFG received an update from Francis Andoh-Adjei regarding the status of the draft M&E policy framework. Francis noted that the NHIA is in the process of identifying how HFG can support policy implementation, and will provide HFG with a proposal of activities to support.

Foster Knowledge Exchange and Study Tour with Taiwan's NHIA - Communication was established between Taiwan's National Health Insurance Administration (NHI) and Ghana's National Health Insurance Authority. Officials from both organizations joined a teleconference to discuss the content and structure of the curriculum of the study tour course to be presented during the Ghanaian delegation's visit to Taiwan in March 2015. Prior to the teleconference, Taiwanese officials shared background information with the Ghanaian officials including the National Health Insurance Annual Report and overview slides about Taiwan's health insurance system. Likewise, Ghanaian officials shared background information with Taiwanese officials about Ghana's health insurance system including the 10th Anniversary Report and the benefits package conference draft report. Email communication was also established, and emails were exchanged between Taiwanese and Ghanaian officials in advance of the

study tour. The study tour, which took place between March 15 and March 21, 2015, was a great success. The Ghanaian delegation comprised eight representatives from the NHIA, the GHS, and Ghana's MOH, and participants joined in a two-day symposium celebrating Taiwan National Health Insurance's 20th anniversary. The delegation also participated in a three-day course about Taiwan's NHI that was tailored to the interests of the Ghanaians. The delegation of eight Ghanaians was made up of a diverse group of senior government officials including three women.

Since returning from the tour, HFG has continued to engage the NHIA and GHS to think about additional areas of collaboration with Taiwan's NHI, while trying to establish a stronger partnership among them. As such, HFG is looking at ways to facilitate continued knowledge transfer, creating a potential opportunity to have a few members from the Taiwan NHI visit Ghana to do this.

As a way of wrapping up this activity, HFG plans to conduct interviews with a few individuals who participated in the study tour with the aim of re-starting conversations about the lessons learned during the tour and looking at ways the various Ghanaian agencies can collaborate to adapt those learnings.

*Systematize, improve, and augment NHIA operations research for strategic purchasing and improved service delivery* - Work planning meetings between HFG and NHIA in Oct. 2014 revealed a need to strengthen the NHIA's capabilities to organize and carry out OR projects that will investigate high-priority operational challenges in the medium term in a rapid, evidence-based manner. A concept note for this activity was circulated among NHIA management, and four NHIA directors were named as points of contact: Lydia Selby, Claims Director; Osei Acheampong, Research and Development Director; Francis Boadi, R&D Deputy Director; and Ben Yanka, Finance Director.

Since January, the team has focused on gathering the information to develop a baseline of current OR practices through document review, one-on-one interviews, phone interviews, and focus groups. The team is analyzing and synthesizing the data to identify areas of weakness with a plan to present these gaps at a meeting at NHIA in April 2015.

The HFG-facilitated meeting discussed current challenges of OR-like projects within the NHIA. By the end of the meeting, HFG, together with several representatives from different directorates in the NHIA, developed a shared vision and road map/process for OR within the NHIA, and brainstormed potential research topics. The next steps are to draft a research proposal and carry out research on the proposed topic, likely to be a malaria-focused analysis of claims data, to validate and adjust the process created during the April workshop.

Since the April workshop, HFG has identified and proposed a first OR project related to claims data for malaria treatment. The HFG team is awaiting approval from the NHIA to launch this first project, and they hope to make progress on this activity during the October TDY.

#### **Q4 Challenges -**

1. The period of high-level financial sustainability concerns and leadership turnover at the NHIA delayed some progress in the past quarter, but activities appear to be going smoothly now.
2. The key NHIA M&E contact person, Francis-Xavier Andoh-Adjei, was in the Netherlands for three months while he completed his PhD dissertation. This significantly delayed updating various drafts of the M&E policy and finalizing plans for a national roll-out of the policy.

Table 33 provides activity-specific updates.

**TABLE 33. GHANA ACTIVITY DETAIL**

Year 3 Q4 Planned Tasks	Year 3 Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
<b>Activity 1: Strategic health purchasing workstream</b>		
<b>Sub-Activity 1: PHC capitation scale-up and formation of preferred PHC provider networks</b>		
Complete refinement of PHC capitation payment system with mapping and recommendations for formation of PPP networks including CHPS	The provider mapping report was prepared and is currently being reviewed and finalized by Ghana partners before their release. It has already been used extensively in dialogue around the topic of PPP network formation and CHPS policy in general.  Data collection for provider mapping in Ashanti region was completed and analysis is currently being conducted by the NHIA with support from a local consultant.	HFG Ghana will follow up on release of provider mapping reports for the PHC capitation scale-up regions during October 2015 TDY.
Support implementation of the first phase of PHC capitation scale-up	Joint NHIA and HFG visits to PHC capitation scale-up regions produced internal notes that will contribute to development of plans for HFG support to capacity-building as part of PHC capitation scale-up implementation.	Dialogue and development of plans is ongoing and will continue during October 2015 TDY.
Develop and implement an early warning monitoring system and process to support implementation of first phase of PHC capitation scale-up	Development of PHC capitation scale-up early warning system specification, report format, etc. continued in preparation for dialogue during the Oct. 2015 TDY.  Four representatives from the NHIA presented the capitation early warning system at a JLN learning exchange on Data Analytics for Monitoring Provider Payment Systems in Manila, Philippines in July, 2015.	Successful implementation of PHC capitation early warning system depends on NHIA implementation of new provider summary claims form to improve routine data collection and enable analysis.
<b>Sub-Activity 2: Refinement Of G-DRGS With Corresponding Service Delivery Improvements</b>		
Engage in dialogue, analyze existing G-DRG development process, and develop plans for G-DRG refinement with corresponding service delivery improvements focusing on malaria and family planning	Based on request from NHIA, provided more detail on DRG systems in general including what is meant by budget neutral payment systems. Also provided more explanation of the exemplary DRG simulation model.	Critical assumption was attained at June 2015 Workshop statement by NHIA -- it's time to consider moving to formula-based DRGs to be more budget neutral or help ensure that payment on claims stays within budget for sustainability.  Next step is further dialogue on G-DRG refinement and development of plans during October 2015 TDY.

Year 3 Q4 Planned Tasks	Year 3 Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
Initiate G-DRG refinement including starting analysis related to case classification, cost accounting, and simulation model		Proceeding on G-DRG refinement including converting exemplary simulation model to Ghana-specific simulation model to start case classification and relative payment rate analysis requires a G-DRG analysis data set. This data set can be developed separately or obtained from routine data if new provider summary claims form is implemented by NHIA.

### **Sub-Activity 3: Claims management and information improvement and development of national unified cost reporting system**

Support NHIA to make short-term improvements to claims management and information systems linking to longer-term shift to eClaims	<p>HFG-Ghana continued to engage in dialogue with NHIA on plans and process related to the agreed solution of improving the provider claims summary form.</p> <p>An exemplary automated provider claims summary form with drop-down menus was further developed.</p>	<p>Dialogue over the last quarter verified the assumption that HFG-Ghana activity to clean, create a data set, and analyze 6,800 manual claims established the foundation for identification of issues and improvements in claims management.</p> <p>Finalizing specification of provider claims summary form fields and drop-down menus is a key task for the October TDY to enable implementation of the new form to begin.</p> <p>The critical assumption is that implementing the refined provider claims summary form is key to NHIA strategic health purchasing and management; monitoring service delivery including malaria services; and producing HFG PHC capitation early warning system, G-DRG simulation model and analysis, and dashboard products.</p>
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### **Sub-Activity 4: Ongoing policy and strategy dialogue and collaborations**

To realize comparative advantages, collaborate with other country development partners	<p>Dialogue continued with other USAID projects, World Bank, JLN, MOH and NHIA on using PBF to stimulate formation of PPPN, costing/cost accounting and linking NHIA strategic purchasing improvements and MOH HFS.</p> <p>HFG Ghana Program Manager participated in meetings to actively coordinate and promote collaborations.</p>	
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Year 3 Q4 Planned Tasks	Year 3 Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
Support ongoing policy dialogue through workshops and other forums for policy dialogue and development; disseminate, promote, and support implementation of HFS-IP and NHIS SRM		Next step is dialogue with NHIA on priority topics and plans during the October 2015 TDY.

## Activity 2: NHIA as an evidence-based health purchaser workstream

### Sub-Activity 1: Replicating/ scaling up dashboards development and use

Creation of beta version of dashboard	The NHIA team is reviewing their internal data management processes as a result of the beta Membership Dashboard creation and outcomes from the July 2015 Data Analytics Workshop organized in collaboration with the HFG Ghana Sustainable Financing work stream. As a result of the beta membership dashboard creation, the NHIA has identified staff training and capacity gaps at the regional and district levels as it relates to the scale-up of biometric identification and registration. The HFG Ghana team will work closely with the NHIA during the October TDY to outline next steps.	
Develop learning tool based on Ghana and Vietnam experiences	The HFG Ghana team is working with members of the JLN and NHIA to integrate the learnings from Ghana's Dashboard development process in to a step-by-step process guide for data analytics for monitoring provider payment systems. Representatives from the NHIA's Claims, Management Information, and Provider Payment Directorates as well as representatives from the HFG Ghana team and 10 other JLN member countries recently participated in a four-day working session in Manila, Philippines, hosted by the JLN Information Technology and Provider Payment technical initiatives, to begin drafting the outline of the Guide. The final product is on track to be completed in July 2016.	

Year 3 Q4 Planned Tasks	Year 3 Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
Creation of second information dashboard	The HFG evidence-based work stream is collaborating with the strategic health purchasing work stream to develop NHIA capacity around data analytics. The HFG Ghana team will organize a training on Tableau to help build capacity in the NHIA. In addition, the HFG Ghana team is working with the NHIA to identify opportunities to support the ongoing development of the NHIA's data warehouse infrastructure.	
<b>Sub-Activity 2: Support the development and roll-out of an organization-wide M&amp;E strategy</b>		
Development of M&E policy	HFG met with Francis Andoh Adjei, Director of M&E at NHIA, to discuss the status of the draft M&E policy, and plans to finalize the draft and implement the strategy. Francis reported that his team has begun indicator development with individuals at the district-level. Next, his team will share these indicators with regional directors at the Regional Directors Forum (12/8-12/11). This will inform purpose of work development with the heads of the directorates, which will take place the following week (12/15-12/18). Francis noted that both the Regional Director's Forum and the meeting with the head of NHIA directorates are activities that could be supported by HFG. HFG will wait for further information from Francis to determine how HFG can provide support to these meetings.	There are likely to be delays in pushing this process forward, but the team hopes to leverage the upcoming October trip to meet with the members of the NHIA M&E Directorate to identify possible areas for support. Activities are increasingly moving into the administrative and management phase requiring less active support from the HFG team.
<b>Sub-Activity 3: Foster knowledge exchange and study tour with Taiwan's NHIA</b>		
Establish and facilitate communication exchange	HFG is in the process of wrapping up this activity. The HFG team has already conducted follow-up discussions with Ghanaian participants. HFG will conduct close out interviews with key members of Ghana's health system (at NHIA, MOH, and GHS) to assess if/how learnings from the tour have been adopted, operationalized, and institutionalized in Ghana. Responses from these interviews will help HFG develop areas for support to the NHIA, especially around best ways of facilitating continued knowledge sharing.	The team is hoping to use the Taiwan tour experience as a springboard to continue conversations with different stakeholders (NHIA, GHS, MOH), but recognizes there are sensitivities in facilitating these conversations.

Year 3 Q4 Planned Tasks	Year 3 Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
<b>Sub-activity 4: Systematize, improve, and augment NHIA operations research for strategic purchasing and improved service delivery</b>		
Support and carry out 2-3 OR projects	After the April workshop, HFG drafted a proposal for a first OR project using the OR proposal template developed by NHIA during the workshop. This first project will help NHIA identify variation in costs for anti-malarial drugs being claimed by like providers in Ghana. The claims directorate at NHIA has expressed interest in this topic, and Dr. Lydia Selby, Director of Claims, has reviewed the proposal and is supportive of the work. The issue was also identified by the HFG strategic purchasing team's analysis of provider claims data in June 2015, and represents a nice example of the early warning system in use. HFG has also sent this proposal to Francis Asenso-Boadi, Deputy Director of R&D, where it is currently under review.	
Develop processes for conducting OR	In April 2015, the team traveled to Ghana to facilitate an OR workshop with the goals of: sharing observations of current process for OR-like projects within NHIA and discuss organizational and methodological challenges; develop a shared vision for OR within the NHIA; and reach a preliminary agreement on a road map for an improved OR process within NHIA and select potential first research question.  An outcome from the workshop was a complete OR methodology that the NHIA remains keenly interested in institutionalizing and is motivated to use to begin a first OR project.	
Facilitate communications and dissemination of results	HFG has provided ongoing support to communications around OR work at NHIA, and will work with NHIA when appropriate to support dissemination of results.	

### 5.1.10 Mali

**Program Objectives** - Two assessments were requested by USAID Mali: a Management Assessment of the Secretary General's office and a Health Systems Assessment (HSA). The HSA will provide an overview of the operational status of Mali's health system. This assessment will inform the USAID Mission's future support of the Malian health sector as well as the Malian government's new health strategy. At the end of the HSA, recommendations and next steps forward will be discussed with USAID Mali to also determine additional activities that might be suitable for technical assistance by HFG.

The objective of the Management Assessment is to recommend ways to improve the efficiency and effectiveness of the Secretary General's (SEGAL) office, which oversees the planning, organization, coordination, and control of the Ministry of Health. The Management Assessment team will conduct an in-depth analysis of current functioning, suggest the number of positions to create, and engage the donors to seek their support. In addition, HFG will engage with key directorates to determine ways they might work more efficiently with the SEGAL.

**Year 3 Activities** - The HSA will cover the six WHO blocks: leadership and governance, service delivery, health financing, pharmaceutical management, human resources for health, and health information systems. The results are to be disseminated at the national level and at the regional level (in two regions). As a collaborative and participatory initiative, the HSA is expected that some of the external partners might have a more direct role in the assessment by supporting the HSA either financially or technically.

The Management Assessment will review the SEGAL's office, which employs senior ministry officials and technical advisors, but too few to handle the significant workload. While a long-term solution is the creation of new positions and finding ways to reduce the workload, the short- and medium-term solution is to use donor support to increase the number of technical assistants.

**Year 3 Progress Against Objectives** - Following initial discussions by phone in May about the potential Scope of Work (SOW), a scoping visit by HFG took place in June (Y3Q3) with four members of the HSA and Management Assessment teams. During this trip the HFG team met with USAID, MOH, and other key stakeholders in order to refine and finalize the scopes of work for both activities.

The HSA team conducted a second visit in September (Y3Q4) to clarify how the HSA will complement, and not duplicate, the ongoing review of the Procedures Manual for the Health Sector Development Plan (PRODESS) as well as the upcoming mid-term review of PRODESS itself. The SOW was finalized and validated by the MOH. The team confirmed support for the HSA from UNFPA, CIDA, the World Bank, and WHO. The team also started the desk-based literature review, in preparation of in-country data collection at the start of Year 4.

The Management Assessment SOW was also finalized and shared with the USAID Mission and the SEGAL. The assessment team began preparations of the data collection instruments such as the interview protocols. The team will travel to Mali in November to conduct the assessment.

Table 34 provides activity-specific updates.

**TABLE 34. MALI ACTIVITY DETAIL**

Year 3 Q4 Planned Tasks	Year 3 Q4 Progress	Critical Assumptions/ Problems Encountered/ Follow-up Steps
<b>Activity: Health System Assessment</b>		
Validate Scope of Work	A draft SOW was drafted following the initial scoping trip in June. However, the team had to travel to Mali again in September to clarify to the MOH and technical and financial partners that the HSA was not duplicative of the Mid-Term Review of PRODESS nor of the review of its Procedures Manual. The SOW has been validated and consists of a desk-based literature review, in-country data collection (at the national level and in 2 districts in the Koulikoro region), and report writing and dissemination. Dissemination is planned for January 2016.	The Planning and Statistics Unit, which is the focal point for the HSA, will coordinate the HSA Steering Committee. While the HSA team has met and presented the SOW of the HSA to members of the Committee, its official role in guiding the HSA is yet to be confirmed.
Do data collection and analysis (through site visits, key informant interviews)	The four-person team has started its literature review through desk-based research, documents collected in country and documents provided by the Planning and Statistics Unit. Potential interviewees are being identified and the interview protocols are being developed.	The in-country data collection trip is planned for November 2015. HFG's Local Coordinator will arrange the interviews in advance.
<b>Activity: Management assessment</b>		
Define and validate SOW	In Q4, the HFG team completed its scoping visit and finalized and validated the SOW for the Management Assessment with the USAID Mission and SEGAL. The result of the visit was that the assessment should focus on the organizational capacity of SEGAL's office and determine how staff capacity could be enhanced.	HFG has identified the two-person team to conduct the assessment. Due to a ministerial change, the mission has not confirmed the November 9-19 dates and will negotiate concurrence on the dates from the Secretary General.
Do data collection and analysis	Data collection will consist of interviews with the nine staff members in the SEGAL office, four or five key directorates that interact regularly with the Technical Advisors in the office, and donors that might fund additional positions.	HFG's local coordinator will arrange the interviews in advance.

### 5.1.11 Namibia

**Program Objectives** - The overarching focus of HFG Namibia activities is to ensure financial sustainability and country ownership of the HIV/AIDS multi-sectoral response through strengthened local capacity in health financing and governance. The HFG project will prioritize the following areas in this project year to achieve results and contribute to sustainable outcomes in Namibia:

- ▶ Provide the Government of the Republic of Namibia with the health financing data it needs to effectively sustain the HIV/AIDS response as PEPFAR further transitions from direct service delivery of prevention, care, and treatment programming to Namibia-owned, -managed, and -led responses.
- ▶ Improve the capacity of the government to collect, analyze, and use health financing data in the allocation of resources for HIV/AIDS services to maximize health impact.

**Year 3 Activities** - Currently, HFG's activities in Namibia continue from Year 2. These include:

- ▶ Institutionalization of National Health Accounts for resource tracking
- ▶ Costing for evidence-based decision making, and
- ▶ Conducting a health financing review to inform the government's discussions on promoting Universal Health Coverage (UHC)

#### **Year 3 Progress Against Objectives –**

**Implementation and institutionalization of National Health Accounts:** In Y3Q1, HFG built on previous progress and supported the Ministry of Health and Social Services' (MoHSS) Health Accounts team to hire and train data collectors as well as facilitate the data collection from insurers, employers, NGOs, and other government agencies. Additionally, the team gathered household spending information from the recently completed Demographic and Health Survey for Namibia. The project then supported the Health Accounts team to clean and upload the data into the Health Accounts Production Tool; analyzing the collected data; and mapping the data to the expenditure categories in the SHA 2011 framework.

In Q2, the Health Accounts team finalized data collection, worked to fill remaining data gaps, vetted results with key stakeholders, and produced preliminary figures that were validated by the MoHSS. HFG joined the MoHSS regular Management Meeting in order to validate the preliminary findings of the 2012/13 health accounts exercise with the Permanent Secretary (PS), Deputy PS, and MoHSS managers. Results of disease spending were not presented at the meeting as the team was still trying to collect additional data and reconcile the health accounts findings with the NASA results. The overall feedback was positive and the group was eager to validate the disease results when the data are available.

In Q3, the Health Accounts Report and Methodological note were finalized based on feedback from the MoHSS and printed for dissemination. Due to scheduling conflicts of MoHSS senior management, final dissemination was moved to early Q4.

In Q4, the MoHSS released the results of the health accounts at an official dissemination event held in Windhoek on July 15, 2015. The findings were presented by the Deputy PS, who highlighted key policy issues that the exercise uncovered and were of concern to the Ministry. The MoHSS noted the importance of conducting health accounts exercises to generate such information for decision making and policy implementation. The MoHSS Health Accounts team is keen to start the next round of health accounts (for 2014/15) and has already begun planning and preparatory work.

**Economic efficiency and effectiveness analysis for sustainable HIV and AIDS financing:** In Q1, HFG engaged with multiple key stakeholders and implementing partners in Namibia to understand current ongoing work in this area. This will help the project ensure that there is no duplication of efforts and allow us to further identify the current gaps in available evidence. However, achieving further progress on this proposed activity will require agreements to be reached between USAID/Namibia and the Government of Namibia on the way forward.

In Q2, further meetings were held with key stakeholders and the MoHSS Directorate of Special Programs to discuss the need for economic efficiency and effectiveness analyses and the parameters of work that is already planned through other partners. It was agreed with the MoHSS that a combined stakeholder meeting would be the most effective way to collectively discuss the support requirements of the MoHSS in the context of the ongoing efforts. This stakeholder meeting is expected to be scheduled in the early part of Quarter 3.

In Q3, Stephen Musau met with key stakeholders and partners implementing costing studies in Namibia to better understand the gaps in costing evidence for HIV/AIDS programming. Following these meetings and consultations with USAID/Namibia, HFG submitted a revised scope of work to conduct an HIV/AIDS Sustainability and Fiscal Space Analysis to inform the development of the HIV/AIDS Investment Case for Namibia. USAID/Namibia approved this revised SOW in June 2015.

In Q4, stakeholder consultations took place with the MoHSS, including the Directorate of Special Programs and other key stakeholders, particularly key development partners and civil society organizations, to re-affirm the scope of the Sustainability and Fiscal Space analysis and to commence data collection. Many of the governmental stakeholders outside the MoHSS were not available during the country visit and will still need to be consulted.

**Production of health financing review:** In Q4, HFG continued to support the Universal Health Coverage Advisory Committee of Namibia (UHCAN) as a technical advisor and member of the Committee's Secretariat. In our capacity as a technical advisor, HFG will produce a health financing review, equivalent to a situational assessment of the current health financing landscape in Namibia. Adhering to MoHSS protocol, HFG submitted a research proposal to the Ministry in June 2014 in order to access government data that will enhance the quality of the analysis. While HFG has yet to receive approval (or feedback) on this proposal, the project has completed collection of all publicly available data and is currently seeking alternative sources for the relevant government data. We have also begun analysis of the data and drafting of the final report.

During Year 2 of the project, HFG began support for the recruitment process of a Health Economist to support the Social Security Commission (SSC) for a 12-month period with funding from the African Development Bank. Administrative complexities of the SSC delayed the recruitment. Nevertheless, hiring was eventually done in Y3Q2 and the selected Health Economist began work in Namibia in February 2015. Since then, progress has been made in revising the UHCAN work plan, developing a concept note for additional studies required to inform the planned feasibility study, and developing country synopses for study tours that are planned for the UHCAN. These documents and proposals will all be presented at the next UHCAN meeting that is scheduled for October 2015.

In Quarter 3 of Year 3, HFG completed data analysis and drafted the health financing review report. Additionally, the SSC planned a study tour on UHC to Thailand, Ghana, Germany, and Mexico. HFG was represented on the study tour by Dr. Carlos Avila, who will provide technical guidance during the tour visits to Ghana and Thailand. Dr. Avila's participation was funded by the SSC from an African Development Bank grant.

In Quarter 4 of Year 3, the health financing review draft report was shared with the UHCAN Secretariat for feedback prior to finalization and presentation to the wider UHCAN audience in Y4Q1. Also, the study tour took place. HFG's Dr. Carlos Avila, provided technical guidance during the tour

visits. Dr. Avila's participation was funded by the SSC from an African Development Bank grant. Dr. Carlos Avila accompanied the UHCAN delegation on the study tours to Thailand, Ghana, Germany and Mexico to provide technical guidance to the team during the study tour.

Table 35 provides additional activity-specific updates.

**TABLE 35. NAMIBIA ACTIVITY DETAIL**

Year 3 Q4 Planned Tasks	Year 3 Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
<b>Activity 1: Implementation and institutionalization of National Health Accounts using the updated framework</b>		
Collaborate with the team in drafting the health accounts report	Health accounts report was finalized and printed.	
Backstop the team to disseminate NHA products to key stakeholders	Support was provided to the MoHSS to plan and facilitate the dissemination event for the health accounts results. The results were officially launched at the event by the Minister of Health and Social Services on July 15, 2015.	
Train the team on how to translate the NHA results into effective policy briefs and communication products	Discussions were held with the MoHSS on the key policy briefs that need to be developed and the team will work in the MoHSS to develop briefs on these key topic areas	
Backstop the team in developing policy briefs and communication products that answer the key policy questions identified at the onset of the exercise	Topics for the policy briefs have been discussed and agreed on with the MoHSS. The outline of the first policy brief have been drafted and shared with MoHSS for input.	MoHSS NHA team to provide feedback and input on the draft policy brief.
<b>Activity 2: Economic Efficiency and Effectiveness Analysis for Sustainable HIV/AIDS Financing</b>		
Do financial sustainability and fiscal space analysis studies as determined above	Currently collecting data and beginning analysis.	
<b>Activity 3: Production of health financing review</b>		
Do data collection and analysis for Health Financing Review	Data collection for the health financing review has been completed and analyses have been conducted	
Produce a Health Financing Review report	Health Financing Review report has been drafted. The draft will be shared with the UHCAN Secretariat for feedback prior to finalization and presentation to the wider UHCAN in Y4Q1.	
Participation in UHC study tour	Dr. Carlos Avila participated in the study tours to Thailand and Ghana to provide technical support to the UHCAN delegation.	

Year 3 Q4 Planned Tasks	Year 3 Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
<b>Activity: Unit Costing Studies</b>		
Approved scope of work and work plan	In discussion with key stakeholder in the MOH on the scope of this activity.	

## 5.1.12 Nigeria

**Program Objectives** - The HFG project's multi-year strategy with the government of Nigeria has three goals. The first goal, which is consistent with PEPFAR's Road Map for an AIDS-Free Generation, is to mobilize additional government of Nigeria (at all levels) funding for state-level HIV/AIDS programming. The objectives of our support in this area are to:

- ▶ Generate financial evidence on the costs, impact, and sustainability of HIV/AIDS programming;
- ▶ Use this financial evidence to mobilize additional government resources; and
- ▶ Ensure efficient, effective, and equitable use of state-level HIV programming resources.

The ability of the Nigerian government to mobilize Nigerian resources (from government at all levels, private sector, and civil society organizations (CSOs)) for the HIV/AIDS response will lessen the country's dependence on donor funding. Secondly, it will contribute toward greater country ownership and sustainability of the HIV/AIDS response. Increasing domestic resources is consistent with the PEPFAR Road Map for an AIDS-Free Generation, and also with the Nigerian President's 2013 Comprehensive Response Plan (PCRP) for HIV/AIDS in Nigeria. Accordingly, HFG is working to support the actualization of the PCRP by playing a catalytic role in the mobilization of domestic resources. The overarching goal of HFG's strategic actions over the next two years is to achieve long-term sustainable financing of HIV/AIDS care and treatment services at both the state and local levels, where greatest impact can be had on care and treatment.

The second goal is to support the national response to TB programming by improving the diagnosis and treatment of TB through improved supportive supervision at the local government authority level. The use of smartphones is instrumental to the achievement of this goal as the smartphones allow for rapid feedback and improvement of TB services. This goal also is consistent with the PEPFAR Road Map for an AIDS-Free Generation, and also with the PCRP for HIV/AIDS in Nigeria. This is because TB is the number-one HIV opportunistic infection and because of the close interrelationship between TB and HIV infections.

The third goal is to improve the functionality of public health facilities by assessing their capacity to carry out key Maternal, Newborn, and Child Health (MNCH), Family Planning (FP), and Reproductive Health (RH) interventions, across five states as a first step with additional work to be determined in Year 4. Specifically, the HFG project will evaluate the capacity of Local Government Authorities (LGAs) to manage and improve human resources for health and maintain adequate physical infrastructure of health facilities.

**Year 3 Activities** - The HFG project is addressing the HIV/AIDS domestic resource mobilization goal through a number of activities, which are interrelated and collectively lead toward the achievement of this goal. HFG will support this goal through the development of strategic actions at the state level to expedite the scaling up of the HIV/AIDS response in the country. This will be complemented with strategic actions to strengthen the effectiveness and efficiency of spending in the area of HIV/AIDS. HFG's work in the HIV/AIDS area will cover four priority states (Akwa Ibom, Cross Rivers, Rivers, and Lagos), which will become model states for increasing domestic funding for HIV/AIDS. This state selection and focus is a result of a new PEPFAR strategy for Nigeria as of July 2015 and supersedes HFG's previous mandate to work in 20 states.

Regarding TB supportive supervision work (second goal), HFG will build off the initial success of GxAlert, and implement the activities below to allow for a more unified TB management system in Nigeria. This system will help provide reliable, real-time data for strategic decision making. To these ends, the National TB and Leprosy Control Program (NTBLCP) has asked HFG for support in the following areas:

- ▶ Create an interactive web-based dashboard for all TB data.
- ▶ CGAT, NTBLCP, and National Agency for the Control of AIDS (NACA) better able to manage supply issues related to TB and TB/HIV co-infection diagnostics.
- ▶ Enable a scalable mobile data plan.
- ▶ Strengthen and expand case detection.
- ▶ Install at facilities and training lab technicians.

Finally, regarding the MNCH assessment (third goal), HFG has seven objectives to achieve across the five focus states (Bauchi, Cross River, Ebonyi, Kogi, and Sokoto) of this assessment. These include describing the human resource policies planned and currently under implementation; assessing service utilization based on key MNCH/FP/RH indicators; determining the availability, distribution, and mix of HRH within the five focus states for MNCH/FP/RH services; identifying the MNCH/FP/RH capacity-building requirements of staff; determining the human resource management capacity of LGAs; documenting the presence of basic amenities and their functionality in a sample of health facilities / LGAs in five states; assess key MNCH/FP/RH -related physical infrastructure indicators (e.g., presence of delivery room). In addition, in Q4 HFG brought in two Domestic Resource Mobilization consultants to conduct a desk assessment of domestic resources. These consultants will generate evidence on historical and projected revenue, budgets and expenditures for the states in order to guide discussion on feasible and sustainable allocations to the health sector.

### **Year 3 Progress Against Objectives -**

**HIV/AIDS:** At the start of Q4 and under the guidance of USAID, HFG shifted the focus of our activities from 20 states to four. HFG had been successful in implementing activities in eight of the original 20 states, including the four priority states: Lagos, Rivers, Cross Rivers, and Akwa Ibom. With the narrowed geographic focus, HFG worked with USAID/Nigeria to reconfigure its work plan across the four states to maximize the project's health financing impact during a critical point in the state governments' FY16 budgetary planning cycle. The amended work plan will also fall in line with the (new) PEPFAR strategy for care and treatment of HIV/AIDS in Nigeria. During Q2 and Q3, HFG identified several bottlenecks to the state-level domestic resource mobilization process. Subsequently, the reorganized work plan was largely the same as the initial Year 3 work plan but included two additional supplemental activities designed to efficiently and effectively address these bottlenecks and better available resources in the states: 1) Resource Planning and Mobilization; 2) Resource Allocation and Utilization; 3) Public Expenditure Process Strengthening; and 4) Resource Tracking.

To effectively implement the refocused work plan during the remaining period of the HFG Year 3, Dr. Elaine Baruwa travelled to Nigeria to support the in-country team on the HIV/AIDS Resource Mobilization activities at the state level. The HFG team also brought on board an additional eight consultants (four State Program Technical Coordinators and four Resource Tracking Specialists) to support state-level resource mobilization and tracking activities in the four priority states. These consultants work directly under the guidance of the new Acting COP Dr. Gafar Alawode and the three senior Domestic Resource Mobilization Field consultants hired in Q3.

At the end of Q4, Mr. Andre Zida travelled to Nigeria to train the local team and the four newly hired resource tracking consultants who will primarily be responsible for the in-state data collection. Mr. Zida will also provide support for the data analysis, reporting, and dissemination of the resource tracking activity.

Across the four priority states, the HFG team was able to accomplish the following:

- vii. **Resource Planning and Allocation:** HFG is in the process of finalizing both the resource mapping activity for which data collection was completed in Q2-4 of Year 3 and the costing of

HIV programming in the (original 20) priority states. These two activities will culminate in a gap analysis document currently being prepared. A draft of this document should be available by the end of Y4Q1. Additional focus on the four priority states is also being considered given the change in focus requested by the mission.

viii. **Resource Mobilization:**

*Cross River State:* A consultant has been brought on board to lead this work and has drafted a situational analysis on resource mobilization and its challenges that will inform engagement with key stakeholders in the state during Year 4 Q1. HFG is working with the SIDHAS project to jointly plan this event and to ensure that the funding of the HIV program activities being transitioned to the state is prioritized. A joint transition planning and resource mobilization workshop is scheduled for October 5-8 and USAID intends to be present.

*Akwa Ibom State:* A consultant has been brought on board to lead this work and has drafted a situational analysis on resource mobilization and its challenges that will inform engagement with key stakeholders in the state during Year 4 Q1. HFG is working with the SIDHAS project to ensure that the funding of the HIV program activities being transitioned to the state is prioritized. A joint transition planning and resource mobilization workshop was held September 21-23 and report is currently being prepared.

*Lagos State:* The HFG team met with the State Agency for the Control of AIDS (SACA) and FHI/SIDHAS project to review the implementation plan for the Lagos state resource mobilization strategy (RMS). HFG and SACA agreed upon several activities and timelines which would be the responsibility of HFG to implement. The first of these include the production of advocacy briefs for various ministries, departments, and agencies (MDAs) and the initiation of the resource tracking activity for the state which have been prepared and shared with the SACA. In addition, a situational analysis on resource mobilization and related challenges in the state has been completed. A joint transition planning and resource mobilization workshop was scheduled for October 13-14 but USAID would like to be present and has requested that it be rescheduled; this is in progress.

*Rivers State:* The HFG team met with the SACA and the FHI/SIDHAS project to discuss and plan a joint transition resource planning/resource mobilization meeting to avoid gaps in technical assistance at the close of the SIDHAS project. A transition concept note, resource mobilization strategy (RMS) process presentation, RMS draft document, and meeting agenda for the transition process were drafted and shared with USAID/Nigeria. A joint transition planning/resource mobilization workshop is scheduled for October 19-22; USAID intends to attend.

- ix. **Resource Tracking:** HFG has hired resource tracking consultants to begin this activity in two priority states, Lagos and Akwa Ibom. Resource tracking using a modified/validated State AIDS Spending Assessment (SASA) tool is an activity in the validated and draft resource mobilization strategies that HFG is working on in all the priority states. In each state HFG is taking responsibility for this activity, but at this time Lagos and Akwa Ibom are the two states that are actually ready to begin implementation. Andre Zida, a resource tracking specialist, will oversee the resource tracking team composed of consultants as well as the HFG state program coordinator in each state. Training and planning exercises for this activity were held in September in Abuja with team and USAID Abuja in attendance. Andre Zida led this event and then also visited Akwa Ibom to initiate the activity there.
- x. **Resource Utilization:** In three of the four priority states HFG was able to document the budgetary allocations for HIV/AIDS and identify bottlenecks to resource utilization in each state, that is, challenges with regards to spending budgetary allocation for HIV/AIDS. These findings were written up in the resource mobilization situational analysis for each state (Rivers state's

analysis is still pending) The state program coordinators will be developing work plans that will focus on addressing these challenges in each state.

*TB:* During Q4, the Year 3 work plan was approved by USAID/Nigeria. The HFG team immediately began finalizing plans for the roll-out of programming, hardware installation, and deployment of GxAlert applications in facilities at the start of Q1 of HFG Year 4.

A sub-award with SystemOne was also finalized and approved during Q4. This sub-award will allow HFG consultant Mr. Chris Macek to travel to Nigeria in early October to meet with the NTP and other stakeholders to identify and discuss indicators that will meet the TB/HIV needs of both the Government of Nigeria and the USG.

*MNCH:* During Q4, HFG concluded data collection for MNCH/FP/RH assessments in Ebonyi, Kogi, and Cross River states. In Kogi and Ebonyi states HFG continued working with JHPIEGO to harmonize activities to leverage activity costs for both partners. Data analysis is underway for information completed in Ebonyi and Kogi and Cross River states. A Memorandum of Understanding was fully executed between HFG and Pathfinder International for the assessment work in Cross River. The data collection is underway in that state.

HFG is collaborating with the World Bank to co-fund the MNCH/FP/RH assessments in both Bauchi and Sokoto states. The World Bank has indicated interest conducting the assessments in all the 36 states of the country and HFG intends to leverage its resources in Bauchi and Sokoto states.

With regards to Bauchi and Sokoto states, HFG is working closely with USAID/Nigeria to develop an appropriate work plan specifically aligned to needs of those states. As part of this process, HFG brought on two Domestic Resource Mobilization consultants to conduct a desk assessment of domestic resources. These consultants will generate evidence on historical and projected revenue, budgets, and expenditures for the states in order to guide discussion on feasible and sustainable allocations to the health sector. The desk review is expected to be completed at the start of HFG Year 4 Q1.

The concept note to stimulate domestic health financing in the two states is still under review by the Mission.

**Q4 Challenges** - During Q4, the COP, Dr. Olalekan Obademi left the project to return to academic duties. The DCOP, Dr. Gafar Alawode was made Acting COP to fill the gap in leadership. HFG expects to fill the gap in technical capacity by bringing a fulltime Health Finance Advisor during HFG Y4Q1 or an HIV activity coordinator depending upon the mission's focus for Year 4.

Due to the change in government at the national and state levels, many key stakeholders within government are yet to be appointed and this delayed engaging officials in resource mobilization.

While USAID wants increased resource mobilization activities and goals to be achieved in all states, HFG has found that each of the four priority states is at a different stage; e.g., Lagos has a validated RMS with an operational plan while Rivers doesn't have a draft strategy as of August 2015. Historically, some states have been better than others at budgeting for HIV and having those funds released. Moreover, the dwindling oil price on the international market has decreased the revenue of both federal and state governments, which in turn hampers their ability to fulfill their financial commitments including funding of HIV/AIDS programs.

Table 36 provides activity-specific updates.

**TABLE 36. NIGERIA ACTIVITY DETAIL**

Year 3 Q4 Planned Tasks	Year 3 Q4 Progress	Critical Assumptions/ Problems Encountered/ Follow-up Steps
<b>Activity 7: HIV/AIDS Resource Planning at the State Level</b>		
Conduct HIV/AIDS financing analysis with state-level focus	In Q4, FHG intensified HIV/AIDS financing analysis activities in USAID's 4 priority states (Cross River, Rivers, Lagos, and Akwa Ibom). Consultants are working with government stakeholders within each state to develop and validate a Resource Mobilization document for each of the states. This activity will continue in during Year 4 Q1. (See text for state-specific progress.)	
Train state-level staff in the use of the OneHealth Tool	This activity is yet to be scheduled.	It is not yet clear that a suitable target group can be identified at this time.
Do HIV/AIDS resource mapping from all sources at the state levels	This is part of the situational analysis reporting completed in 3 states and also included in the gap analysis due and of Q3.	It is important to note that USAID priority is government financing of transition activities at this time.
Do HIV/AIDS financing gap analysis	This activity continued in Cross Rivers state in Q4 and began in Q4 for Akwa Ibom, Lagos, and Rivers states. It is expected to continue in Year 4 Q1.	
Finalize the RMS with innovative financing options at the state level	In Q4, HFG intensified efforts in all 4 states with stakeholder engagement workshops completed in Akwa Ibom and scheduled for all other states.	
Develop RMS operational plan	Developed in Lagos with HFG having specific roles (e.g., resource tracking) and development is ongoing in other states.	HFG is working with SIDHAS on transition planning which needs to be incorporated into the state RMS.
Develop policy instruments to improve health financing	Advocacy materials drafted for Lagos state being reviewed by SACA. HFG will use these as templates for other state advocacy briefs.	
<b>Activity 8: HIV/AIDS Resource Mobilization at the State Level</b>		
Develop Investment Cases that demonstrate the return on investing in HIV treatment	Considered to be part of RMS development,	May not be required if other resource mobilization approaches are adopted in priority states.
Work with CSOs on innovative financing for HIV/AIDS programming	State-level program coordinators have been hired and the tasks related to this activity are being developed in the one-year work plan commencing Oct (Y4Q1). Draft RMS in Lagos and Akw Ibom have CSO-focused activities.	

Year 3 Q4 Planned Tasks	Year 3 Q4 Progress	Critical Assumptions/ Problems Encountered/ Follow-up Steps
<b>Activity 9: HIV/AIDS Resource Allocation at the State Level</b>		
Develop detailed activity work plan	State-level program coordinators have been hired and the tasks related to this activity are being developed in the one year work plan commencing Oct (Y4Q1).	
Train CSOs on advocacy for resource allocation for HIV	See above	
Develop and implement state-level Budget Engagement Plans	See above	
Do state-level interest group mapping	See above	
Develop KPIs for states	See above	
<b>Activity 10: Support State-Level Institutionalization of Resource Tracking for Health and HIV/AIDS Spending</b>		
Review and refine the key questions related to government HIV/AIDS spending for the resource tracking system to address	Resource tracking team mobilized, Andre Zida overseeing activity. Lagos and Akwa Ibom states are ready to commence. Resource tracking is being considered for all state RMS and HFG is taking on the task in coordination with SACAs.	Rivers and Cross Rivers states do not yet have draft RMS so resource tracking is not yet a SACA priority in those states but HFG will be pushing for it as it is critical to resource mobilization efforts.
Develop indicators that would help answer the identified questions (including their definitions)	Part of ongoing resource tracking efforts. Zida initiated discussions in Akwa Ibom.	
<b>Activity 11: HIV/AIDS Resource Utilization at the State Level</b>		
Initiate dialogue between state-level health-related institutions and state ministries of finance to promote greater allocation and appropriate utilization of resources for HIV/AIDS	State-level program coordinators have been hired and the tasks related to this activity are being developed in the one-year work plan commencing Oct (Y4Q1).	
<b>Activity 12: MNCH Infrastructure and HRH Assessment</b>		
Desktop review	This activity was completed in Q4.	
Survey instrument	This activity was completed in Q4.	
Sampling	This activity was completed in Ebonyi, Kogi, and Cross River states in Q3.	
Data collection	This activity was completed in Kogi and Cross River states in Q4.	
Data analysis	This activity commenced in Ebonyi and Kogi and Cross River in Q4. This activity will commence in Cross River in Y4Q1.	
Data validation	This activity will commence in Y4Q1.	

Year 3 Q4 Planned Tasks	Year 3 Q4 Progress	Critical Assumptions/ Problems Encountered/ Follow-up Steps
<b>Activity I3: Connecting TB data streams for better planning and establishing a secure and streamlined data network</b>		
Stakeholder meetings to get agreement on connecting all TB systems	This activity will commence in Y4Q1.	Work plan approved mid-Aug 2015.
Identify elements necessary to connect systems	See update above.	
Connect the systems and test	See update above.	
Train/orient stakeholders to dashboard as necessary through training of trainings	See update above.	
Monitor dashboard use and modify as necessary	See update above.	
Negotiate contract GlobalCom for integrated platform data bundle	See update above.	
Get all mHealth users onto platform	See update above.	
Procure necessary hardware to enable a scalable mobile data plan	See update above.	
<b>Activity I4: Strengthen the Capacity of CGAT, NTP, and NACA to best monitor and utilize GeneXpert machines.</b>		
Hold stakeholder meeting for application specs	This activity will commence in Y4Q1.	Work plan approved mid-Aug 2015.
Develop application	See update above.	
Train select NTBLCP staff on application	See update above.	
Roll out applications onto GeneXpert machines	See update above.	
Monitor stock rates, EQA indicators, and machine utilization	See update above.	
<b>Activity I5: Strengthen and expand case detection</b>		
Custom data capture component	This activity will commence in Y4Q1.	Work plan approved mid-Aug 2015.
One click installer	See update above.	
Secure data transmission component	See update above.	
In country SMS provider	See update above.	

Year 3 Q4 Planned Tasks	Year 3 Q4 Progress	Critical Assumptions/ Problems Encountered/ Follow-up Steps
<b>Activity 16: Install all GxAlert applications in facilities and orient lab technicians.</b>		
Custom data capture component	This activity will commence in Year 4 Q1.	Work plan approved mid-Aug 2015
One click installer	See update above.	

### 5.1.13 South Africa

**Program Objectives –** - South Africa has requested USAID technical assistance in planning how HIV financing and service delivery can be integrated with National Health Insurance (NHI). Given NHI policy has not been finalized, improving HIV financing and purchasing of services could either play a leading role in broader NHI development or be encompassed into NHI together with other services. Over 2015-2017, HFG will provide policy actors in South Africa – mainly the National Treasury (NT) and the Department of Health (NDOH) – with tailored and in-depth advice on how to approach such integration and sequencing including whether and how South Africa’s current HIV conditional grant funding can form a foundation for the future NHI. HFG will produce policy analysis on integrating HIV services into NHI’s benefits policy, estimate the impact of doing so on NHI revenue requirements, and help develop options for strategic purchasing of HIV services by the future NHIF. The project will also produce early input for the government of South Africa on better geographic targeting of the HIV response.

USAID is a partner with the government of South Africa in transforming the country “into an equitable, effective, and exemplary nation.” Over 2013-17, USAID is pursuing the development objective of improving health outcomes for South Africans. Critical to doing this is the mutual understanding that official development assistance, at less than 1 percent of South Africa’s budget, is best utilized to improve the effectiveness of domestic resources and enhance the knowledge and capacity of development actors. In fact, a Partnership Framework signed between the governments of South Africa and the United States regarding HIV and TB commits the two governments to a collaborative engagement that enables South Africa to lead the charge on making these programs sustainable, responsive, and innovative. Hence, the two governments have agreed to channel PEPFAR support into “system strengthening, prevention, and health services innovation” so as to facilitate a transition to full domestic programming and financing. This HFG analysis on NHI/HIV will support this agenda by sourcing vital analysis to help enhance more efficient and sustainable use of domestic health resources for HIV, put in place systems to purchase and deliver more effective services, and better target limited resources for greater impact.

HFG’s primary counterparts will be the NT, NDOH, provincial departments of health and treasury, and public and private providers. HFG will work with a variety of partners to leverage existing activities and strengthen local institutions to maximize outcomes during the project period and beyond, including other development partners and potentially South African universities.

The overall objective of this activity is to ensure the long-term sustainability of HIV/AIDS services as donor resources diminish by supporting the government’s efforts to:

- ▶ Integrate HIV services into the benefits policy of the proposed NHI;
- ▶ Estimate ongoing resource requirements for doing so;
- ▶ Identify options for pooling and strategic purchasing of HIV and other services through existing arrangements and the future NHI Fund; and
- ▶ Target HIV resources to geographies where they will have the most impact on the epidemic.

HFG will contribute to USAID South Africa’s Development Objective 1: Health outcomes for South Africans improved; IR 1.2 Sustainability of effective HIV and TB response systems increased; and IR 1.3 Care and treatment of vulnerable populations improved; as well as HFG IR 1 Improved financing for priority health services.

**Year 3 Activities** - In March 2015, USAID South Africa sent a scope of work to HFG outlining 4 activity areas: 1) Integrating HIV/AIDS into the NHI benefits policy, 2) Estimating HIV/AIDS-related revenue requirements for a future NHI; 3) Developing options for strategic purchasing mechanisms between NHI and HIV/AIDS service providers; and 4) Analyzing impact of geographic prioritization. HFG's overall approach is based on strategic assumptions about the relationship and synergies between the four project activities: 1) a balance of revenue increases and expenditure management improvements including efficiency gains is required to ensure sustainable financing of HIV services; 2) improving purchasing of HIV services requires a strong and direct relationship between specification of HIV benefits and payment to providers for those benefits or services; 3) work needs to encompass national, provincial, and district levels in order to improve financing and geographic targeting; 4) appropriate implementation sequencing and achievement of small victories is imperative to improving purchasing of HIV services and sustainability of HIV financing in the context of both domestic programs and declining donor funds.

**Year 3 Progress Against Objectives** - During Q3 (April), HFG submitted a preliminary work plan to begin outlining how HFG will provide technical assistance to support the NT. HFG received AOR approval for forward funding to do Activity 4 (see below), and to meet with the Mission and NT to plan tasks for activities 1-3 in Q4 and Year 4.

Due to the time sensitivity of Activity 4, HFG (Avenir) began conducting the analysis of geographic prioritization through the generation of a district-level analysis to determine the incremental impact of HIV/AIDS intervention services in 27 districts on the national epidemic as compared to the current approach of providing HIV/AIDS intervention services in all 52 districts in South Africa. The model developed is also being used to explore alternate geographic prioritization scenarios. The expected time horizon is two years (2017) for OGAC and five years (2020) for SAG. The findings are expected to be made available by the end of Q3.

HFG met with the Mission (Rob Stanley) and the NT on May 27 to review a list of specific requests from the NT. The NT has expressed interest in using local organizations, such as the Health Systems Trust and the University of Witwatersrand, for some of the activities. HFG proposed a timeline for implementation of the activities. HFG met again with NT on June 22-23 to further discuss the scopes of the activities prioritized for Q4 and Q1 of next year. The work plan was finalized with the Mission and the NT, and approved and submitted to the AOR in August. On August 21, HFG met with Rob Stanley while he was in Washington, DC, for training, to review activities and the upcoming trips in October: 1) Results for Development (R4D) in early October to do the UNAIDS assessment of options to integrate the financing of HIV/AIDS with other health; and 2) HFG's Sheila O'Dougherty and Catherine Connor, to work on the road map for integration of HIV/AIDS and PHC.

Table 37 provides additional activity-specific updates.

**TABLE 37. SOUTH AFRICA ACTIVITY DETAIL**

Year 3 Q4 Planned Tasks	Year 3 Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
<b>Activity 1: Deciding What To Buy/ Integration of HIV Services with NHI Benefits</b>		
A way forward for HIVAIDS and NHI	NT asked Sheila O'Dougherty to contribute to initial dialogue and strategy development ("road map") with the NT and USAID/Pretoria to leverage South Africa's HIV/AIDS program to advance the principles and plans for NHI, ensuring sustainability of a high-quality HIV response and advancing the design and eventual implementation of NHI.	Sheila O'Dougherty and Catherine Connor will travel to South Africa in October to work on the road map.
Global landscaping on HIV financing integration and application to South Africa (co-funding from UNAIDS)	UNAIDS has funded R4D to complete an assessment of options for integrated financing of HIV/AIDS and PHC. The R4D team completed the document review and will travel to South Africa in early October to conduct interviews with government officials at the national and provincial levels, and representatives of private providers and medical schemes.	The UNAIDS assessment will inform HFG activities and many of the key informants are stakeholders who are relevant to the HFG program.
Engaging stakeholders for different perspectives on HIV integration in the context of NHI and PHC	HFG drafted terms of reference for the stakeholder group and submitted to NT and USAID. NT had minor comments and clarified that DOH is to lead/host the stakeholder group.	HFG will meet with the DOH contact, Yogan Plessy, to plan the stakeholder group.
<b>Activity 2: Costing and Revenue Requirements for HIV/AIDS under NHI</b>		
Analyzing the South Africa HIV Investment Case plan and NDOH budget bid	<p><b>Task Overview:</b> The NT asked HFG to analyze the bids submitted by the NDOH to augment the budget available for South Africa's HIV and TB responses in 2017/18 and 2018/19. The analysis will inform NT's recommendations to MTEC on allocating additional funding for these programs in the health budget for those years. NT sought clarity on the following key questions: 1) Are the proposals from NDOH clear and comprehensive? 2) Are they consistent with the analysis contained in the Investment Case for HIV and TB? 3) Are the additional funding estimates accurately calculated?</p> <p><b>Key Findings and Recommendations:</b> Our analyses found that although both bids reinforce NDOH's commitment to achieving the HIV and TB 90-90-90 goals set out in the Investment Case, the funding requests fall short of estimated resource requirements for HIV in 2017/18 and 2018/19 and for TB in 2018/19. Additional information was also needed in both bids to clarify funding figures, rationales, and links to the Investment Case.</p> <p><b>HIV Bid:</b> The HIV funding envelope should enable NDOH (I) to achieve the treatment, adherence, and</p>	<p>Next Steps</p> <p>Informed by HFG's analysis, NT reported its recommendations to MTEC on September 9. Over the next two weeks NT will finalize its recommendations for the Cabinet through an additional presentation to MTEC on September 16 and subsequent discussions with Mincombud. HFG continues to support NT, including with additional input on how to better align the government's HIV and TB investments with the Global Fund and PEPFAR's plans. Specifically, Teresa Guthrie will spend approximately one day working with the primary author of NDOH's budget bids to help clarify connections between the bids and the Investment Case scenarios.</p>

Year 3 Q4 Planned Tasks	Year 3 Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
	<p>prevention targets articulated in the Investment Case and the National Strategic Plan on HIV, STIs, and TB, 2012-2016; (2) to deploy funds needed to make up for a phased withdrawal of PEPFAR financing; and (3) to support efforts to control the country's HIV epidemic in the long run.</p> <p>However, NDOH is targeting a more modest overall scale-up because of absorption and capacity constraints in the public sector. The cost estimates for total annual needs are lower than provided in the Investment Case, and NDOH's proposed coverage volumes are lower than those suggested under the Investment Case's 90-90-90 scenarios.</p> <p>HFG suggested that NT request NDOH to provide more information on the scale-up rates for each intervention, their unit costs, and the assumptions and efficiency drivers underlying the funding projections for various HIV treatment and care and prevention program components. This would allow verification that the request for additional funds in 2017/18 and 2018/19 represent the resources needed to achieve the projected scale-up rates.</p> <p><b>TB Bid:</b> The bid's coverage and outcomes targets align with the TB 90-90-90 targets, but the funding amount requested may be insufficient to realize cost savings in the next 20 years.</p> <p>HFG recommended that NT ask NDOH to explain the gap between estimated resource needs and the augmentation request and to potentially revise the bid amounts upward.</p>	
<b>Activity 4: Impact Analysis of Geographic Prioritization</b>		
Conduct a modeling analysis of PEPFAR's district prioritization	<p>The original need for this analysis was to address NDOH concerns about the PEPFAR prioritization strategy that will shift PEPFAR support from all 52 districts to focus on achieving the UNAIDS 90-90-90 goals at current treatment guidelines within 27 high-burden districts by 2017. In June, Avenir had clarification questions for USAID regarding assumptions for the modeling of the impact of the PEPFAR prioritization strategy. In August, USAID advised that the DOH appreciation of the strategy was growing and the need to conduct this analysis for the DOH was fading. HFG suggested that the analysis could be of interest to OGAC which is rolling out this strategy in multiple countries.</p>	<p>Avenir advised that the analysis can still be done and would be interesting. But to do it correctly they need guidance on the following key question: When PEPFAR decides to focus on certain districts, does that mean that non-focus districts actually have reduced coverage of some services or just no scale-up? Is PEPFAR supporting some level of scale-up in all districts versus a larger scale-up effort in some districts and none in others?</p>

### 5.1.14 Swaziland

**Program Objectives** - The PEPFAR Partnership Framework on HIV and AIDS 2009-2013 between the Government of the Kingdom of Swaziland and the U.S. Government committed the two countries to work together to address challenges in Swaziland's health and social welfare (SW) systems to mitigate the impact of HIV/AIDS.

One of the key intervention areas focuses on the development of human and institutional capacity to manage an effective HIV response. Within this key intervention area, the countries plan to “further strengthen human resource capacity in the areas of human resource management, policy reform, recruitment, and retention and training, and to build institutional capacity across program areas through management systems strengthening and enhanced infrastructure” (PEPFAR Partnership Framework). HFG's program activities in Swaziland support the strengthening of human resource capacity within the system, particularly the capacity of the Ministry of Health (MOH) for human resources for health (HRH) management, policy reform, and retention.

A second key intervention area that HFG's program focuses on is the mitigation of the impact of HIV/AIDS on vulnerable children and their families. The Partnership Framework prioritizes the development and implementation of national program standards and strategies for quality improvement, enhancement of program monitoring, and scale-up of quality services and support for vulnerable children. HFG supports the strengthening of the Department of Social Welfare (DSW) and regional social service providers to deliver in these strategic areas.

**Year 3 Activities** - HFG opened an office in Mbabane, Swaziland in Year 2, which is now fully operational in implementing the project's work plan. In Y3, HFG is building upon this momentum to make progress in its HRH and SW portfolios.

In HRH, HFG works with the MOH, mission, and other stakeholders in four areas that were identified as priority by HRH stakeholders: 1) supporting completion and implementation of strategic plans; 2) improving the structure and capacity of human resources management and oversight; 3) strengthening human resource information system (HRIS) and use; and 4) strengthening the professional councils' capacity for regulatory oversight. These areas will be revisited early in 2015 and form the basis for the next HFG work plan.

The HFG SW activities complements and builds on prior PEPFAR investments in the Lubombo region to establish a comprehensive decentralized SW delivery system, and to explore potential expansion of the decentralized approach to the Manzini region. In addition, the project works with the DSW and other SW stakeholders in the country to identify priority barriers to SW service delivery and to develop concrete strategies for addressing them. All HFG SW work in Swaziland is guided by two parameters articulated by PEPFAR/Swaziland: (1) Technical support to strengthen SW systems and connect human resources to concrete improvements in service delivery; and (2) Bottlenecks in service delivery should be addressed as a priority, even while restructuring or other large-scale efforts are ongoing.

#### **Year 3 Progress Against Objectives -**

##### **Social Work:**

- ▶ Developing and delivering a five-day Case Management Training for 40 DSW SW assistants, SW officers, senior SW supervisors, and the Deputy Director January 16-20, 2015.
- ▶ Developing case management practice guidelines in conjunction with the DSW
- ▶ Developing a mentoring guide and tools for social workers
- ▶ Planning and conducting a five-day Customer Care training for 12 social workers and 8 supervisors

- ▶ Providing support to DSW's Public Sectoral officers during an assessment for justification of additional positions, which resulted in DSW being given 5748 additional Social Work positions nationally. in the Lubombo and Shiselweni regions
- ▶ Issuing a subagreement with the Institute for Child Witness Research, Training and Trust (ICWRT) for court Intermediary, prosecutors and Magistrates court trainings to be conducted in the next quarter.
- ▶ Issuing three additional sub-awards to two local NGOs: Cabrini Ministries (2 sub-awards) and Bantwana (1 sub-award), with the objectives of increasing the supply of quality SW services in Lubombo; strengthening referral and coordination mechanisms; contributing to the evidence base on SW practice service delivery models; and improving the capacity of the Lubombo SW workforce.
- ▶ Planning and hosting a kickoff meeting for sub-recipient NGOs in January 2015.

**Human Resources for Health:** During the year, HFG made tremendous strides toward the achievement of intended project results. In line with the new PEPFAR strategic direction and the PEPFAR HRH strategic strategy, HFG expanded its scope of providing HRH technical support to include PEPFAR partners, in addition to the MOH. A number of achievements have been realized and more promising practices are emerging. Key achievements include:

*HRH assessment:* HFG worked collaboratively with PEPFAR headquarters and the country team, the MOH, and PEPFAR clinical partners to conduct an HRH assessment to inform the partner transition and staffing plans for COP 15. The HRH assessment, which was the first of its kind since the new PEPFAR HRH strategy, covered a total of 94 'scale-up' and 'high maintenance' sites. The number and mix of staff required to meet COP 15 PEPFAR targets were determined and the results compared with existing staff, to determine the staffing gap and work pressure, so as to guide partner staffing plans and prioritization of HRH support.

The assessment results were widely applauded by key stakeholders and through extensive dissemination/advocacy with clinical partners, MOH, and PEPFAR, the use of the results has been extensive. All the clinical partners (ICAP, EGPAF, and URC) revised their staffing plans based on the assessment results. So far, the support for data clerks and lay cadres is in consonance with the recommendations of the assessment results, while that for lab cadres needs further enhancement. HFG is working closely with PEPFAR to further advocate for additional support for lab cadres to be able to meet the PEPFAR country targets and the 90-90-90 targets.

*HRIS data quality improvement:* Another significant achievement during the year was the HRIS data verification exercise. In collaboration with WHO and support from the Ministry of Public Service (MOPS), HFG worked with the Health Resources Unit (HRU) team over the weekends to verify staff's physical location versus the establishment and the HRIS. Inaccurate HRIS data compared to the actual location of staff has been a key challenge, rendering most of the HRIS reports unusable for HRH planning and management. With HFG's support, the MOH was able to obtain accurate information of the location of each staff and this will be used to correct the HRIS. A smaller task team has been selected to finalize this process and a detailed HRH status report after the verification is being finalized.

Further, for the first time, the MOH was supported to obtain an accurate vacancy list that is currently being used to guide the recruitment and promotion of health workers in the sector. Unlike the past, HRH managers and policymakers are using the improved HRH data to make HRH planning and management decisions in the MOH.

*Streamlining job descriptions benefit packages and recruitment processes for donor-supported positions:* Streamlining the job descriptions and recruitment process for these positions has been a key achievement. HFG worked with PEPFAR partners and the MOH to review the job descriptions of data clerks and all lay cadres, i.e., lay counselors, cough monitors, mentor mothers, expert clients, and cough

monitors. Moreover, using the results of the salary survey, the benefit packages of the supported cadres were streamlined across PEPFAR partners and in line with MOPS pay grades. Although the process was difficult at the beginning, with high-level support from the MOH and PEPFAR, the revised job descriptions and benefit packages are being used by the partners to engage staff.

Similarly, with technical support from the MOH legal advisor, the employment agreements and service level agreements for donor-supported positions were revised to align them to the labor laws in Swaziland. The employment agreements were readily used by all partners including non PEPFAR partners. Given this success, the MOH senior management has asked that the streamlining process include all partners in health. Currently HFG is supporting the Global Fund to adopt the same process for the staff in the new Global Fund funding cycle effective October 2015.

*New positions for MOH:* During the year, HFG supported the MOH in developing a request for new positions for the MOH to meet the increasing workload and scale-up of services. Out of the 279 positions requested, 117 (42 percent) positions were provided by the MOPS. These included two human resource officers (HROs) whose presence will greatly improve the performance of the unit.

*Undersecretary for Administration:* After 18 months of not having an undersecretary for administration to whom the HRU reports, a substantive candidate was finally appointed in December 2014. She started work in January 2015. The filling of this high-level management position is hoped to tremendously improve the functioning of the unit especially the functioning of the Human Resources for Health Technical Working Group (HRHTWG), the Human Resource Management Committee (HRHMC) and high-level representation at senior management level.

*Recruitment guidelines:* Although still in draft form, the recruitment guidelines have greatly influenced the recruitment and promotion of health workers in the sector. The guidelines recommended the establishment of the HRHMC, which is functional and chaired by the undersecretary for administration. Since its inception in September 2014, the committee has processed the recruitment of over 343 staff including 6 doctors, 57 nurses, 8 phlebotomists, 23 health assistants, and 127 paramedics. The committee has also processed the promotion of at least 131 health workers, which not only improves the staffing situation but also enhances health worker motivation.

*HRHTWG annual work plan:* HFG worked with key stakeholders in HRH to develop the 2015/16 annual HRHTWG work plan. This work plan currently under implementation and its implementation is reviewed on a monthly basis during the HRHTW meetings.

*Key achievements from the HRU team perspective:* When asked what the key achievements of the unit have been since the first unit operational plan and the support from HFG and WHO, the team highlighted the following:

1. Clearer roles for staff
2. More feasibility and trust of key stakeholders in the HRU
3. Improved performance of the department, e.g., timely stopping of payment for retiring officers, which is saving government money, timely access of newly recruited health workers on the payroll, i.e., within one month of recruitment, improved access to the HRIS, increased staffing reducing work stress, improved storage facilities for personnel files, and development of recruitment guidelines for the sector to guide the recruitment of health workers.

Table 38 provides additional activity-specific updates.

**TABLE 38. SWAZILAND ACTIVITY DETAIL**

Year 3 Q4 Planned Tasks	Year 3 Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
<b>Activity: Support evidence-based policies for hiring and deployment for PEPFAR scale-up</b>		
Determine and cost the HRH implications (number and skills mix) for meeting PEPFAR scale-up and targets	<p>An HRH assessment was done covering 94 'scale-up' and 'high maintenance' sites. The number and mix of staff required to meet the PEPFAR targets was determined, and compared with existing staff, to determine the staffing gap and work pressure.</p> <p>Results of the assessment have been discussed extensively with the clinical partners, PEPFAR, and relevant departments in the MOH, to inform HRH staffing decisions.</p> <p>The assessment results were applauded by all stakeholders for providing objective HRH information to inform HRH staffing decisions in the regionalization process and PEPFAR scale-up of HIV/AIDS care and treatment services.</p> <p>The study report will be finalized by the end of September 2015, ready for dissemination in the next quarter.</p>	<p>HRH assessment report will be finalized and shared with all stakeholders.</p> <p>In consultation with PEPFAR, the plan is to share results with the MOH senior management.</p>
Standardize job descriptions, recruitment, and management and benefit package for CHWs	<p>The job descriptions for facility-based lay cadres (cough monitors, lay counselors, mentor mothers, and expert clients) and those for phlebotomists and data clerks were reviewed and standardized across PEPFAR clinical partners.</p> <p>The benefit package for the lay cadres, phlebotomists, and data clerks were standardized based on the PEPFAR partner salary survey and government pay scales.</p>	<p>The need for further streamlining of facility-based cadres with the possibility of merging scopes became apparent during the job description standardization. This will be pursued in the next quarter.</p> <p>Further, based on the PEPFAR streamlining process, the PS health requested to expand the streamlining process across all partners including GF, MSF, and CHAI. This will be done in Y4Q1.</p>
Conduct an inventory of PEPFAR salary support	<p>A PEPFAR salary support inventory was done as part of the process for standardizing the benefit package across PEPFAR partners. The results of the assessment informed the standardization of salaries and benefits for cough monitors, lay counselors, mentor mothers, expert clients, phlebotomists, and data clerks.</p> <p>The report for the standardization process including a summary of the salary inventory was shared with PEPFAR clinical partners, the MOH and PEPFAR in electronic format.</p>	Activity successfully completed.

Year 3 Q4 Planned Tasks	Year 3 Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
Develop system and tools for recruitment and management of PEPFAR-funded positions	<p>With technical support from the MOH legal advisor, the employment contract and service level agreement templates were reviewed to address areas of potential litigation. The revised tools were used by PEPFAR partners in contracting/engaging the supported staff.</p> <p>In collaboration with Global Fund (GF) and MOH, HFG developed the key processes/steps in the recruitment of contract staff funded by donors. These will be presented to program managers and once finalized will be included in the MOH recruitment guidelines.</p>	<p>Collaborate with MOH and partners (GF &amp; MSF) to ensure use of the revised employment contract and service level agreements.</p> <p>Finalize the recruitment processes for donor supported positions and incorporate them in the MOH recruitment guidelines.</p>
<b>Activity: Improve the structure and capacity of human resources management and oversight</b>		
Change management, organizational development, and training for implementation of plan	<p>All work to support the interim structure, including change management, organizational development and training, have been assigned to WHO in 2015. However, HFG will continue to provide technical assistance as appropriate.</p> <p>In line with this, HFG worked with WHO to support the HRU to review its previous work plan and develop an operational plan for the period of September 2015-March 2016.</p> <p>HFG's Senior HRH Advisor also worked with the HRU senior staff to draft a calendar of key meetings affecting the unit. This tool is hoped to improve individual work planning and attendance at key unit meetings like the unit's monthly meeting, and the HRHTWG monthly meeting.</p>	Discuss the draft calendar with the HRU team before it is finalized.
Propose and support the implementation of structural reforms for HRU	<p>In addition to the above, HFG supported HRU's senior management to review the mandate of the unit as spelled out in the HRH strategic plan and MOH's structure. In response, with guidance from the PS for health, it was agreed that each HRO is assigned to a region for which she/he is responsible for all the HRH management functions as a middle ground to complete decentralization of the HRH function as outlined in the strategic plan. The job schedules developed in December 2014 were reviewed and duties assigned across staff including the new HROs. Individual staff job schedules/duties were aligned to this strategic direction within the available job descriptions, to ensure achievement of the unit's mandate</p>	<p>The role clarification exercise was hampered by unclear reporting lines and lack of approval of the HRH structure. HFG will continue to collaborate with the organizational capacity-building partner WHO, the HRU team, and PEPFAR to accomplish this task.</p>

Year 3 Q4 Planned Tasks	Year 3 Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
Provide organizational development support, day-to-day mentorship in core functions, and systems-building support	<p>HFG's HRH Senior Technical Advisor continues to provide support to the HRU, co-locating in the HRU's offices 1-2 days per week to provide ongoing training and mentorship to the staff in HRH technical areas.</p> <p>The mentoring approach has been revised to make it output-based and targeted to individual staff including: the undersecretary, PHRO, SHRO, and HROs.</p> <p>A draft mentoring plan has been developed and will be finalized in Y4Q1.</p> <p>HFG provided training in key human resource policies and procedures, including contract management and industrial relations; work planning; recruitment planning, HRIS analysis; HRIS reports and in collaboration with WHO and CHAI IT training for the HRU.</p>	<p>Time has been a constraint; HFG's HRH Senior Technical Advisor was also supporting PEPFAR partners addressing key HRH issues during the transition period.</p> <p>The mentoring plan will be finalized in consultation with HRU and PEPFAR.</p>
Build HRU and MOH capacity in three core functions: IT use, contract management, and industrial relations	HFG provided training in key human resource policies and procedures, including contract management and industrial relations; work planning; recruitment planning; HRIS analysis; HRIS reports and in collaboration with WHO and CHAI IT training for the HRU.	Continue mentoring and coaching selected HRU staff as they do their work based on the mentoring plan.
<b>Activity: Support the MOH Human Resources Unit to strengthen systems for health worker management</b>		
Improve the HRIS data completeness and accuracy and build capacity for use at the regional and facility levels	<p>HFG worked diligently with the MOH, MOPS, and health facilities to validate the data in the HRIS with the staffing situation on the ground. The validation results were presented to the HRHTWG and were commended and approved for presentation to the MOH senior management.</p> <p><b>Summary of the validation exercise:</b></p> <p>Of the 4,357 established positions, over 720 were used in responsibility centers other than those to which they were allocated, 447 were vacant, 42 were used by staff at school, and 295 were unlinked after promotion or exit from service. Sixty-five percent (2,831) were used correctly, i.e., in the responsibility center where they were allocated by the establishment register.</p> <p>The established positions were compared with the staff currently present to determine the filling rate (current staff/established posts %). The overall filling rate was good at over 82% and varied by responsibility center and cadre. Notably, the clinics had high filling</p>	<p>The many public holidays delayed the presentation of the validation results to the MOH senior management; however, this will be further pursued in the next quarter.</p> <p>HFG will work with the HRIS task team to formulate concrete recommendations based on the validation results.</p> <p>HFG will continue to work with the MOH's HRHMC to ensure the vacant positions are filled. The challenge currently is that the CSS term has expired.</p> <p>HFG will work with the MOH and CHAI to use the staffing norms as a way of validating them before their final approval.</p>

Year 3 Q4 Planned Tasks	Year 3 Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
	<p>rates of over 85% and yet the HRH assessment showed that the current staff is not adequate to accomplish the workload at that level. This is a clear testimony of the inadequacy of the staff establishment and the need to base staffing norms on workload.</p> <p>A number of vacancies exist and offer potential for improving staffing in the facilities; however, of the 447 vacant positions, only 133 (30%) are for cadres directly involved in the delivery of HIV/AIDS and TB services. Of those vacancies, 77 were in advanced stages of being filled leaving only 56 vacant - lab (16), medical officer (8), nurses (31), and pharmacy (1).</p>	
Support development of a standardized recruitment process for MOH professional and support staff at the central and regional levels	Draft recruitment guidelines are in place and are guiding recruitment in the MOH. The guidelines instituted the HRHMC, which is functional but needs further strengthening to ensure regular meetings. Approval of the guidelines was stayed to allow the MOH learn from the experience using the draft guidelines so that lessons learned can be used to finalize the guidelines. So far, a number of recruitments have been done based on the recruitment and revisions to the draft suggested.	Finalize the recruitment guidelines based on lessons learned during recruitment and include a component on recruitment processes for positions not supported.
Support the HRU to develop the annual HRH TWG 2016 implementation plan	This activity will begin in January 2016.	
Support the HRU to develop an evidence-based annual request for new positions and budget	<p>HFG is currently working with the MOH to compile the annual request for new positions. A meeting was held with the heads of cadres to discuss the key considerations in developing their request so that it is more realistic, and a template for the request was shared with them.</p> <p>Requests have been received from most heads of cadres and compiled into one request. CHAI has also supported the process by providing a comparison of the staffing norms and staff currently at the facilities to inform prioritization of the requests.</p>	Meet with all the heads of cadres to discuss and prioritize the request before a presentation to the MOH senior management and, subsequently, submission to MOPS.
Develop and produce the second annual HRH Status Report	<p>A draft report has been developed and shared with PEPFAR and MOH for input. The report will be finalized based on feedback and disseminated per MOH guidance.</p> <p>The HRH status report provided vital HRH information to guide HRH policy, planning,</p>	Finalize HRH status report based on feedback from MOH and PEPFAR and agree on dissemination plan with MOH.

Year 3 Q4 Planned Tasks	Year 3 Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
	and management decisions. Key information presented in the report include: (1) health worker filling and vacancy rates by cadre and responsibility center, (2) health worker distribution by region, cadre, health facility type, gender, and nationality, (3) number of staff on long in-service training, by cadre, course, and return date, (4) health worker population ratios compared with WHO standards, and (5) MOH wage expenditure by cadre and responsibility center.	
Draft a mentoring plan for the US, MOH	<p>The process of developing a mentoring plan for the undersecretary for health began in January 2015. The plan will be finalized in the next quarter; however, mentorship in the areas identified is ongoing.</p> <p>During the quarter, the undersecretary was supported to clarify roles and responsibilities for each of her staff and this will continue into the next quarter. Further, with financial support from WHO, HFG provided technical support and tools to facilitate the process of developing the 2nd annual plan for the HRD.</p>	<p>Finalize the development of a mentoring plan for the undersecretary for admin.</p> <p>Agree with PEPFAR and WHO on how to finalize the HRD work plan and role clarification process.</p> <p>Develop a six-month calendar for key activities in the HRD.</p>
<b>Activity: Support the development of an enabling environment and strong systems for the delivery of social work services</b>		
Overhaul the electronic case management system	During Q3, meetings were held with PEPFAR, HFG's M&E and IT consultants and advisor to improve data collection and the electronic case management system. Consequently, a plan has been developed to overhaul the system and get it fully operational including level of effort (LOE) of the consultants.	Work plan will be approved to enable implementation.
Strengthen Lubombo Regional Child Friendly Court	Requests for the rotation system and maintenance agreement for the Lubombo Child Friendly Court CCTV system has been submitted to the F&A and is awaiting work plan approval.	
Support the set-up of systems for better management and support of social work staff		To be completed in Y4Q1.
Finalize the customer service charter	The consultant who conducted the customer service trainings for both social workers and supervisors has committed to finalizing the charter. Upon work plan approval, she will be contracted to provide the service.	
Establish formal structures for collaboration between key stakeholders on social	During this quarter, the PS for DPMO met with HFG's COP and SW Advisor to initiate this process.	

Year 3 Q4 Planned Tasks	Year 3 Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
work issues at the level of the Principal Secretary		
<b>Activity: Support human resources information systems (HRIS) and use</b>		
Support HRU to undertake an analysis, and reporting cycle with HRH data sources	Individual mentoring sessions were conducted for two of the four social workers in the Lubombo region.	<p>The remaining three individual mentoring sessions will be conducted in the next quarter.</p> <p>Two group mentoring sessions will be conducted in the next quarter.</p> <p>Social work assessments completed by Cabrini will be amended to include action plans and combined with mentoring guidelines for Lubombo social workers and handed over to DSW in March 2016.</p>
<b>Activity: Consolidating and Strengthening Social Welfare Delivery System in Lubombo through NGO Sub-awards</b>		
Build capacity of CFC Court Intermediaries, Court Interpreters, Judicial Officers, and Magistrates and Prosecutors	Trainings were successfully completed during the last quarter. All training reports were submitted to PSs in the DPMO and Ministry of Justice as well as the Acting Chief Justice with recommendations.	

### 5.1.15 Tanzania

**Program Objectives** - During Year 1 and 2, the HFG/Tanzania program focused on supporting the goals of the Government of Tanzania's health care financing efforts through the provision of technical assistance to produce the Mid-Term Review (MTR) of the government's Health Sector Strategic Plan III (HSSP III). The MTR provided stakeholders with information on progress toward meeting health sector targets and identified areas requiring further strengthening. The Ministry of Health and Social Welfare (MOHSW) is currently using the MTR in the development of the HSSP IV and its new health financing strategy (HFS).

In Year 3, HFG's work in Tanzania builds upon previous years' investments and further continues to support health care financing efforts.

HFG/Tanzania Year 3 program objective are as follows:

- ▶ Produce a public expenditure review (PER) for HIV/AIDS for 2012/13, in collaboration with the MOHSW, Tanzania Commission for AIDS (TACAIDS), and other stakeholders. The objective of the PER will be to assess HIV and AIDS activities in both the public and private sectors in Tanzania, including an analysis of expenditures on HIV and AIDS, the identification of financing gaps, and recommendations on measures for ensuring a more effective contribution to the National Multi-Sectoral Strategic Framework for HIV/AIDS by all stakeholders.
- ▶ Develop a framework and report for cross-walking expenditure data between the PER, the PEPFAR Expenditure Analysis tool, and the Global Fund Enhanced Financial Reporting. Doing so will allow for easier data sharing across these different expenditure tracking platforms and among various government and donor agencies. This will assist the MOHSW to harmonize and rationalize the process of collecting and analyzing HIV and AIDS expenditure data, and ensure that the HIV/AIDS PER includes a classification scheme that can map to equivalent elements in these other tools and reporting systems.
- ▶ Provide technical assistance to the MOHSW Health Systems Strengthening (HSS) Unit in the development of a one-year Action Plan for the Unit. This will help the Unit to better fulfill their role in coordinating all HSS activities across the sector, including a Global Fund (GFR 9) HSS grant.
- ▶ Building on a foundation of work already completed by the MOHSW and local stakeholders, provide technical inputs to finalize the HFS currently in draft version. The HFS will give direction as to how critical goals of the ministry as outlined in the HSSP, can be funded. This will be the first HFS to have been developed or implemented in Tanzania's history.

**Year 3 Activities** - In Year 3, HFG activities in Tanzania focus on supporting the government's health care financing strategies through three different areas of focus - the PER, HSS Unit, and HFS. A summary of activities is as follows:

HFG will conduct an HIV/AIDS PER and crosswalk data categories between the PER, PEPFAR Expenditure Analysis tool and Global Fund Enhanced Financial Reporting system to ensure harmonization. Activities will include: PER study design, data cleaning, data analysis, drafting the PER and the crosswalk reports; presenting and validating the findings with TACAIDS and relevant MOHSW technical working groups (TWGs), and finalizing and disseminating the report. Local consultant(s) will be contracted to support the conduct of this activity.

HFG will support the MOHSW HSS Unit with action planning that will help them to fulfill their role in coordinating HSS activities across the sector. Activities will include: working alongside the HSS Unit to develop coordination strategies and an action plan that will enable them to launch and maintain activities and provide oversight of the overall health system as the coordinative HSS body; health systems

stakeholder mapping that will assist the HSS Unit with coordination; developing HSS indicators that the Unit can use for monitoring HSS activities.

HFG will support MOHSW to finalize the HFS, in collaboration with local stakeholders, building upon the work and HFS drafts already started by the MOHSW and its development partners. Activities include: reviewing HFS options; providing technical health financing input; facilitating workshop(s) with the MOHSW and stakeholders to further agree to and refine strategies; and finalizing and disseminating the HFS.

**Year 3 Progress Against Objectives** - A new HFG Year 3 work plan was approved by USAID/Tanzania at the end of Year 2, which led to activity kickoff in Q1 of Year 3. Immediately after work plan approval, HFG contacted counterparts to further clarify, plan, and launch activities. With respect to the HIV/AIDS PER, consultants were identified and hired to support data collection and preparation of the PER. Data collection tools were developed and in Q3 data collection was completed at the central level and in several districts. By the end of Q3, HFG completed the analysis of donor and government spending on HIV/AIDS, including the calculation of distribution keys to further break down government, PEPFAR and Global Fund spending to categories that are harmonized with PEPFAR Expenditure Analysis and Global Fund reporting. The PER therefore enables HIV and AIDS spending to be compared to PEPFAR Expenditure Analysis categories. This analysis using distribution keys was new to the PER in Tanzania and also combined data from the health accounts. In Q4, HFG presented the preliminary results to TACAIDS and USAID and incorporated feedback into the final report and presentation, which was distributed in August. The PER analyzes spending by development partners and the government of Tanzania between 2011/12 and 2013/14, and projections until 2017/18.

Regarding technical support to the HSS Unit, conversations between HFG and the MOHSW determined that the Ministry changed its expectations regarding the type of assistance required, which is different from what was earlier agreed to and included in the HFG work plan. HFG informed USAID/Tanzania of the shift in MOHSW thinking, and the mission held discussions with the MOHSW. In Q2, the MOHSW informed HFG that, based on their discussions with USAID/Tanzania, this activity should be put on hold until next year, after the new HSSP IV is finalized as this will define the work that the HSS Unit does. HFG reached out to USAID/Tanzania in Q2 and Q3 to confirm this decision, seek advice on how HFG should proceed, and explore whether there is alternative support that HFG could provide to the MOHSW in the interim. In Q4, alternative activities for the use of these funds were explored with USAID/Tanzania and approved activities will be reflected in the Year 4 work plan.

Lastly, HFG coordinated with the MOHSW, USAID/Tanzania, and local development partners to advance the HFS work. In Q1 and Q2, HFG provided technical input and helped facilitate sessions of a workshop led by the MOHSW and organized by GIZ to advance the draft HFS toward approval and implementation. This included facilitating sessions on: (1) potential financing sources; (2) the role of the private sector; and (3) activities that would demonstrate "visible impact" before full implementation of the Single National Health Insurance program. Review and comments on the draft HFS were provided, as well as a revision of the section concerning results \-based financing. Following the workshop, USAID/Tanzania, in consultation with GIZ, requested assistance from HFG with two items to help the MOHSW advance the HFS; HFG provided: (1) a summary of the literature on Ghana's initiative to make maternal health services free of charge and (2) a summary of the literature on earmarked taxes devoted to supporting national health insurance efforts. Additionally, HFG drafted two briefs in response to a follow-up request from the MOHSW and development partners for written inputs related to: (1) promoting equitable access to maternal health services in the context of universal health coverage, with examples from other countries and (2) how results based financing relates to the HFS. In Q3 and Q4, HFG contacted USAID/Tanzania and GIZ (and the MOHSW via GIZ), regarding next steps and to check on the status of the HFS. HFG remained prepared to respond to any additional requests for technical and strategic inputs. In Q4, at the request of the Ministry and USAID/Tanzania, HFG agreed in principle

to work on aligning the Community Health Fund with the new health financing strategy. HFG has reached out to the MOHSW regarding specifics, and awaits their input. Year 4 HFG work planning will explore this area as a possible future activity.

Table 39 provides additional activity-specific updates.

**TABLE 39. TANZANIA ACTIVITY DETAIL**

Year 3 Q4 Planned Tasks	Year 3 Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
<b>Activity 1: Conduct an HIV/AIDS public expenditure review and crosswalk data categories between the PER, PEPFAR expenditure analysis tool, and Global Fund financial reporting system to ensure harmonization</b>		
Present first draft PER to TACAIDS and HF TWG	HFG presented PER preliminary results/first draft to TACAIDS and USAID and solicited feedback.	
Receive feedback and finalize reports	HFG finalized the PER, which incorporated feedback received from TACAIDS and USAID. HFG submitted the final report, PowerPoint presentation of the results summary, and data files to TACAIDS and the USAID Mission.	
Disseminate final report	Over Q3, HFG remained available to participate in any dissemination meetings or events with TACAIDS as lead. By the end of the quarter, HFG had not been requested to support dissemination activities.	
<b>Activity 2: Support HSS unit to develop action plan</b>		
Work with HSS Unit to develop coordination strategies and an action plan	Activity on hold pending USAID guidance. Alternative activity programming was explored with USAID/Tanzania. Final determination is reflected in the Year 4 work plan.	
<b>Activity 3: Support MOHSW to write a health financing strategy</b>		
Provide additional technical and strategic inputs as the draft goes to Cabinet, as requested	<p>HFG contacted USAID/Tanzania and GIZ (and the MOHSW via GIZ), regarding next steps and to check on the status of the HFS. HFG remained prepared to respond to any additional requests for technical and strategic inputs, however, none were received by the end of the quarter.</p> <p>HFG agreed in principle to work on aligning the Community Health Fund with the new financing strategy. HFG has reached out to the MOHSW regarding specifics, and awaits their input. Y4 HFG work planning will explore this area as a possible future activity.</p>	

## 5.2 Asia

### 5.2.1 Asia Bureau

**Program Objectives** - HFG's objectives under the Asia Bureau focus on supporting and facilitating countries' progress toward universal health coverage (UHC) to end preventable maternal and child deaths in the Asia region. Asian nations are at various stages of the trajectory toward achieving UHC with some nations still in the developing phases and others already implementing financing reforms. In the context of limited time and resources, countries and USAID missions want to pursue steps that are most likely to succeed and benefit from global experience and evidence.

**Year 3 Activities** - HFG activities are to build local and regional institutional capacity to design and implement smart reforms to expand access to priority services and reduce out-of-pocket health expenditures. HFG and the Asia Bureau are working closely with regional and local partners on two activities that simultaneously advance reforms and build capacity, as described below.

#### **Year 3 Progress Against Objectives -**

**1. Flagship Course:** Throughout Year 3, HFG collaborated with the World Bank and the Asia Network for Capacity Building in Health Systems Strengthening (ANHSS) to host the Asia Regional Flagship Course on Health Systems Strengthening and Sustainable Finance, held April 20-25 at the Galle Face Hotel in Colombo, Sri Lanka. Eighty-five government officials, donor agencies, the private sector, and civil service members from 12 countries participated. A one-day training of trainer's (TOT) course was also delivered one day prior to the Flagship course, to increase the capacity of the ANHSS to deliver the course independently in the future. The course used an updated curriculum that drew from past Flagship material, but included more contextualized cases and examples from Asia as well as new material on the private sector and politics. The participants evaluated the course as highly useful in terms of understanding the challenges of UHC and providing them analytic tools to assess policy options.

**2. ANHSS Capacity Building:** HFG has developed a sub-award with the purpose of strengthening the capacity of the ANHSS; the sub-award was fully executed in Q3. ANHSS is a network of 12 academic, research, and policy institutions in the Asia Region that was established in 2009 with support from the World Bank in response to the need for knowledge sharing on health systems in the region. HFG identified the ANHSS as a strategic entity to strengthen for its mission alignment, to empower health policymakers to advance health delivery through evidence, and to be a platform for knowledge sharing. Because the ANHSS does not have legal status or separate financial management capacity, the sub-award is directed at the Institute for Health Policy (IHP), a founding member of the ANHSS as well as the institution from which the current chair, Ravi Rannan-Eliya, comes. Under the leadership of IHP and the full endorsement of the ANHSS executive, ANHSS members collaboratively developed a list of key objectives and strategies to strengthen its capacity; all are covered in the sub-award. Key elements include facilitating board meetings to develop strategic goals and work plans and obtaining legal incorporation. An in-person board meeting in one of the member countries is tentatively scheduled for December 15-16 (Y4Q1). One full day will be dedicated to discuss overall strategy; a board meeting will be held on the other day. A priority agenda item includes amending the operating procedures to allow for virtual decision making.

**3. Implementation Research (IR) Indonesia:** In Q1 and Q2 of Year 3, HFG completed and presented a Landscape Analysis, agreed with USAID on the focus of the IR and on the primary government counterpart, and oversaw a competitive process resulting in the selection of a local research partner.

*Completion of the Landscape Analysis:* In response to a request from the USAID mission, HFG completed a Landscape Analysis that mapped the key players and issues in the implementation of Indonesia's health sector reform, called JKN (Jaminan Kesehatan Nasional), and identified gaps in research on JKN and

UHC. HFG submitted and presented the Landscape Analysis and matrix of JKN studies to USAID, and shared the JKN studies matrix with participating stakeholders.

*Identification of the IR focus:* On the basis of the Landscape Analysis, HFG provided recommendations for the focus of the IR activity. HFG and USAID agreed that IR will focus on implementation questions that influence how JKN financing is affecting primary care. The IR will look at how primary care facilities (public and private) are using their JKN capitation payments; how these payments are altering primary care facilities' provision of services, budget priorities, and resource allocation; and how JKN payments are affecting referrals between primary and secondary care facilities, and between public and private facilities. The strategic value of this focus includes: there is little research on and understanding of these issues; strengthening primary care centers is a critical element of JKN and overall health reform; the questions are highly implementation focused and likely to generate actionable findings; the topic allows for high peer-to-peer learning among primary care facility staff nationwide; and there is clear strategic alignment with USAID interests and with HFG project intermediate results.

*Identification of government counterpart:* On the basis of the Landscape Analysis, HFG provided recommendations for the government of Indonesia's primary counterpart for the IR activity. HFG and USAID agreed that the Center for Health Financing and Insurance (PPJK) within the Ministry of Health (MOH) would be the most suitable counterpart given the IR focus on the effect of JKN financing on primary care. As part of their core activities, PPJK focuses on health financing and the impact of JKN on service delivery. In addition, PPJK has legal access to data of BPJS, the entity that implements JKN, and a history of leading multi-entity working groups, which is important given the involvement of additional government stakeholders at the national and local levels. PPJK has also been receptive to engaging in the IR for UHC activity.

*Selection of local IR research partner:* In Q2 and Q3, HFG oversaw a competitive process to select the local research partner for the IR activity. An Expression of Interest (EOI) resulted in invitations to five organizations to bid on the full RFA. After a comprehensive evaluation, the HFG selection committee agreed that the Center for Health Policy and Management (CHPM) at the University of Gadjah Mada had the strongest proposal. CHPM brings subject matter expertise in health financing, has relevant experience in research on JKN implementation issues, has a nationwide network of university researchers to tap into, and has had previous USAID sub-awards. In Q4, upon finalizing the sub-award, CHPM worked closely with HFG on developing work plans jointly with the government counterpart, and engaging key national and district stakeholders to prepare for the launch of the IR for UHC research activity.

**4. Harvard Asia Public Policy forum in Indonesia:** In Year 3 Quarter 2, USAID/Indonesia asked HFG to support Harvard's implementation of their Asia Public Policy Forum (APPF) for 2015 in Indonesia, with the topic of engaging ASEAN nations in policy dialogue around implementing national health insurance, provision of basic health care in rural areas, cross-cutting issues in financing, and delivering public health. HFG worked quickly to get a sub-award in place for Harvard. In Quarter 3, Harvard worked tirelessly to plan for the APPF, including securing speakers and participants in a short time frame, and in Quarter 4, the APPF took place successfully in Jakarta involving policymakers and implementers from all ASEAN countries.

**5. Implementation Research Myanmar:** In Q3 the focus of the initial IR was identified, a concept note on UCH was drafted, and a local partner was found.

*Identification of initial focus of IR:* Conducting IR on the topic of convergence between health systems in non-state controlled areas and the central government health system has proved increasingly difficult for the initial phase, especially with recent setbacks in the peace talks. A more promising option has been explored: linking IR to the soon-to-be-started World Bank-supported Essential Health Services Access Project (EHSAP). The project aims to: get money to peripheral government facilities to cover

operational costs (through facility grants); strengthen financial management at all levels of the system; strengthen planning at township level, making it comprehensive and inclusive; and strengthen the role of Region/State Health Departments. Advantages of this option: (i) the topic of financial management and township planning is less controversial and politically loaded than that of convergence; (ii) relatively easier buy-in from the central level given the high visibility of the project and the interest from MOH high-level leadership to make the project a success; (iii) possibility of incorporating IR into the project from the beginning; (iv) potential to piggy back on many activities. The USAID mission supported this option and negotiations with the World Bank, which led to an agreement to collaborate.

In Q1, a concept note on IR for UHC was drafted that explains the IR concept and approach and outlines the different steps that need to be undertaken before IR can be launched in a limited number of townships. In Q2, existing documents relating to health planning and financial management were reviewed.

*Identification of a local partner:* Key to implementing and institutionalizing implementation research in Myanmar will be to collaborate with and enhance the capacity of a local institution. An agreement was signed with Yangon University of Public Health (UoPH). A close collaboration with the MOH Department of Research was also approved in principal.

**6. Rapid Health System Assessment for Timor-Leste:** In Q3, HFG was approached by USAID to conduct a small rapid health system assessment for Timor-Leste to assist the USAID Mission to shift to a focus on supporting changes in health systems, to enhance delivery and financial sustainability while pursuing UHC. In Q3 and Q4, HFG worked with USAID and the USAID Timor-Leste mission to refine the scope of work to align with the expectations and budget of the client. In consultation with the client, a work plan was developed and a literature review of recent relevant government and external policy documents was conducted. Christopher Lovelace and Andrea Feigl conducted a TDY, September 19-26, and interviewed key government officials and partner agencies, presenting their findings to the mission. A trip report and a final report focusing on practical recommendations for USAID and the MOH will be produced in Q4.

**7. Reshaping the Agenda to Support Achieving UHC in Asia:** HFG is in consultation with USAID on conceptualizing an activity that will support achieving UHC in the Asia region. Asia Bureau will work with HFG to think through how the shift from service delivery to broader health systems governance might take place within a country portfolio, and develop long-term plans for transitioning USAID assistance for health to other actors in countries likely to be approaching health sector phase-out in the near to medium term. The first step in defining this process will be a brainstorming session involving Asia Bureau, the Office for Health Systems, and HFG, and possibly other stakeholders, meeting in Y4Q1, after which a detailed work program will be prepared.

**Q4 Challenges -** The request from the USAID mission for HFG to conduct the Landscape Analysis in Indonesia delayed the identification and selection of a government counterpart and local IR partner. Nevertheless, the Landscape Analysis provided valuable understanding of the complex and changing political environment in which Indonesian health reforms are taking place. The decisions made on the basis of the Landscape Analysis have maximized the relevance and longer-term strategic value of the IR for the UHC activity. Now that the sub-award to CHPM is finalized, the main challenges are ensuring the ownership of and buy in of MOH PPJK, and the engagement and participation of multiple stakeholders in shaping the research questions and priorities. These stakeholders include USAID, HFG, CHPM, PPJK, and political and health system representatives at the national, provincial, and district levels. These challenges will be evident as HFG works with CHPM, MOH PPJK, and USAID to plan and hold a launch workshop with multiple stakeholders in Y4Q1.

Myanmar is a challenging environment. HFG is investing considerable efforts in building relationships to establish a foundation of trust that will enable HFG to move forward. As stated by William Slater of USAID Myanmar in a recent email: "starting to make progress and focusing on building capacity in UPH [University of Public Health] linked with the WB [World Bank] project and a big learning curve, but Alex' persistence and patience is starting to take shape. Other development partners are supportive as the MOH but the biggest challenge is bandwidth with so much going on - thus the critical need for continuous learning." IR activities are on hold until government approval is granted.

Given the short time period and limited budget for the Timor-Leste rapid health system assessment, refining the scope to something manageable yet useful can be a challenge. The team is working closely with USAID to define the needs of the client and focus their efforts on a narrow subset of broader research questions.

Table 40 provides additional activity-specific updates.

**TABLE 40. ASIA BUREAU ACTIVITY DETAIL**

Year 3 Q4 Planned Tasks	Year 3 Q4 Progress	Critical Assumptions/ Problems Encountered/ Follow-up Steps
<b>Activity 1: World Bank Institute Flagship Course on Universal Health Coverage</b>		
Delivery of UHC flagship course	HFG along with World Bank and ANHSS hosted the Flagship Course on Health Systems Strengthening and Sustainable Finance on April 20-25 at the Galle Face Hotel in Colombo, Sri Lanka.	
<b>Activity 2: Revision Asia Network for Health Systems Strengthening (ANHSS) Capacity Building</b>		
Build the capacity of regional faculty	HFG along with World Bank and ANHSS hosted the Flagship Course on Health Systems Strengthening and Sustainable Finance on April 20-25 at the Galle Face Hotel in Colombo, Sri Lanka.	
Deliver Training of Trainers Course	A one-day TOT session, led by consultant Professor Thomas Bossert, was delivered on April 19, in Colombo, Sri Lanka.	
Draft Sub-award for Capacity Building Activities	In Q3, a sub-award to IHP on behalf of the ANHSS was fully executed. The sub-award will support tasks such as obtaining ANHSS legal incorporation, facilitating strategic planning meetings, developing work plans, and raising the profile/contributions of the ANHSS and its members in policy forums.	
Organize an in-person strategy and board meeting	A two-day in-person strategy and board meeting is tentatively scheduled for December 15-16 and will likely take place in Bangkok, Thailand.	
<b>Activity 3: Indonesia Implementation Research on UHC</b>		
Stakeholder consultations at the district and national level to inform priority questions	Consulted with national-level stakeholders during previous TDYs and as part of the landscaping study (Y2Q4 and Y3 Q1, Q2, and Q3).	Consultations and engagement with primary Government of Indonesia counterpart (PPJK) and other relevant national- and district-level stakeholders have increased during

Year 3 Q4 Planned Tasks	Year 3 Q4 Progress	Critical Assumptions/ Problems Encountered/ Follow-up Steps
	CHPM is beginning to engage district- and national-level stakeholders in discussions around the IR for UHC activity. Stakeholder engagement is critical to the process and full participation from all stakeholders will make the results richer and more useful.	the post-sub-award planning process and launch workshop preparation. However, the challenges of engaging all of the stakeholders, agreeing to a methodology, mutually understanding the nature of IR, and logistical coordination are not insignificant. Stakeholder engagement will need to be ongoing, address limited understanding of the new field of IR, and carefully negotiated.
Six-monthly cycle of results	Not yet started. Stakeholder engagement to define research questions for first cycle underway.	If first cycle of research happens in Y4Q1, analysis and results will be finalized in Q2. However, this depends on the Launch workshop and full stakeholder engagement taking place before the end of November 2015.
IR research plan, including key questions, methods to answer them, integration with learning at the district and national level	Agreement with USAID on the overarching focus of the IR activity: the effect of financing of JKN on primary care and referrals. The specific research questions and ensuing methods will be agreed upon in a launch workshop with the relevant national- and district-level stakeholders in Y4Q1.	Delays in making the sub-award occurred. However, CHPM is now fully engaged, HFG is closely supporting CHPM in work planning, launch preparations, and developing their sub-award management system for this award.  Also, we foresee challenges in ensuring and coordinating the active participation of multiple stakeholders involved in this activity (USAID, HFG, CHPM, and health officials at the national, provincial, and district levels) Thus, the process for engagement and dialogue will be critically important and CHPM and HFG are planning for this accordingly.
Implementation of IR in four districts	Not yet started.	Expect to happen in Y4Q1 depending on time of launch and completion of stakeholder engagement.
<b>Activity 4: Harvard 5th Annual Asia Public Policy Forum in Indonesia</b>		
Support launch and delivery of Harvard's 2015 APPF	In Q3, USAID/Indonesia asked HFG to support Harvard in planning and implementing the 2015 Asia Public Policy Forum. HFG immediately began to prepare the sub-award to Harvard for managing the conference. The sub-award was submitted for AOR approval and approved in early June. HFG also supported Harvard in developing the participant and speaker list. By the end of Q4, the successful 5th annual APPF had taken	No problems encountered.

Year 3 Q4 Planned Tasks	Year 3 Q4 Progress	Critical Assumptions/ Problems Encountered/ Follow-up Steps
	place in Jakarta, Indonesia. Ongoing work with Harvard to collect all of the deliverables outlined in their sub-award is ongoing, including collecting the final brief from the APPF.	
Issue sub-award to Harvard	Issued sub-award to Harvard in June. Start to finish in under 3 months.	No problems encountered, though we did seek approval from USAID AOR to allow Harvard to incur some charges before the sub-award was finalized.

#### Activity 5: Myanmar Implementation Research on UHC

Diagnosis of the situation and exploration of potential IR opportunities	A matrix has been created to help select the initial IR townships. For each township in the country, the matrix shows the values relating to a number of selection criteria.	As soon as the official approval from MOH has been received, a scoping mission will be conducted in one township to better understand the situation on the ground. The approach for the scoping mission has already been designed.
Identification of initial focus of implementation research	IR will initially be linked to the World Bank-supported Essential Health Services Access Project, which officially started on April 1, 2015. The project aims to: get money to peripheral government facilities to cover operational costs (through facility grants); strengthen financial management at all levels of the system; strengthen planning at township level, making it comprehensive and inclusive; and strengthen the role of Region/State Health Departments..	While a Steering Committee has been established for the Essential Health Services Access Project, the M&E Working Group (or focal point) that would become our MOH counterpart for the IR activity still needs to be appointed. As soon as this has happened, HFG will need to present the activity and get the official green light.
Concept note on implementation research drafted	A concept note on IR for UHC was drafted that explains the IR concept and approach and outlines the different steps that need to be undertaken before IR can actually be launched in a limited number of townships.	
Stakeholder mapping	This will be part of the scoping mission mentioned within the stakeholder consultation activity.	
Build the capacity of local stakeholders in the area of UHC	Representatives from UoPH attended the Asia Regional Flagship Course on Health Systems Strengthening and Sustainable Finance, held April 20-25 in Colombo, Sri Lanka. UoPH, DMR, and MOH leadership have also attended various courses/workshops on health financing and UHC.	

Year 3 Q4 Planned Tasks	Year 3 Q4 Progress	Critical Assumptions/ Problems Encountered/ Follow-up Steps
<b>Activity 6: Timor-Leste Rapid Health System Assessment</b>		
Develop a work plan	HFG developed a work plan in Q3 that was reviewed and approved by USAID.	The work plan may be revised as the activities unfold and new needs emerge from the findings.
Conduct a literature review	In consultation with USAID and the mission, HFG drafted a literature review of recent and relevant policy documents which served as a background for stakeholder interviews.	
Do health system assessment interviews	In Q3-Q4, Christopher Lovelace and Andrea Feigl conducted a TDY to interview key government and development partner stakeholders	
<b>Activity 7: Reshaping the Agenda to Support Achieving UHC in Asia</b>		
Define a scope of work	HFG had an initial call with USAID to discuss a scope of work.	USAID had a brainstorming session with the World Bank to generate initial ideas. HFG awaits the outcome of that meeting to progress further.

### 5.2.2 Bangladesh

**Program Objectives** – In Years 1 and 2, the HFG/Bangladesh project focused on supporting the goals of the government of Bangladesh’s Health, Population, and Nutrition Sector Development Program (HPNSDP) through a multi-pronged technical assistance approach: 1) HFG worked with USAID implementing partner Pathfinder of the NGO Health Service Delivery Project (NHSDP) to support the Smiling Sun NGO network to better achieve its mission of serving the poor and underserved with a focus on enhancing quality and long-term sustainability of the network, thereby improving access to health services as well as health outcomes, particularly for girls and young women; 2) HFG provided technical assistance to the Health Care Financing Resource Task Force and to the Ministry of Health and Family Welfare (MOHFW) Health Economics Unit (HEU). These organizations are working together to implement the country’s Health Care Financing Strategy (HCFS) through such initiatives as community-based health insurance and micro health insurance; 3) Beyond the health sector, HFG collaborated with UNICEF, the Ministry of Women’s and Children’s Affairs (MoWCA), the Ministry of Social Welfare’s Department of Social Services, and NGOs and local Child Protection Services Committees to complete a final report summarizing what has been learned about the short-term effects of the cash transfer program on delaying age of marriage and presence of social norms around child marriage. In addition to the presentation of findings, the report provided recommendations to UNICEF to strengthen the M&E approach and the program.

In Year 3, HFG work in Bangladesh builds upon previous years’ investments and further continues to support implementation of the country’s HCFS in a focused way that transforms health care financing in Bangladesh so it can achieve UHC. In our approach, both the NGO and formal sector will be addressed, and our work will be complementary to support provided by other development partners (e.g., World Bank, SIDA, GIZ, KfW, WHO), and collaborative as in the case of the World Bank and GIZ activities.

HFG/Bangladesh Year 3 program objective are as follows:

- ▶ Demonstrate how USAID funds flowing through the World Bank Public International Organization (PIO) grant mechanism to the Bangladesh Health Sector Program have been used to address USAID Bangladesh objectives for vulnerable populations, including EPCMD objectives. Conduct PIO grant attribution analysis to track the flow of USAID funds and disbursements.
- ▶ Conduct a feasibility study and, potentially, design an NGO provider-based pre-payment scheme to: (i) increase utilization of services through increased access and lower household direct out-of-pocket expenditures; (ii) increase provider sustainability through better cash flow and increased population participation; and (iii) prepare NGO providers to integrate, eventually, into the national social health insurance (SHI) scheme.

- ▶ Support BRAC-GIZ in the design, development, piloting, and implementation of a comprehensive SHI model (the “Health Security Scheme”) focusing on ready-made garment workers; through: (i) the design of the M&E system and implementation research and (ii) the design of a quality of services provider-centered performance-based mechanism (subject to approval for the pilot scheme by BRAC’s Executive Committee). The purpose of the scheme is to: test the potential benefit of employer/employee contributive health insurance; develop tools and mechanisms to provide health protection; improve access and quality of health care available; and reduce out-of-pocket expenditures on health. Findings from the pilot will inform scaling up and eventual integration into a yet to be designed national health protection scheme.
- ▶ Conduct joint analytic work with the World Bank focusing on: (i) secondary analysis of NHA data to inform sector program implementation and design of the next health sector program; and (ii) urban health, through the conduct of a landscape analysis, research design, and potentially participation in conducting the research itself, to inform discussions on how to resolve urban health challenges. The NHA work will provide information to inform discussions on the financing of key diseases and services, equity, efficiency, and adequacy of financing. Better understanding of the urban health situation will provide an overview of existing sector dynamics, including: policy, financing mechanisms, stakeholders, studies, and data, with an emphasis on gap identification, and research focused on addressing those gaps. A focus will be on maternal and child health and primary health care services.

**Year 3 Activities** - In Years 1 and 2, HFG activities were aimed at supporting NHSDP with the provision of data through a demographic re-analysis report and discrete choice experiment (DCE) study. The results of this work will provide NHSDP with information that can be used to guide the design of interventions to increase patient utilization of Smiling Sun clinics, support decision making on which interventions to prioritize, and increase the efficiency of intervention resource use. Finalization and dissemination of the final DCE report is part of the HFG/Bangladesh Year 3 portfolio of activities.

Also during Years 1 and 2, HFG collaborated with the MoWCA, the Ministry of Social Welfare’s Department of Social Services, UNICEF Bangladesh, NGOs, and local Child Protection Services committees to finalize the design and implementation of a monitoring framework to be used in operation research for an empowerment of adolescents program. HFG finalized a report that documented this operational research including an analysis of existing social norms in Khulna and Sylhet, issues on the implementation of the subset of UNICEF activities selected for the level 3 monitoring (L3M) pilot, and the implementation of the L3M methodology. The report summarizes what has been learned about the short-term effects of the cash transfer program on delaying age of marriage and about the presence of social norms around child marriage. In addition to the presentation of findings, this report provided recommendations to UNICEF to strengthen the M&E approach and the program.

In Year 2, USAID/Bangladesh asked HFG to undertake an analysis of USAID’s contribution to the World Bank-managed health sector support. The World Bank PIO grant is a mechanism to provide direct government-to-government assistance from USAID to the government of Bangladesh in fulfillment of the goals and objectives of USAID Forward, the first of its kind among USAID missions worldwide. The World Bank administers USAID’s contribution to the sector through single- and multi-donor accounts that are part of a multi-donor collaborative effort between USAID, the World Bank, and other international donor partners for achievement of the HPNSDP goals and objectives as implemented under 32 specific “Operational Plans” (OPs). In Year 2, HFG began work to draft a note explaining the process of contribution and use of USAID funds and attribution analyses of the eight OPs that USAID funding is supporting. Finalization of these analyses continues into Year 3. Data resulting from this work is expected to demonstrate how funding has been used to support USAID objectives.

In Year 3, HFG activities are summarized as follows:

- ▶ HFG finalized the DCE study that identifies preferences or factors affecting the demand for maternal and child health services in the target population of NHSDP-supported facilities. A workshop was held with key stakeholders to validate and share findings, and a final report drafted and disseminated.
- ▶ HFG finalized the PIO flow of funds and OP fund attribution analyses.
- ▶ HFG will conduct a feasibility study and, potentially, design a provider-based prepayment mechanism in order to enhance the capacity (increased utilization and sustainability) of a Smiling Sun NGO health service provider to integrate into the national SHI scheme. The approach involves conducting analyses of provider-based prepayment mechanisms, including a demand analysis to determine demand and, based on these findings, the preliminary design of a prepayment scheme.
- ▶ Related to formal sector, HFG will collaborate with BRAC and GIZ on the development and implementation of BRAC's SHI scheme for ready-made garment workers (the "Health Security Scheme") to improve access and quality of health care available and reduce out-of-pocket expenditures on health.
- ▶ HFG will conduct joint analytical work with the World Bank on: 1) conducting secondary analyses of NHA data that would inform sector program implementation as well as the design of the next health sector program and 2) on urban health, through the conduct of a landscape analysis and the design of research that would inform discussions on how to resolve urban health challenges.

**Year 3 Progress Against Objectives** - In Q1, the HFG/Bangladesh team continued work on the DCE and PIO activities that began in Year 2. HFG finalized the PIO flow of funds and OP fund attribution analyses, which were submitted to and approved by USAID/Bangladesh. The DCE study data analysis was essentially completed in Q1, and a workshop was held with NHSDP and other stakeholders in Dhaka to validate and share key findings. The study was finalized and disseminated in Q2.

In Q1, a new HFG Year 3 work plan was approved by USAID/Bangladesh, which led to the launch of HFG activities related to the feasibility study for a provider-based prepayment mechanism of a Smiling Sun NGO provider, support to the development of the SHI scheme for ready-made garment workers, and the joint analytical work with the World Bank on NHA secondary analyses and urban health. After work plan approval, a TDY was undertaken by Yann Derriennic, Activity Lead, to move activities forward, including planning and coordination with partners, drafting terms of reference, selecting and meeting with a Smiling Sun NGO provider, among other tasks. In addition, Abt HFG Resident Senior Economist/Activity Lead, Dr. Mursaleena Islam, was recruited to start work in Q2, based in Dhaka.

In Q2, local consultant Dr. Abdul Syed Hamid of the Institute of Health Economics, University of Dhaka, was retained to support analyses for the feasibility study and, potentially, design of a provider-based prepayment mechanism. Dr. Hamid has started with a review of provider-based prepayment mechanism micro-insurance schemes in Bangladesh, which will support this activity. With Activity Lead Yann Derriennic's support, he is also working closely with Concerned Women for Family Development (CWFD) management and clinics to conduct a costing and pricing study – the methodology and tools for the study have been finalized and fieldwork is planned for Q3. The costing methodology has been shared with NHSDP, USAID Bangladesh, and Brandeis (Brandeis is a NHSDP partner undertaking a rural focused service costing). Dr. Hamid will also support information gathering for the urban health landscape analysis. Dr. Islam has completed initial discussions with development partners, through the urban health forum of development partners, as well as with the World Bank. While the World Bank will take a broader view of urban health, HFG will stay focused within the health system context for this analysis.

Also in Q2, HFG supported technical discussions with BRAC and GIZ on the ready-made garment formal sector health security scheme. It was agreed that HFG will support the development of the scheme by incorporating quality of service using performance incentives. In addition, HFG was to support the design of the monitoring and evaluation (M&E) of the scheme to link it to broader universal health coverage (UHC) efforts in the country, in the context of implementation of the HCFS. The BRAC team expects to present the concept to its Executive Management Committee. At the end of Q3, HFG was advised the pilot scheme will not go forward and HFG will be discussing options with the USAID mission for re-orienting this activity.

**Q3: Provider-based prepayment feasibility study:** With the support of Activity Lead Yann Derriennic, Resident Senior Economist Mursaleena Islam, HFG local consultant Dr. Abdul Syed Hamid completed data collection for costing services at four CWFD clinics and started the data analysis. Dr. Hamid also collected pricing and competitor information and drafted the prepayment scheme landscape report. The next phase of this activity, the demand-side analysis, was discussed with the BRAC James P. Grant School of Public Health (JPGSPH).

**Joint analytical work with the World Bank - NHA secondary analysis:** HFG, with support from the World Bank, initiated and led the Bangladesh National Health Account (BNHA) Cell in executing the urban health secondary analysis of BNHA IV. HFG also prepared a four-page brief with the preliminary findings and the final report is currently in process. HFG also led the design of a special session on urban health financing at the International Urban Health Conference in Dhaka on May 27. At the conference, the Director General of the HEU presented and distributed the brief. Although the brief was not included in HFG's work plan for Y3, the Mission requested it in order to increase visibility for the analysis and direct attention to the work of USAID and HFG.

In Q3, HFG also supported the BNHA cell by initiating technical preparations for the reproductive, maternal, neonatal, and child health (RMNCH) secondary analysis of BNHA IV.

In Q4, Consultant Dr. Hamid Syed with support of Resident Senior Economist Mursaleena Islam and activity lead Yann Derriennic, completed the data collection, costing, pricing, and competitor analysis of four CFWD clinics. Costing and pricing report was drafted. The prepaid NGO provider-based prepaid scheme landscape review was also completed. The final reports will be available in Q1 of FY16.

In Q4, HFG collaborator, JPGSPH, implemented the demand-side analysis for prepaid schemes at CWFD clinics. This included developing the study protocols and tools and implementing 120 individual interviews and eight focus group discussions. Draft findings were presented in PowerPoint. The final report will be available in Q1 of FY16.

Also in Q4, the NHA consultants provided preliminary results for the RMNCH secondary analysis to the BNHA cell. HFG facilitated technical discussions with the BNHA cell to address pending methodological challenges. Final RMNCH report will be available in Q1 FY16.

#### **Q4 Challenges -**

**Feasibility Study:** Completion of the data collection at the four clinics was slower than anticipated due to the variations in findings resulting from a range of service practices (for example, drug prescriptions). This resulted in further visits being carried out to check the data.

**RMNCH secondary analysis:** the consultants and BNHA cell, with support from the health accounts team at HFG, reviewed available data and discussed boundaries between maternal and child health: where neonatal expenditures should be considered? BNHA team decided to include neonatal expenditures with child health. HFG also supported discussions with the BNHA cell on how to include family planning expenditures in the analysis.

Table 4I provides activity-specific updates.

**TABLE 4I. BANGLADESH ACTIVITY DETAIL**

Year 3 Q4 Planned Tasks	Year 3 Q4 Progress	Critical Assumptions/ Problems Encountered/Follow-up Steps
<b>Activity 2: Design provider-based prepayment mechanism, focused on 1-2 Smiling Sun NGO network providers</b>		
Conduct feasibility study of NGO provider-based prepayment mechanisms	Costing of four CWFD clinics completed, costing, pricing, and competitor analysis drafted.	Feasibility study draft Q1 FY16.
Conduct demand analysis of a provider-based prepayment scheme	BRAC partner implemented demand analysis. Draft findings available.	Demand analysis report, key section of feasibility report, available Q1 FY16.
<b>Activity 4: Provide support to the design and implementation research of a formal sector social health insurance scheme</b>		
Conduct landscape analysis of the information and data on the organization and delivery of health services in urban areas	Information and data compiled.	Landscape analysis report to be finalized during Q1 FY16.
Conduct two NHA secondary analyses, in collaboration with the BNHA cell	Urban health secondary analysis completed. RMNCH preliminary findings available.	RMNCH report to be finalized during Q1 FY16. Dissemination of findings of the Urban Health and RMNCH secondary analysis during Q1 FY16.

### 5.2.3 India

**Program Objectives** - Under the Ministry of Health and Family Welfare's (MOHFW) Reproductive, Maternal, Child and Adolescent Health (RMNCH+A) strategy, USAID is the lead partner in six states of northern India, and it has been tasked with strengthening program management and service delivery of various RMNCH+A-related programs and activities.

To this end, USAID asked HFG to provide technical assistance in six states, especially in HFG's technical domain areas of human resources for health (HRH), health information systems (HIS), and health financing. By Year 3, USAID, HFG, and Indian public sector partners had decided to focus on strengthening the country's capacity for managing the health workforce, assessing HIS data quality and improving HIS capacity, and understanding the health financing situation at the state level. HFG's approach prioritizes developing local solutions and innovations that can be applied to other states and transferred to other countries. By supporting an efficient execution of health financing activities, improved management of HRH, and better quality of data for decision making, HFG is contributing to India's achievement of key RMNCH+A health outcomes.

**Year 3 Activities** - HFG India's Year 3 activities build upon the project's progress to date in its technical areas of HRH, HIS, and health financing. Specific activities include:

- ▶ Strengthening capacity for improved management of the health workforce, including implementation and use of best practices in HRH policy making, performance appraisals, supervision, HRIS, and Performance-Based Incentives (PBI); and obtaining better HRH data that policymakers can use to address worker shortages and maldistribution, especially for RMNCH+A services.
- ▶ Assessing the quality of Health Management Information System (HMIS) data and its use for establishing policy priorities; designing a pilot study for improving the quality and completeness of National Health Mission (NHM) reporting and to ensure that policymakers have access to the data and use it for decision making; and providing technical assistance for strengthening HMIS.
- ▶ Producing health accounts (HA) in the state of Haryana as a model for other states.

**Year 3 Progress Against Objectives** - During Year 3, HFG has achieved significant progress, in collaboration with the NHM in Haryana State, in improving the quality of HMIS data and improving the use of that data by health sector decision makers at the district level. After completing two rounds of routine data quality assessments (RDQAs) in seven high-priority districts, the NHM decided to institutionalize the RDQA methodology throughout the state and conduct regular RDQAs in all districts. HFG has developed training materials and methods to build the capacity of state and district M&E personnel to conduct the assessments and use them as a means to identify and implement actions to improve HMIS data quality. A progress report has been completed and delivered, and a summary report analyzing the findings of both rounds of RDQA in Haryana will be finalized. Furthermore, during Year 3 HFG trained one M&E officer from each of the 22 districts of the state of Punjab on the RDQA methodology. This capacity-building effort will allow Punjab to conduct RDQA in the future.

The MOHFW has developed a strategy for data quality improvement that will involve the creation of an external third-party agency that will be charged with data quality assessment (DQA) and development of action plans for data quality improvement. HFG (at the request of USAID/India and the MOHFW) will draft the scope of work for this agency. In Year 3, HFG submitted a request for proposal (RFP) to USAID and MOHFW and the MOHFW Technical Advisory Group (TAG) selected HFG to finalize the methodology and implement a pilot test of the proposed methodology in five districts. HFG is moving forward with the pilot, and thus far has submitted several drafts of the pilot methodology for review by MOHFW, and has developed qualitative and quantitative data collection tools. HFG is currently hiring data collection teams and will commence data collection in Year 4.

HFG has made progress toward the development and operationalization of a Geographic Information System (GIS) portal for HMIS data in Haryana State that allows decision makers to have real-time access to HMIS data and the ability to analyze and visualize those data using a GIS platform. In Year 3, HFG hired a consultant to work closely with the NHM Haryana team on developing GIS capabilities. The GIS application has been deployed in Haryana and is currently being tested. In Year 4, HFG will finalize this activity by training program managers how to use the system.

HFG has drafted data dictionaries for primary and secondary health facilities in Haryana. Data dictionaries have also been drafted for the community level ("area-wise" data as opposed to "facility-wise" data) for integration into the state HMIS platform. The data dictionaries are currently being edited and will be submitted to Haryana state in Year 4.

In addition, during Year 3 HFG provided technical assistance to review the status of the Mother and Child Tracking System (MCTS) in Uttarakhand State and provided recommendations for MCTS strengthening. The state government is planning to overhaul the MCTS system and therefore no additional support is required.

Furthermore, HFG India made significant preparations in Year 3 for implementing PBIs in the states of Haryana and Uttarakhand. The project collected data and completed formative research to inform the design of PBIs, and conducted three consultation workshops in New Delhi, Gurgaon, and Panipat. The workshops engaged different stakeholders in discussion and deliberation on the design of the PBI intervention that would be implemented in Haryana under the aegis of the NHM. In general, the participants appreciated the potential benefits that PBI could have on the health staff's working conditions, motivation levels, and quality of health services. During the workshop, participants reached a consensus on who should receive incentive payments, the payment model to be implemented, and the indicators and targets that should be used to measure progress toward meeting the incentives. They also identified topics that need to be discussed further. After the workshops, HFG produced and submitted a summary report to USAID India. Unfortunately, political changes in the Haryana state government has delayed implementation of PBI, but HFG is continuing discussions with Haryana officials and has begun to engage top-ranking officials from Uttarakhand state to gauge interest in implementing PBIs there.

Finally, regarding health accounts (HA), the National Health Systems Resource Center has asked HFG to assist in the development of training materials. HFG completed an India-specific basic training guide (five-day version) based on the materials developed for a training conducted in Chandigarh. This training guide will allow other states to replicate the System of Health Accounts 2011 training that HFG conducted in Chandigarh in Year 3. HFG also made progress on a Public Health Expenditure Review (PHER) of Haryana state. The most recent Haryana State HA is in progress and will be completed in the first quarter of Year 4.

**Q4 Challenges** - The departure of two members of the HFG HA team taxed remaining members in managing activities and requests. HFG is currently in the process of hiring a health financing advisor and field-based staff to assist with Haryana health accounts. This has delayed some activities.

A political and budgetary crisis in Haryana has led to high staff turnover among state health authorities and a steep reduction in Haryana state funds available for implementing PBI. HFG is attempting to secure a renewed commitment to PBI from Haryana officials through face-to-face meetings. HFG has also initiated discussions with Uttarakhand state regarding implementing PBI there.

Table 42 provides activity-specific updates.

**TABLE 42. INDIA ACTIVITY DETAIL**

Year 3 Q4 Planned Tasks	Year 3 Q4 Progress	Critical Assumptions/ Problems Encountered/ Follow-up Steps
<b>Activity 1: Haryana State Health Accounts</b>		
Customize training materials to Indian context	HFG was asked by the National Health Systems Resource Center to work on training materials. HFG has produced a India-specific five-day fundamental training material package and submitted it to USAID India.	Based on available data and experience in Haryana, guidance and discussion paper will be available in Y4Q1.
Conduct a PHER as an initial step to the SLHA	The HFG team completed a draft of the PHER report and is currently editing and formatting it for publication.	The team will submit the final report to the USAID India mission when editing and formatting is completed in October 2015.
Support Haryana health accounts	Data collection is ongoing and should be finalized in October 2015. A firm has been hired to collect data from NGOs and private firms, including from insurance companies.	The Postgraduate Institute of Medical Research (PGIMER), Chandigarh shares the household survey data in a format that enables the team to input it in the HAPT.
<b>Activity 2: HRH landscape analysis</b>		
Field visits to document best practices and convert into toolkits	This activity is on hold at mission request.	This activity has concluded.
Development of HRH manual and toolkit and dissemination	This activity is on hold at mission request.	This activity has concluded.
<b>Activity 3: Institutional strengthening of program management systems in Jharkhand</b>		
Support workflow analysis	This activity is on hold per the mission's request	This activity has concluded
Design and implement staff survey and mapping exercise	This activity is now on hold per the mission's request.	This activity has concluded.
Draft capacity-building plan	This activity is on hold per the mission's request.	This activity has concluded.
<b>Activity 4: Integrated supportive supervision to improve RMNCH+A-Related outcomes</b>		
Pilot revised system in select sites	This activity has been cancelled by the mission.	This activity has been cancelled by the mission.
<b>Activity 5: Institutional strengthening on human resources management to improve RMNCH+A-related outcomes</b>		
<b>Haryana</b>		
Haryana performance-appraisal system designed	This activity is on hold per the mission's request.	This activity will be handed to state health officials and completed in Y4Q1.
Haryana seconded staff member in place	The seconded staff member is currently supporting HRIS implementation in Haryana.	HFG will reassess the viability of continued support for this position.

Year 3 Q4 Planned Tasks	Year 3 Q4 Progress	Critical Assumptions/ Problems Encountered/ Follow-up Steps
Haryana Transfer and Posting Module in place	Data have been validated for contractual workers. The Haryana state government used this information to decide which contractual workers to cut during a recent budget crisis.	This activity will be handed to state health officials and completed in Y4Q1.
Haryana recruitment system in use	The task is delayed due to the delay in validation of terms of reference (TORs) of various health functionaries.	This activity will be handed to state health officials and completed in Y4Q1.
<b>Jharkhand</b>		
Jharkhand HRH Policy	This activity has been cancelled by the mission.	This activity has been cancelled by the mission.
<b>Punjab</b>		
Punjab HRIS customized	This activity has been cancelled by the mission.	This activity has been cancelled by the mission.
Punjab recruitment system in use	This activity is on hold per the mission's request.	This activity is on hold per the mission's request.
<b>Uttarakhand</b>		
Uttarakhand HRH cell documents and tools in place	Four NHM consultants are currently working with the state HRH cell to develop tools and documents.	HFG will play a limited stewardship role in supporting the cell in Y4Q1. The mission will also consider transferring responsibility for this activity to a local partner.
Uttarakhand HRH cell operational	The HRH cell will not be operational until relevant documents and tools are completed by NHM consultants	The mission is considering handing responsibility for this activity to a local partner.
Uttarakhand supportive supervision system in use	USAID India has requested that HFG cease work on supportive supervision.	This activity has been cancelled by the mission.
<b>Activity 6: Support the MOHFW in identifying, analyzing, and operationalizing key HRH reform</b>		
Contribute to subworking group on performance-based incentives for health workers	This activity is ongoing.	This activity will continue in year 4.
<b>Activity 7: Performance-based incentives pilot</b>		
Finalize PBI design	PBI design will not be finalized until officials from Haryana and/or Uttarakhand decide to move forward with PBI implementation.	Finalizing PBI design in Haryana depends on the state government renewing its commitment to implement PBIs. HFG would use its learnings from Haryana to design the PBI intervention for Uttarakhand, in consultation with the state officials and health workers.
PBI tools, guidelines, and manuals	The development of tools, guidelines, and manuals is on hold until PBI design is finalized in either Haryana or Uttarakhand states.	Development of tools, guidelines, and manuals assumes that at least one state fully commits to implementing PBIs. Uttarakhand has

Year 3 Q4 Planned Tasks	Year 3 Q4 Progress	Critical Assumptions/ Problems Encountered/ Follow-up Steps
		expressed interest in pursuing this intervention. HFG thus intends to support the state in developing these tools, manuals, and guidelines over the next two quarters.
Technical support for PBI Design Decisions	<p>The PBI design workshop report has been finalized and submitted to the mission and Haryana NHM.</p> <p>HFG held meetings with officials from Uttarakhand state to discuss the possibility of implementing PBIs in the state.</p>	<p>Budget cuts and political uncertainty in the Haryana state government has delayed the PBI design process in the state. HFG will continue to meet with Haryana officials to advance the process.</p> <p>HFG will also continue to meet with officials from Uttarakhand to finalize plans for implementing PBI in the state. So far, the state has expressed interest and will seek budgetary support for this intervention in the upcoming Supplementary PIP, and the PIP for 2016/17.</p>
<b>Activity 8: National Nodal Agency for Data Quality Improvement</b>		
Prepare for data collection	HFG has developed data collection tools and submitted them to the MOHFW for approval. The HFG team is now in the process of hiring data collectors to collect data in the five pilot districts [Kota (Rajasthan), Ferozpur (Punjab), Malda (West Bengal), Chirang (Assam), and Ernakulum (Kerala)]. The job advertisement for data collectors has been posted and CVs have been shortlisted.	HFG needs to hire eight data collectors in all. The team will field test the data collection tools in Jharkhand state in October prior to conducting the pilot.
Do data-collection tools constructed	Data collection tools have been submitted to MOHFW for approval.	HFG can finalize the tools once they have been approved by the MOHFW, and commence with field testing the data collection tools in Jharkhand state.
Finalize pilot methodology	The HFG team finalized the methodology report and submitted it to both USAID India and the MOHFW. HFG later addressed USAID and MOHFW's comments and resubmitted the report. The MOHFW is still reviewing some aspects of the methodology such as the sample size selection.	MOHFW requested that a service quality assessment be added to the planned data quality assessment, which would require the development of a separate methodology. HFG complied with this request.
<b>Activity 9: HMIS Strengthening Toolkit for use at the state level</b>		
Draft HMIS Strengthening Toolkit	The mission has decided not to move forward with development of the toolkit.	This activity has been cancelled.

Year 3 Q4 Planned Tasks	Year 3 Q4 Progress	Critical Assumptions/ Problems Encountered/ Follow-up Steps
<b>Activity 10: Synthesize existing HMIS assessments to inform design and implementation of technical assistance for strengthening HMIS</b>		
Provide technical assistance to implement HMIS strengthening roadmap	The HFG team submitted the MCTS report to USAID India.	HFG is waiting for USAID India's instructions on how to proceed regarding the MCTS support. However, MOHFW is planning on overhauling the MCTS and is unlikely to request support to strengthen the current system.
<b>Activity 11: Assess and develop capacity-building plan to improve HMIS data quality and data use</b>		
Engage with five additional states to identify HMIS technical support needs	USAID India has instructed HFG not to engage with additional states regarding HMIS technical support needs.	HFG will not start new areas of cooperation on HMIS unless instructed to do so by USAID India.
Carry out DQA in target states, districts	HFG completed the second round of DQA exercises in Haryana in Y3Q3.	The team is currently analyzing the data collected during the second round of DQA and finalizing the report. The report will be completed in Y4Q1.
Develop GIS-related info products, capacity building	The development of the GIS solution is ongoing. The application is undergoing testing by the HFG developer and the state IT team.	The application will be launched by the state in Y4Q1 and the program managers will be trained in November and December 2015 to use the GIS application.
Develop written SOPs and data dictionaries for routine reporting in Haryana	Data dictionaries for Secondary Care and Primary Health Care are currently being edited.	The data dictionaries will be submitted to the state in October 2015.
RDQA training of district M&E staff	In Haryana, two district officials from all the 21 districts have been trained on RDQA.  In Punjab, one district M&E officer from each of the 22 districts has been trained on RDQA.	Haryana state will institutionalize the RDQA and conduct periodic RDQA in the districts.

## 5.2.4 Indonesia

**Program Objectives** - Many changes have taken place in Indonesia since the fall of 2014. On October 22, 2014, President Jokowi began his five-year term as leader of the world's third largest democracy. His stated priorities include poverty reduction, education, and health, including successfully rolling out UHC or JKN (Jaminan Kesehatan Nasional) a social health insurance (SHI) scheme to cover the entire population. When fully implemented, Indonesia will have the largest SHI program in the world. Overall, health expenditure is less than 3 percent of GDP, of which government spending represents approximately 1.2 percent. By cutting the fuel subsidy in November 2014, economists believe Jokowi could potentially save Indonesia \$8 billion by the end of calendar 2015. A modest amount of the fuel subsidy cut will be directed to the health sector.

The future financial sustainability of UHC and JKN is currently a popular topic of conversation among Indonesians. BPJS has been established as the "single payer" and implementer of JKN. In Indonesia, policy is set by the MOH, budget allocations are made by the Ministry of Finance, and BPJS' role is to implement the national SHI program.

Given the backdrop of declining donor resources for development in the health sector and increasing domestic resources for health in Indonesia, as well as the advent of UHC, HFG conducted a rapid assessment to identify opportunities for USAID to engage with the Government of Indonesia in strengthening health systems and UHC, and implementing an Implementation Research (IR) for UHC activity. The assessment identified areas of opportunity and points of leverage where USAID/Indonesia can work with the government in a targeted, strategic, and systematic way as it relates to HSS and the UHC activities in Indonesia, while the IR for UHC activity supports the MOH and other key stakeholders to refine and improve implementation of and policy around JKN and UHC.

**Year 3 Activities** - In Y3Q2, USAID/Indonesia requested HFG support in a rapid external health systems assessment to feed into the development of the HSS and UHC Engagement Plan. HFG engaged in the following activities: reviewing and summarizing sources of health system performance data – Health Sector Review, NHA, PER, SARA, etc.; identifying the continuing challenges to and opportunities for strengthening Indonesia's health system, with particular attention to: financing, governance, service delivery, and information systems; describing current efforts being made in country in identifying the poor and vulnerable; identifying strategies to leverage and engage the private health sector and improve the quality of private health service provision; identifying areas of national progress and successful strategies in the health sector; and identifying opportunities for USAID to engage in HSS. The rapid health systems review and assessment methodology drew from the Health System Assessment methodology and was conducted at national and subnational (district) levels.

Simultaneously, USAID/Indonesia and HFG initiated an IR for UHC activity. The activity will support policymakers and implementers to develop research questions and undertake rapid cycles of research to explore gaps and bottlenecks and offer improvements to implementing the universal SHI scheme in Indonesia.

Also in Q2, USAID/Indonesia asked HFG to support Harvard's implementation of their Asia Public Policy Forum (APPF) for 2015 in Indonesia, with the topic of engaging ASEAN nations in policy dialogue around implementing national health insurance, provision of basic health care in rural areas, cross-cutting issues in financing, and delivering public health.

### **Year 3 Progress Against Objectives -**

**Health system rapid assessment:** In Q3, HFG conducted a comprehensive review of literature pertaining to each of the six WHO health systems building blocks as well as social protection programs in Indonesia. The literature review informed the development of a prioritized list of key informants to

interview, as well as the development of key informant interview questionnaires. The literature review also formed the basis of the Key Document Repository deliverable and matrix analysis, which was completed and submitted to USAID Indonesia through the "Google docs" platform. HFG recruited and contracted three local consultants with expertise in HIS, decentralization, and health financing. A team of recognized international experts in health financing, health governance, service delivery, and social protection traveled to Indonesia to join the Indonesian team members in late April/early May. The team spent two weeks in Indonesia collecting and distilling critical information, conducting interviews with over 100 respondents, and visiting three field districts. At the end of the two weeks, the team debriefed USAID/Indonesia about critical findings. They prepared and delivered a four-hour comprehensive PowerPoint presentation on findings and recommendations, presented to USAID/Indonesia and USAID/Washington via videoconference. Subsequently, the local consultants also presented findings and recommendations to the Indonesia MOH in early June. HFG received feedback from MOH representatives and from USAID in late June.

In Q4, HFG produced the first written draft report for USAID, including in-depth analysis and recommendations. USAID provided initial comments on the draft in late September.

**IR for UHC:** In Y3Q2, HFG completed a landscape analysis of research conducted on UHC efforts in Indonesia. HFG also worked with USAID to determine research questions, focus, country counterparts and district selection. In February, HFG issued a Request for Expressions of Interest and subsequent Request for Applications, and ultimately, in Q3, issued a sub-award to the Center for Health Policy and Management (CHPM) at the Universitas Gadjah Mada to be the national implementing partner for this work. In Q4, CHPM and HFG began rapidly engaging key counterparts in the MOH on the topic of IR for UHC, getting critical district and national buy-in and inputs to prepare for a Y4Q1 launch workshop. More details on the IR for UHC activity related to current status of tasks can be found in the Asia Bureau section of this Annual Report.

**Harvard Asia Public Policy Forum:** Finally, in Q3, HFG worked quickly to prepare and request approval for a sub-award for Harvard to manage the APPF. The sub-award was submitted for AOR approval and approved in early June. Harvard initiated planning for the APPF, and in Q4 successfully secured logistics and invited speakers and participants in a short time frame. The APPF took place successfully in August 2015 in Jakarta, with participation from policymakers and implementers from Indonesia and several ASEAN countries.

**Q4 Challenges** - The timeframe for the rapid health system assessment was extremely compressed; the team had approximately three weeks to conduct an extensive literature review (prioritizing hundreds of documents to distill quickly the most relevant), organize interviews, and hire local consultants. Given Indonesia's size and complexity, it was challenging to complete even a rapid assessment in a two-week field visit. The HFG team successfully tackled this challenge and quickly delivered results.

Rapidly supporting Harvard in planning the APPF in 2015 also was challenging, though ultimately successful. The Harvard team requested an extension to their sub-award to allow for completion of documentation from the event.

IR is a new concept for Indonesian stakeholders and local partners. Gaining trust and engaging multiple stakeholders as active participants in shaping the IR for UHC activity will take more time than initially envisioned.

**Q4 Additional Information** - HFG looks forward to receiving comments from USAID on the draft assessment report and to sharing the report with external Indonesian stakeholders.

Table 43 provides activity-specific updates.

**TABLE 43. INDONESIA ACTIVITY DETAIL**

Year 3 Q4 Planned Tasks	Year 3 Q4 Progress	Critical Assumptions/ Problems Encountered/ Follow-up Steps
<b>Activity 1: Rapid Analytical Review and Assessment of Indonesia Health System</b>		
Rapid Analytical Review and Assessment of the Indonesia Health System	HFG finalized the literature repository and submitted the draft assessment report to USAID. USAID provided comments on two sections of the report in late Q4, and HFG is now in the process of responding to USAID's first round of comments and clarifications.	Indonesia's health system is complex with a multitude of actors and stakeholders. It is also highly decentralized. The team managed a large volume of information, working with USAID counterparts to synthesize and focus on key strategic areas, documents, and stakeholders. Only a few months after the initial analysis, the health system is changing. Therefore ensuring recommendations remain valid is critically important in finalizing the report.
<b>Activity 2: Asia Public Policy Forum 2015</b>		
Supporting launch and delivery of Harvard's 2015 APPF	HFG supported Harvard in developing the participant and speaker list. By the end of Q4, the successful 5th annual APPF had taken place in Jakarta, Indonesia.	Work with Harvard to collect all of the deliverables outlined in their sub-award is ongoing, including collecting the final brief from the APPF.

## 5.2.5 Vietnam

**Program Objectives** - The overall objective of HFG in Vietnam is to support the Government of Vietnam in ensuring the sustainability of HIV/AIDS programs as donor resources diminish in the medium and long term. HFG interventions contribute to key PEPFAR Blueprint road maps for achieving an AIDS-Free Generation, namely Smart Investments and Shared Responsibility. Key activities are designed to support the expansion and increased coverage of HIV prevention, care, and treatment services through the inclusion of these as core services under the benefit package financed by social health insurance (SHI). HFG/Vietnam's core strategy is to find a stable entry point and work from "within" the system by:

1. Supporting the MOH in defining a benefit package by contributing to a road map document and the relevant analytical work;
2. Promoting the inclusion of essential and cost-effective HIV/AIDS services in the package and, critically,
3. Enabling key affected populations to use their subsidized health insurance to pay for HIV/AIDS services.

**Year 3 Activities** - To contribute to the PEPFAR/Vietnam and Government of Vietnam goals in support of innovative financing approaches, of which risk pooling through health insurance is a major component, to meet the national HIV/AIDS program efforts, HFG's work focuses on the following activities:

1. Support the definition and design of an essential benefit package for SHI; this includes drafting and implementing a road map to a defined health insurance benefit package and supporting the MOH and the Vietnam Social Security (VSS) to assess the data availability to perform a comprehensive actuarial analysis. The analysis is needed to see if the combination of benefits in the package and provider payment methods will be financially feasible or will be unsustainable for the SHI fund.
2. Support definition, validation (by VSS especially), and costing of the HIV care and treatment services to be included in the benefit package. The option of including HIV in the services provided under health insurance has to go hand in hand with definition and approval of the essential insurance benefit package;
3. Provide evidence-based knowledge to key decision makers, at MOH/Vietnam Administration of AIDS Control (VAAC) and the Office of Government to disseminate and advocate for the most cost-effective practices of HIV service delivery and provider payment methods applicable to Vietnam;
4. Continue supporting the Capitation Pilot activity as a way to support the MOH's efforts to increase efficiency and cost-savings. The savings are expected to contribute the financial space necessary for funding of HIV services by the Government of Vietnam.

**Year 3 Progress Against Objectives** - During the first three quarters of Year 3, HFG started by laying the groundwork for the definition of a basic benefit package for SHI and for the inclusion of HIV/AIDS services in the package. A training course on benefit package design using cost-effectiveness methods was delivered, and the road map for the development of the package was drafted and subsequently revised to incorporate feedback from key stakeholders. In Q3, as a critical deliverable for the benefit package activity, Vice Minister for Health, Prof. Pham Le Tuan, officially signed the Road Map to the Basic Health Service Package (BHSP) for health insurance. HFG also engaged an international actuarial expert and in Q3 selected a local research firm to conduct an actuarial analysis for the purpose of producing a snapshot of the current viability of the SHI's risk pool and modelling potential cost and utilization of various options for designing the benefit package. Furthermore, HFG assisted VAAC in

finalizing a report on the model to estimate the health insurance liability for the treatment of people living with HIV/AIDS (PLHIV) in Vietnam; the model has been distributed to key stakeholders along with an accompanying policy brief. A concept note for conducting an impact analysis of external assistance for HIV/AIDS interventions was also developed, and a consultative workshop was held with key stakeholders to validate the objectives and design of the analysis. Consultations in Q3 further consolidated the alignment of the various stakeholders with HFG's approach. In Q1 and Q2, HFG provided ongoing support to the implementation of the capitation pilots in the form of technical inputs and participation in supportive supervision visits. Provinces agreed on the appropriate calculation of base rate and total capitation fund. An HFG-supported training enhanced database management skills of Department of Health (DOH) and Provincial Social Security (PSS) staff in the four pilot provinces. In Q3 the MOH became engaged with other priorities and paid less attention to the capitation pilot. Subsequently, there has been less need for support from HFG in this regard.

In Q4, HFG Vietnam started the implementation of activities to be financed by the new, PEPFAR-funded, Sustainable Financing Initiative (SFI) of USAID and it carried out additional staff recruitment to cope with the increased need for LOE due to additional tasks and expectations. Q4 has seen the consolidation and closure of activities well under way in Q3, and the beginning of the National Health Account activity as planned in the SFI work plan. For COPI4 activities, worth notice is the training course, led by HFG/Vietnam on the "Actuarial Analysis and Data Collection in Phase II of BHSP Reimbursed by HI Fund" and the ensuing data collection activity, now well underway in six provinces of Vietnam. One of the positive aspects of the activity is the interest and participation of the VSS, since their cooperation is key to a successful result. The training session represents a key milestone in the planned road map to the BHSP for the years 2014-2017 and the analysis of the data will allow for the estimation of utilization rates of current services and the projection for future packages of health services, including HIV. Also, under COPI4 funding, HFG/Vietnam presented the preliminary results of two surveys recently completed in Vietnam: 1) Facility exit interview with clients of Methadone Maintenance Therapy (MMT) clinics and impact of therapy of socio-economic status and 2) Facility exit interview with PLHIV and the socio-economic impact of HIV interventions. Both surveys are part of a larger study to quantify the socio-economic impact of HIV interventions in Vietnam. Results from these surveys were highly appreciated and used by VAAC leaders with National Assembly and in public fora about the recent Circular 15 (provision of HIV services under SHI). With SFI funding, HFG Vietnam undertook the bulk of data collection and analysis activities for the NHA for 2013, with details for the HIV subaccount. Part of these activities included the first national training on the new System of Health Accounts 2011 methodology in Vietnam, and a key meeting for sharing preliminary results with participants from HFG, USAID, WHO, members of the NHA groups, VSS and VAAC and Department of Planning and Finance (DPF). Lastly in Q4, HFG Vietnam was able to further strengthen the relationship with the MOH and Government of Vietnam, providing, among other things, key advice to the planning of the next five-year implementation of the National Target Program in Vietnam, which will include Health and HIV.

Table 44 provides additional activity-specific updates.

**TABLE 44. VIETNAM ACTIVITY DETAIL**

Year 3 Q4 Planned Tasks	Year 3 Q4 Progress	Critical Assumptions/ Problems Encountered/ Follow-up Steps
<b>Activity 1: The definition, validation, and integration of HIV services in the health insurance benefits package</b>		
Develop impact analysis of external aid for HIV interventions	HFG successfully delivered the results of the surveys needed to describe the socio-economic impact of HIV and MMT to government and other stakeholders.	Next steps: produce printed and digital media with the information from the surveys and the report to inform next year's advocacy activities.
Develop expenditure tracking tool for HIV/AIDS programs	This task was integrated with the current analytical work carried under the NHA/HIV subaccount financed through the SFI and implemented by HFG in Vietnam. We are currently working with VAAC to reach a consensus on the right balance of information detail and scope with data collection requirements.	The workshop to share the preliminary results of the NHA and HIV subaccount will take place in early October.
Participate in the design of the BHSP and provide policy advice and advocacy for inclusion of HIV/AIDS services	HFG continues to be the major non-government proponent and supporter of the insurance benefit package design process.	This task is currently proposed to continue as part of next year's work plan.
Review the current list of all HIV/AIDS services covered by health insurance system	Activity concluded as part of the development of the unit costing of HIV interventions.	
Develop a baseline evaluation for units of costs used in estimating HIV interventions cost	Activity ongoing as part of the development of the unit costing of HIV interventions.	This activity needs to be completed with wider validation of results, possibly to be undertaken in October 2015
Participate in the identification of HIV services to be proposed for inclusion in the BHSP	In Q4, HFG called for a multi-stakeholder meeting (including USAID, UNAIDS, MOH Departments of Health and Finance - DPF/MOH) at VAAC to plan for an assessment of HIV/AIDS service provision in preparation for HIV/AIDS package. The assessment team was led by VAAC together with DPF, and consisted of managers and technical staff of relevant MOH departments such as Medical Service Administration, Health Insurance Department, Vietnam Social Insurance at central and provincial levels, and USAID, CDC, UNAIDS.	The assessment was conducted in Hoa Binh province and Hanoi at the end of September and will be continued in Ho Chi Minh City and Dong Thap in mid-October. This task is also a part of Activity 3 in the work plan proposed for next year.  Problems encountered included VAAC being reluctant in fulfilling the needed leading role of the activity. To fill the leadership gap, the HFG technical team led the process to draft the assessment plan, the assessment tool, and the questionnaires and will also be a key contributor to the final report review and circulation within VAAC.

Year 3 Q4 Planned Tasks	Year 3 Q4 Progress	Critical Assumptions/ Problems Encountered/ Follow-up Steps
		<p>Suggest follow-up steps would be:</p> <p>(1) Disseminate the BHSP road map widely to MOH departments including VAAC and Provincial DOH;</p> <p>(2) Request high-level commitment of VAAC leaders in developing HIV/AIDS package and assignment of tasks with deadline to complete to the focal point division at VAAC.</p>
<b>Activity 2: Support the MOH in the draft of a comprehensive benefit package for health insurance</b>		
Provide technical leadership to prepare the road map to develop a BHSP for health insurance in Vietnam	The BHSP road map was approved in May under Decision 1935/QĐ-BYT by MOH Vice Minister Pham Le Tuan.	The road map should be more widely circulated to relevant stakeholders within the MOH as well as other ministries and agencies. Together with circulating, the MOH should also reinforce implementation of the road map to speed up BHSP development. HFG Vietnam will reinforce the use of the road map as an advocacy and informative tool in next year's activities.
Provide technical coordination to monthly technical group meetings on benefit package development	This task is ongoing. The DPF conducted technical meetings on both a monthly and as-needed basis. The HFG team participated in all meetings and provided technical advice as needed and appropriate	<p>This activity is well coordinated and managed by the DPF Division of Payment Method.</p> <p>HFG plans to continue providing advisory services to MOH in such technical meeting as planned in next year's work plan.</p>
Conduct actuarial research on the expected demographic composition of the SHI insured base and their needs to seek care for illness or injury	<p>This activity started in Q3. The subcontractor, the Institute of Social and Medical Sciences (ISMS), along with the MOH and VSS, is collecting data from the databases of 6 provinces (Ha Nam, Hoa Binh, Dong Thap, Ho Chi Minh City, Gia Lai, Binh Dinh) and the central VSS. Visits and conversations between DPF and DOH and hospitals have been organized to facilitate data collection in provinces. Data collection from the model province (Ha Nam) will be completed to provide full data sets for trial processing and analysis.</p> <p>In September 2015, representatives from DPF, HFG and ISMS conducted one meeting in each province to provide guidance on data collection for the ongoing actuarial analysis. Participants in each province included representatives from provincial hospitals, provincial social security</p>	<p>This activity required active and regular follow-up from DPF and ISMS to assure that the provinces send the data in a timely fashion to speed up the data analysis process. There will be 2 major challenges to overcome in the near future:</p> <p>(1) VSS had the technical specialist work and run data in the VSS office for privacy and security reasons.</p> <p>(2) The data in each province are not stored in the same software application which could lead to difficulties in generating data. The technical team will work closely and hold discussions with provinces and VSS in order to have the most accurate data, but this will take additional time.</p>

Year 3 Q4 Planned Tasks	Year 3 Q4 Progress	Critical Assumptions/ Problems Encountered/ Follow-up Steps
	and district hospitals, and 4 communes. The raw data collection for the analysis was proposed to be sent to the ISMS team by mid-October 2015.	
Provide technical, logistical, and financial supports to organize a dissemination workshop on 3-year road map of a benefit package	This activity was completed in Q3.	
<b>Activity 3: Provide technical inputs to the implementation of the Capitation Pilot activity in four provinces</b>		
Provide ongoing coordination and technical assistance to DPF and VSS	In Q4, the MOH and the VSS did not require any substantive support or coordination from HFG. HFG participated in the monthly meetings and provided comments as appropriate, but no trainings or workshops were held.	It is likely that the Capitation Pilot activity in its current form will be discontinued or radically modified, which would be an opportunity for HFG to work with the MOH and VSS on a more rational and effective capitation model, focused on a grassroots level of service delivery.
Provide technical inputs and logistics to organize a basic database training for key staff of DOH and PSS in 4 pilot provinces	In Q4, the MOH and the VSS did not require any substantive support or coordination from HFG. HFG participated in the monthly meetings and provided comments as appropriate.	It is likely that the Capitation Pilot activity in its current form will be discontinued or radically modified, which would be an opportunity for HFG to work with the MOH and VSS on a more rational and effective capitation model, focused on a grassroots level of service delivery.
Provide contribution for a road map for enhanced capitation	As the MOH has not pursued further modifications of the Capitation Pilot activity, this task will not be required of HFG.	It is likely that the Capitation Pilot activity in its current form will be discontinued or radically modified, which would be an opportunity for HFG to work with the MOH and VSS on a more rational and effective capitation model, focused on a grassroots level of service delivery.
Provide technical inputs to a uniform software that could be used for both district hospital and PSS	Since the database training in Q1, there have been no discussions on this topic.	MOH's attention has shifted from the Capitation Pilot activity to other priorities, so it is unlikely there will be a need for additional inputs to this task in Year 4.
Provide technical inputs through monthly meetings, trainings, and workshops on Capitation Pilot activity implementation	In Q4, the MOH and the VSS did not require any substantive support or coordination from HFG for the Capitation Pilot activity.	It is likely that the Capitation Pilot activity in its current form will be discontinued or radically modified, which would be an opportunity for HFG to work with the MOH and VSS on a more rational and effective capitation model, focused on a grassroots level of service delivery.
Participate in supervision teams to provide supportive supervision visits to pilot sites	In Q4, the MOH and the VSS did not require any substantive HFG support or coordination.	It is likely that the Capitation Pilot activity in its current form will be discontinued or radically modified, which would be an opportunity for HFG to work with the

Year 3 Q4 Planned Tasks	Year 3 Q4 Progress	Critical Assumptions/ Problems Encountered/ Follow-up Steps
		MOH and VSS on a more rational and effective capitation model, focused on a grassroots level of service delivery.
Participate in data analysis and reporting on capitation pilots results	There has been some reporting on pilot results at the monthly capitation meetings at the MOH, but HFG was not asked to play a substantial role in data analysis.	It is likely that the Capitation Pilot activity in its current form will be discontinued or radically modified, which would be an opportunity for HFG to work with the MOH and VSS on a more rational and effective capitation model, focused on a grassroots level of service delivery.

## 5.3 Eastern Europe and Eurasia

### 5.3.1 Eastern Europe and Eurasia Bureau

**Program Objectives** - HFG's Europe and Eurasia Bureau program will strengthen local HIV/AIDS NGOs serving MSM and IDU populations in Armenia, Azerbaijan, and Georgia across key areas of organizational capacity, including financial management, internal management and governance, advocacy and constituency building, and networking and partnerships.

Outcomes of the program will include:

- ▶ Technical assistance, training, and support provided for local HIV/AIDS NGOs
- ▶ Capacity-building sub-grant(s) awarded to local NGO(s) in Armenia, Azerbaijan, and Georgia
- ▶ Network of HIV/AIDS NGOs strengthened within and across countries in the region

**Year 3 Activities** - Activities for the E&E Bureau program include capacity development support and strengthening country-based NGOs.

**Year 3 Progress Against Objectives** - In Q3, HFG concluded the review of the applications submitted in response to our RFA for the Strengthen HIV and AIDS NGOs in Europe and Eurasia activity. A local Armenian for-profit firm was selected as the preferred implementer based on exceptional technical and cost value. HFG prepared a detailed scope of work to outline the schedule of implementation as well as the deliverables to initiate the sub-award. It expected that the final sub-award contract will be approved by USAID in Q4 and implementation of activities will begin.

**Q4 Challenges** - During Q4, the sub-award for the local implementing partner, Business Support Center LLP (BSC), was approved by USAID. However, HFG learned that we needed to complete a VAT exemption process for the three countries of implementation (Armenia, Azerbaijan, and Georgia) to ensure that neither party was beset with additional costs at the end of the project. HFG is in the process of finalizing our VAT exemption with each country.

Table 45 provides additional activity-specific updates.

**TABLE 45. EASTERN EUROPE AND EURASIA BUREAU ACTIVITY DETAIL**

Year 3 Q4 Planned Tasks	Year 3 Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
<b>Activity I: Capacity development technical support</b>		
Sub-award initiated	This task was completed in Q4.	

### 5.3.2 Ukraine

**Program Objectives** - HFG in Ukraine will work closely with country counterparts to test new ways of managing and financing basic HIV services that are fully aligned with the government's current health reforms. The piloted activities will include HIV testing and counseling, as well as basic HIV care, through their integration into the primary health care (PHC) centers in selected towns and districts in Chernigiv Oblast.

Given the current reforms in Ukraine aimed to improve health services, the purpose of this work is to explore the following questions:

- ▶ What are the costs and benefits of providing integrated HIV testing and treatment at PHC centers, as compared to the current vertical model of provision based on specialized trust/AIDS centers?
- ▶ What are the impacts of the integrated HIV care model on HIV testing rates, counseling uptake, and timely AIDS treatment?

**Year 3 Activities** - In Year 2, HFG supported the development and implementation of the service delivery model and conducted a baseline cost analysis. The project adapted a training curriculum for PHC doctors and nurses, trained 64 pairs of PHC doctors and nurses located in four pilot rayons of Chernigiv Oblast, facilitated the donation of HIV rapid test kits and related materials from the Clinton Health Access Initiative (CHAI) and the Alliance, developed a supervision protocol and monitored the offering of HIV testing and counseling services in PHC centers, developed a cost-effectiveness study design, and conducted baseline data collection and analysis.

In Year 3, HFG will complete the project. It will continue to supervise and monitor the offering of HIV counselling and treatment services at PHC centers. It will continue providing supportive supervision and collaborating closely with the AIDS Center and Trust Offices in pilot rayons, communicating frequently and directly with PHC doctors and nurses. The project will continue collecting and analyzing data, including data on costs of providing counselling and treatment services, and will finish the cost-effectiveness study. Finally, the project will support the health financing framework to integrate HIV into PHC with technical recommendations.

**Year 3 Progress Against Objectives** - In Q4, HFG finalized the cost-effectiveness evaluation, and disseminated the results via in-person presentations to stakeholders in Ukraine, including Chernigiv regional health officials, the Ukrainian Ministry of Health, and CHAI, as well as via the electronic dissemination of the final report and Ukrainian language summary report. Project-developed tools such as a supervision protocol for HIV rapid testing at the PHC level, training materials for PHC physicians and nurses, and reporting templates were transferred to local counterparts and stakeholders. While HFG's participation in the pilot concluded this quarter, the steering committee that HFG helped to establish in Year 2, which comprises various local stakeholders and organizations, has decided to independently continue implementing the model that HFG has developed. The HFG Project supported the local partners in planning the work for the next year, estimating the needs for HIV rapid tests, and looking for potential partners to continue the implementation of the model. HFG worked with the International HIV Alliance in Ukraine to procure the donation of additional HIV testing kits for project partners to use moving forward after the end of the HFG project.

**Q4 Additional Information** - In September 2015, HFG was obligated Ukraine Mission funding to develop a new TB hospital payment system for Poltava Oblast. Because HFG had carried out earlier work on TB strategic purchasing in Ukraine using core funding in the first through third quarters, this annual report keeps all Ukraine reporting together under the TB section of the report. Beginning in Year 4, Ukraine TB activities will be reported under the Ukraine section of the report.

## 5.4 Latin America and Caribbean

### 5.4.1 LAC Bureau

**Program Objectives** - In 2012, the governments of the United States, Ethiopia, and India, along with UNICEF, convened A Child Survival Call to Action to help refocus the efforts of governments and organizations worldwide in addressing preventable child and maternal mortality. Participants, including USAID, committed to supporting maternal and child health globally and to deliver on existing commitments to child survival. This commitment became recognized as A Promise Renewed (APR). In September of 2013, a regional conference called A Promise Renewed in the Americas was convened in Panama City, Panama. The APR in the Americas event recognized the regional improvements of maternal and child mortality rates in the Americas region, but also the fact that gaps persist, especially due to inequality and a lack of universal access to appropriate care. The conference focused specifically on maternal and child health challenges in the region and the way forward, recognizing diminishing donor funds for maternal and child health and the need to mobilize local resources to focus on sustainability of existing programs and services. Countries and donors cited the specific problem of policymakers introducing new reforms to achieve Universal Health Coverage (UHC) that do not adequately protect or promote maternal and child health services and goals. USAID was part of the region-wide commitment at the conference to help reduce the equity gaps for maternal and child health in the region and eliminate preventable maternal and child mortality by 2035.

In Latin America and the Caribbean (LAC), HFG is supporting national, regional, and local government organizations and health facilities in initiating and implementing a wide range of health finance and governance projects. As countries in LAC graduate from bilateral assistance in health, USAID's LAC Regional Bureau seeks to help transitioning countries ensure maternal and child health programmatic sustainability. To achieve this goal, the LAC Bureau's program focuses primarily on health system strengthening and capacity building to ensure that reforms to achieve UHC reflect the latest evidence and incorporate maternal and child health services. In order to implement reforms and affect broader policy decision making, there is a strong need for the generation and use of evidence to provide policymakers with the information they need to make sound policy and operational decisions. The lessons learned and research findings from within LAC countries can also be shared in regional global forums.

**Year 3 Activities** - HFG will work with sub-awardee Bitran y Asociados to ensure the successful delivery of the four-day course "The Challenges to Advancing Universal Health Coverage," in close collaboration with the World Bank Institute. Through HFG, the LAC office at USAID is collaborating with the World Bank Institute (WBI) to host The Challenges to Advancing Universal Health Coverage, for government officials and USAID staff. The course will be based on the WBI's three-week flagship course that uses a practical framework for understanding health systems and their performance, and a structured approach to developing health system reform policies to improve systems performance. The course will provide a unique opportunity for participants to explore key issues in health financing, payment systems, organizational change, regulation and influencing provider/client behavior. Sessions will include a closer look at the reality of political/ethical trade-offs, leadership challenges, and ensuring quality to progress toward UHC.

**Year 3 Progress Against Objectives** - A successful course was held March 10-13, 2015 in Panama City, Panama. The course was attended by over 40 Ministry of Health (MOH) and Ministry of Finance (MOF) representatives from seven LAC countries: Dominican Republic, Haiti, Honduras, El Salvador, Guatemala, Guyana, and Peru. Course evaluations showed high praise and satisfaction from the course participants, all of whom are eager to remain engaged. Materials from the course will be posted on the HFG website to continue engagement with participants.

## 5.4.2 Barbados and the Eastern Caribbean

**Program Objectives** - The HIV/AIDS epidemic is the leading cause of death for adults in the Caribbean region aged 25 to 44 years. With an HIV prevalence rate of 1 percent, it is the hardest hit region after sub-Saharan Africa. Multiple factors, such as leveled donor funding, the global economic recession, and increased prevalence of non-communicable diseases have placed more weight on the importance of sustainability in health programs. As external aid for HIV programs decreases across the Caribbean, investments in health financing systems are necessary to enhance sustainability of and access to HIV programs. The seven countries where HFG is working – Antigua and Barbuda, Barbados, Dominica, Grenada, St. Kitts and Nevis, St. Lucia, and St. Vincent and the Grenadines – have made great strides in their HIV response, and have an achievable goal to end mother-to-child transmission in the next three years. Careful management and investments in the face of declining external funding will be important to sustain the momentum and gains that have been achieved.

The overall objective of HFG's activities there are to build country capacity in core health system components – financing, governance, and operations – enabling health systems and HIV programs in particular to function more sustainably and efficiently. Our anticipated results include:

- ▶ Increased use of health and HIV expenditure data and unit cost information to inform resource allocation decisions, health sector reforms, financial sustainability planning, and advocacy, including among both public and private sector health stakeholders
- ▶ Strengthened MOH financial management capacity, including the ability to conduct costing analyses and utilize costing data for strategic and operational planning
- ▶ Strengthened regional institutional capacity to provide health financing technical assistance, specifically in National Health Accounts (NHA) and resource tracking for HIV
- ▶ Strengthened capacity within the Pan Caribbean AIDS Partnership (PANCAP) to provide sustainable strategic leadership for the regional HIV response in the Caribbean
- ▶ Increased long-term sustainability of HIV programs throughout the region
- ▶ Increased capacity of civil society to engage in the HIV response, particularly on issues of governance and the financing of the response

**Year 3 Activities** - USAID/Barbados and Eastern Caribbean provided a budget of \$1,219,000 for the Caribbean region in March 2014. In August 2014, USAID/Barbados and the Eastern Caribbean directed HFG to spend against that budget up to \$1,159,132 in order to reflect new programming guidance from PEPFAR.

HFG will complete all activities not already completed in the first quarter of Year 3. As a follow-up to the UNAIDS and PEPFAR support of the “Second Caribbean Regional Meeting On Strategic HIV Investment And Sustainable Financing (January 2014),” HFG Caribbean will support the development of HIV Investment Cases in six of the Organization of Eastern Caribbean States (OECS) nations: Antigua and Barbuda, Grenada, Dominica, St. Kitts and Nevis, St. Lucia, and St. Vincent and the Grenadines. The goal of an Investment Case is to outline strategic HIV investments to maximize available resources and achieve the greatest impact on the epidemic. Each case will be used to inform planning, resource allocation decisions, and funding applications for the HIV responses in these countries. The development of the cases will include participation from the governments, civil society, the private sector, and development partners. In Y3Q1, HFG will work with country teams to refine estimates of resources availability for HIV and AIDS responses, necessary to complete Investment Cases. HFG will then draft and finalize briefs summarizing each country's case and presenting policy implications. These results will then be validated with countries and discussed with the OECS Global Fund Working Group Committee to determine country and regional priorities and cost implications for HIV and AIDS programming.

These results will be first presented and discussed at a regional meeting in Dominica with the Global Fund Working Group along with representatives of the countries' National HIV/AIDS Programs. Following this meeting, HFG will provide additional assistance to provide resource estimates for HIV spending in each of the six countries from 2012-2013 and actively participate with the Working Group to use information from the Investment Cases to help to shape the Concept Note for the upcoming Regional OECS Global Fund grant application. This application is scheduled to be submitted in April 2015.

HFG also will facilitate the finalization of NHA estimations in Barbados and St. Vincent and the Grenadines in the Y3Q1. The NHA methodology quantifies health spending and tracks expenditures from financing sources (such as households, donors, and Ministries of Finance) to fund managers (such as MOHs and insurance companies) that allocate and manage health care funds, and ultimately to health care providers and health functions. Under the latest version of the NHA methodology, called the System of Health Accounts (SHA) 2011 framework, all expenditures are allocated to disease categories, including HIV. The results provide stakeholders with a comprehensive map of resource flows funding the HIV response and the entire health system. Continuing the approach of the Health Systems 20/20 and Health Systems 20/20 Caribbean projects, HFG will support the NHA estimations in close collaboration with the University of the West Indies Health Economics Unit (UWI-HEU). To the extent feasible, HFG will rely on MOH staff to assist with data collection, analysis, report writing, and dissemination. HFG will continue to use the updated Health Accounts Production Tool (HAPT) software that incorporates the new SHA 2011 framework to facilitate and streamline the data analysis process.

After forming technical teams and Steering Committees, as well as holding launch events in both countries in Year 2, in Year 3 HFG will provide support to the technical teams in data collection. This includes primary institutional data from donors, NGOs, insurance companies, and employers, secondary data from governmental agencies, and primary health expenditure surveys of PLHIV to capture out-of-pocket spending for HIV prevention, treatment, and care. In Barbados, HFG will also conduct a household health expenditure survey in order to estimate out-of-pocket spending on health by households in that country. HFG will then facilitate an analysis workshop to map all expenditures gathered to the SHA 2011 classifications, triangulate sources, and validate preliminary results. With finalized data, HFG will write reports summarizing and synthesizing findings as well as "Methodological Notes" compiling methods, assumptions, and limitations of the estimation process. HFG will then hold dissemination events in both countries to share findings and discuss policy implications with stakeholders.

Other activities to be completed in Year 3 include:

- ▶ Capacity-development assistance for PANCAP to strengthen its role as a regional resource for the HIV response. Support for PANCAP includes technical inputs, such as costing of a regional operational plan for PANCAP in support of a Global Fund application, as well as organizational development technical assistance.
- ▶ Submission to journal of an article on the lessons learned from USAID's transition from family planning programming that can be applied to the transition from donor funding for the HIV response in the region.

**Year 3 Progress Against Objectives** - HFG has actively supported planning for sustainable financing of the HIV response in the seven countries of Barbados and the Eastern Caribbean. Its participation began in January 2014 with the UNAIDS- and PEPFAR-sponsored "Second Caribbean Regional Meeting on Strategic HIV Investment and Sustainable Financing," with senior leaders from eight Caribbean countries who are engaged in HIV program planning and financing, including Permanent Secretaries of Health, MOF representatives, National AIDS Program coordinators, and civil society and private sector representatives. HFG has helped to define an approach for Investment Case development for these

small states, including a method to use existing data to suit the countries' multiple needs, and to aggregate results for a combined regional contribution to the regional Global Fund application as well as an OECS Regional HIV Strategic Framework. After providing technical content and facilitating discussions with stakeholders on the Investment Cases in the six OECS countries in the first quarter of Year 3, HFG finalized the models and drafted HIV Investment Case Briefs in each country. Drafts were shared with and validated by stakeholders. The results have clearly outlined the resources required and projected impact in terms of new HIV infections and AIDS deaths averted by scenarios, including maintenance of the status quo, reduced funding for prevention, and the 90-90-90 scenario. The resources needed to execute these scenarios in each of the countries as well as in the OECS region was quantified to aid in planning and definition of priorities. HFG also provided additional support to the Government of Dominica to update the country's HIV/AIDS Strategic Plan (2015-2019) based on Investment Case results and HFG-facilitated discussion on strategic priorities. Using the draft developed with the HFG team, Dominica's National HIV/AIDS Response Program completed their plan, which was submitted for approval in January 2015. The Dominican officials also presented Investment Case findings at a regional meeting in Trinidad on October 23, 2014, illustrating the empowerment by countries of their data and potential for future use to inform decisions regarding HIV and AIDS country investments. All six of the HIV Investment Briefs are being used as inputs into the regional OECS Global Fund application submitted in April 2015.

This quarter also saw the completion of two HIV-focused health accounts exercises, one in Saint Vincent and the Grenadines and the other in Barbados. In both countries, HFG worked closely with the MOH, local consultants, and UWI-HEU. With these partners, HFG completed primary institutional data collection from donors, employers, NGOs, and insurance companies, secondary data collection from government agencies and facilities, among other sources, and primary surveys of PLHIV (30 respondents in Saint Vincent and the Grenadines and 135 respondents in Barbados). In addition, HFG conducted a household health expenditure survey in Barbados, covering 972 households. HFG then held an analysis workshop to compile all spending data and map them to the SHA framework. Analysis included triangulation of estimates from different sources, weighting of estimates, and removal of double counting entries. Results were validated with local stakeholders and analyzed to articulate their policy implications and recommendations. HFG held dissemination workshops with 24 local stakeholders in Saint Vincent and the Grenadines and 45 in Barbados. With their input, HFG finalized the Health Systems and HIV Response Accounts reports and methodological note and shared them with country counterparts. Throughout this effort, HFG integrated capacity-building activities into the production and analysis of health accounts data in order to ensure that both MOH counterparts and UWI-HEU staff were guided through the process and given resources to facilitate the strengthening of their technical and managerial capacities for health accounts estimation. HFG found that, by the end of this activity, all counterparts were significantly more able to conduct future health accounts. Barbados has expressed its intent to use the NHA results to inform the design of health financing reforms and to continue NHA estimations in the future, as the SHA 2011 methodology has proven more amenable to its context than the Health Satellite Accounts.

Other activities completed in Year 3 include:

- ▶ HFG delivered capacity-development assistance to PANCAP to strengthen its role as a regional resources for the HIV response by i) costing the regional operational plan for PANCAP to support its Global Fund application, ii) providing organizational development technical assistance, including co-development of an orientation package, stigma and discrimination module, and resource mobilization strategy.
- ▶ HFG submitted a manuscript of an article on the lessons learned from USAID's transition from family planning programming that can be applied to the transition from donor funding for the HIV response in the region to the *Global Health: Science and Practice* journal.

### 5.4.3 Guatemala

**Program Objectives** - HFG will carry out a Health Systems Assessment in Guatemala. The primary objective of the HSA will be to map the health system's strengths and weaknesses. The USAID/Guatemala Mission intends to use the resulting report in discussions with political actors in Guatemala in preparation for the elections scheduled for November 2015.

**Year 3 Activities** - HFG and USAID/DC are conducting an HSA for USAID/Guatemala.

**Year 3 Progress Against Objectives** - During Q2, the HFG/USAID team developed zero drafts of the HSA report based on literature reviews across the health system building blocks. The drafts were used to identify key issues for further review, while also compiling a set of indicators measuring the performance of the health system building blocks. The team also developed a list of key stakeholders with whom they will meet during in-country interviews, information gathering and site visits.

In Q3, the HSA Team traveled to Guatemala for the in-country data collection phase of the HSA. Over a two-week period, the team interviewed over 100 key informants and presented initial findings to key stakeholders including the USAID Mission and the Ministry of Health. A draft HSA report was sent to the USAID/Guatemala Mission on June 12, 2015, with feedback expected from the Mission on July 1, 2015. At the request of the USAID/Guatemala Mission, HFG began joint planning with the SHOPS Private Sector Assessment team for a series of dissemination meetings in Q4.

In Q4, HFG incorporated the Mission's feedback and finalized the HSA report. The HSA team also presented a summary of findings and recommendations via teleconference at the request of the Mission, and larger in-country dissemination meetings are planned for early 2016.

Table 46 provides activity-specific updates.

**TABLE 46. GUATEMALA ACTIVITY DETAIL**

Year 3 Q4 Planned Tasks	Year 3 Q4 Progress	Critical Assumptions/ Problems Encountered/ Follow-up Steps
<b>Activity I: Health Systems Assessment (HSA)</b>		
Finalize HSA report	HFG submitted the final HSA report on August 21, 2015, and initial feedback has been positive. HFG awaits final approval before moving forward with translation of the document into Spanish.	The Guatemala Mission has indicated they would like the HSA team to return to Guatemala in early 2016 for a large dissemination meeting. HFG awaits further guidance from the Mission as the political situation in the country evolves.

## 5.4.4 Haiti

**Program Objectives** - At the start of HFG, USAID Haiti requested that the HFG project work closely with the Haitian Ministry of Public Health and Population (*Ministère de la Santé Publique et de la Population*, MSPP) to strengthen the ministry's capacities in human resources for health (HRH) management and in health financing, enabling it to carry out its role as an effective steward of the health sector. HFG developed a country strategy to address the mission's request, which was approved in Year 1. To execute this strategy, HFG works directly with five MSPP operational units: *Unité d'Appui à la Décentralisation Sanitaire* (UADS) (decentralization unit), *Unité d'Evaluation et Programmation* (UEP) (planning and evaluation unit formerly called the UPE), *Direction de l'Administration et du Budget* (DAB) (budget and administration directorate), *Direction des Ressources Humaines* (DRH) (human resources directorate), and *Direction de Formation et Perfectionnement de Sciences de la Santé* (DFPSS) (training) on institutional and technical capacity building as well as technical implementation support.

**Year 3 Activities** - HFG continues its country strategy to support the MSPP and its five focal units. The focus of activities with the DAB is on strengthening public financial management (PFM) at both the central and department levels. HFG continues to strengthen MSPP's capacity through the UEP to effectively plan its activities and track resource flows in the health sector. HFG continues to build the capacity of UADS to strengthen the decentralized functions of the departments, particularly with respect to financial management and certain HRH management activities. HFG supports the DRH in strengthening the HRIS and using the data for planning and decision making in addition to improving career and performance management processes. Finally, HFG supports the DFPSS to design and implement effective processes to ensure minimum standards are followed across Haiti's private nurse training institutions.

**Year 3 Progress Against Objectives** - In Q4 of Year 3, HFG continued to implement its country strategy by working with the five departments of the MSPP. The project's achievements in Q4 were as follows:

**DRH:** The HFG team provided an MSPP orientation session for 28 MSPP administrators at the central level. This session aimed to strengthen their capacity to (1) manage human and financial resources, equipment, and materials, (2) better understand the MSPP organizational culture, and (3) better understand programs dealing with health priorities (HIV/AIDS, human rabies, blood transfusion, vaccination). HFG organized the third quarterly quality control and participatory review of HRH and launched the EHRIS-2. Data collection is currently conducted in two departments.

**DFPSS:** HFG provided continuous support to DFPSS to conduct reconnaissance visits in nine additional nursing schools. In Q4, HFG developed an audio spot and launched the process to communicate reconnaissance results to potential students via radio and media; and an online reconnaissance management tools.

**UEP:** The NHA 2012-2013 presentation/dissemination ceremony was held on September 17. The event was chaired by the MSPP, in the presence of the USAID/Haiti Deputy Director, WHO representatives, a representative from the Ministry of Economy and Finance (MEF), the President of the Supreme Audit Institution, and the MSPP's Director General. About 200 people participated in the ceremony. In addition, HFG continued to participate in the technical committee for the development of the health financing strategy.

**St. Damien Hospital's Costing Update and Business Plan Development:** Saint Damien Hospital (HSD) services costing ended in Y3Q3. The costing study report was submitted in August 2015. The next stage of the study, which consists of costing 14 pathologies, has started.

**Sacré Coeur Hospital of Milot (HSCM):** HFG team composed of the Country Manager, the Deputy Country Manager, the COP, the Costing Specialist, and USAID/Haiti Health Systems Strengthening

Advisor visited Milot to meet with the CEO to discuss the need and objectives of costing the hospital's services and of developing a business plan. HFG team developed the methodology and scope of work for costing and business planning.

**Government to Government (G2G) Public Financial Management risks assessment:** In Q4, HFG developed the G2G risk assessment tool tailored to the MEF, MSPP, and Ministry of Planning with the objective of finding a funding mechanism to pilot a result-based financing (RBF) program for Haiti health facilities. HFG held introductory meetings with these ministries' management and conducted their G2G PFM risk assessment. The draft assessment report was completed and submitted to USAID /Haiti Mission for review.

**Justinian University Hospital (JUH) Pediatric Ward Costing Estimates and Revenue Assessment:** In Q4, HFG assisted hospital's team in providing costing estimates and revenue assessment for its pediatric unit aimed at informing the facility's management and USAID infrastructure team about the operating and maintenance costs of the reconstructed pediatric ward and potential sources of revenue to assess prospects for and suggest strategies to achieve financial sustainability. The report on costing estimates and revenue assessment was submitted to USAID Haiti.

**Financial Sustainability Planning:** To respond to an audit report of the Office of the Inspector General (OIG), USAID/Haiti requested that HFG prepare a status report compiling accomplishments to-date and delineating areas yet to be completed with regards to financial sustainability planning for three project sites being provided USAID infrastructure support: *Hôpital de l'Université d'Etat d'Haiti* (HUEH), Justinien University Hospital (JUH) Pediatric Ward and the National Campus for Health Sciences (NCHS). The OIG report recommends completing these plans "to ensure the local government has the capability and aspiration to maintain USAID's investment" in the health infrastructure. HFG conducted site visits and interviews to respond to this request and submitted a final report, following two rounds of comments from USAID, that summarized the project background; outlined and explained the suggested components of a sustainability plan; and presented what had been accomplished and what remained outstanding using the sustainability plan presented in the previous section as a guide. This submission supports HFG's project objective of supporting the financial capacity of the MSPP to advocate and plan for financial resources for health.

**Q4 Challenges** - Most activities that HFG planned in support of DAB didn't take place. HFG conducted a DAB technical capacity assessment and submitted the report. However, DAB has shown little interest in moving forward with the implementation of the assessments recommendations.

HFG experienced delays in some health financing and institutional capacity-building activities after the resignation of the Capacity Building Advisor and the Health Financing Advisor. The process for replacing them was initiated.

**Q4 Additional Information** - HFG Haiti Home Office Country Manager and her Deputy visited Haiti. During the visit, they assisted HFG Haiti site team with the Y4 and Y5 work plan, Y4 performance monitoring plan, and hiring of replacement staff. They also traveled to Cap Haitien to meet the Executive team of the Sacré-Coeur Hospital of Milot to discuss the upcoming costing activity.

HFG and LMG participated in a meeting where they presented to the MSPP and USAID the projects' key achievements and next two years' activities.

Table 47 provides activity-specific updates.

**TABLE 47. HAITI ACTIVITY DETAIL**

Year 3 Q4 Planned Tasks	Year 3 Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
<b>Activity 1: Supporting PNS target setting with a needs and outcomes analysis</b>		
Finalize consolidated costing data for operational plans (OP) and Plan Directeur de la Santé (PDS) and delivery activity-cost database	Completed.	Costing data and delivery activity-cost database will need to be updated to budget OP and PDS for 2016-2022.
Finalize consolidated costing data for OPs and PDS/ train UEP on consolidation tool/process	Completed.	
Develop data collection and scenario analysis using OneHealth tool set up for Haiti	Future milestone.	This activity is linked to the development and costing of OP and PDS for 2016-2022. Activity will be implemented while preparing this plan.
Support the dissemination of PDS 2012-2022 budget	Met with UEP management team and the MSPP top management to discuss PDS 2012-2022 budget, with a focus on the next seven years.	Assistance to UEP in budgeting PDS 2012-2022 (with a focus on the next seven years) is planned for the next FY.
<b>Activity 2: Health financing strategy development and resource mobilization capacity building</b>		
Develop draft health financing strategy options	The draft health financing strategy is ongoing.	Departure of Health Financing Advisor has slowed progress. Successor advisor will be hired in Q1 of FY16.
Health financing concepts capacity building for MSPP staff	Future milestone.	HFG is waiting for feedback from the MSPP Minister on the recommendations from the health financing conference. MSPP staff capacity building depends on the validation of the proposed recommendations.
Support Minister-appointed consultant to implement UEP assessment recommendations	This activity is ongoing through Dr. Junot's work (institutional capacity-building consultant) in implementing UEP capacity-building plan. He organized meeting with UEP personnel, submitted to MSPP Minister finalized drafts of the documents guiding the implementation of the new organizational structure.	Activity will continue in next FY. Next steps include creation of a committee in charge of attributions of personnel assignment; development and distribution of flyers presenting mission and function of the new UEP; definition of profiles and competencies; analysis of HR need; and development of an updated organigram.

Year 3 Q4 Planned Tasks	Year 3 Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
Support UEP with technical expertise with embedded advisor (health financing, costing)	Delayed.	In Q4 the Health Finance Advisor resigned. His replacement will be identified in next quarter.
Stakeholder engagement to review/ debate draft health financing strategy options	The health financing conference report with strategy options, recommendations and key takeaways was submitted to USAID and MSPP in July.	HFG is waiting for feedback from USAID and MSPP.
<b>Activity 3: Strengthening PFM budget preparation and execution</b>		
Support TOT for the implementation of hospital financial reporting processes	Activity is included in Y4 work plan.	Two key prerequisites before this activity takes place: (1) validation of the assessment report that proposed the TOT; (2) finalization of the training material.
Finalize DAB technical capacity assessment	Completed.	Awaiting DAB feedback on the report submitted in Y3Q1.
Develop vision and strategy for DAB that supports evidence-based planning across MSPP	Future milestone.	Activity depends on the pending validation of DAB technical capacity-assessment report.
Support DAB with technical expertise with embedded advisor on PFM. Implement HFG-conducted technical capacity-assessment recommendations on PFM and budget prep	Future milestone.	Activity dependent on the pending validation of DAB technical capacity-assessment report.
Improve filing system capacity	In progress. Completed the situational analysis and the needs assessment of DFPSS, DRH, and DAB.	Activity will be completed in next FY. The next steps include designing and implementing activities to improve filing system capacity of DFPSS, DRH, and DAB.
Strengthen DAB leadership and supervision skills	Future milestone.	Activity dependent on the pending validation of DAB technical capacity assessment report.
Support Office of Management and Human Resources (OMRH) for the implementation of its inventory tools and process for MSPP	Future milestone.	Awaiting SOW from OMRH for this activity.
<b>Activity 4: Resource tracking /NHA</b>		
Support UEP on the use of the production tool for NHA 2012/13	HFG supported MSPP through UEP in producing/editing and disseminating the NHA 2012/2013 report.	Next NHA was launched. HFG will work with UEP to include HIV data.

Year 3 Q4 Planned Tasks	Year 3 Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
Provide technical assistance as requested by MSPP	HFG provided some technical support to UEP.	UEP asked HFG to postpone training on the use of OneHealth tool. Training will take place in Y4.
<b>Activity 5: Development of MSPP UADS's capacity to strengthen department-level health directorates</b>		
Assist UADS in developing and implementing an organizational structure	Future milestone.	This activity will complement the assistance provided to UEP. It follows the in-depth institutional assessment of roles and function that the MSPP has requested.
Support day-to-day management skill of UADS staff (e.g., strengthening linkage between UADS and other units like the DAB, DRH, UEP)	Ongoing.	This activity will take place after the in-depth institutional assessment of roles and function.
<b>Activity 6: Support institutional capacity building of the MSPP DRH to implement, manage, and monitor civil service reforms, and conduct workforce capacity assessments</b>		
Support DRH to improve/ implement orientation process for MSPP staff	HFG assisted in organizing orientation session for 28 MSPP administrators at central level.	
Conduct EHRIS-2 to broaden EHRIS-1 to extend Human Resource Information Management System (SIGRH) to the private sector; budget and advocate increase financial contribution of DRH to this activity	Technical working group composed of people from DRH, UEP, <i>Direction d'Organisation des Services de Santé</i> (DOSS), and DSI met. HFG assisted in preparing ERHIS 2 (finalized TORs, data collection tools, and data collection plan for the private sector). HFG facilitated meetings between the TWG, the nurses and midwives associations, and the Haitian Association of Doctors to introduce them to the ERHIS 2 exercise. HFG supported a test of data collection tools in St. Damien Hospital and Ste. Croix Hospital of Leogane. HFG trained human resources correspondents at provincial level on data collection tools as focal points for data gathering in their geographical departments. HFG started data collection for ERHIS 2 in two geographical departments, North West and Artibonite.	Data collection will be completed in other geographical departments. ERHIS 1 conducted in the public sector will be published in October after updating data.
Assist DRH in developing and implementing an organizational structure	Future milestone. HFG plans to start in the next quarter.	This activity depends on the findings of the organizational diagnosis that was carried out. The approach will be designed to assist DRH in developing and implementing a new organizational structure.

Year 3 Q4 Planned Tasks	Year 3 Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
Support DRH to assist with the implementation of the draft Process for the Development of a Training Plan (provided to MSPP by OMRH)	Future milestone pending validation of draft training plan. Draft training plan was presented during a roundtable organized by OMRH in September.	Validation workshop of the training plan was postponed until early October because of the unavailability of DFPSS team who focused on organizing final exams and the need to coincide the launch of the development plan with the performance evaluation exercise (scheduled for the end of the fiscal year) to demonstrate the nexus between the two activities.
Support DRH with technical expertise with embedded advisor(s)	Ongoing.	
Support Minister-appointed consultant for DRH in-depth institutional assessment of roles and function	Completed.	HFG will support restructuring activity based on the findings of the institutional assessment of DRH roles and function.
Strengthen DRH capacity to conduct quality control and participatory review of HR data to produce quarterly HR public health sector report	Third quarter review of HR activities workshop was held in August.	
Identify performance indicators in coordination with OMRH; production of evaluation grid for performance monitoring by cadre	Completed.	
Test performance monitoring tools in at least two central units	HFG assisted DRH in testing the performance monitoring tools in two central units, DRH and DPSPE. HFG organized two separate workshops to develop the tools for the pilot phase. HFG developed two manuals for DRH employees with 24 job descriptions and objectives and another for DPSPE employees with 49 jobs descriptions and objectives.	The manuals will be used to facilitate the performance evaluation process that will be carried out at the end of MSPP current fiscal year.
Support MSPP on developing feasible strategy options to improve retention of medical professionals	HFG drafted a four-phase retention plan: phase 1- determine strategies; phases 2- prioritize interventions linked to strategies; phase 3- cost rural retention strategies and interventions; phase 4- create resource mobilization and retention plans. Strategies will be developed in Year 4.	This activity was postponed because the MSPP has not yet clearly defined the option to improve retention of medical professionals. There is an ongoing debate on retention plan strategy. While some favor wage and salary improvements to retain medical professionals in rural areas and remote regions, others propose a plan to attract more medical professionals in rural areas. The MSPP

Year 3 Q4 Planned Tasks	Year 3 Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
		seems to favor and prioritize the first option which involves OMRH and the MEF. However, this option will require an increase in the budget of the MSPP to pay higher wages and salaries to medical professionals.
<b>Activity 7: Accreditation of HRH training institutions and professional bodies</b>		
Support DFPSS with technical expertise with embedded advisor(s)	Ongoing.	
Communicate reconnaissance results to potential students via print/radio media	HFG developed and launched a radio spot to communicate 2015 reconnaissance results to students.	
Develop online reconnaissance management tools	HFG developed a Website, prepared a workshop to train DFPSS and nursing educational institutions on online management of the reconnaissance system.	
Continue support to DFPSS to conduct nursing school reconnaissance visits	9 additional nursing school reconnaissance visits were conducted.	
Support DFPSS in development of a strategic and operational plan	Planned in Y4.	
<b>Activity 8: Costing and business plan development for Hôpital Universitaire De Mirebalais (HUM)</b>		
Costing update	Completed.	
Outline for business plan for discussion (HUM/ZLS/MSPP/USAID)	Business plan draft sent in Q3 but feedback from HUM ZL and MSPP has not been received.	
<b>Activity 8: Improving administration of the National Nursing Exam</b>		
Review current exam process	Cancelled activity.	
Hold workshop on national exam best practice	Cancelled activity.	
Hold workshop on strengthening content of national exam	Cancelled activity.	
<b>Activity 9: Costing and business plan development for St. Damien (and Sacre Coeur de Milot TBD)</b>		
Do data collection/ analysis/ costing of the services for St. Damien	HFG submitted the essential services' costing report, shared data collection tools, and started costing specific pathologies. This exercise will feed into business planning and will identify areas for revenue generation and fundraising.	Costing of pathologies will be completed in Y4Q1.

Year 3 Q4 Planned Tasks	Year 3 Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
Develop and validate outline for business plan for St Damien hospital	HFG will develop business plan outline in Y4.	Costing of pathologies is a prerequisite to this activity.
Develop business plan for St. Damien	HFG will develop the business plan in Y4.	Costing of pathologies is a prerequisite to this activity.
Data collection/analysis / costing of the services for Sacre Coeur, Milot	HFG met with the hospital's CEO, discussed need and objectives of costing, and shared costing methodology.	Next steps in Y4 include meetings with Executive team, data collection and costing of services.
Develop and validate outline for business plan for Sacre Coeur-Milot	HFG sent business plan concept note to hospital's CEO.	This activity will come after costing exercise.
Develop business plan for Sacre Coeur, Milot	Future milestone.	This activity will come after costing exercise.
<b>Activity 10: Organizational assessment of the Department de Santé, Ouest (DSO) and DOSS</b>		
Do organizational assessments/validation	Completed.	
Support Minister-appointed consultant for DSO in-depth institutional assessment of roles and function	Ongoing.	Next step includes the implementation of (DSO) restructuring activity.
Support Minister-appointed consultant for DOSS in-depth institutional assessment of roles and function	Ongoing.	Next step includes the implementation of Direction d'Organisation des Services de Santé (DOSS) restructuring activity.
<b>Activity: Fiduciary risk assessment for a G2G pilot project</b>		
Develop assessment tool	Completed. HFG tailored the assessment tool and the assessment plan for MEF, MSPP, and Ministry of Planning.	
Conduct the assessment	Completed. HFG held several meetings with each institution and conducted the assessment.	
Draft a report outlining the results from the assessment	HFG presented the primary findings and submitted assessment report to USAID that includes risk mitigation measures.	Awaiting USAID approval of the report to plan support in implementing risk mitigation measures.

## 5.4.5 Peru

**Program Objectives** - USAID/Peru's support to the health sector in the country spans more than half a century. From 1990 to date, the mortality rate for children under five has fallen from 78 to 21 per 1,000 children (64 percent decline); maternal mortality has fallen from 318 to 103 per 100,000 live births (71 percent decline); and the total fertility rate has been reduced close to the desired number of children, from 4.1 to 2.6 births per woman.

Given the limits of time and resources available for health assistance in Peru – 2015 will be the last year for USAID/Peru technical assistance in the health sector – the mission is focusing on strengthening decentralization of the health sector in the region of San Martin through a transferable Health Systems Strengthening approach, based on the WHO framework of six health system building blocks: Finance, Governance, Human Resources, Service Delivery, Information Systems, and Pharma/Medical supplies logistics. This approach involves the transfer of proven USAID-developed tools, guidelines, and procedures and their institutionalization at the national, regional, and local governmental levels.

Over the last five years, USAID/Peru has been providing technical assistance mainly through three projects: 1) USAID/Health Policy Reform (HP), 2) USAID/Healthy Communities and Municipalities II (HCM-II), and 3) USAID/Quality Healthcare (QHC). All of them have developed health tools, methodologies, and strategies that USAID wants to disseminate.

To preserve the knowledge and progress acquired under these and earlier projects, HFG will work to systematize and transfer the USAID-designed tools and other products, in coordination with the Government of Peru (GOP) as well as national and subnational institutions and stakeholders.

**Year 3 Activities** - Following work planning discussions, USAID/Peru outlined four components for HFG support in Year 3:

1. **National and subnational institutions and stakeholders have access to a user-friendly toolkit to improve health service delivery systems under decentralization.** To achieve this result, HFG will design and develop a toolkit matching available tools with the needs of national and subnational institutions and stakeholders. This toolkit will be made available to GOP national and subnational governments and other stakeholders. It will also be disseminated through at least four existing national public service and administration fora and one international health development forum.
2. **Regional health directorate in San Martin (SMT-RHD) continues improving governance and financial reform.** To achieve this result, the project will advance the implementation of new organizational frameworks within SMT-RHD. Moreover, HFG will consolidate improved strategic budgeting procedures, financing modalities, and payment mechanisms for SMT-RHD and operational units. Finally, HFG will follow up the achieved results under the HP program in SMT and the MOH.
3. **SMT-RHD has 11 micro-networks using Sistema de Información en Salud (SIS) GalenPlus and GOP gives technical assistance to health facilities that have installed SIS GalenPlus through the SIGES Project.** HFG will support the implementation of SIS GalenPlus for decision making in SMT-RHD and at least 11 micro-networks. HFG will also advance technical capabilities transfer to the MOH in order to consolidate its leadership in rolling out GalenPlus use in public health facilities and to perform the regular maintenance of the software.
4. **Public health community has access to concise and clear technical reports and briefs sharing USAID results and lessons learned.** HFG will disseminate USAID experience and

lessons learned to both the local and international public health community through technical briefs and papers. USAID and HFG will jointly develop a list of available “experiences and lessons learned,” based on reports provided by USAID implementing partners (HP, HCM-II, and QHC).

### **Year 3 Progress Against Objectives -**

**National and subnational institutions and stakeholders have access to a user-friendly toolkit to improve health service delivery systems under decentralization.** HFG presented the toolkit and its web page jointly with San Marcos University (UNMSM) in September. The web page provides access to 17 health management tools in health governance, provision, promotion, finance, workforce, information systems, and logistics. The UNMSM is actively involved in the maintenance of the toolkit [web page](#), and HFG is deploying a technical transfer plan to update the tools when the project is over.

HFG held technical meetings with the MOH to explore define synergies for dissemination purposes through their institutional website. The Human Resources Directorate at the MOH indicated their interest to institutionalize and disseminate several tools that might be used by training programs for young professionals starting their civil service within the health sector. Introduction of the toolkit logo within their web pages is expected to be executed in October.

The National Public Service Authority (SERVIR) has indicated that the scope of the workforce-related tools goes beyond the health sector, and that they will be institutionalized within SERVIR. Currently SERVIR is already disseminating the toolkit through its [web page](#).

Lima Regional Government has received the toolkit, so selected tools can be applied across the institution. This involves tools in health information system, health workforce and pharmaceutical logistics. Currently this regional government is already disseminating the toolkit through its [web page](#).

Current statistics on the toolkit web page reveal that there are approximately 5,000 visits on a monthly basis.

**Regional health sector in San Martin continues improving governance and financial reform.** HFG finished its technical assistance to SMT-RHD, successfully aiding in the redesign of its health networks and micro-networks. The organizational rearrangement was accomplished in July. For the financial component, operational and financial planning was advanced by staff in Moyobamba, Rioja, and Lamas health networks, with decreasing technical support from HFG. These activities were executed as part of the HFG phase-out and sustainability plan in San Martin.

**SMT-RHD has 11 micro-networks using SIS GalenPlus and the GOP has scaled-up SIS GalenPlus information system to 230 health facilities nationwide.** HFG has provided technical assistance to SMT-RHD and implemented SIS GalenPlus in 11 health micro-networks in SMT-RHD. The monitoring of the implementation of SIS GalenPlus was expanded to 12 health facilities that accelerated their implementation following IT infrastructure strengthening efforts by USAID. HFG provided technical assistance to SMT-RHD Health Information to design the IT sustainability plan, and also helped in the implementation of its design of directives and the implementation of a regional technical assistance forum.

HFG worked together with the MOH to provide permanent maintenance to SIS-GalenPlus. During this quarter, this involved the integration of SIS-GalenPlus with new information requirements by the Public Health Insurance Authority.

According to MOH SIS-GalenPlus is implemented in more than 232 health facilities, involving 35 hospitals and 197 health facilities at the first level of care.

**The public health community has access to concise and clear technical reports and briefs sharing USAID results and lessons learned.** The HFG team advanced the preparation of eight technical briefs, which will be finalized by October. The content of the briefs will focus on the following topics: health governance (2); health finance (4); health workforce (1); pharmaceutical logistics (1). HFG began preparation of several academic articles to be submitted to peer-reviewed journals on the following topics: health governance (1), health finance (1) and pharmaceutical logistics (1).

The HFG project has also had several successful abstract submissions that will share the successes of health systems strengthening at international conferences. The accepted submissions include:

**International Health Economics Association (IHEA) Milan:** 2 presentations, on Demand for Health Services and Insurance in Peru; and Out of Pocket Payments in Medicines in Peru

**5<sup>th</sup> ISPOR Latin American Conference (Chile):** 9 poster presentations including: institutional costs for conditions included in the Peruvian Health Benefit Plan (PEAS): diabetes mellitus, tuberculosis, mental diseases, hypertension, metaxenic diseases, and cancers of breast, prostate, stomach, and cervix

**Global Maternal Newborn Health Conference in Mexico:** Health Management Toolkit Helps Reduce Chronic Child Malnutrition in Peru

Table 48 provides additional activity-specific updates.

**TABLE 48. PERU ACTIVITY DETAIL**

Year 3 Q4 Planned Tasks	Year 3 Q4 Progress	Critical Assumptions/ Problems Encountered/ Follow-up Steps
<b>Activity 1: National and subnational institutions and stakeholders have access to a user-friendly toolkit to improve health service delivery systems under decentralization</b>		
Toolkit(s) designed and developed matching available tools with needs of the national and subnational institutions and stakeholders	17 tools were selected jointly with USAID and USAID partners, to be included in the USAID toolkit: 11 tools were validated for use at the national level, and re-designed to make them easy to apply; 17 user manuals and 17 methodological guidelines were designed. These tools were presented to and approved by the MOH for further dissemination and institutional use. A clear vision of the toolkit was defined including what to expect from it and user requirements to allow its proper functioning. All revised versions of the tools of the application for the toolkit were developed and hosted within a public university website. The toolkit was formally presented by UNMSM and now is publicly available from: <a href="http://gestionensalud.medicina.unmsm.edu.pe/">http://gestionensalud.medicina.unmsm.edu.pe/</a>	

Year 3 Q4 Planned Tasks	Year 3 Q4 Progress	Critical Assumptions/ Problems Encountered/ Follow-up Steps
Toolkit disseminated through at least four existing national public service and administration fora and one international health development forum	Dissemination of the toolkit at: XXI CIGS-MOH meeting VI International Congress of the Peruvian Nurses Association XVII Research Forum in Health by UNMSM Cooperation Group Against Poverty (MCLCP) International Society for Pharmacoeconomics and Outcomes Research -ISPOR 5th Latin America Conference	
Toolkit made available to GOP national and subnational governments and other stakeholders	Toolkit available through the following institutional web pages: San Marcos University San Martin University SERVIR Lima RG San Martin RG Ucayali RG San Martin RHD Ayacucho Regional Hospital Tumbes Regional Hospital Huaral Province Hospital	
<b>Activity 2: SMT-RHD continues improving governance and financial reform</b>		
Legal and organizational frameworks established for the regional social development office, the RHD, operational units, and health networks	Three micro-networks have completed the assignment of functions to their staff (e.g., for the regular generation and/or update of a database on children anthropometrics for the monitoring and control of child chronic malnutrition) Approval of institutional manual for the functions allocation within SMT-RHD (RD No. 446-2015-GRSM/DIRES-SM/DG) Approval of institutional functional manual for health networks and micro-networks (RD No. 447-2015-GRSM/DIRES-SM/DG)	
Strategic budgeting procedures, financing modalities, and payment mechanisms established for the RHD, operational units, and health networks	Project trained 14 new regional officials as facilitators on the implementation of health operation plans at Moyobamba health network, to ameliorate the impact of personnel turnover and improve sustainability. Project trained six newly appointed managers at Moyobamba health network to update operational plans, keeping its health and financial consistency, according to newly available official information (MOH operational definitions and 2015 MOF guidelines for multi-year budget programming). Three sentinel micro-networks in San Martin completed their health operational plans	

Year 3 Q4 Planned Tasks	Year 3 Q4 Progress	Critical Assumptions/ Problems Encountered/ Follow-up Steps
	(through three face-to-face workshops and one distance monitoring workshop led by newly trained regional officials).	
<b>Activity 3: San Martin DIRES has 11 micro-networks using SIS GalenPlus, and GOP has scaled-up SIS GalenPlus information system to 230 health facilities nationwide</b>		
SMT-RHD and at least 11 micro-networks are fully implementing and using SIS GalenPlus for decision making	Project made follow-up visits to 11 health micro-networks (Segunda Jerusalén, Soritor, Jerillo, Jepelacio, and Lluylucucha) to verify the level of implementation of GalenPlus and for capacity building of GalenPlus operators. Project provided technical support to 11 health micro-network (Soritor) on GalenPlus maintenance and update to allow full compliance with GalenPlus with MOH-HIS standards in primary care facilities. Project provided technical assistance to SMT RHD to design a GalenPlus sustainability plan jointly with the Health Information Office staff. SMT-RHD Planning Office supported this plan. Project provided two free softwares to the office staff to support: (i) regional help-desk management to respond to health facility requirements regarding technical assistance in SIS GalenPlus implementation; and (ii) the operation of a virtual forum to share information about SIS GalenPlus. They were also helped to configure and use all its functionalities.	
MOH trained and ready to roll out software for use in public health facilities and to provide ongoing technical support in SIS GalenPlus nationwide	Project continued technical and legal coordination to complete the formal transfer of SIS GalenPlus to the MOH, and to register its formal recognition at the National Institute for the Defense of Competition and Protection of Intellectual Property. As a result, the MOH will authorize, through a ministerial decree, the General Administration Office to sign this transfer.  Alternatives were evaluated to expand GalenPlus dissemination directly to MOH entities and other public institutions that demand it. The alternative analyzed involves the free licensing of the software, in addition to the legal transfer to the MOH. This is a comprehensive and versatile alternative, and is aligned to accelerating the use of the application by various public institutions (SUSALUD, IGSS, SIS, and other IPRES). Project provided technical assistance to three public hospitals for the maintenance of GalenPlus (JAMO in Tumbes, Belen in Trujillo, and Regional in Ayacucho).  The project jointly with the staff of the MOH-Statistics and Information Office responded to SIGES-SIS GalenPlus users' requests for technical assistance in the maintenance of the application. Two MOH offices (Statistics and Information, and	MOH keeps an active interest in disseminating SIS GalenPlus as integrated health information system

Year 3 Q4 Planned Tasks	Year 3 Q4 Progress	Critical Assumptions/ Problems Encountered/ Follow-up Steps
	<p>Health of the People) received HFG technical assistance for the use of Current Procedural Terminology 2014 (CPT 2014); it replaces CPT 2004 (currently in use) which is part of the Standard Identifiers of Health Data (DS 024-2005-SA).</p> <p>Implementation of SIS GalenPlus in Huaral Hospital from Lima Region. SIS GalenPlus is currently implemented in 232 health facilities nationwide.</p>	
<b>Activity 4: Public health community has access to concise and clear technical reports and briefs sharing USAID results and lessons learned</b>		
<p>USAID experience and lessons learned disseminated to local and international public health community through technical briefs and papers, based on reports provided by USAID implementing partners (HP, HCM-II, and QHC)</p>	<p>The list of technical reports has been defined as well as the document structure. Project prepared a database of specialized publications, indexed journals, and social media for the dissemination of the technical briefs and scientific articles. Project defined the procedures for the appraisal of scientific articles prepared, involving the participation of HFG-HQ and the Peruvian academic community, before sending the request for publication.</p>	

## 6. INDICATORS

While work plans and quarterly reporting are now up to date in MandE (the HFG M&E system), the final component of the transition from the previous system, the entering/loading of deliverables and accomplishments, is still in progress and this could directly influence the indicator calculations. The deliverable updating will be complete by the end of Y4Q1, at which time MandE will be completely aligned with the project.

**TABLE 49. ATTRIBUTION INDICATOR TABLE**

Result	Performance Indicator	Year 1	Year 2	Year 3				
				Q1	Q2	Q3	Q4	Total
Linkages	Indicator							
All IR	Number of organizations contributing to HFG-supported work (cumulative)	98	116	127	132	132	133	133
All IR	Number of HFG-supported partnerships (cumulative)	7	21	25	30	30	30	30
All IR	Number of participants at HFG-supported events	1,826	25,745	987	741	9	N/A	1,737
All IR	Number of HFG-supported technical resources	186	922	178	128	22	37	365
IR1.3, 3.3	Number of HFG-supported PBI schemes	0	0	0	0	0	0	0
IR 2.2	Number of HFG-supported mechanisms established to improve transparency and/or accountability	0	0	0	0	0	0	0
All IR	Number of organizations where HFG-supported technical resources are used (cumulative)*	7	19	26	29	30	31	31
All IR	Management capacity to perform core functions in country institutions (score)	N/A	N/A	N/A	N/A	N/A	N/A	N/A
All IR	Technical capacity to perform core functions in country institutions (score)	N/A	N/A	N/A	N/A	N/A	N/A	N/A
IR1.3	Country capacity to perform NHA estimations (score)	-	-	-	-	-		-
IR2.2, 2.3, 4.3	Use of evidence-based information to perform core functions in country institutions (score)	-	-	-	-	-		-

N/A: Not appropriate at aggregate level "-": Not measured;

\* Requires additional measurement/follow-up



## 7. FINANCIAL UPDATE

The financial overview for Year 3 is presented in Table 50.

**TABLE 50. FINANCIAL OVERVIEW**

Client	USAID
Project Director	TBA
Total Potential Worth	\$199,702,730
Obligated to Date	\$108,750,140.42
Expensed to Date	\$68,956,562 (thru September 2015)
Funded Backlog Remaining	\$39,793,578.42
Project End Date	09/29/2017

### Cost Share

Through the end of September 2015, the HFG project has obtained \$3,743,270.12 in actual cost share contributions. Sources of these contributions include the Namibia Social Security Commission, the Ministries of Health in Benin, Botswana, Tanzania, and Vietnam, the Health Systems Board, the U.K. Department for International Development, Abt Associates, the World Bank Haiti Living Standards Measure Survey, Results 4 Development Ghana, the Ghana National Health Insurance Scheme, USAID's Africa Bureau, the Addis Ababa, Ethiopia, City Administration Regional Health Bureau (RHB) as well as RHBs of Amhara, Benishangul-Gumuz, Oromia, Tigray, and SNNP, the Ethiopian Health Insurance Agency, the SADC conference in Pretoria, and the World Bank - Asia Regional Flagship Course..



## 8. KNOWLEDGE MANAGEMENT/ COMMUNICATIONS UPDATE

**New - Technical Updates:** HFG's Brown Bag lunches (BBLs) will be re-branded as "HFG Technical Updates." After consulting with project staff and Yara Francis, we decided that the name Technical Update better captures the rigor of these presentations. Technical staff spend considerable time preparing the content and slides, and practicing, and were disappointed by the small turnout at HFG's first round of BBLs. Going forward, the Technical Updates will be offered at USAID, and via webinar, likely at a later date given USAID's limited technology and firewalls. The webinars will allow us to reach a much broader audience, and to record the presentations and house them on the website as a KM resource. HFG has developed a list of possible topics, which we will share with Yara Francis to vet with USAID's Office of Health Systems this fall.

**Website:** Website traffic continued to grow this quarter as the figures, likely helped by the high interest in the new report Impact of Health Systems Strengthening on Health, which was released in late July.

Sessions: 16,146 (14,581 Q3)

Users: 12,649 (11,549 Q3)

Page views: 42,772 (41,102 Q3)

76% new visitors; 25% returning

This quarter, we added 12 new results and news stories to the website. Results and new stories Documents, including USAID's Office of Health Systems released a major new report, which for the first time presents a significant body of evidence linking health systems strengthening interventions to measurable impacts on health outcomes. The Impact of Health Systems Strengthening on Health identifies 13 types of health systems strengthening interventions with quantifiable effects.

**Expanding Social Media Reach:** We continue to grow the project's external visibility via social media. The number of HFG's Twitter followers increased from 750 to 908, with increasingly engagement by followers in HFG's conversations.

Health Systems Global's *Translating Evidence into Action Working Group* hosted a webinar exploring Chile's use of evidence in the design of their Universal Access with Explicit Guarantees (AUGE) health benefit plan (HBP) and reflecting on factors that can facilitate and hinder the process of evidence-based design. The focus of the webinar was the use of evidence to inform policy. During the webinar, the presenters considered trade-offs and criteria through which evidence is filtered into the design process, and reflected on the factors, stakeholders, and implementation processes that influence when and how evidence is used in the development of an HBP.

**E-Newsletters:** We sent out two HFG project e-newsletters this quarter, and reached 3,754 subscribers with news of the project's results and resources.

**Challenges** - USAID expects HFG to clearly communicate how the agency's investments in the project's programs, activities, and deliverables are expanding access to health services and improving health outcomes. Going forward, HFG will strive to better articulate the project's results and their link to health impact. To build the capacity of technical staff to do this, Megan Meline wrote a guide to

external communications. This five-page guide describes: HFG's audiences and key messages; deliverable designs; quality control; strategic dissemination; role of the KM and Communications team; dissemination vehicles; and country communications plans. The guide was introduced and explained to the entire project staff in July at an all-staff meeting, and also with the AOR team.

## 9. GENDER UPDATE

In Year 3, the HFG Gender team continued to work with country teams to develop gender strategies, supporting teams to articulate plans to mainstream gender considerations into their technical assistance, in line with USAID's Gender Equality and Female Empowerment Policy. To date, the team has worked with 20 country teams. The country teams for Bangladesh, Benin, Burundi, the Caribbean, Ghana, Ethiopia, India, Lesotho, Nigeria, Peru, Swaziland, and Ukraine have completed and submitted their gender strategies. Additional HFG country teams have begun working on their gender strategies: Botswana, Côte d'Ivoire, the DRC, Haiti, Namibia, and Vietnam. The Gender team has also met with Angola and Tanzania. These teams will develop their gender strategies once greater clarity has been achieved on the scope of the technical assistance programs. The Bangladesh team updated its gender strategy in Year 3 to align with the current work plan.

Throughout Year 3, the Gender Advisor continued to provide support across the project and to interface with counterparts on the issues of gender equality, female empowerment, and social inclusion. Within the project, the Gender Advisor supported the HFG India team to respond to a request from their Mission to articulate the links between HFG India's technical activities and USAID's priorities in gender and LGBT inclusion. The Gender Advisor and two project staff attended a capacity-building workshop on gender and social inclusion and provided an update to HFG staff. The Gender Advisor contributed to the project's feedback on the Office of Health Systems Strengthening draft Vision for Action for Health Systems Strengthening, to articulate linkages between the Vision for Action and USAID's Gender Equality and Female Empowerment policies. Finally, the Gender Advisor met with representatives from the Global Fund to Fight AIDS, TB and Malaria and UNAIDS to discuss gender integration in health-systems strengthening projects. The Global Fund and UNAIDS officers were interested to learn about HFG's approach and requested a copy of the project's Gender Framework as well as example country gender strategies. In Quarter 3, the Gender Advisor led a webinar for HFG Chiefs of Party on the project's approach to gender and social inclusion. The Gender Advisor also participated in the Gender 360 Summit, hosted by FHI360. The Summit provided opportunities to hear USAID's latest thinking on issues of gender equality and social inclusion and to engage with other implementing partners who are focused on this issue. The Gender Advisor participated in a breakout session on implementing gender with "key populations." Lessons learned from the Summit will be incorporated into HFG's gender work. The Gender Advisor and a member of the HFG India field office staff attended a webinar on gender and health financing in Quarter 4. Insights were shared with the project to promote a gender-integrated approach to health finance work.



## 10. M&E UPDATE

In Year 3, M&E activities continued with country Performance Monitoring Plan (PMP) development/management, MandE (M&E system) training and use, reporting, internal review, and data quality audits (DQAs).

Country PMP development and updating continued to progress, with the following changes:

- ▶ PMPs updated with FY2014 results and submitted to respective missions: Angola, Bangladesh, Benin, Burundi, Cote d'Ivoire, Ethiopia, Haiti, Lesotho, Namibia, Nigeria, Tanzania, Ukraine
- ▶ PMPs developed/updated and distributed to respective missions: Botswana, Democratic Republic of Congo, Ghana, Swaziland, Barbados and Eastern Caribbean, Peru, E&E Bureau, Vietnam
- ▶ PMPs to be developed: Guatemala, India, Indonesia, Mali, South Africa
- ▶ PMPs to be updated: Angola, Namibia, Nigeria

MandE development also continued with both enhancements and ongoing maintenance and support:

- ▶ Quarterly reporting - All past quarterly reports are integrated in the system. All teams use MandE for quarterly reporting. Over 200 team members have contributed to the quarterly report across 22 countries.
- ▶ Data/deliverable loading - All teams are using MandE for deliverables/supporting information. Nearly all three years of project deliverables are in MandE.
- ▶ Indicator development - Over 180 indicators were developed in MandE, aligning with the indicators in all country/project PMPs.

Also in Year 3, HFG conducted the Abt Associates-funded internal review of HFG. The first phase of the review included an online survey distributed to approximately 175 HFG clients, partners, and donors on implementation effectiveness, operating principles, and project management. Approximately 50 responses were received. The second phase included focus groups with HFG program/country managers to get internal perspective of how HFG is doing. The third phase included interviews with select HFG stakeholders to obtain a deeper perspective on HFG performance. The final report has been developed.

DQAs continued, on reported accomplishments/deliverables/supporting files, on the following programs: Africa Bureau, Angola, Lesotho, Swaziland, Tanzania, E&E Bureau, Haiti, Gender, Knowledge Management.

Finally, in Q4, HFG M&E Director (Steve Peck) stepped down, and Kenya Datari took over M&E leadership for the project. Since Ms. Datari has been supporting HFG M&E for the past year, the transition to her management will be seamless. Also, with the full roll-out/adoption of MandE across the project, and increasing M&E responsibilities assumed by the activity/program/country teams, it is both appropriate and cost-effective that the project has moved from a two-person M&E team to one person.



## II. MANAGEMENT UPDATE

At the mid-point of the five-year project, HFG is in high gear, and the management systems have needed to keep up with the pace of program growth. Demand for the project is at an all-time high and with two years left to go, there is sufficient time left to make a difference and show results. To guarantee that HFG is on track to show results by the end of the project, a number of actions have been taken this year. These involve:

1. Deliberate planning to obtain and **demonstrate results** to date as well as projected results
2. Launching efforts to meet the needs of our **special initiatives** such as HIV/AIDS Care and Treatment, and EPCMD, as well as cross-bureau initiatives such as SFI in direct support of OHS
3. Making sure we have our **country field offices** operating smoothly
4. Undertaking a **mid-term internal assessment**

The following demonstrates work this year in these four areas.

**Demonstrating Results:** HFG now implements more than 150 activities in over 25 countries, and all activities are mapped to the HFG results framework in HFG's M&E database "MandE," which this year was fully launched. To increase the focus on results, this year we launched an initiative to ensure that there is at least one clear result per country and program, and each can articulate the connection between the HFG interventions, the result(s), and the "line of sight" with health outcomes. We have completed over 24 result reports and have an additional 10 in the pipeline. This result harvesting also begins to shift the activity lead mind-set from activity implementation to showing the "so what" value of USAID's investment. A key success this year has been the launch of the HSS Impact Brief, which is a groundbreaking analysis on the health impacts and HSS inputs.

**Addressing Special Initiatives:** Within the HFG goal of increased use of priority health care, we look to demonstrate how our work specifically addresses EPCMD, HIV/AIDS Care and Treatment, and PMI goals. As an example, this year we undertook an intensive effort with our health economists and governance experts to clearly articulate how each PEPFAR-funded activity contributes to at least one of the cascade elements of HIV Care and Treatment. As a result, HFG is extremely pleased that our efforts seem to have at least partially contributed to the absence of a significant reduction in HFG HIV funding.

**Strengthening Country Field Offices:** Success for any global project and especially for one of this magnitude is determined by the staff. As our country activities have focused on shifting their own implementation weight from headquarters to the field, this means additional staff are needed at the field level. We have seen a growth in the number of country-based staff in India, Vietnam, DRC, Burundi, Haiti, Swaziland, Nigeria, and Ghana. This also means dealing with normal staffing shifts, and over the this project year we have hired new HFG country Chiefs of Party in Nigeria, DRC, Swaziland, Haiti, Vietnam, Burundi, and Ivory Coast. This staffing shift involves transferring significant decisionmaking and authority to the country level, which HFG leadership is committed to, and is leading and reinforcing.





