



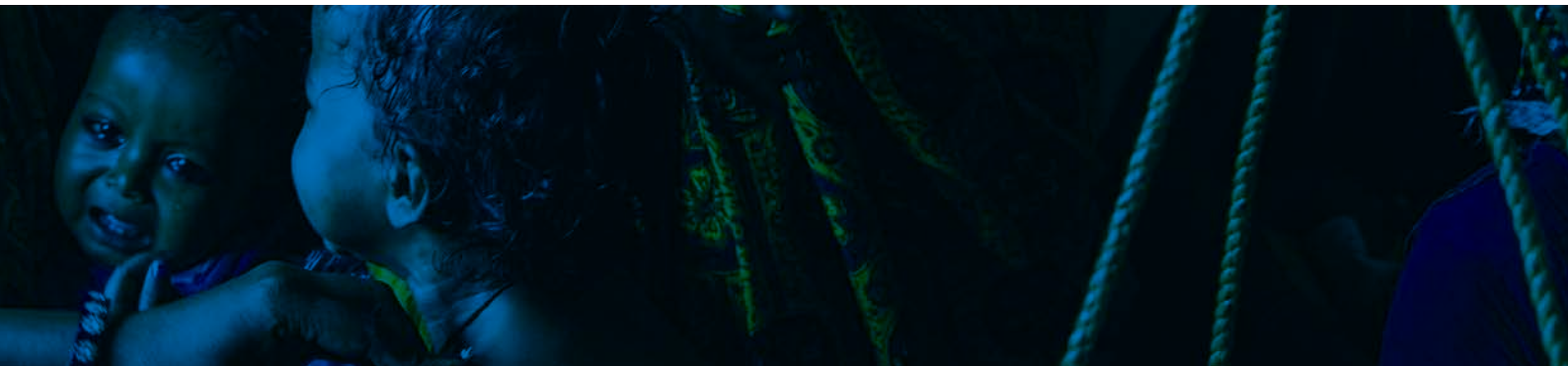
**ACTION
AGAINST
HUNGER**



**HEALTH SYSTEM
STRENGTHENING**

**FROM DIAGNOSIS TO PLANNING
GUIDE**

JANUARY 2017



HEALTH SYSTEM STRENGTHENING

FROM DIAGNOSIS TO PLANNING

Nutrition and Health Sector
Action Against Hunger - International

January 2017

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LIST OF ACRONYMS

ACF	ACTION CONTRE LA FAIM
CCM	COMMUNITY CASE MANAGEMENT
CHW	COMMUNITY HEALTH WORKER
CMAM	COMMUNITY-BASED MANAGEMENT OF ACUTE MALNUTRITION
CMN	COVERAGE MONITORING NETWORK
CSO	CIVIL SOCIETY ORGANIZATION
DHMT	DISTRICT HEALTH MANAGEMENT TEAM
DHO	DISTRICT HEALTH OFFICE
FGD	FOCUS GROUP DISCUSSION
HF	HEALTH FACILITY
HS	HEALTH SYSTEM
HSAA	HEALTH SYSTEM ASSESSMENT APPROACH
HSS	HEALTH SYSTEM STRENGTHENING
IMCI	INTEGRATED MANAGEMENT OF CHILDHOOD ILLNESSES
INGO	INTERNATIONAL NON-GOVERNMENTAL ORGANIZATION
IYCF	INFANT AND YOUNG CHILD FEEDING
LFA	LOGICAL FRAMEWORK
LNGO	LOCAL NON-GOVERNMENTAL ORGANIZATION
MOH	MINISTRY OF HEALTH
MUAC	MID UPPER ARM CIRCUMFERENCE
M&E	MONITORING & EVALUATION
PM	PROJECT MANAGER
RMNCH	REPRODUCTIVE MATERNAL NEONATAL CHILD HEALTH
R&R	ROLES & RESPONSIBILITIES
SAM	SEVERE ACUTE MALNUTRITION
SC	STEERING COMMITTEE
SMART	SPECIFIC MEASURABLE ACCEPTABLE RELEVANT TIME-BOUND
SWOT	STRENGTHS WEAKNESSES OPPORTUNITIES THREATS
TOR	TERMS OF REFERENCE
UN	UNITED NATIONS
WHO	WORLD HEALTH ORGANIZATION

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1

DESCRIPTION OF THE HSS DIAGNOSIS AND PLANNING APPROACH

BACKGROUND

HOW TO USE THIS GUIDE

OBJECTIVE OF THE APPROACH

UNDERLYING PRINCIPLES OF THE APPROACH

GENERAL CHARACTERISTICS OF THE APPROACH

SUMMARY OF THE APPROACH



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DESCRIPTION OF THE HSS DIAGNOSIS AND PLANNING APPROACH

**SYSTEM
BUILDING BLOCKS**

SERVICE DELIVERY

HEALTH WORKFORCE

INFORMATION

**MEDICAL PRODUCTS,
VACCINES &
TECHNOLOGIES**

FINANCING

**LEADERSHIP /
GOVERNANCE**

**ACCESS
COVERAGE**

**QUALITY
SAFETY**

**OVERALL GOALS /
OUTCOMES**

**IMPROVED HEALTH
(LEVEL AND EQUITY)**

RESPONSIVENESS

**SOCIAL AND FINANCIAL
RISK PROTECTION**

IMPROVED EFFICIENCY

**THE WHO HEALTH
SYSTEM FRAMEWORK**

(Adapted from Lancet 2009)

BACKGROUND

In 2010, Action against Hunger (ACF), an international nongovernmental organization, identified the need to develop an easy to use guide to help identify health systems gaps and bottlenecks at District level in order to allow the development of health system strengthening strategies. External specialist conducted two studies in order to develop ACF understanding on HSS and propose recommendations in terms of approach. From 2011 onwards ACF started to review other partner's experience in HSS and existing literature, tools and methods. A first version of the actual guide was developed in 2013 and second version early 2015. The two versions of the guide were piloted from 2013 to 2016 with government (Ministry of Health) counterparts in 12 countries.

Action Against hunger was previously viewed as a nutrition organization but has drastically reconsidered its approach in the last 10 years and shifted from a vertical approach focused on nutrition interventions (particularly the management of severe acute malnutrition) to a horizontal and health system strengthening approach. This section explains what the rationale of this shift is.

THE NEED TO GET OUT OF THE VERTICAL, "DISEASE BASED" APPROACH

Within the UNICEF conceptual framework for undernutrition, health is positioned as a key determinant of under nutrition. Adolescent girls' and women's health are strongly related to their future children's health and nutritional status. Therefore, health and nutrition interventions that are part of the basic package of health services such as family planning, micronutrient supplementation, and ante/post- natal care are critical actions to be implemented in order to break the intergenerational vicious cycle of undernutrition. In addition universal coverage of any disease can only be achieved by ensuring availability and access to treatment at all levels of the health system (including the community level), as well as utilization of the services. Severe acute malnutrition (SAM) management follows the same logic and needs to be integrated and mainstreamed as part of the basic package of health services. In its revised nutrition and health strategy ACF has maintained a specific focus on nutrition while ensuring that basic health interventions are made available and delivered at health centers (diagonal approach).

THE NEED TO BETTER UNDERSTAND THE BARRIERS TO ACCESS SAM MANAGEMENT

For the last few years the international community has been increasingly assessing the coverage of community based SAM treatment services. Recently, the Coverage Monitoring network (CMN) studied the factors influencing access and published a report on the subject [1]. Five of the most frequently reported barriers to access across interventions were: Lack of knowledge on the disease; Lack of knowledge of the program; High opportunity costs; Distance to site; Previous rejection. The "SAM community" realized that a large proportion of the identified barriers were common to all services and only a few were really specific to SAM.

ACF therefore started to look at the lessons learned from existing large global health program experiences, developed in the early 2000s and realized that while promoting the integration of SAM management into the basic package of health services, we faced similar challenges and questions as the GHIs. Indeed, GAVI (for immunization), PEPFAR (for HIV/AIDS) and Global Fund (for HIV, malaria & TB), applied at their early stages a "disease based/ vertical approach". This approach revealed its limitations as the countries where these global health initiatives were implemented had fragile health systems, continuously struggling to operate effectively and to deliver accessible standard quality care. In the mid-2000s there was recognition that a health systems' status was intrinsically related to the success and outcomes of the global health initiatives (GHI). Weak health systems presented bottlenecks towards the same initiatives meeting their objectives and conversely GHI using a vertical approach potentially overburdened the system, thus having an adverse effect on it.

THE NEED OF A GLOBAL SHIFT TOWARDS DIAGONAL APPROACH AND HEALTH SYSTEM STRENGTHENING

The international community has started to recognize the counter-productive effects of vertical approach and has begun to shift to horizontal or diagonal schemes (Annex 5 provides key explanations about these approaches). In order to achieve horizontal/diagonal programs health systems needs to be reinforced. Guidance tools on Health System Strengthening (HSS) are fairly new with the WHO framework on HSS and its 6 building blocks having been developed in 2005. Moreover, it was only during the 62nd World Health Assembly (2009) that a resolution addressing Health system strengthening and Primary health care was passed. With the transition to increasingly mainstream SAM treatment into health services since 2008, it became important to look at health systems' strengthening frameworks as a new outlook on the context and adapt accordingly.

HOW TO USE THIS GUIDE

WHAT IS IN THIS GUIDE?

The Health System Strengthening from diagnosis to planning Guide provides an overview of the approach and describes eleven steps covering the preparation and planning processes. The diagnosis aims at creating a common vision, and identifying the weaknesses and strengths of the health system and the planning phase build up synergy between actors, by defining solutions and activities to be implemented to strengthen the health system, and enhance its resilience. Guidance and tools are provided for each step. Global explanations regarding the approach are described, as well as practical guidance or tips, to facilitate the implementation of the approach.

WHO IS THIS GUIDE FOR?

Since this guide is holistic, it gives an overview of the whole HSS approach, therefore it is to be read and used by all the actors involved in the process. Each of them can pick the information relevant for his role and task, and at the same time have a global overview and understanding of the whole approach.

The guide also serves to orientate national level Ministry of Health staff, key health staff, focal points representing the community and all relevant partners in the targeted area who should also be involved in any diagnosis or planning steps. Links should be made to any national, regional, District development plans which need to be aware of, and possibly involved in any action that require their input.

ADAPTING THE GUIDE TO DIFFERENT CONTEXTS

Content within the guide is kept as generic as possible with the intention that when applied the materials are adapted to the context. Templates or tools are based on current experience but it is recommended that they are adapted to be country specific. Tools, procedures, etc. which are already available in the District where the HSS is taking place, should be used and accounted for when implementing the proposed HSS approach. The guide is structured as a toolbox from which the needed steps can be picked and used according to the needs and situation of the addressed health system.

OBJECTIVE OF THE APPROACH

This manual describes a step by step approach to carry out health systems assessment, and planning at the District level. The approach is based on very simple and straight forward methods. A review of existing tools and practices is performed prior to developing the method.

The objective of the assessment is to get a snapshot of the health system structure and understand its strengths and weaknesses (diagnosis), in order to determine the priority actions required for the development of a health system strengthening strategy (planning phase). Ultimately, this approach aims not only at strengthening health system, but also at contributing to build its resilience by allowing the system to prepare, absorb, adapt and transform from stresses/shocks.

1 THE DIAGNOSIS PHASE OF THE APPROACH AIMS TO:

- Identify the **strengths and weaknesses** of the health system
- **Create a common vision** amongst partners at District level
- **Build a consensus** among stakeholders on priority actions to be taken to strengthen the health system

2 THE PLANNING PHASE OF THE APPROACH AIMS TO:

- Introduce the health system strengthening thinking **within the District health planning agenda**
- Allow **synergy between actors** through the development of a multi-annual District action plan with clear roles and responsibilities of all relevant actors
- Develop a **resilience building approach**

It also aims to:

- Establish **indicators and mechanisms** to monitor the implementation of the District Action Plan for health
- **Develop an “adaptive planning” and “real time learning” that will allow** flexibility of the system and contribute to the resilience of the system

UNDERLYING PRINCIPLES OF THE APPROACH

*This section of the manual should be read before **and** after having read the full document as it could be a little difficult to really understand what the key elements are about before knowing the method.*

NOTE

AN ADAPTABLE APPROACH

This guide promotes a process, not a model. What does it mean concretely?

The approach is flexible and shall be adapted to the context and situation of the health system. In most of the countries assessment or planning methods/ tools are either already in place or being tested. It is very important not to reinvent the wheel and replace all what has been performed but to make use of the existing forums, tools and data and find a way to integrate them with the step by step approach proposed in this chapter.

This step by step approach aims at helping field practitioners and ministries of health to identify key steps required to perform a quality diagnosis and planning, and articulate these steps with what is already existing (such as a diagnosis tool or questionnaire, or a planning platform at District level).

The tools proposed in the guidance (questionnaires, matrix...) should systematically be adapted to the context.

FOCUSED ON PRACTICAL ACTION

The step by step approach promotes **a comprehensive process focusing on practical action**. What does it mean concretely?

Too often assessments are performed without any planning of response analysis and translation of the finding into concrete actions. No work should be started with the idea of performing only the diagnosis part of the approach. The planning part is a compulsory element.

PROMOTING 'SYSTEM-THINKING'

In addition, the complexity of the health system shouldn't be neglected. A system thinking approach takes into consideration that changes in one building block of the health system are likely to affect other building blocks since there are constant interactions between them.

"Every intervention, from the simplest to the most complex, has an effect on the overall system, and the overall system has an effect on every intervention. (...) If we accept that no intervention is simple and that every act of intervening has effects – intended and unintended – across the system, then it is imperative that we begin to understand the full range of those effects in order to mitigate any negative behaviour and to amplify any possible synergies. We must know the system in order to strengthen it." [2]

In the planning phase anticipation on how the proposed interventions will interrelate and react should be central in the working dynamic.

FIGURE 1: HEALTH SYSTEM BUILDING BLOCKS - SYSTEM THINKING APPROACH [2]



A DISTRICT BASED AND GOVERNMENT LED APPROACH

Many documents and tools have recently been developed for health system assessments. Most of them are country based, and provide a top-down approach. Meaning, that recommendations remain at a national level, which is useful to guide the global public health policy of the country, but might not take into account the actual needs and situations of the lowest levels of the HS. One of these, the Health Systems Assessment Approach (HSAA): A How-To Manual [3] developed in 2008 and updated in 2012 by Health Systems 20/20 has been designed to provide a rapid and yet comprehensive assessment of key health system functions at national level. This model can also collect data and information at District level as part of the wider process. Recommendations remain nevertheless at national level. This method is very interesting and has been used, as most of health system 20/20 work, as a model for developing the present guide. But we believe that performing health systems assessment at national level is key to inform policy changes and actions to be taken at country level, often the translation of these recommendations at District level is hard to be seen. **This guide adopts a bottom up approach and starts the process from the District. We believe District health system assessment has a great potential to inform national policy change. The process promoted in this guide should complement country led health system strategies.**

PROMOTING COMPLEMENTARY PARTNERSHIPS

A Health System Strengthening strategy can only be developed if all actors are involved. **The following step-by-step approach has to be developed in partnership with all health actors of the District and under the leadership of the District health office.** This is an absolute precondition. No organisation intervening at District level has the legitimacy to propose such a process alone. Involving all actors is clearly the biggest challenge of the proposed approach, nevertheless achieving to build or reinforce partnership and coordination can be considered as a first outcome and achievement as it will enable, on the longer term, to increase synergy. The leadership of the local health authorities is also critical in the process. **Last but not least community and health services users should be represented in the key discussions and workshops all along the process.**

THINK HORIZONTAL &/OR DIAGONAL BUT NOT VERTICAL

This approach promotes a horizontal diagnosis and planning process. What does it mean concretely?

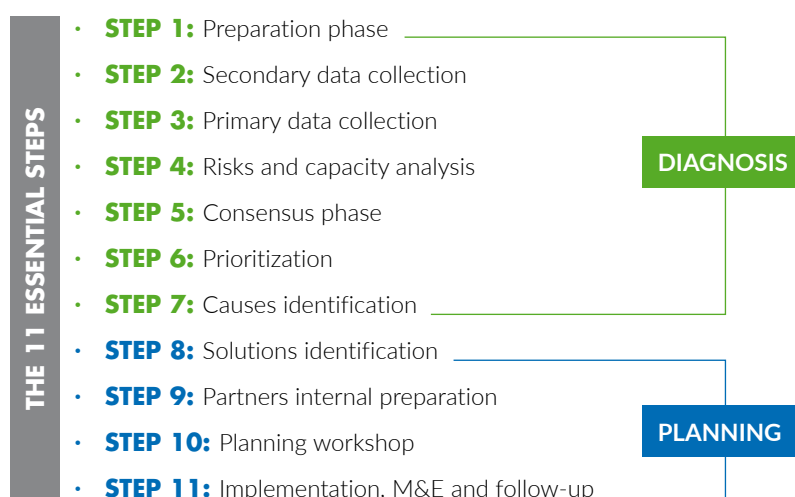
Health services (curative and preventive) can be provided using two modes of delivery: horizontal and vertical. Horizontal delivery services are delivered through public financed health systems and are commonly referred as comprehensive primary care. Vertical delivery of health services implies a selective targeting of specific interventions not fully integrated in health systems. The diagonal approach attempts to improve disease-specific outcomes through Health Systems Strengthening. It can be seen as a mechanism to address health systems weaknesses. Diagonal approaches reconcile the need to keep some specialised functions while recognising that programmes and their scaling up require stronger health systems. "Health systems strengthening interventions should be comprehensive. Much as vertical, or disease-specific, interventions may paradoxically weaken primary health systems, narrowly focused HSS interventions may limit value by neglecting other gaps in the health system. For example, a robust initiative to recruit and train health workers is unlikely to succeed if those health workers are asked to perform in a setting of decrepit infrastructure, inadequate equipment, drug stock outs, and absent information systems. For this reason, our intervention deliberately emphasizes capacitation across all six WHO building blocks at the District, facility, and community levels of the health system." [4]

The following process and its proposed tools have been developed in a comprehensive, horizontal approach. A diagonal approach could also be chosen (additional elements could be proposed to the initial comprehensive diagnosis depending on the speciality of the stakeholders)

GENERAL CHARACTERISTICS OF THE APPROACH

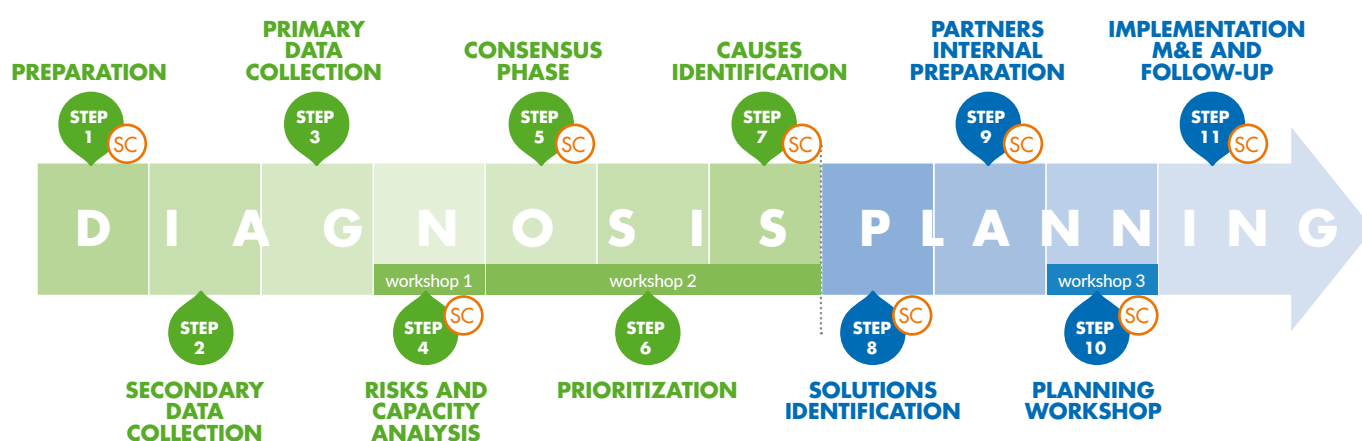
STRUCTURE OF THE APPROACH

This document proposes an 11 steps process promoted by ACF that should be seen as a process to be implemented rather than a compulsory method and tool to be used. If annual planning, budgeting processes or other tools already exist in the District and/or country where you are working it is important to first see how this step by step approach can complement these existing processes, and how to articulate those together, or complement the existing ones. The main steps of the approach are described below.



- **THE DIAGNOSIS PHASE** intends to provide detailed information on strengths and weaknesses of the health system with regards to the WHO six building blocks of the health system namely: i) Governance; ii) Financing; iii) Service delivery; iv) Health Workforce; v) Supply; and vi) Health Information Systems. The approach proposed for the diagnosis steps is a combination of several different methods that have been adapted to fit the purpose (see Annex 1).
- **THE PLANNING PHASE** is intended to support the development of comprehensive strategies to reinforce the health system based on the initial diagnosis. The planning phase is not only aiming at reinforcing the health system but also takes into account what needs to be done on the short term to meet the needs of the population. In addition, resilience oriented activities/ approaches are identified in order to enable the health system to prepare, absorb, adapt and transform from predictable or exceptional small medium or large shocks. This phase was based on several studies and projects that were done on this subject, and were adapted to fit the purpose (see Annex 1).

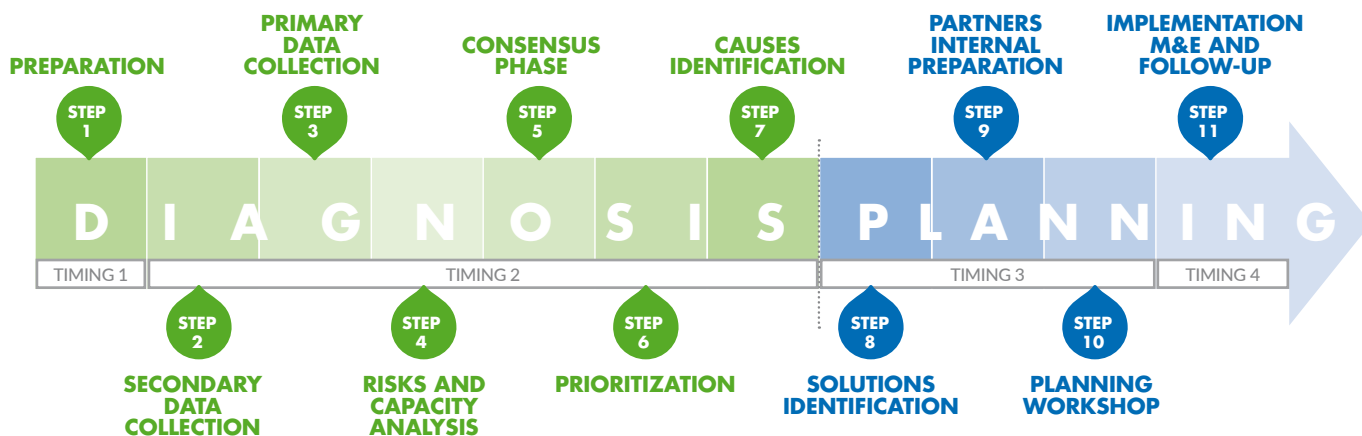
The sketch below describes the various steps of the HSS approach.



GEOGRAPHICAL SCOPE

The proposed approach is to be implemented at the lowest health system administrative unit which is often the “District”. It is not recommended to use it at Regional level (refer to underlying principles of the approach-District based approach). For the diagnosis to be representative, differences within the area need to be considered. For example differences between rural set up and urban set up should be taken into account in each step of the process.

TIMING AND DURATION



- TIMING 1:** The preparation step can take 4 to 8 weeks and is the most important one. It should be started far in advance of the other steps. It will determine the whole timing and duration of the exercise. It is recommended to start the preparation phase at least 2 months before the diagnosis phase starts. Ideally 4 months could be a good average.
- TIMING 2:** The diagnosis steps take a minimum of 6 weeks, from secondary data collection to the preliminary report writing and prioritization step (see table in Annex 2). This can take longer in other contexts (and needs to be readjusted in the preparation phase). The time period can vary depending on the number and the capabilities of the assessment team, the scope of the assessment, and the surface area to be covered. It depends also highly on the proactivity of the partners, their availability for the diagnosis workshop (finding a date to organize a 3-4 days' workshop where all partners will be available is often the reason for this phase to be extended).
- TIMING 3:** The planning steps can take a minimum of 5 weeks and will, in certain contexts, follow immediately the diagnosis phase but could in other contexts be performed 1 to 3 months later. This will highly depend on the local health and development planning agenda and should be determined during preparation phase.
- TIMING 4:** The implementation of the activities as well as the follow-up and the evaluation will last several years, (period of time for which the activities have been designed). Here it is important to keep in mind that the approach is a long-term one, and must be implemented over the period of time needed by the District to correctly achieve the objectives of the HSS.

Timing and duration will be very context specific. There is no single rule, every exercise will have to adapt to local calendars, partners availability, conflicting agendas. A detailed estimation of the time required is presented in Annex 2. HSS diagnosis and planning should be fitting within other planning exercises (District health planning and budgeting, partners strategic planning, etc.). The following information is an estimation of the minimum number of required weeks based on the experience of the pilots performed from 2014 to 2016.

NOTE

MAIN ACTORS AND HR NEEDS

The main actors involved in the HSS approach, are generally all those who contribute to the function of the health system at the District level. It is important to have a clear understanding of the roles and responsibilities of each actor within the health system before setting up the HSS approach. Below is a list of the main actors with a description of their role, as well as the needed additional human resources. In each step, further details are presented regarding the roles and responsibilities of each of them.

TABLE 1: DESCRIPTION OF THE MAIN ACTORS

MAIN ACTORS	
ACTORS	ROLES AND RESPONSIBILITIES
MINISTRY OF HEALTH AT DISTRICT LEVEL	The DHMT (District health management team) is in the lead during the whole process. The Steering committee is directly responding to the DHO head.
STEERING COMMITTEE (SC)	Led by the DHMT, and made of representatives of all the key stakeholders (it shouldn't be made of more than 10 parties), it is created during the Step 1. Main roles: <ul style="list-style-type: none"> · Adaptation of the methodology to the context · Setting up tools to be used, timing and duration · Engage actively each step of the process and validate them · Brief partners about the steps, results, etc.
SUPPORTING PARTNER	One partner will take a greater role and support the MoH in leading and organising the whole process this partner will be called the "co-lead" or the "supporting partner" .
ADDITIONAL PARTNERS	Additional partners include all the actors having a role in the health system of the District, and not already involved in the SC. It includes local and international NGOs, UN, donors, regional health management team members, public and private health care providers, communities, etc.) All partners are involved in the workshops 2, and 3, and can be solicited at other moments.

TABLE 2: DESCRIPTION OF THE ADDITIONAL HUMAN RESOURCES

ADDITIONAL HUMAN RESOURCES	
ACTORS	ROLES AND RESPONSIBILITIES
HSS PROJECT MANAGER (HSS PM)	Recruited during the preparation phase, s/he will stay for the whole duration of the project and support the DHMT and the SC in leading the process, and implementing the diagnosis and planning steps. (The HSS PM is most of the time recruited by the supporting partner or co-lead).
HSS MODERATOR/ FACILITATOR	Recruited for a minimum of 2 months. S/he has a facilitator role and should help the teams to organize the workshops, reach the set objectives for each of them, and moderate the essential moments of the diagnosis and planning phases (Steps 4-5-6-7-8-9-10). The consultant work is divided into 2 phases: diagnosis and planning. Either the planning is organized very quickly after the diagnosis and therefore the consultant remains in the District, or the consultant leaves the District and comes back when the Step 10 is ready to start (<i>ToR are available in Annex 4</i>). The HSS Moderator/Facilitator is most of the time recruited by the supporting partner or co-lead but will not be affiliated to the agency. S/he needs to remain neutral and will be supporting essentially the DHMT in leading the process.
ASSESSMENT TEAM, INCLUDING A DATA ENTERER	Recruited for the secondary and primary data collection (Step 2 and 3). Members can be from any partner agency or from the MoH. The main roles of this team are first to gather relevant documentation (Step 2). Take part in the primary data collection by performing direct observations, and animating individual interviews, and focus group discussions. The assessment of the collected data will also be part of the scope.

POTENTIAL CHALLENGES

The potential challenges of the proposed approach are related to its underlying principles listed above. This is not an exhaustive list as you may find by yourself challenges for each step of the proposed method, according to the context you are dealing with. This list below should help you anticipate some shortcomings experienced during the various pilots undergone between 2014 and 2016.

TABLE 3: KEY ELEMENTS AND LIMITATIONS OF THE APPROACH

POTENTIAL CHALLENGES	WHAT SHOULD BE DONE?
There is a need to explore what exists and prepare far in advance the exercise.	It will require an initial investment of the partners before planning anything.
Mobilisation of the partners and field teams for a long period. Potential negative effect on their active participation.	Define with partners, a detailed planning far in advance. It is key to ensure proper participation. Remind regularly the planning to partners is also key.
Users and community inclusion in the process is a great challenge.	Several strategies can be implemented according to the context in each of the steps these strategies are highlighted along the guide.
The system thinking element is often neglected after the diagnosis and during the planning process.	Ensure that all partners are well included in all the steps. It is key to take enough time to properly develop the planning and articulate it not around building blocks but around problem and solution trees. The tools proposed from step 7 to step 10 are designed to reduce this risk.
A great proportion of the bottlenecks or weaknesses identified during the process will depend on regional or national structures, and regulations.	Representatives of national level should be included in the process. As part of the planning phase an important number of actions will be designed for the regional central level. An advocacy strategy and action plan should be designed as an outcome of the process.
Partners cover a whole range of actors from the users to the private sector. Engaging all of them is a challenge. Having the MoH leading the process and spending much time for it is another great challenge.	The discussion and preparation phase is the most important moment to engage partners. A 4W mapping (who is doing what, where and when) is essential not to miss any partner. A constant vigilance on the facilitation of users' engagement will be required.
INGOs have the tendency to remain in their comfort zone and only cover the service they traditionally support. In certain countries even the MoH itself has organised service delivery in a very vertical manner.	Getting out of the vertical logic could require an awareness raise, as well as preliminary trainings on the key concepts of health system strengthening.

SUMMARY OF THE APPROACH

OBJECTIVES

OVERALL OBJECTIVES

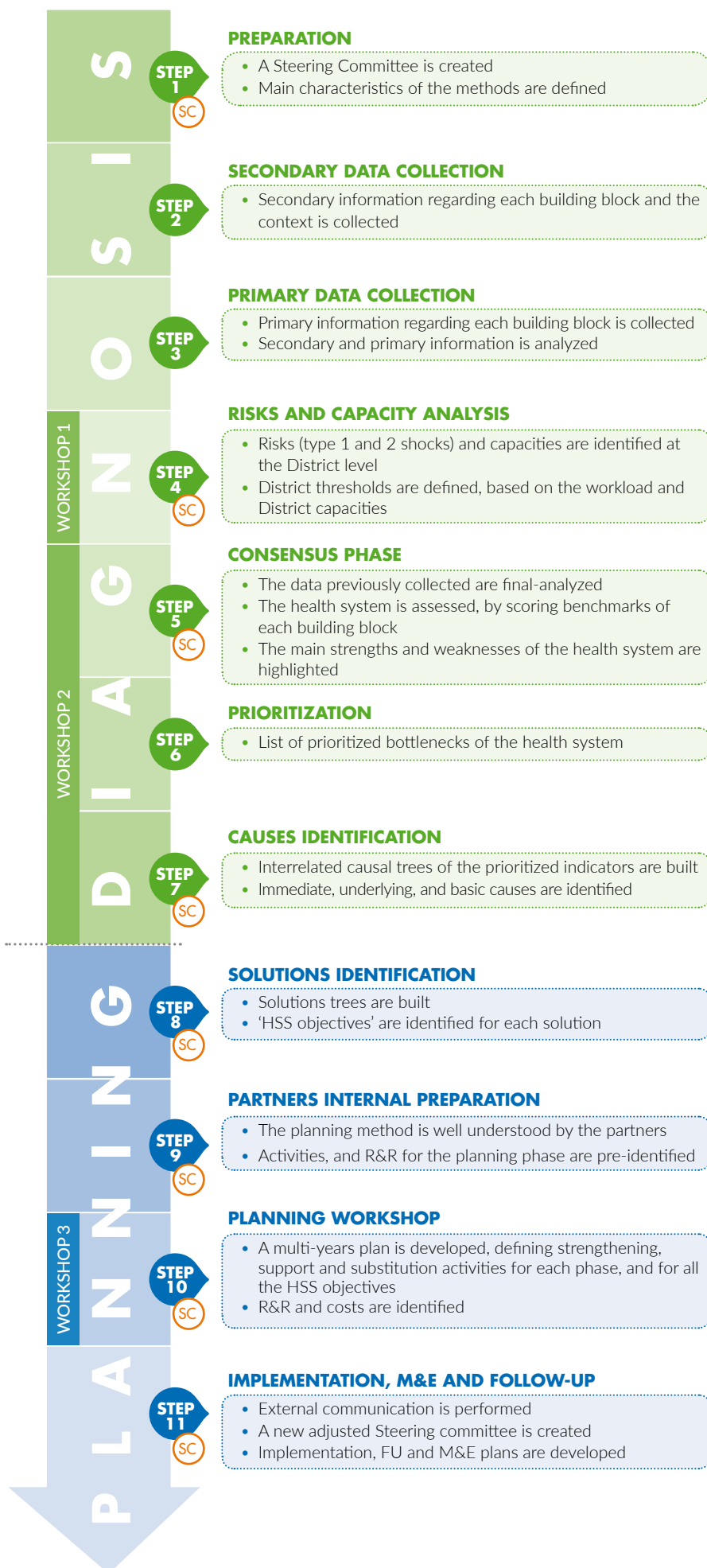
- Strengthen the health system
- Develop the resilience of the health system

SPECIFIC OBJECTIVES

- Perform a diagnosis of the health system, highlighting its strengths and weaknesses.
- Develop a District HSS multi-annual plan with all the partners, which includes strengthening, support and substitution activities, for each phase, and for all the HSS objectives. Roles, responsibilities, and costing estimations are also defined.

UNDERLYING PRINCIPLES

- An adaptable approach
- Focused on practical action
- Promoting system thinking
- A District based and government led approach
- Promoting complementary partnerships
- Think horizontal &/or diagonal but not vertical



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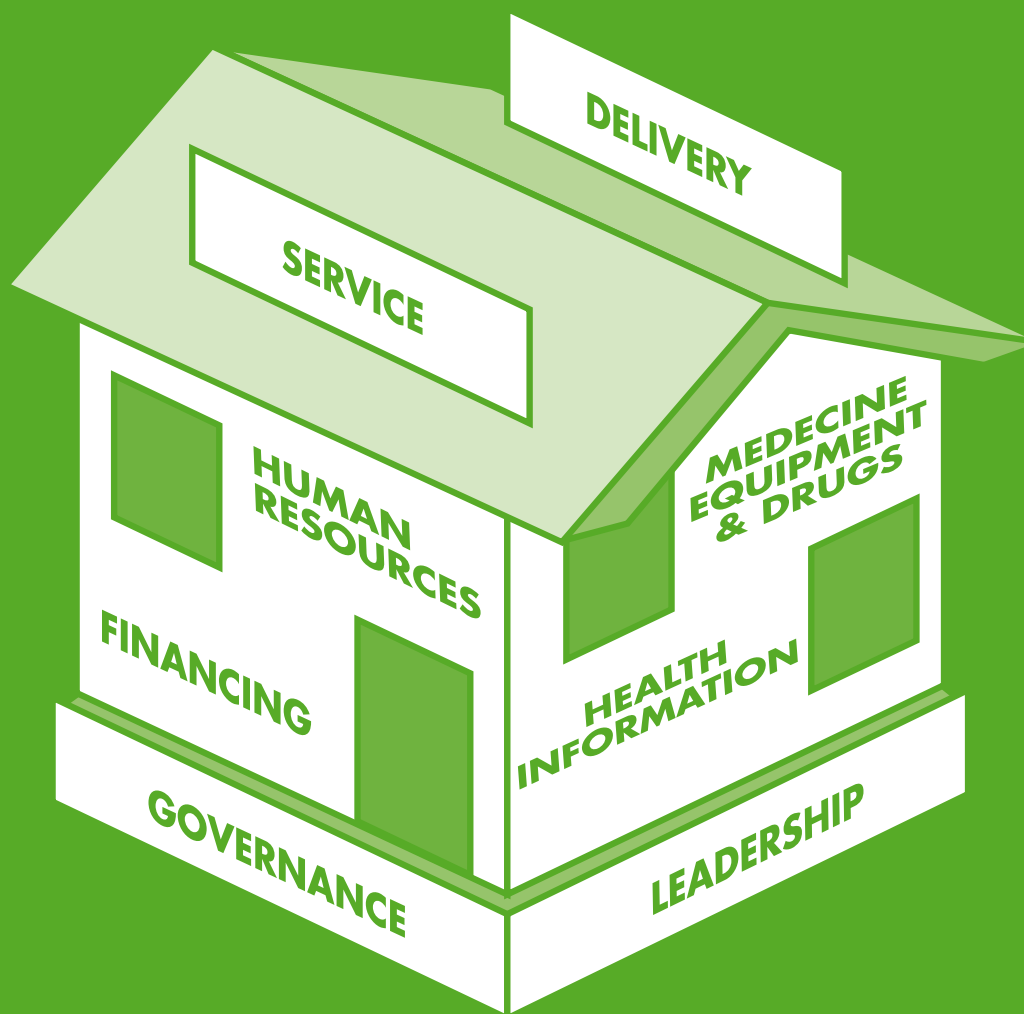
DIAGNOSIS

- STEP 1: PREPARATION PHASE**
- STEP 2: SECONDARY DATA COLLECTION**
- STEP 3: PRIMARY DATA COLLECTION**
- STEP 4: RISKS AND CAPACITY ANALYSIS**
- STEP 5: CONSENSUS PHASE**
- STEP 6: COMMON PRIORITIZATION**
- STEP 7: CAUSES IDENTIFICATION**



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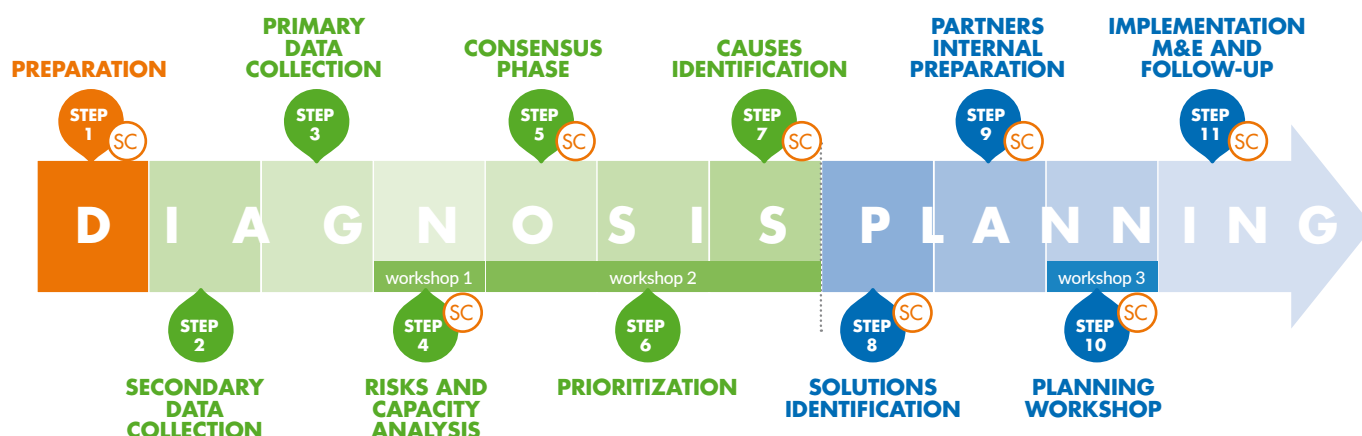




REPRESENTATION OF WHO SIX BUILDING BLOCKS FOR EFFECTIVE HEALTH SYSTEMS

(Adapted from Lancet 2009)

STEP 1: PREPARATION PHASE



During preliminary discussions it has been agreed with the DHMT/MoH to perform the HSS from diagnosis to planning. A rough timeframe including timing for preparation, diagnosis and planning phases has also been drafted.

TABLE 4: FRAMEWORK OF THE STEP 1

STEP 1 – PREPARATION PHASE	
OBJECTIVES	<ul style="list-style-type: none"> Develop and agree with District partners on the basic principles and objectives of the HSS diagnosis and planning exercise Set up the scope, methodology, tools, and time schedule Define key stakeholders to be involved and mobilize them
WHO IS INVOLVED	<ul style="list-style-type: none"> District authorities Project Manager Partners Other key stakeholders
METHODS	<ul style="list-style-type: none"> Identify the key partners by performing a 4W mapping of the District Create a Steering committee Train the Steering committee and partners on the approach Raise awareness about the partnerships' importance and challenges
OUTCOMES	<ul style="list-style-type: none"> A Steering committee is created Main characteristics of the methods are defined

This step is a key for the whole process to be successful, since it anchors the basic structure and strategy of the HSS approach.

MoH LEADERSHIP AND OWNERSHIP

As mentioned before preliminary discussions with the District health authorities have taken place prior starting the process. A strong willingness and interest to perform and lead the health system diagnosis and planning exercise is required.

The objectives and the scope of the process have to be defined:

- Will the diagnosis and planning exercises cover the whole District or a sub administrative entity? In certain countries a District can cover a large area with a lot of sub Districts. The feasibility aspects and homogeneity of the area will be critical in making this decision.
- In urban context the area to cover will depend on the density of the population, feasibility elements and the lowest local decision power in health sector. Again, the homogeneity of the area will be critical.

Once these points have been identified, an investigation must be performed regarding the present processes and tools existing at the DHMT level, such as annual planning, budget, etc.

Terms of references for the whole process should be drafted by the DHMT and the supporting partner (example in Annex 4):

- 1 Background
- 2 Aim of the process, overall objective and specific objective
- 3 Methodology
- 4 Deliverables/ expected outcomes
- 5 Timeframe
- 6 Steering committee composition and role

The MoH should lead the whole process with the support of the supporting partner.

IDENTIFYING KEY PARTNERS: THE 4W MAPPING

Identifying and understanding **who is doing what, where and when** is a key precondition for the whole process to start well. It is important to link here with other mappings that might already exist, such as advocacy plans, sectorial strategies, etc.

Most INGOs involved in supporting health systems do think they know very well who the actors are, but do often bypass some key non-traditional actors. **All actors should be considered from users to INGOS, private sectors, traditional healers and academic institutions.** The mapping proposed below should help identify all relevant actors involved in the health system at District level.

2 objectives for the 4W mapping:

- Identifying and selecting key stakeholders for the creation of a well-balanced Steering committee
- Identifying key informants for the diagnosis phase and identifying key partners for the planning phase

To perform a health system actors mapping see Annex 3.

ENSURING COMMUNITY INVOLVEMENT AND PARTICIPATION IN THE PROCESS

Community involvement in health is a contribution of community members to health by fulfilling given responsibilities, which have been broadened or narrowed from a situation to another or from a country to another.

In some cases, the community assumes only social responsibilities by setting up structures to support the implementation of health programmes. In some others, communities have both social and technical responsibilities. Community involvement in health basically means that communities take responsibility for their own health through:

- Adoption of behaviour to prevent and treat diseases
- Promotion of optimal health behaviours
- Effective participation in disease control activities
- Contribution to the design, implementation and monitoring of health programmes
- Provision of resources for health

Community involvement in health therefore requires community to take part in the achievement of the goals and objectives of health programmes. Community involvement in health has been the linchpin of primary health care programmes as designed in Alma Ata in 1978 as well as the Bamako Initiative. **In the whole process community involvement should be looked at and**

taken into consideration. The Steering committee creation stages, as well as the secondary and primary data collection steps are critical moments to:

- Include community members in the process
- Assess the actual level of community involvement and take it into account in the planning phase

CREATING THE STEERING COMMITTEE

Once the 4W has been performed a meeting should be held with the District health authorities in order to define the composition of a Steering committee. Indeed it is essential that important stakeholders are actively involved throughout the process of conceptualising, planning and carrying out the exercise with the MoH as leader of the process. This is important for transparency and ownership of the process from the beginning.

The main roles of the Steering committee are described in the table below. A first meeting should rapidly be organised to launch officially the preparation phase.



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Users/ community members should be represented in the Steering committee. Private sector if playing an important role in the context should also be included (see Annex 3).

NOTE

TRAINING THE PARTNERS

It is very important to make sure that all the key stakeholders involved in the HSS approach have the same good level of understanding of the approach itself, as well as of the background behind this whole strategy. This will allow the partners to bring more added values to the approach, and it will also develop their own capacities. Key notions on health systems, HSS should be understood and known by the Steering committee members and all partners involved in the process. During the preparation phase it will be critical to assess their level of understanding and propose half a day discussion/ training on the key HSS definition as presented in Annex 5. Also a typical presentation of the main points to be understood is available in Annex 6.

DETAILS OF THE PREPARATION PHASE

Preparation phase will consist of:

- Activities performed by the Steering committee headed by the MoH
- Activities performed by the supporting partner with the MoH focal point and proposed to the Steering committee for validation

TABLE 5: ACTIVITIES RELATED TO THE PREPARATION PHASE

STEERING COMMITTEE	SUPPORTING PARTNER WITH THE PM AND MOH
<ul style="list-style-type: none"> • Agreeing on the ToRs • Define roles and responsibilities within the Steering committee • Collect tools and methods already in place at District level or proposed at national level (for diagnosis and planning phases) • Agree on the diagnosis and planning methodology • Adapt the proposed tools to the context • Define timing and duration • Collect existing literature for secondary data collection • Develop the list of partners to be included in each of the workshop 	<ul style="list-style-type: none"> • Establish the budget according to the chosen methodology • List the secondary information that will be needed, people that will be interviewed and health centres that will be assessed • Develop the timeframe, frequency and dates of Steering committee meetings • Select and train the assessment team (translator(s), data collector(s), data transcriber(s)) on the objectives and methodology of the assessment) • Prepare the equipment and logistics for the period of assessment • Prepare and validate the travel plan for primary data collection • Prepare report outline

RAISING AWARENESS ABOUT PARTNERSHIPS

MONITORING THE PARTNERSHIPS

It is essential to understand from the start that the partnership aspect will be the greatest challenge of the whole approach. This aspect has to be regularly monitored and a partnership charter (with key partnership principles attached to the ToR) could be developed and endorsed by the Steering committee.

RISKS RELATED TO THE PARTNERSHIPS

- **POWER IMBALANCE:** INGOs have the tendency to impose their ideas to local health authorities, CSOs or LNGOs and such power struggle can also happen between UN agencies and INGOs.
- **NEUTRALITY:** There will be, along the process, a risk for all the actors to influence the diagnosis according to what they want, or do not want to be seen or proposed at the later stage. It is important to try to maintain neutrality during the whole process.

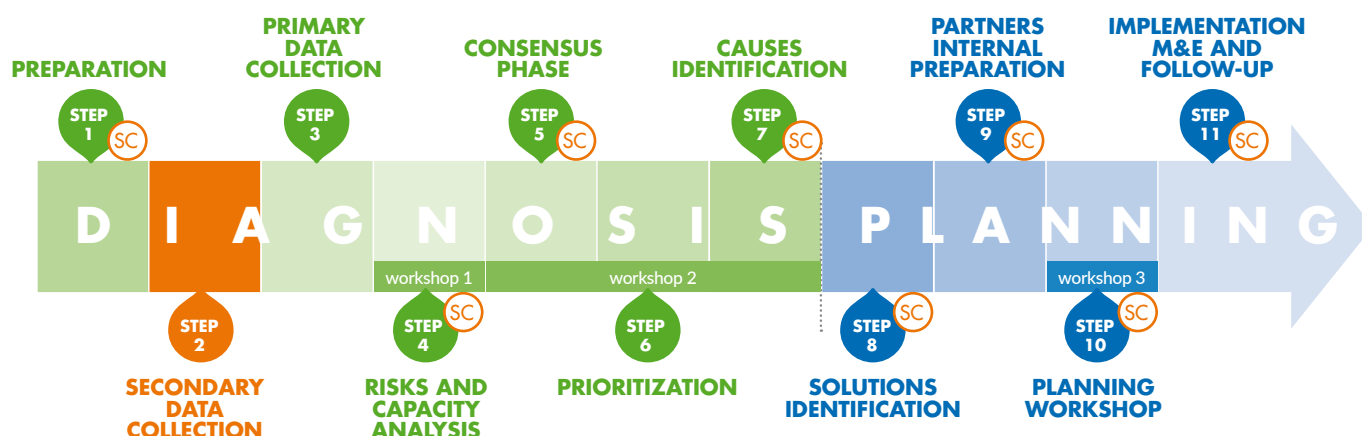


AT THE END
OF STEP 1

MAKE SURE THAT:

- Representatives of each stakeholder of the health system are involved in the Steering committee. Communities shall participate.
- Steering committee members and partners are trained about the HSS approach and the background.
- All the characteristics of the approach are deeply discussed and agreed.

STEP 2: SECONDARY DATA COLLECTION



The previous step has allowed the creation of a trained Steering committee, and the main aspects of the method have been agreed on i.e. scope, methodology, tools, time schedule, and key stakeholders.

TABLE 6: FRAMEWORK OF STEP 2

STEP 2 – SECONDARY DATA COLLECTION	
OBJECTIVES	<ul style="list-style-type: none"> Provide relevant information on each of the health system building block and on the context
WHO IS INVOLVED	<ul style="list-style-type: none"> Project Manager Steering Committee Assessment team
METHODS	<ul style="list-style-type: none"> Collect existing official documents from key informants
OUTCOMES	<ul style="list-style-type: none"> Secondary information regarding each building block and the context are collected and will be analysed later

Secondary information = information that already exists.

The assessment team with the support of the Steering committee will gather official documents (both published and grey literature) obtained from key informants of the government, the MoH, donors, UN agencies, NGOs, and from official websites. These documents shall provide an overview of the context, information and data on the health system, the current health situation, state of child diseases, and thus for past, current and planned policies, programmes and/or interventions, as well as a critical analysis of it (advocacy reports). Type 1 and type 2 stresses/ shocks (see the definitions in Annex 5) shall be described as well, including trends of shocks, understanding of the causes, and response. This information is collected at the national, regional and District levels.

This step does not need to be fully completed before starting primary data collection. The process can continue up to the analysis and reporting steps. Any major gaps should be identified and prioritized for primary data collection, where feasible and complementary information should be obtained through primary data collection.

A table (Annex 7) gives an overview of documents to be reviewed by building block, and the associated indicators/information for the health system assessment. Specific focus on the community organisation should be made.

Key documents are:

- 1 Community health policy and strategy
- 2 On-going community child health and nutrition interventions
- 3 The community administrative structure
- 4 Documents and articles on causes of the main diseases in the country/District
- 5 Management mechanisms of community interventions (RMNCH, IMCI, IYCF, CCM, etc.)
- 6 Documents and article on the preparation and response to all types of stresses/shocks
- 7 Advocacy reports on health and nutrition

A table (Annex 8) presents indicators/information to be identified by capacity "domain", for community assessment.

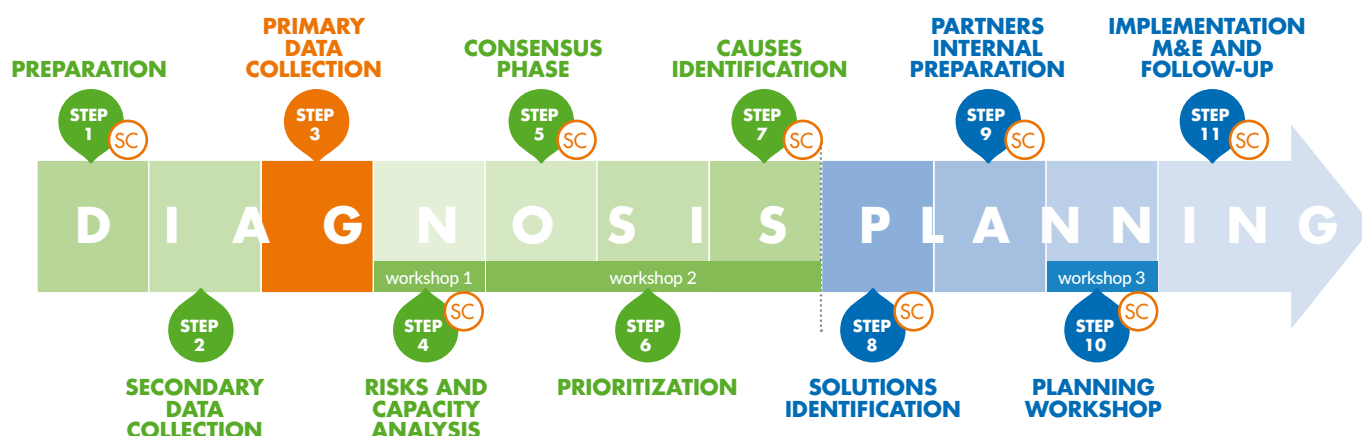


AT THE END
OF STEP 2

MAKE SURE THAT:

- All the key documents listed above have been collected.
- Information has been gathered from all the key informants, and for each level of the health system.
- The community organizations have been consulted regarding the key documents.

STEP 3: PRIMARY DATA COLLECTION



The previous step has allowed the collection of secondary data at the national, regional and District levels, and brought some insight about the context and each building block's situation of the present health system. If it appears that a similar kind of diagnosis study has been performed recently, the primary data to be collected has to be reassessed, in order not to duplicate the collected information.

TABLE 7: FRAMEWORK OF THE STEP 3

STEP 3 – PRIMARY DATA COLLECTION	
OBJECTIVES	<ul style="list-style-type: none"> Provide an overview of the health District regarding the health system situation, and begin to identify weaknesses and strengths Describe and understand the perception of the health system by the communities and the health workers
WHO IS INVOLVED	<ul style="list-style-type: none"> Project Manager Steering Committee Partners Facilitator
METHODS	<ul style="list-style-type: none"> Use the data collected during the previous step and adapt the method accordingly to address any gaps Sampling of health facilities to be representative of the health District Primary data collection through: <ul style="list-style-type: none"> Direct observations Focus group discussions Individual interviews Analysis of the collected data: <ul style="list-style-type: none"> Basic statistics for the quantitative data SWOT analyses for the qualitative data
OUTCOMES	<ul style="list-style-type: none"> Analysis of the secondary and primary data through basic statistics and SWOT analyses Provision of relevant information regarding the health system situation (context, building blocks, availability, demand, utilization, trends of shocks, perceptions of the services, etc.)

The primary information is new information that needs to be collected.

The health District situation is assessed by collecting information in a sample of health facilities. The situation of the health system facilities, as well as the perception of the community and the health personnel on the service delivery are assessed through various methods of data collection. All this information will result in an overview of the health facility's situation, and will be a major reference in the diagnosis. The table below shows in more details, at which level data are collected, and the main objectives.

TABLE 8: TECHNIQUES OF DATA COLLECTION

TECHNIQUES	LEVEL OF DATA COLLECTION	OBJECTIVES
Direct observations	Health facility level	Collection of qualitative and quantitative data to assess health facilities' general weaknesses and strengths. It includes information regarding the 6 building blocks, availability, demand, utilisation, trends of shocks of type 1 and 2, etc.
Individual interviews	National, regional, District and facility levels	Collection of qualitative data to assess the perception of the community and the service delivery actors regarding the health services.
Focus group discussions	Health facility level	Collection of qualitative data to assess the perception of the community on the health services.

Primary health care structures are assessed in priority: Health centers/ health posts of the covered area have to be listed and selected (following the method proposed below).

DIRECT OBSERVATIONS

Observation is used to assess the health infrastructures at the District level, particularly with regards to the six building blocks. Also, the trends of shocks are assessed. The combined questionnaire and check-list in Annex 9 gives an idea of the observation items.

Ideally, all the health structures of the District should be observed in order to get a full picture of the local health system situation. In the case this is not possible, lists identifying the various types of HFs (near/ far, urban/ rural, health centers/ health posts) are described. All types of health structures have to be included in the list and we have to make sure that in the final sample we have all types of health facilities represented. Then a sample from each type of HFs should be selected, at least 10% of health structures described in each list should be observed, as per the evaluation rules. Selected health structures should be "representative" of the health District.

A direct observations tool or checklist is proposed in Annex 9.

INDIVIDUAL INTERVIEWS

After the direct observations, individual interviews are performed in the same health facilities. When relevant, interviews can be performed at the national and regional levels in order to gather additional information. Semi-structured individual interviews are used to collect primary data from key informants. These are open-ended questions prepared in advance to guide the discussion. The style of the interview is conversational, and the interviewees

This can be adapted in each health District/ national context and standards.

NOTE



are encouraged to say what they think on a given question, and are also encouraged to bring up issues they want to talk about regarding the discussion. The selection procedure for interview participants is snowball technique. Interviews are carried out until reaching saturation of information, which occurs when further interviews are not adding to the findings or repeating what was already found in the previous interviews. Interview sessions are recorded or the answers to the questions are written down, and the discussion should last a maximum of an hour.

Three types of individual interviews are proposed:

- 1 **Health system assessment**, people involved in delivering health services at District levels are interviewed. They include policymakers, donors, health and nutrition implementing partners, health and nutrition workers. Questions related to different building blocks are covered during the interview sessions. *Interview questionnaire guides are proposed in Annex 10, 11, and 12.*
- 2 **Community system assessment** includes local administrative authorities, as well as leaders such as religious, school teachers or elders. Representatives of community groups should also be interviewed. Community involvement is a key characteristic of success of service delivery, the assessment provides information on its ability to be involved in the service, as per the nine 'domains' of community capacity, namely *i) Participation; ii) Leadership; iii) Social and inter-organisational networks; iv) Role of external support; v) Asking why/critical reflection; vi) Resource mobilisation; vii) Skills, knowledge, and learning; viii) Linking with others; and ix) Programme management.* *An interview guide is proposed in Annex 13.*
- 3 **User feedback assessment** includes a representative sample of the users of the health system, for each type of attended health infrastructure (health facility, health post, etc.). This will help assess the point of view of the services users, thanks to questions related to the six building blocks. *An interview guide is proposed in Annex 14.*

FOCUS GROUP DISCUSSIONS (FGD)

The FGD will take place at the facilities, in continuation to the previous data collection steps. In each of the structures selected to do the observations FGD should be organised ideally with the groups detailed below. However, when you start hearing the same things repeated, you can stop. At the simplest level, a focus group is an informal discussion among a group of selected individuals about a particular topic (Wilkinson 2004).

FGD will be conducted to assess the community involvement in the health system. Target participants are community health volunteers, **community health workers (CHWs) from the government and NGOs, as well as parents of under-five children.** A focus group discussion is a good way to gather people from similar backgrounds or experiences to discuss a specific topic of interest.

Detailed outline of the process:

- **FGD sessions need to be prepared carefully:** identification of the main objective(s) of the session, development of key questions, development of an agenda, identification of different groups based on the cultural context (men/women, elder/ young, etc.) and planning of the recording of the session. *An example of a FGD guide is proposed in Annex 15.*
- **Identify and invite suitable discussion participants;** the ideal number is between six and nine and should last from 60 to 120 minutes.
- **A facilitator introduces the topic and assists the participants to discuss it,** by encouraging interactions and guiding the conversation. The facilitator makes sure that asked questions are open-ended, and he also plays a major role in obtaining good and accurate information from the focus groups. There can be more than one facilitator in one focus group.
- **The group does not need to reach any kind of consensus.** The prime objective is to obtain accurate data on a limited range of specific issues. The responses obtained shouldn't be turned into quantitative figures (for instance, x% of participants agreed).
- **The participants usually have shared social and cultural experiences** (such as age, social class, gender, ethnicity, religion and educational background) or shared particular areas of concern (access to health, childbirth, infant feeding, childhood immunisation, diarrhoea, nutrition, etc.).
- In order to go deeper in **the understanding of the shocks** that the health facilities faced in the past. The facilitator can choose to present the calendars of shocks that have been obtained in the direct observations, to orient the reflexion on this topic.

ANALYSIS OF DATA (PRELIMINARY STAGE)

DIRECT OBSERVATIONS

Data collected through the observations check-list are entered in Excel sheets in order to compute frequencies. Some of the outputs that could be obtained from the Excel quantitative data computations are:

- The mapping of health centres
- The classification of health centres according to the types of child health services offered
- The health centre coverage
- The % of available staff as compared to the expected (vacancy rate)
- The needed staff for proper management of expected caseloads
- The % of facilities geographically accessible
- The % of health centres applying properly the quality standards
- The % of health facilities having materials in good working order for RMNCH services to be delivered
- The % of health facilities having materials in good working order for inpatient and outpatient management of acute malnutrition
- The % of health centres regularly supplied with medicines
- The % of health centres regularly supplied with therapeutic foods
- The reported completion rate
- The % of patient regularly monitored through monitoring tools, etc.
- Monthly new cases over a year
- Yearly caseloads trends with explaining causes, factors and consequences on the health facility
- Yearly trends of type 2 shock with explaining causes, factors and consequences on the health facility

INDIVIDUAL INTERVIEWS AND FOCUS GROUP DISCUSSIONS

Immediately after the sessions, notes taken during the interviews and focus group discussions should be discussed and summarised under each study theme (building block) into **strengths, weaknesses, opportunities and threats (SWOT)**. The SWOTS will be essential tools for the triangulation phase.

The SWOT developed with the interviews and focus group discussions should be presented back to the community leaders interviewed (or a sample of them) in order to have them validate them, and gather their comments.

INITIATE THE WRITING OF THE REPORT

The results of the analysis should be compiled in a very brief report, in order to give an overview of the main findings of the first two steps to the partners. The PM will be working on it, and the Steering committee will validate it. This report will be completed with the information collected in the next step as well, and could be used as a basis for the diagnosis report.

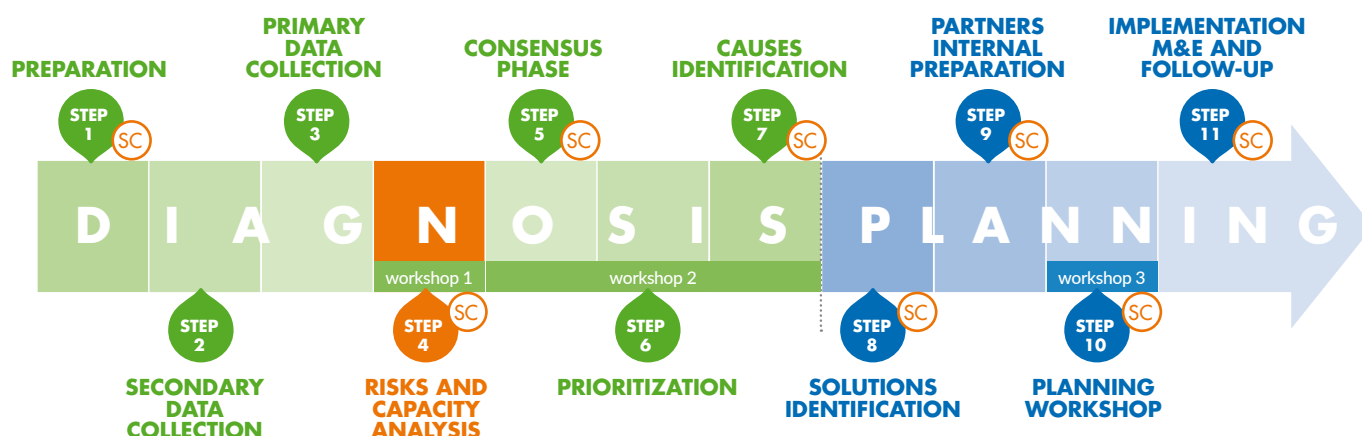


AT THE END
OF STEP 3

MAKE SURE THAT:

- The health facilities sampling is representative of the health District.
- The three techniques of data collection have been used at the right levels, and the necessary information has been correctly collected.
- All the key actors of the health facilities have been involved.
- The results from the quantitative and qualitative analyses reflect the real situation of the health facilities.

STEP 4: RISKS AND CAPACITY ANALYSIS



In the previous steps, secondary and primary data were collected and analysed. A report about the situation of the health District is now available, and offers a precise overview of the status, strengths and weaknesses of the health system.

TABLE 9: FRAMEWORK OF THE STEP 4

STEP 4 – RISKS AND CAPACITY ANALYSIS
OBJECTIVES
<ul style="list-style-type: none"> Identify and analyze the type 1 & 2 shocks to which the health District is exposed over a period of 2 years (characteristics, causes, effects of the shocks) Reflect the capacity of the health District to cope with shocks Define thresholds for the District to indicate various phases
WHO IS INVOLVED
<ul style="list-style-type: none"> Project Manager Steering Committee Facilitator Representatives of the Health Facilities involved in the sampling (manager/ medical doctor/ referent nurse/ etc.)
METHODS
<ul style="list-style-type: none"> Presentation of the secondary and primary information collected, regarding the type 1 and type 2 shocks, and the present capacity of the health facilities to deal with them. Perform a risks and capacity analysis for the District for type 1 shocks <ol style="list-style-type: none"> Identify the total monthly new cases trends for the District over two years. Identify the monthly new cases of the 3 or 4 main killing diseases for the District, over two years (epidemiological causes). Identify the main practical causes of the caseloads fluctuations, as well as influencing factors. Identify the effects of the shocks on the health system. Identify the existing strategies and the capacity of the Health District to prepare and respond to these shocks. Perform a risks and capacity analysis for the District for type 2 shocks <ol style="list-style-type: none"> Identify and describe the type 2 shocks for the District over two years. Identify the effects of the shocks on the health system. Identify the existing strategies and the capacity of the Health District to prepare and respond to these shocks. Identify parallel and linkages between the two types of shocks (type 1 graph and type 2 graph). Set up the District's thresholds <ul style="list-style-type: none"> Introduce the thresholds systems to the Steering committee Define the thresholds for the District using one of the methods
OUTCOMES
<ul style="list-style-type: none"> Calendar over 2 years describing the type 1 and type 2 shocks occurrence, magnitude, causes, at the District level. Strategies and present capacity of the District are also described. Definition of thresholds at the District level, based on the workload and District capacity.

This step aims at ensuring that the potential shocks the **health District** could face are well accounted for in the diagnosis part, so that proper preparation and response can be designed in the planning stage. It is important to include them in the diagnosis, since shocks can stop and erase all the long-term efforts and activities developed to strengthen the health system. The encountered shocks can be of two types (Annex 5):

- **Type 1: Stresses/ shocks inducing a caseload increase.** They are called surges, and are a rise in the number of cases regardless the cause, the rapidity and the length of the rise. It can be seasonal case peaks as well as the result of a natural disaster for instance. It can also be caused by health system issues e.g. mass screenings, changes in operational systems (such as referral systems). Developing the surge capacity of the health District will permit to cope with the surges and provide an accurate response.
- **Type 2: Stresses/ shocks not necessarily inducing a caseload increase.** The intrinsic structure of the health system (the 6 pillars) is disrupted which provokes a dysfunction of the system itself, affecting the demand or the supply side. However, a rise of caseloads is not necessarily observed. For instance, a flood would prevent the drugs and materials to be delivered to the health facility. The preparation and response to these stresses/shocks have to be accounted for while developing the HSS strategy with the District.

A risks analysis, as well as a capacity review and the definition of thresholds at the District level will then ensure a good inclusion of the shocks for the next steps of the HSS approach.

A workshop of a day is organized to perform this step. For the presentation of the secondary and primary information, the risk analysis and the capacity review, representatives of the sampled health facilities as well as the Steering committee should be present (half a day). For the thresholds setting, only the Steering committee should attend (half a day). The facilitator and the HSS Project Manager should be present the whole time.

Before doing this step, the HSS Project Manager should make sure that the required information are available, be it for the risks and capacity analysis and the thresholds settings. The various data to be used are described in the corresponding part of the step.

NOTE

The method and tools used in this step are mostly based on the CMAM Surge approach developed by Concern [5], which provides tools to efficiently prepare and respond to SAM surges. Further information can be found on their website: <https://www.concern.net/resources/cmam-surge-toolkit>.

NOTE

PRESENTATION OF PRIMARY AND SECONDARY DATA

The workshop is coordinated by the facilitator, and will start with a presentation of the results related to risks and capacity analysis, obtained during the secondary and primary data collection. The various calendars obtained for the type 1 and type 2 shocks, will be described by the facilitator. Also, the strategies or protocols already in place in certain health facilities are described. Finally, the observed gaps, or weaknesses are also mentioned. Health facilities representatives will be invited to comment these result if they wish. This information will be used as a basis in the next steps of the workshop to better analyze the risk and capacity of the District.

RISKS AND CAPACITY ANALYSIS

Once a good overview of the sampled health facilities has been provided through the secondary and primary data, the risks and capacity analysis for the District can be performed. It will permit to identify and explain the trends of type 1 and type 2 shocks at the District level, as well as the level of preparation of the District to these shocks.

The outputs of the risks and capacity analysis will be one graph for each type of shocks. The graph should describe the shocks, the causes, the effects on the health system, and the present capacity to cope with them.

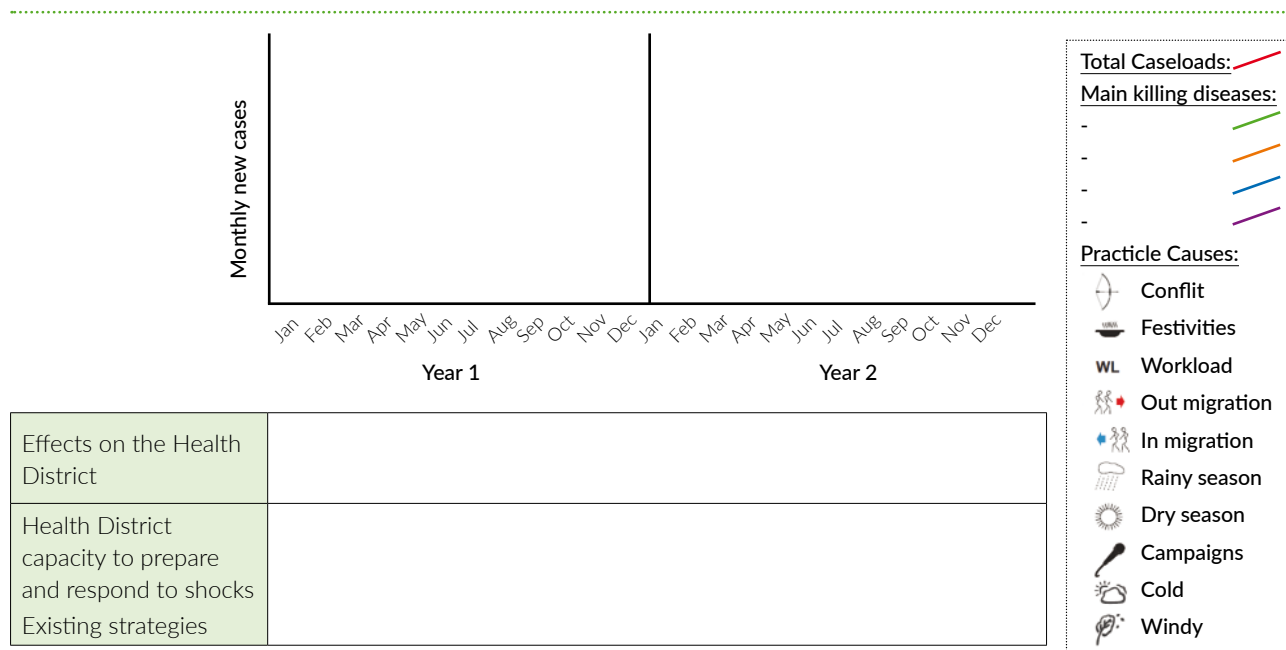
The secondary and primary data have mainly been collected at the health facility level, information for the risks and capacity analysis has also been collected at this level in the previous step. Here, these data will be used to analyze the risks and capacity of the entire health District. This difference must be kept in mind during the analysis.

NOTE

TYPE 1 STRESSES/ SHOCKS

The following blank graph (inspired from [5]) is provided and presented by the facilitator. This graph will be used for the analysis of the type 1 shocks, and be filled in by the facilitator at each sub-step. The graph is hung on the wall, to be seen from everybody. The available graph is presented below.

GRAPH 1: TYPE 1 SHOCKS DESCRIPTION



Instructions to fill in the Type 1 graph

- 1 Identify the total monthly new cases trends for the District over the previous two years.**

 - Based on the monthly new cases trends identified at the health facilities' level (see presentation at the beginning of the workshop), total caseloads trends (for all kinds of diagnosis) for the District can be estimated.
 - The health facilities representatives and the Steering committee discuss these results together and agree on District trends.
 - **The facilitator** will draw the total caseloads fluctuations on the graph for a period of two years in the corresponding colour.
- 2 Identify the monthly new cases of the 3 or 4 main killing diseases for the District, over two years (epidemiological causes).**

 - The main killing diseases of the District are identified, as well as the corresponding caseload trends. Also, the main killing diseases and the corresponding trends identified at the health facilities level can be used as a basis (see presentation at the beginning of the workshop). Identifying the main killing diseases is equivalent to the identification of the epidemiological causes.
 - The Steering committee together with the health facilities representatives discuss and agree on the estimations.
 - **The facilitator** writes a legend on the side of the graph (in the legend 'Main killing diseases') to identify the main killing diseases. He then draws the caseloads fluctuations for each of them for a period of two years in the corresponding colour. It is done on the same graph than before. He will also make sure that it is consistent with the total caseloads trends.
- 3 Identify the main practical causes of the caseloads fluctuations, as well as influencing factors.**

 - The epidemiological causes of the caseloads trends have already been identified. Here the practical causes and the influencing factors are described (i.e. environmental factors, agricultural calendar, cultural events, etc.). Indeed, practical events can also be responsible for caseloads increases. Again, the results obtained at the health facilities can be used as a basis (see presentation at the beginning of the workshop).
 - The Steering committee and the health facilities representatives discuss these results and highlight the driving practical causes that will be observed at the District level.
 - **The facilitator** will add on the graph the identified practical causes. They should be well positioned regarding the period of the year and the caseloads trends. Some pictograms are available on the side of the graph, and can be used. If needed, new ones can be added.

4 Identify the effects of the shocks on the health system.

- Now that the caseloads fluctuations are identified, the effects of each of them on the health system can be examined. Effects on all the building blocks should be considered.
- The results of the direct observations (see presentation at the beginning of the workshop) are used as a basis.
- The Steering committee and the health facility representatives will discuss and agree on these points together.
- **The facilitator** will use the table available below the graph to clearly describe with key words the effects of the shocks on the health system. Each description should be positioned under the corresponding shock, to allow a clear understanding. Also, the facilitator should keep in mind the 6 building blocks, and make sure they are all examined while discussing the consequences on the health system.

5 Identify the existing strategies and the capacity of the health District to prepare and respond to these shocks.

- The capacity of the District to deal with this type of shocks is described here, as well as the available strategies. It can encompass activities from all the building blocks. Information collected at the health facilities should be used in this exercise as well (see presentation at the beginning of the workshop).
- If gaps are already identified, they can also be mentioned here.
- The Steering committee and the health facility representatives will discuss and agree on these points together.
- **The facilitator** includes this information in the table available just under the graph. He will write the capacity under the shock/ peak to which it is related. Therefor it allows a vertical reading, directly giving information about the magnitude of the peak, the causes (epidemiological or practical), and the available District capacity.
- **The facilitator** will help the discussion about the capacity by raising some questions:
 - Do the key actors know the strategies?
 - Are the strategies actually implemented?
 - How did you handle the situation? What did you do?
 - What went well?
 - What didn't go well? What were the 'bottlenecks' to the response? What were your gaps?
 - Were the types of actions/responses appropriate and adequate?
 - How was the timing of your actions/responses (late, on time)?
 - Was there appropriate communication and involvement of key stakeholders?
 - Was the District able to manage the overall workload?

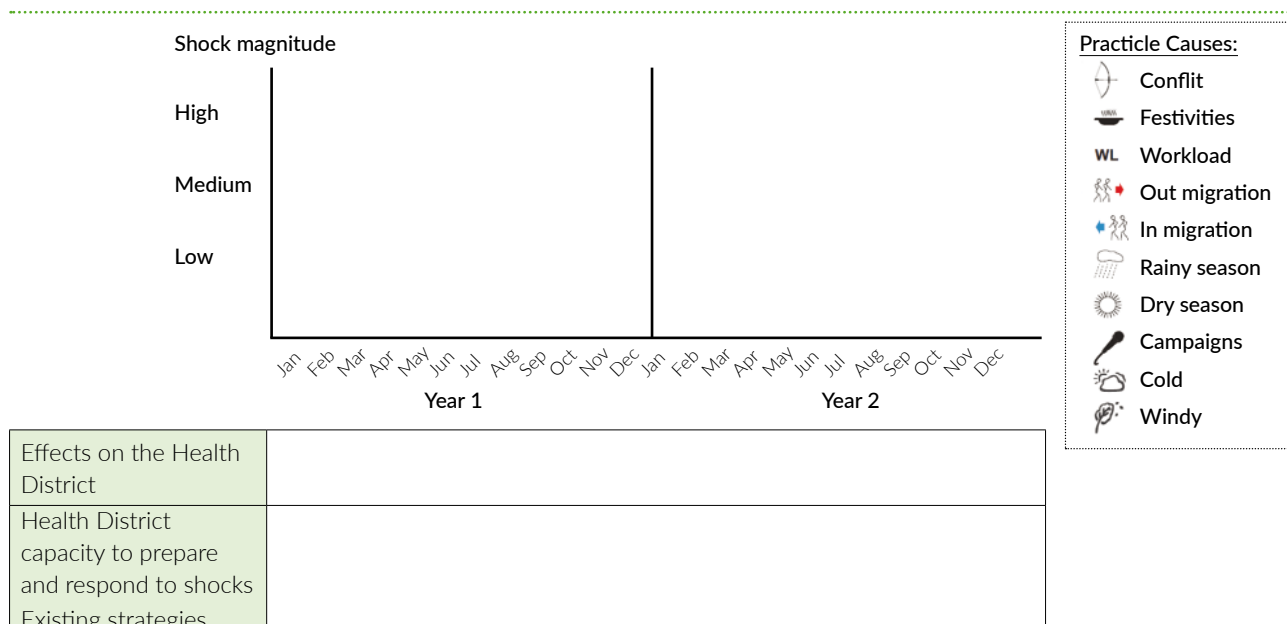


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TYPE 2 STRESSES/SHOCKS

The same kind of approach than for the type 1 shocks is adopted. The following blank graph (inspired from [5]) is provided and presented by the facilitator. This graph will be used for the analysis of the type 2 shocks, and filled in by the facilitator at each sub-step. The graph is hung on the wall, to be seen from everybody (if possible below or above the type 1 graph to allow comparisons).

GRAPH 2: TYPE 2 SHOCKS DESCRIPTION



Instructions to fill in graph 2

1 Identify and describe the type 2 shocks for the District over two years.

- The type 2 shocks are identified here. The nature of the shocks is described (ex: flood, drought, political events, etc.).
- The magnitude of shocks is identified between High, medium, and low. Also the duration of it is highlighted.
- The results of the direct observations (see presentation at the beginning of the workshop) are used as a basis.
- The Steering committee and the health facility representatives will discuss and agree on these points together.
- **The facilitator** will write/ draw on the new graph the identified shocks, accounting for their nature, magnitude and duration.

*Here, **only the shocks which DO NOT induce surges are described.** The shocks inducing surges have already been described in the Graph 1.*

NOTE

2 Identify the effects of the shocks on the health system.

- Now that the type 2 shocks are identified, the effects of each of them on the health system can be examined. Effects on all the building blocks should be considered.
- The results of the direct observations (see presentation at the beginning of the workshop) are used as a basis.
- The Steering committee and the health facility representatives will discuss and agree on these points together.
- **The facilitator** will use the table available below the graph to clearly describe with key words the effects of the shocks on the health system. Each description should be positioned under the corresponding shock, to allow a clear understanding. Also, the facilitator should keep in mind the 6 building blocks, and make sure they are all examined while discussing the consequences on the health system.

3 Identify the existing strategies and the capacity of the health District to prepare and respond to these shocks.

- The capacity of the District to deal with this type of shocks is discussed and described here. Also, the existing strategies developed to cope with them are described, and the status of development or implementation of these strategies is also mentioned. It can encompass activities from all the building blocks. Information collected at the health facilities should be used in this exercise as well (see presentation at the beginning of the workshop).
- If gaps are already identified, they can also be mentioned here.
- The Steering committee and the health facility representatives will discuss and agree on these points together.
- **The facilitator** includes this information in the table available just under the effects table filled in 2.). He will write the present capacity and available strategies under the shock to which it is related. Therefor it allows a vertical reading, directly giving information about the nature and magnitude of the peak, the effects on the health system and the present District capacity and strategies.
- **The facilitator** will help the reflexion around the capacity by raising some questions (see point 5.).

4 Identify parallels and linkages between the two types of shocks (type 1 graph and type 2 graph).

- These two thorough analyses of the shocks and capacity of the District, can now be compared. Indeed, linkages and parallel might be relevant to better understand the shocks interactions, causes scheme and shared effects. Interactions between the two graphs can be discussed.
- The Steering committee and the health facility representatives will discuss and agree on these points together.
- **The facilitator** should (if it is not already the case) position the two graphs above each other, or side-by-side to allow an easy comparison. If relevant, some arrows can be added on the graphs to better explain dependencies or interactions, and effects from one shock to another, or from one causes to a shock, etc. However, he will make sure that the graphs remain readable, and consistent with each other.
- **The facilitator** can guide the discussion with some questions, here are some examples:
 - Was there an increase or decrease of new cases at the time you expected it?
 - How did different events (i.e. workload, rain, population movement, festivals, conflict etc.) impact new cases?
 - Do you see a concentration of seasonal events just before a peak of cases – if so what factors seem to be important and when do they concentrate?
 - Were there any health system activities or events that took place during the period that might explain any increases or decreases seen in the graph?
 - Was the scale of the increase/ decrease as high as you expected it to be?
 - Do you find anything unusual/ unexpected in your charts?

REPORT WRITING

If the time schedule allows it, the main results of the risk and capacity analysis should be added by the Project Manager to the report gathering the secondary and primary data's results performed previously. This report will then be used as a basis for the diagnosis workshop and for the diagnosis report.

DISTRICT'S THRESHOLDS SETTING

It has been observed that the planning activities are developed in a static way and are not always fitting the District's needs as they don't take into account the fluctuations that can affect the District overtime. Indeed, depending on the caseloads fluctuations, or the season for instance the needs and priorities of the District might not be the same. It is then necessary to take into account the District situation to define the best activities, and this is what the HSS planning method is doing here. Indeed, the method used during the planning stage is based on the definition of the caseload thresholds, and phases. The idea behind the thresholds is to have a "normal" phase, standing for a situation where the workload is supposed to be managed, and then some other phases/ situations that the health District might have to cope with along the year, based on the workload and its capacity. These thresholds define the level at which the District's way of working need to evolve and, in extreme situations where its capacity is not able to cope with the caseloads anymore, and need external support. Defining these various thresholds allow to offer tailored-made activities fitting better the needs and capacity of the District at every moment.

The Steering committee should meet with the Project Manager and the facilitator after the risk analysis to set the thresholds.

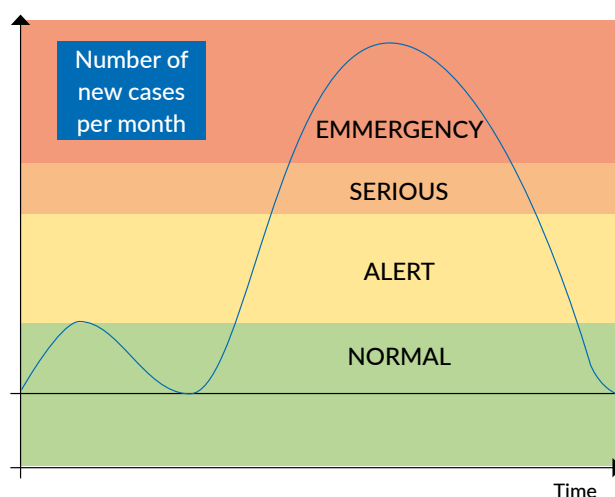
INFORMATION ABOUT THRESHOLDS

• Purpose and description

Thresholds are a number of monthly new cases regardless the diagnostic, and represent the point at which the District is overstretched beyond its capacity and requires action in order to cope with the situation. They take into account both the capacity and the workload of the health District: when the workload surpasses the capacity, this is the ideal value to set a threshold.

The thresholds system defined by Concern Worldwide, allows the District to prepare and cope with surges, thanks to a monitoring of the new cases and a comparison to established thresholds that are based on information gathered during the diagnosis. Based on Concern Worldwide's [5] definition, thresholds reflect the boundary between one phase and another, a phase being defined as how overstretched the District is. Four phases can be identified: normal, alert, serious and emergency (see Figure below). Thresholds are defined at the District level first, and HF should then be encouraged to define their own thresholds as well.

FIGURE 2: THRESHOLDS MONITORING OVER A PERIOD OF TIME [5]



The four phases described do not necessarily have to be defined. Indeed, if the District thinks that more or less phases should be defined, it is definitely possible. For instance if the caseloads chart shows several small peaks, this District will probably not need the same phases that one facing one very high peak. **The method is flexible** here. However, the **normal** should always be defined, as it will be the basis of the whole strategy. A description of these phases is presented in the table below.

TABLE 10: PHASES DEFINITION FOR DHMT [5]

PHASE	DESCRIPTION FOR THE DISTRICT HEALTH MANAGEMENT TEAM (DHMT)
NORMAL	When the DHMT feels they can handle their workload and have adequate resources to support appropriate functioning of all of the HFs in the District.
ALERT	When the DHMT begins to be overstretched due to additional needs from HFs but can handle the situation by reorganizing themselves to focus on key priorities with existing external support; this phase may entail a slight reduction in some functions that are carried out during normal times. During this phase, the DHMT should be able to access additional supplies easily and mobilize their own resources for additional supportive supervision, distribution of supplies and communication
SERIOUS	When the DHMT is overstretched and requires additional support from Regional level (and possibly national level) in order to appropriately support the HFs in the District; this is when reorganizing within the DHMT and mobilization of the DHMT's own resources are insufficient to handle the situation. The DHMT should be able to mobilize resources from the RHMT for staff deployment, increased supplies, mentoring and communication. The RHMT may request support from national drought or emergency bodies or partners to fulfill the needs.
EMERGENCY	When the DHMT is overstretched to the point where additional support is required from the Regional and National level, including national drought or emergency bodies as well as partners in order to ensure that a) the HFs in the District cope with exceptional demand for services and b) the population is able to access appropriate services in a timely manner.

• Monitoring and activities

In order to use effectively the thresholds, the total number of new cases of the month (regardless of the diagnostic) has to be monitored, and is then compared to the established thresholds. This will permit a monthly monitoring of the health situation of the District by the personnel. The frequency of comparison to thresholds can increase when upper thresholds are crossed (fortnightly or weekly). The crossing of thresholds into a higher phase will trigger actions that have been previously agreed with the health management team to ensure the District can handle the caseload (see planning step). On the contrary, when crossing a threshold into a lower phase, supportive activities will be phased down, whereby when there is a normal situation, the District returns to its normal way of functioning.

THRESHOLDS SETTING

• Definition of the normal phase

This sub-step aims to establish what a 'normal' or manageable caseload is, based on what the District feels they can handle without overstressing themselves or sacrificing quality of care. At the end of the discussion, a good estimation of the workload capacity should be defined and an approximate number of patients that can be seen in a day without being overstretched should be identified. The Steering committee will discuss several topics, guided by the facilitator. Results from the secondary and primary data collection should be used as a basis.

The **facilitator** will guide the discussion, and make sure all the themes and main questions are discussed in the following list [5].

1 Number of consultations per day

- How many patients are normally seen per day?
- Is this the same throughout the year?
 - Which months have more consultations per day?
 - Which months have fewer consultations per day?
 - What is the range (minimum/maximum) number of patients seen throughout the year?

2 Workload and capacity

- On a 'normal' day, how is the workload for the staff? Is it manageable? Is staff overstretched?
- During months with a high number of consultations per day, how is the workload? Is it manageable?
- Is the staff overstretched?
- What would be the maximum number of consultations that could be seen in a day?
- What factors affect whether the staff is able to handle the caseload arriving?

3 Overall

- What should be considered a normal and manageable workload in terms of total consultations per day?
- What should be considered a normal and manageable workload in terms of total consultations per month?
- What workload in terms of total consultations per month would be too much?

• Methods used

Depending on the situation of the District, two different methods are available to actually define the various thresholds. One must be chosen over the other based on the situation of the health facilities of the District. **In any case, the results of the risks and capacity analysis, the normal phase definition, the past experience of the District, as well as the secondary and primary information report should be used as a basis along the thresholds process. The questions presented above for the normal phase, can be used as inspiration and adapted by the facilitator to define the other thresholds.**

The facilitator should guide the whole process.

Method 1 - Based on the District's information

With this method, **thresholds are a number of monthly new cases.** They are defined based on the information received at the District about the status of all the health facilities. This method is recommended when no thresholds system is already set up at the health facility level. The information is compiled at the District level, and includes:

- Definition of the total monthly new cases for each month of the past years, accounting for new cases of all the health facilities.
- For each month look back on how did the District handle the situations, and compare it with the phases' definition presented above.
- Challenge the past years data, by identifying changes that could have an impact on the future's trends and District response capacity, for instance, new human resources, new equipment, etc. Also assessed whether it was a one-time event or if it is going to happen seasonally.
- Based on these assessments, and the normal phase defined earlier, set up the thresholds.

Method 2 - Based on the health facilities' information - Percentage assessment

Prerequisite: All the health facilities of the District have set their own thresholds already.

Preliminary check: With this method, **the thresholds are a percentage of health facilities being in a specific phase for the month.** The District thresholds fully depend on the thresholds of the health facilities. Before using this method, it shall be ensured that the information system and the communication between the health facilities and the District are efficient enough to allow a good functioning. Also the thresholds system (thresholds value, triggering system, communication lines, etc.) must be up and running at the facilities level.

This method is recommended when the thresholds system at the health facilities is running well.

TABLE 11: THRESHOLDS SETTING TOOL BASED ON HEALTH FACILITIES' PHASE

PHASE OF THE DISTRICT	MORE THAN % OF THE TOTAL NUMBER OF HEALTH FACILITIES IN THE SPECIFIC PHASE	
NORMAL	% of HF in normal phase
ALERT	% of HF in alert or serious phase
SERIOUS	% of HF in alert or serious phase
EMERGENCY	% of HF in serious or emergency phase

The thresholds set should reflect when the District feels overstretched according to the descriptions of each phase above. However, each District will need to try out the thresholds that have been decided to see if they feel appropriate in practice. Therefore, it is important that this is seen as a process that requires regular review and adjustment before the DHMT can feel confident that the thresholds reflect their capacity to manage the situation.

THRESHOLDS AT THE HEALTH FACILITY LEVEL

- The second method requests that the health facilities also define their own thresholds. This can take place after this step, but should happen soon to ensure a good functioning of the thresholds system.
- The Annex 16 described how to define thresholds at the health facilities.

REPORT WRITING

If the time schedule allows it, the main results of the District thresholds should be added to the report gathering the secondary and primary data's results performed previously. This report will then be used as a basis for the diagnosis workshop and for the diagnosis report.

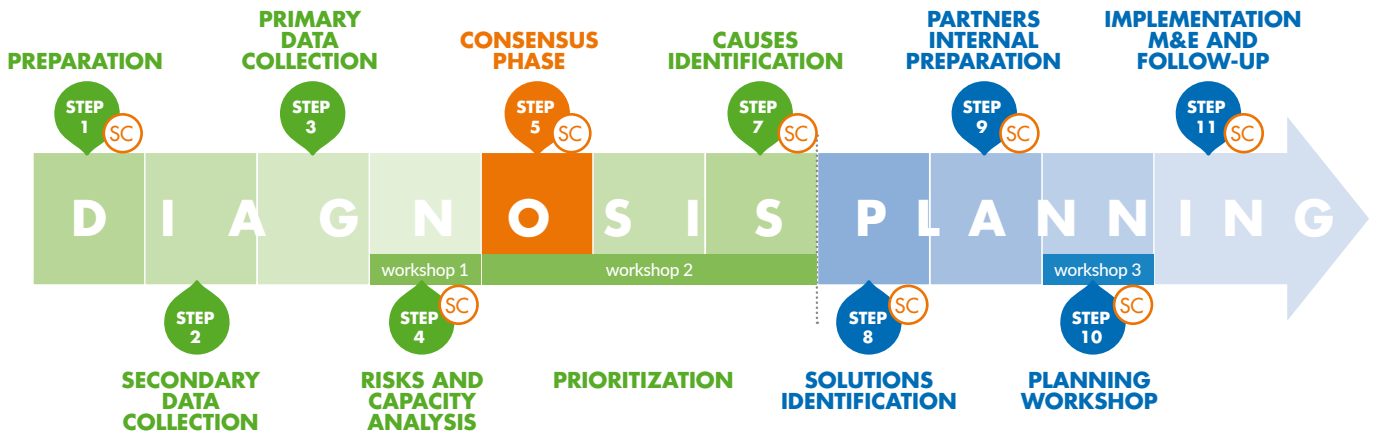


AT THE END
OF STEP 4

MAKE SURE THAT:

- The two graphs are representative of the District's situation regarding the shocks (type 1 and 2) calendar.
- A good understanding of the shocks nature, magnitude, causes, effects, and seasonality has been reached.
- The method used to define the District thresholds should take into account whether the Health Facilities (will) have their own thresholds.
- The District thresholds are representative of the District capacity and workload.

STEP 5: CONSENSUS PHASE



The previous steps allow a broad assessment of the health District situation. Secondary and primary data bring information regarding the context in which the District is, as well as information regarding the six building blocks. Then, the type 1 and type 2 shocks, and the present District capacity to cope with them have been analysed, to finally define District thresholds at the end of the previous step.

TABLE 12: FRAMEWORK OF THE STEP 5

STEP 5 – CONSENSUS PHASE	
OBJECTIVES	
<ul style="list-style-type: none"> Thoroughly assess the health system situation, and find its main strengths and weaknesses by analyzing each building block Cross check the findings of the previous steps with the results of the scoring 	
WHO IS INVOLVED	
<ul style="list-style-type: none"> Facilitator Project Manager Steering Committee Advocacy or policy advisor (when existing) Partners 	
METHODS	
<ul style="list-style-type: none"> Preparation of the workshop (3 days) <ul style="list-style-type: none"> Finalisation of the secondary and primary data collection analysis One day meeting to: <ul style="list-style-type: none"> Validate the analysis Include findings of the secondary and primary data collection in the matrix, as well as information about the presence and sustainability of external aid for relevant indicators Organise the workshop Workshop (2 days) <ul style="list-style-type: none"> Presentation of the results of the primary and secondary data collection, risks and capacity analysis Scoring of the indicators Visualization of the results Triangulation of the results with the findings from the previous steps 	
OUTCOMES	
<ul style="list-style-type: none"> Final analysis of the results of the secondary and primary information, and the risks and capacity analysis Thorough assessment of the health system, by scoring indicators of each building block Highlight of the main strengths and weaknesses of the health system 	

This step initiates the Workshop 2, and will allow all partners not only to participate in the data collection but also to comment and crosscheck the data collected during steps 2, 3 and 4.

PREPARATION PHASE

The partner in charge of supporting the MoH in leading the process will, together with the DHMT, send in advance to the Steering committee members a preliminary report on the primary and secondary data collection, and on the risk and capacity analysis, as well as thresholds setting. The Steering committee will be meeting to discuss and validate the reports. Findings will then be integrated in the indicator matrix.

The Steering committee will also prepare the workshop, which includes:

- **Review the priorities** of the workshop, the scope and process.
- Prepare the scoring exercise, by **pre-filling the matrix**. Guidelines on how to do it are available in the matrix itself (See Annex 17), and in the Annex 19.
 - **Review accuracy of indicators for each of the building blocks.**
 - **Fill in the matrix with all the findings of the secondary and primary data collection.** All results that could help the rating of the indicators, by bringing some qualitative background should be included in the adequate columns. When information really needs to be flagged, the cell has to be coloured in red, to make sure it will be accounted for during the scoring.
 - **Fill in the matrix with all the findings regarding the external aid.** This information will allow a better overview of the real capacity of the health system itself during the scoring.
- Review the agenda and the animation method.
- It is essential that one or more facilitators or resource people support the workshops and group meetings. Facilitators should be thoroughly familiar with the whole assessment tool and with RMNCH services but has to be regarded as neutral by the participants. The facilitator recruited by the supporting partner will lead the whole process.

PRESENTATION OF THE WORKSHOP AND TOOLS TO BE USED

WORKSHOP GENERAL PRESENTATION

Before getting into the exercise of using the indicator matrix, participants need to be introduced to the entire process and methodology used from the diagnosis to the planning phases. They should already be informed (by letter or mail) about the main steps and the time they will need to spend on this process. It is critical that they commit to participate to the planning phase as well.

The facilitator introduces the various sub-steps of the workshop, and shortly presents each of them. He will also introduce the schedule to be followed in the coming days. An indicative planning is described below.

TABLE 13: INDICATIVE SCHEDULE OF THE WORKSHOP 2 (1)

	DAY 1	DAY 2	DAY 3
MORNING	Step 5: Presentation of the main results & start indicators scoring	Step 5: Visualization of the results and discussions	Step 6: Analysis and prioritization
AFTERNOON	Step 5: Indicators scoring	Step 5: Triangulation of the results	Step 7: Causes identification

The Step 5 initiates the workshop.

MATRIX GENERAL PRESENTATION

The indicator Matrix or “self-assessment” tool will be used during the workshop. It allows open discussions with all relevant stakeholders. The tool is adapted from UNICEF’s framework of integration on the management of acute malnutrition (see Annex 1). The “self-assessment” tool includes components that were initially developed for three levels: national, District and community. The step-by-step approach has been developed in priority for the District level and will therefore focus solely on this level. The matrix (Annex 17) is made of the following components:

- User guidelines explaining how to use the matrix (1 tab)
- An indicator matrix for District level for each building block (6 tabs, A-F tabs)
- Visual tools to help summarise assessments findings for all pillars, and then more specifically for the key and shocks indicators (3 tabs, G-I tabs)
- A prioritization tool (1 tab, J tab)

The indicator matrix is developed to measure baseline and progress of the health system according to the 6 building blocks at the District level. Each of the building blocks is divided into pillars to better describe them, and each of these pillars is proposing a list of indicators to be used. The list is indicative and has to be modified according to the context.

In the Annex 18 you will find the exhaustive list of pillars by building blocks.

WORKSHOP 2 – PRESENTATION OF THE PREVIOUS RESULTS

The workshop should be attended by the Steering committee extended with other partners such as interested and informed members of the communities, service providers from the District specialized in different building blocks. Half a day is allocated to this exercise (see suggested schedule below).

TABLE 14: INDICATIVE SCHEDULE OF THE WORKSHOP 2 (2)

	DAY 1	DAY 2	DAY 3
MORNING	Step 5: Presentation of the main results & start indicators scoring	Step 5: Visualization of the results and discussions	Step 6: Analysis and prioritization
AFTERNOON	Step 5: Indicators scoring	Step 5: Triangulation of the results	Step 7: Causes identification

Community representatives and health system users should be included in the process

NOTE

Members of the Steering committee will present the results from the data collection and highlight preliminary conclusions emerging from these steps. A specific focus will be proposed for the community assessment element (SWOTs prepared with individual interviews/ FGD and validated by the community). The main findings of the risks and capacity analysis workshop are also presented, to allow the participants to keep in mind the stresses/shocks going on during the year.

Participants will be invited to shortly comment the findings.

WORKSHOP 2 – INDICATORS SCORING

Key stakeholders will then be invited to participate in the “scoring exercise”. The main purpose of this exercise is to mark the indicators of the matrix to assess the present state of the health system, following the building blocks structure. This will be the second part of the whole workshop, as suggested in the schedule below.

TABLE 15: INDICATIVE SCHEDULE OF THE WORKSHOP 2 (3)

	DAY 1	DAY 2	DAY 3
MORNING	Step 5: Presentation of the main results & start indicators scoring	Step 5: Visualization of the results and discussions	Step 6: Analysis and prioritization
AFTERNOON	Step 5: Indicators scoring	Step 5: Triangulation of the results	Step 7: Causes identification

GUIDE OF MATRIX UTILIZATION FOR THE SCORING

A presentation of the matrix's structure, logic is described below.

1) How to use the matrix for the scoring exercise

For each building block, a specific tab is available. Each tab is organized with the same structure, and has to be filled using the same approach. See Annex 17 and Annex 19 for detailed explanations.

2) Scoring of the indicators

Additional guidelines are presented here to explain how to score the indicators. This information is complementary to the ones provided about the matrix structure.

- **The indicator matrix was developed to allow an objective and quantitative rating.**

Within the indicator matrix, each block is detailed by **pillars** and provides normative guidance for the user. For each pillar, a set of internationally recognized indicators will permit to assess the level of integration and the implementation of RMNCH services within each building block and to identify the main bottlenecks. (Annex 18 describes the pillars by building block). These indicators will be marked. An example of the pillars constituting a building block is described below.

TABLE 16: EXAMPLE OF PILLARS FOR HUMAN RESOURCES

HUMAN RESOURCES	
9	Policies
10	Planning
11	Performance Management
12	Training and Education

For each indicator included in the tool, a range of possible scenarios is provided allowing for an objective and quantitative rating from the highest score to the lowest one:

- (3) the highest score is given for a scenario considered as **Highly Adequate** compared to a gold standard
- (2) for a scenario considered as **Adequate**
- (1) for a scenario considered as **Present but not adequate**
- (0) is given for a situation regarded as **Not adequate at all**

- **Rating process per small groups**

- Read and discuss the information described in the column "**Presence and sustainability of external aid**". The rating also has to be based on this information. It will help the partners to better evaluate the actual capacity of the District for this specific indicator. The colour code of this column, reflects the situation of the external aid, if the cell is red or even yellow, this point has to be flagged during the rating discussion.
- Read and discuss the information described in the column "**Results from secondary and primary data collection**". The rating has to be based on this information. It is paramount to take them into account.
- Based on the information presented just above, discuss the score for the indicator. **If people from the group disagree, the various arguments have to be written down** in the column "Comments on the discussions about the scoring". This will help assessing the score, and better understand the results. **Prior experience of using this kind of assessment tool suggests that it is important to capture these detailed qualitative remarks.**
- **Score the indicator.** Group members write their scoring in the matrix in the column "Participants' responses". Every participant's score has to be included in the columns, to show the opinions' diversity. If there are more than four participants in the group, additional columns can be inserted in the matrix. The matrix will then calculate the overall scores automatically.

The total score for each category will be aggregated and compared with the maximum possible score to yield a percentage rating. For the purposes of the overall report, scores are converted into quartiles (see table below). Items with scores falling in the lowest quartile are classified as: **Not adequate at all**. Scores falling into the next lowest quartile are classified as **Present but not adequate**, followed by **Adequate**, and **Highly adequate** for those in the third and fourth quartiles respectively.

TABLE 17: CONVERSION OF SCORES INTO QUARTILES AND COLOR-CODE

2.25 TO 3.0 (75% -100%)	Highly adequate
1.5 TO 2.24 (50%-74%)	Adequate
0.75 TO 1.49 (25%-49%)	Present but not adequate
0 TO 0.74 (0 %-24%)	Not adequate at all

FIGURE 3: EXAMPLE OF THE MATRIX (SERVICE DELIVERY TAB)

SERVICE DELIVERY - Health system assessment tool														
Building Block	Reference indicator	Specifications	Very satisfactory	Satisfactory	Existing but not satisfactory	Not satisfactory at all	External aid	Results from secondary and primary data collection	Participants' responses			Average scores	Comments on the discussions about the scoring (disagreement, debates, etc.)	
									3	2	1			0
16. Availability and continuity of care	16.1. % of HC for which essential services in the continuum of reproductive, maternal, newborn and child health are available	RWNC essential care services: Family Planning, pre-natal consultations, childbirth with presence of qualified staff (midwife, nurse or doctor), 2 postnatal consultations preventive child consultations (growth monitoring, immunization and preventive treatment), care for major child diseases including SAM	Yes, 80-100% of HFs apply the continuum of care recommendations	Yes, 50-79% of HFs apply the continuum of care recommendations	Yes, but less than 50% of HFs apply the continuum of care recommendations	No, less than 50% of HFs apply the continuum of care recommendations	<p>Definitions:</p> <p>Support: supporting the MoH in achieving this element; participation is at least 50%.</p> <p>Subsidy: the activity directly or partners' participation is above 50%.</p> <p>Short term: aid planned for less than 18 months with uncertainty of renewal.</p> <p>Long term: aid planned for more than 18 months.</p>		1	2	3	2	2.0	Strong disagreements between the participants
	16.2 SAM management for children under 5 is integrated in a single circuit	From screening to treatment	Yes, SAM is integrated, from screening to treatment	Yes, SAM is integrated but screening and treatment are insufficient	Yes, SAM is integrated but screening and treatment are rarely done	No, SAM is not integrated	No aid		2	3	2	2	2.3	All participants agreed on this indicator
	16.3 Existence of a referral system between the different levels of the healthcare system	National referral system strategy implemented and works well	Yes, the system exists, is implemented and works well	Yes, it exists but it does not work systematically	Yes, it exists but it does not work	No, there is no referral system in place	Actors substitute for the HD – short term		3	1	1	2	1.8	
	16.4 Communities can access RWNC services at all times (on-call services system)	Opening hours allow a regular access and there is an on-call service system	Yes, it exists in 80-100% of health areas	Yes, it exists in 50-79% of health areas	Yes, it exists in 25-49% of health areas	No, it only exists in less than 25% of the health areas	Actors substitute for the HD – long term		1	2	3	2	2.0	

FACILITATION OF THE SCORING EXERCISE

• Explanations of the scoring exercise

The Steering committee should provide on-going oversight, direction and coordination of the self-assessment through the workshop. The scoring exercise has to be thoroughly explained to the partners either by the Steering committee or by the facilitator. An example will be presented to make sure it is well understood by the attendants.

• Facilitation of the workshop (adapted from [6])

As stated before, one or more facilitators should animate the workshops and group meetings.

- **Divide participants into small groups** that can work either sequentially or simultaneously to reach consensus on a subset of items. There is no optimal number of participants, nevertheless there should not be more than 30 people in the same room and sub thematic groups of 5 people max should be created for the exercise. While doing that, remember that some participants may not be familiar with certain aspects of the basic package of health services, others may be more specialised in dealing with a specific building block (for example the District pharmacist is likely to be the best person for the medical products building block). Moreover participating in broad discussions of all items included in this self-assessment tool would be highly time-consuming.
- **Allocate one group per pillar.** If experts are present, they should be put on the pillar related to their specialty. Depending on how the workshop evolves, the facilitator can mix group, give additional pillars to groups, etc. One group shouldn't rate more than about 60 items.
- Make sure that **feedback and discussion** of the **findings** takes place among all key stakeholders, especially when assessment is conducted by only a subset of meeting participants. This will be necessary to meet the objective of informing and **building consensus among all stakeholders.**
- **Circulate among the smaller groups,** help to clarify the meaning of particular items and answer questions.
- **Apply the principles** of impartiality, and collaboration.
- **Encourage the participants to use the “Results from secondary and primary data collection” and “Presence and sustainability of external aid” columns in the indicator matrix** to inform the discussion.
- The facilitator can also explain how the composite scores for each aspect can be compiled and the findings summarized in the assessment report.
- The table below describes some items to be kept in mind by the facilitator while leading the sessions.

TABLE 18: NOT TO DO DURING THE WORKSHOP

NOT TO DO
It is not advisable to administer the assessment as a “questionnaire” to be completed by individual informants. It is important that groups of informants discuss together the assessment items.
Persons who are not technically qualified to assess a given item or experiences in this particular District should be asked NOT to score the item to reduce the risk that someone who is poorly informed will score a given assessment item.
Avoid power imbalance within the groups. Make sure all the participants are free to participate to the exercise and are not influenced in their notation by someone (such as a manager/ authority).

The major advantage of a self-assessment approach is that **it engages all partners in a shared learning experience.** Facilitators may help to speed up the assessment and make the findings more comparable but **it is important that they do not interfere with the process of self-discovery** among District stakeholders. The advocacy advisor, if existing, can provide as much as possible neutral information on policy related bottlenecks (on whether the policy is planned or exists, has been adopted, etc.), in liaison with technical colleagues. Self-assessment can lead to a genuine desire to significantly improve the health system and management of certain diseases.

IMPORTANT POINTS TO KEEP IN MIND WHEN SCORING THE INDICATORS, TO AVOID POTENTIAL BIAS

- The final results depend on the opinion of the assessors. It is therefore essential to include **all relevant stakeholders**. Ideally, these are HS specialists, RMNCH program managers, M&E specialists, technical and financial partners, etc. Therefore a proper mapping of actors prior to the assessment is advised. This will limit the risk of biased results. **Nevertheless experience has shown that offering people to rate their own area of responsibility could lead to a lack of objectivity.**
- The organization of the groups should take into account the necessity to have potential “challengers” in each group but should also be careful with potential power imbalance (lower staff not feeling confident to contradict the hierarchy).
- The primary and secondary data collection results are made available to inform discussions and reduce the risk related to the lack of objectivity. **It is essential to encourage triangulation of the rating with the “Results from secondary and primary data collection” and “Presence and sustainability of external aid”** columns that have been prepared prior to the workshop.
- **The more varied the involved (informed) respondents are**, the lower the risk of bias in the end results.
- If one indicator is not applicable: it should be omitted from the scoring process and the reasons for doing so recorded.
- Blank pages should be distributed to **capture qualitative remarks** or provided for additional assessment items.
- **The insertion or deletion of rows is not recommended** as this may lead to errors in the formulae used to sum the scores and color-code the results. Instead of deleting an item, it should be skipped so that it does not affect the final scores.

WORKSHOP 2 - VISUALIZATION OF THE MAIN FINDINGS

The second day of the workshop starts with the visualization of the results of the scoring exercise of day 1 (see suggested schedule below).

TABLE 19: INDICATIVE SCHEDULE OF THE WORKSHOP 2 (4)

	DAY 1	DAY 2	DAY 3
MORNING	Step 5: Presentation of the main results & start indicators scoring	Step 5: Visualization of the results and discussions	Step 6: Analysis and prioritization
AFTERNOON	Step 5: Indicators scoring	Step 5: Triangulation of the results	Step 7: Causes identification

PREPARATION OF THE RESULTS VISUALIZATION

Either the Steering committee or the supporting partner together with the facilitator, has worked overnight to clean and compile all the results of the scoring exercise in one single matrix. All the ratings and comments of each group have been included in the matrix. Therefore, all the results can be visualized.

PRESENTATION OF THE TOOL

When the indicators have been scored, visualization tools automatically present the findings through color-codes and diagrams. There are three tabs for visualization (tabs G, H, I):

- **“Key Indicators Results”:** the scores of the key indicators of each building block are presented here with a histogram using the same color code.
- **“Shocks Indicators Results”:** shows the results that are concerned by the preparation and response to type 1 and to type 2 shocks. A radar diagram describes the results.
- **“Global Results”:** summarizes all results of the 6 building blocks with radar diagrams, and give an overview of all the results.

The results are to be presented to all the attendants, and provide a good overview of the main findings of the scoring exercise. Examples of results visualization are available below.

FIGURE 4: KEY INDICATORS RESULTS – VISUALIZATION



FIGURE 5: SHOCKS INDICATORS RESULTS - VISUALIZATION

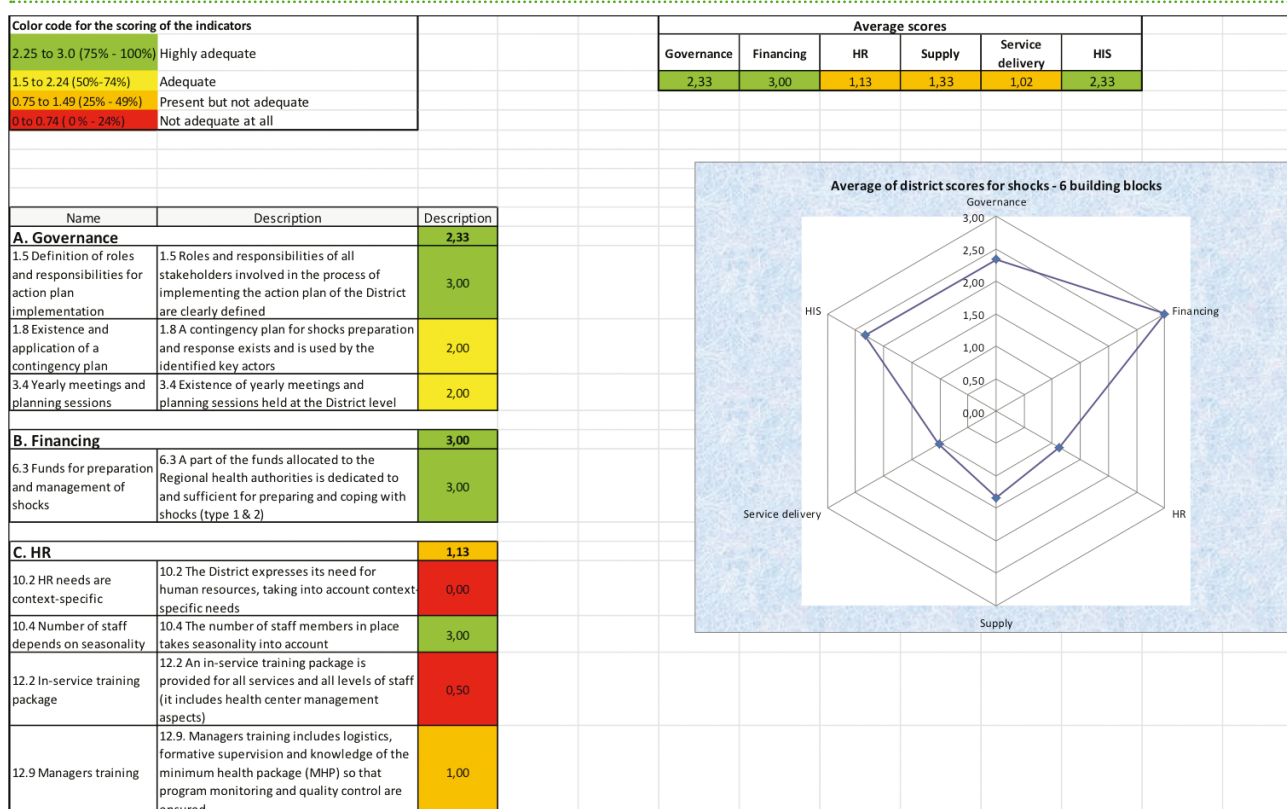
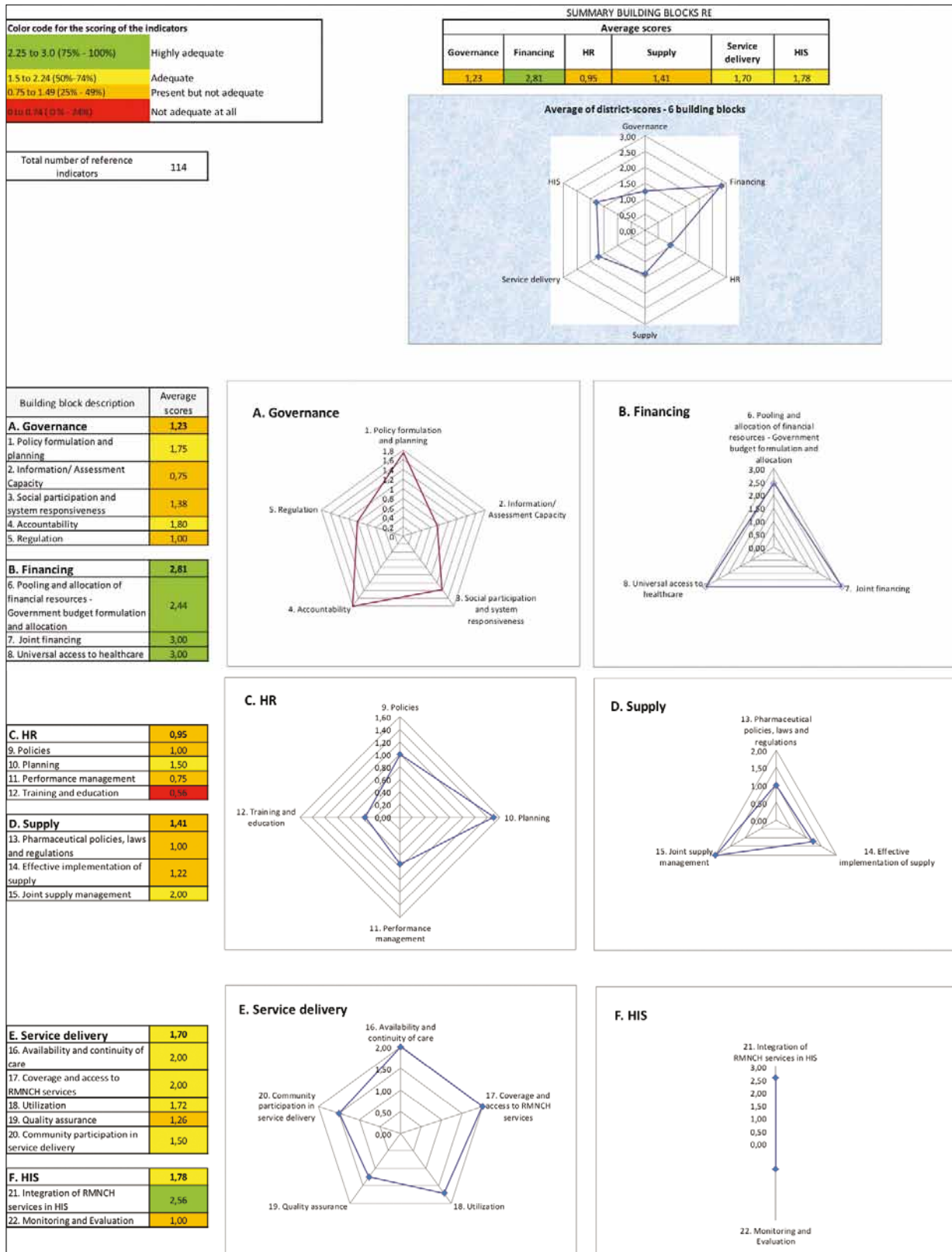


FIGURE 6: GLOBAL INDICATORS RESULTS – VISUALIZATION



RESULTS VISUALIZATION

The Steering committee together with the facilitator will present the results of the scoring exercise. They will make sure that the three visualization tabs are shown and explained. It is expected to discuss and comment the results with the attendants, and raise critical results.

The facilitator will make sure that the results are discussed and commented with the attendants and that critical results are highlighted. Further analysis of the results will be done in the afternoon.

WORKSHOP 2 - TRIANGULATION OF THE RESULTS

After all the items have been scored and visualized the fourth part of the workshop will take place. A plenary session of at least 3 hours should be organized to review the findings, and reach consensus about them. It should be attended by the Steering committee, the facilitator(s), and the partners present during the scoring. Also, key stakeholders that have not been able to participate in earlier meetings, or in the scoring exercise, should be encouraged to join this final plenary session. This session will end day 2.

TABLE 20: INDICATIVE SCHEDULE OF THE WORKSHOP 2 (4)

	DAY 1	DAY 2	DAY 3
MORNING	Step 5: Presentation of the main results & start indicators scoring	Step 5: Visualization of the results and discussions	Step 6: Analysis and prioritization
AFTERNOON	Step 5: Indicators scoring	Step 5: Triangulation of the results	Step 7: Causes identification

TRIANGULATION CONCEPT

This is called **the triangulation phase** where the findings of the matrix are compared to the findings of the secondary data collection (step 2), primary data collection (step 3), and risks and capacity analysis (step 4). This should already have been done during the scoring exercise itself. However, this additional comparison will ensure that the whole process leads to a diagnosis that reflects the reality, and provide coherent and reliable results. If the triangulation shows that results are not coherent a discussion should take place in order to identify why and find a consensus. **It is to keep in mind that alone the quantitative matrix findings are insufficient, and that qualitative information is also paramount.**

At this stage it is ESSENTIAL to make sure that the results of this rating exercise are matching with the summary results of the step 2, 3 and 4.

NOTE

FACILITATION OF THE TRIANGULATION

The facilitator will guide the session. First, the key indicators will be triangulated, followed by the shocks indicators, and then the other ones. The facilitator will invite the rapporteur of each group to present the results obtained during the scoring exercise. The indicators' overall scores will be presented. Scores allocated by key individuals may be presented only if there are important differences of opinion. The main points of the discussions that took place during the scoring can be mentioned if relevant. Also, information regarding the primary and secondary data, SWOT developed as well as the external aid is mentioned to back-up the discussions. Discussions about these findings and results are then taking place between the various partners, in order to agree on a final scoring.

Once a consensus is reached and **the matrix findings are matching the qualitative data collected in the previous steps** (SWOTs and risk analysis), the main points discussed during the scoring and triangulation exercises are included in the column "Comments on the discussions about the scoring", by the facilitator.

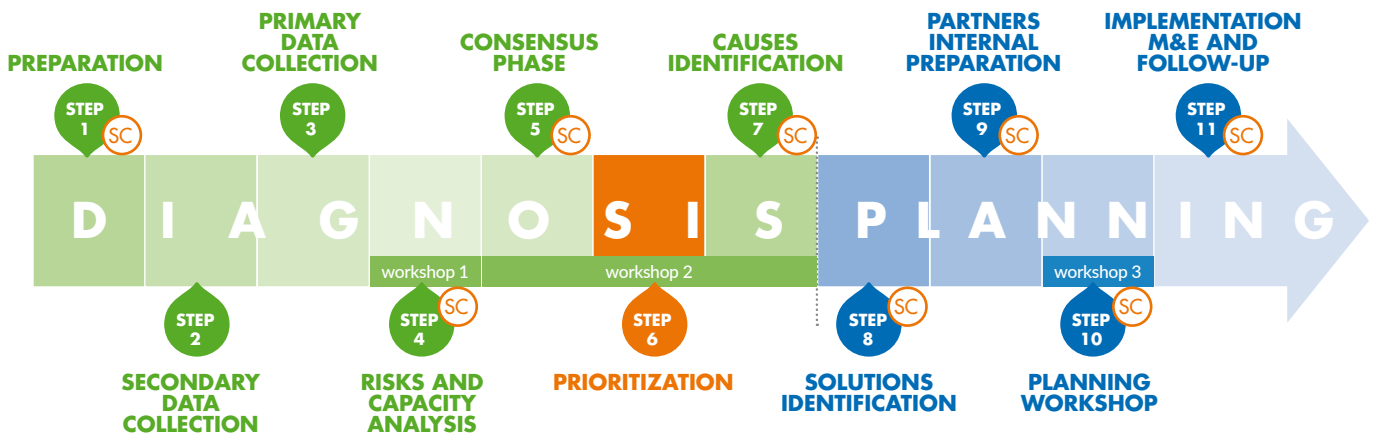


AT THE END OF STEP 5

MAKE SURE THAT:

- During the scoring exercise, the secondary and primary information are used to realistically score the indicators.
- All key stakeholders of the health system are involved in the scoring exercise (including communities, healthcare users, etc.).
- The groups' composition and expertise allow a realistic scoring of the indicators (involvement of key actors in regards to the scored topics, avoidance of power imbalance).
- Open and fruitful discussions about the scoring results take place among the participants, since the triangulation of the results is a very critical point.

STEP 6: COMMON PRIORITIZATION



The previous step allowed a deep assessment of the health system's pillars, and highlighted its main strengths and weaknesses. Indeed, for each building block, indicators have been assessed and rated by small groups. The results have then been discussed with the whole assembly and cross-checked with the secondary and primary data, and the results of the risks and capacity analysis. From now on, indicators will be qualified as bottlenecks, since only the indicators with a low score are still considered.

TABLE 21: FRAMEWORK OF STEP 6

STEP 6 – PRIORITIZATION	
OBJECTIVES	<ul style="list-style-type: none"> Identify the main weaknesses of the health system on which actions can be taken to improve them Prioritize these bottlenecks according to specific criteria
WHO IS INVOLVED	<ul style="list-style-type: none"> Facilitator Project Manager Steering Committee Advocacy or policy advisor (when existing) Partners
METHODS	<ul style="list-style-type: none"> Preparation of the workshop <ul style="list-style-type: none"> Pre-identification of prioritization criteria Workshop <ul style="list-style-type: none"> Define prioritization criteria to assess the main bottlenecks Prioritize the main bottlenecks
OUTCOMES	<ul style="list-style-type: none"> Prioritization criteria List of the main weaknesses of the health system List of prioritized bottlenecks of the health system

This Step is the fifth sub-step of the Workshop 2, and takes place directly after the end of step 5.

TABLE 22: INDICATIVE SCHEDULE OF THE WORKSHOP 2 (5)

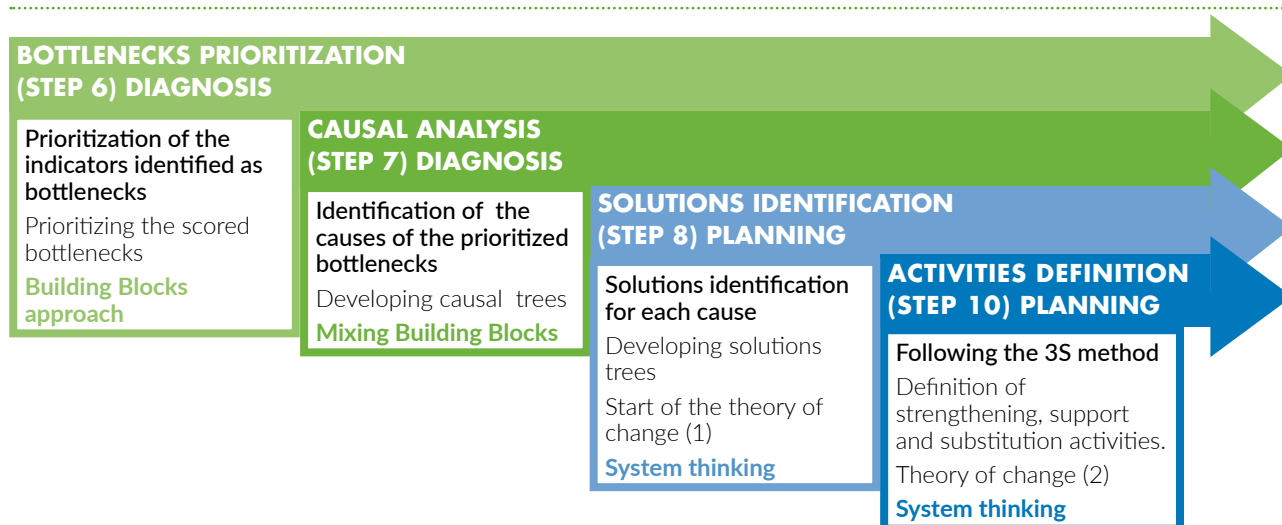
	DAY 1	DAY 2	DAY 3
MORNING	Step 5: Presentation of the main results & start indicators scoring	Step 5: Visualization of the results and discussions	Step 6: Analysis and prioritization
AFTERNOON	Step 5: Indicators scoring	Step 5: Triangulation of the results	Step 7: Causes identification

Data collected during steps 2, 3, 4 and 5 have, along the process, been analysed and triangulated by the group of partners. At the end of step 5, the group has reach consensus on the main assessment findings and a report will be written. *Annex 20 proposes a report format.*

At this stage there is a need to reassess whether or not the group of partners still represents the essential actors involved in the health system at District level (stakeholders from the national level can also be invited). Some organisations might not have been very much involved in the diagnosis phase but are interested in taking part in the prioritization and planning phase. These actors should be encouraged to join in this prioritization meeting.

WORKSHOP 2 – PRIORITIZATION GENERAL APPROACH

This step is initiating a longer process, which describes how after the bottlenecks prioritization, a causal analysis is performed, followed by solutions identifications, and concluded by the definition of activities that ensures the improvement of the prioritized bottlenecks. The theory of change is included in the process to ensure a reliable structure in the approach from the causal analysis up to the activities definition. *An overview of the process is available in Annex 21.*

FIGURE 7: PROCESS FROM DIAGNOSIS TO PLANNING STAGES

The main idea of this prioritization process is to identify the weaknesses of the health system, show the dysfunctions, and at the end identify the ones that we can improve. The prioritization criteria as well as the scoring must be carried out with this perspective.

PREPARATION OF THE PRIORITIZATION SESSION

The Steering committee should gather between the end of the step 5 and the beginning of this session, to carry out two tasks:

- Prepare the prioritization criteria that will be proposed to the partners and discussed during the workshop. These criteria will be used to evaluate the selected bottlenecks and prioritize them.
- Include in the prioritization tab of the matrix, the indicators that obtained a low score in the indicator scoring (under 0.74 – red), it includes keys indicators, shocks ones, and the other ones as well.

PRESENTATION OF THE TOOL

A tool is available in the matrix to perform the bottlenecks prioritization (Prioritization tab of the matrix, Annex 17). Each low score bottleneck is rated according to the prioritization criteria. The following rating references are used:

- Low priority – (1)
- Medium priority – (2)
- High priority – (3)

At the end of the process, bottlenecks with the highest scores will be of high priority. *Further explanations are available in the Annexes 17 and 19.*

FIGURE 8: EXAMPLE OF THE PRIORITIZATION TAB FROM THE MATRIX

Prioritization of reference indicators									
Building Block	Reference indicator	Specifications	Comments on the discussions about the scoring (disagreement, debate, etc.)	Average indicator scores	TO BE FILLED IN during the workshop				Total
					Prioritization criteria				
KEY INDICATORS									
Governance									
1. Policy formulation and planning	1.1 National protocols, tools and guidelines are disseminated by the government in all health services	All national protocols are available at all times in every health facility of the district		0,5	1	1	1	2	5
1. Policy formulation and planning	1.2 An implementation strategy for the health sector strategic plan is established at District level within the framework of a national plan	The main health issues are taken into account in the annual operational plan of the District		0,6	2	2	3	3	10
1. Policy formulation and planning	1.4 Existence of a coordination mechanism established at District level to facilitate joint planning, supervision, financing and monitoring of the various health services	Actions are taken to ensure that all RMNCH and nutrition services are included in the plans. Through a sector-specific approach, the basket funding for health (common funding pool to which partners in the sector-specific approach contribute) enables to allocate funds according to government priorities and programs.		0,7	3	1	1	3	8

DETAILS ON THE PRIORITIZATION PROCESS

- **Final validation of the workshop findings.** This step is just to formalise the agreement reached at the end of Step 5, and remind the main results to the participants (NOTE: it should be avoided to spend too much time in discussion that already happened at the end of Step 5).
- **Definition of prioritization criteria:** These criteria should be prepared in advance by the Steering committee and proposed to the wider group for comments and validation (examples of criteria: size of the problem, seriousness of the problem, availability of the response, availability of the funds, feasibility in the next 5 years, cost-effectiveness, coherence, priority for the community, etc.). These criteria should be relevant and specific to the present situation.

The **facilitator** or the Steering committee will present the criteria pre-identified by the Steering committee. The discussion with the other partners about the criteria should be encouraged. The facilitator will then write the final criteria in the prioritization tab of the matrix (Annex 17).

- **Prioritization of the findings:** The prioritization criteria defined just before will be used to prioritize the indicators. Each criterion must be scored in order to allow a good assessment of the indicators' actual priority.

The **facilitator** will guide the process, and make sure that all the indicators with a low score (under 0.74 – red) are discussed and prioritized. First, the bottlenecks related to the key indicators category will be addressed, then the shocks indicators, and finally the regular ones. Discussions between the attendants should be allowed.

- **The final picture with priorities should be agreed by all partners.**

At the end of the session, the **facilitator** will summarize the main results of the prioritization, and make sure that everybody agrees.

Since the key indicators can be a proxy for more global issues, they must be analyzed thoroughly. The consequences implied by these indicators shall be considered and known when doing the prioritization.

NOTE

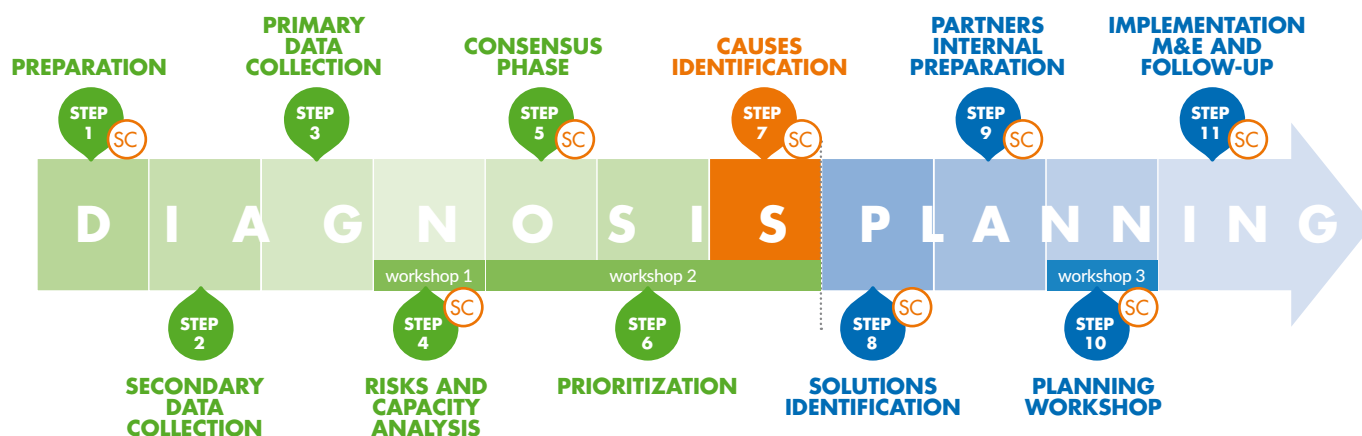


AT THE END OF STEP 6

MAKE SURE THAT:

- The criteria defined allow a realistic and smart prioritization of the bottlenecks.
- All the indicators with low scores have been included in the prioritization process.
- During the prioritization scoring discussions have taken place and all key actors could participate.

STEP 7: CAUSES IDENTIFICATION



During the previous step, the main bottlenecks and weaknesses of the health system have been prioritized with specific criteria. Hence, an overview of the main weaknesses to be addressed is available. Before going into the heart of the planning the prioritized bottlenecks have to be better looked at and the root causes of the issues have to be identified.

TABLE 23: FRAMEWORK OF STEP 7

STEP 7 – CAUSES IDENTIFICATION	
OBJECTIVES	<ul style="list-style-type: none"> Describe the causes of the prioritized bottlenecks
WHO IS INVOLVED	<ul style="list-style-type: none"> Facilitator Project Manager Steering Committee Advocacy or policy advisor (when existing) Partners
METHODS	<ul style="list-style-type: none"> Workshop <ul style="list-style-type: none"> Small group work: pre-identify causes of each prioritized bottleneck Plenary session: Building of the causal trees
OUTCOMES	<ul style="list-style-type: none"> Interrelated causal trees of the prioritized bottlenecks Identification of the immediate, underlying, and basic causes of the prioritized bottlenecks Team appointed responsible for the diagnosis report

This is the last part of the workshop 2, and it should be organized over a half a day session.

TABLE 24: INDICATIVE SCHEDULE OF THE WORKSHOP 2 (6)

	DAY 1	DAY 2	DAY 3
MORNING	Step 5: Presentation of the main results & start indicators scoring	Step 5: Visualization of the results and discussions	Step 6: Analysis and prioritization
AFTERNOON	Step 5: Indicators scoring	Step 5: Triangulation of the results	Step 7: Causes identification

This is the moment where the building blocks approach will be abandoned in order to engage in system thinking. Indeed, it is no longer required to think about the building blocks as isolated blocks, but they should be seen as inter-connected blocks, which constantly have an impact on each other. The interactions between them should be put forward, and they should be considered as a whole. This change takes place now, because several bottlenecks will be found closely interrelated and share the same cause, and therefore perhaps a similar solution.

WORKSHOP 2 - IDENTIFY CAUSES – BUILDING OF THE CAUSAL TREE

The causes identification (building of the causal trees), is divided in two different phases, a group work (about 1.5h) aiming at preparing the next sub-step, which will be the plenary session (about 2.5h), during which the causal trees will be agreed on. Before starting the group work, a short description and explanation of the Annex 22 should be done in plenary, by the facilitator. The Annex provides an example of causal tree that should help the participant to understand the process. Also a causal tree format is provided to help the participants build one.

The **Annex 22** has to be used to build the causal tree. This Annex is a tool designed to support the participants to build causal trees. It includes:

- Guidelines about the process
- A causal tree format to be used during the workshop, to guide the participants
- An example of causal tree related to HSS

NOTE

SMALL GROUP WORK

Small groups of max 5 people are set by the facilitator. It is very important to have a mix of expertise and profiles within the groups. Indeed, since the system thinking approach is now used, a diversity of points of view is necessary. Each group will work on all the prioritized bottlenecks, and will identify as a group the major causes of each of them.

The **facilitator** will remind the various types of causes to the attendants before they start (also see figure further below):

- Immediate causes, likely related to service delivery
- Underlying causes, likely related to HR, supply and HIS
- Basic causes, likely related to financing and governance

Several causes and types of causes can be identified for one bottleneck. Each identified cause will be written on colour cards provided by the facilitator. A representative is appointed for every group.



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PLENARY SESSION

The objective of the plenary session is to **build and describe causal trees for all the prioritized bottlenecks**. The method of the causal tree is common, and used in very different situations. After discussions between all the attendants, consensus shall be reached on the causes' description. Each prioritized bottleneck will not have its own tree; trees can be related to each other, and merge together. One root cause can be responsible for several bottlenecks.

The causes identification should take place the following way:

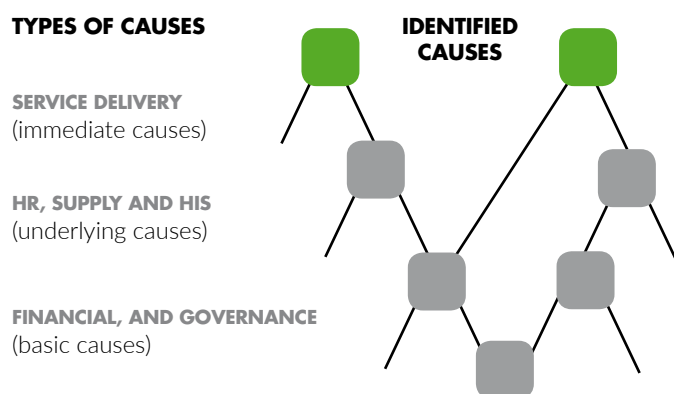
- First a prioritized bottleneck from the service delivery building block is selected. The causal tree of this bottleneck is built thanks to the prior work performed in the group work.

The **facilitator** gathers all the cards and the representatives of each group are invited to present and explain the findings. After discussion, the identified causes of each bottleneck are written on cards and put on the wall by the facilitator.
- Bottleneck prioritized in the other building blocks will most probably be found in the underlying and basic causes of the causal tree designed for the service delivery bottlenecks.
- If the same causes have been identified for another bottleneck, they can already be included in the tree, and mapped.
- Once the tree on one service delivery bottleneck is agreed, another service delivery prioritized bottleneck is selected, and the same exercise is performed. Links with the previous tree will be looked at.

When an identified cause encompasses **shocks aspects** that are not explicitly mentioned in the cause's title; the cause shall be marked with a (*) to remember that there is a shock aspect to be accounted for. For instance, one identified cause for supply shortages could be "impossibility of the suppliers to deliver the ordered supplies in time at this period of the year". If this impossibility is due to floods during the rainy season that damage the access roads to the health facility, a (*) will be put on this cause, to correctly account for the floods' consequences (shock) in the next steps.

Facilitator tips:

- The causal analysis starts with the service delivery prioritized bottlenecks, then HR, supply, HIS, and finally the financing and governance ones.
- Make sure that the identified causes are specific and not too generic.
- When hanging the cards on the wall, the facilitator should keep in mind the causes' hierarchy structure (immediate, underlying and basic) to ensure a certain vertical structure in the causal trees, and facilitate the merging of the causes.
- Linkages between each levels and each cause need to be drawn clearly
- Do not hesitate to draw on the advocacy/policy advisor for support on unpacking causal chains until governance and policies.
- Make sure the Annex 22 is well understood and used by the participants during the workshop.

FIGURE 9: CAUSES HIERARCHY**IMPORTANT**

Going back to root causes of the bottlenecks may look like a backward. It can give the impression that the work done in trying to be very specific in identifying the weaknesses of the health system at District level is deconstructed. However it is not the case. This step is absolutely essential to make sure the planning phase is not only constructed on micro element (not taking into account major structural bottlenecks to be addressed) but has gone through details as much as the wider picture and made links between all the causes and consequences.

WRITING OF THE REPORT

The writing of this report is the completion of the workshop 2, and of the diagnosis phase. It includes all the information collected during this phase (secondary, primary, risks and capacity analysis) as well as the results of the workshop 2 (indicators scoring, and causes identifications).

At the end of the session, the facilitator together with the Project Manager will decide who will be in charge of drafting the report of the diagnosis workshop and its results. This should then be distributed for reviews and comments to a broad range of stakeholders prior to its finalization. The Steering committee will validate the final report. Once completed, this process should help considerably identify the next steps, and should provide a bridge between the assessment findings and the planning.

**AT THE END OF STEP 7****MAKE SURE THAT:**

- The building blocks thinking is abandoned, and the system thinking is now used.
- The order in which the prioritized bottlenecks' causes are mapped is: service delivery, HR, supply, HIS, financing and governance.
- Interrelations between the bottlenecks' causes are well identified, and mapped on the causal trees (the facilitator should make sure of that).
- The shocks aspects are well identified on the causal tree thanks to a (*).

3

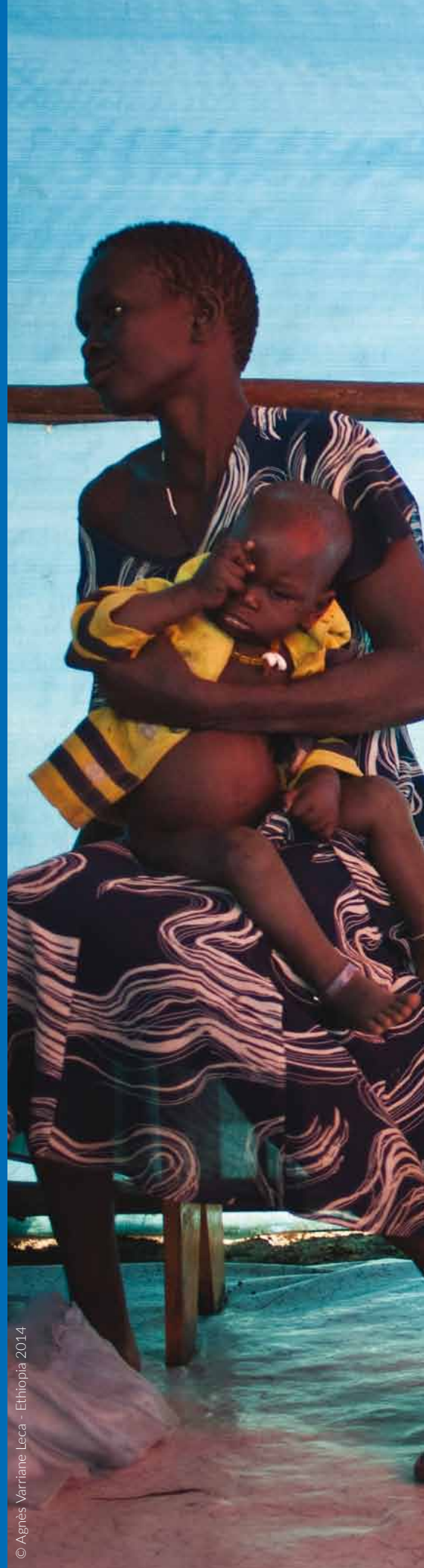
PLANNING

STEP 8: SOLUTIONS IDENTIFICATION

STEP 9: PARTNERS INTERNAL PREPARATION

STEP 10: PLANNING WORKSHOP

STEP 11: IMPLEMENTATION, M&E AND FOLLOW-UP

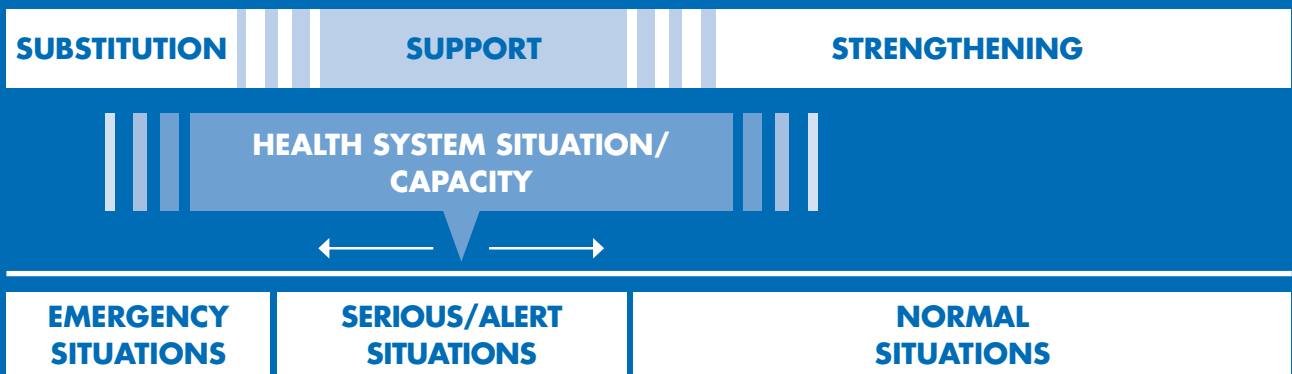


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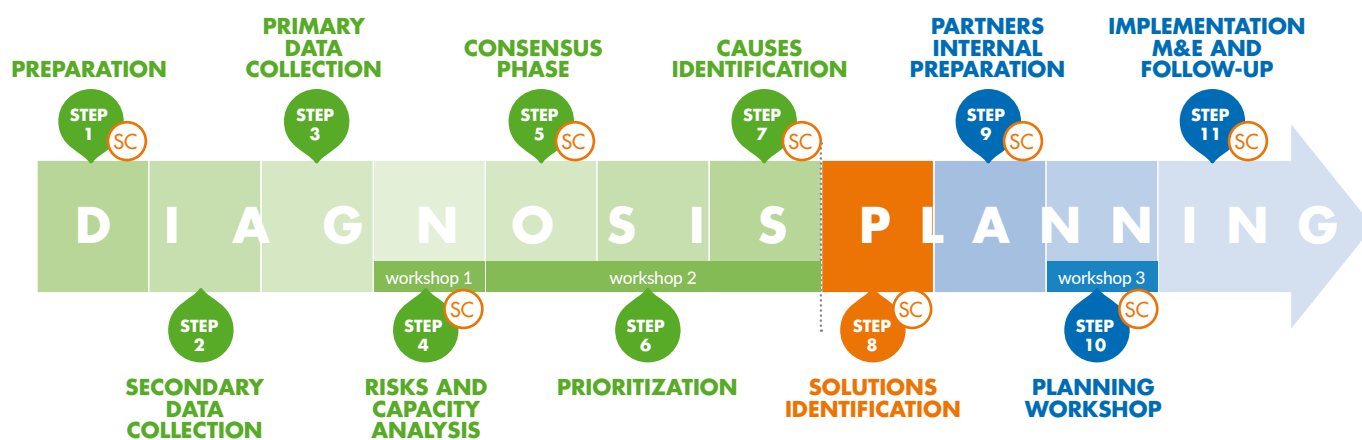
PLANNING



.....

ARTICULATION OF SUBSTITUTION, SUPPORT AND STRENGTHENING ACTIVITIES

STEP 8: SOLUTIONS IDENTIFICATION



The previous step has ended the diagnosis phase. Indeed, the secondary and primary data collected, as well as the risks and capacity analysis have allowed a thorough assessment of the health system situation. The causes identification of the prioritized bottlenecks, which was done through causal trees, will now be the starting point of the planning phase that is being initiated with this step.

TABLE 25: FRAMEWORK OF THE STEP 8

STEP 8 – SOLUTIONS IDENTIFICATION	
OBJECTIVES	<ul style="list-style-type: none"> Identify specific solutions for each of the highlighted issues Transform the identified solutions into SMART objectives
WHO IS INVOLVED	<ul style="list-style-type: none"> Project Manager Steering committee Advocacy or policy advisor (when existing) Facilitator Partners
METHODS	<ul style="list-style-type: none"> MoH and the supporting partner prepare the solution tree Steering committee session <ul style="list-style-type: none"> Finalize the identified solutions Define SMART 'HSS objectives'
OUTCOMES	<ul style="list-style-type: none"> Solutions trees List of 'HSS objectives' which addresses the identified causes

The planning phase starts with this step of solutions identification. The main objective is to **identify specific solutions for each of the identified issues**, by building a solutions tree and define SMART objectives. The step is divided in two phases, a preparation session with the MoH and the supporting partner (half a day) to draft the solutions trees, and a Steering committee session (half a day) to finalize the solutions identifications, and define HSS objectives.

DRAFTING OF THE SOLUTIONS TREES

This session should be attended by the DHMT and the supporting partner. A briefing about the process to build the solutions trees will also be presented by the facilitator, with the help of the Annex 23. The Annex provides an example of a solutions tree that should help the participants to understand the process. Also a solutions tree format is provided to help the participants build one.

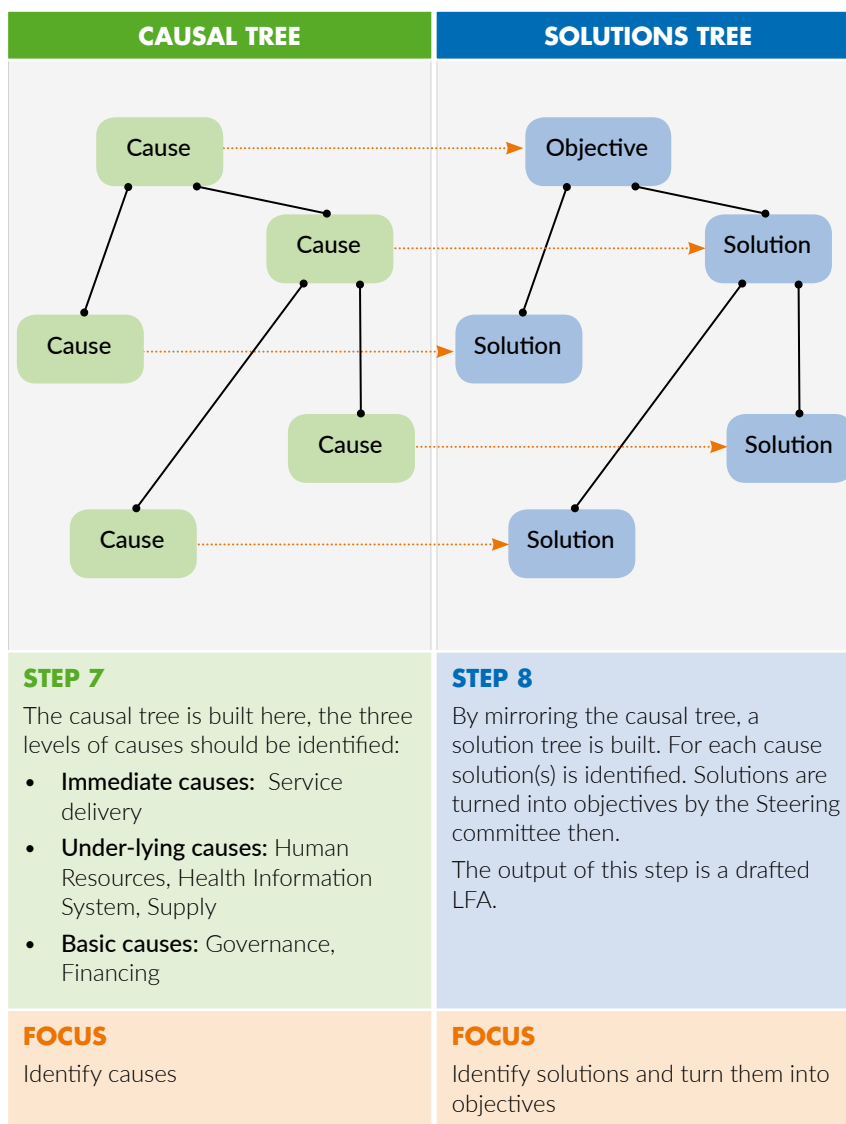
Then, the solutions identification can start. The main idea is to mirror the causal tree defined during the previous step, and use its structure to identify as a group the main solutions. Solutions for immediate, underlying and basic causes shall be highlighted. The format presented in the figure below can be used as a framework.

The **Annex 23** has to be used to build the solutions tree. This Annex is a tool designed to support the participants to build solutions trees. It includes:

- Guidelines about the process
- A solutions tree format to be used during the workshop, to guide the participants
- An example of solutions tree related to HSS

NOTE

FIGURE 10: PARALLEL CAUSAL AND SOLUTIONS TREES (ANNEX 21)



Solutions can be identified at the District level, but also at the regional and national ones when relevant. For instance, global budget allocations, or HR repartition in the national plan will depend on the national level. It is therefore important to think about the solutions with this perspective.

It is highly recommended to have advocacy advisors taking part in this process. They should be involved in the solutions identification, and provide inputs regarding possible advocacy solutions. Also, a good understanding of the political and governance framework, as well as a spread network can be useful to help the attendants to better build the solutions trees.

In some situations, the group may face some difficulties in finding adequate, feasible or specific solutions, this is not an issue. However, the facilitator should then support and guide the group to define precise enough solutions. They will be finalized by the Steering committee later on.

Facilitator tips:

- Use the Annex 23 as a basis to explain and illustrate the solutions tree and the process around it.
- Solutions identification will follow the same structure than the causal trees. First, solutions for the immediate causes will be defined, then for the underlying ones and finally for the basic ones. The causal trees are mirrored.
- Hang on the wall the causal trees, and build the solutions trees in parallel to it on the same wall.
- One solution can be related to various causes, and one cause can have various solutions.
- Make sure that the identified solutions are specific and not too generic.

STEERING COMMITTEE SESSION

- After the preparation, the Steering committee meets to finalize the solutions trees. The Steering committee defines and eventually fine-tunes specific solutions to best address the main causes of the causal tree.
- Afterwards, based on the highlighted solutions, the Steering committee identifies 'HSS objectives', which will permit to implement the identified solutions. The Steering committee prepares global and specific SMART objectives (See box below). **The facilitator** should assist the Steering committee in this task, and check that the concept of SMART objective is well understood by everybody (if necessary, a briefing can be organized at the beginning of the session). Moreover, he will make sure that all the objectives are actually SMART.
- When finalized, the objectives are shared with the partners. Once completed, this process should help considerably in identifying the next steps, and should provide a bridge between the assessment of the findings and the strategic planning.

SMART OBJECTIVES

SPECIFIC: identifies concrete events or actions that will take place.

MEASURABLE: quantifies the amount of resources, activity, or change to be expended and achieved.

APPROPRIATE: logically relates to the overall problem statement and desired effects of the program.

REALISTIC: Provides a realistic dimension that can be achieved with available resources and plans for implementation.

TIME-BASED: specifies expected time for the objective to be achieved.

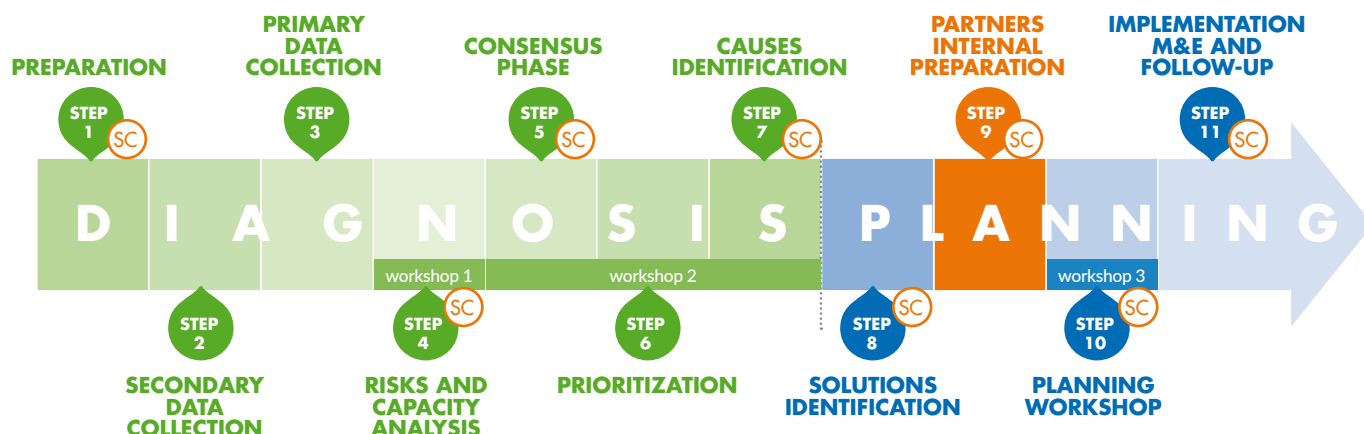


AT THE END
OF STEP 8

MAKE SURE THAT:

- The system thinking replaced the building block thinking that was used in the previous steps.
- Every cause has a solution or a set of solutions.
- The 'HSS objectives' are SMART.
- When defining HSS objectives, preparation and response to shocks have been taken into account.

STEP 9: PARTNERS INTERNAL PREPARATION



The previous step was focused on the building of the solutions trees, which then led to the definition of HSS objectives. These objectives will permit to tackle all the prioritized bottlenecks and weaknesses of the health system, and make sure that all partners do now share common objectives.

TABLE 26: FRAMEWORK OF THE STEP 9

STEP 9 – PARTNERS INTERNAL PREPARATION	
OBJECTIVES	
<ul style="list-style-type: none"> Ensure that all partners have the same level of understanding on: <ul style="list-style-type: none"> Results from the diagnosis Solutions identified The planning phase The role they will play Have the partners prepared for the planning workshop 	
WHO IS INVOLVED	
<ul style="list-style-type: none"> Project Manager Steering committee Advocacy or policy advisor (when existing) Partners Facilitator (if needed) 	
METHODS	
<ul style="list-style-type: none"> Information briefing to the partners <ul style="list-style-type: none"> Brief description of the main results from the diagnosis Explanation of the planning step (3S method, thresholds, etc.) Partners internal preparation <ul style="list-style-type: none"> Each partner pre-identifies activities and roles they could play in the planning 	
OUTCOMES	
<ul style="list-style-type: none"> Good overview of the results of the diagnosis phase and of the solutions identification Good understanding from the partners of the proposed planning method Pre-identification of activities (including advocacy ones), and roles for the planning 	

This step is divided in two sub-steps.

- First, the Steering committee will provide information to stakeholders **on the diagnosis and planning phases**, including information about the main results of the diagnosis, the solutions trees as well as the HSS objectives, and the framework of the 3S method. This information briefing **should be organised fairly soon after Step 8** to avoid losing momentum on the issue.
- Then, partners should prepare the planning workshop internally, and pre-identify the activities their organisation could be carrying out to contribute to the achievement of the HSS objectives set.

Do not forget about the “process oriented approach”, a key notion presented earlier in this manual. If processes for planning are already in place at District level, efforts should be made to merge this step to these mechanisms. For instance, the information session could be included in the planning and coordination meetings if they are already scheduled in the area of intervention.

NOTE

Ideally we would suggest to organise the session at the end of the Step 8 session.

INFORMATION BRIEFING TO PARTNERS

As mentioned above, it would be ideal to organize the meeting at the end of the Step 8 session. However, if it is not possible several options are available to organize this briefing:

- The Steering committee, the DHMT, the supporting partner or the facilitator organizes an ad-hoc meeting with all the partners specifically for this briefing.
- The regular coordination meetings are used, and the Steering committee or the facilitator briefs the whole group during these regular meetings.
- Steering committee members or the facilitator/ HSS Project Manager visits each partner to brief them individually.

The purpose of this briefing is to **inform the group on the next steps and make sure the key documents are made available and are understood**. The following points are addressed:

- A consolidated report of the diagnosis phase's results, including District's thresholds, prioritization, causal and solutions identification, as well as identified HSS objectives is presented and disseminated.
- **The conceptual frame of the 3S method**, detailing the method structure (method presented in Step 10, and threshold system in Step 4), and the number of years the planning will focus on. Also, the tools proposed to partners for the internal preparation phase shall be revised accordingly.

If the briefing takes place with all partners, a role-play can be organized to concretely explain the 3S method. The facilitator will have to organize it, and make sure that each participant understands well the process of activities definition. This activity will ensure a good efficiency during the planning workshop.

IMPORTANT

A printed copy of all the key documents provided during the briefing should be brought at the workshop 3. It is expected that each participant brings its own set of documents, including:

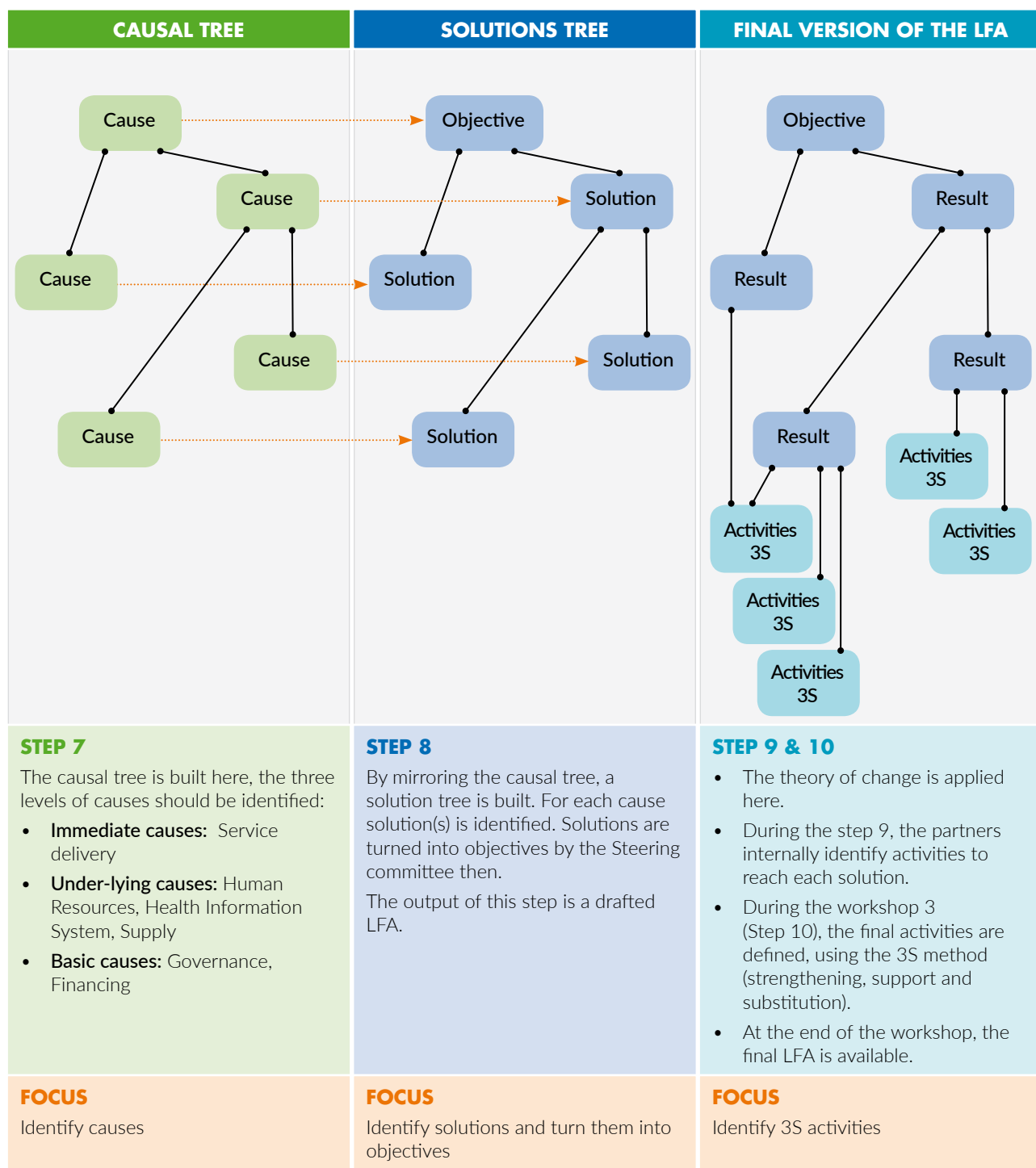
- The report of the results of the previous steps
- The conceptual framework of the 3S method

PARTNERS' INTERNAL PREPARATION

Each partner will have to prepare internally the planning workshop. The internal preparation phase will have the objective to pre-identify the potential role that each partner could have in the future District health plan.

- The partners will develop a proposition regarding its contribution to the overall health system strengthening strategy on the basis of the **HSS objectives** prioritized during the earlier meeting
- Partners should work on a multiyear strategy
- The **3S method** will be proposed to each partner as a guide for planning (see Step 10)
- To help the partners documents are available:
 - A logical framework (See below, and Annex 21), that should be used to better understand the theory of change.
 - A tool to define the 3S activities, on a multi-year model, and for the various phases (Annex 24).
 - A LFA toolbox (See Annex 25), providing key points of the process, format and examples (related to the examples used for the causal and solutions trees). It shows what type of results should be achieved by the end of the workshop.

FIGURE 11: THEORY OF CHANGE AND LFA (ANNEX 21)



During the preliminary/ internal phase, as mentioned before each partner will identify which HSS objectives (highlighted during the diagnosis phase) its organization will focus on. Each partner will also identify what they would expect from other partners. Therefore bilateral discussions can be initiated during the preparation phase to facilitate the articulation and synergy between actors.

It is important to recognize from the start that all actors will have an important role to play. Community leaders and representatives should be included in the process. Each of the “partners” planning will have to be articulated with the other partner’s planning. It is an absolute precondition for a successful health system strengthening strategy.

ADVOCACY STRATEGY DEVELOPMENT

Each partner or group of partners should during the workshop preparation process, draft an advocacy strategy, based on the diagnosis results and the activities that will be implemented during the planning phase. These drafts will be shared and discussed during the workshop.

ADVOCACY - SOME KEY POINTS

Advocacy is a process that aims to influence strategic frameworks and policies, or the way they are elaborated and implemented. It targets those in power in order to make changes happen, using a range of strategies and tactics such as lobbying, communication, technical advice or research.

An advocacy strategy relies on a thorough initial analysis (not specific to advocacy), varies in every context and can be developed both at national and local level (District, province).

Taking a strategic approach to advocacy requires following a step by step methodology that will help:

- To pinpoint the problem and identify the change needed to achieve **(WHAT change do we want to bring about)**
- To identify the individuals and organizations that are able to make that change **(WHO)**
- To provide guidance on how to influence them **(HOW can you bring them to the desired change)**

The purpose of developing an advocacy strategy is to ensure that plans are well thought through, commonly understood and adequately resourced before launching advocacy initiatives.

The various steps of the HSS method have yielded substantial material, which can be used to develop advocacy priorities. While many elements have already been identified along the process, it is vital that drafted advocacy priorities are thought through at this stage, since they will be identified in the next step (planning). If advocacy activities are then developed without a clear view of what the advocacy priorities should be, planning will be considerably complicated. This advocacy approach should later be understood and adopted by the organizations participating in the development of HSS diagnosis strategic documents.

The advocacy elements are the following and should rely on:

- 1 **Context analysis:** It should draw especially on the findings from steps 2, 3, 6, 7 and 8. The HSS objectives defined above should absolutely be taken into account.
- 2 **Definition of objectives:** There should be one change objective and no more than 3 sub-objectives. They should present clearly where the priorities are from an advocacy perspective, and where it adequately supports the delivery of the planning objectives. Not all the building blocks should be systematically included – to be realistic, policies and financing are often identified as priorities, along with human resources.
- 3 **Stakeholders mapping, target and ally definition:** this relies on the result of the 4W mapping.
- 3 **Tactics:** actors who will be involved in the strategy need to agree on which kind of advocacy each partner is ready to support (technical assistance, lobbying, campaigning etc.). A local authority, a donor or a UN agency (and not just NGOs) can agree to take the responsibility to influence a specific, stakeholder at the national level.
- 5 **Message, time & places:** to be developed in liaison with local and national level stakeholders.

For more details on how to develop an advocacy strategy, have a look at [7] and Annex 26.

Tools for the internal preparation phase are proposed in Annexes 21, 24 and 25.

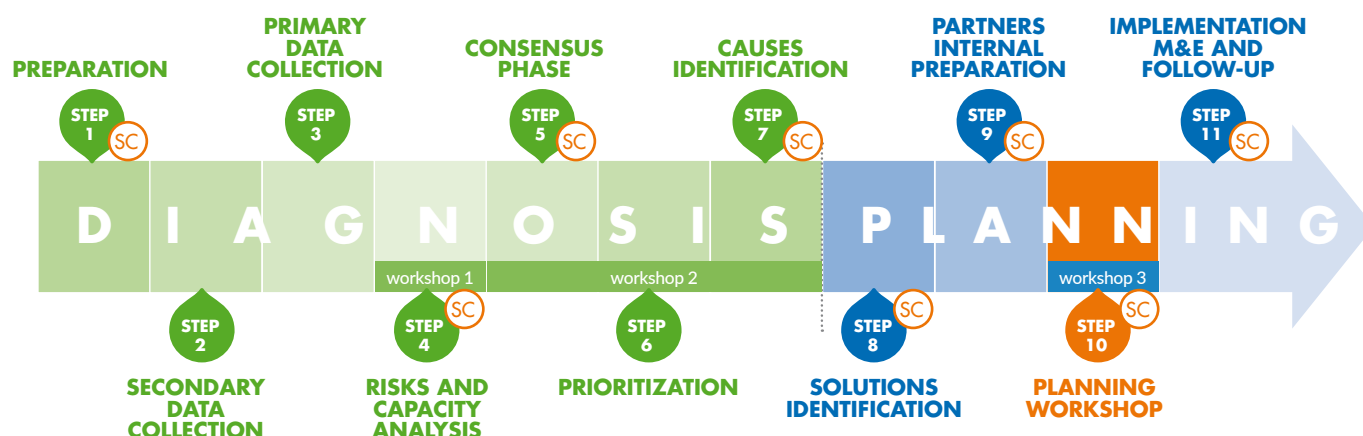


AT THE END
OF STEP 9

MAKE SURE THAT:

- If planning processes are already in place in the District, efforts are made to incorporate them in the HSS steps.
- All actors are involved in the process and it is acknowledged that they have an important role to play, especially Community leaders and representatives.
- The 3S method is well understood and mastered by all the key partners.
- All key partners are well prepared for the workshop, and have identified activities, roles & responsibilities and an advocacy strategy.

STEP 10: PLANNING WORKSHOP



The previous step gave the opportunity to the partners to get prepared for the planning workshop. Hence, each partner should arrive to this workshop with pre-identified activities and roles that they could perform to achieve the HSS objectives.

TABLE 27: FRAMEWORK OF THE STEP 10

STEP 10 – PARTNERS INTERNAL PREPARATION	
OBJECTIVES	
<ul style="list-style-type: none"> Develop a multi-annual plan with all the partners Identify strengthening, support, and substitution activities Describe the modalities of each activity (roles and responsibilities, costs estimations) 	
WHO IS INVOLVED	
<ul style="list-style-type: none"> Facilitator Project Manager Steering committee Advocacy or policy advisor (when existing) Partners 	
METHODS	
<ul style="list-style-type: none"> Workshop preparation by the Steering committee (1 day) Workshop 3 (2-3 days) <ul style="list-style-type: none"> Presentation of the pre-identified activities and roles of the partners Discussions between the partners to define activities to fulfil all the HSS objectives Development of a plan with 3S activities for each objective, with roles and responsibilities Costs estimation of each activity Writing the report of the results of the planning workshop (2-3 days) 	
OUTCOMES	
<ul style="list-style-type: none"> A District HSS multi-annual plan developed by all the partners, which includes: <ul style="list-style-type: none"> Strengthening, support and substitution activities, for each phase, and for all the HSS objectives Activities defined for the District, regional and national levels Roles, responsibilities, and costs estimations for all the (sets of) activities Finalized diagnosis and planning report 	

The planning workshop will allow all partners not only to develop their own planning for the years to come but also to ensure synergy between the different actors present in the District with a common goal to strengthen the system, and improve its resilience.

The Steering committee will make sure:

- The workshop scope and process are clearly stated
- One or more facilitators will support the workshops. Facilitators should be thoroughly familiar with the 3S method and with RMNCH services. They must be considered as **neutral** by the participants.

GUIDANCE FOR PLANNING – STRENGTHENING, SUPPORT AND SUBSTITUTION: THE 3S METHOD (R2S IN FRENCH)

The aim of the approach is to support the development of **comprehensive strategies** that are not only aiming at **strengthening the health system (long-term perspective)** but do also take into account what needs to be done in the **short-term to meet the immediate needs** of the population and what specific actions are to be taken to **prepare and respond to all types of stresses/shocks**.

It can only be used if a diagnosis has been performed before. This diagnosis will highlight the actual capacity of the health system in a District to propose services that are in line with national/international standards.

The explanations of the global approach and the 3S method described below have been provided to the participants in Step 9. Each of them should come to the workshop with a printed version of all the key documents (See Step 9). Additional printed versions will be available during the workshop.



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DEFINITIONS

Before going into the details of the 3S method, it is paramount that the three dimensions of the method i.e. strengthening, support and substitution are well understood by all the participants. The confusion between support and strengthening happens quite often since the perception of the difference between the two concepts can be slim. *“It is important to distinguish activities that support the health system, from ones that strengthen the health system. Supporting the health system can include any activity that improves services, from distributing mosquito nets to procuring medicines. These activities improve outcomes primarily by increasing inputs. Strengthening the health system is accomplished by more comprehensive changes to performance drivers such as policies and regulations, organizational structures, and relationships across the health system to motivate changes in behaviour and/or allow more effective use of resources to improve multiple health services.”* [8]

- **Strengthening:** The strengthening strategy is built on the initial diagnosis presented above and focuses on the performance drivers of the system (see figure below). *“Quite simply, health system strengthening is about permanently making the system function better, not just filling gaps or supporting the system to produce better short-term outcomes.”* [8]

For instance, when it comes to the improvement of the health personnel’s training system, strengthening activities could be to assist the District in planning, finding means and developing mechanisms to deliver regular refresh training to the health professionals of the District. It could also be to develop a university program including the adequate trainings, and articulate it with the present available trainings.

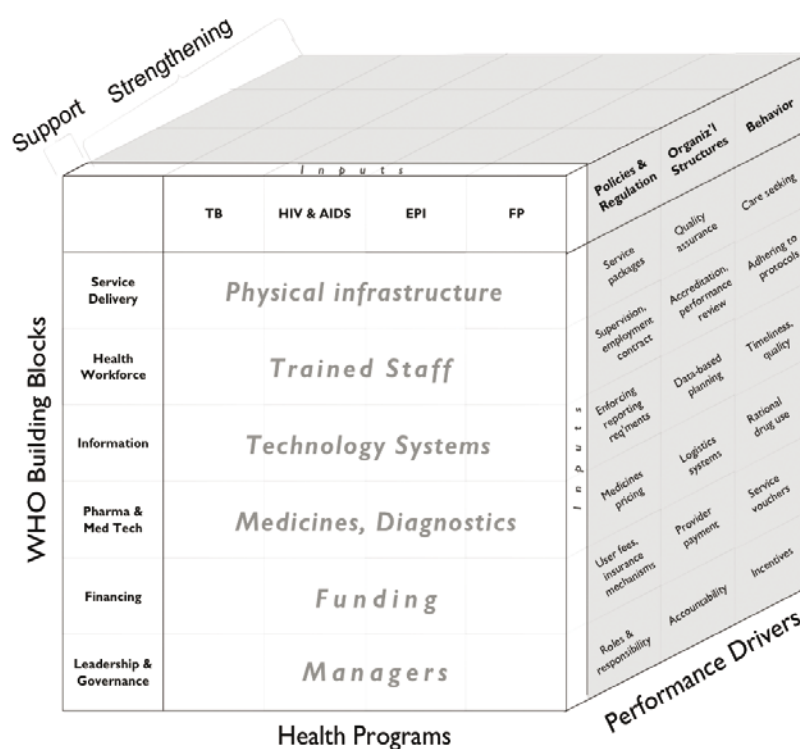
This strategy provides benefits beyond a single disease or issue and is **complementary to the support activities**. Strengthening activities require a longer-term investment, and more active commitment from the health authorities, but ultimately produce results that may lead to the end of support and make the system stronger.

- **Support:** This strategy can include any activity that improves the system’s functionality primarily by increasing inputs [8]. Support is most of the time focused on one specific issue. It offers a short term response on pre-identified key elements of the 6 building blocks. It should not be sustained, since it aims at meeting the immediate needs of the facility. It is based on the health system’s initial capacity to manage a basic package, and addresses specific inputs that the local health system can momentarily not handle. Support is supposed to decrease over time, since facility’s capacity is supposed to increase thanks to the strengthening efforts/ activities.

If we keep the example proposed above on improving the health personnel training system, support activities would be to have partners directly training the health professionals. Here, there is no sustainability ensured, and only the inputs of the human resources building block are impacted.

Another way to see the difference between strengthening and supporting activities is to see them through the health system cube [8]. As the cube shows, an intervention to strengthen the system goes beyond providing inputs (it must have depth) and applies to more than one health program (it must have breadth). Whereas, support interventions only act on the inputs of the building blocks, and doesn't go deep into the issue.

FIGURE 12: HEALTH SYSTEM CUBE [8]



- Substitution:** This strategy goes beyond the support. In specific pre agreed situations partners are entirely taking the place of the health authorities, and perform most tasks by themselves. It offers short-term solutions to improve the immediate access to good quality services, and is mainly focused on one specific issue or spike. Substitution activities will mostly take place in case of important stresses/shocks undergone by the health system.

The support, strengthening and substitution strategies are complementary, and are accordingly articulated together for each phase. The idea is to arrange activities of support (short-term) together with activities of strengthening (long-term) to better respond to the needs of the District. When the situation requires it, activities can go beyond support, and become substitution. For each phase (normal, alert, serious and emergency), substitution, support and strengthening activities are defined, and balanced according to the needs, this way shocks can be handled without destabilizing the other strategies established for the normal phase. The HSS objectives highlighted during the diagnosis, and the assessment of the health system's capacity, should help the actors involved, to take responsibility of activities based on to their skills and competencies.

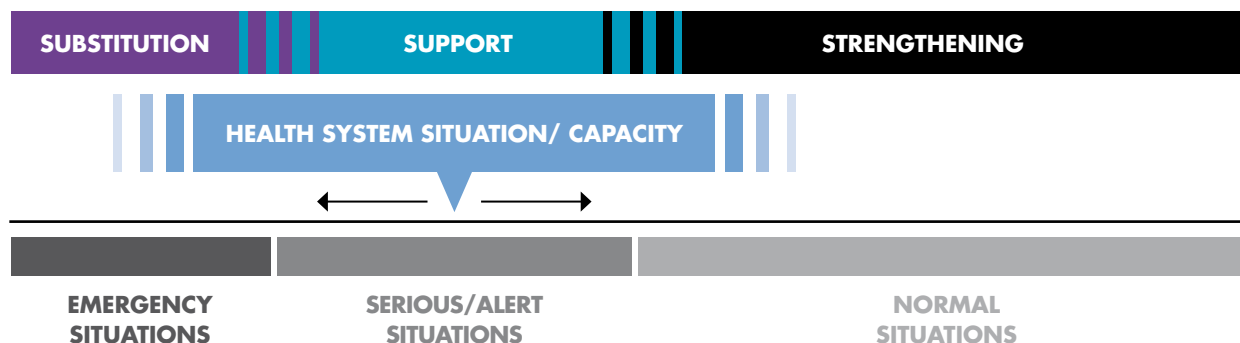
IS IT STRENGTHENING, SUPPORT OR SUBSTITUTION ACTIVITY?

- **Distribution of measles vaccination sets to health facilities by external partners.**
 - Support, because inputs are directly provided (vaccines) by external actors, to ensure a short-term solution.
- **Vaccination of the population against measles by an external partner.**
 - Substitution, because the external partner totally takes the place of the local actor, and performs the vaccination instead of him.
- **Elaboration of a national plan embedded in the health policy strategy to ensure the availability and timely distribution of vaccines against the main killing diseases in the health Districts.**
 - Strengthening, because it tackles organizational and policy constraints, should provide a sustainable solution, and is adapted to the context of the country.
- **Provide mobile phones to improve the communication between the District and the HF.**
 - Support, because inputs are directly provided (mobile phones) by external actors, to ensure a short-term solution.
- **External actors ensure that the communication between HF and District takes place, by directly transmitting the messages.**
 - Support, because inputs are directly provided (communication) by external actors.
- **Develop a District plan to ensure a good communication between the HF and the District (including financial aspects, provision of materials, training of the personnel, etc.).**
 - Strengthening, because, it addresses all aspects to make a sustainable change (financial, HIS, supply) which is tailored-made for the District situation.

GLOBAL APPROACH

The sketch below presents the contiguum of activities, and shows how all types of activities overlap one on the other in a non-linear way.

FIGURE 13: ARTICULATION OF SUBSTITUTION, SUPPORT AND STRENGTHENING ACTIVITIES



The proposed model presented above should help articulating interventions that will make sure the health system capacity matches the expected needs. Activities of strengthening, support and substitution are defined and articulated together in order to perform health system strengthening, but also prepare to and cope with type 1 & 2 shocks. Depending on the health system's capacity, and the situation where it is standing between emergency, serious, alert and normal situations, activities of substitution, support or strengthening are implemented.

The model will help identifying what is required to do in order to:

- 1 Make sure the population has an improved access to available and adequate health services in the short-term (support approach)
- 2 Strengthen the system to ensure access and availability on the longer run (strengthening approach)
- 3 Respond to stresses/shocks of all types (substitution approach)

3S METHOD

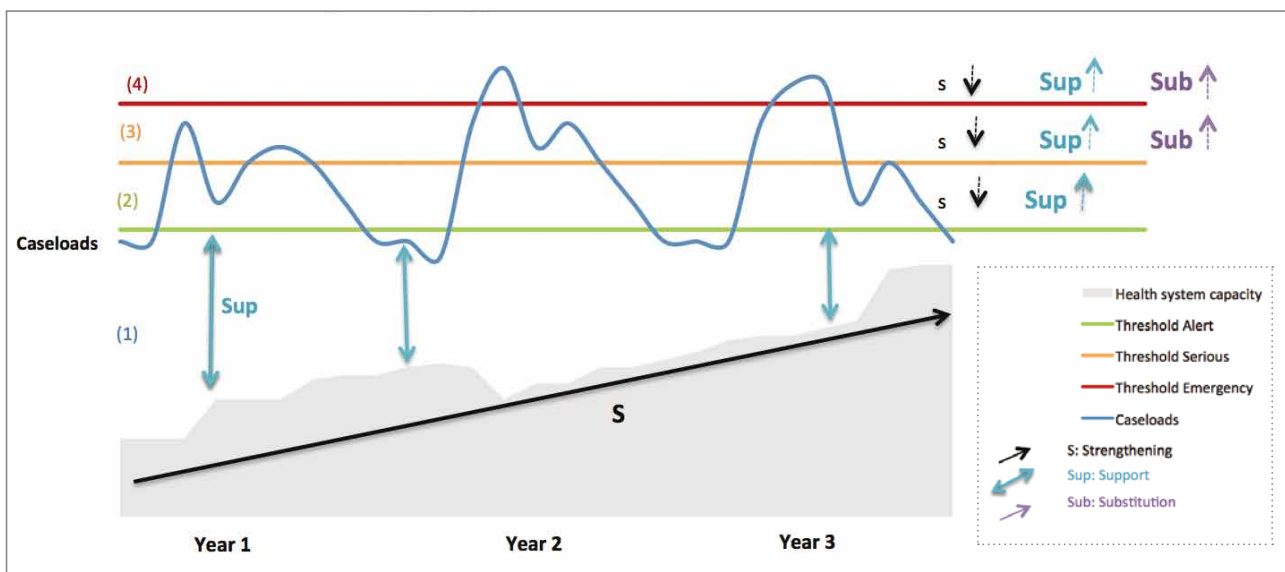
The 3S method based on an initial idea of Hailey and Tewoldeberha (see Annex 1), has been developed to articulate long-term strengthening, preparation and response to shocks. The following diagram illustrates the logic of the method.

The **blue caseload** line in the diagram highlights roughly an expected caseload of a given District, sub-District or health zone (for RMNCH services), it often fluctuates according to seasonal events such as epidemics, drought etc. **The capacity of the HS** shows the actual capacity of the District to provide the services, it is not linear and can also fluctuate along the year. It is represented by the grey surface. The detailed diagnosis per building block performed in the earlier steps helps to understand why this capacity is lower than required.

The **support activities** are light blue arrows. They represent the short-term strategies formulated by prioritized objectives to respond to immediate needs, in normal phases, but also in surge situations, where they can be associated to surge capacity activities. These activities provide short-term results [8]. They can go beyond support and turn into **substitution activities**. Indeed, when the health system is not able to ensure the correct functioning of the whole system anymore, partners can take the lead and temporally replace the health authorities in agreement with them. The **strengthening activities** are long-term ones, and aim at reinforcing the structure of the health system itself by addressing all the building blocks as well as the interactions that exist among them [9].

The various **thresholds** define four different phases of the District's situation: **normal (1)**, **alert (2)**, **serious (3)** and **emergency (4)**. These phases will enable the District to better prepare for surges, and adapt their activities to the health needs and their capacity.

FIGURE 14: STRENGTHENING, SUPPORT, AND SUBSTITUTION ACTIVITIES ARTICULATION AROUND CASELOADS AND HS CAPACITY – 3S METHOD



FACILITATION OF THE WORKSHOP

The objective of common planning is to mutualize resources and expertise to achieve synergy in strengthening the system. The workshop can last 2 to 3 days according to the number of HSS objectives listed and the actors involved. One or several facilitator(s) shall be present during the whole workshop.

Partners will work on a multiyear strategy, to define an adaptive planning. Indeed, the activities identified during this step, might be modified in the coming months and years to better fit the context and the needs of the District (see Follow-up plan in Step 11).

TABLE 28: SCHEDULE OF THE PLANNING WORKSHOP

WORKSHOP 3 - PHASES	
1	Introduction
2	Remind clear objectives
3	Remind risks and capacity analysis results
4	3S method and LFA briefing
5	Define activities by objectives and results following the 3S method
6	Agreement on the activities proposed and Roles & Responsibilities (R&R)
7	Costs estimation of the activities
8	Summarizing LFA

1 INTRODUCTION

The first session of the workshop should briefly summarise the diagnosis outcomes. The **4W mapping** developed in step 1 should be visible in the meeting room all along the workshop. It will help understand the best ways to develop a synergic approach between actors.

2 REMIND CLEAR OBJECTIVES

The **HSS objectives** identified in the solutions identification step will be listed and looked at (they need to be SMART).

3 REMIND RISKS AND CAPACITY ANALYSIS RESULTS

It is paramount that the shocks (type 1 & 2) are taken into account when defining the activities for each phase. Posters developed at the end of step 4, are hung in the room, showing the yearly calendar of shocks of type 1 and 2, describing the shocks type, occurrence, causes, consequences, existing mitigation, etc. During activities definition, the shocks description shall be kept in mind to ensure that activities are well designed to also cope with the shocks context of the District. Facilitator should encourage the participants to integrate the shocks in their reflexion.

4 3S METHOD AND LFA BRIEFING

The facilitator will briefly explain the core principles of the 3S method, and the expected LFA to be produced at the end of the session (the Annex 25 will be used). To do so, the example as well as the format described in the Annex 25 will be explained by the facilitator.

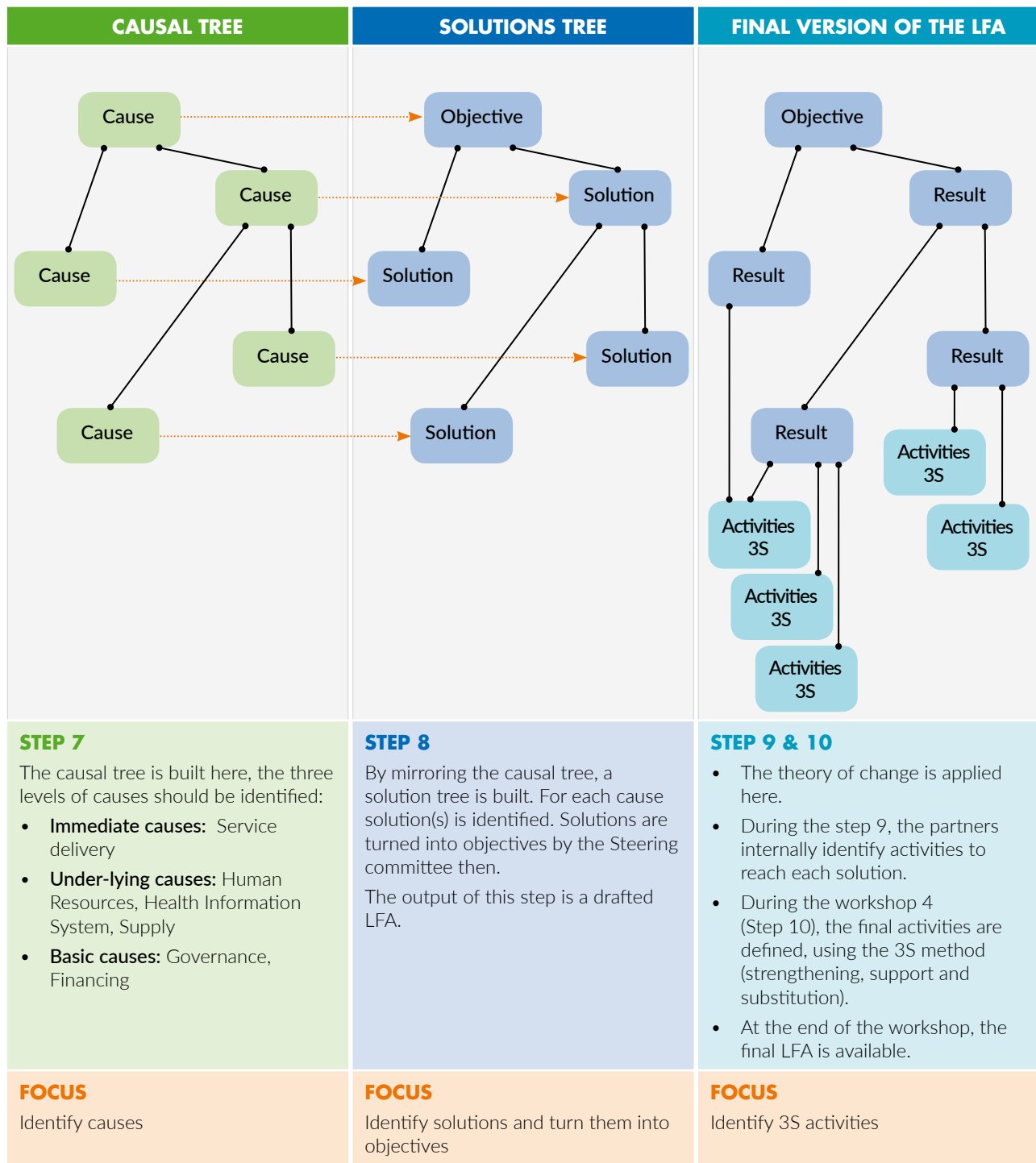
This shouldn't take too long, since participants are supposed to have understood the process in the previous step.

5 DEFINE ACTIVITIES BY OBJECTIVES AND RESULTS FOLLOWING THE 3S METHOD

Participants will start working on defining the activities per results (see figure below), and will use the same logic presented during step 9 and presented below (also in Annex 21). It describes the adopted theory of change, and the type of LFA structure to be developed. Additional information regarding the LFA is also mentioned in Annex 25, and the format to be used is described in it. The partners are supposed to have prepared this workshop using this model.

In addition, the tool proposed to accompany the activities definition should have also been used during the preparation (Annex 24).

FIGURE 15: THEORY OF CHANGE AND LFA (ANNEX 21)

**Facilitator tips:**

As stated before one or more facilitators should animate the workshops.

Depending on the size of the group the work can be organised according to different methods:

If attendants are less than 10, the entire work can be done in plenary.

- Participants will go through the listed objectives and results and share their vision on the base of the 4W and the work prepared during the internal phase using the Annex 21 and 24 (pre-identified activities, roles and responsibilities, etc.).
- Partners will not systematically target all the objectives set/ or results proposed, but complement other initiatives developed by the other partners.
- For each objective, activities shall first be defined for the normal phase over a multi-years period of time, and then for the other phases. Strengthening activities are first discussed, and when needed support and substitution ones are also described. Activities will be written by the facilitator in the table presented in Annex 24, and hung on the wall, to allow everybody to see it.

- Strengthening, support and substitution activities will change along the years and this evolution has to be highlighted in the activities.
- The expected outcomes of each activity should be described at this stage. Also, the indicators used in step 5 could be used as baseline indicators for the future activity's outcome monitoring.
- When an activity requires additional costs, a dollar (\$) should be put on the card for later.

If attendants are more than 10, subgroups need to be created. Each subgroup will work on one objective. A rotation of the groups will be organised so to make sure partners can cover all the topics they want.

- Each sub-group will for each objective and result define activities for first the normal phase over a multi-years period of time, and then for the other phases. Strengthening activities are first discussed, and when needed support and substitution ones are also described. Activities will be written by the facilitator in the table presented in Annex 24, and hung on the wall, to allow everybody to see it.
- Then, in each group a member will stay with the table, and the other members will visit and discuss the other sub-groups' tables. At the end of the viewing, each sub-group gathers again and improves the identified activities.
- Then, each group appoints a representative. The facilitator will animate a plenary session, where all appointed representatives will be able to discuss and consensually choose activities and R&R for each objective and result and each phase, based on the sub-group work.
- The expected outcomes of each activity should be described at this stage. Also, the indicators used in step 5 could be used as baseline indicators for the future activity's outcome monitoring.
- When an activity requires additional costs, a dollar (\$) should be put on the card for later.

In addition, to help lead the sessions, the facilitator(s) should:

- Be thoroughly familiar with the 3S method and with the District services but considered as neutral by the participants.
- Make sure printed guidelines are available for everybody, and that they are well understood by each participant. Facilitator(s) should remain available for any question.
- Provide big printed version of the Annex 24.
- Circulate among the smaller groups, help clarify the 3S method utilization.
- Be thoroughly familiar with logical framework (LFA) model that will be used during the workshop as a tool to structure the whole process (Annexes 21 and 24).
- **Ensure the plan is multiyear (minimum 3 years).**
- Encourage the participants to identify actions required also at regional and central level.
- Encourage the participants to identify actions that will target appropriation of the topic by other actors (or the community).
- Encourage participants to think about advocacy activities.
- Encourage participants to take into accounts the type 1 & 2 shocks when defining activities.

IMPORTANT

An important part of the activities that will be listed during the workshop may not depend on the District level and would require actions at central level. Most of these actions are often advocacy ones (see below advocacy action plan box).

ADVOCACY ACTION PLAN - WHAT SHOULD YOU KEEP IN MIND?

- Often, participants tend to identify many issues related to policies and governance. Facilitators and advocacy staff should support them in selecting and addressing the most strategic issues.
- Activities identified by the participants that are aiming at influencing policies and are therefore labelled as advocacy should be systematically integrated in the broader activities.
- **Advocacy solutions can be identified for each of the 3S.** Advocacy during the substitution phase can be to alert authorities or donors regarding a specific issue (for instance: gap in emergency funding). For support and substitution activities, advocacy can be done to enhance the structure of the health system (improve availability and accessibility of services). Here are some examples of this advocacy:
 - Calling for the national budget for health to be increased
 - Calling for a specific line for nutrition commodities to be added
 - Supporting the revision of the human resources for health policy etc.
- Facilitators should be able to rely on the advocacy/policy advisor to ensure that activities related to policies, financing, or labelled as "advocacy" are effectively advocacy and not only technical points. As such "advocating for health workers to screen sick children for undernutrition" should be either rephrased into "MoH to provide training to health workers to perform screening" and/or into "screening of malnutrition to be included in standard protocols and trainings in medical schools" (if it is not the case).

6 AGREEMENT ON THE OBJECTIVES, ACTIVITIES, EXPECTED OUTCOMES, AND THE R&R

- A clear common plan should be drafted, 3S articulation visible with concrete objectives, expected outcomes and activities, related to the different phases. The framework described in Annex 24 should be used.
- Roles and responsibilities are also to be defined for each activity. It might be quite difficult as competition between actors might emerge. The 4W should help define R&R. R&R should be specified per activity or per results, and for each level of threshold.
- Again, the format used could follow the LFA format (Annex 21 and 25), and the tool proposed to define activities (Annex 24).
- If one or more HSS objectives are not covered by any of the partners at the end of the discussion, the feasibility of covering this objective shall be discussed. If finally no solution has been found, reasons for this need to be documented in the report.
- The supporting partners together with the Project Manager will be in charge of writing this report after the workshop, and having it validated by the Steering committee.

7 COSTS ESTIMATION OF THE ACTIVITIES

The cost of each activity has to be estimated. First, it should be noticed if the activities have an additional costs involved, or if they could be carried out within the present partners' budget. In the part 4 of this step, activities requiring additional costs have already been identified with a (\$). The costs estimations of these activities can be performed using the Annex 27. If a proportion of the additional budget is already covered by the present budget, it should also be mentioned in the costing matrix. However, only the actual additional costs should be calculated. Later on, these costs will need to be integrated in the partners' annual budget.

It is recommended to have this step carried out only by the Steering committee, several ways are possible:

- Partners bring the financial data at the workshop 3, and the Steering committee do the costs estimation together with each of them.
- Partners bring the financial data at the workshop 3, and the Steering committee will perform the costs estimation later, based on the data provided by each partner.
- Partners are not able to bring the financial data at the workshop 3. Data will then be provided later, and the costs estimation will also be performed later by the Steering committee, during another meeting.

If some partners bring the data, and some others don't, the Steering committee, can estimate some costs during the workshop 3, and the other during a later meeting. The organization is flexible here.

8 SUMMARIZING LFA

As a conclusion of this step, and to make sure that all the causes and 'HSS objectives' are well addressed through the activities, and that all the pathways between each of them are well identified, the Steering committee will develop a final LFA. It is based on the macro structure (suggested in Annex 21), the activities structure (Annex 24), and on the LFA format (Annex 25). It will serve as the theory of change for the programme and will be used during the implementation and follow-up phases to ensure a good understanding of the taken actions. If there is time left, this can be done at the end of the workshop, otherwise it will be developed afterwards by the Steering committee. However, it is recommended to do it quickly after the workshop, since it must be done before the writing of the report.

WRITING OF THE REPORT

After the 2-3 days of workshop with all the partners, the Project Manager will gather with the DHMT to write a report about the results of the planning workshop. About 2 to 3 days are allocated for this task. This report should include all the results reached during this workshop. This document will be used as a basis for the implementation M&E and follow-up steps. The Steering committee will review and validate this report prior to communicate it to all the partners and to the other actors.

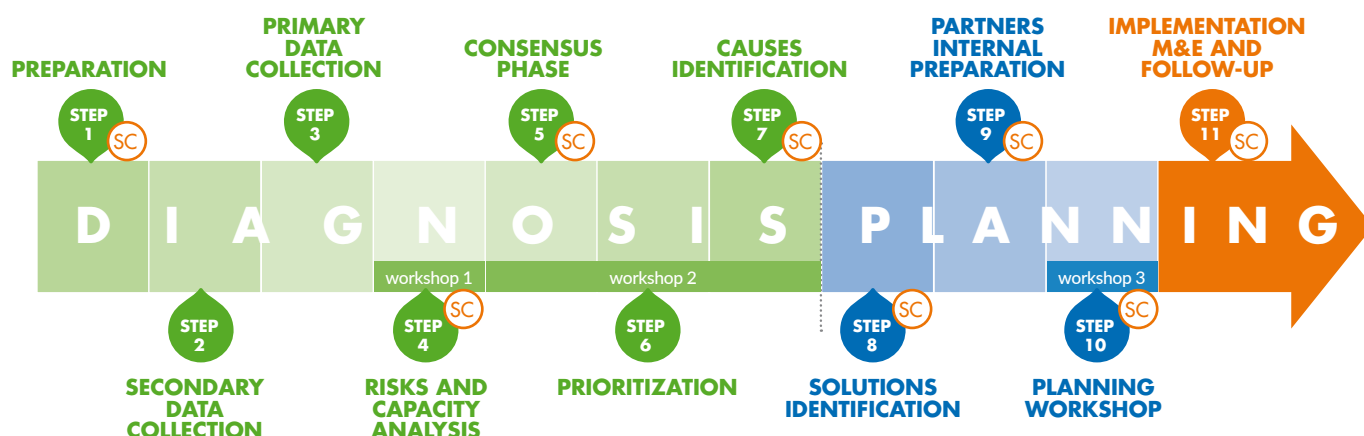


AT THE END
OF STEP 10

MAKE SURE THAT:

- For each solution/ results, activities are defined with the 3S method and on a multiyear basis.
- Results from the risks and capacity analysis have been kept in mind while defining the activities.
- Activities are defined for the national, regional and District levels, and include advocacy.
- For each activity, roles and responsibilities, as well as costs are identified.
- This step is not the end of the mobilization. It is rather the beginning of a common work.

STEP 11: IMPLEMENTATION, M&E AND FOLLOW-UP



All the diagnosis and previous planning steps have led to a global understanding of the health system, leading to the definition of a multiyear HSS plan for the District encompassing strengthening, support and substitution activities. The modalities of this plan have also been described, including roles, responsibilities, and costs estimation.

TABLE 29: FRAMEWORK OF THE STEP 11

STEP 11 – IMPLEMENTATION, M&E AND FOLLOW-UP
OBJECTIVES
<ul style="list-style-type: none"> Define the framework of the implementation, M&E and follow-up plans
WHO IS INVOLVED
<ul style="list-style-type: none"> Project Manager Steering committee Partners Advocacy or policy advisor Facilitator (not compulsory)
METHODS
<ul style="list-style-type: none"> Communicate externally about the main results of the workshop 3 Adjust the Steering committee Develop project plans and organize regular meetings
OUTCOMES
<ul style="list-style-type: none"> Workshop 3 results are communicated to the external stakeholders A new adjusted Steering committee is formed Plans allowing the implementation of the interventions: <ul style="list-style-type: none"> District action plan Resources plan M&E plan Follow-up plan to ensure adaptability of the planning

All actors involved in the process will have to engage and be accountable for the activities proposed. The following next steps should be planned at the District level.

EXTERNAL COMMUNICATION

External communication will be done to inform the national authorities (authorities, donors, UN, MoH, Ministry of finance, CSO, INGO, etc.), as well as all the relevant stakeholders, about the diagnosis and planning results, and about the theory of change. The Steering committee will be in charge of organizing the communication of the results. Various options are available:

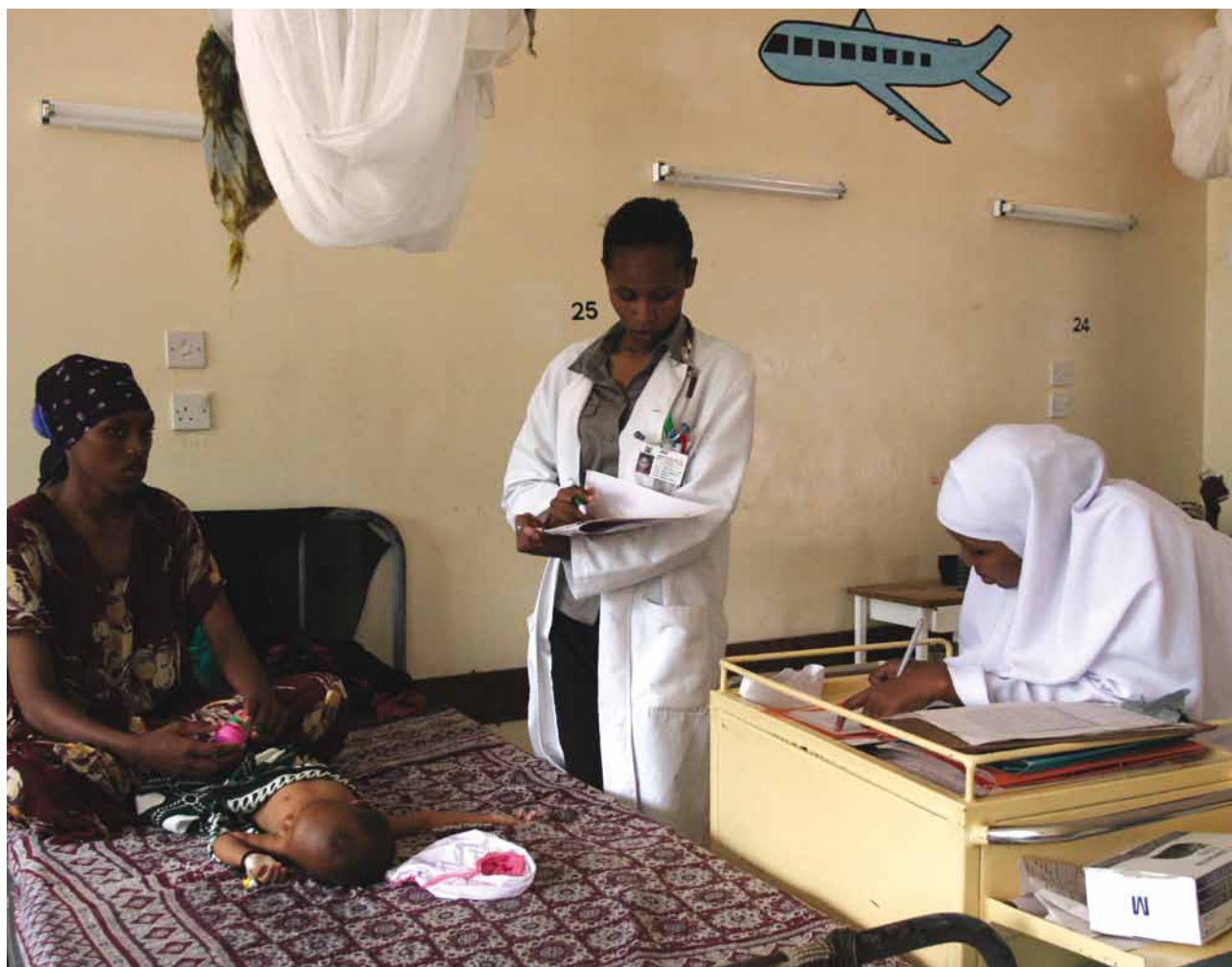
- Press conference or press release
- Donor communication/ presentation
- Other influencing spheres communication/ presentation

ADJUSTING THE STEERING COMMITTEE

At this stage, the former Steering committee should be adjusted in order to remain representative of the key actors involved in the approach. This new group of representatives will be supported by the former Steering committee, to ensure an efficient continuation of the HSS approach. The method used in step 1 to create the Steering committee, can be re-used here if necessary. It will be critical at this stage to make sure that **the users are represented in this new Steering committee which will ensure the setting up of “user a feedback mechanism”**.

ACTIVITIES IMPLEMENTATION

Now that objectives and activities have been defined, the executive phase of the approach can start. The local health authorities should again lead the process. Several plans have to be developed, in order to ensure that activities are correctly developed and adequate resources are allocated to it. **The Steering committee is responsible for the development and the revisions of these documents, he is in charge of collecting the relevant information, involve the adequate partners when needed, perform the writing and the validation of the final versions. Partners and health authorities can be involved in the development of these documents, but this will be done under the supervision of the Steering committee.**



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DISTRICT ACTIONS PLAN

This plan should describe and explain at least the following points:

- Precise description of all the activities (strengthening, support, substitution), the phase to which they are related (normal, alert, serious, or emergency), roles and responsibilities of the partners regarding the activity.
- Overall planning including activities of strengthening, support and substitution over the coming years (with a GANTT diagram development).
- If the District thresholds rely on the thresholds of each health facility (threshold definition method 2), all the health facilities of the District should define theirs. The Steering committee will be supervising the health authorities, which will be in charge of managing it at the health facility level. The thresholds should be available, in the first six months after the start of step 11. Instructions for the health facilities are available in the Annex 16.
- Set-up or use a reliable system to transmit the information from the health facilities up to the District/required level, and vice-versa, and thus with an efficient timing.
- A reliable system must be set-up or used (if already available), to make sure the thresholds system, and the activities set is well used, it includes:
 - Triggering process to inform stakeholders of the phases' evolution.
 - Actual provision of the activities related to each phase. And scaling down of the activities when new cases level goes down.
- Set up of a M&E plan (see below)
- Set-up or use of a reliable "user feedback mechanism"

RESOURCES PLAN

The resources needed to execute the actions plan have to be defined in this document. It should include:

- **Financial resources**
The budget needed to perform the program has to be elaborate. To do so, each partner costs the activities and tasks he is in charge of, and assesses its own contribution. A compilation of these budgets is then done by the DHO. The cost estimation of the activities done in the step 10 is used as a basis. The donors are also approached to share the joint planning.
- **Human resources**
Human resources needed to carry out the program are defined here. Roles and responsibilities defined in the step 10 shall be re-used here. Requested qualifications, trainings etc. for specific staff shall also be mentioned here. The partner in charge of the activities will be estimating the needs, and have them validated by the District authorities.
- **Equipment resources**
When additional equipment is necessary, it also has to be mentioned here. If further costs are created, they will be included in the financial resources as well. The partner in charge of the activities will be estimating the needs, and have them validated by the District authorities.

MONITORING AND EVALUATION (M&E)

The Steering committee will be in the lead of the development and implementation of the M&E plan. Bi-annual meetings should be organized by the Steering committee, with all the partners, to discuss the main topics of the M&E plan.

M&E PLAN

The M&E plan will include at least the following information:

- **Indicators:** The monitoring and evaluation of the program will be done through the 22 key indicators (see Annex 17), this way the outcomes can be efficiently evaluated.
- **Frequency:** The collection and analysis of the indicators will be done at a regular frequency. This frequency is to be defined by the Steering committee, and can be annual, bi-annual, or quarterly. In any case, it is to make sure that a mid and end line studies are planned, and thus identify if the key indicators with a low score are showing any improvement. The results obtained during the diagnosis will be used as a baseline.
- **Procedures and tools:** M&E procedures and tools are described in the plan.
- **Roles and responsibilities:** The Steering committee will be leading the M&E activities. Plus, needed resources to perform the M&E are described here, as well as the R&R, and ToR for each of them.

FOLLOW-UP - REAL TIME LEARNING PROCESS

This part describes how to follow-up the process itself and implement a real time learning mechanism. First, follow-up meetings should be organized on a quarterly basis with all the stakeholders to discuss all the points of the follow-up plans, and any other coming issues. The Steering committee is in charge of organizing these meetings. It is possible to have these meetings integrated in the regular District meetings. However, it shall be ensured that the required frequency of the follow-up meetings is observed, relevant people are attending, and that required topics are addressed.

A follow-up plan should be developed and made available to all the stakeholders. Like for the other plans described above, the Steering committee is in charge of developing and reviewing the follow-up plan.

FOLLOW-UP PLAN

- **Activities follow-up:** The activities are followed-up during the whole process, to make sure they are well implemented, and bring good improvements. The partner in charge of the activity is responsible of the follow-up of the activity. When needed, adjustments are to be made on the activities. At each quarterly meeting, the activities will be discussed.
- **The “user feedback mechanism”** will be key in identifying the success and adequacy of the HSS activities developed in the initial plan.
- **Activities review:** The context in which the health Districts evolve is dynamic, and constantly changing. Therefore, in order for the activities to remain relevant and useful, the activities defined in step 10 need to be reassessed and eventually modified according to the feedback mentioned above and when important changes happen. This is the adaptive planning. For instance, events such as a reassessment of thresholds, important changes in the seasonality, or the emergence of a new disease, will need a redefinition of the activities. This has to be kept in mind on the long-run. The staff satisfaction also has to be accounted for in this reassessment. Every six months, this point will be tackled during the follow-up meetings, if needed a modification of the activity will be written by the Steering committee to describe the changes, and communicated to all the partners. The partner in charge of the activity will be responsible for suggesting or flagging the need to review specific activities during the follow-up meetings. This must be backed-up with some facts to justify the need to review the activity. The District can also suggest some changes, if the need is observed.
- **Monitoring against the thresholds:** Monitoring against the thresholds will be carried out at the District and health facility levels every month. The monitoring by the health authorities is to be intensified when caseloads increase and upper thresholds are crossed (from monthly to fortnightly or even weekly monitoring). At the health facility level, it can be considered to use a visual tool where the thresholds are marked in a daily patient register or via a simple case by case tally sheet, so health workers will be alerted each day if a threshold is passed, as explained above. When thresholds are crossed up or down, it should be mentioned during the follow-up meetings.
- **Regular thresholds review:** Thresholds are based on dynamic parameters: the District capacity and the workload. Hence, they have to be reassessed on a regular basis to make sure they reflect well the current context, and the District situation. Concern Worldwide [5] recommends doing a review at least twice a year, thus every six months the District thresholds will be revised by the Steering committee, with the help of the District authorities, and communicated during the follow-up meeting.
Health facility thresholds review will take place at about the same moment. They will be reviewed by the health facility staff, with the support and validation of the District authorities. These changes will be mentioned during the follow-up meetings. Moreover, additional reviews can be done when significant changes in the health District capacity happen, such as HR changes, equipment break down, etc. This will be on the initiative of the health facility or District personnel, and should be performed following the same instructions than for the regular reviews.
- **Forward planning** for the coming three months has to be done every three month. Also, a review of the caseloads fluctuations as well as the shocks occurrence charts from the previous years is to be performed, this way the seasonal shocks can be anticipated enough in advance. The forward planning will be done by the Steering committee, and presented on the follow-up meeting every three months.

A template for follow up phase is proposed in Annex 28.

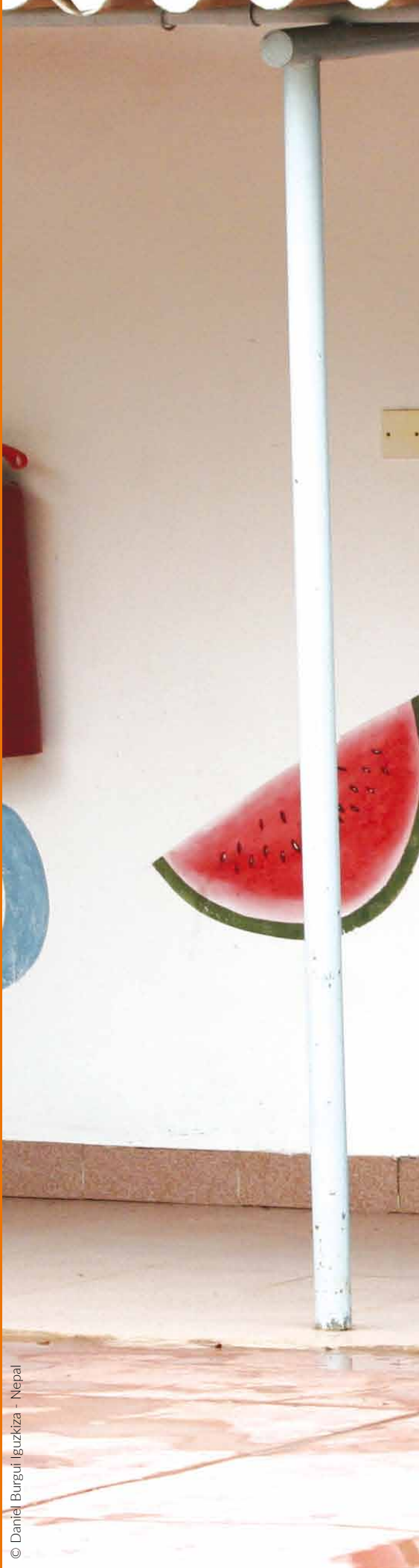
REFERENCES

- [1] Chloe Puett et al 'Access for All Volume 2 What Factors influence access to community-based treatment of Severe acute malnutrition', CMN- 2013
- [2] Systems thinking for health systems strengthening, WHO 2009
- [3] The health system assessment approach: a how to manual. Version 2.0. Health system 20/20. Sept 2012
- [4] Peter C. Drobac et al in BMC Health Services Research 2013, 13(Suppl 2):S5 "Comprehensive and integrated District health systems strengthening: the Rwanda Population Health Implementation and Training (PHIT) Partnership"
- [5] Global CMAM Surge Approach: Operational Guide, from Concern Worldwide, 2016. <https://www.concern.net/resources/cmam-surge-toolkit>
- [6] Adapted from Assessment of IMSAM integration into the HS- Samburu central- April 2012, Anne Berton-Rafael, UNICEF
- [7] http://www.actioncontrelafaim.org/sites/default/files/publications/fichiers/acf-advocacy-toolkit_june_2013.pdf
- [8] Chee, Grace et al. "Why Differentiating between Health System Support and Health System Strengthening Is Needed." The International Journal of Health Planning and Management 28.1 (2013): 85-94
- [9] WHO. Everybody's Business: Strengthening Health Systems to Improve Health Outcomes: WHO's Framework for Action. 2007

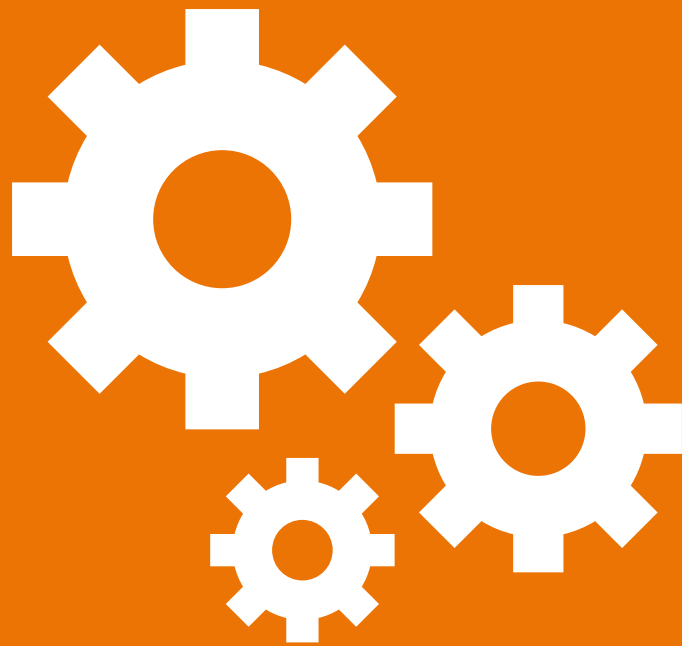
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ANNEXES

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ANNEX 1: JUSTIFICATION OF THE METHOD

To develop the ACF HSS approach, many references have been used as inspiration or as a basis. The main ones are listed below and an explanation on how they have impacted the ACF approach is presented.

REFERENCES DESCRIPTION	USE IN ACF HSS APPROACH
<p>Everybody's Business: Strengthening Health Systems to Improve Health Outcomes: WHO's Framework for Action. 2007</p> <p>Framework to perform health system strengthening, based on the building blocks theory.</p>	Used in the whole approach.
<p>Systems thinking for health systems strengthening, WHO 2009.</p> <p>Description of the system thinking applied to health systems</p>	Used in the whole approach. A system thinking approach is used from the causes identification, until the planning phase.
<p>"Why Differentiating between Health System Support and Health System Strengthening Is Needed." Chee, Grace et al. The International Journal of Health Planning and Management 28.1 (2013): 85-94.</p> <p>Study explaining the important differences between the concepts of supporting health systems and strengthening health systems.</p>	Used in the 3S method presented in the planning phase (Step 10).
<p>The health system assessment approach: a how to manual. Version 2.0 Health system 20/20. Sept 2012¹.</p> <p>Assessment of health systems.</p>	The HSA approach has been used to develop the diagnosis phase. Most HSA has been performed at national level. It is still feasible in decentralized settings but not at a lower level than the region.
<p>« Comprehensive and integrated District health systems strengthening: the Rwanda Population Health Implementation and Training (PHIT) Partnership », Peter C. Drobac et al in BMC Health Services Research 2013².</p> <p>It is a How-To Manual developed in 2008 and updated in 2012 by Health Systems 20/20. It has been designed to provide a rapid and yet comprehensive assessment of key health system functions at national level.</p> <p>This model can also collect data and information at District level as part of the wider process. Recommendations remain nevertheless at national level.</p>	One of the underlying principles: District based approach is based on this reference.
<p>A method developed by Dr. Camille Eric Kouam used by ACF in Bangladesh in 2010 and adapted in 2013.</p> <p>Diagnosis method.</p>	Step 2 and 3 of the diagnosis phase were inspired from this method.
<p>Guidance on the framework of integration of management of acute malnutrition³, First version, September 2012, Anne Berton-Rafael, UNICEF.</p> <p>This benchmark matrix (District level part) developed by Anne Berton-Rafael and UNICEF was adapted from USAID's Health Systems Assessment Approach: A How-To Manual (2007 version). In 2013 and 2016 the tools were updated (horizontalisation and benchmarks reformulation).</p> <p>The main objective of this tool was to support countries in assessing gaps and bottlenecks, in planning priority actions to address bottlenecks and to guide sustainable scaling-up of management of SAM through primary health care.</p>	Used in the step 5 of the diagnosis phase, (matrix). The matrix is based on this reference. The initial benchmarks of the matrix have been adapted to a more horizontal approach. Initially SAM management was the main focus of the matrix, whereas in the modified version the overall basic package of health services is assessed (MNCH services). It should in any case include SAM management depending on the country/context.
<p>Global CMAM Surge Implementation Guide, Concerns Worldwide (2016)³.</p> <p>A vertical method aiming at addressing SAM seasonal and exceptional surges by developing surge capacity, based on a thresholds system.</p>	Used in the diagnosis and planning phases, especially for the parts concerning the preparation to shocks (mostly Steps 4, 5 and 10). The capacity assessment, as well as the thresholds system of the Concern's approach have been adapted and integrated in the ACF approach.
<p>"Suggested New Design Framework for CMAM Planning" (ENN Field exchange 39)⁴, by Peter Hailey and Daniel Tewoldeberha.</p> <p>New approach to design CMAM Programs, based on thresholds and capacity analysis.</p>	Used in the planning phase, especially Step 10, using the initial idea of this article as a starting point.
<p>District Planning Tool for Maternal and Newborn Health Strategy Implementation, A practical tool for strengthening Health Management System, WHO, 2011⁵.</p> <p>Guide providing District health managers with practical resources for planning and implementation of maternal and newborn health services.</p>	Used in the planning phase. The Step 10 especially follows the logic promoted in the WHO guide published in 2011.

1 - <http://apps.who.int/medicinedocs/documents/s19838en/s19838en.pdf>

2 - <https://www.biomedcentral.com/qc/1472-6963/13/S2/S5>

3 - <https://www.concern.net/resources/cmam-surge-toolkit>

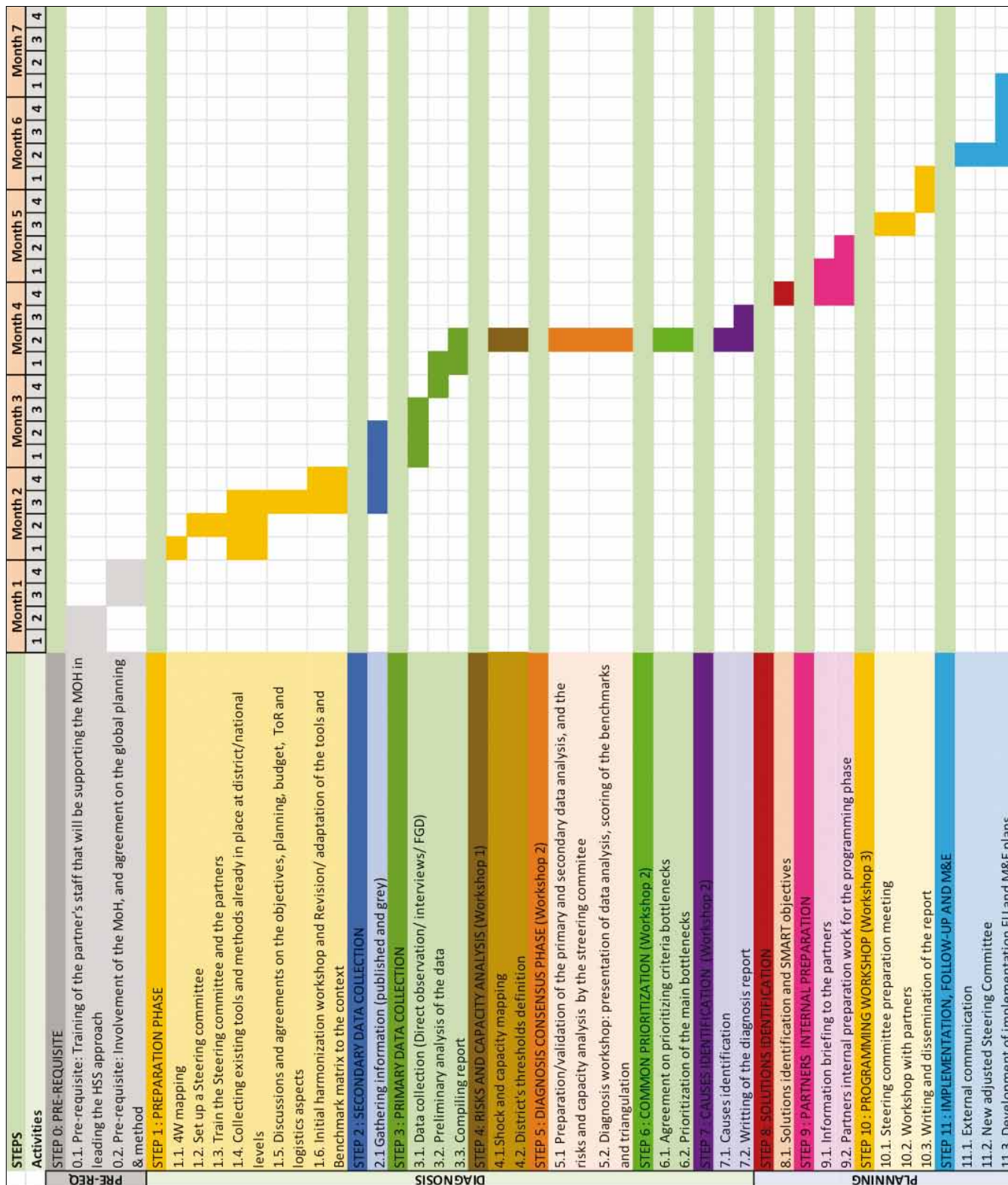
4 - <http://fex.ennonline.net/39/suggested>

5 - http://whqlibdoc.who.int/publications/2011/9789241500975_eng.pdf

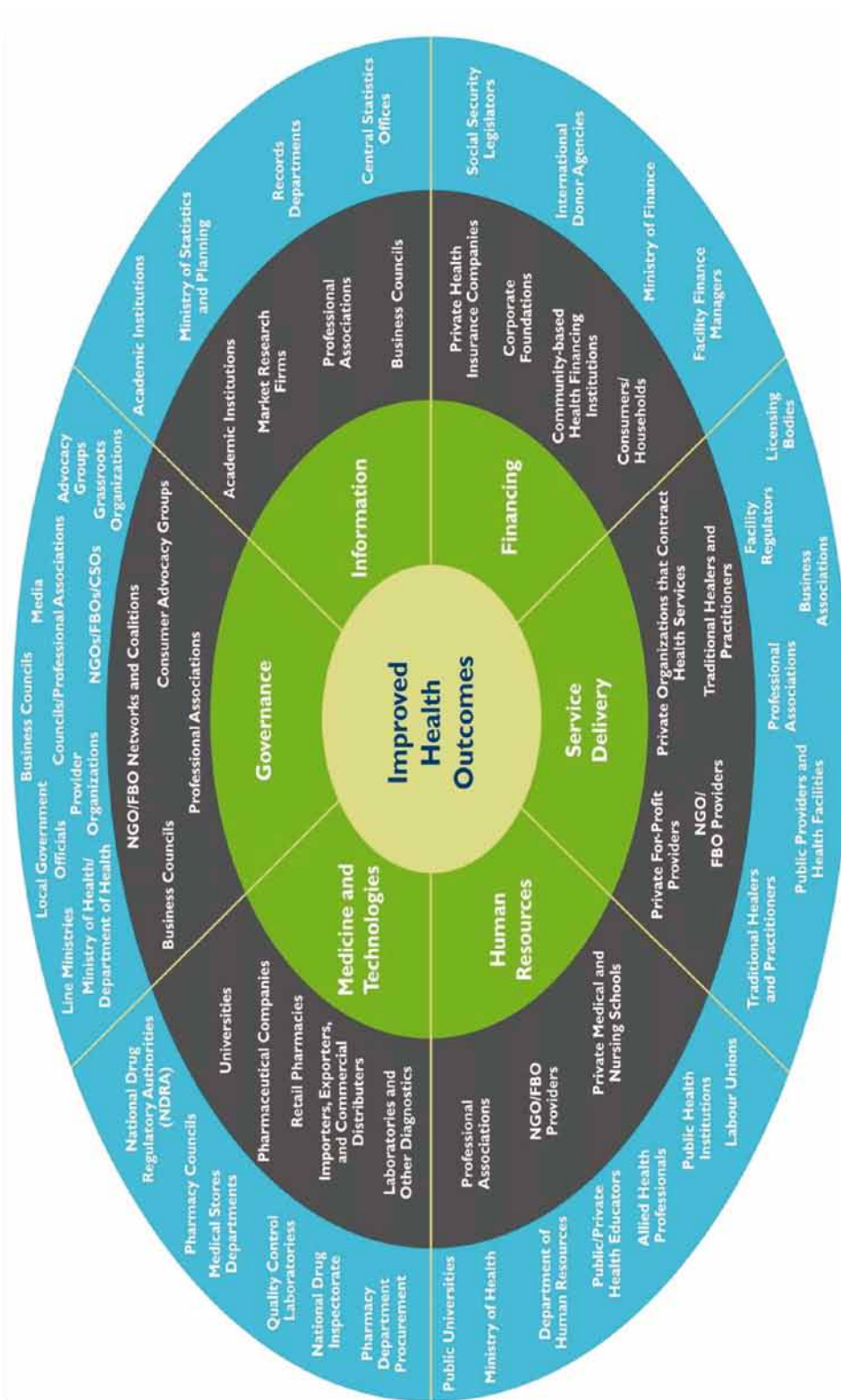
ANNEX 2: TIMEFRAME EXAMPLE

STEPS	INDICATIVE TIMING	ACTIVITIES	COMMENTS
STEP 0 Pre-requisite	4 weeks	<ul style="list-style-type: none"> • Training of the partner's staff that will be supporting the MoH in leading the HSS approach • Involvement of the MoH, and agreement on the global planning & method 	
STEP 1 Preparation	4 to 6 weeks	<ul style="list-style-type: none"> • 4W mapping • Creation and training of the Steering committee • Collecting existing tools and methods already in place at District/national levels • Discussions and agreements on the objectives, planning, budget, ToR and logistics aspects • Initial harmonization workshop and Revision/ adaptation of the tools and Benchmark matrix to the context 	PM recruited. Launch the facilitator recruitment
STEP 2 Secondary data collection	4 weeks	<ul style="list-style-type: none"> • Collection of secondary data, the analysis will be done later. • Team recruitment, and training also take place. 	PM, Steering committee, assessment team
STEP 3 Primary data collection	6 weeks (can start while Step 2 is still on-going)	<ul style="list-style-type: none"> • Data collection (Direct observations/ interviews/ FGD) • Preliminary analysis of the data • Compiling report 	PM, Steering committee + supporting partners
STEP 4 Risks and Capacity Analysis	A day or half a day	<ul style="list-style-type: none"> • Identify and analyse the type 1 & 2 shocks to which the Health District is exposed over a period of 2 years (characteristics, causes, effects) • Reflect the capacity of the Health District to cope with shocks • Define thresholds for the District to indicate various phases. 	The PM, the Steering committee, and the facilitator Workshop 1
STEP 5 Consensus phase	1 week	Preparation phase + workshop	Part of Workshop 2
Details for Step 5:			
Preparation phase	3 days	<ul style="list-style-type: none"> • Finalisation of the secondary and primary data collection analysis • One day meeting to: <ul style="list-style-type: none"> - Validate the analysis - Include findings of the secondary and primary data collection in the matrix, as well as information about the presence and sustainability of external aid for relevant indicators - Organise the workshop 	
Partners workshop	2 days	<ul style="list-style-type: none"> • Presentation of the results of the primary and secondary data collection, risks and capacity analysis. • Scoring of the indicators • Visualization of the results • Triangulation of the results with the findings from the previous steps 	
STEP 6 Prioritization	Evening + Half a day	<ul style="list-style-type: none"> • Preparation of the workshop <ul style="list-style-type: none"> - Pre-identification of prioritization criteria • Workshop <ul style="list-style-type: none"> - Define prioritization criteria to assess the main bottlenecks - Prioritize the main bottlenecks 	Part of Workshop 2
STEP 7 Causes identification	Half a day+ 2 weeks	<ul style="list-style-type: none"> • Causes identification for the prioritized bottlenecks, thanks to causal trees. • Writing of the diagnosis report 	Part of Workshop 2

STEP 8 Solutions identification	Half a day + half a day	<ul style="list-style-type: none"> MoH and supporting partner prepare the solution tree Steering committee session <ul style="list-style-type: none"> Finalize the identified solutions Define SMART 'HSS objectives' 	
STEP 9 Partners internal preparation	2 to 3 weeks	<ul style="list-style-type: none"> Ensure that all partners have the same level of understanding on: <ul style="list-style-type: none"> Results from the diagnosis Identified solutions The planning phase The role they will play Have the partners prepared for the planning workshop 	The Program Manager, Steering Committee, facilitator, and partners
STEP 10 Planning workshop	3 weeks	Identification of activities (strengthening, support and substitution) for each phase. Roles, and responsibilities, costs, and indicators are also identified.	Coordinated by the PM. Steering committee, partners, facilitator Workshop 3
Details for step 10			
Preparation phase	1 day	Meeting with the Steering committee for the preparation of the planning workshop	
Partners Workshop	2 - 3 days	<ul style="list-style-type: none"> Presentation of the pre-identified activities and roles of the partners Discussions between the partners to define activities to fulfil all the HSS objectives Development of a plan with 3S activities for each objective, with roles and responsibilities Costs estimation of each activity 	
Report writing	2 weeks	The PM and the DHMT will develop a report regarding the whole workshop and submit it to the Steering committee for validation.	
STEP 11 Implementation, M&E and Follow-up	TBD	<ul style="list-style-type: none"> External communication about the main results of the workshop 3 Adjustment of the Steering committee Development of project plans and organize regular meetings 	



ANNEX 3: ACTORS MAPPING TOOL



Extracted from: The Health System Assessment Approach: A How-To Manual. Health systems 20/20.

ANNEX 4: EXAMPLE OF HSS FACILITATOR/ MODERATOR - TOR

The mission will be divided in 2 phases.

FIRST PHASE OF THE MISSION

- **OBJECTIVE 1: Preparation of the diagnosis – Optional since the facilitator might not always be here at this stage**

Activities:

- Become familiar with the project proposal, methodology and exchanges with the country team on the different steps of the process
- Discussion and update of the timetable drafted by the mission
- Revision of the actors mapping conducted by the mission during the preparation phase

- **OBJECTIVE 2: Support the program manager in the collection, treatment and analysis of primary, secondary data – Optional since the facilitator might not always be here at this stage**

Activities:

- Adaptation and development of data collection tools and team training in data collection
- Participation in data collection/Data Processing and Analysis
- Writing a summary report to the partners (which will be a chapter of the final global report)

- **OBJECTIVE 3: Coordinate and organize the risks and capacity analysis workshop (workshop 1)**

Activities:

- Make sure the information needed for the workshop is available
- Organize and moderate the workshop with the Steering committee and the health facilities representatives
- Organize and moderate the Steering committee session to define the District thresholds

- **OBJECTIVE 4: Coordinate the work with partners, organize and lead the workshop 2 in cooperation with the competent authorities and the local program manager**

Activities:

- Organize and conduct the preparation of the workshops with the Steering committee
- Organize and moderate the workshops 1 and 2
- Train the various stakeholders on the 3S method

- **OBJECTIVE 5: Support the program manager in writing the diagnosis part of the final report, and start to organize the planning next steps**

Activities:

- Support in the development of a diagnosis report in consultation with partners that will prepare the planning stage
- Coordinate with the HSS team to organize the planning phase

SECOND PHASE OF THE MISSION

- **OBJECTIVE 6: Support the preparation of the planning phase – Optional since the facilitator might not always be here at this stage**

The preparation will be implemented mainly by the local team, the expert must simply ensure that the upstream activities have been planned and on his return that they have been carried out.

Activities:

- With the support of ACF methodology prepared with the Steering committee, develop the planning phase activities: drafting agendas and finalizing the tools, list of participants and shared responsibility to ensure ownership of the exercise by health authorities
- Launch the internal preparation phase and animate the ACF internal phase (and other partners if they wish)

- **OBJECTIVE 7: Provide support in organizing and leading the planning workshop (workshop 3)**

Activities:

- Provide methodological support to the competent authorities in co-facilitating the workshop (preparing various presentations and carrying out group work)
- Ensure a coordinated and smooth communication between participants
- Ensure the achievement of the planning workshop objectives

- **OBJECTIVE 8: Support the Writing of the final report of the whole process – Optional since the facilitator might not always be here at this stage**

Activities:

- Provide support to the health authorities and to the program manager to develop a report about the different phases (from diagnosis to planning)
- Support the competent authorities and the partners to define the roadmap for the monitoring of the action plan

ANNEX 5: KEY DEFINITIONS

Ensuring that everyone involved in the process has the same level of understanding on the key definitions related to HSS is a very important precondition.

- **VERTICAL APPROACH [1]:** Vertical approaches focus on a single disease, such as HIV or SAM, provide a top-down mass prevention campaign or treatment to a specific disease, and are not fully integrated in the health systems. DOTS (Direct Observed Treatment Strategy) against tuberculosis, or NID (National Immunization Day) against Polio are examples of vertical programs.
- **HORIZONTAL APPROACH:** horizontal programs deliver services “through (public financed) health systems and are commonly referred as comprehensive primary (health) care” [2]. They focus on making the health system work well to administer prevention and treatment to patients, whatever the patient’s health problem may be [3]. Horizontal strategies are derived from the Primary Health Care approach, defined in the Alma Ata declaration in 1978. Routine immunization programs are an example of the horizontal approach.
- **DIAGONAL APPROACH:** Diagonal approaches are “aiming for disease-specific results through improved health systems” [4]. More precisely, it is a “strategy in which we use explicit intervention priorities to drive the required improvements into the health system, dealing with generic issues such as human resource development, financing, facility planning, drug supply, rational prescription, and quality assurance” [5]. What is mentioned here as generic issues stands actually for some of the health system building blocks defined by WHO.
- **HEALTH SYSTEM [6]:** (i) all the activities whose primary purpose is to promote, restore and/or maintain health; (ii) the people, institutions and resources, arranged together in accordance with established policies, to improve the health of the population they serve, while responding to people’s legitimate expectations and protecting them against the cost of ill-health through a variety of activities whose primary intent is to improve health.
- **HEALTH SYSTEM BUILDING BLOCKS [6]:** an analytical framework used by WHO to describe health systems, disaggregating them into 6 core components: leadership and governance (stewardship), service delivery, health workforce, health information system, medical products, vaccines and technologies, and health system financing.
- **HEALTH SYSTEM FUNCTIONS [6]:** an analytical framework describing four key work packages health systems have to perform: providing services; generating the human and physical resources that make service delivery possible; raising and pooling the resources used to pay for health care; and, the function of stewardship - setting and enforcing the rules of the game and providing strategic direction for all the different actors involved. These functions are performed in the pursuit of three goals: health, responsiveness and fair financing.

HS Functions are today often used as a synonym for the 6 HS Building blocks (see diagram below).

NOTE

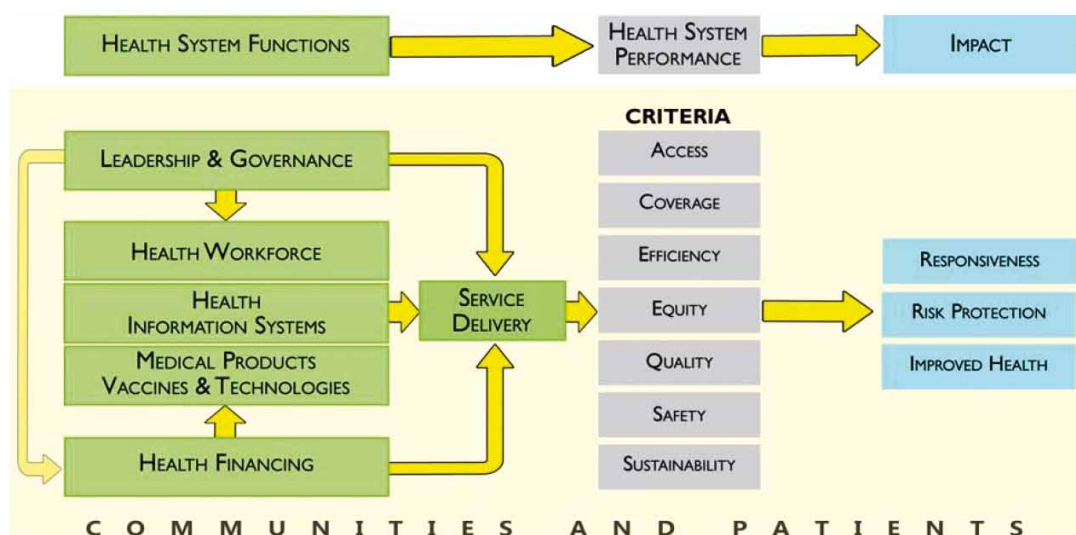


Figure 1 Health system functions, performance, and impact [7]

- **HEALTH PLANNING [6]:** the orderly process of defining health problems, identifying unmet needs and surveying the resources to meet them, establishing priority goals that are realistic and feasible, and projecting administrative action, concerned not only with the adequacy, efficacy and efficiency of health services but also with those factors of ecology and of social and individual behaviour that affect the health of the individual and the community.

- **HEALTH SYSTEMS STRENGTHENING [6]:** (i) the process of identifying and implementing the changes in policy and practice in a country's health system, so that the country can respond better to its health and health system challenges; (ii) any array of initiatives and strategies that improves one or more of the functions of the health system and that leads to better health through improvements in access, coverage, quality, or efficiency. This approach adopts a long-term perspective.
 - **HEALTH SYSTEM SUPPORT [8]:** activities that aim at improving the system's functionality primarily by increasing inputs, it aims at having short-term results and is narrowly focused.
- The table below described the main differences between support and strengthening activities.

ASPECTS	HEALTH SYSTEM SUPPORT	HEALTH SYSTEM STRENGTHENING
SUSTAINABILITY	Short-term impact	Long-term impact
ACTS ON	Health system functionalities, inputs	Structure of the Health System as a whole
ACTS ON (BUILDING BLOCKS THINKING)	One single building block	Several building blocks as well as the interactions that exist between them
CONTEXT'S CONSIDERATIONS	Type of generic solutions set up by external aid actors	Context specific and tailored made solutions Involvement of the countries institutions

- **RESILIENCE [9]:** Resilience refers to the capacities of people, households, communities and systems, on which they depend, to resist, absorb, cope and adapt when exposed to hazards while preserving, restoring or enhancing their food and nutrition security. ACF associates resilience with the capacities of anticipation, absorption, adaptation and transformation, when shocks affect the population (surge), or directly the system (shocks not necessarily inducing surges).
- **HEALTH SYSTEM RESILIENCE:** Resilience can be defined as the capacity of health actors, institutions, and populations to prepare for and effectively respond to crises; maintain core functions when a crisis hits; and, informed by lessons learned during the crisis, reorganize if conditions require it [10]. Thus, resilience is not an action to be implemented but rather a dynamic objective of investments and reforms. Besides, the concept of resilience is associated to stresses or shocks. ACF describes them with two different types, as well as the response to them:
 - **Type 1:** Stresses/ shocks inducing a caseload increase. They are called surges, and are a rise in the number of admissions regardless the cause, the rapidity and the length of the rise. It can be seasonal admission peaks as well as the result of a natural disaster for instance. Developing the surge capacity of the health District will permit to cope with the surges and provide an accurate response.
 - **Type 2:** Stresses/ shocks not necessarily inducing a caseload increase. The intrinsic structure of the health system (the 6 pillars) is disrupted which provokes a dysfunction of the system itself. However, a rise of caseloads is not necessarily observed. For instance, a flood would prevent the drugs and materials to be delivered to the health facility. The preparation and response to these stresses/shocks have to be accounted for while developing the HSS strategy with the District.
- **SUBSTITUTION:** Partners are entirely taking the place of the whole local health system, and perform all tasks by themselves. It offers short-term solutions to improve the immediate access to good quality services. It is mainly observed in emergency situations.
- **SURGE:** a rise in the number of admissions regardless the cause, the rapidity and the length of the rise. Daily surge represents the seasonal peaks, and disaster surge the epidemics outbreak or natural disasters.
- **SURGE CAPACITY:** ability to cope with caseloads surges (daily or exceptional ones), and thus by including all the stakeholders and elements involved in the health system.

REFERENCES

- [1] Institute of Medicine (US). Griffin & Robinson. Addressing the Threat of Drug-Resistant Tuberculosis: A Realistic Assessment of the Challenge: Workshop Summary. 2009. <http://www.ncbi.nlm.nih.gov/books/NBK45008/>
- [2] The World Bank. Joyce Msuya. Horizontal and vertical delivery of health services: What are the trades-offs? 2003
- [3] William Easterly. Can the West Save Africa? Journal of Economic Literature, American Economic Association, vol. 47(2), pages 373-447, June 2009.
- [4] <https://globalizationandhealth.biomedcentral.com/articles/10.1186/1744-8603-4-6>
- [5] WHO. Julio Frenk. Bridging the Divide: Comprehensive Reform to Improve Health in Mexico.
- [6] http://www.who.int/healthsystems/hss_glossary/en
- [7] The health system assessment approach: a how to manual. Version 2.0 Health system 20/20. Sept 2012. <http://apps.who.int/medicinedocs/documents/s19838en/s19838en.pdf>
- [8] Why differentiating between health system support and health system strengthening is needed, Grace Chee, 2012
- [9] ACF, 2012, "Enhancing climate resilience and food & nutrition security policy"
- [10] What is a resilient health system? Lessons from Ebola, Dr Margaret E Kruk, Michael Myers, S Tornorlah Varpilah, Bernice T Dahn, The Lancet, 2015

ANNEX 6: HSS TRAINING PRESENTATION

A powerpoint presentation is available in the additional documents.

ANNEX 7: DOCUMENTS TO BE REVIEWED BY BUILDING BLOCK, AND THE ASSOCIATED INDICATORS FOR THE HEALTH SYSTEM ASSESSMENT

	DOCUMENTS	INDICATORS/ INFORMATION
GENERAL COUNTRY AND HEALTH SYSTEM OVERVIEW	<ol style="list-style-type: none"> 1) The population size, economic, socio-cultural, religious, political and geographical context 2) WHO country profile 3) Demographic and health survey 4) The profile of the health system 5) The administrative divisions within the country from regional to District and sub-District level 6) Food security and seasonality (dry season, harvest, hunger gap) documents. 	<ul style="list-style-type: none"> • Total population and under-five population • Number and locations/mapping of livelihood zones, socio economic dynamics, religious and ethnic groups • Total expenditure on health • Fertility rate • Life expectancy at birth (years) • Adult literacy • Infant mortality rate • Under-five mortality rate • % Population with access to drinking water • Diarrhoea prevalence among under-five children • % Population with access to improved sanitation • Prevalence of GAM, SAM • Prevalence of stunting and underweight • Main causes of morbidity and mortality • Prevalence of child diseases (malaria, diarrhoea, ARI, HIV, TB, etc.) • Immunisation coverage (measles, DTP3) • Number of seasonal variations in the country • Calendar of seasonal health crisis, including caseloads, epidemiological and practical causes, and preparation and response management • Presence of preparation and response plans to all types of stresses/shocks
LEADERSHIP AND GOVERNANCE	<ol style="list-style-type: none"> 1) Reports on civil society engagement in policy formulation and legislation 2) National health and nutrition policies, strategies, guidelines, protocols, training packages, IEC tools, etc. (including any related to MCH, IMCI, IYCF, CCM, etc.), as well as those indirectly relevant to health and nutrition. 3) On-going child health and health interventions 4) Other actors in health, food security, WASH, education, finance, etc. and type of support 	<ul style="list-style-type: none"> • Stakeholder mapping and coordination • Transparency of the government with stakeholders regarding health sector goals, planning, budgeting, expenditures, and data • Public, private sector, civil society organizations and community members participation with public officials in the establishment of policies, plans, and budgets for health services • Influence of evaluation studies, research and existing HIS on government formulation of laws, policies, strategic and operational plans • Diffusion of protocols, standards, and procedures to institutions and health facilities for normal and crisis situations

HEALTH FINANCING	<ol style="list-style-type: none"> 1) National health financing strategy 2) MOH budget 3) Studies/documents on user fees and unofficial payments 	<ul style="list-style-type: none"> • General government expenditures on health • Donor mapping and coordination • Out of pocket payments (user fees and fee-for-service) • Population coverage of health insurance • User fee exemption • Health budget allocated to health crises preparation and response
SERVICE DELIVERY	<ol style="list-style-type: none"> 1) Organisational chart of the MOH 2) MOH registry of facilities (public and private) 3) Country health service delivery package 4) Standards for health service delivery 	<ul style="list-style-type: none"> • Number and state of primary, secondary and tertiary health centres and links with the community • Number of primary health centres per 10,000 population • Number of hospital beds per 10,000 population • Access to services (geographical) • Inpatient, outpatient and outreach activities delivered by the health centres • Referral system for normal and crisis situations • Yearly caseloads trends
HEALTH WORKFORCE	<ol style="list-style-type: none"> 1) Health worker recruitment and deployment process 2) National health human resources strategy and regulations 	<ul style="list-style-type: none"> • Ratio of health care professionals per 10,000 population • Number of health care workers in the public, private, and NGO sectors • Number of health workers per type of health centre (primary, secondary, tertiary) • Health worker education and training, including nutrition/CMAM training • Professional bodies such as nursing councils and medical boards • Public and private pre-service and in-service training health institutions • Production of health workers according to the national needs • Working conditions and motivation • Involvement of the community in service planning and provision • Personnel management and provision in situation of crisis
SUPPLY	<ol style="list-style-type: none"> 1) National drug law, policy and procurement guidelines 2) Logistics management and supply monitoring system 3) Essential Medicines' lists 	<ul style="list-style-type: none"> • % of out-of pocket expenditure for health on medicines • Government and private expenditure on equipment, medicines and therapeutic foods • Essential medicines and therapeutic foods procurement and provision mechanisms • Drugs and equipment provision plan in case of crises
HEALTH INFORMATION SYSTEM	<ol style="list-style-type: none"> 1) National Health Information System strategy 2) National data management tool/software 3) Monitoring and evaluation reports (including nutrition) 4) Guidelines for data collection and reporting procedures 	<ul style="list-style-type: none"> • Health indicators of the Health Information System • Health data monitoring and reporting mechanisms • Report completion rate • Information flow from the bottom to the top of the health system pyramid, and vice versa • Frequency of monitoring and supervision

ANNEX 8: INDICATORS FOR COMMUNITY ASSESSMENT, TO BE IDENTIFIED BY CAPACITY “DOMAIN”

INDICATORS/INFORMATION	
PARTICIPATION	<ul style="list-style-type: none"> • Involvement of community organizations into health/nutrition interventions • Motivating factors for community participation • Methods used to inform community members about health/nutrition interventions
LEADERSHIP	<ul style="list-style-type: none"> • Key roles and responsibilities of community leaders • Influence of leaders on community members and their mobilisation capacity • Involvement of community leaders into health/nutrition interventions • Mapping of traditional and political structure; identification of decision makers and ‘influencers’
SOCIAL AND INTER-ORGANISATIONAL NETWORKS	<ul style="list-style-type: none"> • Areas for improvement in community structures that the intervention could work on • Identification of social structure and intra community/household relations on decision making and support
ROLE OF EXTERNAL SUPPORT	<ul style="list-style-type: none"> • Support provided by external organisations in normal and crisis situations
ASKING WHY/CRITICAL REFLEXION	<ul style="list-style-type: none"> • Root causes of diseases/malnutrition in normal and crisis situations • Involvement of the community in the process of identifying the causes • Involvement of the community in finding solutions to the causes • Involvement of the community in finding solutions to stresses/shocks faced by the HS
RESOURCE MOBILISATION	<ul style="list-style-type: none"> • Internal resources available for success of health/nutrition interventions for normal and crisis situations • External resources available for success of health/nutrition interventions for normal and crisis situations
SKILLS, KNOWLEDGE, AND LEARNING	<ul style="list-style-type: none"> • Programme team skills and knowledge for the programme's success • Opportunities of community members for learning
LINKING WITH OTHERS	<ul style="list-style-type: none"> • Networking with different community interventions
PROGRAMME MANAGEMENT	<ul style="list-style-type: none"> • Involvement of community members in the process of decisions on planning, implementation, administration and reporting of community interventions in normal and crisis situations

ANNEX 9: OBSERVATION AND ASSESSMENT QUESTIONNAIRE FOR PRIMARY HEALTHCARE STRUCTURES

STRUCTURE CHARACTERISTICS OF THE HEALTH FACILITY

Date of visit: Day Month Year (DD, MM, YY)

___/___/ ___/___/ ___/___/

District name_____

Health facility name_____

Title of the person in charge of the facility_____

Total population (HF) _____

Population located within a 5 km radius of the health facility _____

Distance between health facility and District hospital _____

Facility location: 1. Rural 2. Urban 3. Semi-urban

Organization: 1. Government/MoH 2. NGO 3. Community-based 4. Private
 5. Other_____

Type of health facility: 1. Referral hospital 2. Health center 3. Health post
 4. Mobile health clinic 5. Community clinic/center 6. Other _____

LEADERSHIP AND GOVERNANCE

	RESPONSES	COMMENTS
Existence of national policies (nutrition, IMCI, etc...) - physically present on site	<input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> DNK	
Presence of protocols and clinical guidelines in the health facility that are adapted into practical easy-to-use forms	<input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> DNK	
The health District carries out supervisions on a regular basis	<input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> DNK	
Are there monthly and/or quarterly meetings for planning, monitoring and evaluation (District management team and health center personnel)?	<input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> DNK	
Presence of specific programs implemented in your health facility (road map, TB program, etc.)	<input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> DNK	
Is the community involved in the governance of the health facility?	<input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> DNK	
Presence of user retro-information mechanisms for healthcare service providers	<input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> DNK	
Presence of an information system for users regarding offers, prices, etc.	<input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> DNK	
Presence of preparation and response plans to type 1 shocks. (see Annex 5)	<input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> DNK	
Presence of preparation and response plans to type 2 shocks. (see Annex 5)	<input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> DNK	

HEALTH FINANCING

	RESPONSES	COMMENTS
Presence of an institution in charge of managing health facility funds.	<input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> DNK	If so, which one?
Presence of a financial process to deal with type 1 shocks i.e. seasonal or exceptional peaks (dedicated funds, financial support, etc.)	<input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> DNK	
Presence of a financial process to prepare and respond to type 2 shocks	<input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> DNK	
Is healthcare free of charge for children under 5 years old?	<input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> NA	
Is the case-management of pregnant women provided free of charge?	<input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> NA	
Is the free care policy applied?	<input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> DKN	
Are the fees for medical consultation paid by the patients themselves?	<input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> NA	
Are the fees for laboratory tests paid by the patients themselves?	<input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> NA	NA for HF
Are the fees for drugs paid by the patients themselves?	<input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> NA	
Are patients covered by a health insurance policy?	<input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> NA	
Presence of a solidarity fund for the most deprived people	<input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> DNK	

SERVICE DELIVERY

Working days _____

Working hours _____

Is there an on-call service system for emergencies ? 1. Yes 2. No NA

Presence of a referral system:

1. Yes 2. No NA

What are the available means of transportation to go to the referral structure? Are there alternatives?

Capacity:

- Number of beds: _____
- Total number of daily consultations: _____

	RESPONSES	COMMENTS
Waiting area/room with seats sheltered from sun and rain	<input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> DNK	
Functional toilets	<input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> DNK	
Functional electricity	<input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> DNK	
Functional drinking water source	<input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> DNK	
Hand-washing areas for caregivers	<input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> DNK	
Procedures to maintain all services up and running in case of a type 1 or 2 shock (see Annex 5).	<input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> DNK	If so, please specify.

Types of health services available (check boxes if yes - leave empty if no)

ACTIVITIES	OUTPATIENT SERVICES	OUTREACH / COMMUNITY SERVICES	HOME FOLLOW-UP
PREVENTIVE AND PROMOTIONAL CARE			
Care for childbearing-age women			
Prenatal consultation			
Childbirth care			
Postnatal consultation			
Family planning			
Care for children under 5 years old			
Monitoring of growth and psychomotor development			
Vaccination			
Care for children and teens attending school			
Information – Education – Communication (IEC)			
CURATIVE CARE			
Integrated management of infant and childhood illnesses (IMICI)			
Moderate acute malnutrition management			
Severe acute malnutrition management			
Adult illnesses management			
OTHER			

Equipment

	RESPONSES	COMMENTS
Permanent construction	<input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> DNK	
Consultation rooms with consultation tables	<input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> DNK	
Observation room	<input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> DNK	
Maternity room	<input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> DNK	
Equipment for maternity care (partograph, delivery bed, urine test strips, blood pressure meter, scale, speculum...)	<input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> DNK	
Existence of a cold chain	<input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> DNK	
Existence of a waste management system : incineration, waste pit	<input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> DNK	
Fitted kitchen	<input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> DNK	
Play area	<input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> DNK	

Utilization

	TOTAL CONSULTATIONS OVER THE LAST 3 MONTHS	COMMENTS
Number of curative consultations		
Number of curative consultations < 5 years old		
Number of PNC 4		
Number of deliveries assisted by skilled personnel		
Can the current equipment put up with an important rise in the number of patients?	If so, what is percentage?	

Quality

Are the protocols displayed and used?

1. Yes 2. No DNK

Are registers correctly filled in :

Curative	<input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> DNK
Prenatal consultation	<input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> DNK
Preventive consultation for children	<input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> DNK

HUMAN RESOURCES FOR HEALTH

STAFF QUALIFICATIONS	EXPECTED NUMBER OF HEALTH STAFF PER TYPE IN NORMAL SITUATIONS	IS THERE A SPECIFIC HEALTH STAFF FORECAST FOR NON-NORMAL SITUATIONS (seasonal peaks, exceptional peaks, etc.)	PAYMENT	TRAININGS DELIVERED OVER THE LAST 12 MONTHS
Doctor		<input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> DNK	<input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> Late	
Midwife		<input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> DNK	<input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> Late	
Nurse		<input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> DNK	<input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> Late	
Assistant/Aid		<input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> DNK	<input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> Late	
Laboratory technician		<input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> DNK	<input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> Late	
Community health workers		<input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> DNK	<input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> Late	
Pharmacist		<input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> DNK	<input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> Late	
Other (specify)				
Volunteers		<input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> DNK	<input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> Late	

Availability of job descriptions for staff members

1. Yes 2. No DNK

SUPPLY

STORAGE SPACE	RESPONSES	COMMENTS
Existence of a storage facility	<input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> DNK	
Storage area is sufficient during normal situations	<input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> DNK	
Storage area is sufficient during seasonal/exceptional peaks	<input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> DNK	
Storage space is clean, well-ventilated, protected from light and humidity	<input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> DNK	
Stock sheets are available and up to date	<input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> DNK	
Inventory is carried out monthly or quarterly	<input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> DNK	
Purchase orders and reports are available	<input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> DNK	
Existence of a fire protection device	<input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> DNK	
Existence of safety grids/ bars	<input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> DNK	
Existence of buffer stocks	<input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> DNK	
Possibility to order and obtain additional equipment quickly in case of a type 1 or 2 shock (see Annex 5)	<input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> DNK	
Do you experience drug / "essential equipment" stock-outs. If so, what is the duration? And for what reasons?	<input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> DNK	

Supplies

TYPE OF PRODUCT/COMMODITY	RESPONSES	COMMENTS
Medical examination supplies (stethoscope, blood pressure meter, thermometer, otoscope)	<input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> DNK	Tick yes only if all 4 items are available.
Existence of anthropometric equipment in good operating conditions:		
Mid-upper arm circumference tapes (MUAC)	<input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> DNK	
Weighting scale for children	<input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> DNK	
Weighting scale for babies	<input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> DNK	
Weighting scale for adults	<input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> DNK	
Measuring rod	<input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> DNK	
Essential medicines (Paracetamol, Amoxicillin, Albendazole, anti-malarial drug, Iron, anti-diarrheal drug/ORS)	<input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> DNK	
Human Immunodeficiency Virus (HIV) drugs	<input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> DNK	
Existence of a routine expanded immunization programme	<input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> DNK	Coverage estimation (%)
Presence of therapeutic foods or food supplements	<input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> DNK	If so, specify which ones
Laboratory equipment and supplies (cover glasses, slide glasses, reagents, rapid tests, microscope)	<input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> DNK <input type="checkbox"/> 4.NA	
Radiology supplies (film, plate)	<input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> DNK <input type="checkbox"/> 4.NA	

Did you experience drug stock-outs over the last 6 months?

1. Yes 2. No

HEALTH INFORMATION SYSTEM

	RESPONSES	COMMENTS
Existence of a checklist for follow-up and supervision	<input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> DNK <input type="checkbox"/> 4.NA	
Are reporting forms available?	<input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> DNK <input type="checkbox"/> 4.NA	Monthly report
Is there a specific person in charge of the compilation and analysis of health information?	<input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> DNK <input type="checkbox"/> 4.NA	
Availability of formats for monthly activity reports (MAR)	<input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> DNK <input type="checkbox"/> 4.NA	
Availability of formats for weekly reports on epidemiological surveillance	<input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> DNK <input type="checkbox"/> 4.NA	
Reports are sent in a timely manner (according to deadlines set up by the MoH)	<input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> DNK <input type="checkbox"/> 4.NA	
NHIS reports are properly completed	<input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> DNK <input type="checkbox"/> 4.NA	
Is the collected data analysed at the District level?	<input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> DNK <input type="checkbox"/> 4.NA	
Do you receive retro-information?	<input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> DNK <input type="checkbox"/> 4.NA	

ESTIMATION OF TYPE 1 AND 2 SHOCKS TO WHICH THE HEALTH FACILITY IS EXPOSED

Definitions:

- **Type 1 shock:** Shock inducing a rise in the number of new admissions regardless the cause, the length and the magnitude of the rise.
- **Type 2 shock:** Shock that have a direct impact on the intrinsic structure of the health system, but not necessarily inducing a rise in admissions. For instance, a flood may affect the proper functioning of the health facility (by preventing the access to the facility or the delivery of drugs and materials) without actually harming the population.

This parts aims at establishing a two-year calendar describing each type of shock showing the magnitude of the shocks, their causes and their consequences on the health facility.

Seasonal calendar for type 1 shocks:

Data can be entered in the following table.

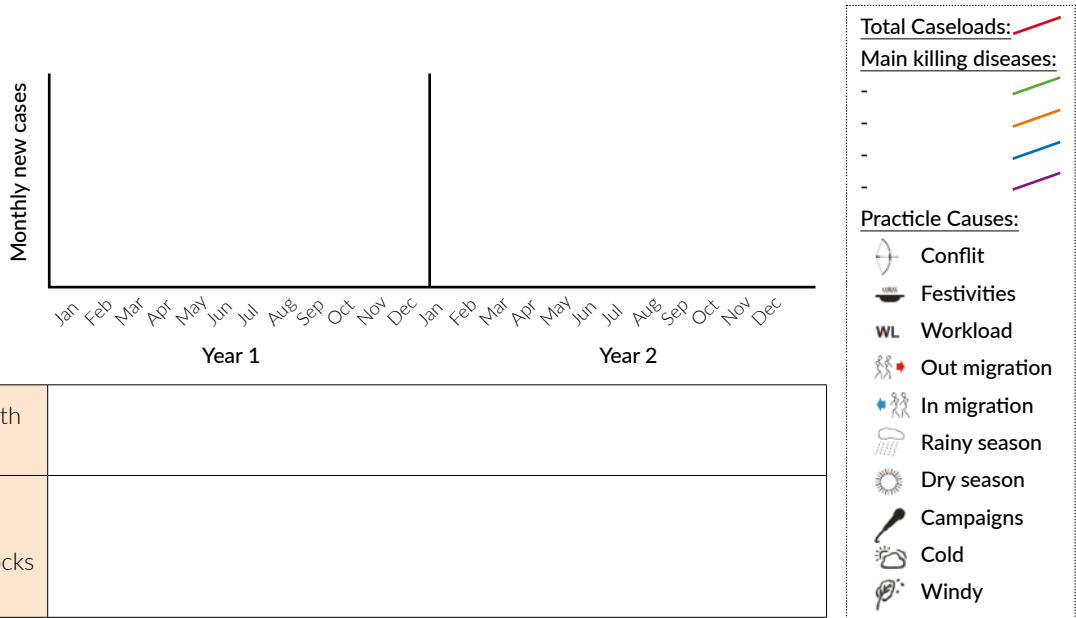
TYPE 1 SHOCKS	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEPT	OCT	NOV	DEC
Number of monthly new cases												
Causes (epidemiological, practical, etc.)												
Factors influencing the number of new cases												
Comments on the health facility's response												

Data is then transposed into Graph 1. The horizontal axis (x-axis) represents a time period of 24 months, the vertical axis (y-axis) shows the number of monthly new admissions.

How to fill in Graph 1:

- Insert the number of monthly new admission for the 3 or 4 major diseases, as well as the total number of new admissions per month. The information is drawn with curves.
- Insert the epidemiological and/or practical causes of these new admissions, and the external factors influencing them. The epidemiological causes can be directly written on the graph or a legend system can be used. For practical causes, there is a list of suggested pictograms on the side of the graph.
- Write down the effects observed on the health facility in the appropriate textbox under the plot.

The model used by Concern Worldwide for severe acute malnutrition can be used (see figure below).



Effects on the Health District	
Health District capacity to prepare and respond to shocks	
Existing strategies	

Graph 1 - Type 1 shocks description

Seasonal calendar for type 2 shocks:

Fill in the table based on events that happened over the last years.

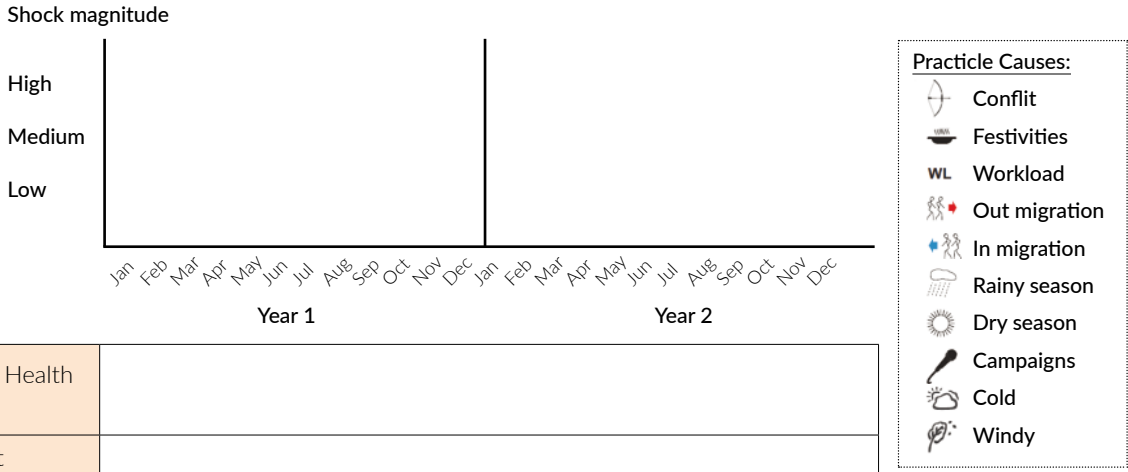
TYPE 2 SHOCKS	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEPT	OCT	NOV	DEC
Shock description (flood, political conflicts, droughts, etc.)												
Shock magnitude (High/Medium/Low)												
Effects on the health facility (6 building blocks)												
Comments on the health facility's response												

Data is then transposed into Graph 2. The horizontal axis (x-axis) represents a time period of 24 months, the vertical axis (y-axis) on the left shows the number of new monthly admissions. The vertical axis on the right represents the magnitude of the shock (high, medium, low).

How to fill in Graph 2

- Insert type 2 shocks taking into account their nature (using the suggested pictograms on the side, new ones can be added if necessary) and their magnitude (position on the right vertical axis).
- Write down the effects observed on the health facility in the appropriate textbox under the plot.

Both graphs should be positioned on top of each other to have a global understanding of these shocks, their causes and their consequences.



Effects on the Health District	
Health District capacity to prepare and respond to shocks	
Existing strategies	

Graph 2 - Type 2 shocks description

ANNEX 10: INDIVIDUAL INTERVIEWS: QUESTIONS FOR HEALTH WORKERS

Individual interviews must be carried out after the observation of the health center.

Date (DD, MM, YY)

___/___/___ / ___/___/___ / ___/___/___

Health structure_____

Name and title/position of the respondent_____

GOVERNANCE

1. Are you aware of the local and national strategies applied by the health center?
2. Do you think the objectives of the nutrition and health sector are met at the local level?
 - a. If so, explain how these objectives are met.
 - b. If not, specify the unsatisfactory points.
3. What problems are you confronted with when trying to involve partners and government?
4. Do you participate in coordination/consultation/strategic planning meetings?
 - a. If so, which ones?
 - b. If not, what mechanisms do you use for micro-planning, monitoring and evaluation
5. What would you recommend in order to meet the objectives of the health and nutrition sector at the local level?
6. Is there a response plan in case of an increase in consultation number, epidemics, seasonal or exceptional shocks?

If so:

 - a. Are key actors aware of it?
 - b. Is it applied when needed?
 - c. Is it effective?

FINANCING

7. What are the financing sources of your health structure?
8. How do you receive funds allocated to your health structure by the government and/or by the supporting partner?
9. How does your health structure collect the direct payments of patients for services provided?
10. Do you manage to reach the operational objectives of your health structure with the funds collected?
 - a. If so, how?
 - b. If not, which objectives are not met and why?
11. What are the financial means available to deal with shocks (response plan)? Are they sufficient?
12. Is the community involved in the financial management of your health structure?
 - a. If so, at which level?
 - b. What are the advantages and drawbacks?

SERVICE DELIVERY

13. What problems do you experience while performing your activities in the health centre?
14. How do you deal with these problems?
15. Do you think the population has a proper access to health services in this District?
16. When you refer a patient to a health centre or a hospital, how do you make sure he gets there?
17. What is your relationship with other health structures?

18. How do you access people living in remote areas?
19. Is there a mechanism ensuring that the services offered to the community meet their needs?
20. Do you organize meetings with the community? If so, are they scheduled on a regular basis?
21. What are the existing communication mechanisms (channels, frameworks...) between communities and your health structure?
22. What are the links between community health workers and the health structure (supervision, training, follow-up meetings)?
23. What is your relationship with traditional healers in your catchment area?
24. How do you make sure that care services provided by your health structure are of good quality?
25. How often are you supervised?
26. What is the content of the supervisions?

HEALTH WORK FORCE

27. What can you say about your motivation and professional satisfaction?
28. What factors affect your motivation the most?
29. What problems do you experience while doing your job as a health worker?
30. Who can be involved in solving general health issues?
31. What incentives can be provided to people involved?
32. When was the last time you received a training?
33. What kind of training was it?
34. And by whom was it sponsored?
35. Is there a training for the management of admission peaks?
36. Are there enough staff members available for normal situations, for admission peaks and for other types of shocks which disrupt the good functioning of your health center?

SUPPLY

37. What is the mechanism for orders and deliveries of supplies?
38. Does the product/commodity supply meet the needs (in cases of peaks and in normal situations)?
39. Did you experience stock-outs in nutritional inputs over the last three months: How often? For what reasons? How did you deal with the problem?
40. When there is a drug stock-out, what are the optional sources of supply for patients? Where do they have to go to get the drugs?
41. What problems do you experience while supplying drugs, inputs...?
42. In your opinion, what would be the solution to these problems?
43. Are you able to quickly obtain drugs/equipment/others in case of an important increase in needs or in case of a shock disrupting supply?

HEALTH INFORMATION SYSTEM

44. Which tools do you use to compile monthly data of your health structure?
45. Do you have a system to monitor the number of new cases?
46. Is the data analysis performed at your level?
 - a. If so, how?
47. Where do you send your monthly activity reports?
48. What problems do you experience with monthly activity reports?
49. What feedback do you usually get after sending your reports?

ANNEX 11: INDIVIDUAL INTERVIEWS: QUESTIONS FOR POLICYMAKERS, DONORS AND PARTNERS (NGOS, UN AGENCIES...)

A LIST OF PERSONS TO MEET SHOULD BE PREPARED DURING STEP 1

- for the national and regional levels
- for the District level

The questions below have to be selected according to who is interviewed (and what information is sought). A total of approximately 10 questions for all 6 building blocks have to be selected depending on the respondent, they sometimes will have to be rephrased. A standard questionnaire cannot be set, it depends on the context.

Date (DD, MM, YY)

___/___/___ / ___/___/___ / ___/___/___

Location _____

Name, organisation and title/position of the respondent _____

GOVERNANCE

1. What can you say about the national health policies and strategies? Are they adapted, comprehensive, implemented?
2. What is your role in the health system (national/District)? Can you explain your involvement in health policy development and planning?
3. How do the nutrition coordination mechanisms operate at national, regional and District levels?
4. What are the existing mechanisms to ensure the effective implementation of health plans/programmes at community and District levels?
5. What are the existing communication mechanisms between the community and health service providers?
6. What would you recommend to reach the objectives of the health sector at both national and local levels?
7. Are there strategies, protocols or plans for shocks response that are being developed or implemented?

FINANCING

8. How much of the national budget is dedicated to health?
9. Who are the main health donors in the country?
10. What is the existing health financing mechanism in the country, from national to subnational levels?
11. Do free care mechanisms exist and are they functioning?
12. What are the main obstacles in terms of health financing at the national/regional/District levels?
13. Explain how you manage to carry out the operational activities planned for the District with the funds collected?
14. Are there specific funds dedicated to shocks preparation and response?

SERVICE DELIVERY

15. What do you think of the quality of care offered at the District level?
16. How do you make sure that care services provided in health structures are of good quality?
17. Do you think the level of utilisation of the services is adequate?
18. Do you think health structures provide all services included in the minimum health package? (meaning : XXXX => describe the minimum health package)
19. How do the public sector, the private sector and traditional healers interact in order to provide services to the population of the country and at the District level?

20. What are the referral and follow-up procedures between the different levels of health structures (primary, secondary, tertiary)?
21. To what extent are supervisions integrated into the programs (primary healthcare, tuberculosis, HIV, malaria, nutrition, etc.)?
22. How do you anticipate and deal with emergency situations caused by epidemic outbreaks or seasonal peaks in the District?
23. In your opinion, what are the main/key barriers to access health services? And what would be the solutions to remove these barriers?

HEALTH WORK FORCE

24. What can you say about the motivation and satisfaction of health staff?
25. What are the factors that affect their motivation and satisfaction the most?
26. Do they have supportive supervisions on a regular basis?
27. When was the last time the health staff received training? What kind of training was it? By whom was it organized/ sponsored?
28. Do you offer specific training for preparation and response to seasonal or exceptional admission peaks?

SUPPLY

29. What challenges do you experience for the procurement of supplies and commodities?
30. What challenges do you experience for the delivery of supplies and commodities to the different health structures?
31. Did you experience stock-outs?
32. Is there an efficient procedure for quick supply in case of a shock?

HEALTH INFORMATION SYSTEM

33. How is the health information compiled and analysed?
34. How does the Ministry of Health ensure the availability of this information to the public?
35. How does this information influence the elaboration of policies, regulations, and planning?
36. Is the information collected at District level transferred to higher-level authorities? Are these mechanisms still active in case of a shock?

ANNEX 12: GAPS IN LOGISTICAL MEANS, HR AND HF

The following data are to be collected from the regional/provincial or District health authorities (depending on where the information is available either via the Steering committee or throughout health authorities interviews).

LOGISTICAL RESOURCES AND COMPUTER EQUIPMENT AT DISTRICT LEVEL

IN NORMAL SITUATIONS	EXISTING	NEEDS	GAPS
4x4 vehicle for supervision			
Functioning ambulances			
Motorbikes			
Power generator			
Computer equipment			
Printer			

IN CASE OF ADMISSION PEAKS (type 1 shocks)	EXISTING	NEEDS	GAPS
4x4 vehicle for supervision			
Functioning ambulances			
Motorbikes			
Power generator			
Computer equipment			
Printer			

GAPS IN SUPPORT STAFF

IN NORMAL SITUATIONS	AVAILABLE	NEEDS	GAPS
Maintenance personnel			
Cleaning personnel			
Secretary			
Front desk officer			
Other, specify according to context			

IN CASE OF ADMISSION PEAKS (type 1 shocks)	AVAILABLE	NEEDS	GAPS
Maintenance personnel			
Cleaning personnel			
Secretary			
Front desk officer			
Other, specify according to context			

FUNCTIONING HEALTH STRUCTURES

TYPE OF STRUCTURE	FUNCTIONING	NOT FUNCTIONING
Health post		
Health center		
Hospital		
Other, specify according to context		

ANNEX 13: INDIVIDUAL INTERVIEWS: QUESTIONS FOR COMMUNITY LEADERS, RELIGIOUS LEADERS, ELDERS...

Date (DD, MM, YY)

___/___/___ / ___/___/___ / ___/___/___

Location _____

Name, organisation and title/position of the respondent _____

1. What are the main causes of child diseases in the locality?
2. What is your opinion on the health services offered by your locality? Is it sufficient, adequate, of quality?
 - a. If so, why?
 - b. If not, why?
3. In your opinion, what would be the solutions to improve the access to health?
4. Who are the key people influencing health in this locality? How do they influence others?
5. How do community members participate in the decision-making process regarding planning and implementation of health programs?
6. What are the different health activities in which community members can participate?
7. What motivates them to participate in the intervention?
8. What are the community-level mechanisms for community involvement in health?
9. What recourses do community members have to express their opinion on health services (feedback mechanism)?
10. If you were personally involved, how would you contribute to the implementation of health and nutrition activities for the community?
11. Concerning community-led health activities: What are the existing links between the various groups involved in these activities?
12. What are the main funding and supporting bodies for community interventions on health in the District? Do you think this support is adequate?
13. Who could be involved in solving health community issues regarding?
14. What other resources are available and could be used to solve these problems?
15. What role could traditional healers play in solving these problems?
16. Have you received one or several health training courses?
17. What is your role in the dissemination of health messages?
18. What partnerships and networks exist among community organizations to address health/nutrition issues in this locality?
19. What community factors/events could explain caseload increases or problems leading to the malfunction of the health system?
20. Can you identify seasonal and exceptional shocks that have an impact on the functioning of the health system? Specify:
 - the type of shock
 - the effects on the health facility
 - if they exist, describe the activities already set up in the community/by local actors/etc. to deal with these shocks

If necessary, you will find more information and resources on resilience of communities by consulting the COBRA method.¹

NOTE

1 - http://www.undp.org/content/undp/en/home/librarypage/environment-energy/sustainable_land_management/CoBRA/cobra-conceptual-framework.html

ANNEX 14: INDIVIDUAL INTERVIEWS : QUESTIONS FOR HEALTH SYSTEM USERS

Date (DD, MM, YY)

___/___/___ / ___/___/___ / ___/___/___

Location_____

Name _____

Number of children under 5_____

Type of health structure usually attended _____

Number of visits to the health structures during the year_____

GOVERNANCE

1. Do you know the health policies in place in the District (example: free health care policy for pregnant women / children under 5 years-old)?

FINANCING

2. When you go to the health center, do you have to pay? What do you pay: consultations, material, drugs?
 - a. If yes, how often does it happen?
3. If you know you will have to pay for some health services, will you still seek them? In what circumstances?

SERVICE DELIVERY

4. Are you usually satisfied with the cares you receive in the health center?
 - a. If yes, why?
 - b. If no, why?
5. Are there health care structures easily accessible for you (distance, transport, timing, etc.)?
6. Were you referred to other health structures? Was it clearly explained to you? Were you provided support to go there?
7. What are the barriers for not going to the Health Center when needed?
8. Are you or your community regularly asked for your feedback on the health system?
 - a. If yes when?
 - b. If no, would you like to be asked?

HUMAN RESOURCES

9. How were the personnel who took care of you (nice, professional, competent, etc.)?
10. Were there enough personnel to take care of you? Did you have to wait for a long time?

SUPPLY

11. Could you receive the medicines that were prescribed by the doctor? Did you have to pay to get them?

HEALTH INFORMATION SYSTEM

12. Do you know where to go if a member of your family has a health issue?
13. Do you feel well informed about:
 - a. Your rights
 - b. The health structures present in the area where you live, and the offered care services
 - c. The health care services that you should seek, such as ante-natal consultations, post-natal consultations, etc.

ANNEX 15: FOCUS GROUP DISCUSSIONS

QUESTIONS FOR PARENTS OF CHILDREN AGED FIVE AND UNDER, PATIENTS OF HEALTH CENTERS, VOLUNTEERS AND COMMUNITY HEALTH WORKERS

- The optimal duration of a focus group discussion is between one and two hours.
- The ideal number of participants in a group discussion is between six and eight.
- It is recommended that participants do not know each other.
- We recommend setting up well-balanced groups (age, gender).
- Eventually, we recommend proceeding to several group discussions having the same type of target and the same interview guide.

INTERVIEW GUIDE

Date (DD, MM, YY)

___/___/___ / ___/___/___ / ___/___/___

Location_____

Names and type of participants (ex: parents, patients, CSO...)

IMPORTANT: The questions below will have to be selected according to the persons interviewed. Only 6 to 8 questions should be selected.

1. What are the main health problems in the locality?
2. What is your opinion on the health services offered by your locality? Is it sufficient, adequate, of quality?
 - a. If so, why?
 - b. If not, why?
3. What are the main obstacles in accessing health services for the population?
4. In your opinion, which solutions would improve the access to health?
5. How do community members participate in the decision-making process regarding planning and implementation of health programs?
6. What are the mechanisms for community involvement in health at community level?
7. What are the different health activities in which community members can participate?
8. What motivates them to participate in the intervention?
9. What recourses do community members have to express their opinion on health services (feedback mechanism)?
10. If you were personally involved, how would you contribute to the implementation of health and nutrition activities for the community?
11. Concerning community-led health activities: What are the existing links between the various groups involved in these activities?
12. Who could be involved in solving community issues regarding health?
13. What other resources are available and could be used to solve these problems?
14. What role could traditional healers play in solving these problems?
15. Have you received one or several health training courses?
16. What is your role in disseminating health messages?
17. What partnerships and networks exist among community organizations to address health/nutrition issues in this locality?
18. What effective means can you use to send information to higher-level authorities, especially in case of shocks?
19. What would you recommend for shock preparation and response at HC and community levels?
20. Can you give an estimation of the maximum number of consultations that can be performed in a day/ number of patients that can be seen in a day?

ANNEX 16: THRESHOLDS DEFINITION AT HEALTH FACILITIES

This section is extracted from Concern Worldwide CMAM Surge Approach- Operational Guide- 2016.

Depending on the way thresholds are defined at the District level, thresholds might also have to be defined at the Health Facility (HF) level.

First, the concept of “thresholds” should be introduced to the health team: thresholds should reflect a combination of capacity and workload. Since the capacity of a HF can vary greatly, thresholds are set by each HF individually to indicate the levels at which the HF’s capacity will be overstretched in front of an increase in cases. A combination of factors influencing capacity (e.g. staffing levels and qualifications, presence of community workers, etc.) and case records help in defining realistic thresholds, as well as drawing from staff members’ experiences during times when service needs exceeded available resources.

Thresholds set by HFs should be validated by the District and partners to help ensure that thresholds are set realistically i.e. not too low or too high or too close together. A mechanism in 3 steps is suggested to guide the process of setting thresholds and to confirm them.

AVERAGE NUMBER OF NEW CASES PER MONTH

- What has been the range of number of new cases per month over the past years?
- What has been the average?
- How has this level of cases been for the staff to manage?

AGREE ON THRESHOLDS FOR EACH PHASE

At this stage, the staff should have a good understanding of the HF’s capacity and what number of new cases will cause them to be overstretched. The HF stakeholders should discuss and debate what they feel are appropriate thresholds for the number of new cases for the HF for each phase – normal, alert, serious and emergency. The HF stakeholders should arrive at a consensus for each threshold.

Use the description of the phases (see below) to aid with this process, keeping in mind that reaching the serious or the emergency phase should be something that rarely happens, i.e. approximately once every two years for the serious phase and once every 8 years or more for the emergency phase, and not something to aim for.

PHASE	DESCRIPTION FOR THE HEALTH FACILITY
NORMAL	When the HF staff can handle their workload and have adequate resources to meet the demand for services. During this phase, there is time to work towards strengthened service delivery, including staff training, as well as staff taking leave, infrastructure repairs, etc.
ALERT	When the HF staff members begin to be overstretched due to increased demand for care services but can handle the situation by reorganising to focus on key priorities with minimal external support; this phase may entail a slight simplification of procedures or some task shifting aimed at being more efficient. During this phase, the HF should be able to access additional supplies easily, as needed.
SERIOUS	When the HF staff is overstretched from the increased caseload and requires additional support from the DHMT/partners in order to appropriately meet the additional demands; this is when reorganising within the HF and mobilization of the HF’s own resources are insufficient to handle the situation.
EMERGENCY	When the HF staff is overstretched to the point where even greater additional support is required from the DHMT and partners in order to a) ensure that services for care are functioning effectively and at full capacity and b) the population is able to access appropriate services in a timely manner. Significant resource inputs from partners are likely (i.e. additional human resource, supply chain support, infrastructure and equipment). Additional partners support will ideally be provided via the DHMT, but if the DHMT is overwhelmed itself, direct support to HFs may be required.

Table 1 Phases description for Health Facilities

CONFIRMATION OF THRESHOLDS

Finally, the HF stakeholders confirm whether the agreed thresholds are appropriate compared to a standard and objective means of threshold setting. For this confirmation step, the District facilitator should display and explain what standard thresholds would roughly be appropriate, if setting by purely objective means, i.e. via a calculation using the normal number of new cases per month, as in the tables here. The example thresholds given here are for both low and high caseload examples, with a graph of the low caseload scenario shown in Figure below displaying malnutrition cases (figure extracted from the Concern Guide with a focus on CMAM). It can be used in the present HSS work by considering the global number of new cases.

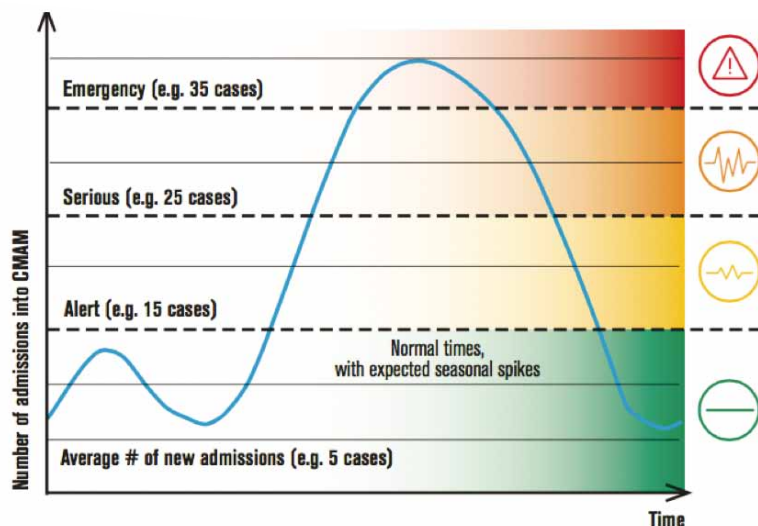


Figure 1 Example of phases and thresholds for malnutrition cases – Can be used for the HSS approach using the global number of new cases.

During this exercise, the stakeholders should calculate what the HF's objective thresholds would come out to using the actual normal number of new cases.

Table 1: Setting thresholds by calculation
– low caseload example

Phase	Thresholds for low caseload example 10 new SAM admissions/month
Normal	Up to 3 x normal # of new admissions From: 0 To: 30
Alert	3-5 x normal # of new admissions From: 31 To: 50
Serious	5-7 x normal # of new admissions From: 51 To: 70
Emergency	7 x normal # of new admissions and up From: 71 To: and up

Table 2: Setting thresholds by calculation
– high caseload example

Phase	Thresholds for high caseload example 100 new SAM admissions/month
Normal	Up to 1.5 x normal # of new admissions From: 0 To: 150
Alert	1.5-2 x normal # of new admissions From: 151 To: 200
Serious	2-3 x normal # of new admissions From: 201 To: 300
Emergency	3 x normal # of new admissions and up From: 301 To: and up

Figure 2 Tables for the calculation of thresholds. Here new admissions are counted, whereas in the HSS approach, new cases in general will be counted.

Looking at these calculated thresholds, the stakeholders should compare to the agreed thresholds from the previous step.

- How do the calculated thresholds compare to the agreed thresholds?
- Do the stakeholders still feel their thresholds are appropriately set or do they want to adjust them at all?
- Are any big differences justifiable based on the HF's capacity?

While it is okay to have differences, the reasons for having much higher or lower thresholds should be discussed and documented.

This calculation method of setting thresholds is helpful as a guide only for confirmation purposes and is not meant to be used to set thresholds on its own; it is important that threshold setting includes the component of the HF's capacity from 2).

NOTE

ANNEX 17: MATRIX INDICATORS

The Excel file of the matrix indicator is available in the additional documents.

ANNEX 18: NUMBER OF REFERENCE INDICATORS

CATEGORIES	NUMBER OF INDICATORS
Governance	30
Policy formulation and planning	12
Information/ Assessment Capacity	2
Social participation and system responsiveness	8
Accountability	5
Regulation	3
Financing	12
Pooling and allocation of financial resources - Government budget formulation and allocation	8
Joint financing	3
Universal access to healthcare	1
HR	20
Policies	3
Planning	6
Performance management	2
Training and education	9
Supply	18
Pharmaceutical policies, laws and regulations	6
Effective implementation of supply	9
Joint supply management	3
Service delivery	22
Availability and continuity of care	4
Coverage and access to RMNCH services	4
Utilization	5
Quality assurance	6
Community participation in service delivery	3
HIS	12
Integration of RMNCH services in HIS	9
Monitoring and Evaluation	3
TOTAL	114

ANNEX 19: MATRIX USER GUIDELINES

GENERAL INFORMATION

PRESENTATION OF THE DIFFERENT TABS

TAB TITLE	DESCRIPTION	CORRESPONDING STEP(S) OF THE HSS METHOD
O. User guidelines	User guidelines on how to use the matrix	All
A. Governance B. Financing C. HR D. Supply E. Service delivery F. HIS	For each of the 6 building blocks, a tab is available and presents a list of indicators to score and assess the Health District situation.	Step 5 - Consensus phase
G. Key Indicators Results	Presentation of the scoring results of the 22 key indicators	Step 5 - Consensus phase Step 6 - Common prioritization
H. Shocks Indicators Results	Presentation of the scoring results of shocks indicators	
I. Building Blocks Results	Presentation of the scoring results of all building blocks	
J. Prioritization	Scoring and prioritization of selected indicators	Step 6 - Common prioritization

PRESENTATION OF THE COLOR CODE

	Key indicators
	Shocks indicators
	Columns to be filled in during the workshop
	Columns containing information for participants. They can be modified by the Steering committee during preparation phases but they MUST NOT be modified by the participants during the workshop

PRESENTATION OF THE COLOR CODE USED FOR THE SCORING OF THE INDICATORS

2.25 to 3.0 (75% -100%)	Highly adequate
1.5 to 2.24 (50%-74%)	Adequate
0.75 to 1.49 (25%-49%)	Present but not adequate
0 to 0.74 (0 %-24%)	Not adequate at all

USER GUIDELINES FOR TABS A TO F

Corresponds to Step 5: Consensus phase.

The six tabs related to the pillars of the health system will allow participants of step 5 to express their views and to score the proposed indicators for each pillar. The table below provides an understanding of how each column will be filled (guidelines):

- Either during the workshop preparation phase, in order to provide the best possible information on the indicator in question
- Either at the workshop itself when the indicators scoring will be realized.

To be adapted during the preparation of the workshop, if needed			To be filled in during the preparation of the workshop				To be filled in during the workshop			To be filled in during the workshop		Comments on the discussions about the scoring (disagreement, debate, etc.)
			Building Block	Reference indicator	Specifications	Very satisfactory	Satisfactory	Existing but not satisfactory	Not satisfactory at all	Presence and sustainability of external aid	Results from secondary and primary data collection	
Information on each column	Building block description	Description of reference indicators for each building block and the indicator	3	2	1	0	Definitions are mentioned in the matrix	<p>Relevant results obtained through steps 2 and 3 are described here in order to help participants to carry out a proper and realistic scoring of the indicators.</p>	<p>These columns are provided so that each participant can enter his score for each indicator. If necessary, other columns can be added.</p>	<p>Automatic calculation of the average score for each indicator building block</p>	<p>This column gives qualitative information regarding the scoring of the indicator. Main points of the discussions about the scoring taking place during the workshop are included. If there are disagreements among participants, it should be mentioned.</p>	
							<p>A drop-down menu is available to assess the presence and sustainability of external aid for each indicator. This allows a better assessment of the actual District situation regarding the indicator. The options are:</p> <ul style="list-style-type: none"> - No aid - Actors support the HD – short term - Actors support the HD – long term - Actors substitute for the HD – short term - Actors substitute for the HD – long term <p>These terms are described above, an automatic color code is included.</p>					
User guidelines / How to fill in each column. Follow the numbering system to know the order of the actions.	<p>1. During the workshop preparation, the steering committee has to adjust (if necessary) the reference indicators and the specifications according to the context.</p>						<p>3. During the workshop preparation, the steering committee has to fill in this column, for each indicator, based on primary and secondary information collected.</p>	<p>2. During the workshop preparation, the steering committee has to fill in this column, for each indicator, based on the results of the primary and secondary data collection. If the information is critical, the cell has to be colored in red. The information should help scoring the indicators.</p>	<p>4. During the workshop, participants score each indicator using the information located in all columns to the left. It is not necessary to fill in all the cells. For example, if the group agrees to give a score of "2" for a given indicator, the value "2" can be entered only once.</p>		<p>5. During the workshop, participants have to fill in this column so that qualitative information on the scoring of the indicator is also collected.</p>	

USER GUIDELINES FOR TABS G TO I

The information below is to be used during the triangulation phase.

The "Results" tabs present the results of the scoring exercise, they must not be modified (formulas allowing the visualization of the results could be altered). There are three tabs for results:

- G. Key indicators results
- H. Shocks indicators results
- I. Building blocks results

For each indicator, the score obtained is described, and a color code facilitates the visualization. Results are also presented graphically with a histogram (G. Key indicators) and radar diagrams (H. Shocks indicator and I. Building blocks). These results will be used for the triangulation phase.

USER GUIDELINES FOR THE J TAB

Step 6: Common prioritization – Guidelines.

For this step, you have to use the "J. Prioritization" tab. The guidelines explaining how to fill in the table used in this step is presented below.

	Building Block	Reference indicator	Specifications	Comments on the discussions about the scoring (disagreement, debate, etc.)	Average indicator scores	TO BE FILLED IN during the workshop				Total
						Prioritization criteria				
						To be filled in	To be filled in	To be filled in	To be filled in	
Information on each column	Building block description	Description of reference indicators for each building block	Important specifications to better understand the indicator	This column gives qualitative information regarding the scoring of the indicator. Main points of the discussions about the scoring taking place during the workshop are included. If there is disagreement among participants, it should be mentioned.	Average scores of the indicators obtained through step 5	Upper row: Criteria defined by the steering committee and the partners to prioritize the indicators. Rows below: Scoring of the indicators according to their priority. The scoring is done as follows: - Low priority: (1) - Medium priority: (2) - High priority: (3)				Automatic calculation of total scores
User guidelines / How to fill in each column. Follow the numbering system to know the order of the actions.	<p>1. Only indicators (keys, related to shocks, and others) with score lower than 0.74 (red) must be listed in this tab. During the preparation of the workshop these indicators (score inferior to 0.74) must be added the tab 'J. Prioritization', and the different columns completed for each of the added indicators. Indicators with a score greater than 0.75 are NOT considered here.</p>					<p>2. After validation with partners, include in the tab 'J. Prioritization' the prioritization criteria that have been defined to rate and prioritize indicators with a low score.</p>				
					<p>3. Rate each indicator listed according to the prioritization criteria. The information presented in the left columns will help the ratings of the prioritization criteria.</p>					

ANNEX 20: STRUCTURE OF THE DIAGNOSIS REPORT

The report should be organised according to the following structure:

EXECUTIVE SUMMARY

Short description of the assessment presenting the key findings

TABLE OF CONTENTS

INTRODUCTION/BACKGROUND

Brief description of the context

Reasons for conducting the assessment

Objectives of the assessment

METHODOLOGY

- Timeframe of the assessment
- Composition of the assessment team and its training
- Collection of *secondary* information (sources and process)
- Collection of *primary* information
 - Direct observations (health centres selection and observation process)
 - Individual interviews (key informants and their selection criteria)
 - Focus group discussions (description of group compositions and their selection process)
- Risks and capacity analysis
 - Analysis of the type 1 and type 2 shocks including the type, occurrence, magnitude, causes and effects on the health system
 - Analysis of the capacity of the District to prepare and respond to these shocks
 - Thresholds setting for District
- Diagnosis workshop
 - Participants and highlights of the workshop

RESULTS

- Practical constraints of the assessment
- Health system assessment
 - Presentation of the strengths and weaknesses of the health system, by describing the findings according to each assessment theme, organized into *strengths, weaknesses, opportunities and threats*. Inclusion of qualitative and quantitative findings.
 - Presentation of the risks analysis results, including the District thresholds
 - List, description, and justification of the prioritized weaknesses

CONCLUSIONS

Conclusions on the health system assessment

RECOMMENDATIONS

Suggestions of possible strategy/scenario for integration and/or perspective of interventions design or adjustment.

ANNEX 21: THEORY OF CHANGE AND LFA

CAUSAL TREE	SOLUTIONS TREE	FINAL VERSION OF THE LFA
<p>STEP 7</p> <p>The causal tree is built here, the three levels of causes should be identified:</p> <ul style="list-style-type: none"> • Immediate causes: Service delivery • Under-lying causes: Human Resources, Health Information System, Supply • Basic causes: Governance, Financing 	<p>STEP 8</p> <p>By mirroring the causal tree, a solution tree is built. For each cause solution(s) is identified. Solutions are turned into objectives by the Steering committee then.</p> <p>The output of this step is a drafted LFA.</p>	<p>STEP 9 & 10</p> <ul style="list-style-type: none"> • The theory of change is applied here. • During the step 9, the partners internally identify activities to reach each solution. • During the workshop 4 (Step 10), the final activities are defined, using the 3S method (strengthening, support and substitution). • At the end of the workshop, the final LFA is available.
<p>FOCUS</p> <p>Identify causes</p>	<p>FOCUS</p> <p>Identify solutions and turn them into objectives</p>	<p>FOCUS</p> <p>Identify 3S activities</p>

ANNEX 22: HOW TO DEVELOP A CAUSAL TREE?

This Annex is based on a document developed by the FAO that explains in details how to develop causal trees for malnutrition¹.

GUIDELINES TO BUILD UP THE CAUSAL TREES

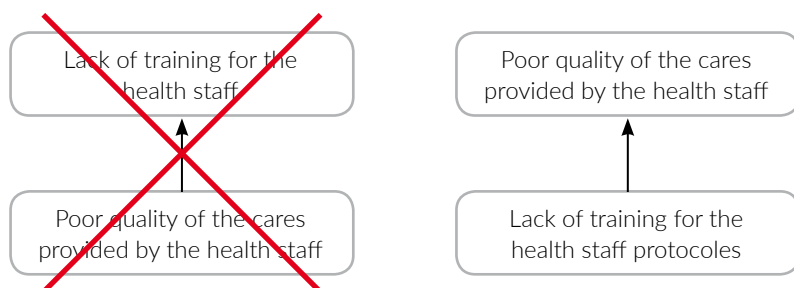
A causal tree is a visual problem-analysis tool to specify and investigate the causes of a problem and to highlight the relationships between them. It will be the base to formulate the solutions trees.

In the proposed HSS approach, the causal analysis will start with the service delivery prioritized bottlenecks, then HR, supply, HIS, and finally the financing and governance ones. Related causes are then identified and mapped according to the causes' hierarchy.

- If the same causes have been identified for another bottleneck, they can already be included in the tree, and mapped. Linkages between levels and causes need to be drawn clearly.
- Bottlenecks prioritized in the other building blocks will most probably be found in the underlying and basic causes of the causal tree designed for the service delivery bottlenecks.
- Once the tree on one service delivery bottleneck is agreed, another service delivery prioritized bottleneck is selected, and the same exercise is performed. Links with the previous tree will be looked at.

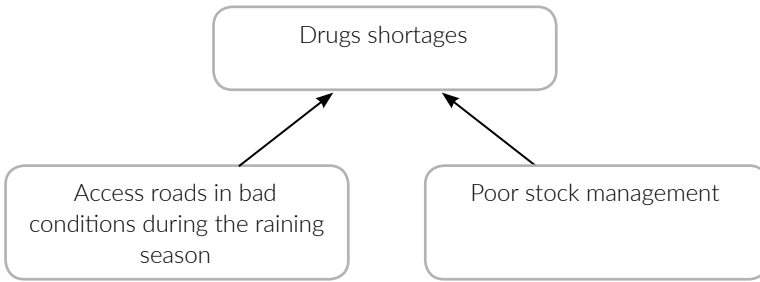
Practical advices for the facilitator to guide the causal tree development:

- **Materials** to provide:
 - Several sheets of brown wrapping paper (2m x 1,50m), or several large flipchart sheets (about 5)
 - Cards or post-it of 3 different colours (about 5 per bottleneck/ per group)
 - Masking tape rolls (3 or 4)
 - Paper markers
 - A flipchart stand
- Distribute cards/ post-it to each group. Different colours are available for each type of causes (immediate, under-lying, and basic). Ask the groups to write on the cards which they think are the main causes of the bottleneck. They should write:
 - One cause per card
 - Short negative phrases
 - The cause on the colour card corresponding to the type of cause
- The facilitator should make sure participants formulate specific enough and not generic causes.
- The facilitator will place one card labelled with one prioritized bottleneck at the top of a large sheet/ wall, and the trees will be built below.
- Using participants' suggestions, the facilitator starts placing the cards into a causal tree. The role of the facilitator is to stimulate discussion and debate and not to build the tree by him or herself! Make sure everyone is participating.
- The facilitator should assist participants in combining the cards into a well-structured causal tree, using the cause's hierarchy. It is essential to make sure that there is a good logical sequence between causes and effects; otherwise, it makes it very difficult to build a meaningful solution tree and thus develop an effective strategy.
- Be careful to follow correctly the causal pathway, for instance:



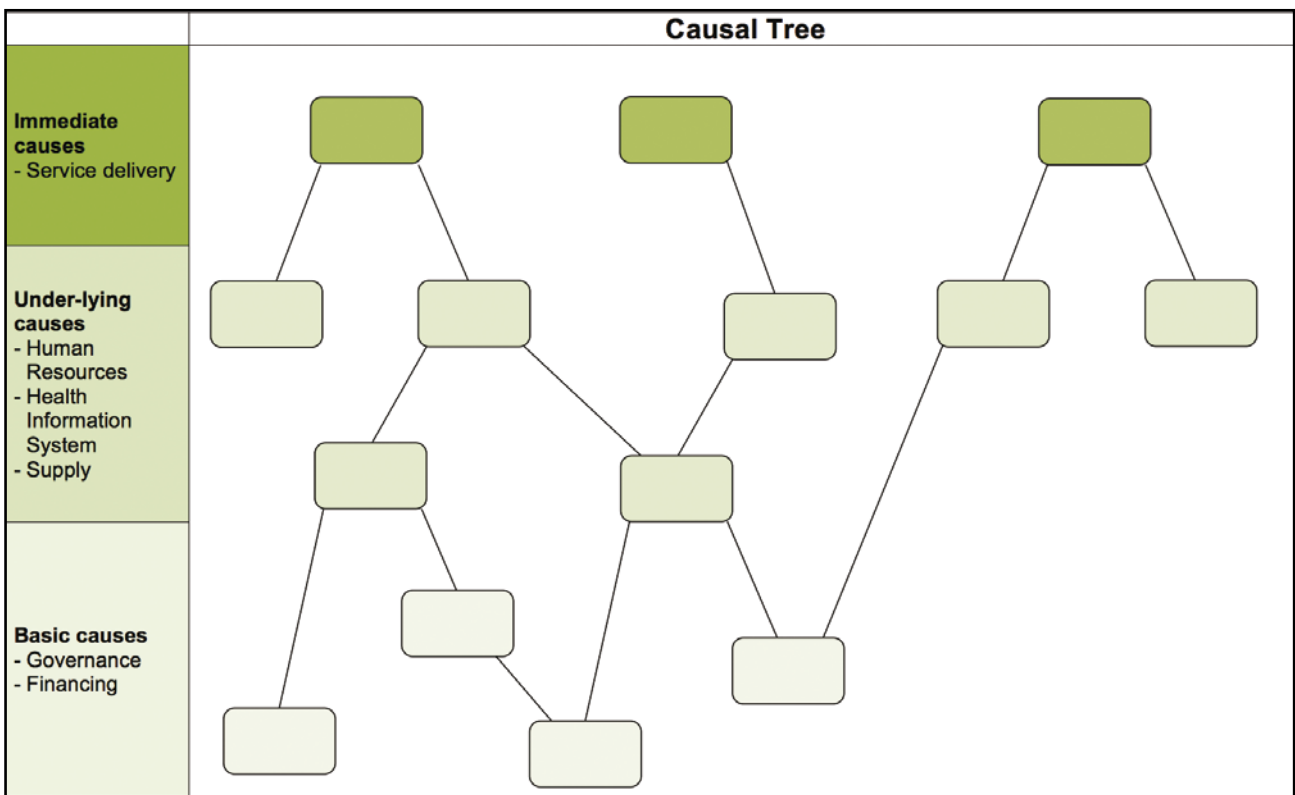
1 - Agreeing on causes of malnutrition for joint action, FAO, 2014. <http://www.fao.org/3/a-i3516e.pdf>

- One problem can have several causes, for example:

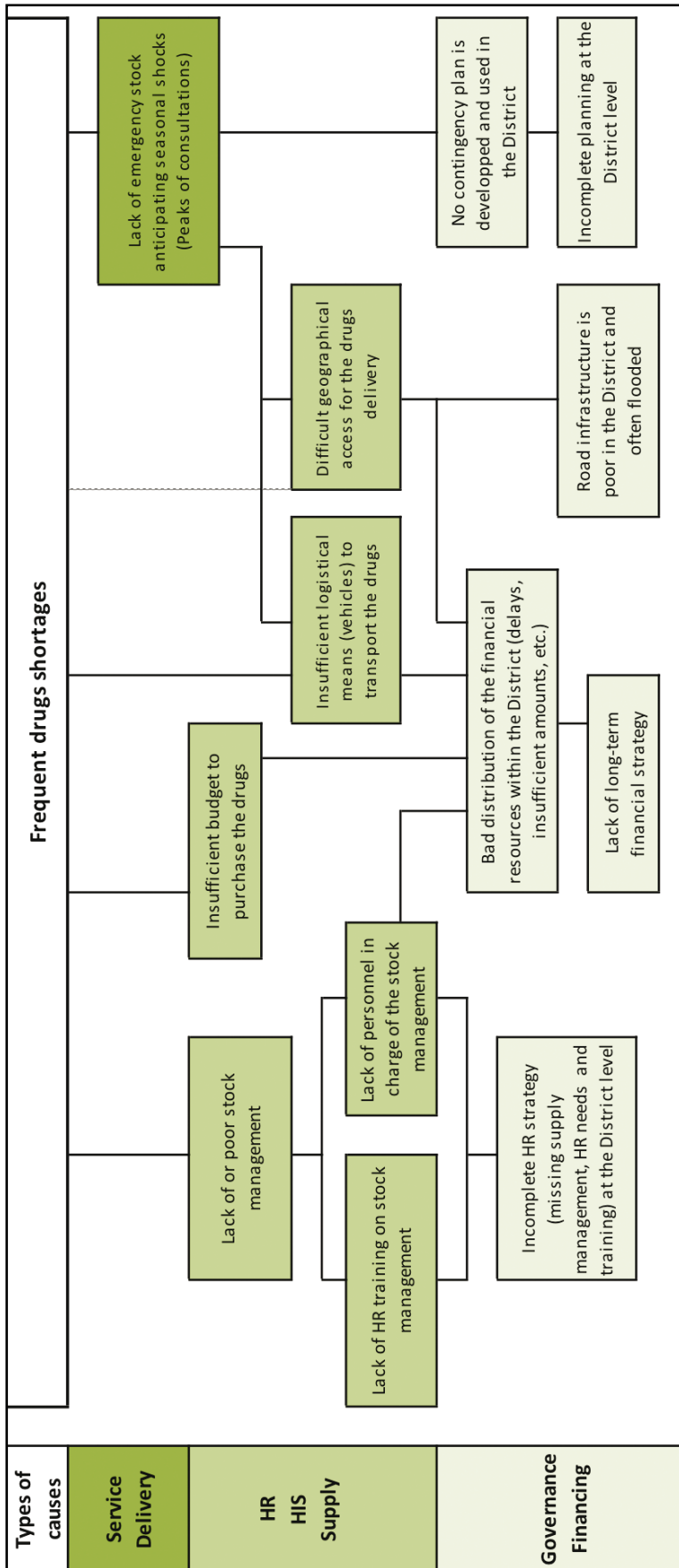


- Make sure there are no missing links in a causal chain.
- Once the cards are placed in the tree, review the tree as a whole to make sure there are no illogical sequences and no missing links or cards. You can draw arrows between the cards to clarify the causal links.

FORMAT OF THE CAUSAL TREE TO BE USED



EXAMPLE OF CAUSAL TREE



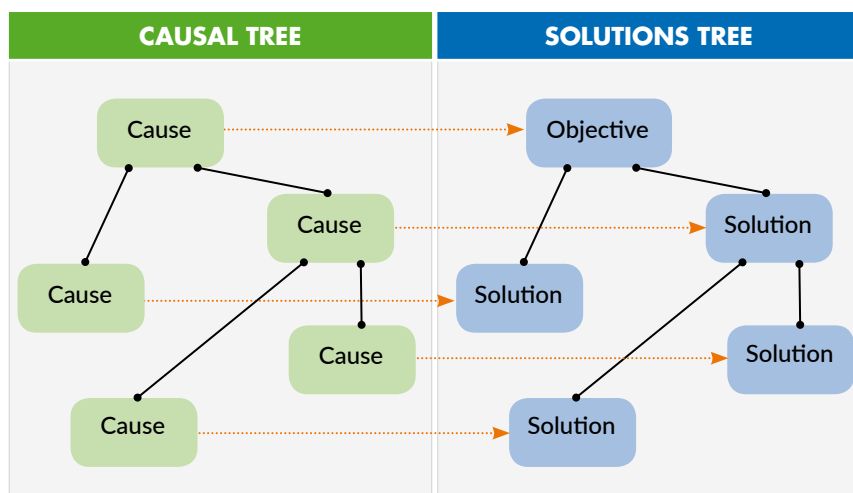
ANNEX 23: HOW TO DEVELOP A SOLUTIONS TREE?

This Annex is based on a document developed by the FAO that explains in details how to develop causal trees for malnutrition¹.

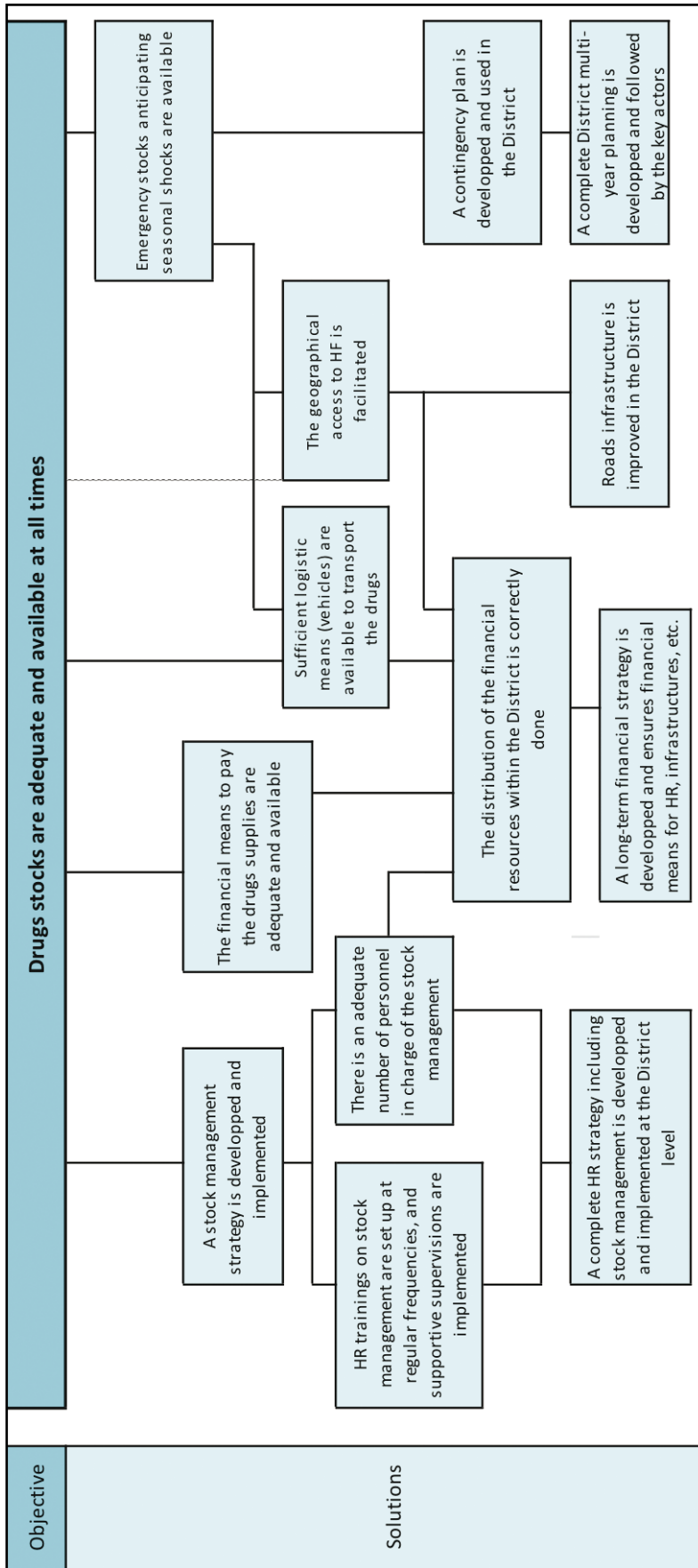
GUIDELINES TO BUILD UP THE SOLUTIONS TREES

- The causal trees defined during the previous step are mirrored, and the trees structures are used to identify the solutions.
- For each cause, a solution is proposed by turning the negative statement into a positive one (e.g. “Lack of participation” becomes “Widespread participation”).
- Once a solution card has been prepared for each problem card, additional cards must be added to highlight more specific and detailed solutions required to achieve the solutions and desired objectives.
- The solutions identified for the immediate causes can be turned into objectives.
- **Materials** to be provided:
 - Several sheets of brown wrapping paper (2m x 1,50m), or several large flipchart sheets (about 5)
 - Cards or post-it
 - Masking tape rolls (3 or 4)
 - Paper markers
 - A flipchart stand

FORMAT OF THE SOLUTIONS TREE TO BE USED



EXAMPLE OF SOLUTIONS TREE



ANNEX 24: TOOL FOR PARTNERS' INTERNAL PREPARATION

For each solution, a set of activities is to be defined over several years. The 3S method is used.

		YEAR 1	YEAR 2	YEAR 3
EMERGENCY	Substitution	Vaccination of the population against measles by an external partner	Vaccination of the population against measles by an external partner in the weakest areas	
	Support			Distribution of measles vaccination sets to health facilities by external partners to the weakest areas
	Strengthening			
SERIOUS	Substitution			
	Support	Distribution of measles vaccination sets to health facilities by external partners	Distribution of measles vaccination sets to health facilities by external partners to the weakest areas	Hand over of the distribution of measles vaccination sets to the MoH for the health facilities in the weakest areas
	Strengthening		Same than normal phase	Same than normal phase
ALERT	Substitution			
	Support	Distribution of measles vaccination sets to health facilities by external partners		
	Strengthening	Same as normal phase	Same as normal phase	Same as normal phase
NORMAL	Substitution			
	Support			
	Strengthening	Elaboration of a national plan embedded in the health policy strategy to ensure the availability and timely distribution of vaccines against the main killing diseases Build capacity of the MoH to handle measles vaccination sets distribution to all areas.	Start the implementation of the plan and the M& E. Build capacity of the MoH to handle measles vaccination sets distribution to all areas.	Carry on the implementation of the plan, evaluation and eventual adjustments

GUIDELINES:

- The order in which the cells should be filled in is described with the **grey shape & numbers**.
- The **blue arrows** show the evolution of the activities along the years.
- The **green arrows** show how activities of the higher phases are based on the activities of the lower ones.

First, activities are defined for the normal phase for the first year of the multi-years period. Strengthening activities are first discussed, and when needed support and substitution ones are also described.

Second, activities are defined for the normal phase for the second year, based on the first year ones (blue arrows).

Then, activities are defined for the normal phase for the third year, based on the activities defined for the previous years (blue arrows).

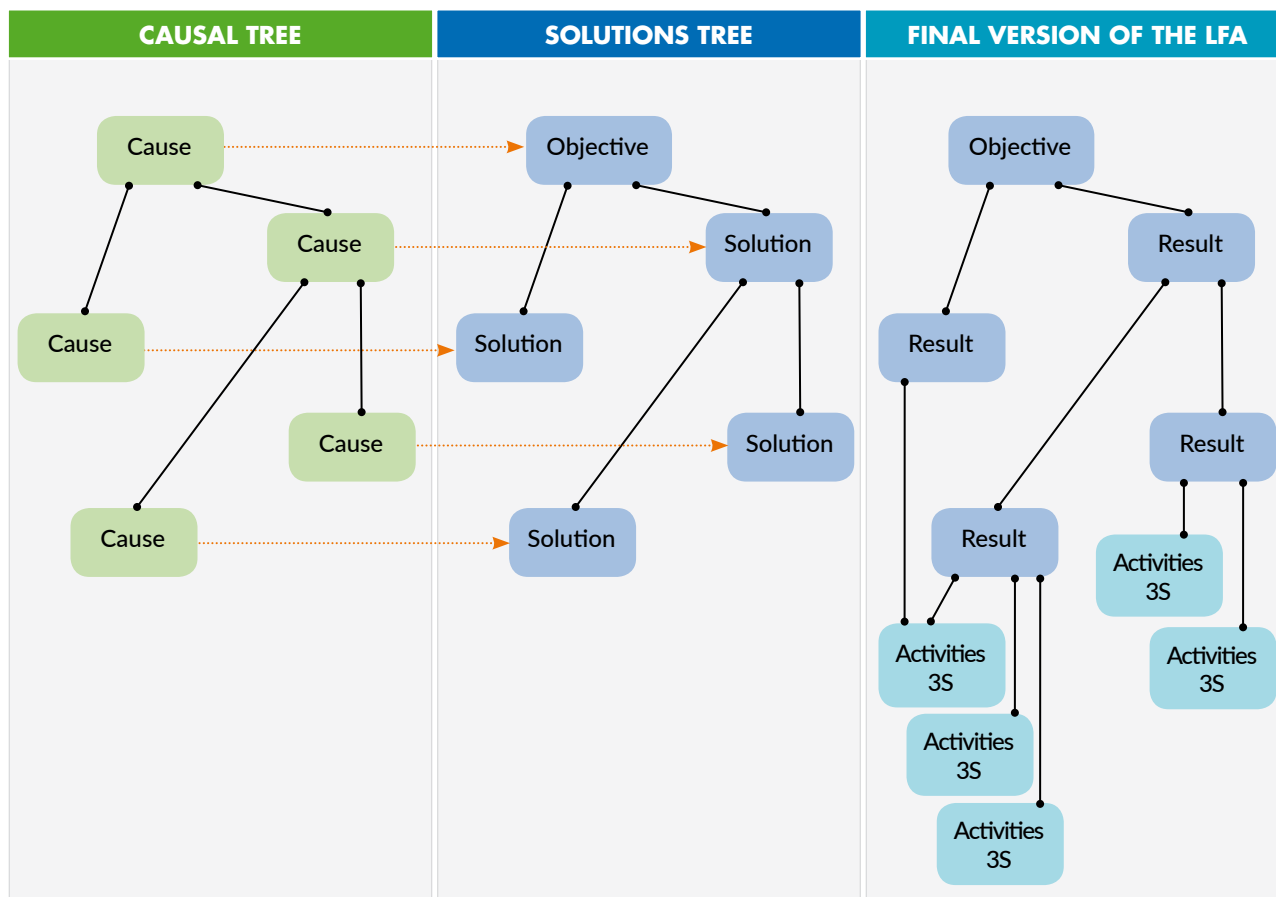
The same order is followed for the alert phase, based on the activities for the Normal phase, and of the previous year (green arrow). The same method is used for the serious phase (green arrows) and for the Emergency one (green arrows).

ANNEX 25: HOW TO DEVELOP A LFA?

INSTRUCTIONS TO BUILD UP A LOGICAL FRAMEWORK

- The main solutions have been identified earlier in the process.
- For each result, activities of strengthening, support and substitution are defined. The 3S method is used here.
- The Annex 24 can also be used here.

FORMAT TO BE USED FOR THE GLOBAL UNDERSTANDING OF THE LOGIC



FORMAT TO BE USED FOR THE DEVELOPMENT OF THE LOGICAL FRAMEWORK

Based on the results from the diagnosis and solutions trees, activities of the three types (Strengthening, support and substitution) must be identified, to achieve the results.

Main objective	
Specific Objective	
Expected Result 1	
Strengthening activities	
Support activities	
Substitution activities	
Expected Result 2	
Strengthening activities	
Support activities	
Substitution activities	
Expected Result 3	
Strengthening activities	
Support activities	
Substitution activities	

EXAMPLE OF A LOGICAL FRAMEWORK

This example is based on the previous examples presented in Annexes 22 and 23.

Main objective	Access to health services is improved in the District
Specific Objective	The health system is strengthened at the District level
Expected Result 1	Drugs stocks are adequate and available at all times
Strengthening activities	<p>Development of a District multi-year planning:</p> <ol style="list-style-type: none"> 1. Accompany the DHMT to develop a complete District multi-year planning 2. Ensure actors are aligned and involved in the process 3. Ensure a contingency plan is effectively developed <p>Improvement of the HR strategy at the District level including:</p> <ol style="list-style-type: none"> 1. Prepositioning of HR dedicated to stock management 2. Training and supportive supervisions on stock management <p>Improvement of the budget lines related to supply in the District health budget, including:</p> <ol style="list-style-type: none"> 1. Forecast of the logistical means required (transportation and storage) 2. Drugs forecast 3. Seasonal fluctuations and shocks <p>Advocacy strategies for:</p> <ol style="list-style-type: none"> 1. An increased budget allocation to the District (at regional and national levels) 2. Road infrastructures to be improved
Support activities	<p>District contingency plan implementation:</p> <ol style="list-style-type: none"> 1. Support the establishment of the emergency stock <p>Support the implementation of the HR strategy at the District level including:</p> <ol style="list-style-type: none"> 1. Support the financing of HR dedicated to stock management 2. Implement training and supportive supervision on stock management <p>Support the last mile delivery:</p> <ol style="list-style-type: none"> 1. Support the transportation of the District drugs 2. Stock management <p>Implementation of roads improvement</p>
Substitution activities	In cases of peaks of consultation, the external partners will manage all the drugs delivery steps from purchase to administration to the patients (they will replace the Health District authorities).

ANNEX 26: BASIC COMPONENTS OF AN ADVOCACY STRATEGY

The following table gives an overview of the 7 steps of the advocacy strategy, with an explanation on how to go through each step. A full description of the methodology and list of different advocacy tools can be found in *ACF Advocacy Toolkit*.

EXPLANATION OF THE ISSUE	STEPS	DESCRIPTION
<p>WHAT change do we want to make?</p> <p>This includes consideration of what is going wrong and what needs to change (context and problem analysis). It is important to provide strong evidence and to be clear about what must stop, as compared to what must change, and what alternative solutions might be adopted (objectives).</p>	1. Context and problem analysis through the HS capacity assessment	<p>Use the secondary and primary information collected to identify:</p> <ul style="list-style-type: none"> • What is the problem and how it relates to a gap of or a lack of political or institutional framework. • What are the opportunities for change: existence of a national political process, international and national commitments, etc.
	2. Definition of specific advocacy objectives	<p>a. Prioritize through several criteria: leverage for change through advocacy, opportunities, expertise, existing evidence, potential risks</p> <p>b. Formulate an advocacy objective</p> <p>An advocacy objective should be SMART and explains: what is the target change, what is the proposed solution, who can bring about the change and when.</p>
<p>WHO can make the change?</p> <p>This includes asking who has the power to make the desired change happen and who may be potential allies and opponents. It is important to be very clear that those identified as having power can actually make the change and to understand how they get involved in the decision making process.</p>	3. Stakeholders mapping and power analysis	<p>a. Identify the stakeholders engaged in the process, those who make or influence policies</p> <p>b. Work on a power analysis to understand the decision-making process</p>
	4. Identification of targets and allies	<p>a. Identify institutions and individuals that have the power to affect the desired change, in policy or implementation</p> <p>b. Identify who to work with: organizations/actors that share a common goal/interest, existing group or coalition who could help to reach the objective</p>
<p>HOW can you make them bring about the desired change?</p> <p>This includes considerations of potential strategies and tactics for influencing people with power, but also to define the messages you will deliver to the different targets and to identify key moments and places where you will concretely advocate for change.</p>	5. Development of messages	<p>An advocacy message must explain what is expected from each stakeholder. Advocacy messages must be:</p> <ul style="list-style-type: none"> • clear and brief, simple, appropriate for the target audience • evidence-based and action-oriented with concrete 'asks' tailored to the target audience and suggested ways of addressing them
	6. Identification of time and places	<p>The success of the advocacy initiative will largely depend on the ability to be in the right place at the right time (according to the decision making process) and to be talking to the right people</p> <p>Key opportunities: meetings, conference, etc.</p>
	7. Tactics and delivery methods	<p>Advocacy is not necessarily confrontational but involves a mixture of tactics such as: identifying and working with allies within the target body, influencing behind the scene, understanding and accepting some of the constraints faced by the target or using technical expertise to reinforce capacities and support the change.</p> <p>Delivery methods include: expertise, lobbying, communication, public mobilization.</p>

ANNEX 27: COSTS ESTIMATION TOOL

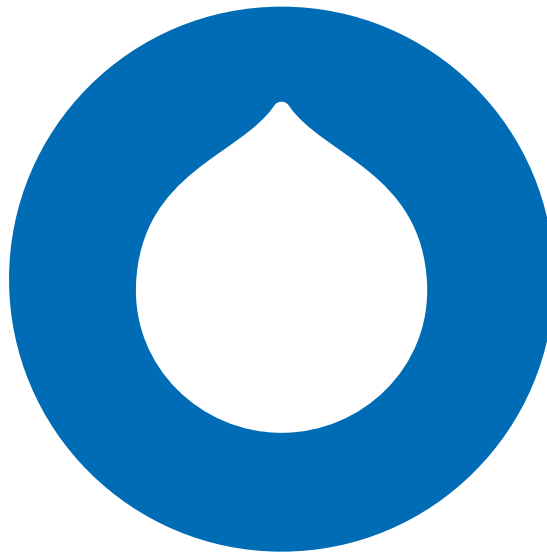
The Excel file of the costs estimation tools is available in the additional documents.

ANNEX 28: FOLLOW-UP TOOL

The Excel file of the follow-up tools is available in the additional documents.

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