



# ANNUAL PERFORMANCE MONITORING REPORT

OCTOBER 1, 2013 – SEPTEMBER 30, 2014

November 2014

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## The Health Finance and Governance Project

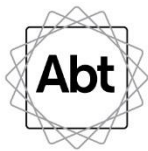
USAID's Health Finance and Governance (HFG) project will help to improve health in developing countries by expanding people's access to health care. Led by Abt Associates, the project team will work with partner countries to increase their domestic resources for health, manage those precious resources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

**November 2014**

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Bureau for Global Health  
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| RTI International | Training Resources Group, Inc. (TRG)



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

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## **DISCLAIMER**

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



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# ACRONYMS

<b>AfHEA</b>	African Health Economics Association
<b>AFR/SD</b>	Africa Bureau Office of Sustainable Development
<b>AIDS</b>	Acquired Immune Deficiency Syndrome
<b>ANAM</b>	<i>Agence National d'Assurance Maladie</i> (National Agency for Health Insurance)
<b>ANHSS</b>	Asia Network for Capacity Building in Health Systems Strengthening
<b>AO</b>	Agreement Officer
<b>AOR</b>	Agreement Officer Representative
<b>APTS</b>	Auditable Pharmacy Transaction and Services
<b>ART</b>	Antiretroviral Therapy
<b>AYUSH</b>	Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homoeopathy
<b>BPR</b>	Business Process Reengineering
<b>BSC</b>	Balanced Score Card
<b>CARICOM</b>	Caribbean Community
<b>CASN</b>	Canadian Association of Schools of Nursing
<b>CBHI</b>	Community-based Health Insurance
<b>CDC</b>	Centers for Disease Control and Prevention
<b>CFC</b>	Child-Friendly Court
<b>CHAG</b>	Christian Health Association of Ghana
<b>CHAI</b>	Clinton Health Access Initiative
<b>CHPS</b>	Community-based Health Planning and Services Initiative
<b>CHW</b>	Community Health Worker
<b>CIDRZ</b>	Centre for Infectious Disease Research in Zambia
<b>CMAM</b>	<i>Central de Medicamentos e Artigos Médicos</i> (Central Medical Store, Mozambique)
<b>CONSAMUS</b>	<i>Le Conseil National des Structures d'Appui aux Mutuelles de Santé</i>
<b>COP</b>	Country Operational Plan
<b>CPHL</b>	Central Public Health Laboratory
<b>CPWA</b>	Child Protection and Welfare Act
<b>DAB</b>	<i>Direction de l'Administration et du Budget</i> (Department of Administration and Budget)
<b>DAI</b>	Development Alternatives, Inc.
<b>DCE</b>	Discrete Choice Experiment
<b>DFID</b>	Department for International Development
<b>DFPSS</b>	<i>Direction de la Formation et de Perfectionnement en Sciences de la Santé</i>
<b>DG</b>	<i>Directeur Generale</i> (Director General)
<b>DGHS</b>	Directorate General Health Services
<b>DHI</b>	Department of Health Insurance
<b>DHMT</b>	District Health Management Team
<b>DPF</b>	Department of Planning & Finance
<b>DPPS</b>	<i>Direction de la Prospective, de la Planification et des Stratégies</i> (Department of Planning and Statistics)

<b>DQA</b>	Data Quality Assessment
<b>DRC</b>	Democratic Republic of Congo
<b>DRG</b>	Center of Excellence on Democracy, Rights and Governance
<b>DRG</b>	Diagnosis-Related Group
<b>DRH</b>	<i>Direction des Ressources Humaines</i> (Department of Human Resources)
<b>DSW</b>	Department of Social Welfare
<b>E&amp;E</b>	Eastern Europe and Eurasia
<b>eCMS</b>	Electronic Case Management System
<b>EFY</b>	Ethiopian Fiscal Year
<b>EGPAF</b>	Elisabeth Glaser Pediatric AIDS Foundation
<b>EHIA</b>	Ethiopian Health Insurance Agency
<b>EHRIG</b>	Ethiopian Hospital Reform Implementation Guideline
<b>EID</b>	Early Infant Diagnosis
<b>eMTCT</b>	Elimination of Mother-to-Child Transmission
<b>EOI</b>	Expression of Interest
<b>EPCMD</b>	Ending Preventable Child and Maternal Deaths
<b>EVD</b>	Ebola Viral Disease
<b>F&amp;A</b>	Finance and Administration
<b>FARA</b>	Fixed Amount Reimbursement Agreement
<b>FGB</b>	Facility Governance Body
<b>FMOF</b>	Federal Ministry of Finance
<b>FMOH</b>	Federal Ministry of Health
<b>FP2020</b>	Family Planning 2020
<b>GDP</b>	Gross Domestic Product
<b>GHB</b>	Global Health Bureau
<b>GHI</b>	Global Health Initiative
<b>GTT</b>	<i>Groupe Technique de Travail</i> (Technical Working Group)
<b>HAPT</b>	Health Accounts Production Tool
<b>HC</b>	Health Center
<b>HCF</b>	Health Care Financing
<b>HCFRTF</b>	Health Care Financing Resource Task Force
<b>HCFS</b>	Health Care Financing Strategy
<b>HEU</b>	Health Economics Unit
<b>HF</b>	Health Facility
<b>HFG</b>	Health Finance and Governance
<b>HFS-IP</b>	Health Financing Strategy Implementation Plan
<b>HHA</b>	Harmonizing Health in Africa
<b>HIS</b>	Health Information Systems
<b>HIV</b>	Human Immunodeficiency Syndrome
<b>HMIS</b>	Health Management Information Systems
<b>HPMI</b>	Hospital Performance Monitoring and Improvement
<b>HPP</b>	Health Policy Project
<b>HRAA</b>	Human Resources Alliance for Africa
<b>HRH</b>	Human Resources for Health
<b>HRIS</b>	Human Resources Information System
<b>HRU</b>	Human Resources Unit
<b>HSA</b>	Health Services Assessment

<b>HSDA</b>	Health Services Delivery and Administration
<b>HSFR</b>	Health Sector Finance Reform
<b>HSG</b>	Health Systems Global
<b>HSHRC</b>	Haryana State Health Resource Center
<b>HSR</b>	Health System Research
<b>HSS</b>	Health Systems Strengthening
<b>HTC</b>	HIV testing and counseling
<b>IDI</b>	Infectious Disease Institute
<b>IDU</b>	Injecting Drug Users
<b>IHME</b>	Institute of Health Metrics and Evaluation
<b>IHP</b>	Institute for Health Policy
<b>IMCI</b>	Integrated Management of Childhood Illness
<b>INFAS</b>	<i>Institute National de Formation des Agents de Santé</i> (National Institute of Health Worker Training)
<b>INFS</b>	<i>Institut National de Formation Sociale</i> (National Institute of Social Worker Training)
<b>IR</b>	Intermediate Result
<b>IR</b>	Implementation Research
<b>IRB</b>	Institutional Review Board
<b>ISS</b>	Integrated Supportive Supervision
<b>IT</b>	Information Technology
<b>JHPN</b>	<i>Journal of Health, Population and Nutrition</i>
<b>JKN</b>	<i>Jaminan Kesehatan Nasional</i>
<b>JLN</b>	Joint Learning Network
<b>JSI</b>	John Snow, Inc.
<b>KEMRI</b>	Kenya Medical Research Institute
<b>KSPH</b>	Kinshasa School of Public Health
<b>L3M</b>	Level 3 Monitoring
<b>LLIN</b>	Long-Lasting Insecticide-Treated Net
<b>LMD</b>	License, Master, Doctorate
<b>LMG</b>	Leadership, Management and Governance Project
<b>LSMS</b>	Living Standards Measurement Survey
<b>M&amp;E</b>	Monitoring and Evaluation
<b>MARP</b>	Most At-Risk Population
<b>MCH</b>	Maternal and Child Health
<b>MDG</b>	Millennium Development Goal
<b>MDTF</b>	Multi-Donor Trust Fund
<b>MEF</b>	<i>Ministère de L'économie et des Finances</i> (Ministry of Economics and Finance)
<b>MHE</b>	Ministry of Higher Education
<b>MINSA</b>	<i>Ministerio da Saúde</i> Ministry of Health
<b>MIS</b>	Management Information Systems
<b>MMT</b>	Methadone Maintenance Treatment
<b>MOE</b>	Ministry of Education
<b>MOF</b>	Ministry of Finance
<b>MOFED</b>	Ministry of Finance and Economic Development
<b>MOH</b>	Ministry of Health
<b>MOHFW</b>	Ministry of Health and Family Welfare

<b>MOHSS</b>	Ministry of Health and Social Services
<b>MOHSW</b>	Ministry of Health and Social Welfare
<b>MOU</b>	Memorandum of Understanding
<b>MPCE</b>	Ministry of Planning and Donor Coordination
<b>MSA</b>	Ministry of Social Affairs ( <i>Ministère en charge des Affaires Sociales</i> )
<b>MSF</b>	Medecins Sans Frontieres (Doctors Without Borders)
<b>MSLS</b>	<i>Ministère de la Santé et de la Lutte contre le SIDA</i> (Ministry of Health and Fight Against AIDS)
<b>MSM</b>	Men Who Have Sex with Men
<b>MSP</b>	<i>Ministère de la Santé Publique</i> (Ministry of Public Health)
<b>MSPP</b>	<i>Ministère de la Santé Publique et de la Population</i> (Ministry of Public Health and Population)
<b>MTR</b>	Mid-Term Review
<b>NACA</b>	National Agency for the Control of AIDS
<b>NGO</b>	Nongovernmental Organization
<b>NHA</b>	National Health Accounts
<b>NHIA</b>	National Health Insurance Authority
<b>NHIA</b>	National Health Insurance Administration
<b>NHIS</b>	National Health Insurance Scheme
<b>NRM</b>	National Health Mission (formerly National Rural Health Mission (NRHM))
<b>NHSDP</b>	NGO Health Services Delivery Project
<b>NHSSPII</b>	National Health Sector Strategic Plan II
<b>OECD</b>	Organization for Economic Co-operation and Development
<b>OECS</b>	Organization of Eastern Caribbean States
<b>OGAC</b>	Office of the Global AIDS Coordinator
<b>OHA</b>	Office of HIV/AIDS
<b>OHS</b>	Office of Health Systems
<b>OMRH</b>	<i>Office de Management et des Ressource Humaines</i> (Office of Management and Human Resources )
<b>OP</b>	Operational Plan
<b>OSM</b>	Office of Strategic Management
<b>P4H</b>	Providing for Health
<b>PANCAP</b>	Pan Caribbean Partnership Against HIV-AIDS
<b>PATHS2</b>	Partnership for Transforming Health Systems, Phase Two
<b>PBF</b>	Performance-Based Financing
<b>PBI</b>	Performance-Based Incentives
<b>PEPFAR</b>	President's Emergency Plan for AIDS Relief
<b>PER</b>	Public Expenditure Review
<b>PF</b>	Partnership Framework
<b>PFIP</b>	Partnership Framework Implementation Plan
<b>PFM</b>	Public Financial Management
<b>PFPA</b>	Procurement, Finance, and Property Administration
<b>PHC</b>	Primary Health Care
<b>PHFI</b>	Public Health Foundation of India
<b>PLHIV</b>	People Living with HIV

<b>PMI</b>	President's Malaria Initiative
<b>PMP</b>	Performance Monitoring Plan
<b>PMTCT</b>	Prevention of Mother-to-Child Transmission
<b>PNDS</b>	<i>Plan National de Développement Sanitaire</i> (National Plan for Health Development)
<b>PNLS</b>	<i>Programme National de Lutte contre le SIDA</i> (National Program for the Fight Against AIDS)
<b>PNS</b>	<i>Politique Nationale de Sante</i> (National Health Policy)
<b>POC</b>	Point-of-care
<b>PPP</b>	Public-Private Partnership
<b>PRB</b>	Population Reference Bureau
<b>PRH</b>	Population and Reproductive Health
<b>QA</b>	Quality Advisor
<b>RAMU</b>	<i>Régime d'Assurance Maladie Universelle</i> (Universal Health Insurance Scheme)
<b>RBM</b>	Results-Based Management
<b>RCM</b>	Regional Coordinating Mechanism
<b>RDQA</b>	Routine Data Quality Audit
<b>RGA</b>	Request for Application
<b>RHB</b>	Regional Health Bureau
<b>RMD</b>	Resource Mobilization Department
<b>RMNCH+A</b>	Reproductive, Maternal, Newborn, Child and Adolescent Health
<b>RRU</b>	Revenue Retention and Utilization
<b>SACA</b>	State Agency for the Control of AIDS
<b>SAMBA</b>	Simple Amplification-based Assay
<b>SCTF</b>	Single Donor Trust Fund
<b>SHA</b>	System of Health Accounts
<b>SHI</b>	Social Health Insurance
<b>SHOPS</b>	Strengthening Health Outcomes through the Private Sector
<b>SIGRH</b>	<i>Système d'Information et de Gestion des Ressources Humaines</i> (Human Resource Information Management System)
<b>SIHFW</b>	State Institute of Health and Family Welfare
<b>SLA</b>	Service-Level Agreement
<b>SLHA</b>	State-Level Health Accounts
<b>SOW</b>	Scope of Work
<b>SSC</b>	Social Security Commission
<b>SNNP</b>	Southern Nations, Nationalities, and Peoples Region
<b>SRM</b>	Sustainability Road Map
<b>SVG</b>	St. Vincent and the Grenadines
<b>SW</b>	Social Welfare
<b>TB</b>	Tuberculosis
<b>TDY</b>	Temporary Duty Yonder
<b>TOR</b>	Terms of Reference
<b>TOT</b>	Training of Trainers
<b>TWG</b>	Technical Working Group
<b>UADS</b>	<i>Unité d'Appui à la Décentralization Sanitaire</i> (Decentralization Unit)

<b>UEMOA</b>	<i>Union Economique de Monitaire Ouest Africaine</i> (West African Economic and Monetary Union)
<b>UEP</b>	<i>Unité d’Evaluation et de Programmation</i> (Evaluation and Planning Unit)
<b>UFR-SM</b>	<i>Unité de Formation et de Recherches des Sciences Médicales</i>
<b>UHC</b>	Universal Health Coverage
<b>UHCAN</b>	Universal Health Care Advisory Committee for Namibia
<b>UN</b>	United Nations
<b>UNAIDS</b>	Joint United Nations Programme on HIV/AIDS
<b>UNDP</b>	United Nations Development Program
<b>UNFPA</b>	United Nations Population Fund
<b>UNICEF</b>	United Nations International Children’s Fund
<b>UPE</b>	<i>Unité de Programmation et d’Evaluation</i> (Planning and Evaluation Unit)
<b>USAID</b>	United States Agency for International Development
<b>USG</b>	United States Government
<b>UWI</b>	University of the West Indies
<b>VAAC</b>	Vietnam Administration of HIV/AIDS Control
<b>VCT</b>	Voluntary Counseling and Testing
<b>VL</b>	Viral Load
<b>VSS</b>	Vietnam Social Security
<b>WBI</b>	World Bank Institute
<b>WHO</b>	World Health Organization
<b>WoFED</b>	Woreda Office of Finance and Economic Development
<b>WorHO</b>	Woreda Health Office
<b>ZHD</b>	Zone Health Department
<b>ZISSP</b>	Zambia Integrated Systems Strengthening Project

# I. HIGHLIGHTS

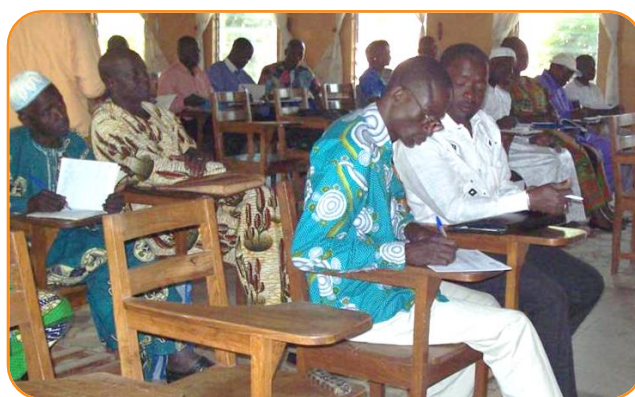
At the end of its second year, the Health Finance and Governance (HFG) project is working with USAID missions and partners in 19 countries and four bureaus. As the project grows, the project team continues to develop HFG programs to contribute in meaningful ways to two of the Global Health Bureau's (GHB's) key initiatives – Ending Preventable Maternal and Child Deaths (EPCMD) and progressing toward an AIDS-free generation.

In broad terms, HFG supports both initiatives by expanding financial access to priority services, such as maternal and child health (MCH) care, and by improving governance and leadership of the health sector. Of the more than 150 activities implemented during HFG's second year, approximately 60 percent related to more than one Intermediate Result (IR). Highlights of HFG's Year 2 achievements follow.

## IR1 Improved Health Financing for Priority Health Services

### UHC roll-out in Benin

HFG Benin supports the government of Benin's initiative to develop and subsequently roll out Universal Health Coverage (UHC) countrywide and as a means of meeting the objectives of EPCMD. While the initiative will eventually cover the entire country, efforts began with six departments in 2013. HFG works in three of those six departments, specifically on supporting community-based health insurance (CBHI) (*mutuelle*) networks. *Mutuelles* are a key element of the government of Benin's strategy to reach informal and rural populations with UHC and to improve health outcomes, notably MCH outcomes. By the end of Q2 of Year 2, HFG Benin had supported the creation of all three *mutuelle* networks as legal entities, and is responsible for coordinating the enrollment of informal and rural populations in their respective catchment areas. Work will continue with these three new networks to ensure their sustainability and integration into the national policy.



Constitutive General Assembly, *Mutuelles* Departmental Network – Borgou/Alibori, Parakou

### Ethiopia Scales Up Community-based Health Insurance

Ethiopia has a long-standing tradition called *idir* or *kire*, in which community organizations provide financial help to families for emergencies, like funerals. Now, a new form of the tradition, called “*idir* (or *kire*) while alive” is gaining popularity as the Ethiopian government pursues its goal of providing UHC through community-based health insurance (CBHI). CBHI is health insurance that pools members' premium payments in a fund that is managed by the members. The fund covers the cost of basic inpatient and outpatient health care services, primarily at local health centers but even at hospitals when a member is referred by the lower-level health facilities. Previously, patients would have had to pay out of pocket for these services.



Piloted in 13 *woredas* - (districts) - in Amhara, Oromia, Southern Nations Nationalities and Peoples (SNNP), and Tigray regions, CBHI has been well received by the communities since being introduced in April 2012. More than 144,000 eligible households have enrolled and more than 650,000 beneficiaries have accessed health services. Most of the services have been accessed at health centers, but some beneficiaries have also been seen at hospitals, following referral.

To inform more people about CBHI and its financial protection benefits, the Ethiopian Health Insurance Agency (EHIA) launched a national communications campaign. In collaboration with the HFG project invited the media to visit the CBHI scheme in Tehuldere district, Amhara region. News stories about the scheme appeared in national newspapers *The Ethiopian Herald* and *The Addis Zemen* and on Ethiopian National Television.

During the visit, *The Ethiopian Herald* spoke with CBHI members like Aselefech Tsegaw. She joined the CBHI scheme and is grateful for the financial protection it provides her and her family of five. Mrs. Aselefech pays a scheme premium of 144 Birr, or \$7.50, each year. She told the reporter that she and her family members have not been sick and haven't needed health care, but she is grateful for the financial protection the scheme provides her and her family and is proud that she joined the scheme because other community members can use the health services. "I have no fixed income because I am engaged in farming. If I encounter health problems I would not be worried about money because I

already have community-based health insurance."



A beneficiary explains the benefits of her CBHI scheme to journalists during the national health insurance communications campaign.

Similarly, Mr. Ahmed Ibru told the media, "I have been benefiting a lot from health insurance. Previously, with not enough money for health care, I encountered great problems. Nowadays, the money is paid once a year without any other expense. My family and I are provided with better health services whenever we experience any type of sickness."

In speaking to the *Addis Zemen* (an Amharic-language newspaper), Mrs. Roman Tesfay, General Director of the EHIA, said the strong ownership of CBHI schemes and their commitment of community members to paying their contributions on time have led to its success.

Perhaps a farmer in Tehuldere said it best:

"Now the CBHI scheme helps us to get treated when we get sick rather than waiting until we die to support our funerals."

Over the past year, the Ethiopian government decided to expand CBHI from 13 pilot districts to additional 160 districts (39 in Amhara, 59 in Oromia, 47 SNNP, and 15 in Tigray). Though there are differences across regions, zones, and districts, the establishment and operationalization of CBHI schemes is progressing very well in all four regions. However, Ethiopia has over 900 districts. There is a need for strong scale-up strategy with due consideration of the policy decisions as well as the practical technical processes and logistical preparations.



## Addressing access problems through provider mapping in Ghana

Strengthening service delivery alone is not sufficient to improve health outcomes. The intersection of financial incentives and desired service delivery improvements is a significant juncture. The imperative of linking health financing and service delivery is what drove HFG-Ghana to partner with the National Health Insurance Authority (NHIA) to refine the primary health care or PHC capitation payment system for scale-up to contain rapidly escalating NHIS costs.

As part of this activity, HFG-Ghana supported a provider mapping exercise to get a picture of the current capacity of and access to basic primary care services in the Upper East, Upper West and Volta Regions where the NHIA is scaling up capitation. This information will eventually be used to organize Preferred PHC Provider (PPP) Networks to provide seamless community health promotion and primary care for capitation contracting. But in the short term, the results of the mapping exercise have demonstrated enormous service delivery gaps, representing woefully substantial access gaps for all citizens but particularly for the poor and vulnerable.

Support for provider mapping has helped the NHIA begin to address these significant access problems through interventions encompassing both health financing and PHC service delivery. Quantifying the access gap has also mobilized other international partners to align their support behind the goal of filling the gaps in access and creating the right financing environment to expand access to community-based primary care in Ghana.

## Asia Regional Flagship Course on Health Systems Strengthening

The five-day *Asia Regional Flagship Course on Health Systems Strengthening and Sustainable Financing: The Challenge of Universal Health Coverage* was successfully delivered in Bangkok, Thailand, March 3-7, 2014. The five-day course was attended by 63 participants from 11 target countries: Cambodia, India, Indonesia, Laos, Myanmar, Nepal, Papua New Guinea, Philippines, Thailand, Timor-Leste, and Vietnam. Participants included USAID mission staff, officials from Ministries of Health, Finance, and Planning, as well as staff from USAID/Washington, the World Bank, AusAID, and various universities.

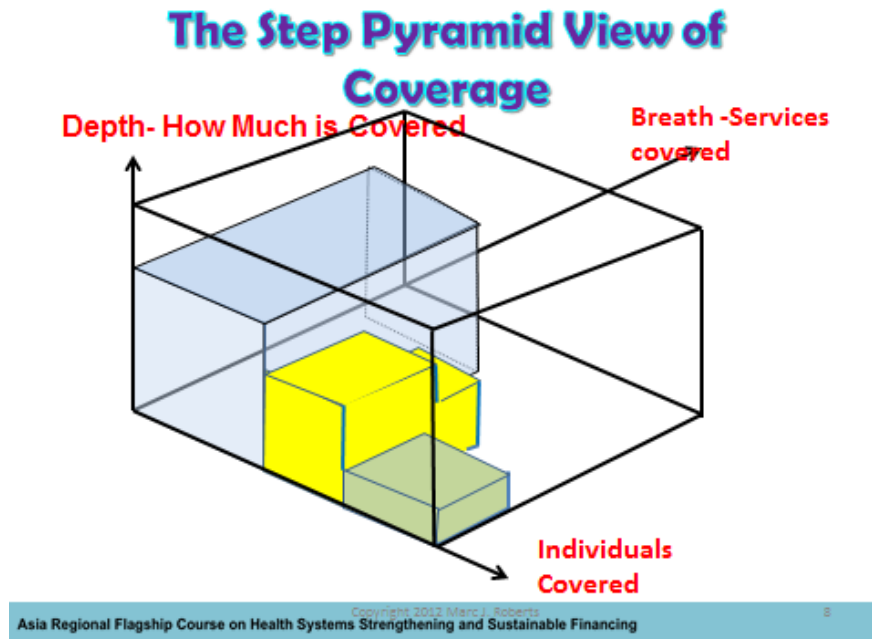
Of note, Harvard University professor emeritus Marc Roberts presented a new refinement of the World Health Organization's (WHO) "UHC cube" with a step pyramid view. The new version better captures the variable state of population subgroups in terms of UHC, and offers better insight into the importance of prioritization on the road to UHC (e.g., initial focus on the poor, targeting breath of coverage and financial protection).



Participants of the Asia Regional Flagship Course on HSS and Sustainable Financing

Photo Credit: WHO photographer

**FIGURE 1: SLIDE FROM MARC ROBERT'S PRESENTATION  
ON THE STEP PYRAMID VIEW OF COVERAGE**



Overall participant assessments were very positive. The faculty will carefully review all of the feedback to draw lessons for the design of future flagship workshops. The flagship course was offered under the auspices of the Asia Network for Capacity Building in Health Systems Strengthening and was also sponsored by the World Bank Institute and Providing for Health (P4H). HFG provided financing and administrative support, while the Sri Lanka-based Institute for Health Policy handled the event's logistics.

## USAID's Africa Health Financing Workshop

An HFG team helped facilitate USAID's East and Central Africa Workshop on Healthcare Financing Capacity-Building, which was held in Dar es Salaam, Tanzania, in June 2014. The workshop was designed to provide USAID staff with the knowledge and tools needed to effectively dialogue with country officials in an effort to increase domestic financing for health priorities, EPCMD, and UHC.

The workshop focused on the basics of health economics and finance, including their application to financing EPCMD and UHC services on a sustainable basis. Participants worked closely with government officials and other country stakeholders on complex issues such as resource mobilization, universal coverage, and provider payments.

Overall, 30 USAID staff dealing with health systems and disease-specific programs participated. Commitment by the host mission, USAID Tanzania, was evident with the participation of the Mission Director and 12 other mission staff members. The workshop was organized and delivered by a collaborative team made up of USAID Office of Health Systems, USAID/Africa Bureau Office of Sustainable Development (AFR/SD), HFG, and the Joint Learning Network.



Workshop participants visiting two health centers (Mkoani Health Center, Medowell Health Center) that are implementing performance-based financing in the Pwani region.

Credit: Amanda Folsom

Workshop participants expressed strong interest in further USAID investment in training on health financing – more than half of the participants recommended that the course, or a more advanced version of it, be offered in the future. One participant noted that the course “gave an excellent foundation on health financing with a clear vision of the state of the art.” Another said, “I don’t work in this field and feel as though I have learned more in this week than any training in my professional career. Thank you, thank you, thank you for this opportunity, it was great!”

Participants especially appreciated the chance to share experiences across countries, discuss the Tanzania health financing strategy, and visit local health care sites. Integration of USAID staff in each presentation and peer-to-peer learning were major ingredients of success. Discussions are underway to replicate the training in several other African countries and Washington.

## Capitation pilot workshop held in Vietnam

On August 6-7, 2014, HFG and the Ministry of Health (MOH) organized and conducted a workshop to discuss the progress of the first six months of the Capitation Pilot - a new payment method for health providers which has been implemented in four provinces (Bac Ninh, Hue, Khanh Hoa and Ninh Binh). The workshop followed a review of the Capitation Pilot performed by the HFG team in May – June 2014, and received supportive endorsements from the participants, especially by Dr. Pham Le Tuan, Vice Minister of Health and Mr. Nguyen Minh Thao, Deputy General Director of Vietnam Social Security



Participants in the Capitation Pilot Workshop held on August 6-7, 2014 in Vietnam

(VSS). During the workshop, participants discussed challenges experienced with the payment system and possible solutions for an improved health insurance payment mechanism.

In addition to the over 150 participants from health and social security sectors, workshop attendees included international stakeholders, such as the Joint Learning Network and the World Bank. The recommendations highlighted during the workshop included the need to design a benefits package for social health insurance in Vietnam, which is, as of July 2014, an integral part of the revised Vietnam’s Law on Health Insurance. It is also a main focus of HFG’s proposed year 3 activities in Vietnam.

## Finalization of Ethiopia’s fifth round NHA

The Health Sector Financing Reform (HSFR)/HFG team provided technical and financial support for successful implementation of Ethiopia’s fifth round of National Health Accounts (NHA). The report was finalized in Q2 and disseminated.

Speaking before 120 people at the dissemination of Ethiopia’s fifth round of NHA in Addis Ababa, State Minister for Health Dr. Amir Aman pledged to make use of the new findings in the government’s policy-making process. He urged partners throughout the health sector to use the NHA evidence to guide their decision-making, as well. He also stressed the government’s commitment to institutionalizing the NHA process.

While total health spending – from all sources, government, households, and donors – has increased significantly since NHA round 4 (2008), per capita spending rose more modestly and, at \$20, is far below the country’s target of \$32 and the WHO 2015 target of \$60. Thus, health is still underfinanced

and there is strong need to make more resources available to the sector to improve health service delivery and, ultimately, the health status of the population. The Federal Ministry of Health or FMOH is already using the NHA findings in budget negotiations with the Ministry of Finance and Economic Development to advocate for more government funding for health.

Although the NHA methodology has been used since the 1990s in low- and middle-income countries, its “institutionalization” – making the NHA a routine and active component of a country’s health system, and using NHA findings – is often constrained by country technical capacity and ownership. As a result, NHA institutionalization is a priority for many governments as well as USAID, the World Bank, and other partners.

Dr. Amin said that the NHA exercise, which was supported by the HFG Project, is part of a larger effort to ensure “healthy and productive Ethiopians.”

In this latest round of NHA, Ethiopia’s government tracked spending in five subaccounts – HIV/AIDS, reproductive health, child health, tuberculosis, and malaria. The data was collected from 10,060 household surveys and 4,000 surveys of people living with HIV/AIDS, as well as information from institutions including donors, NGOs, and government (mainly from audited government expenditure accounts and parastatals) and private entities.

## Haiti Completes Second NHA Exercise

With support from the HFG Haiti team, the Haitian Ministry of Health (MOH) successfully completed a second round of NHA, using the Systems of Health Accounts (SHA 2011) methodology for the year 2011-2012. The HFG Project worked closely with the MOH to plan the second NHA, and collaborated with Ministry of Health officials to prepare the survey instruments and customize the SHA to the Haitian context. HFG has collaborated with the World Bank’s Living Standards Measurement Survey project in obtaining the household expenditure data; however, all other data were collected from secondary sources allowing the activity to complete NHA data collection in six months – a very short timeframe and a significant achievement. By using a process that leveraged existing data, HFG has made significant strides in ensuring that Haiti can conduct future NHA estimations with minimal donor support, in a sustainable and consistent manner. The results were disseminated in Q3 at a meeting which attended by the country’s Minister of Health, as well as the US Mission Director in Haiti and other government officials and partner organizations.

## Prominent Health Accounting Approaches Explained

Health accounting data that show economic and financial resource flows within a health system are critical to informing health and economic policy – at both national and international levels. However, countries vary widely in their health accounting histories as well as the demand for and capacity to produce these data.

HFG developed a brief, System of Health Accounts and Health Satellite Accounts, to introduce two prominent health accounting approaches – the System of Health Accounts (SHA), developed by the Organization for Economic Cooperation and Development (OECD), Eurostat, and the World Health Organization, and the Health Satellite Accounts (HSA) developed by the World Health Organization’s Regional Office for the Americas. Written for non-technical policymakers and other stakeholders, this brief compares the SHA and HSA approaches to health accounting in terms of their objectives and content, standardization and scope, and data requirements, and highlights the implications of this comparison for low- and middle-income countries.

## HFG Financial Modeling Support for the Dominica HIV National Strategic Plan

In Dominica, HFG provided financial modelling support to the development of an HIV National Strategic Plan, Investment Case and inputs for a regional Global Fund application due to be submitted in early 2015. The country dialogue meeting supported by HFG brought together representatives of government, private sector, civil society, and regional and international development partners. HFG facilitated with the country representatives the establishment of the following targets, and through financial modelling, projected that more than \$500,000 will be required by 2019 to successfully support the proposed targets, which poses an important challenge for the financing of the National HIV/AIDS Response. See table I for the targets in an excerpt from the draft National Strategic Plan. HFG worked with the Dominica stakeholders to develop preliminary strategies for accessing these increased funds, including the upcoming Global Fund application and increasing domestic spending for HIV and AIDS.

**TABLE I. DOMINICA KEY COVERAGE TARGETS (2013-2019)  
FOR ARVS, PMTCT, STI SERVICES AND PREVENTION**

Intervention	2013	2019
Percentage of the adult population tested every year	17.7%	20%
Population covered by condom promotion and distribution	42%	80%
Prevention for sex workers and clients	25.7%	50%
Prevention for MSM	50.3%	75%
STI treatment	13%	60%
Blood safety	100%	100%
ART for adults*	41.5%	80%
ART for children*	80%	80%
PMTCT**	100%	100%

\*Eligibility for ART for both adults and children changes in 2015 to the new WHO guideline recommendations. For adults this translates to eligibility at CD4 count < 500 cells/μl plus all HIV+ pregnant women, sero-discordant couples, HIV/TB co-infected, and HIV/HBV co-infected. For children this indicates eligibility for all HIV+ children below the age of 5 and all others with CD4 counts < 500.

\*\*PMTCT will be provided under the Option B+ regimen.

## IR 2 Health Governance Capacity of Partner Countries Strengthened

### Strengthening of HRH, Management and Provision of Social Work Services in Swaziland

In Q4, HFG worked closely with the Swaziland Nursing Council and numerous local stakeholders to produce entry-to-practice nursing competencies. Through an intensive process that involved several participatory workshops and meetings with a variety of stakeholders, including representatives from Swaziland's nursing schools and hospitals, nursing competencies were developed and refined in the areas of general nursing, midwifery, community health, and community mental health. This accomplishment advances the project's HRH portfolio by increasing the regulatory capacity of Swaziland's professional councils.

One of the primary objectives of HFG assistance is to strengthen the capacity of the MOH Human Resources Unit (HRU). To date HFG capacity-building efforts have included training in human resource policies and procedures, collecting data for contracts, and operational planning, as well as intensive day-



to-day mentorship. To develop an overall strategy and plan for building the capacity of the HRU, HFG completed a HRH technical capacity assessment of the unit. This technical assessment will be paired with a WHO-sponsored institutional capacity assessment to prioritize and develop a capacity-building plan for the unit. The capacity assessment has also informed the development of a proposed short-term organizational structure of the HRU to support increased efficiency and effectiveness in performing its duties. HFG plans to continue to build upon the results of this assessment over the course of the next year to ensure that the HRU has the skills required to manage and retain health workers.

Also in Swaziland, HFG collaborated closely with the Department of Social Welfare and Ministry of Justice to equip and roll out a newly established child-friendly court (CFC) in the Lubombo region. HFG organized a CFC launch event, held on June 12, 2014, which was attended by the U.S. Ambassador to Swaziland and high-level Swazi governmental authorities including the Deputy Prime Minister, and the Ministers of Justice and Constitutional Affairs and of Health. Key to the continued success of these efforts is building the capacity of court intermediaries to interact with child witnesses and of other CFC role-players to carry out the unique processes and procedures of a CFC. These trainings will be undertaken by HFG early in Year 3.

## Generating More Evidence for Governance Contributions to Health

As donors and governments increasingly emphasize improved accountability and transparency of health systems, there is a significant need for sustained learning about what governance activities best contribute to health outcomes, such as lives saved and increased coverage of HIV/AIDS services. Demonstrating direct attribution of improved health system governance to specific and quantifiable health outcomes, however, is not an easy task.

On July 23, 2014, USAID and the HFG project hosted a one-day workshop at the National Press Club in Washington, DC, on generating evidence of governance contributions to health outcomes. The event brought together almost 60 health and governance professionals from USAID, prominent external organizations such as the WHO and the World Bank, and implementing partners to discuss the key evidence gaps and develop an action plan to address them.

Leading industry experts, including Karen Cavanaugh, Director of the Office of Health Systems at USAID, and Dr. Sara Bennett, HFG's Health Systems Research lead and Associate Professor of Health Systems at the Johns Hopkins Bloomberg School of Public Health, kicked off the discussion, highlighting the role of governance in reducing maternal and child mortality rates and eradicating AIDS.

Participants then developed a prioritized list of evidence gaps and corresponding research questions for how governance contributes to health outcomes. The top-ranked gaps included:

**Fostering political will** – what factors, incentives, and motivations influence decision making of health sector leaders and effective coalitions for reform?

**Sustaining accountability mechanisms** – how are country mechanisms for oversight and accountability institutionalized after external support ends?



Experts from USAID, WHO, the World Bank, and implementing partners gathered on July 23 to discuss evidence gaps and corresponding research questions for how governance contributes to health outcomes.

Photo: Caytie Decker (HFG).

**Prioritizing governance interventions** – how can donors and countries determine which governance activities provide the greatest return to increase access to health services, improve health service quality and equity, and increase health system efficiency?

Workshop attendees also identified pragmatic opportunities to generate evidence within these priority areas. The most promising and immediate prospects focused on leveraging existing USAID evidence generation efforts, developing clear health governance metrics, fostering cross project collaboration, and mining existing evidence.

HFG's Governance Advisor Jodi Charles stated that the success of the workshop was “a means to launch future closer collaboration with a group of people who work in health and also outside of the health sector” and to further advance evidence generation for the field of governance. The workshop also provided a foundation for continued discussions at the USAID Leadership, Management and Governance project Governance Roundtable in September 2014, and the Third Health Systems Research Symposium. A comprehensive workshop report summarizing the key elements of the discussion and next steps was distributed to participants.

## Media Briefing Kit testing in Kenya

*The Essentials of Health Finance and Governance Media Briefing Kit* was successfully tested in Kenya in partnership with Internews through two trainings – one for MOH officials and one for journalists – as well as one joint roundtable event with representatives of both. The activity generated immediate results. A radio journalist aired two pieces on health insurance on national radio, and a print journalist published a feature story in *The Daily Nation* on health financing and the MOH process of devolution in the health sector. In the photo, Kenyan journalists work on developing and researching their health finance and governance stories.



In addition, at the conclusion of the workshops, participants were very enthusiastic. “Before this training, I used to think of health finance stories as always being sensational – only about money and certain politicians and big, splashy headlines – but now I understand that they are much deeper, that they touch all Kenyans,” said Jimmy Makhulo, journalist and Internews trainer.

And Joseph Kamocho, MOH Chief Public Relations Officer, observed, “We want the media to understand us, but we never try to understand them. As a sector, we need to wake up. The media has the role of agenda setting. We want them to understand our agenda and buy into our agenda so we can move together. We need to do media better.”

## IR 3 Improved Country-Owned Systems in Public Health Management and Operations

### HFG's Ukraine Team Pilots Groundbreaking HIV Service Integration Model

During Year 2, the HFG Ukraine project successfully piloted a new model of HIV service integration in one northern region of Ukraine, Chernigiv Oblast. The project plans to evaluate the pilot's cost-effectiveness to support a proposal for a nationwide scale up of the model.

Despite the ongoing political instability in Ukraine, the HFG team trained 70 physicians in four two-week training sessions that covered HIV/AIDS counseling, rapid testing, and basics of HIV care. During that time, HFG also organized training for 75 nurses in practical skills of HIV counseling, testing, and data reporting in partnership with the Clinton Health Access Initiative and the AIDS Center of Chernigiv Oblast.

"We are very impressed at what the team managed to do in a very challenging and difficult time for the country," wrote Paola Pavlenko, HIV Specialist, Office of Health and Social Transition, USAID Mission to Ukraine, Belarus, Moldova, in an e-mail to the project team.

The implementation of the pilot received support from the national and oblast governments. The program is seen as groundbreaking because it is testing the inclusion of HIV prevention, detection of HIV using rapid tests, and basic care as part of a routine family practice scope of work in Ukraine, as a model to be incorporated into the national health reform agenda. Given the changing nature of the disease and foreseen declines in donor funding to support the response, the MOH has recognized the need to revisit the vertical service delivery and financing models, and identify strategies to better integrate HIV prevention and counseling efforts into primary health care.

Of the 65 doctors and nurse pairs trained, all started providing HIV testing and counseling (HTC) in early 2014. Since the beginning of the intervention 3,903 HIV tests have been conducted and 33 positive results have been detected as of September 1, 2014. This indicates a prevalence rate of 0.85 percent HIV positive among the total tested, comparable to the overall prevalence in *rayons* (districts) in which the project works (Chernigivsky rayon: 0.93 percent; Bobrovytsky: 1.17 percent; Nizhyn: 0.43 percent; Pryluky: 0.87 percent), indicating outreach is adequate. The project notes that a significant percentage of HIV positive are most at-risk populations (MARPs), which bodes well for the hypothesis that increasing availability of services through integration at the primary health care (PHC) level will allow increased or at least equal access to both MARPs and the general populace.

The protocol for the study was developed and exempted by the Abt institutional review board (IRB). The costing tool was piloted within four Trust Cabinets in pilot regions of the Chernigiv oblast. The costing of the pre-intervention HTC model is being conducted as a baseline assessment.

### HRH Strategic Plan Development Support in Côte d'Ivoire

HFG supported the Ministry of Health and of the Fight against HIV/AIDS (*Ministère de la Santé et de la Lutte contre le SIDA*, MSLS) in developing the HRH Strategic Plan for 2014/2015, which includes a monitoring and evaluation (M&E) plan. The HRH Plan was the result of a participatory process with donors and partners, such as the WHO, which are involved in national HRH policy development. The HRH Strategic Plan focuses on improving capacities and competencies of midwives and nurses to directly address the challenges related to achieving Millennium Development Goals 4 and 5. These midwives and nurses also play a critical role in the care and treatment of people living with HIV/AIDS (PLHIV), and the HRH strategy will assist the MSLS in expanding access to quality care.



## Strengthening the outsourcing of non-clinical services in Botswana by developing conflict resolution/negotiation skills

To increase the efficiency and quality of health services, the Government of Botswana has launched an ambitious plan to expand public-private partnerships in the health system. As part of these reforms, the Ministry of Health has started to outsource non-clinical services, including laundry, cleaning, food services, and security, at several major hospitals across the country.

Managing outsourced services at hospitals, however, requires a unique set of skills, including conflict resolution and negotiation. To address the challenges associated with the rapid implementation of outsourcing, USAID through the HFG Project facilitated two highly-participatory workshops on Conflict Resolution and Negotiation Skills for 37 senior hospital administrators, contracts managers, and head matrons from seven different hospitals, as well as Ministry of Health personnel. Both workshops were held in Gaborone in late summer 2014.

“Too often our approach with our vendors has been adversarial rather than respectful. We need to change that and start treating our vendors as partners and real people who care about their work like we do,” said one mid-level manager.

The consistent message throughout the workshop was how to achieve “win-win solutions” that would work for both the hospitals and the vendors.

“Conflicts between [outsourced] vendors and hospital[s] seem rarely to get resolved; issues simmer and the hospitals respond by deducting funds from vendor payments. This creates serious labor relations problems and occasional work-stoppage actions, leaving the hospitals with disturbing security gaps and cleanliness issues that compromise patient, visitor, and staff safety,” said HFG’s Louise Myers who helped to design the workshop after gathering information about the types and nature of the conflicts between hospitals and vendors.

Negotiation practice revealed and reinforced the need for timely two-way communication between both parties, clarity on roles and expectations, give-and-take on the part of both sides, a positive attitude, and validation of one’s assumptions when in doubt.

Participants came away with practical tools and experience resolving differences and, perhaps most importantly, developed an improved attitude toward the vendors and issues that may arise. Evaluations completed by participants indicated a high degree of effectiveness and participation satisfaction: “The workshop has made me understand clearly the issues that contribute to conflict and how to resolve them.” Another commented that, “The workshop has taught me to be open and say out my views but in a manner that the other party will understand.”

Managers agreed to several key action steps in order to strengthen the hospital-vendor relationship, including:

- Hold regularly scheduled meetings between the hospital contracts manager and the vendor site manager to review the vendor reports, identify any areas that need attention, and address any questions/concerns on either side.
- Plan one meeting each month as a joint “walk about” to observe and discuss what is going well and what needs attention.
- Hold periodic meetings between the higher-level hospital manager and the vendor’s general manager.

The Ministry of Health's five-year outsourcing plan includes extending outsourcing mechanisms to additional health facilities around the country and to clinical areas as well. The HFG Project is supporting the Ministry's scale-up of outsourcing non-clinical services at tertiary and secondary level hospitals by developing and monitoring the service level agreements and estimating reference costs of laundry, gardening, security, and porter services.

## Strengthening supervision of HIV/AIDS programs and services in Burundi

A situational analysis of supervision of HIV/AIDS activities in Burundi was completed in the second quarter. The results of this analysis were presented at a national-level workshop in May, consisting of 60 representatives from the provincial and district health offices, central ministry staff, the HIV/AIDS Commission and implementing partners. During the workshop stakeholders were asked to



Hilaire Ninteretse, Director of PNLS, speaking at the national-level supervision workshop

identify strategic priorities to strengthen the

quality of technical supervision of HIV/AIDS activities. These strategic priorities are being finalized and validated by PNLS's senior management team in a national strategy for supervision of HIV/AIDS programs. HFG will provide assistance in developing and implementation of a plan to put the strategy into practice. The national workshop proved to be an excellent opportunity for PNLS to exercise leadership in a critically important area and was very well received by the participants.

## **IR4 Improved Measurement of Global Health System Progress through Increased Use of Evidence-Based Tools and Innovative Measurement Techniques**

### Health Systems Research Society Takes Off

Over the past year, HFG continued its support for Health Systems Global (HSG) – the first international society focused solely on promoting health systems research. HSG acts as a catalyst for researchers, decision-makers, and implementers to conduct and utilize health systems research in order to strengthen health systems, and aims to build the capacity for health systems research in low- and middle-income countries.

The Third Global Symposium on Health Systems Research was held in Cape Town, South Africa, on September 30-October 3, 2014. Nearly 2,000 participants from 125 countries gathered to discuss and debate the science and practice of people-centered health systems. The symposium included four plenary sessions, 170 concurrent and satellite sessions, 572 posters, and 11 films.

Cape Town was the first meeting where HSG's new Thematic Working Groups met and began to coalesce. Dr. Elaine Baruwa moderated a satellite session, *The Bridge from Research to Action*, which was co-hosted by the Translating Evidence into Action Thematic Working Group (TWG) and Abt Associates. The TWG is one of eight groups approved by the HSG Board. Co-chaired by HFG's Kate Stillman and Heather Cogswell, the TWG will focus on the translation of health systems evidence into action through knowledge exchange of best practices, lessons learned, and practical guidance and tools. The aim is to help reduce the gap between health systems knowledge, and policy action.

HFG's Sara Bennett was elected Chair of HSG, and the next meeting will be held in Vancouver, Canada.

## Monitoring, Evaluating Progress toward Universal Health Coverage in Ethiopia

*PLOS Medicine's* newly released Monitoring Universal Health Coverage Collection features an HFG country case study on the availability of globally proposed UHC indicators in Ethiopia. The study, "Monitoring and Evaluating Progress toward Universal Health Coverage in Ethiopia," explored 61 proposed indicators and found that 28 are collected through surveys and 14 are recorded and reported through the health management information system or other administrative sources.

The study also found that while Ethiopia has indicators that measure service coverage, progress lags in terms of indicators for chronic conditions. Also, data are not available in country for the financial protection indicators. The authors concluded that some of the WHO's proposed UHC measurement indicators may not yet be appropriate for low-income countries. Local stakeholders suggested that indicators more relevant to their country's context would be most useful.

## Evaluation of performance-based Fixed Amount Reimbursement Agreement Grant

HFG collaborated with the DELIVER project to conduct a qualitative evaluation of the \$500,000 performance-based Fixed Amount Reimbursement Agreement (FARA) grant between USAID and Mozambique's central medical store (CMAM). Technical assistance to design the performance-based FARA was provided under the Health Systems 20/20 project.

The purpose of the evaluation was to understand what drove and constrained performance; how stakeholders understood and perceived the grant program; and how it was being implemented and managed. Evaluation findings will provide lessons that can strengthen the current design and implementation of the program, feed into possible future iterations of FARA and other U.S. government (USG) government-to-government grants, as well as other initiatives in Mozambique and beyond.

The grant has demonstrated results. In the first year, CMAM demonstrated solid performance on indicators related to planning and distribution, and uneven but nonetheless fair performance on warehouse indicators. Informants widely agreed that the performance incentives are motivating staff, enhancing collaboration and accountability, and enabling CMAM to invest in institutional improvements.

USAID is pleased with the approach and already discussing the possibility of a 2015 FARA. CMAM, USAID, the Supply Chain Management System (SCMS) project, and other donors appear to agree that the moderate FARA start-up grant was a catalyst for years of large financial investments by USAID and other donors into inputs (infrastructure, training, and management information systems). Informants are keen for the grant program to continue. However, they also recognize key areas that need to be strengthened, which we discussed in the debriefing; these include CMAM's internal monitoring and evaluation (M&E) capacity; USAID's management of the verification process; and the continued evolution and refinement of indicators, targets, and other design elements.

## HFG Knowledge Management

### HFG Launches Brown Bag Lunch Discussion Series

In coordination with the OHS, HFG launched its brown bag lunch (BBL) discussions at the Ronald Reagan Building this year. HFG and OHS organized five BBLs, attracting a wide range of staff from USAID. The first BBL – National Health Accounts: New and Improved! – was held on April 23<sup>rd</sup>, and featured A.K. Nandakumar, Chief Health Economist, USAID, Scott Stewart, Health Economist and AOR for the HFG Project, and Tesfaye Dereje, HFG. "NHA provides extremely powerful information that should be used increasingly for policymaking ... The power of the [NHA] evidence is that they trigger discussions about how to allocate resources," said A.K. Nandakumar during the event.

The second BBL – Results-Based Financing: Promising Results from Mozambique – was held in May. HFG and DELIVER shared results and analysis of the FARA with the Mozambique Central Medical Store or CMAM. In June, three HFG Chiefs of Party shared lessons learned in strengthening health finance and governance systems in their countries – Côte D'Ivoire, Ethiopia, and Haiti. In August, Kristina Yarrow and Joe Naimoli, USAID, and Rena Eichler, HFG, spoke about Investing in Universal Health Coverage in Indonesia. And in September, Bob Emrey, USAID, and Laurel Hatt, discussed new strategies and country case studies for Measuring Progress toward Universal Health Coverage. HFG looks forward to working with OHS to schedule more BBLs discussion in year three.

### **HFG Website Launched**

USAID approved HFG's new website, and it officially went live in early October 2013. The website includes the improved Health Systems Database, which underwent significant updating and revision from the Health Systems 20/20 version. As a result of launching the website, HFG's social media outreach began in Quarter I via Twitter and Facebook. HFG is tweeting (@HFGProject) and is coordinating with Abt Corporate Communications and other partners to expand the project's Twitter reach.

## 2. CROSS-BUREAU ACTIVITIES

The two leading health initiatives – EPCMD<sup>1</sup> and PEPFAR’s AIDS-Free Generation – both call for targeting selected interventions and populations. EPCMD recognizes that under-five mortality is concentrated in certain populations of a few countries, and subregions of other countries, where national averages mask a disproportionate burden of disease. EPCMD also recognizes that the causes of under-five mortality are concentrated in a few diseases and conditions. Similarly, the PEPFAR Road Map for an AIDS-Free Generation targets smart investments in evidence-based interventions for populations at greatest risk. These initiatives rely on a targeting strategy that requires mobilizing and pooling resources and aligning financial incentives with the targeted interventions and populations. Both initiatives also appreciate that economic growth among many developing countries creates an opportunity for greater country ownership and sustainability.

HFG’s cross-bureau activities contribute directly to these two global health initiatives by helping countries mobilize resources for health, promote mutual accountability, target financing and accountability to priority services and populations, and generate new evidence to inform country actions. The value added of cross-bureau activities is to accelerate the adoption of state-of-the-art policies by countries, and interventions by USAID missions, by facilitating learning among countries and other partners, gathering and generating evidence, and packaging and disseminating knowledge in ways that are accessible.

Cross-bureau activities are funded by the various offices in USAID’s GHB – Population, MCH, HIV/AIDS, and other infectious diseases – which represent a broad constituency for cross-bureau results. Cross-bureau activities are global technical leadership activities that contribute to the project’s four IRs and to the results of the GHB offices to reduce the unmet need for family planning, end preventable mother and child deaths, and secure an AIDS-free generation. In Year 1, HFG established a foundation of technical materials, collaborative relationships with external partners, and integration among the IRs. This foundation will advance the implementation of health financing and governance work at the global and country levels over the life of the project.



### ***Support USAID’s Collaboration with Global Partners to Advance USAID’s Objectives in Health Financing and Governance***

**Activity Objectives** – HFG will engage collaboratively with USAID and partners to advance best practices in health financing and governance. This could include the following efforts:

- Support coordinated efforts to provide leadership on health financing and governance at the global, regional, and country levels.
- Ensure that discussions on health financing and governance issues at the highest levels are well informed and help support leveraging resources in a coordinated, efficient, and effective fashion.

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<sup>1</sup> EPCMD is USAID’s initiative to contribute to *A Promise Renewed* for Child Survival and family planning.

- Help eliminate duplicative or contrary health financing and governance efforts and initiatives.
- Promote increased use of technical products produced by HFG.

**Year 2 Progress** – In Q1, HFG’s governance specialist Jeremy Kanthor participated in a WHO Technical Consultation regarding the mandate of WHO’s new Health Governance and Finance Department. In addition to providing an overview of HFG’s governance work, he shared a description of the project’s *Ministry of Health-Ministry of Finance Toolkit*. Since then, HFG and WHO staff have continued to discuss how to coordinate next steps once the toolkit is ready for dissemination.

In Q2, HFG’s Health Finance Lead was invited to present at a plenary session of a conference of the African Health Economics Association (AfHEA) in Nairobi in March. AfHEA devoted the session to the topic of “How to measure UHC [Universal Health Coverage]: Presentation of ongoing work by teams from the Global Network for Health Equity [GNHE], USAID, and WHO/World Bank.” Dr. Laurel Hatt presented cross-cutting findings from HFG’s three country case studies on UHC measurement to an audience of 200 health economists and health systems practitioners from Africa and around the world. The audience was very engaged and asked questions such as how non-communicable diseases can become part of the UHC agenda in low- and lower-middle-income contexts; how measurement at the district level can be improved; to what extent country stakeholders really understand what UHC means; how the important role of the social determinants of health can be captured when we measure UHC indicators; and whether donors support needed investments in Health Information Systems (HIS) to ensure that countries can produce UHC indicators.

Also in Q2, Tesfaye Dereje represented HFG at a National Health Accounts Resource Tracking Meeting in February in Geneva. While the trip was funded through Activity 1 funds, the findings are described in greater detail under Activity 5 below.

Funds for this activity were fully exhausted by the end of Q2. This activity is complete.

## **ACTIVITY 2**

### *Develop Analytical Framework for Innovative Financing*

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

**Year 2 Progress** – This activity initially aimed to produce two deliverables: a literature review report and a framework document that provided guidance on implementation. The project submitted a draft document containing both elements (literature review and framework) to the AOR team for review and feedback early in Q1, and the team discussed next steps with the AOR team in mid-November. During this discussion, it was agreed that an augmented, more comprehensive literature review and framework document would be finalized using remaining activity funds, rather than a stand-alone guidance document. The agreed-upon deliverable is a synthesis of available literature on alternative and innovative domestic financing approaches, including country case studies and a framework for understanding the range of approaches available to low- and lower-middle-income countries and for assessing these approaches according to a set of criteria. The document will also discuss how resource mobilization for health should align with the country’s fiscal and monetary policies, and demonstrate the effect these approaches have on macroeconomic efficiency and social welfare.



While not its focus, the document also links domestic innovative and alternative financing for health to broader efforts intended to improve fiscal space for health through other means, including increased efficiency within the health sector. Though the document will be useful for USAID missions and health sector partners, the primary intended audience was clarified to be professionals working at Ministries of Health, who would benefit from accessible text and examples that explain options for generating new resources for health from domestic sources and place them within a larger resource mobilization and macroeconomic context. The document will be useful for health officials engaging in dialogue with counterparts at the MOF, and will provide essential understanding of key concepts and emerging ideas for those initiating, designing, and implementing resource mobilization approaches.

In Q1, the team received detailed written comments from the AOR team's Dr. Caroline Ly. After holding a conference call to review her suggestions and clarify the way forward, the team prepared a revised work plan for finalizing the draft.

In Q2, the team conducted a search for macroeconomists who could support the next phase of work on this activity, and secured the interest and availability of John Langenbrunner, expert advisor on social health insurance in Indonesia and former lead health economist and sector coordinator at the World Bank. The team held a series of calls with Dr. Langenbrunner to detail the scope of the final document, identify specific tasks to complete, and prepare a timeline for completion. The team drafted the terms of reference (TOR) for the consulting agreement and shared these with Dr. Langenbrunner, who provided final feedback on March 31, 2014.

After finalizing the consulting agreement with Dr. Langenbrunner early in Q3, the team proceeded to synthesize additional reference materials under his leadership. Using a template for extracting data from the additional literature, three HFG analysts were able to complete the review by July. Dr. Langenbrunner also proposed a revised outline for the report. The team provided feedback on this outline and circulated it with the AOR team, who also provided feedback while somewhat expanding the requested scope of the review. The new scope involves several forms of innovative financing that mobilize domestic resources yet require international cooperation.

In addition, the HFG held conversations with Priya Sharma, Policy and Innovative Financing Advisor at the USAID Center for Accelerating Innovation and Impact. She shared her suggestions, as well as contact information for relevant organizations working in this area. She provided documents from the work that the Center for Global Development is conducting on Development Impact Bonds. She also facilitated contact with Aron Betru, Managing Director of Financing for Development, who specializes in innovative financing solutions for international development. He provided information about the work that Pledge Guarantee for Health is conducting in facilitating guarantee-backed bridge financing for the procurement of donor-funded global health commodities.

In Q4, Dr. Langenbrunner shared an initial draft of the paper with the team. The team worked to integrate his writing with the original document and sections the team had written. During this synthesis process, the team compiled key messages from the document and used them to refine the structure and flow of the paper as well as to craft the executive summary and conclusion chapters. The team also changed the tone in some sections of the paper in order to ensure that the language used would be accessible to the primary audience of the paper: MOH officials and other health professionals in developing countries who may not have a strong economics and finance background.

The team also noted specific passages that required additional research and development and addressed each in turn. For example, the team noticed that the paper still had insufficient discussion on the role of the private sector in many of the innovative options discussed. The team then invited a colleague with significant experience in private sector policy and engagement to add some depth to these sections as well as comment on and further revise the classification scheme covering non-tax options in the paper.

With these changes complete, the team shared the paper for internal review. Dr. Langenbrunner also reviewed and shared comments on the paper. At the end of Q4, the team was finalizing its work to address their comments. In October, the final paper will go through a second round of review, and will be edited and formatted. The team will share it with the AOR team by October 31.

Table 2 provides additional activity-specific updates.

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

Y2Q4 Planned Tasks	Y2Q4 Progress	Critical Assumptions/Problems Encountered/ Follow-up Steps
Revise paper on innovative financing in response to comments from USAID	The team completed the draft document in collaboration with Dr. Langenbrunner and circulated it for internal review. The team is finalizing revisions based on comments received.	Complete editing and formatting of the document and submit to the AOR team for feedback.

## ACTIVITY 3

### *Universal Health Coverage Through Research and Development, Capacity Building, and Standard Setting*

#### **Activity Objectives –**

- Increase global knowledge of low- and middle-income countries' measurement priorities and needs as they institute UHC reforms, in order to enhance the relevance and impact of donor guidance and technical assistance in the area of UHC measurement, and provide similar countries with examples of achievement and lessons learned.
- In coordination with the WHO and other country research teams, complete case study reports covering the experiences of Ethiopia, Senegal, and Côte d'Ivoire in measuring their progress toward UHC, and submit a journal manuscript based on the Ethiopia case.
- Based on key informant interviews, draft a brief assessment of the survey research capacity of statistics units in low- and middle-income countries in order to raise awareness among global partners of these units' strengths and weaknesses in conducting population surveys, as well as document systemic constraints to country ownership and long-term sustainability.
- Generate common understanding among USAID stakeholders of UHC definition and approaches.

#### **Year 2 Progress –**

**Case studies:** In Q1, HFG worked closely with its in-country consultants to prepare reports summarizing the results of the three case studies, including extensive annexes.

- In Q2, the Senegal and Ethiopia reports were finalized, formatted, submitted to the AOR team, and disseminated on HFG's website.
- In Q3, the Côte d'Ivoire report was finalized, formatted, submitted and disseminated.
- As described under Activity 1, in Q2 HFG presented results of all three case studies at the AfHEA conference in Nairobi. The reports contributed to the ongoing discussion about UHC measurement and donors' role in supporting strengthening of measurement systems.



**Survey research capacity:** In Q1, HFG compiled findings and recommendations based on previously completed interviews with five key organizations that support international household survey research and provide technical assistance to national statistics units in low- and middle-income countries. The organizations included the USAID-funded MEASURE Demographic and Health Survey project, the World Bank's Living Standards Measurement Survey (LSMS) unit, the U.S. Census Bureau, the Service Availability and Readiness Assessment group at WHO, and the Multiple Indicator Cluster Survey unit at UNICEF. Interviews assessed respondents' perceptions of country-level survey capacity in low-income contexts, and solicited their recommendations for global technical assistance. These findings were shared with the AOR team again in Q2 for their review.

**PLOS Medicine article:** After receiving positive feedback from the WHO organizers of the September 2013 Singapore meeting on countries' approach to UHC measurement, HFG agreed to submit a manuscript to the journal *PLOS Medicine* summarizing the findings of the Ethiopia case study on UHC measurement. WHO organized a special issue of the journal to showcase the UHC measurement case studies prepared by research teams from 12 countries. As one of the few case studies representing low-income sub-Saharan African countries, HFG's manuscript will play an important role in raising awareness about measurement priorities and capacity in countries receiving UHC technical assistance and donor support. HFG submitted the initial draft of the manuscript on schedule during Q1.

- In Q2, the project received comments from *PLOS Medicine* editors and a peer reviewer. The team made revisions to the text and tables in response to these comments, and submitted the revised version on March 21.
- In Q3, the project received additional editorial and format comments; made two additional sets of revisions; and was informed on May 22 that the manuscript was accepted for publication.
- In Q4 (September 22, 2014), the article was published: Alebachew A, Hatt L, Kukla M (2014) Monitoring and Evaluating Progress toward Universal Health Coverage in Ethiopia. *PLoS Med* 11(9): e1001696. doi:10.1371/journal.pmed.1001696. Hard copies of the PLOS journal were distributed at the Health Systems Research (HSR) Symposium in Cape Town.  
<http://www.ploscollections.org/article/info%3Adoi%2F10.1371%2Fjournal.pmed.1001696>

**Challenges** – French to English translations of UHC-related technical materials proved challenging, given the need for advanced technical vocabulary. Translation challenges required HFG staff to invest more effort into cleaning and rewriting than initially envisioned, leading to a delay in finalization of the Côte d'Ivoire report. Activity funding did not permit re-translation of the final reports into French, which may limit uptake by policymakers in Senegal and Côte d'Ivoire.

**Q4 Additional Information** – This activity is now complete.



## **Support World Health Organization to Convene, Support, and Inform the Global Health Community on Universal Health Coverage**

**Activity Objectives** – HFG will support another meeting, workshop, or other high-profile global event sponsored by WHO, resulting in greater consensus on UHC and UHC measurement as well as identified concrete next steps for the global community.

**Year 2 Progress** – The project had planned to support a global stakeholder meeting on the topic of UHC measurement, being planned by WHO and the World Bank. The meeting had been tentatively proposed for December 2013, but was postponed until an indeterminate date in 2014. In March, HFG

suggested to the AOR team that the funds that would have supported the meeting be reprogrammed to the Resource Tracking portfolio (Activity 5), given budget shortfalls for those activities and uncertainty about the meeting.

In Q3, the AOR approved this reallocation to Activity 5. This activity is now complete.



## ***Institutionalize and Set Standards for Health Resource Tracking and Help the World Health Organization to Convene, Support, and Inform the Global Community***

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

The Year 2 objectives of this activity are as follows:

- Institutionalize tools to support country-led resource tracking within the WHO, such as an updated Health Accounts Production Tool (HAPT) and the NHA-Satellite Accounts brief.
- Increase knowledge of the Systems of Health Accounts (SHA 2011) framework through training and awareness-raising activities.
- Demonstrate the value of resource tracking data by analyzing national investments in health promotion and disease prevention.
- Reduce the cost and streamline the production of health expenditure data by embedding expenditure questions into the LSMS, and updating the HAPT to reflect the SHA 2011 framework.

### **Year 2 Progress –**

- Throughout Year 2, HFG continued to test and submit suggested HAPT software updates to WHO for incorporation into the tool.

### **In Q1:**

- On October 10, 2013, HFG contributed to a meeting convened by Michael Borowitz from the Global Fund for AIDS, Tuberculosis and Malaria and Peter Berman from the Harvard School of Public Health, along with participants from several other organizations. The purpose was to reach a common understanding on how various expenditure tracking approaches meet key policy and programmatic needs for HIV, TB, and malaria programs in low- and middle-income countries. The Global Fund indicated that it is now requiring production of selected resource tracking information from recipient countries under its new financing model. To support this requirement, the Global Fund has already started to collaborate with WHO directly on resource tracking (including helping to roll out the SHA 2011 with a focus on the three diseases), and incorporated a provision for recipient countries to request \$50,000 in funding for resource tracking efforts, per disease and per grant (up to \$150,000 total). Key next steps agreed upon at the meeting included exploring feasible approaches for allocating health spending by diseases, and exploring how to link expenditure information to health outcomes to better measure efficiency and value for money.

- In December 2013, HFG and the WHO co-facilitated a five-day training in Geneva on the SHA 2011 framework. The goal of the training was to train regional NHA/SHA experts who could serve as consultants and provide future technical assistance to countries conducting SHA estimations. Twenty resource tracking experts from 13 countries participated in the training, which covered the updated SHA 2011 methodology. HFG prepared materials for, and provided the overview of, the mechanics of conducting a SHA 2011 estimation using the HAPT. The HFG team also led the small group discussions and exercises around using the different functionalities of HAPT. This was a critical contribution given that most of the participants did not have the expected level of knowledge of the tool.
- While in Geneva in December 2013, HFG met with the WHO resource tracking team to share progress updates and align our work. The HFG team discussed its support for the continued development of the HAPT, including helping to enhance the embedded survey instruments. The teams also discussed countries where HFG can complement WHO in providing technical assistance to support roll-out of the new health accounts framework. HFG's draft HAPT software guide and its optional set of SHA 2011 survey instruments were discussed with WHO.

Next steps on the brief comparing the Pan American Health Organization health satellite accounts approach with the SHA 2011 were also discussed. The tasks and timeline for its completion were elaborated.

## In Q2:

- HFG's Resource Tracking lead Tesfaye Dereje attended the National Health Accounts Resource Tracking Meeting, on February 25-27 in Geneva. The meeting brought together a variety of stakeholders including the WHO, Bill and Melinda Gates Foundation, Global Fund, CHAI, World Bank, GAVI Alliance, Joint United Nations Programme on HIV/AIDS (UNAIDS), and United Nations Population Fund (UNFPA). Given increased global interest in health resource tracking, the objectives of the meeting were to discuss and get preliminary agreement (where possible) around: 1) key policy questions that countries and international stakeholders desire to answer via resource tracking exercises; frequency and data collection mechanisms; who leads the effort and at what cost; 2) harmonization/integration of the multiple resource tracking efforts; 3) how to handle additional (granular) expenditure data requirements which are not necessarily tracked as part of the "core" framework; and 4) how to handle boundary issues between the different diseases/priority areas. During the meeting, different methodologies for resource tracking and costing were presented. Some of the countries shared their initial experiences using the SHA 2011 framework and various challenges around resource tracking efforts, including weak information systems and multiple topics requiring more-granular information. On the final day, the group prepared the following set of objectives, which will shape HFG's resource tracking-related activities moving forward.
  - **Prospective resource tracking:** By 2030, there should be a similar framework for both prospective (budgets) and retrospective (expenditures) resource tracking efforts that can support "budgeting for impact" and "fiscal sustainability."
  - **Retrospective resource tracking:** By 2030, countries should have a "country owned (and) aligned resource tracking system, which provides routine, timely and reliable information that is aligned with the continuum of health financing needs... which is also flexible and responsive to the changing needs of countries."
  - **Costing:** Costing information should be built into routine Health Management Information Systems (HMIS) by 2030, thereby allowing regular measurement and providing inputs for better technical and allocative efficiency.

- In response to a request from the AOR team, HFG prepared a summary of “policy nuggets” highlighting country examples where out-of-pocket health expenditure data have been used to influence policy, planning, and budgets. HFG also spoke with the AOR team regarding the advantages and disadvantages of different sources of health expenditure data. These served as inputs to internal USAID discussions on revising the Demographic and Health Survey, which may include questions on health spending as part of the core module in the future.
- In response to a request from the AOR team, HFG prepared an updated version of the HAPT brief, an accompanying poster, and a demo slide presentation for the USAID Innovations Market held on March 31.
- HFG’s draft HAPT software reference guide was finalized and submitted to the WHO team in Q2; HFG awaits final edits from WHO. HFG will incorporate WHO’s comments and finalize the guide once the next iteration of the HAPT is released in Q4.
- In Q2, a voice script for the HAPT software video tutorials was drafted.

### In Q3:

- The NHA Policy Primer, which was originally developed for SHA 1.0 under the Partners for Health Reform<sup>plus</sup> project, was updated in Q3 to reflect the SHA 2011 methodology. The draft underwent internal review.
- In Q3, HFG co-facilitated a SHA 2011 training course sponsored by the OECD in Paris from April 1 through 4, entitled *Using Health and Disease Accounts to Inform Policy: Learning from Experience*. The objective of the workshop was to share country experiences on using NHA and disease accounts to inform health financing decisions. Around 50 participants representing a wide range of countries attended (including OECD as well as lower- and middle-income countries). Discussions from the workshop revealed the need to broaden the dissemination and use of NHA data beyond government stakeholders.
  - The University of Washington’s Institute of Health Metrics and Evaluation (IHME) also presented its NHA Database at the training. The IHME database compiles summary NHA data and provides user-friendly dashboards for comparisons. There is some apparent overlap with the WHO’s Global Expenditure Database. The HFG team met with the AOR team on May 21 to discuss this overlap; the agreed-upon next step is for the AOR team to discuss the issue with both IHME and WHO and provide guidance on next steps to the project.
- HFG and the WHO co-facilitated a five-day training in Johannesburg, South Africa, on the SHA 2011 framework and use of the HAPT. The goal of the training was to train country health accounts experts on both the concepts and application of the updated SHA 2011 framework. Twenty resource tracking experts from 13 countries participated in the training. HFG’s resource tracking lead Tesfaye Dereje facilitated a session on converting “old” NHA data (developed using SHA 1.0) to the new SHA 2011 framework to allow countries to conduct time series analyses. Tesfaye also provided small-group support to the country teams from Namibia, South Sudan, Lesotho, and Seychelles.
  - While in Johannesburg, Tesfaye met with the WHO’s Nathalie Van de Maele to discuss ongoing collaboration on resource tracking. He shared country updates on HFG’s support for the roll-out of SHA 2011, discussed preparing and testing alternative survey instruments to improve the completeness of financial information reported by key stakeholders, and identified other possible areas for HFG support. A detailed meeting note was shared with the AOR team in early Q4.

- The Satellite Accounts Brief was completed and disseminated.
- In Q3, video recording for the HAPT voice scripts was initiated. The videos reflect the updated SHA 2011 methodology, and once recording is complete, they will be sent to WHO for incorporation into the latest version of the software.

#### In Q4:

- The HAPT user guide was finalized and is awaiting WHO's final input before it is disseminated.
- The updated NHA policy primer reflecting the key features of the updated SHA 2011 was finalized and is undergoing final review and formatting.
- The "back end" of the revised and simplified NGO survey was adjusted so that it can be uploaded directly into the HAPT software. The revised survey is currently being piloted in Barbados.
- The updated HAPT tutorial voice script and preliminary recordings of the first three screens were shared with the WHO Health Accounts team and initial feedback was obtained. Discussions with WHO are ongoing to refine the script, while challenges with technical compatibility between the most recent version of the HAPT software and the video recording software are being worked out.

Table 3 provides additional activity-specific updates.

**TABLE 3. CROSS-BUREAU ACTIVITY 5 DETAIL**

Y2Q4 Planned Tasks	Y2Q4 Progress	Critical Assumptions/ Problems Encountered/ Follow-up Steps
Work with WHO on development/adoption of guides and instruments to support countries in their transition to the new SHA framework for future resource tracking exercises	<p><u>Health Accounts Production Tool support to WHO:</u></p> <ul style="list-style-type: none"> <li>• HFG continued to test the HAPT and identify areas that require updates. Suggested updates were relayed to WHO for incorporation into the HAPT.</li> <li>• HAPT video tutorial recording continued.</li> </ul> <p><u>User Guide Development:</u></p> <ul style="list-style-type: none"> <li>• HFG's draft HAPT software guide was finalized and submitted to WHO.</li> </ul>	<ul style="list-style-type: none"> <li>• User testing is ongoing and HFG will continue to provide feedback on the HAPT and survey instruments based on observations from practical application.</li> <li>• The HAPT User Guide will be incorporated into the tool once the next iteration of the HAPT is released in the near future.</li> </ul>
Strengthen the use of resource tracking through measures ensuring broad access, tools to facilitate data analysis, and policy links.	<p><u>NHA data conversion for WHO's Global Health Expenditure Database:</u></p> <ul style="list-style-type: none"> <li>• The team learned that IHME has an existing database that overlaps with WHO's <u>Global Health Expenditure Database</u>. They discussed the issue with the AOR team and temporarily halted work on this activity.</li> <li>• The NHA Policy Primer was updated to reflect the SHA 2011 framework and will be disseminated in Year 3 Q1.</li> <li>• Through ongoing support to countries, HFG is in the process of exploring/ identifying products (including policy briefs and presentations) and processes to promote uptake of health accounts results to inform policy and planning.</li> </ul>	<ul style="list-style-type: none"> <li>• HFG awaits further guidance from the AOR team on next steps with regard to the Global Health Expenditure Database.</li> <li>• HFG proposed developing guidance, including examples of policy communication products, to support optimal uptake of the health accounts results to inform policy and planning.</li> </ul>

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

One pathway decision facing many countries has been how to allocate limited resources across primary, preventive, and hospital care – and at the same time ensure broad access to quality services, without creating individual financial hardship. This new activity will use a cross-cutting case study approach, including desk reviews and key informant interviews, to document experiences across several countries as they have designed a benefits package. The overall objective will be to draw cross-cutting lessons on selecting pathways toward UHC.

**Year 2 Progress** – This activity was originally entitled “Analyzing decision points along the path to UHC.” After receiving Year 2 cross-bureau funding late in Q2, HFG initiated discussions with the AOR team in Q2 to narrow down the selection of a UHC policy decision point to investigate, and agreed to move forward with the benefits coverage question above. HFG also initiated discussions with the Joint Learning Network (JLN) for UHC regarding possible collaboration. The project discussed leveraging a planned fall meeting of the JLN’s new PHC technical initiative to conduct interviews or group discussions with member countries.

In Q3, HFG prepared a one-page handout summarizing the proposed activity for distribution among country participants at a JLN meeting in Manila in early May. The handout summarized the objective of the study, the types of questions being posed, and the type of government representatives who might be best equipped to answer them. This helped to raise awareness among participants of the HFG study and laid the groundwork for the future collaboration.

The activity team in consultation with USAID, internal quality advisors, and partners continued to refine the focus and scope of the research effort to ensure that it provides actionable, useful lessons for EPCMD countries considering UHC initiatives. A revised work plan was prepared and submitted to the AOR team. Two specific modifications to the analysis emerged from these discussions:

- The review would focus more narrowly on the role of evidence in defining UHC benefits packages. When has evidence influenced the inclusion or exclusion of covered benefits in a service package? When are explicit criteria (such as cost-effectiveness or financial protection) most likely to be used to influence benefit package design, and what factors have amplified the “voice” of technocrats?
- The literature review would broadly consider experiences from countries at different stages of economic development (e.g., Latin America, Central Asia) and different approaches to population coverage; lessons from middle-income countries’ experience may be relevant for EPCMD and lower-income countries.



In Q4, the activity team began data collection through a systematic review of the literature and key informant interviews. The team reviewed three seminal works: an InterAmerican Development Bank-funded monograph on health benefit plans in Latin America (Giedion et al. 2014<sup>2</sup>), the World Bank's UNICO case study synthesis paper on the impact of UHC schemes (Giedion et al. 2013<sup>3</sup>), and the World Bank-Government of Japan's case study synthesis paper on the political economy of UHC (2013). Based on the review of these papers, the team created a data collection template to capture key findings from continuing literature review efforts. The team also prepared a detailed summary of the use of evidence to inform benefit package design in Chile, an exemplary and well-documented case. Based on the data collection template and the summary prepared for Chile, the activity team prepared protocol for key informant interviews.

In late Q4, the activity team conducted the first three key informant interviews. The team leveraged the JLN Steering Committee meeting at the Health Systems Research Symposium in Cape Town. Of the JLN countries represented at this meeting, three (Ghana, Philippines, and India) were selected based on 1) the current relevance of and degree of experience related to benefit package design to the countries/region and 2) the profile of the particular representatives attending the meeting and their ability to provide information on the topic of evidence use in benefits package design.

The activity team also prepared for additional key informant data collection. After the Steering Committee meeting, JLN will host a meeting for country representatives collaborating on the JLN's PHC initiative, rescheduled for December 2014, as well as a meeting of the Population Coverage initiative, also in December 2014. Next quarter, the activity team will complete additional key informant interviews with participants of these meetings. The team will also continue the global literature review to identify further examples of use of evidence to complement information gathered from the JLN countries.

**Challenges** – One challenge is the difficulty in selecting a meaningful, representative set of countries within the scope of our work plan – countries that have experience grappling with the process of benefits package design with lessons relevant for EPCMD countries and to whose representatives the activity team has access. In addition, global literature documenting the process of benefits package design for many countries is limited. The activity team continues to strategize about the optimal set of country case interview and literature-based examples from which to draw cross-cutting lessons.

Table 4 provides additional activity-specific updates.

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

Y2Q4 Planned Tasks	Y2Q4 Tasks	Critical Assumptions/ Problems Encountered/ Follow-up Steps
Initiate desk review	The team collated and reviewed seminal documents on benefits package design in Latin America and Asia and developed a data collection template. The team also drafted a summary of Chile's use of evidence using the data collection template to inform design of a protocol for key informant interviews.	Next steps: <ul style="list-style-type: none"> <li>Identify additional literature for review.</li> <li>Complete literature review and draft summary report.</li> </ul>

<sup>2</sup> Ursula Giedion, Ricardo Bitran, Ignez Tristao, eds., Health benefit plans in Latin America: a regional comparison (Inter-American Development Bank, 2014)

<sup>3</sup> Ursula Giedion, Ricardo Bitran, Ignez Tristao, eds., Health benefit plans in Latin America: a regional comparison (Inter-American Development Bank, 2014)

Y2Q4 Planned Tasks	Y2Q4 Tasks	Critical Assumptions/ Problems Encountered/ Follow-up Steps
	The team reviewed and commented on the framework used in the benefit package framework/definitions (Cross Bureau Activity 15).	
Prepare for and conduct key informant interviews	The team prepared logistical and technical review for key informant interviews with representatives of four JLN countries attending the Steering Committee meeting in September 2014. Interviews were held and notes compiled.	<p>Next steps:</p> <ul style="list-style-type: none"> <li>• Complete logistical and technical review for additional key informant interviews, which the team will conduct as part of two JLN meetings in December 2014.</li> <li>• Compile notes from interviews</li> </ul>

## ACTIVITY 6

### *Develop a Toolkit for Ministries of Health to Work More Effectively with Ministries of Finance (Year 1 Activity)*

**Objectives** – The importance of an MOH working effectively with an MOF is often viewed through the lens of resource capture. The more effectively an MOH can work with its MOF, the more appropriate resource allocation the health sector will likely receive. The HFG toolkit offers Ministries of Health a set of resources to better understand how efficiently and effectively they are spending resources. An MOH can use the outputs of these tools to guide future decisions on allocations and expenditure and demonstrate to the MOF that additional investments in health will be well spent.

**Year 2 Progress** – In Q4 the MOH/MOF toolkit was approved by USAID. The toolkit was presented in its component parts: an introduction summarizing the issues and conceptual framework, and four individual tools: 1) A self-guided assessment for Public Financial Management (PFM) Performance; 2) Guided self-assessment for internal controls; 3) Developing key performance indicators for health; and 4) Collecting data for efficiency.

**Challenges** – The HFG Governance team is still running into challenges to engage country activities to help disseminate and use the now approved toolkit.

Table 5 provides additional activity-specific updates.

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

Y2Q4 Planned Tasks	Y2Q4 Progress	Critical Assumptions/ Problems Encountered/ Follow-up Steps
Consult with MOH and MOF officials at Harmonizing Health in Africa (HHA) training	N/A	HFG received approval for the MOH/MOF toolkit on September 10, 2014. Year 2 programming has been reformulated in the Year 3 work plan to highlight completion of an additional tool and dissemination activities, without a specific focus on HHA.



Y2Q4 Planned Tasks	Y2Q4 Progress	Critical Assumptions/ Problems Encountered/ Follow-up Steps
Develop new tools	A fifth Year 1 tool was finalized and submitted.	HFG received approval for the MOH/MOF toolkit on September 10, 2014. Year 2 programming has been reformulated in the Year 3 work plan to highlight completion of an additional tool that builds upon the initial set of approved tools.
Draft case study	HFG identified Rwanda as the subject of the case study for constructive MOH/MOF engagement.	HFG received approval for the MOH/MOF toolkit on September 10, 2014. Year 2 programming has been reformulated in the Year 3 work plan to highlight completion of an additional tool and dissemination activities without a focus on a case study.
Develop productive engagement mechanisms guidelines	Guidelines have not yet been started, and will be based on the new tool and case study.	HFG received approval for the MOH/MOF toolkit on September 10, 2014. Year 2 programming has been reformulated in the Year 3 work plan to highlight completion of an additional tool and dissemination activities without a focus on specific engagement guidelines.

## **ACTIVITY 7\***

### ***Develop Tools to Engage Civil Society in Health Systems Finance and Governance (Year 1 Activity<sup>4</sup>)***

**Objectives** – Host-country governments, development partners, and civil society organizations from the national to local levels will have a guide to a set of tools they can apply to effectively engage in health finance and governance, and at least two tools will be developed for use in engaging civil society in health sector governance.

**Year 2 Progress** – The *Guide to Engaging Civil Society in Health Financing and Governance* and *Entry Point Mapping Tool* were finalized during Q4. They are currently being formatted for submission early in Quarter 1.

Table 6 provides additional activity-specific updates.

**TABLE 6. CROSS-BUREAU ACTIVITY 7\* DETAIL**

Y2Q4 Planned Tasks	Y2Q4 Progress	Critical Assumptions/ Problems Encountered/ Follow-up Steps
Document social accountability tool's impact on health in three countries	The tool has been finalized and formatted.	To be submitted in Y3 Q1.

<sup>4</sup> \*Activity # 7 from Year 1

Y2Q4 Planned Tasks	Y2Q4 Progress	Critical Assumptions/ Problems Encountered/ Follow-up Steps
Document field test and revise tools based on feedback	The Entry Point Mapping Tool and descriptions of seven other tools are included in the <i>Guide to Effective Tools for Engaging Civil Society in Health Finance and Governance</i> , and are ready for submission. The Media Briefing Kit was reviewed internally and is being finalized.	<ul style="list-style-type: none"> <li>• Entry Point Mapping Tool submitted in Q4.</li> <li>• Media Briefing Kit to be submitted in Q1.</li> <li>• Guide will be submitted in Q1.</li> </ul>

## ACTIVITY 7

### Case Studies of Tax Administration Reform and Resource Mobilization for Health

**Activity Objectives** – Launch an activity examining the effect of increased tax revenue mobilization and resource allocations for health to ultimately produce two or three country case studies.

**Year 2 Progress** – In Q4, the team has completed a report on an analytical framework that uses country examples and regression analysis to evaluate the relationship between tax administration reforms and government health expenditures. The report finds that changes in tax revenues are not associated with changes in government health expenditures relative to other sources of government funding; however, there are strategies like prioritizing health within the government budget, decentralizing spending, and earmarking tax revenues toward health that can facilitate the use of tax revenues for health purposes. One of two case studies (El Salvador) to complement the report also has been completed.

**Challenges** – Identifying a second case study country has been challenging due to data validity challenges.

Table 7 provides additional activity-specific updates.

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

Y2Q4 Planned Tasks	Y2Q4 Progress	Critical Assumptions/ Problems Encountered/ Follow-up Steps
Identify and select countries for case studies	El Salvador has been chosen for one of the case studies. Tanzania is being explored as a potential second case study country; others in Eastern Europe and Africa are also being considered.	Identifying a second case study country has been challenging due to limited availability of valid data.
Develop annotated outline based on landscaping to guide quantitative analysis and qualitative interviews for each case study for review by Quality Advisor (QA)	Outline completed and revised according to QA comments in Q3. Draft of qualitative section reviewed by QA.	

Y2Q4 Planned Tasks	Y2Q4 Progress	Critical Assumptions/ Problems Encountered/ Follow-up Steps
Obtain approval of country selection from QA and HFG project team, and vet with USAID mission	<ul style="list-style-type: none"> <li>• QA approved El Salvador as first case; no travel needed for this case.</li> <li>• Second country case study selection to be sent to HFG project team and QA for approval.</li> <li>• Susna De from USAID Tanzania Mission contacted in Q3.</li> </ul>	Susna De has not yet responded to multiple email requests. Follow-up is ongoing.
Do quantitative analysis	Regression analysis final. Despite the positive correlation between tax revenue performance and government expenditures on health, when tax revenue is included as an independent variable in regression analysis with other determinants of government health spending such as GDP, general government expenditures, health indicators, and external funds for health, tax revenue is not significantly associated with changes in government health expenditures.	
Conduct qualitative interviews with various key experts	Completed for analytical framework draft. Interviews will continue for case studies.	
Update annotated outline for each case study based on quantitative and qualitative data and findings for review by QA	1 case study submitted to HFG management. Second case study in development.	
Have annotated outlines reviewed by QA and edits incorporated by Lead Author	Completed for first case study.	Second case country still being finalized.
Write 1 <sup>st</sup> draft of case studies and submit for review by QA	Completed for first case study.	
Finalize 1 <sup>st</sup> draft and incorporate edits	Completed for first case study.	
Edit and format final 1 <sup>st</sup> draft	Final first draft of report and first case study submitted to Abt for editing and formatting.	
Finalize case studies and send to USAID	First case study submitted to HFG management.	

## **ACTIVITY 8**

### *Promote Use of Mobile Money for Health Solutions*

**Objectives** – The overall objective of Year 2 activities is to continue to build knowledge (through continued documentation of mobile money applications) and to generate evidence (through targeted in-country technical support) for mobile money as a tool to expand the reach of health services to underserved populations and improve the efficiency, transparency, and accountability of financial transactions in the health sector. Lessons will be widely disseminated in the form of briefs, presentations, conferences, a regional workshop, the quarterly newsletter, and the HFG website.

**Year 2 Progress** – The team has received formal concurrence from mission and HFG/USAID client for a rapid assessment exploring mobile money for strengthening the results-based financing interventions in Senegal. A desk review is currently underway.

Table 8 provides additional activity-specific updates.

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

Y2Q4 Planned Tasks	Y2Q4 Progress	Critical Assumptions/ Problems Encountered/ Follow-up Steps
Provide technical support to 2–4 missions or governments	<ul style="list-style-type: none"> <li>Pathfinder has invited the HFG team to conduct a cost-effectiveness analysis of mobile money use for conditional cash transfers to pregnant women in the Nigerian government-led Sure-P program, for which Pathfinder is serving as technical lead. While HFG has received mission approval for the work, Pathfinder has experienced delays in rolling out the mobile money platform, which has pushed HFG travel for in-country consultations back to late November 2014. In the meantime, the HFG team is continuing to finalize the work plan for the analysis, and is reviewing background information and literature on the conditional cash transfer program.</li> <li>HFG also has received approval to conduct an assessment in Senegal in partnership with the Abt bilateral Health Systems Strengthening project and the MOH, assessing the potential for mobile money in results-based financing. A desk review is underway.</li> </ul>	The team has officially launched the cost-effectiveness study in Nigeria and is developing a research protocol and seeking IRB approvals. This effort will be coordinated with a separate impact evaluation of the larger cash transfer program that is underway.
Build on and update YI efforts to gather and disseminate existing evidence and best practices from case studies on mobile money for health	<ul style="list-style-type: none"> <li>The HFG team released its fifth newsletter in September. The newsletter is reaching close to 400 individual subscribers, almost double the numbers reached in the first edition, and is being widely circulated through several channels with high readership including the Joint Learning Network for Universal Health Coverage, Center for Health Market Innovations, and USAID's Digital Development e-newsletter.</li> <li>The team continues to conduct interviews with stakeholders to learn more about mobile money and health applications and develop case studies featuring these applications.</li> </ul>	

Y2Q4 Planned Tasks	Y2Q4 Progress	Critical Assumptions/ Problems Encountered/ Follow-up Steps
Convene a regional experts and practitioners' meeting, bringing together the health, finance, insurance, mobile, and IT sectors for knowledge exchange. This is expected to accelerate concrete applications of mobile money	<ul style="list-style-type: none"> <li>The team's abstract for a session that would bring experts and implementing partners to discuss barriers and solutions to mobile money scale-up at the December 2014 Global mHealth Forum of the mHealth summit has been accepted. The team also has been invited to participate on a panel on mobile money at the upcoming November 13–14 GETHealth Summit in Ireland.</li> </ul>	
Facilitate public-private partnerships at the global and regional level	<ul style="list-style-type: none"> <li>The team is collaborating with several partners in approved country activities, including Ministries of Health, the Abt bilateral Health Systems Strengthening project in Senegal, World Bank, and Pathfinder Nigeria.</li> </ul>	

## **ACTIVITY 9**

### *Support USAID Leadership in Health Systems Research*

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

By the end of this activity, HFG will:

- Support USAID to identify and share HSR priorities;
- Obtain agreement and guidance on best practices that promote effective and efficient investments in HSR; and
- Stimulate mission and partner interest in HSR, leading to additional support for HSR.

**Year 2 Progress** – HFG completed 13 stakeholder interviews with 20 USAID country and regional mission staff to inform USAID's HSR strategy. During these interviews, HFG explored mission staff views on the current needs for HSR, sources of HSR evidence they access, and potential avenues for USAID to support building an HSR knowledge base through its various partners.

These findings were collated with findings from Office of Health Systems on the HSR landscape at USAID HQ. Both sets of results were presented at a stakeholder workshop with USAID staff in Q4 of Year 2 to take stock and strategize about developing a cohesive USAID HSR agenda.

HFG has initiated the subaward process with two regional partners that will implement up to four country case studies to complement this work, but that process has not been finalized yet.

**Challenges** – The timing of the country case study implementation is contingent on the subaward process with selected regional partners. The process has taken significant time.

Table 9 provides additional activity-specific updates.

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

Y2Q4 Planned Tasks	Y2Q4 Progress	Critical Assumptions/ Problems Encountered/ Follow-up Steps
Launch country case studies	HFG initiated subaward processes with two regional partners, Witwatersrand University and the Public Health Foundation of India (PHFI). The subaward process is underway.	Next steps: <ul style="list-style-type: none"> <li>Finalize subawards with Wits University and PHFI.</li> <li>Initiate country case studies.</li> </ul>
Implement country case studies	Delays have been encountered due to a lengthy process in finalizing subawards with regional partners that will carry out this work.	Next step: Once subawards are in place, initiate country case studies in up to four countries.
Do interim review of findings from consultative and country studies	Complete for consultations (not country studies)	None
Develop a comprehensive, prioritized USAID HSR agenda	HFG supported stock-taking workshop for USAID HQ stakeholders toward an HSR agenda on September 3 <sup>rd</sup> at the Press Club. Ariel Pablo-Mendez and Karen Cavanaugh opened the workshop, which was attended by about 20 USAID staff. Key conclusions: <ul style="list-style-type: none"> <li>Many staff across GHB and missions are working on health systems strengthening (HSS) and HSR</li> <li>People would value better coordination of HSR to improve efficiency, learning, and knowledge management.</li> <li>Indications that people are not ready for single HSR agenda that would be prescriptive</li> </ul>	Next steps: HFG to submit work shop report Joe and Sweta Sept–Dec 2014 <ol style="list-style-type: none"> <li>Disseminate profiles from landscape analysis</li> <li>Organize event to “Bring Cape Town to RRB”</li> <li>Webinar series – ‘Call for HSS Impact’ success stories.</li> </ol>
Engage with global partners to share and disseminate HSR priorities, recommendations	No work on this task during Q4.	
Identify opportunities to promote or advance USAID’s HSR priorities	No work on this task during Q4.	Next steps: Identify potential activities to support HSR priorities at USAID in coordination with client team
In consultation with USAID, develop scope of work (SOW) for two new activities on strengthening regional partners and developing tools to measure effects of health systems strengthening investments	No work on this task during Q4.	Next steps: Develop SOWs based on activities identified for advancing HSR priorities.

## ACTIVITY 10

### Co-sponsor the International Society for Health Systems Research

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

The objectives in Year 2 are:

- Support a board retreat to develop an approach to implement the Strategic Plan developed in Year 1 and continue planning for the 2014 HSR Symposium in South Africa.
- Develop a business plan based on the strategic plan to guide resource mobilization and leverage USAID support.
- Continue to strengthen the governance processes, including the development of the Secretariat itself.

**Year 2 Progress** – During the first quarter, the Strategic Plan 2013-2015 was finalized, formatted, and disseminated by HSG. In addition, discussions were initiated on how to approach the development of a business plan including the development of a concept note. In the second quarter, HFG assisted HSG in planning a retreat for its board that was held February 20-21 in London. In addition to funding the travel for nine board members, HFG provided assistance on a range of organizational issues that were discussed at the retreat. Specifically, HFG provided input into the development of a business plan, developed guidelines for the eight Thematic Working Group that have been formed and their relationship to the Secretariat, and reviewed a draft communications plan. The retreat was successful in achieving its outcomes. The third quarter focused on follow-up to the retreat and finalizing plans for HFG support for the rest of Year 2. In Q4, HSG took advantage of board member travel to Cape Town for the biennial Symposium (Sept 29-Oct 3) to plan a two-day board retreat. The retreat was especially important with five new board members and ensuring a smooth transition from the outgoing board. HFG assisted in planning and facilitating the retreat described below.

Table 10 provides additional activity-specific updates.

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

Y2Q4 Planned Tasks	Y2Q4 Progress	Critical Assumptions/ Problems Encountered/ Follow-up Steps
Conduct board retreat	Conducted two-day board retreat to piggyback on board members already in Cape Town for the HSR Symposium. The retreat focused especially on the transition to a new board. Specific issues discussed included an overview of the Secretariat structure, review of position descriptions for board members, election of officers, review of TOR for call for proposals for new Secretariat, and strategy for membership drive.	Next steps: Complete retreat report.



Y2Q4 Planned Tasks	Y2Q4 Progress	Critical Assumptions/ Problems Encountered/ Follow-up Steps
Develop business plan	No work on this activity took place this quarter.	
Continue support to develop governance structures and processes	Developed drafts of board member and board officer roles and responsibilities and then finalized them for circulation to the board.  Consolidated the organizational role and responsibilities of the Secretariat Director as well as the role and responsibilities of the Secretariat in general into a draft call for proposals for the new Secretariat.	
Assist HSG in conducting feasibility study to establish regional hubs	HFG support on regional hubs is on hold.	
Develop capacity of HSG in use of social media platforms	Consultant was hired to develop the capacity of HSG thematic working group focal points, and others involved in the organization and its governance, in the use of social media platforms. This supports HSG communication objectives and more importantly is aimed at expanding the network of HSG and its membership base.	Complete inventory of existing basic (online) learning materials that support the use of social media platforms.  Develop social media capacity building materials, including facilitator and participant handbooks.



## ACTIVITY II

### ***Develop and Improve Tracking and Reporting Systems, Including Indicators, for Health Systems Strengthening***

**Objectives** – This activity covers two streams of work to achieve the following objectives:

- Ensure the GHB, missions, and implementing partners have access to a common menu of indicators for measuring and monitoring USAID investments in HSS.
- Ensure global access to comprehensive health system performance data through the Health Systems Database.

**Year 2 Progress** – During the first three quarters of Year 2, the HFG team initiated its review and consolidation of indicators for the health financing and human resources for health (HRH) building blocks. The team started the process of finalizing the performance indicator reference sheets for both building blocks. In Quarter 3, HFG started on the Governance building block. The team received performance monitoring plans (PMPs) from several other implementing partners. In Q3, HFG met with the AOR team to review progress made to date. During this meeting, it was decided that due to budget considerations, HFG work would cover three building blocks (financing, governance, and human resources) within the compendium, rather than all six building blocks. In Year 2 Quarter 4, the HFG

team finalized the health financing and HRH indicators and their related performance indicator reference sheets. The team is planning to invite the Capacity Plus project monitoring and evaluation (M&E) team to provide feedback on the HRH indicators. HFG has already started working on the Governance building block, and plans to complete it by the end of the calendar year.

**Challenges** – Additional funding was needed to complete final product. The AOR team approved using \$30,000 of unprogrammed IR4 funds to meet the gap.

Table 11 provides additional activity-specific updates.

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

Y2Q4 Planned Tasks	Y2Q4 Tasks	Critical Assumptions/ Problems Encountered/ Follow-up Steps
<b>Health Systems Strengthening Indicators</b>		
Produce a list of indicators for the remaining building blocks	Consolidated and reviewed indicators related to Governance. Finalized a list of indicators and reference sheets for HRH.	Next step: HFG initiated the indicator review process for the Governance building block.
Hold consultative meetings and conversations with implementing partners		HFG will solicit feedback from Capacity Plus on indicators related to the HRH building block.
<b>Health Systems Database</b>		
Conduct presentations and meetings with USAID	Postponed until Y3Q1 due to scheduling challenges.	
Troubleshoot as needed, respond to comments and requests	Ongoing, as needed.	



## ***Implementation Research to Support Scale-Up of Health Financing Interventions to Meet the Goals of Universal Health Coverage***

**Objectives** – USAID missions and country counterparts will gain a deeper understanding of the value of research to advancing UHC and results-based financing and of how to integrate research in this context. This will be done by:

- Creating an Implementation Research (IR) Framework for health financing and governance interventions to support UHC, which will synthesize results of field testing of an IR strategy applied to a health financing intervention
- Testing an IR methodology in one country that produces an IR strategy for a health financing and governance intervention in that country
- Dissemination of lessons globally through publication on HFG website and via prominent web forum

**Year 2 Progress** – This activity has been delayed during Year 2. In Year 1 Quarter 4- Year 2 Quarter 1, HFG worked with the AOR team to reformulate the original scope of this activity, and conducted a modest literature review that looked at the types of resources available on UHC and how the existing literature refers to the utility of IR. HFG broadened the review to look at guides to IR with the goal of understanding how it is defined and conducted, and its uses. A revised concept note for this activity was submitted to the AOR team for approval in Year 2 Quarter 1. Following further discussions and developments, including additional new work funded by Asia Regional Bureau related to IR within HFG, the activity now comprises two elements. The first is a series of technical briefs to share lessons in designing and implementing two specific IR for UHC initiatives, in Myanmar and Indonesia. The second element will leverage the experience in Asia and offer technical assistance to a country in Africa that is implementing or planning to implement a UHC initiative and that is keen to develop an IR strategy to inform their UHC rollout. HFG is compiling initial lessons for the first technical brief based on the current development of IR for UHC initiatives in Myanmar and Indonesia.

**Challenges** –The timing of the technical briefs and ensuing technical assistance will be tied to the pace and progress of the development and launch of the IR for UHC initiatives in Myanmar and Indonesia.

Table 12 provides additional activity-specific updates.

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

Y2Q3 Planned Tasks	Y2Q3 Progress	Critical Assumptions/ Problems Encountered/ Follow-up Steps
Select priority research questions together with USAID	Building on development of the Asia Bureau funded IR for UHC work in Indonesia and Myanmar, HFG further developed the concept of documenting the experiences of implementing IR for UHC.	Next step: In YR3,Q1, HFG will begin developing the framework and moving forward to develop IR for UHC in Myanmar and Indonesia.
Develop IR for UHC briefs from the field	Specific plans to proceed with a revised activity were submitted and approved. The activity now involves producing a series of technical briefs to share lessons from specific IR for UHC initiatives in Myanmar and Indonesia.	Next steps: Document the initial steps of building stakeholder buy-in for the concept of IR for UHC and the first steps taken to define priority questions together with decision makers.

## **ACTIVITY 13**

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

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

**Year 2 Progress** – Much of the funding from Year 1 for knowledge management carried over to Year 2. HFG requested guidance on how to program these funds, and held several discussions with the AOR. USAID has decided that the funds will be used to finalize the e-learning course on health systems strengthening. HFG has developed a plan for finalizing the e-learning course including technical review of selected modules and pilot testing with a sample of representative users followed by limited revisions. The four selected modules have been reviewed by HFG subject matter experts and plans were

developed to identify representative users to take the entire course. Nine people were identified and will have taken the course by mid-October.

**Challenges** – Key challenges include budget constraints if the pilot testing results in extensive revisions and working out final details with the Global Health e-Learning Center so the course can be posted online.

Table 13 provides additional activity-specific updates.

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

Y2Q3 Planned Tasks	Y2Q3 Progress	Critical Assumptions/ Problems Encountered/ Follow-up Steps
Do pilot testing by representative users	Pilot testers were identified and began taking the HSS e-learning course.	Evaluate feedback to determine final revisions, if any.
Make final revisions	Revisions will be made right after pilot testing is completed.	
Post course online		Work with Knowledge 4 Health to post the course in the USAID Global Health e-learning Center.

## **ACTIVITY 14**

### ***Preparing for Transitions in Financing: Institutional Capacity Building, Country Ownership, and How to Measure It***

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

Through this activity, HFG will achieve the following objectives:

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

**Year 2 Progress** – HFG developed a conceptual framework and guiding documentation for approach transition and its M&E. The framework and guiding document were informed by an extensive literature review, expert consultations within HFG and its partners, and limited external interviews. The framework and guiding document have been reviewed internally and an updated draft is currently being finalized for dissemination with the client team and other relevant USAID stakeholders.

Table 14 provides additional activity-specific updates.

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

Y2Q4 Planned Tasks	Y2Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
Summarize key lessons learned from other transition processes (GAVI, family planning, etc.)	Complete.	None.
Develop framework for how countries approach transition/sustainability planning (including how countries can monitor and evaluate transition-related processes)	Following the internal consultative workshop in Q3 and revised draft was circulated and critiqued at a meeting at HFG on September 12. Final revisions are underway in advance of sharing with client team and other USAID stakeholders.	Next steps: Finalize draft of conceptual framework and guiding document to be reviewed with client team and other stakeholders. Hold consultative meeting with client team and other USAID stakeholders. Finalize conceptual framework and guiding documentation.
Develop concept note for pilot testing framework in select country	No activities in Q4.	Next steps: Upon finalizing the guiding document, concept notes for piloting the framework will be developed.
Country pilot launched in at least 1 country (TBD, pending funding availability)	No activities in Q4.	Next steps: Launch country pilot, pending funding availability.

## **ACTIVITY 15**

### ***Governance of Benefits Packages to End Preventable Child and Maternal Deaths***

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

HFG will implement this activity, which can be built upon in future years, through four steps.

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

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

**Step 2: Conduct a Landscape Analysis of EPCMD Country Benefit Packages**

HFG will assess the current landscape of the benefit packages in EPCMD countries from publicly available data. The assessment will include the following:

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

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

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

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

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

**Year 2 Progress** – We received partial approval for the activity on June 22, 2014. HFG submitted a draft of the framework in Q4. The framework included definitions of EPHS and greater detail on the activity deliverables.

Table 15 provides additional activity-specific updates.

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

Y2Q4 Planned Tasks	Y2Q4 Progress	Critical Assumptions/ Problems Encountered/ Follow-up Steps
Develop taxonomy of benefit packages and governance framework	Draft framework for this activity was finalized and prepared by the HFG project team and submitted to the AOR on August 29, 2014.	The AOR team provided feedback on the draft framework that the team is working to address.
Do landscape analysis of benefit packages	The initial task – determining the content of benefit packages – was approved on June 11, 2014. Data collection is ongoing.	
Assess benefit packages' governance	This step of the activity is not yet approved.	The team is coordinating with XB activity regarding the role of evidence in developing benefit packages to maximize synergies.
Develop benefit packages' governance guidelines	This step of the activity is not yet approved.	



## ACTIVITY 16

## *Governance Indicators Impacting Intermediate Outcomes for Monitoring and Evaluation*

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

### I. Facilitating dialogue to develop a shared learning agenda:

Working in collaboration with Office of Health Systems and the Center of Excellence on Democracy, Rights and Governance (DRG), HFG will conduct an evidence workshop to discuss the existing state of research findings on the impact of good governance on health, and help to coordinate potential parallel evidence generation efforts. The objectives of this workshop, which will bring together stakeholders from the GHB, the DRG, and potentially the Bureau of Economic Growth, Education and Environment (for focus on PFM), would include:

- a. Review existing state of evidence and ongoing evidence generation efforts;
- b. Identify the gaps in evidence; and
- c. Help to gain consensus on a common threshold for research and evidence standards among health and governance participants.

HFG will work with the various stakeholders to develop the workshop agenda to ensure it addresses the range of interests and ongoing initiatives already focused on evidence generation. The workshop content will leverage DRG efforts, including presentations of research generated through DRG solicitations.



Parallel to this workshop, HFG will work with other USAID implementing partners, including the Leadership, Management and Governance (LMG) project and the Health Policy Project (HPP), to develop and coordinate evidence generation efforts.

2. Contribute to the evidence base for health impact on intermediate outcomes for health.

HFG will seek to address evidence gaps identified in the workshop. These efforts, which will be initiated in coordination with USAID, may include the following:

- a. Building upon ongoing HFG research in Ethiopian facility governance boards;
- b. Building upon ongoing HFG research on tax administration and health revenues;
- c. Developing a set of governance indicators for a specific set of health intermediate outcomes;
- d. Building upon ongoing PFM field-based research;
- e. Case study of how oversight institutions and civil society organizations can work collaboratively to promote accountability and contribute to improved health outcomes and quality and access to care; and
- f. Contributions and collaboration with LMG and HPP on evidence generating activities.

**Year 2 Progress** – On July 23, 2014, HFG hosted a one-day workshop at the National Press Club in Washington, DC, on generating evidence of governance contributions to health outcomes. The event brought together almost 60 health and governance professionals from USAID, prominent external organizations such as WHO and the World Bank, and implementing partners to discuss the key evidence gaps and develop an action plan to address them. A comprehensive workshop report summarizing the key elements of the discussion and next steps was developed and shared with participants.

Table 16 provides additional activity-specific updates.

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

Y2Q4 Planned Tasks	Y2Q4 Progress	Critical Assumptions/ Problems Encountered/ Follow-up Steps
Workshop Agenda Setting Meetings with Office of Health Systems and DRG	The Evidence Generation workshop was held on July 23.	
Learning Agenda Setting with LMG and HPP	The shared learning agenda is based upon the priorities identified in the Evidence Generation workshop.	
Evidence workshop	Workshop was held in July 2014 and was well received by participants.	
HFG contributions to the evidence base	Speakers for the HSR panel have prepared presentations to present in Y3Q1 at the HSR Symposium conference Sept 29-Oct 3 in Cape Town.	Summary of presentations will be forthcoming following the conference.



## 3. DIRECTED CORE ACTIVITIES

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

### 3.1 Population and Reproductive Health

**Program Objectives** – In Year 2, HFG will support USAID’s commitment to meeting the goal of 100 million additional users of modern family planning methods by 2015 and USAID’s contribution to meeting the global goal of 120 million additional family planning users by 2020 that was established during the London Summit on Promise Renewed, and resulted in the global initiative Family Planning 2020 (FP2020).

**Year 2 Activities** – In Year 2, HFG will support the development of resource tracking methods that focus on sources and uses of funding for family planning; it will provide technical support to Track 20, the resource tracking component of FP2020, to implement these methods in FP2020 countries. We will continue our collaboration with John Snow Inc. (JSI) and the DELIVER project on performance-based incentives (PBI) for strengthening country supply chains to procure, store, and deliver family planning commodities with IR in Mozambique on the performance-based “government-to-government” Fixed Amount Reimbursement Agreement (FARA) grant with the country’s Central Medical Store (*Central de Medicamentos e Artigos Médicos*, or CMAM). As countries choose health insurance as part of their strategy to attain UHC, it is important that family planning is not overlooked. In Year 2, we will work with the Population Reference Bureau (PRB) to develop a brief on including family planning in the benefits packages covered by insurance. We also will continue to provide support to USAID to enhance understanding about how to incorporate family planning into results-based initiatives that reward results instead of pay for inputs.

**Year 2 Progress** – In Quarter 1, Lindsay Morgan presented at the International Family Planning Conference in Addis Ababa, on a multi-country study about how and whether PBI programs that include incentives for family planning can support quality family planning and voluntarism. The panel was well-attended, and presentations were followed by a lengthy Q&A session. Also in Quarter 1, we began planning for IR on the FARA grant to Mozambique’s CMAM; the FARA program conditions payment on achievement of performance milestones. Technical assistance to design the performance-based FARA was provided by the Health Systems 20/20 project. The research was conducted jointly with the USAID DELIVER project in Quarter 2.

In Quarter 2, HFG collaborated with DELIVER to conduct a qualitative evaluation of the performance-based FARA between USAID and Mozambique’s CMAM. The purpose of this assessment was to understand what drove and constrained performance; how stakeholders understand and perceive the grant program; and how it is being implemented and managed. The evaluation provided lessons that can strengthen the current design and implementation of the program, and will feed into possible future iterations of FARA and other U.S. Government (USG) government-to-government grants, and other initiatives in Mozambique and beyond.

The program has demonstrated results: during the first year there was solid performance on indicators related to planning and distribution, and uneven but nonetheless fair performance made on warehouse indicators. Informants widely agree that the performance incentives are motivating staff, enhancing collaboration and accountability, and enabling CMAM to invest in institutional improvements.

USAID is pleased with the approach and already discussing the possibility of a 2015 FARA. Among CMAM, USAID, Supply Chain Management System and other donors, there appears to be a general consensus that FARA is successfully catalyzing, with a small amount of money (\$500,000 in Year 1), the large financial investments of USAID and other donors. Informants are keen for the program to continue. However, they also recognize that key areas will need to be strengthened in the future, which we discussed in the debriefing. These areas include CMAM's internal M&E capacity; USAID's management of the verification process; and the continued evolution and refinement of indicators, targets and other design elements.

In Quarter 3, HFG collaborated with PRB to draft a brief on including family planning in insurance packages. Both USAID and PRB believe that it is important to communicate the value of family planning to ensure that family planning is not left out of the benefits package as countries transition to a UHC model that includes insurance.

In Quarter 4, HFG completed a first draft of the guidance document for tracking family planning expenditure using the SHA 2011 methodology. This guidance document will form part of WHO's Guide to Disease Classification. The guidance for family planning will enable country resource tracking teams to collect and analyze family planning data for better planning and monitoring purposes. In September 2014, Karishmah Bhuwatee travelled to Burundi to support the NHA team to code the NHA data, including verifying and coding family planning data. The preliminary analysis for family planning was shared with the National Reproductive Health Program to validate the results, i.e., ensuring all sources of data were captured, all in-kind donations were accounted for and that the flow of funding for family planning is accurate. HFG also shared the first draft of the guidance document and received comments from the NHA team about additional issues which countries find challenges and which should be addressed in the guide. HFG will work with the HPP project to update the draft and circulate more widely for review.

Table 17 provides activity-specific updates.

**TABLE 17. POPULATION AND REPRODUCTIVE HEALTH ACTIVITY DETAIL**

Y2Q4 Planned Tasks	Y2Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
<b>Activity 1: Technical recommendations for inclusion of family planning in PBI</b>		
Draft joint guidelines for Inter-Agency Working Group members and convene a meeting with donors to discuss	HFG confirmed with PRH that this activity won't go forward as initially envisioned. HFG is discussing options to reprogram the funding that was initially intended for this work.	
Revise guidelines and publicize	See previous.	
<b>Activity 2: Policy brief on Inclusion of Family Planning in Health Insurance</b>		
Draft publication	Technical content of the brief is finalized and it is being formatted.	None

Y2Q4 Planned Tasks	Y2Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
<b>Activity 3: Technical assistance to FP2020 Working Groups on Expenditure Tracking</b>		
Draft guide to support countries to collect accurate family planning data and calculate the disease distribution	In line with WHO's Guide to Disease Classification, a first draft of the chapter for tracking family planning resources was drafted. The draft was piloted with the Burundi NHA team, during data analysis.	HFG will work with the HPP project to address the comments of the Burundian NHA team to produce an updated draft.
Provide technical assistance to understand expenditure tracking of international financial commitments	HFG supported the NHA team to clean and analyze health expenditure data, including family planning, for 2012 and 2013 using the NHA Production Tool. HFG worked with the team to validate the results with the National Reproductive Health Program.	HFG will continue to assist the NHA team to triangulate the preliminary analysis with other reproductive health data sources to ensure the NHA analysis is complete for family planning.
<b>Activity 4: PBI to strengthen family planning supply chains</b>		
Draft Mozambique case study	Report is being formatted and finalized.	
Revise PBI supply chain guide	Supply chain guide was used by JSI Deliver in Tanzania and they found it useful. JSI Deliver will revise and update based on field experience.	
Choose country for joint technical assistance with DELIVER project	HFG provided support to JSI Deliver on indicators for a performance based payment arrangement with the central medical store in Tanzania.	
Finalize report	Mozambique and revised supply chain guides to be finalized after field work is completed.	Finalization of supply chain guide conditional on JSI Deliver input.
<b>Activity 5: Ensure voluntary service delivery within PBI</b>		
Country and program consultations	None.	USAID needs to decide whether to continue to pursue details about country-specific results-based financing initiatives.

## 3.2 Maternal and Child Health

**Program Objectives** – As 2015 approaches, the international community is dedicated to ending preventable maternal and child deaths, and helping countries meet MDGs 4 (Reduce Child Mortality) and 5 (Reduce Maternal Mortality). While substantial progress has been made in the last several years, only half of women in developing countries receive the recommended health care during pregnancy, and more than 6 million children worldwide die before their fifth birthday. In June 2012, the USG, along with the United Nations Children's Fund (UNICEF) and the governments of Ethiopia and India, launched the Child Survival Call to Action, and challenged the world to reduce child mortality to 20 deaths or less per 1,000 births in every country by 2035. Harnessing the momentum from the Call to Action and its subsequent initiative, *A Promise Renewed*, USAID invigorated its efforts to improve maternal and child survival in the five countries which account for over half of global child deaths: Ethiopia, the Democratic Republic of the Congo (DRC), India, Nigeria, and Pakistan. Early in 2014, USAID once again renewed its commitment to ending preventable maternal and child deaths, and pledged a reduction in under-five mortality by 4 deaths per 1,000 live births in 24 priority countries by 2015 (as compared to a 2013 baseline). The goal of ending preventable maternal and child deaths is at the heart of the post-MDG conversation, and promises to remain at the center of the global community's attention until 2015. The two-year anniversary of the Call to Action in June 2014 added to the momentum, serving as an interim milestone and an acute reminder of the progress yet to be realized. The USAID MCH office and HFG recognize that without the proper policies in place and the country-level capacity to provide MCH services, as well as reduced financial barriers to access these services, the goals set by these initiatives are unlikely to be met. HFG's MCH portfolio supports the following intermediate objectives, each of which links to MDGs 4 and 5 and aims to end preventable child and maternal deaths:

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

**Year 2 Activities** – The project continued implementing three activities carried over from Year 1:

- ***Manuscripts on the effect of financial incentives on maternal health service use:*** The project was asked to prepare a journal article on user fee exemptions summarizing the review initiated under the 2012 U.S. Government Evidence Summit on the *Enhancing Provision and Use of Maternal Health Services through Financial Incentives*. The project also conducted an additional literature review on the impact of insurance on maternal health service use and prepared a manuscript for publication. This activity was completed in Year 2 Quarter 1.
- ***Evaluation of a health microinsurance pilot program in Lagos, Nigeria:*** HFG is conducting a pre-post impact evaluation of an insurance scheme for informal sector workers in Lagos state, Nigeria. The insurance program promotes a newly forged partnership between a Nigerian health insurance company (Health Care International) and a microfinance bank (Infinity) in Lagos; the partnership and development of the insurance product have been supported over the past two years by the Abt-led Partnership for Transforming Health Systems Phase Two (PATHS2) Project, funded by the U.K. Department for International Development (DFID). As of October 2013, all

Infinity clients who take out a new individual loan or renew an existing individual loan of 200,000 NGN or more (roughly US\$1,200) are automatically enrolled in the insurance scheme. Premiums are added (interest-free) to the loan principal, and can thus be paid in small increments as the loan is repaid. Since lower- and middle-income women of reproductive age constitute the bulk of the clients of the microfinance bank, providing access to otherwise unavailable health insurance coverage is expected to increase their access to high-quality health care, including essential MCH services. HFG's evaluation will contribute to the evidence base on the effectiveness of health financing interventions for MCH service use.

- **Technical contributions to the “Technical Reference Team on Innovative Financing” of the UN Commission on Life Saving Commodities for Women and Children:** The Commission was formed in 2012 to increase access to essential medicines and supplies that can prevent numerous maternal and child deaths. The Commission agreed upon a list of 13 priority commodities and promotes 10 cross-cutting recommendations to increase access to and use of these commodities. Technical Reference Teams were established for each commodity and recommendation. HFG supports the Innovative Financing team by providing technical expertise that promotes the team's goals and Commission's framework. This activity was completed in Year 2 Quarter 1.

After several discussions with USAID MCH colleagues, the following three activities were approved in May 2014 and will use the remaining unprogrammed Year 1 carry-over funds (~\$130K). All three activities aim to improve resource allocation for MCH services, and support stakeholder accountability.

- **Resource tracking for MCH:** In the context of the global economic transition, in which middle-income countries are increasingly able to finance health with domestic resources, tracking how much countries and donors are spending on priority MCH services is more critical than ever. The updated NHA methodology, known as the SHA 2011, aims to track overall health spending across a spectrum of program- and disease-specific categories – beyond what used to be tracked for selected priority areas like the Reproductive Health and Child Health subaccounts. The new methodology will ultimately provide opportunities for more-granular analysis of MCH spending, but countries also need guidance to meet the increased information requirements it entails. To this end, HFG will support the following three activities.
- **Develop practical guidance materials on MCH resource tracking for countries applying the updated SHA 2011 methodology.** To ensure that MCH-related spending is consistently and accurately measured using the new framework, countries need support and guidance. Similar to the guidance that is being developed for tracking spending on tuberculosis (TB) and family planning expenditures, the aim is to integrate the MCH guidance into the broader guidance that WHO is developing; HFG will work in close collaboration with WHO on this activity.
- **Support development of policy advocacy and communications tools to enhance uptake and use of findings by government officials and civil society organizations.** HFG will create a summary brief analyzing existing MCH resource tracking data across several countries, showcasing how this information can be interpreted and used. We will create basic templates for policy-relevant communication of MCH resource tracking results. These tools will demonstrate how MCH expenditure information can be used to improve national strategic planning, domestic resource mobilization, and resource allocation for MCH programs.
- **Pilot MCH guidance in a USAID-identified priority country that is conducting an SHA 2011 estimation.** This experience will be used to improve and finalize the guide. HFG has identified Zambia as a possible context for this support; the final determination will be made in collaboration with MCH colleagues.



Using Year 2 funds, the project received approval in May 2014 to support the following activities:

- Additional funding for the baseline Evaluation of a health microinsurance pilot program in Lagos, Nigeria
- A study of Lessons learned from the Nigeria micro health insurance scheme using key informant interviews to distill broader implications for practitioners and policymakers.

Also using Year 2 funds, the project received approval in July 2014 to support the following activity:

- **Modeling the Effects of Health Systems Strengthening on Coverage and Lives Saved:** HFG will build an optional addition to existing Spectrum projection models that will incorporate available evidence on the effects of health systems strengthening on health outcomes. The tool will support strategic planning, prioritization, and advocacy efforts worldwide.

**Year 2 Progress against Objectives** – HFG’s MCH team was notified in Q2 that two manuscripts had been accepted for publication in a supplemental issue of the *Journal of Health, Population and Nutrition* (JHPN) on financial incentives for maternal health (available on JHPN’s website, <http://www.jhpn.net/index.php/jhpn/issue/view/711>). With strong support from the AOR team, the HFG MCH and Communications teams drafted a short description of a brown bag discussion on the papers, which was included on a list of eight topics for future HFG presentations at USAID. The event proposed an interactive discussion on how fee waivers and insurance impact the use of maternal health services, using the two publications to guide the conversation. HFG awaits feedback from the AOR team on the appropriate fora for this topic, given the timeliness and relevance to USAID’s spotlighted MCH initiatives, and the complementarity to other similar events being held.

In order to address the gap in evidence quantifying the impact of health insurance on health outcomes in low-income contexts, HFG completed in-country data collection and data entry of the baseline survey evaluating the Lagos-based micro health insurance scheme in Q3. Without a site office or HFG staff based in Lagos, ongoing communication with in-country contacts during all phases of the study was both imperative and challenging. HFG also worked closely with the PATHS2 project staff based in Lagos, who provided on-the-ground administrative and logistical support during the planning and implementation stages of the study, as well as the team of 14 local consultants hired to conduct data collection and entry.

After a key trip made by Ms. Lauren Peterson to finalize preparations in Lagos in Q2, field testing for the baseline survey and pilot testing of the process evaluation and MCH questionnaires had been conducted and a sampling plan generated. Data collectors worked with Infinity loan officers to identify, locate, and recruit respondents, and data collection began in late February. After data collection concluded in late March, data entry was initiated. The data entry team consisted of three entry clerks and one data manager, whose support and previous experience managing research proved to be an invaluable asset to the team in the final stages of the study. The HFG MCH team based in Washington received the first tranche of data from the field team in early April and, after quality checks were completed, the final, verified data set was received in late April. The Washington-based team worked closely with PATHS2 and HFG staff in Abuja to address remaining administrative tasks such as final compensation for consultants and reporting the training of the local research team.

During the final phases of data entry and verification, the team was pleased to learn that their abstract submission, “Increasing access and financial protection: Evaluation of an innovative microinsurance partnership in Lagos, Nigeria” was accepted as a poster presentation at the Third Global Health Systems Research Symposium, to be held in Cape Town in late September/early October 2014. Three of the co-authors of the submission are locally hired PATHS2/HFG staff and consultants. Given resource limitations, the team is currently determining whether the poster can be presented by someone already attending the conference.

Following a March meeting with the Nigeria microinsurance team, Dr. Koblinsky approved the use of some of the unprogrammed Year 2 funds to complete the baseline evaluation, given that the team had exceeded the original allocation of funds due to the challenges outlined in previous progress reports. Dr. Koblinsky also indicated her support for a small portion of Year 2 funds to go toward a process evaluation. The team held initial work planning discussions in Q3, focused on harnessing lessons learned from the baseline study. The research team also learned that the local research coordinator, Dr. Omasan Edun, would be continuing to work with PATHS2 to support the partnership. Through conversations with Dr. Edun as well as other PATHS2 staff, the team gained insight into PATHS2 plans to implement an education campaign about the value and benefits of insurance, in order to bolster the roll-out of the insurance product. This supplementary information may be useful as the HFG team plans for the process evaluation.

In Q4, the HFG team completed cleaning and analysis of baseline data and drafted a baseline report. The baseline report explores the characteristics of the sample population, self-reported health seeking behavior at the time of insurance enrollment, and estimated health expenditures relative to the health insurance premium. In addition, the report considers the challenges associated with extending comprehensive health insurance coverage (inpatient, outpatient, and maternity care) to urban, informal sector workers and lessons learned from the study. The report is currently undergoing internal review for quality assurance and will be shared with USAID for feedback.

In order to build on the findings and challenges identified during the baseline study, improve how the insurance is offered, and enhance the product to better reach low-income clients and meet their needs (in terms of pricing, benefits, and the process for enrolling and using the product), HFG began planning to conduct a series of key informant interviews in Q4. These will be held with stakeholders involved in the design and delivery of the insurance product (including the microfinance bank, the insurance partner, and technical assistance providers) as well as insured and uninsured clients and health care providers at facilities covered by the insurance product, if available. During Q4, a qualitative research consultant was identified to lead key informant interviews, a trip was planned in consultation with partners in Lagos, and a semi-structured interview guide was developed for key informant interviews. In early Year 3 Q1, the consultant will travel to Lagos with the objective to 1) validate, update and augment findings and observations on the development, operationalization, and roll-out of the product via this partnership model; 2) develop a more nuanced understanding of successes and challenges previously identified; 3) report on the current status of the health insurance scheme drawing from conversations with key stakeholders; and 4) identify emerging lessons learned in collaboration with the research team.

In Q4, HFG also initiated efforts to develop guidance for maternal health and child health resource tracking using the SHA 2011 framework. The team conducted desktop research for relevant materials, including the subaccount guidelines under the previous SHA 1.0 framework, and developed detailed annotated outlines for both chapters. Currently the team is in the process of fleshing out the guidelines per the outline. Country reports with MCH subaccounts were also compiled in preparation for compiling a policy implications brief.

Finally, in Q4 the HFG project initiated a new activity: developing a quantitative tool to model the effect of health systems strengthening interventions on health outcomes and lives saved. Health systems provide the basic inputs for the delivery of health services, yet it has historically been difficult to quantify contributions of HSS interventions and their importance for improving MCH outcomes and reducing mortality. As a result, policymakers, health planners, and donors find it challenging to demonstrate the importance of investing in HSS activities. HFG proceeded to prepare a concept note and work plan for developing a Spectrum tool module, and shared this with USAID staff for input. The team initiated a literature review on the effects of HSS interventions. USAID is planning to convene a steering committee with representatives from the World Bank, the Child Health Epidemiology Reference Group (CHERG), UNICEF, and other key stakeholders, to provide oversight to the tool development process.

Table 18 provides activity-specific updates.

**TABLE 18. MATERNAL AND CHILD HEALTH ACTIVITY DETAIL**

Year 2 Q4 Planned Tasks	Year 2 Q4 Progress	Critical Assumptions/ Problems Encountered/ Follow-up Steps
<b>Activity 1:</b> Conduct research on micro health insurance enrollment and use of Maternal, Neonatal and Child Health services in Lagos, Nigeria		
Analyze survey data	Data cleaning and analysis of baseline data collected in Q2 and Q3 was completed in Q4.	
Draft analytical report	Following the completion of data analysis, the research team drafted a baseline report. The report provides background on efforts to extend health insurance coverage to urban, informal sector women, findings from the baseline data, study limitations, and interpretation of the findings and recommendations for key stakeholders. Specific findings include individual and household characteristics of the target population, health seeking behavior prior to insurance enrollment, and health expenditure relative to the health insurance premium.	The draft is currently undergoing an internal review for quality assurance. Once the draft is finalized, it will be shared with USAID.
Revise draft of report based on feedback - final report	The final report is currently undergoing an internal review for quality assurance purposes.	The research team will address USAID's feedback once USAID has an opportunity to review the report.
<b>Activity 2:</b> Develop practical guidance materials on MCH resource tracking for countries applying the updated SHA 2011 methodology		
Draft Guidance materials for tracking MCH spending within SHA 2011	Conducted desk research for MCH resource tracking, including reviewing the subaccount guidelines under the SHA 1.0 framework. The team has developed detailed annotated outlines for both chapters. Currently the team is in the process of fleshing out the guidelines per the outline.	Initial discussion with WHO Health Accounts team on the draft outline tentatively slotted for mid-October. Aim is to produce both sets of guidance by the end of Y3Q1.
<b>Activity 3:</b> Support development of policy advocacy and communications tools to enhance uptake and use of findings by government officials and civil society organizations		
Draft the brief summarizing findings on MCH spending and their use	The SOW has been finalized, country reports with subaccounts on MCH have been compiled, and the team is in the process of reviewing and compiling the results and policy implications identified by the country reports.	Next steps: Review of country policy, planning, and other relevant documents followed by key informant interviews to identify uptake of recommendations from the health accounts exercises. The team expects to complete a draft brief by the end of Y3Q1.

Year 2 Q4 Planned Tasks	Year 2 Q4 Progress	Critical Assumptions/ Problems Encountered/ Follow-up Steps
<b>Activity 4:</b> Pilot MCH guidance in an USAID-identified priority country that is conducting a SHA 2011 estimation		
Pilot the MCH guidance in Zambia	Activity awaiting finalization of the draft guidance materials and for the Zambian Health Accounts team completing the initial data collection, based on which HFG will provide concrete guidance around further understanding MCH-related spending.	Activity tentatively slotted to be conducted in Y3Q1 and feed into the refining the guidance for its completion. Further discussions with the country health accounts team and USAID mission are expected after review of the preliminary data collected for SHA 2011 and work required to further unpack the MCH component of the spending is clearly understood.
<b>Activity 5:</b> Lessons learned from Nigeria micro health insurance scheme		
Identify key informants and determine questions to be addressed	<ul style="list-style-type: none"> <li>Identified key informants in consultation with local partners in Lagos. Examples of key informants include representatives from the microfinance bank, the insurance partner, and technical assistance providers responsible for the design and distribution of the health insurance product as well as insured and uninsured clients and health care providers at facilities covered by the insurance product.</li> <li>Identified qualitative research consultant with skills to effectively communicate with a range a key stakeholders while understanding cultural boundaries.</li> <li>Developed semi-structured interview guide for key informant interviews and received IRB approval to move forward with key informant interviews.</li> </ul>	Consultant will travel to Lagos, Nigeria in mid-October to spend two weeks conducting key informant interviews with 20–25 stakeholders. While he will be assisted by a local coordinator who assisted with the baseline study (activity 3), locating all relevant stakeholders may be challenging.
<b>Activity 6:</b> Modeling the Effects of Health Systems Strengthening on Coverage and Lives Saved		
Draft concept note and finalize work plan in consultation with USAID	<ul style="list-style-type: none"> <li>A draft concept note was developed and two meetings were held with representatives from the Office of Health Systems and USAID's MCH Division to present, discuss, and further refine the proposed approach to modeling the impact of HSS interventions on coverage and lives saved.</li> <li>An updated iteration of the concept note is currently being reviewed by USAID, and HFG anticipates receiving feedback in Year 3 Q1. Once received, the concept note will be further</li> </ul>	

Year 2 Q4 Planned Tasks	Year 2 Q4 Progress	Critical Assumptions/ Problems Encountered/ Follow-up Steps
	<p>updated and a version appropriate for external distribution will be shared with an oversight group that will be established and convened by USAID to oversee the overall process of this activity and provide feedback. Key members of the oversight group are expected to be members of UNICEF, WHO, World Bank, and the Child Health Epidemiology Reference Group (CHERG), and a country perspective representative.</p>	
Conduct literature review	<ul style="list-style-type: none"> <li>• Progress was made in the conduct of the literature review. Key search terms (HSS components) were identified, and the literature review spreadsheet was further refined to better consolidate all of the findings. Progress has been made to document the impact of HSS interventions related to financing on client demand for services.</li> <li>• In Year 3 Q1, HFG plans to recruit a consultant to run a thorough review of the McMaster University Health Systems Evidence database, which synthesizes evidence about governance, financial and delivery arrangements within health systems, for potential literature to include.</li> </ul>	

### 3.3 Malaria

#### Program Objectives –

- Disseminate findings from research conducted under the USAID Health Systems 20/20 project concerning the impact of malaria control on the health system, focusing on hospitalizations, outpatient visits, blood transfusions, and costs incurred at the health facility level.
- Conduct a costing study examining long-lasting insecticide-treated net (LLIN) distribution via campaigns. The study's aim will be to provide evidence and guidance to countries on ways to save money while maintaining the objective of increasing LLIN coverage and use. (This objective is being finalized with USAID/President's Malaria Initiative (PMI), pending further discussion of approach.)
- Evaluate the impact of malaria control strategies at the microeconomic level, including at the household and, potentially, the firm levels. Limited research exists on the microeconomic impact of malaria control. A rigorous evaluation would demonstrate the potential microeconomic benefits of malaria control, thereby helping to place policy discussions about malaria control within the broader discussion of poverty alleviation and economic growth.

**Year 2 Activities** – Through conference presentations and journal publications, HFG will disseminate the findings from research conducted under the Health Systems 20/20 project on malaria control and its effect on hospitalizations, costs, and hospital inputs, namely blood transfusions. HFG will also develop a research protocol for the implementation of a study that assesses the microeconomic impact of malaria control. Depending on feedback from PMI, including country selection, HFG may also initiate the implementation of this study by preparing for baseline data collection to be implemented as soon as possible. Finally, HFG will also develop the research protocol for collecting cost data on LLIN distribution campaigns; timing of this study will depend on feedback from PMI.

**Year 2 Progress against Objectives** – The manuscript entitled “Hospitalizations and costs incurred at the facility level following the scale up of malaria control: pre-post comparisons from two hospitals in Zambia” was published in the print version of the *American Journal of Tropical Medicine and Hygiene* in January 2014.

HFG revised the second manuscript, entitled “Association between malaria control and pediatric blood transfusions in rural Zambia: an interrupted time series analysis,” based on comments received by a reviewer at *Malaria Journal*. In September, the manuscript was accepted for publication and is now available online at *Malaria Journal*. Earlier in July, HFG presented this research in Dublin at the International Health Economics Association conference.

HFG met with PMI/Washington, DC, and PMI/Zambia during Q2 to discuss the feasibility of conducting the microeconomic study in Zambia. During the meeting, it was agreed that Zambia would be the appropriate context for this study, particularly due to the variation within the country in terms of malaria control efforts and malaria incidence. HFG presented PMI two proposed approaches for possible microeconomic studies in Zambia: One prospective study focusing on the planned roll-out of indoor residual spraying in certain areas and not in others, and one retrospective study using secondary data sources. In proposing both approaches, HFG detailed the potential benefits and drawbacks of each. PMI then requested that HFG develop the retrospective proposal into a concept note, which HFG submitted in Q3 for review and feedback from PMI. HFG has been following up regularly with PMI. In Q4, HFG received feedback from PMI requesting further clarification about how the team would deal with what Abt and PMI acknowledged likely would be poor-quality HMIS data, particularly given missing data. The team proposed various modelling approaches, including multiple imputation. The team also suggested a few approaches for determining the feasibility of carrying out the retrospective study, given data quality concerns, and asked PMI whether it also might be appropriate to revisit the prospective study concept.

HFG is waiting for follow-up feedback from PMI regarding next steps, including whether the prospective study should be revisited because of concerns with the retrospective data.

With regard to the LLIN cost analysis, based on conversations with PMI on their desired outcomes and use of the findings, HFG will proceed with a cost-effectiveness study in Ghana and Tanzania. Also based on conversations with PMI, the study scope will be expanded to examine various LLIN distribution approaches, not just campaigns. At the end of Q3, we received permission from PMI to develop a concept note for the study. In Q4, HFG submitted to PMI the concept note outlining the costing approach, data requirements, and potential partners to conduct this study in Ghana and Tanzania. PMI's review committee is expected to provide feedback on the concept note in Year 2 /Q1.

**Q4 Challenges** – The main challenge for both the microeconomic study and the LLIN costing study has been the delays in receiving feedback from the client regarding approval of the activities. There were also delays on HFG's side in submitting the proposal for the LLIN costing study. PMI explained that there had been issues in getting the entire committee together to review the proposed concept notes. As a result of these delays, the activities still have not been approved and so work cannot begin. In addition, there are still unprogrammed funds for Year 2, which HFG has not yet received guidance on how to program.

Table 19 provides activity-specific updates.

**TABLE 19. MALARIA ACTIVITY DETAIL**

Year 2 Q4 Planned Tasks	Year 2 Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
<b>Activity 1:</b> Research on impact of malaria control on use of blood transfusions: Evidence from Macha Mission Hospital, Zambia		
Revise and resubmit paper	During Q4, HFG received a revise and resubmit from <i>Malaria Journal</i> . The reviewer requested that we change our analytical approach to use of an interrupted time series approach. This method would allow us to assess both changes in the rate of blood transfusion use over time, and changes in average total use over time. We adopted this new method and revised the paper to take into account all the reviewer's comments.  The revised manuscript was submitted to the journal on September 19, after having been approved by all co-authors. It was accepted for publication and is now available on-line.	PMI is pleased to see this activity completed with a peer reviewed publication.
<b>Activity 2:</b> Microeconomic impact of scaled-up malaria control		
Finalize concept paper	In early August, HFG received feedback from PMI regarding the concept note for this proposed retrospective study. The Operations Research Committee at PMI shared some concerns regarding the use of HMIS data on outpatient malaria cases. HFG also had noted these concerns. The committee requested that HFG further clarify potential techniques that could be	HFG shares PMI concerns about using HMIS data, particularly given other researchers' experiences in using Zambia's HMIS data (as outlined in a Harvard study on malaria in Zambia). HFG offered to hold a conference call with PMI in order to discuss potential next steps. The different options could include



Year 2 Q4 Planned Tasks	Year 2 Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
	<p>used to improve the quality and reliability of these data.</p> <p>HFG revised the concept note and elaborated on different potential approaches to dealing with missing HMIS data. These approaches include using multiple imputation, using a zero-inflated model, and testing for outliers. Because of the committee's concerns with using self-reported fevers as a measure of malaria, HFG eliminated this from the proposed data. Unfortunately, Malaria Indicator Survey data could not be used for this study because the timing of this data collection is not the same as the timing of data collection for the microeconomic data.</p> <p>After another review of the concept note, the Committee requested that HFG provide supporting evidence for the use of these approaches in dealing with poor-quality and missing data. HFG shared an example of another study conducted by Abt where multiple imputation was used when 30% of data were missing. Because HFG shares similar concerns with using HMIS data, the team also proposed potentially revisiting the possibility of a prospective study.</p>	revisiting the prospective study, going forward as planned but highlighting that the analyses with HMIS data are secondary analyses as opposed to primary analyses, and/or setting up a stop-gap approach with the first step involving a closer investigation of the quality of the HMIS data. HFG is awaiting a response.
Prepare study protocols, data collection instruments, etc.	Waiting for PMI approval of concept note.	
Submit to IRBs and revise as needed	Waiting for PMI approval of concept note.	
Prepare for study launch, procure data collection subcontractor	Waiting for PMI approval of concept note.	
<b>Activity 3: LLIN campaign costing study</b>		
Develop concept paper	HFG drafted a concept note which was submitted to PMI in August. The concept note outlines the proposed approach for estimating the costs of different distribution mechanisms in two countries: Ghana and Tanzania. The concept note includes the proposed costing methodology, including estimating coverage over time, as well as the different data sources required. PMI's Operations Research Committee has not yet been able to review the concept note.	Delays in receiving feedback on the concept note have delayed the initiation of this study.

Year 2 Q4 Planned Tasks	Year 2 Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
	HFG is awaiting feedback in early October in order to proceed with study planning and implementation.	
Finalize concept paper development	Waiting for PMI approval of concept note.	
Prepare study protocols, data collection instruments, etc.	Waiting for PMI approval of concept note.	
Submit to IRB/IRBs	Waiting for PMI approval of concept note.	

## 3.4 HIV/AIDS

**Year 2 Objectives** – HFG activities funded through core resources from the Office of HIV/AIDS (OHA) contribute to USAID and PEPFAR mandates of a more sustainable and country-owned HIV/AIDS response. HFG interventions support PEPFAR blueprint goals for an AIDS-Free Generation. Program activities ultimately contribute to saving lives and controlling the epidemic through key actions under the Road Maps on Smart Investments and Shared Responsibility. In keeping with the new mandates outlined by the incoming Global AIDS Coordinator, Amb. Debbie Birx, HFG interventions are designed to contribute to the critical agendas on *Impact, Efficiency, and Sustainability*.

**Year 2 Activities** – The HFG OHA team continued to support the following activities in Year 2:

1. Expand the reach of HIV services by enhancing fiscal space (transitional financing for Botswana)
2. Conduct market analysis of optimal price points for novel viral load point-of-care (POC) diagnostics (adult)
3. Conduct market analysis of optimal price points for novel HIV nucleic acid load POC diagnostics (pediatrics)
4. Complete a costing study that examines the efficiencies of the integration of HIV and family planning services
5. Provide financial management and costing support to Global Fund applicants and recipients
6. Q4 new: Review and assess PEPFAR Country-Led Partnerships to generate key lessons and develop recommendations for future planning

**Year 2 Progress against Objectives** – HFG activities support countries to make strategic and scientifically sound investments to scale up core HIV interventions and maximize impact through increased efficiencies. In Year 2, HFG continued work with key implementing partners providing global technical leadership in health financing and governance in the context of HIV/AIDS. HFG made significant progress on all five major activities that were initiated in Year 1 and continued on to Year 2. One new activity was approved in Q3, and its description is included under the Additional Information section below.

HFG collaborated with different USAID missions to determine market prices for emerging point-of-care viral load (POC-VL) technologies and to examine integration efficiencies activities in Uganda, Tanzania, and Zambia. Key collaborations were established with partner agencies including Doctors Without Borders (*Médecins Sans Frontières*, MSF) on the VL market pricing activities, and with USAID implementing partners such as FHI 360, Population Council, and EngenderHealth on the integration efficiencies activity. The Integration Efficiencies Study concept note went through two additional rounds of review early on in Year 2. With technical inputs from HFG health economists and HIV experts, the final concept was submitted to OHA, approved, and disseminated to interested missions. Tanzania and Zambia were subsequently agreed upon as the study's pilot sites. Both countries are PEPFAR FP-HIV Integration Acceleration countries, which makes them ideal settings for complementary integration initiatives with core funding.

Progress on the respective OHA portfolio of activities are described in detail below:

- **Botswana (Transitional Financing/Activity 1):** The authorization of field support funds from USAID-Botswana in Q1 required close coordination between field support and core-funded activities. As recommended by the USAID mission and OHA, HFG focused on supporting the field-funded activity in the early part of Year 2. This included development and support for the Private Public Partnership (PPP) unit, in response to the needs of the Botswana MOH. The concept note for the core-funded activity was developed and submitted for USAID approval. Approval was given and

a protocol for a study on improving efficiency in the delivery of antiretroviral therapy (ART) services in Botswana was finalized. In September, data collection tools and consent forms were developed for the study, and a complete IRB application package was submitted to both the Botswana MOH and Abt IRB. The USAID-OHA client for this activity (Chutima Suraratdechcha) is coordinating with the Botswana Mission to facilitate this activity.

- **Uganda (POC-VL/Activities 2 and 3):** HFG is working with MSF, which is piloting the POC-VL technologies in Uganda and Malawi. HFG established a relationship with MSF and has been in regular communication with that organization to understand the nature of these pilots. MSF began implementing Simple Amplification-Based Assay (SAMBA) technology for HIV testing in Uganda in September 2013; in Malawi, the technology was rolled out even earlier and therefore may have more established costing data. HFG obtained IRB approval in Uganda at the end of Q2 and made contact with the mission to prepare for in-country data collection in Q3. From April 28 to May 9, 2014, the HFG team traveled to Uganda and successfully conducted data collection at seven facilities in the Kampala and Arua regions. The team obtained data on program operations, costs, and patient utilization from health facility laboratories, HIV clinics, and early infant diagnosis programs, as well as an MSF-run pilot program for the novel SAMBA POC technology. The HFG team also met with MSF France, finalized data collection on the SAMBA pilot program, and validated all data. As of Q4, costing workbooks (data entry forms linked to the model, which is a MSeExcel spreadsheet) have been drafted and data collected to-date has been inputted into those workbooks to determine the cost per VL and the Early Infant Diagnosis (EID) test. The team has been following up and collecting missing data with support from the local Uganda consultant. Recent staff turnovers at the Centers for Disease Control and Prevention (CDC) Uganda have affected the momentum of this activity. Key information on utilization and costing from the Central Public Health Laboratory and the VL laboratory at CDC is still outstanding. Based on conversations with CDC-Entebbe, the Uganda USAID mission and USAID Washington, activity lead Carlos Avila will travel to Uganda in October to meet with key partners and finalize data collection. Upon completion, the costing workbooks will be finalized and entered into the model. The team expects to review the model and make necessary adjustments in early Year 3, after which a preliminary draft report will be completed and shared with the USAID-OHA.
- **Kenya (POC-VL/Activities 2 and 3):** During Q4 HFG had initial conversations with Kenya Medical Research Institute (KEMRI)/CDC in Kenya regarding conducting a VL and EID costing and cost-effectiveness analysis in Kenya in Year 3. The HFG team is in the process of developing a scope of work for Kenya, drafting a memorandum of understanding between KEMRI/CDC and HFG, and adapting the data collection tools to the Kenyan context.
- **Tanzania (Integration Efficiencies/Activity 4):** HFG is working with EngenderHealth in country to conduct the integration efficiencies study. Under the RESPOND project (Responding to the Need for Family Planning through Expanded Contraceptive Choices and Program Services), EngenderHealth received additional Family Planning/HIV Acceleration funds from the USAID mission to further explore the impact of service integration on various operational aspects, such as human resources, infrastructure, and cost. The end product will be a toolkit for MOH use in assessing and improving integration programming. On a teleconference in mid-March and later at a meeting (end of Q2), representatives of USAID/Tanzania and USAID/Washington colleagues shared their vision for this joint work. Subsequently, HFG collaborated with EngenderHealth in Q3 on a joint research protocol, with defined roles for the respective projects. HFG's defined focus is to develop a model framework for measuring efficiencies that will support EngenderHealth's and USAID/Tanzania's broader research objectives. USAID approval of the joint protocol is still pending; this has slowed progress on the activity. The HFG team has reached out to USAID-OHA for guidance on how to proceed under these circumstances; and a final decision is expected in Year 3. Population

Council was also proposed as a partner by USAID/Tanzania given their involvement in integration initiatives in country. So, ultimately three implementing partners may work together on this activity.

- **Zambia (Integration Efficiencies/Activity 4):** Early discussions with USAID/Zambia in Q2 also emphasized the integration efficiencies study as a priority for the MOH. HFG conducted a landscaping trip to meet with various stakeholders (including MOH counterparts, and integration implementing partners Population Services International, FHI 360, etc.) in late Q3. Continued communication with in-country partners throughout Q3 and Q4 enabled the team to determine potential study sites and candidates for a local research coordinator position. In Q4, HFG developed the draft survey instruments and a country-specific research protocol and submitted it to Abt's IRB. HFG expects to receive and address comments, obtain formal approval, and submit it to the local ethic review committee in Zambia in Year 3. Data collection is expected to commence in mid-November.
- **Global Fund Support/Activity 5:** The priorities under Activity 5 evolved over the course of Year 2 based on Global Fund technical assistance needs as elaborated by the Global Fund Liaison team at OHA. Given the transition to and changes with the new funding models, the Global Fund team communicated that key country activities requiring HFG support may be delayed. In July, HFG participated in a WHO-organized workshop in Tunisia on costing GF concept notes using the OneHealth Tool. HFG participation helped establish the project as a lead source of support for countries undertaking Global Fund applications under the New Funding Model. HFG also continued to work with USAID to identify countries in need of support in costing or financial management, in preparation for Global Fund processes. Two countries, Cambodia and Botswana, were proposed, although Botswana was dropped. At the end of Q4, HFG was making preparations for support to Cambodia in costing their HIV Health Sector Strategic Plan, with a SOW agreed upon with the country team.

**Q4 Challenges** – HFG's key contact at CDC-Entebbe, who was assisting with collecting missing data on VL cost and utilization, suddenly left her position at CDC. This has delayed follow-up data collection. To collect the data, HFG must travel to Uganda and meet with key stakeholders to get them on board and finalize data collection.

**Q4 Additional Information** –HFG was requested to begin a new activity, funded through the Country Ownership team at OHA, to examine the effectiveness of PEPFAR Partnership Frameworks (PFs) and Partnership Framework Implementation Plans (PFIPs) supporting country ownership and sustainability planning of HIV programs. This activity will develop and pilot an assessment protocol to gather lessons learned from countries where PFIPs have ended or will soon end, to inform the next phase of the PEPFAR sustainability planning. In Q4, the HFG team worked to develop a concept note for this activity and collaborated with the client to further refine the scope, including participation at meetings with representatives from the Office of the U.S. Global AIDS Coordinator (OGAC) on their sustainability planning framework. The HFG team also conducted preliminary work related to obtaining and reviewing PFs and PFIPs, conceptualization of a data extraction tool to be used for a document analysis of all countries that developed PFIPs, country selection for in-depth country case studies, and identification of in-country technical assistance resources. Activity will effectively launch full implementation in Year 3.

Table 20 provides activity-specific updates.

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

Year 2 Q4 Planned Tasks	Year 2 Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
<b>Activity 1:</b> Expand the reach of HIV services by enhancing fiscal space (transitional financing in Botswana)		
Further develop SOW.	HFG revised the SOW to focus on monitoring and improving efficiency in the delivery of ART services based on feedback from USAID/Botswana and the Botswana MOH. The final study plan was submitted as part of the IRB application to the Botswana MOH and Abt IRB Committee.	
<b>Activity 2:</b> Conduct market analysis to determine the optimal price points for novel POC-VL technologies		
Collaborate with Dr. Helen Lee and MSF on sharing data in Uganda and Malawi	MSF is currently implementing Dr. Lee's SAMBA technology in Uganda and Malawi. In Q4, HFG has continued to collaborate with MSF and keep the team updated on progress.	While Malawi was one of the countries of exploration at the start of the activity, other countries are under review, including Kenya, where HFG has already initiated conversations with key groups.
Review literature related to VL testing, ART, and ART costs	The team has been pulling out relevant values from the literature review into a structured Excel file.	The literature review values will be used to populate the final model.
Select countries for assessment and conduct primary data collection	HFG travelled to Uganda for data collection in Q3 and collected data on program operations, cost data, and patient utilization from health facilities' laboratories, HIV clinics, and EID programs from 7 facilities in Kampala and Arua. The team also collected data on the MSF-run pilot program for the novel SAMBA POC technology. The team has been working on collecting follow-up data on costs and utilization of VL tests from the CDC lab in Entebbe, Central Public Health Laboratories (CPHLs), and the Infectious Disease Institute (IDI).	In order to complete follow-up data collection, an HFG team member will travel to Kampala to meet with key stakeholders including individuals from CDC, CPHL, and IDI in order to facilitate the collection of these final pieces of data.
Develop model	A preliminary Markov Model and the data entry workbooks were developed in Q3.	
Finalize model	Awaiting completion of follow-up data collection. Anticipated to be underway in Y3Q1.	
Prepare final report	Awaiting completion of follow-up data collection. Anticipated to be underway in Y3Q1.	

Year 2 Q4 Planned Tasks	Year 2 Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
<b>Activity 3:</b> Conduct market analysis to determine the optimal points for novel HIV nucleic acid test POC technologies		
Review literature related to pediatric HIV and pediatric ART costs	The team has been pulling out relevant values from the literature review into a structured Excel file.	The literature review values will be used to populate the final model.
Select countries for assessment and conduct primary data collection	HFG travelled to Uganda for data collection in Q3 and collected data on program operations, cost data, and patient utilization from health facilities' laboratories, HIV clinics, and EID programs from 7 facilities in Kampala and Arua. The team also collected data on the MSF-run pilot program for the novel SAMBA POC technology. The team has been working on collecting follow-up data on costs and utilization of EID tests from the CDC lab in Entebbe, CPHL, and IDI.	In order to complete follow-up data collection, an HFG team member will travel to Kampala to meet with key stakeholders including individuals from CDC, CPHL, and IDI in order to facilitate the collection of these final pieces of data.
<b>Activity 4:</b> Prepare costing studies on integration		
Conduct exploratory TDY to Zambia and Tanzania to survey possible integration models and meet with key stakeholders	After Dr. Peter Cowley's trip to Zambia at the end of Q3, the team began the fourth quarter by debriefing the interested country counterparts and circulated a comprehensive trip report. Through the rest of the quarter, relationships with in-country partners were strengthened and the HFG team maintained regular communication and provided updates to USAID/Zambia, and implementing partners FHI 360, the Society for Family Health, and the Centre for Infectious Disease Research in Zambia (CIDRZ) on the progress of the study.	While the dynamic partnership with Engender Health, the mission, and Population Council in Tanzania offers a unique and rich opportunity, to increase HFG's knowledge, agreement on an overall study protocol between Engender Health and the mission has not yet been reached and therefore progress on the activity has stalled. After a joint HFG-EngenderHealth meeting in early June to discuss how HFG's study question/methods fit within EngenderHealth's broader objectives, HFG provided substantial comments as well as inserted our relevant section and methods for achieving OHA's goals. It is our understanding that EngenderHealth has not finalized the protocol or shared the final version with the mission. At the end of Quarter 4, HFG and the USAID/Washington OHA team agreed that USAID/W would follow up with the mission directly. At the time of this report, HFG was waiting to hear from OHA on the outcome of that call.



Year 2 Q4 Planned Tasks	Year 2 Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
Submit protocol for IRB approval	The team has drafted and submitted draft survey instruments, a research protocol, and a data security plan to Abt's internal IRB in September. Input from implementing partners has helped ensure that the tools will be applicable to each facility's model of integration. At the time of this report, the team was addressing the comments and feedback received in order to prepare for a resubmission to the IRB.	
Develop country-specific study protocol for integration costing study	With the insights gained from Dr. Cowley's trip to Zambia, the team was able to shape the broad research protocol approved by OHA for a Zambia-specific context. HFG communicated further with the study's three key partners (Society for Family Health, FHI 360, and CIDRZ) throughout the quarter to ascertain their recommendations for study sites, and to understand how integration is operationalized by each partner. These in-depth conversations informed the drafting of the survey instruments, including a patient exit interview form, interview guide for health workers and facility managers, and several data extraction templates. The team also devised a data security plan to ensure the confidentiality and protection of the patients and data collected. Based on this progress, the team submitted the Zambia-specific research protocol to Abt's IRB in early September. Abt/ZISSP colleagues also provided information to the team about the local ethics review board process; before submitting the protocol to the local authorities, the team will obtain letters of authorization from the MOH and the Ministry of Community Development, Mother and Child Health (MCDMCH). Once these approvals are obtained and the protocol is finalized based on Abt's internal evaluation, it will be sent to the local Zambia Ethics Review Board in Zambia for review. The team expects this step will be completed early in Y3.	

Year 2 Q4 Planned Tasks	Year 2 Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
Conduct data collection and costing analyses	Preparations for data collection at approximately 10-15 health facilities in Zambia began in Q4. Approximately three study sites from each implementing partner were identified. HFG also interviewed several candidates for the local research coordinator position. Mr. Petan Hamazakaza, who worked on a malaria costing study for the predecessor Health Systems 20/20 project, was deemed the best fit for the position with his extensive research coordination experience, connections at the ministry, and costing experience. The team expects his contract to be finalized in late Q4 and his work to begin in early Y3Q1.	
Baseline integration efficiency indicator analysis	The team expects analysis of data collected at Zambian facilities to begin in Y3Q2.	
<b>Activity 5:</b> Provide financial management and costing support to Global Fund applicants and recipients		
Identify countries requiring support for Global Fund proposals and develop SOWs	HFG has responded to requests for information from Cambodia and Botswana during Q4. Botswana decided to use a local consultant. Cambodia moved forward with the project, and HFG will be supporting the costing of Cambodia's HIV Health Sector Strategic Plan, with the first trip planned for October 2014.	

## 3.5 TB

**Program Objectives** – As per the Lantos-Hyde USG Tuberculosis Strategy, HFG works toward improving overall health systems, specifically provider payment systems, as an important part of the effort to improve TB control. Specific objectives by activity are cited below:

### **Kyrgyzstan:**

- Design and develop new TB hospital payment system which will target health budget funding to priority services and will structure payment such that payment will vary based on relative weight or cost of the type of TB case to establish incentives that end the expensive and unsafe practice of extended inpatient stays, and instead encourage treating and reducing the spread of MDR-TB.
- Support implementation of the new TB hospital payment system
- Collaborate with the Global Fund to develop a strategy in the context of Den Sooluk Health Sector Strategy/Sector Wide Approach (SWAp) to improve quality and further integrate TB services into PHC by improving the relationship between health financing and service delivery including both the new TB hospital payment system and PHC per capita payment system in order to increase sustainability

### **Kazakhstan and Tajikistan:**

- Disseminate Kyrgyzstan's new TB hospital payment system and build capacity of Kazak and Tajik partners to adapt the system and implement in their countries

### **Ukraine:**

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

### **Asia:**

- Assess 4-6 Asian country public financing and PFM systems including recommendations on how to better target public funds to TB services delivered by private providers
- Design and develop at least one specific technical methodology to enable an Asian country to better target public funds to TB services delivered by private providers (e.g., new provider payment system, improved budget formation process, improved funds flow, removal of PFM barrier, supporting system improvement, operational policies and procedures)

**Year 2 Activities** – TB Strategic Purchasing is a new activity that began in Q3. In Year 2, HFG planned to engage in policy dialogue with the MOH and MHIF on revision of the TB payment system, gather background information on current TB financing/cost accounting, and begin looking at new TB DRG classifications for Kyrgyzstan. For Ukraine, the Project planned to engage in Policy dialogue resulting in understanding of any proposed provider payment system reform and its importance for TB strategic purchasing activities and learn more about the situation in the country with TB treatment system and TB payment. For Asia, the Strategic Purchasing activity planned to conduct a preliminary assessment of Asian countries toward coming to a decision on which country(ies) to work in Y3 of the project.

**Year 2 Progress – Kyrgyzstan:** Through meetings with the Mandatory Health Insurance Fund, Ministry of Health, and the National Tuberculosis Center, the team gained political support and buy-in for revising the hospital payment system as described above and for the eventual accompanying changes

in the hospital payment system. The Project began work on both the clinical side to determine the classification of clinical TB groups by which to pay, and on the cost accounting side, the team undertook a cost accounting exercise of TB hospitals to determine the cost per bed day and cost per case. Toward this goal, the team collected data on over 21,000 TB cases (discharged patients database, based on form 66) from all TB hospitals in the country; this analysis showed that around 12% of patients did not even have TB, around 30% of patients have repeated hospitalization during a year, and about 48% of those with pulmonary TB were smear negative; length of stay for smear negative cases was around 60 - 112 days. The data analysis confirms that KG still has ineffective TB system with extensive number of TB hospitals, lack of hospitalization criteria and outdated treatment protocols that resulted in unnecessary hospitalization, long stay in the hospitals and poor treatment outcomes. It also showed that current TB payment system supports inefficiency of TB sector. Next step included development of TB groups for hospital cases. The Project defined hierarchy for TB grouping that includes age, diagnosis (ICD-10), bacilli excretion and, complications (ICD-10), co-morbidities (ICD-10) and average length of stay (ALOS), and created 15 initial groups. The project completed cost accounting analysis in eight TB hospitals with the highest number and range of discharged TB patients. The Project conducted training for representatives of these hospitals and MHIF on cost accounting, collected data, and analyzed the data. The results of clinical and statistical analysis of discharged TB patients was combined with cost accounting study results and relative weights were assigned to the initial 15 groups of TB hospital cases. The Project team met in Bishkek to work with local partners to present preliminary results of data analysis and created groups. The Project will continue working with MHIF to develop a simple tool and carry out an impact analysis, refine TB groups and prepare recommendations for implementation of new TB hospital system.

**Ukraine:** During the Q3 startup period, HFG held introductory discussions with USAID in Ukraine, including plans for a visit to Ukraine by Activity Manager Dr. Peter Cowley to discuss the situation with TB treatment and payment in more detail with USAID and local and international partners in that country. In Q4, Peter Cowley visited Ukraine to meet with national and international partners policy dialogue resulting in understanding of any proposed provider payment system reform and its importance for TB strategic purchasing activities, and examine opportunities for eventual adaptation/introduction of the Kyrgyzstan TB hospital payment system into Ukraine. Dr. Cowley met with government officials and the Ukrainian National Center for Disease control, implementing partners working on the service delivery side of TB, the World Bank and World Health Organization country offices, and Poltava Oblast Health Administration. The meetings with the Poltava Oblast Health Administration focused on their experiences to date in program targeted budgeting (PTB), which were shared with the consultant. While PTB is not currently used at the Oblast level, it has been calculated on a shadow or paper basis for the last three years. The visit revealed great interest at the oblast level in flexibility in TB budget and expenditures. Additionally, there is evidence that a greater percentage of TB cases being treated on an outpatient basis due to risk of nosocomial infection. On the request of USAID/Ukraine, HFG team member Olga Zues made a presentation via video weblink about the situation with TB financing reform in Kyrgyzstan, which was received very well in country. After a debrief with USAID/Ukraine, the mission reported that they have planned additional money for the HFG project to expand the HFG strategic purchasing activities in Ukraine.

**Asia-** The team engaged in discussions on the Asia situation with USAID. With outside (non-HFG) funding, Dr. Cowley attended the Bangkok Health Insurance and TB conference, and made a presentation on Strategic Health Purchasing: Better Target Health Funding to Gaps in TB Continuum of Care in Public and Private Providers. Representing Abt at this conference allowed Dr. Cowley to make contacts with counterparts working in Asia, and to learn more about the situations in various Asian countries. The team also began the desk review in quarter four.

Table 21 provides activity-specific updates.

**TABLE 21. TB ACTIVITY DETAIL**

Y2Q4 Planned Tasks	Y2Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
<b>Activity 1: Develop TB hospital payment system for <i>Kyrgyzstan</i> and redirect savings to support outpatient TB</b>		
Develop and have approved relevant indicators and Performance Monitoring Plan (PMP) Process	Indicators were submitted to USAID in July 2014. However, USAID has not provided approval or comments on the indicators.	
Confirm TB funds in MHIF	Confirmed- Funds for TB hospitals are flowing through MHIF.	
Engage in dialogue on basic TB hospital payment system design	HFG staff and consultants worked closely with the MHIF and MOH to gain buy-in for improvements in the TB financing system. Meetings revealed that local counterparts were already supportive of these changes.	
Analyze and make recommendations to the DRG categories which have been proposed for <i>Kyrgyzstan</i> , in light of the country's new TB CPGs and WHO recommendations	The team analyzed the MHIF database of 21000 discharged TB patients from all TB hospitals in the country (28 TB hospitals), and analyzed this data and created initial 15 groups. The team also collected cost accounting data from selected eight TB hospitals and completed cost accounting analysis. The two types of data were crosswalked, to connect clinical and accounting sides.	
Examine current role of MHIF in TB hospital payment and monitoring	The team met with the MHIF, and determined that the MHIF understands its role, but is unable to fulfil the role because DRG and coefficients do not support the treatment which is recommended in the national CPGs.	
Meet with national partners, including Global Fund, SWAp partners, and WHO to discuss joint approaches	The team has engaged in ongoing discussions with Global Fund on potential GF support for the outpatient side of TB financing reform, which would complement the work HFG is doing on TB hospital payment system.	HFG staff will make a visit to KR in November, to coincide with the joint annual review, during which both national partners and SWAp partners will discuss future steps on health system reform in <i>Kyrgyzstan</i> . The HFG team will hold individual meetings with GF portfolio manager and SWAp partners, and will take part in discussions on TB strategy in the country.

Y2Q4 Planned Tasks	Y2Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
<b>Activity 2: Engage in Policy Dialogue in Ukraine to Improve TB Financing Within Context of Any Broad Provider Payment Reforms</b>		
Meet with MOH and other national partners to plan and gain buy-in for changes in TB hospital payment system	<p>Activity lead Dr. Peter Cowley visited Ukraine September 7-12, 2014, and met with Ukraine governmental officials at the central level from both State Services Against HIV and other Socially Dangerous Diseases as well as the Ukrainian National Center for Disease Control. At both set of meetings, the need for and potential of reform in TB strategic purchasing was discussed. While State Services is being disbanded as an organization, support was given by the then Director for investigating further the potential for TB strategic purchasing reform. Meanwhile, the Ukrainian National CDC requested that a presentation be given either in person or by video link of the HFG TB Strategic Purchasing activities that have already taken place in Kyrgyzstan and how these lessons can be applied in Ukraine. Dr. Cowley also met with Poltava Oblast health officials, who expressed a desire for flexibility in TB budgeting and expenditures.</p> <p>These meetings revealed universal recognition that the current method of budgeting by number of beds, Order 33 and three year historical budgets does not allow for sufficient flexibility to treat patients in an efficient manner or to enable TB service delivery improvements.</p>	
Meet with international partners in Ukraine, including WHO, World Bank, and USAID Strengthening Tuberculosis Control in Ukraine Project to coordinate any potential activities	<p>While in Ukraine, Dr. Cowley met with PATH, Chemonics/Strengthening TB Control in Ukraine Project, World Bank Ukraine, Belarus and Moldova Country Unit, Deloitte/HIV Reform In Action Project, and WHO/Ukraine.</p> <p>There is a possibility to cooperate with the World Bank and MOH on the planned implementation of Diagnostic Related Group (DRG) costing which is part of the World Bank loan. In addition, the World Bank was extremely interested in seeing how using a base rate based on available budget funds together with relative weights to differentiate payment by level and severity of TB case can be used to maximize the efficiency of TB Global Budget spending.</p>	
Conduct a desk review of any relevant provider payment system reform efforts ongoing or proposed in Ukraine	Met with national, oblast, and international partners to gather relevant documents, and reviewed data including Prikaz 33 and 584.	

Y2Q4 Planned Tasks	Y2Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
<b>Activity 3:</b> Develop a Public Finance Private Provider Strategic Purchasing Model for Asia that Encompasses Various Points from the TB Continuum of Care		
Finalize initial group of Asian countries for assessment	Delayed until Year 3, as funding received only late in Q3. Through discussions with USAID, list includes Cambodia and Philippines.	Cambodia and Philippines will be visited in Q1 Y3. Other countries may be added for detailed assessment later as research continues.
Develop selection criteria and associated questionnaire	Delayed until Year 3.	
Conduct desk review for selection of an Asian country	Desk review began with gathering of data, with Dr. Cowley attending the Health Insurance and TB Meeting in Bangkok (with non-HFG funding). This allowed the team to learn more about the situation with TB financing in many Asian countries (at least on the health insurance side), and provided the team an opportunity to make contacts in the Asian countries. Dr. Cowley gave a presentation entitled, "Strategic Health Purchasing: Better Target Health Funding to Gaps in TB Continuum of Care in Public and Private Providers".  The team also held a call with USAID experts on TB and financing and gained further perspectives on Asian countries.	
Travel to countries in Asia for assessing potential inclusion.	Delayed until Q1 Y3.	Cambodia and Philippines to be visited in Q1 Y3, with other visits to be scheduled later in Y3.



## 4. FIELD SUPPORT ACTIVITIES

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



## 4.1 Africa

### 4.1.1 Africa Bureau

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

**Year 2 Activities** – In Year 2, HFG-AFR/SD proposes to

- Host a regional Health Care Financing training in Tanzania to build the capacity of USAID staff in countries that are striving to EPCMD to understand and apply tools, methods, and options available to transition toward sustainable domestic financing of UHC. Content will focus largely on the basics of health economics and finance, including their application to financing EPCMD and UHC services on a sustainable basis. Central to the learning format will be technical presentations, a sharing of country experiences, and peer-to-peer exchanges on financing innovations being piloted or scaled to improve efficiency, equity, and sustainability of health system financing.
- Collaborate with the Africa Bureau on a study to better understand the domestic allocation of resources to the social sectors to determine the efficiency in allocation and utilization of resources by a small sample of countries with high rates of economic growth and at varying stages of fiscal devolution. The analysis will provide policy and program options for the countries to transition to self-sustaining growth in the social sectors.
- Produce a synthesis paper based on the three CBHI case studies completed in Year 1 to highlight key lessons learned and best practices on CBHI linkages to a national health financing framework.
- Conduct two activities aimed at promoting the use of promising mobile money and mHealth applications: 1) a cost-effectiveness study of an mHealth application, including a framework and study protocol, to contribute needed evidence of cost-effectiveness of mobile applications within health systems, and 2) review existing grey literature and conduct stakeholder interviews to prepare a white paper on mobile money's potential in the health sector and to highlight innovations, trends, and opportunities.
- Develop a two- to four-page brief documenting best practices for transition planning based on the Botswana experience, which is relevant to the positive economic outlook for Africa and calls for transitioning resource mobilization from external to domestic sources.

**Year 2 Progress** – In Q3, HFG facilitated USAID's first Healthcare Financing Capacity Building workshop in Dar es Salaam, Tanzania. Thanks to a collaborative team made up of HFG, Joint Learning Network, and ex-World Bank consultants, with the USAID Office of Health Systems and AFR/SD the workshop was well-organized, well-attended, and highly successful. Overall, about 30 USAID staff dealing with health systems and disease-specific programs participated, representing 10 EPCMD countries. Commitment by the host country, Tanzania, was apparent by the participation of Sharon Kromer, Director, USAID/Tanzania, Hope Soukin, and 12 USAID/Tanzania participants.

Participants expressed very positive feedback on the workshop and strong demand for further USAID investment in health financing training. They especially appreciated the quality of the content presented, the opportunity to share experiences across countries, the Tanzania health financing strategy discussion and local site visit, and opportunities to internalize and apply their learning through role playing and other interactive exercises. As the workshop unfolded, it became clear that integration of USAID staff in each sessional presentation (as co-chairs and co-presenters) and peer-to-peer learning were major ingredients of success. All sessions were lively and engaging as a result. Over half of the participants recommended that the course (or a second, more-advanced version of the course) be held again and/or institutionalize this workshop (e.g., USAID/university courses) because it focuses on fundamental knowledge and skills that USAID health staff need to be effective in their roles. One participant said that the course “gave an excellent foundation on health financing with a clear vision of the state of the art.” Another commented that “I don't work in this field and feel as though I have learned more in this week than any training in my professional career.”

Based on their participation in the Tanzania workshop, USAID Nigeria requested a country-specific training in Abuja. In Q4, HFG worked with USAID/AFR to adapt the learning framework and training agenda that was piloted in Tanzania to relate specifically to challenges and opportunities confronting Nigeria. A draft agenda was submitted and discussion is currently underway with the mission counterparts to refine agenda, timing, and participants.

As part of the project's mHealth activities, HFG's concept note was approved for the cost-effectiveness analysis of D-Tree's Integrated Management of Childhood Illness (IMCI) phone-based decision support application in Malawi to improve the health worker standard of care for management of childhood illness. The objectives of the study are to provide quantitative evidence of the cost per unit of improved accuracy in treatment of childhood illness attributable to the phone-based tool, and to provide a model for other health programs to use in projecting costs and effectiveness of planned mHealth investments. The study aims to answer the research question, how cost effective is the D-Tree decision-support application compared to a paper-based approach?

Data collection and analysis is underway. HFG has been working closely with D-Tree to validate the data they collected comparing adherence to protocol by health workers using paper-based forms compared to those using phone-based tools. A literature review of existing mHealth costing models has begun to guide HFG study methodology and assist in development of a replicable model for mHealth cost effectiveness analyses. In Q4, cost data collection was initiated including identifying all relevant cost categories and sources, and accessing records (electronically) from D-Tree, implementing partner Catholic Relief Services, and local resource partners such as the Catholic Diocese Health Commissions. These partners implemented the IMCI program on behalf of the Ministry of Health (MOH). In addition, an IRB amendment was prepared to extend the approved D-Tree research dates and data access terms.

In Q4, the USAID AFR/SD team (Health, Education, and D/G) and HFG finalized a SOW for the study on the efficient allocation and utilization of domestic resources. This included agreement on a detailed methodology, timeline, and roles and responsibilities for the study team. It was agreed that the primary objective of this study is to analyze the efficiency in allocation and utilization of resources in selected countries in order to generate policy and program options for USAID to implement. The ultimate goal is to assist countries toward transitioning to self-sustaining support to the social sectors. The secondary objective is to provide countries with recommendations for improving the efficiency of resource allocation and utilization at different administrative levels in order to improve value for money. The team is in the process of finalizing study implementation plans as well as selection of countries and approval of budgets. In mid-September, USAID/AFR requested that the study be temporarily put on hold while the SOW is re-evaluated by the entire study team and also in light of the Ebola situation in West Africa.

HFG presented its case study “Building on Community-based Health Insurance to Expand National Coverage: The Case of Ghana” at the Global Health Research Symposium in Cape Town, South Africa, September 2014. The presentation was part of a session on “Universal health coverage experiences in Africa and Asia,” which also included presentations about African and Asian experiences around pathways to universal health coverage, including civil society involvement and potential impacts on fairness in financing and impoverishment. Furthermore, the case studies developed on the Senegalese and Ethiopian experience were finalized and development of a case studies synthesis paper is underway.

**Challenges** –The intersectoral study documenting experience in and lessons learned about domestic resource allocation in four countries has been put on hold while being re-evaluated by the AFR/SD study team and also in light of the Ebola situation in West Africa affecting data collection in country.

Table 22 provides activity-specific updates.

**TABLE 22. AFRICA BUREAU ACTIVITY DETAIL**

Y2Q4 Planned Tasks	Y2Q4 Progress	Critical Assumptions/ Problems Encountered/ Follow-up Steps
<b>Activity 1:</b> Health insurance (with focus on CBHI) case studies in three countries (from Year 1)/Case Studies Synthesis Paper: CBHI linkages to national health financing framework (new Year 2)		
Finalize CBHI case studies and share with key stakeholders	The Ghana case study will be presented at the Global Health Research Symposium in South Africa Sept 2014. Ethiopia case study was finalized. Senegal case study was updated.	Posting of the Senegal and Ethiopia case studies on HFG website and disseminating them via email to country stakeholders. Currently exploring mechanisms to further disseminate the case studies.
Develop case studies synthesis paper: CBHI linkages to national health financing framework	Activity currently underway.	
<b>Activity 2:</b> Regional capacity building workshop in Tanzania on health finance and UHC		
Hold a follow-on HCF training workshop in Nigeria	Currently in the planning phase of organizing a country specific follow-on HCF training for Nigeria. The workshop will build upon, and incorporate, a <i>learning framework</i> as well as a <i>training agenda</i> that was piloted in Tanzania and will be adapted and modified such that they relate more specifically to challenges and opportunities confronting Nigeria.	Confirmation of workshop dates and implementation dependent on Nigeria MOH and Ebola situation in West Africa.
<b>Activity 3:</b> Domestic allocation of resources to the social sectors		
Review drafted activity description and coordinate activity planning with partners	USAID/AFR asked that the study be temporarily put on hold as the SOW is re-evaluated by the entire study team and in light of the Ebola situation in West Africa.	

Y2Q4 Planned Tasks	Y2Q4 Progress	Critical Assumptions/ Problems Encountered/ Follow-up Steps
<b>Activity 4: mHealth cost-effectiveness analysis</b>		
IRB review	An IRB amendment was prepared to extend the approved D-Tree research dates and data access terms.	
Data gathering and analysis	<p>Per the concept note, D-Tree provided the “effect” data, which compares diagnoses made and treatments provided (per ICMI protocol) for health providers using paper forms versus the mobile tool. Using Stata, HFG is analyzing the results for four different, common IMCI symptoms: fever, diarrhea, fast breathing, red eye.</p> <p>HFG is collecting cost data from Catholic Relief Services, implementer of the IMCI program including program management, stakeholder outreach, and training. Cost data from D-Tree includes software development, testing, network charges, hosting and maintenance. Cost data from local NGO partners includes the cost of recruiting, training and supporting health workers on the tool.</p>	The HFG concept note assumed it would compare costs for mobile and paper based tools. In fact, no paper costs are relevant because the mobile tool under study does not replace paper but provides new functionality to the health worker in the form of decision support to improve adherence to recommended WHO protocol. Paper registries are still used to manage patient records and submit data, and all health workers receive same IMCI face-to-face training. As a result, the research question of interest is what the percent improvement in diagnoses and treatment is on a cost per user basis for mobile application.
<b>Activity 5: Brief on transitions to domestically supported health programs in Africa</b>		
Develop brief on country transition	In the process of gathering relevant literature, activity to be completed in Year 3 Q1.	

## 4.1.2 Angola

**Program Objectives** – Angola’s National Plan for Health Development 2012–2015 (*PNDS Plan National de Développement Sanitaire*) is a strategic and operational tool designed to support the implementation of the principles expressed in the Long-Term Development Strategy Angola 2025 and in the National Health Policy’s frame of National Health System reform. The preparation of the PNDS fits within a context of political stability and socio-economic growth, and it is seen as a fundamental pillar of the process of sustainable development in which the country is currently engaged. The Ministry of Health in Angola (*Ministerio da Saúde*, or MINSA) recognizes the need for support in estimating the cost and other system implications of implementing the PNDS at the national and decentralized level. As most of the national-level estimates will be completed in Year 1, MINSA has expressed interest in continuing the cooperation with HFG in Year 2 in order to pilot and subsequently scale up the application of program-based planning and budgeting to provincial and municipal levels of the Angolan health system. Support to MINSA fits within USAID/Angola’s objective to partner with the Government of Angola and other stakeholders to support the development of an integrated, comprehensive, and sustainable health system and a strong workforce capable of providing quality health services to all Angolans.

**Year 2 Activities** – In FY13, HFG completed the costing of the Angolan National Health Strategy 2014-2025. In Year 3, HFG will work with the Ministries of Health and Finance on a system to monitor the implementation of the National Health Strategy. MINSA needs to improve budgeting and financial management at the central and district levels, and develop a system to hold the government accountable for funding the strategy. Also, Angola has been implementing a major decentralization of the health system to the district level since 2010, and the decentralized structure has major implications for the financing and implementation of the National Health Strategy.

As part of HFG’s scope in Angola and as requested by USAID/Angola, HFG is purchasing two short courses in fiscal decentralization, budgeting, and financial management at a U.S. university for senior officials from the Ministries of Health and Finance. These courses will train key counterparts in topics such as intergovernmental transfers, local financial management, participatory planning and budgeting, and local service delivery. This knowledge base will greatly facilitate the assistance HFG will provide that is tailored to the Angolan system.

**Year 2 Progress Against Objectives** – Year 2 Quarter 1 activities involved finishing the PNDS budget as planned and submitting it to USAID and our MINSA counterparts. HFG also conducted a training for MINSA staff on the OneHealth tool and is adapting the tool for application at the district level. HFG has arranged for the payment and visas for four MINSA staff members to travel to Duke University for their courses, which took place between July 7 and August 9.

**Q4 Challenges** – The Angola program received an additional \$300,000 at the end of Year 2. Discussions are still ongoing with the mission as to how those funds will be spent. HFG has drafted terms of reference for work to monitor the programmatic and financial implementation of the PNDS. A concept note on how HFG might roll out an NHA in Angola was also prepared for the mission.



Table 23 provides activity-specific updates.

**TABLE 23. ANGOLA ACTIVITY DETAIL**

Year 2 Q4 Planned Tasks	Year 2 Q4 Progress	Critical Assumptions/ Problems Encountered/ Follow-up Steps
<b>Activity 1: Costing of the Angola PNDS</b>		
Continue the analytical and proofing work on data already collected	While our OneHealth tool activity is complete, we continue to receive additional ad-hoc requests to finalize and update the budget projections for implementing the PNDS. Our contacts at the Angola Mission and our counterparts at MINSA are still reviewing the final report and seeking clarifications and amendments in order to respond to cabinet level deliberations on the PNDS.	
<b>Activity 2: Public Financial Management training for MINSA staff</b>		
Purchase requisition for Duke University courses on Program on Fiscal Decentralization and Local Government Financial Management and Budgeting and Financial Management in the Public Sector	A purchase requisition was successfully completed to pay for the courses for Government of Angola officials who traveled to Duke University attend courses on PFM. HFG provided support through payment of tuition costs to Duke, assistance with the J-1 visa application process, tracking participants in TraiNet, coordinating with USAID/Angola and Washington stakeholders, and covering the cost of HAC insurance. A total of seven participants were sent to two training courses at Duke with three of the participants continuing on to internships in Austin, Texas with the Legislative Budget Board. Five participants from the MOF and one each from MINSA and the Ministry of Planning attended training on Fiscal Decentralization and Local Government Financial Management program and Budgeting and Financial Management in the Public Sector. Feedback from the participants was very positive with the content of the courses being highly relevant to their day-to-day work.	
Arrange Health and Accident Coverage Insurance for travelers	Travel insurance was obtained for MINSA travelers to Duke course.	
Provide logistical support	Travel was coordinated and arranged for all participants and they all successfully returned home to Angola.	We are finalizing the ITIN packets for the participants so they can properly file taxes as required by their J-1 visas.



### 4.1.3 Benin

**Program Objectives** – HFG supports Benin’s priorities of investing in Universal Health Coverage (UHC) to serve its poorest and most vulnerable populations, especially women and girls. In Year 2, HFG is coordinating closely with other partners in Benin to assist the USAID/Benin Mission in achieving its objectives.

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

The Benin national health sector strategy is described in the 10-year National Plan for Health Development (*Plan National de Développement Sanitaire*, PNDS), a policy document that provides guidance on health efforts over the period of 2009-2018. The government of Benin’s priorities are to achieve universal access to health care and improve service quality in order to achieve significant and lasting reductions in infant, child, and maternal mortality. The President of Benin recently announced the roll-out of UHC in order to promote greater access to health services and facilitate the scale-up of health interventions through reducing financial barriers. This initiative is called the Universal Health Insurance Scheme (*Regime d’Assurance Maladie Universelle*, RAMU). Reducing financial barriers to accessing quality health services in a timely manner is an effective method of increasing the demand for health care among the poor and underserved, especially women and children, and is a recognized contribution to *A Promise Renewed* and EPCMD. The HFG activities in support of this initiative all support HFG’s Intermediate Result 1, improving financing for priority health services.

**Year 2 Activities** – To ensure effective implementation of the RAMU, HFG will support the Ministry of Health (MOH) in the initiative’s technical design and scale-up. The President has identified six provinces where RAMU will be piloted before it is rolled out nationally; HFG will support three of the six provinces. At the request of the USAID mission, the HFG team will engage in the following three activities, each of which supports a different aspect of the RAMU initiative.

- **Supporting the network of community health financing organizations (mutuelles).** *Mutuelles* are a key element of the government’s approach to achieving UHC. They are expected to help reach the rural and informal sectors, much as they have done in Ghana and Rwanda. Bringing *mutuelles* together into networks allows them a more consistent message and greater voice as stakeholders and providers in the RAMU initiative.
- **Strengthening the coordination of the private sector to be able to engage with the RAMU initiative.** The private sector is an important part of nations’ health systems: research shows that much of the African population, even poor and vulnerable segments, get care from private sector providers. However, the private sector is composed of a multitude of diverse actors. Building on work done under the Strengthening Health Outcomes through the Private Sector (SHOPS) project, HFG supports the creation of a formal private sector platform, through which the different members can coordinate and prepare for inclusion in the RAMU.

- **Supporting the most recent National Health Accounts (NHA) exercise, especially the reproductive health analysis.** Given that Benin last did an NHA exercise in 2008, another round will be useful to improve understanding of health expenditures in the country. Understanding the sources for financing is key to monitoring RAMU impact on household spending. The MOH and World Health Organization (WHO) are very involved in all aspects of this activity.

## Year 2 Progress:

**Supporting the *mutuelles*** – The RAMU initiative faces both technical and political challenges, despite significant political support from the President of Benin. A technical working group (TWG-RAMU), of which the HFG Resident Activity Manager is a member, was formed to address the technical issues. Providing for Health (P4H) is also a member of the TWG, and regularly sends the WHO health systems advisor from the Ouagadougou sub-regional office. In Year 2, the TWG met twice during the first quarter, held a five-day workshop during the second quarter, and held another workshop in the fourth quarter. The session in February focused on member recruitment and premiums to address questions that had been raised in regard to earlier drafts of the National Health Financing Strategy. The TWG-RAMU also discussed the structure of RAMU, deliberating on the structure of the governing body (*Agence Nationale d'Assurance Maladie*, ANAM) and financial management. The results of these deliberations were shared with the MOH.

During the second quarter, the results of the earlier TWG costing exercise were presented to the MOH and the council of ministers, contributing to improvements in the draft National Health Financing Strategy and serving as inputs for revisions to the RAMU law. Decisions regarding next steps for RAMU were based on the information shared and ultimately presented on national TV by the Minister of Health. For example, according to the TWG-RAMU's advice, the RAMU is being developed as a contributory scheme for all sectors of the population. The MOH also agreed on the need to revisit the financial simulations on which the projections are established. At the request of the USAID/Benin mission, HFG's resident activity manager undertook a short analysis of key discrepancies and possible inconsistencies in the proposed UHC law. The National Assembly removed the law from deliberation in early 2014, possibly based on donor suggestions that improvements could and should be made. This pause provides an opportunity for HFG to also suggest language that will allow the private sector to participate in the RAMU scheme when the government of Benin is ready to take that step.

HFG Benin provided technical support to the MOH, developing further suggested revisions to the RAMU law during a four-day workshop in April 2014. The objective of the workshop was to provide inputs for communication tools targeted at political decision-makers regarding the law. Recommendations included decision-maker dialogues regarding the law, possible amendments and reconsideration of the text by the Codification Commission (*la Commission de codification*).

HFG works in three of the six departments specifically supporting departmental-level *mutuelle* networks in collaboration with the *mutuelles'* national umbrella organization, the *Conseil National des Structures d'Appui à la Mutualité Sociale* (CONSAMUS). All three departmental networks have been successfully established as legal entities. The network in Borgou Alibori was inaugurated during HFG's first quarter of Year 2, and the Zou/Collines and Atlantique/Littoral networks were officially launched in the second quarter of Year 2. Their effective participation in the RAMU is a key element of the national



Dissemination results of 2012 HA, 4/29/2014

Photo Credit: Pascal Soglohoun

strategy to reach informal and rural populations with the national roll-out of UHC. HFG will continue to work with these three networks to assist their sustainability and integration into the national RAMU scheme. HFG Benin also assists CONSAMUS to dialogue with the ANAM and MOH. CONSAMUS representatives were involved in the inauguration of the three departmental *mutuelle* networks, as the national umbrella organization. To support the network of *mutuelles* in Benin financed by the Belgian Technical Cooperation. HFG provided IT equipment to CONSAMUS in order to house the national *mutuelles* database and HFG has strengthened four CONSAMUS member's capacity to host, manage, and maintain the national database.

HFG representative Pascal Soglohoun participated in the workshop on capitalization of *mutuelles* organized by the Swiss Cooperation and the Belgian Technical Cooperation agencies. The purpose of this workshop was to develop advocacy materials in support of *mutuelles* for political decision-makers.



M. Aboubakar K. Y., president of CONSAMUS, is testing the new equipment  
Photo Credit: Pascal Soglohoun

HFG provided technical assistance to the MOH's DNSP to formulate a request to the West African Economic and Monetary Union (*Union Economique de Monitaire Ouest Africaine*, UEMOA) to finance the establishment of the administrative body of mutuality in accordance with Regulation No. 07/2009 / CM / UEMOA regulation of mutuality within the social UEMOA. This organization has just granted the MOH funding in the amount of 17,500,000 CFA (USD 35,000) for the establishment the administrative agency for the Social Insurance Mutual in Benin. Similarly, HFG provided technical assistance to the dialogue on the health financing strategy in Benin.

**Strengthening the organization of the private sector** – While current MOH plans for implementing UHC focus on public sector provision of services, HFG and USAID/Benin are working with the private sector to ensure that it is ready to be integrated into the initiative in the medium term. HFG leveraged the momentum of the Private Sector Assessment workshop in Year I to establish the Private Sector Platform. This year, HFG supported the platform members in several meetings. These meetings helped to develop and validate the vision and mission, membership, and organizational texts to frame the formal constitution of the group. They also took an in-depth look at examples of private sector platforms in Tanzania and Uganda. Particularly, in February, the platform met to discuss the role eventually envisaged for the private sector in the RAMU. The platform members held the General Assembly on May 16, 2014,



Private Sector Platform governing board, Mme Toukourou (president), 5/16/2014  
Photo Credit: Pascal Soglohoun

where Private Sector Platform members also elected a governing board. In September, the Platform Board prepared a collection of formal registration administrative processes and started its strategic planning process.

While HFG recognizes the need to strengthen private sector coordination, concomitant actions will need to be undertaken to ensure that, as the legal framework is developed for the RAMU, the approved texts leave the necessary space for the future involvement of the private sector. Next year, HFG will support the platform to develop the strategic plan and the legal formalities.

**National Health Accounts** – Benin previously carried out two rounds of NHA, for fiscal years 2003 and 2008, with USAID's and other partners' support. The NHA data provided critical information for the government's health sector planning and budgeting. Currently, the MOH is finalizing the latest round of NHA covering fiscal year 2012 with the support of the WHO, using the updated System of Health Accounts (SHA) framework, SHA 2011.

In light of the new framework and departure of staff who conducted earlier rounds of NHA, the MOH lacked technical capacity needed to conduct the current round of data collection, analysis, and dissemination. Accordingly, the government asked WHO and USAID for technical support to fill these gaps and build capacity for future rounds. The HFG team has supported the timely collection of expenditure data from the public health sector, NGOs, and development agencies, risk pooling mechanisms (including private insurance, *mutuelles*, and mandatory employer insurance), and households. Technical assistance from HFG ensured robust data and appropriate classification. Cleaning the data, doing the data mapping, and running additional analysis was conducted. Furthermore a framework for continued support to a sustainable NHA process was developed to assist USAID in its planning for the future.

In Year 2, HFG Benin assisted the MOH to complete the 2012 Health Accounts process. This included:

- Finalizing the general NHA report, including some disease subaccounts (malaria, HIV, and TB)
- Finalizing the 2012 reproductive and child health report
- Validating the two reports
- Formatting and printing the reports

HFG also developed and produced a flyer and poster for the Benin NHA team (1,500 flyers and 250 NHA posters). HFG is in the process of printing a second round of 1,000 flyers and 200 posters.

Likewise, HFG supported the MOH's dissemination of the 2012 NHA exercise results at the health sector annual review on April 29, 2014. Data from the NHA can be extremely helpful for decision-makers, contributing to improved allocation of financial resources and enhanced sustainability. For example, in Benin, the National Program on Tuberculosis has indicated its interest in using the 2012 data in Benin's upcoming Global Fund grant request. The Maternal and Child Health (MCH) program is also planning to use the sexual and reproductive health analysis results to discuss with policymakers the budget allocation at the department level. Indeed, the 2012 NHA results in Benin highlight low public and/or donor expenditure in departments with high population or high maternal mortality, while some of the departments with low population density or low-mortality have the highest public and/or donor funding.





Dissemination of the results of the 2012 Health Accounts  
Photo Credit: Pascal Soglohoun

**Additional Information** – The Benin gender strategy was finalized and translated into French and shared with the USAID Benin mission.

Table 24 provides activity-specific updates.

**TABLE 24. BENIN ACTIVITY DETAIL**

Y2 Planned Tasks	Y2 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
<b>Activity I: RAMU support</b>		
Participate in RAMU GTT	<ul style="list-style-type: none"> <li>One workshop held.</li> <li>HFG continued to provide technical assistance to the MOH to develop a national health financing strategy.</li> </ul>	Regular meetings planned for the TWG. ANAM leadership needs to be chosen. HFG will work with WHO/P4H and USAID to mobilize development partners and other stakeholders to advocate for quick resolution to the leadership gap.
Support departmental networks	<ul style="list-style-type: none"> <li>Three departmental networks <i>mutuelles</i> were created.</li> </ul>	Strengthen the managerial capacity of the three departmental networks, and their members, as an integral part of implementing the professionalization strategy.
Draft legal framework	<ul style="list-style-type: none"> <li>Members of the TWG engaged in conversation with political decision-makers on fundamental issues related to the law.</li> <li>Amendments to the law suggested and submitted to the parliamentary body in charge of reviewing the law.</li> </ul>	Further clarification on the application UEMOA regulations required.
Support <i>mutuelles</i> database	<ul style="list-style-type: none"> <li>Trained 4 members of CONSAMUS staff on updating and maintaining the <i>mutuelles</i> database</li> </ul>	Monitor update of database.

Y2 Planned Tasks	Y2 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
<b>Activity 2:</b> Support to the private sector platform		
Support platform meetings/deliberations on a monthly basis	<ul style="list-style-type: none"> <li>• The private sector platform continued to meet regularly.</li> <li>• A platform for stakeholders in the private health sector was created.</li> </ul>	Plan capacity and governance strengthening activities.
Support development of the strategic plan	<ul style="list-style-type: none"> <li>• First meeting on the development of the strategic plan held.</li> </ul>	Finalize strategic plan.
<b>Activity 3:</b> NHA		
Provide technical assistance to the Beninese MOH team	<ul style="list-style-type: none"> <li>• NHA specialist Andre Zida provided remote support in data cleaning, data analysis, and report writing.</li> <li>• HFG is currently helping the MOH to plan next NHA exercise for the 2013 fiscal year.</li> </ul>	Institutionalization of the NHA.
Results analysis and draft report	<ul style="list-style-type: none"> <li>• The MOH approved the final NHA and sexual and reproductive health reports.</li> </ul>	

#### 4.1.4 Botswana

**Program Objectives** – The Ministry of Health (MOH), through the Office of Strategic Management (OSM), has designed and implemented a number of outsourcing agreements for private provision of nonclinical services at three major hospitals (soon to expand to seven). The MOH five-year outsourcing plan includes extending the access to outsourcing mechanisms to health facilities around the country and eventually expanding outsourcing to clinical services as well. The pressing reasons for MOH promotion of the outsourcing plan include aligning with government of Botswana efforts to strengthen the private economy and improve the quality of nonclinical services provided in hospital settings.

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

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

To respond to these challenges, the MOH requested the support of the USAID mission in Botswana, which in turn tasked HFG with responding to the MOH's request. HFG proposed to support all the challenges above as they all align with HFG's mandate, specifically as described in IR3. Please note that this support began in the first quarter of Year 2.

The first year of HFG activities are focused on addressing the most pressing short-term issues; in the two following years (HFG Years 3 and 4), it will be necessary to ensure a successful transition of strengthening and training functions from HFG to a robust and capable PPP unit.

**Year 2 Activities** – Following preliminary work planning discussions with USAID/Botswana and a work planning trip in Quarter 1, HFG is proposing four specific areas of technical support for Year 2. These include:

- Strengthening the capacity of hospitals and the PPP unit to manage outsourced contracts;
- Organizational development of the PPP unit;
- Benchmarking the cost of outsourced services; and
- Thorough documentation of the government of Botswana's ongoing process of institutionalizing PPPs and outsourcing nonclinical and clinical services at hospitals.



## Year 2 Progress –

**Q2** - HFG traveled to Botswana from January 25 to February 8, 2014. As part of that trip the team:

- Conducted a week-long assessment of the seven hospitals currently outsourcing or soon to outsource their nonclinical services;
- Conducted a four-day workshop with 48 hospital managers to cover all issues of outsourcing, from pre-bid preparatory work, to bidding, to post-bid evaluation, to issuance of SLAs to management of contracts;
- Met with the PPP unit; and
- Collected data and conducted key interviews to be utilized in the documentation of the outsourcing program in Botswana.

In addition, HFG met with the OSM to conduct an initial scoping of the activity to assess benchmark costs of outsourcing nonclinical services. The OSM offered preliminary approval of the facilities selected and the draft data collection tools for the benchmarking study.

Two abstracts were submitted to the Health Systems Research Symposium in Cape Town. One abstract looked at the policy impact of Botswana's outsourcing policy in the health sector: Assessing public hospitals' new outsourcing policy in Botswana; the second abstract investigated the budgetary impact of outsourcing nonclinical services in hospitals: Outsourcing services to add value and improve efficiency among public hospitals in Botswana.

## Q3

**Activity 1:** On May 20-23, 2014, the OSM/PPP unit held a workshop titled "Development of SLAs." During this workshop, the PPP unit and hospital administrators from the seven hospitals that do outsourcing developed SLAs for their outsourced services. After the workshop, HFG worked with the OSM/PPP unit to review and provide feedback on five of the SLAs, contracts, and tender documents that were developed during this workshop.

Observations and feedback on the SLAs helped to inform HFG's second round of hospital outsourcing technical assistance. This trip will build off of the February workshop material, allowing HFG's hospital outsourcing consultant to meet one-on-one with hospital staff and administrators to discuss challenges in implementing the material from the prior workshop. In addition, the outsourcing consultant will build the capacity of the hospital administration to address their current outsourcing issues and help to strengthen hospitals' SLAs.

**Activity 2:** Based on insights drawn from 1) interviews with OSM Director Dr. Ndwapi and the current OSM/PPP coordinator, Mr. Mompoti Buzwani; 2) hospital site visits; and 3) observations during the training, the HFG team concluded that additional technical assistance and capacity building for the hospitals should be a higher priority than the PPP unit development, at least for the remainder of 2014. Therefore, this activity was re-scoped and will move forward with building capacity of hospital staff. Preparations are under way for a three-day Conflict Resolution and Negotiation workshop to be held twice, over the course of July 28-August 8. Each workshop will be attended by approximately 20 hospital managers and staff. Hospital managers responsible for contract administration have not had training or experience in managing out-sourced service contracts. Combined with the inexperience of service vendors, this has resulted in significant conflict with contract service providers. This activity is aimed at further developing the capacity of hospital staff to manage the outsourcing function. Training will focus on an initial set of seven hospitals.

**Activity 3:** In Q3, a work order for the Futures Institute was approved, allowing for this activity to go forward. Drafting of the Excel-based tool that will be used during data collection to identify the total cost for each outsourced service delivered, cost by facility, and the cost drivers for each service began in this quarter. In addition, the process of assembling the data collection team is underway.

**Activity 4:** A paper evaluating the Botswana Outsourcing Policy was drafted and is under internal review. In addition, an SLA narrative was developed to help fill some information gaps in the documentation process. A set of sample survey questions to evaluate the nursing and hospital staff's perception of outsourced service quality was drafted and will be piloted and then used for cost-effectiveness data collection.

## Q4

**Activity 1:** Louise Myers, HFG's hospital outsourcing consultant, travelled to Botswana July 5–19, 2014, as part of the Botswana field-support Activity 1, Contract Management Strengthening, to build the capacity and improve overall contracting and performance management of the MOH/PPP unit and hospital administration staff. During week one, Ms. Myers conducted a three-day technical assistance meeting for 28 participants from the MOH and seven regional and referral hospitals to assist the hospitals in developing and revising their SLAs. She then spent the rest of the week visiting Letsholathebe II Memorial Hospital and working one-on-one with hospital administration contract managers. In the second week, Ms. Myers spent a day each visiting and working with staff at Scottish Livingston Hospital, S'brana Psychiatric Hospital, Mahalapye Hospital, and Princess Marina Hospital to provide technical support and capacity building around facility-specific outsourcing issues. Participant feedback was very positive and by the end of her trip, hospital and MOH staff were able to clearly define issues of conflict in outsourced service contracts and identify how carefully drafted Service Level Agreements can be used to address and minimize these conflicts.

**Activity 2:** Marsha Slater, our TRG consultant, travelled to Botswana from July 26–August 9, 2014, to conduct a highly participatory three-day workshop in Conflict Resolution and Negotiation Skills for 37 hospital managers and MOH personnel. To accommodate as many participants as possible, the training was delivered twice, first on July 29–August 1 and again on August 5–7, 2014. The MOH outsourcing initiative is being rolled out quickly before hospital teams have time to appropriately transition into new roles as contract managers of outside service providers. This three-day workshop provided practical tools and practice for resolving differences, and challenging and influencing the attitudes of hospital managers toward their private contractors. To this end, the constant and consistent message for this workshop was how to achieve “win-win solutions”.

The workshop was extremely well received and highly rated by participants. Participants' comments indicate a shift in their attitudes toward vendors to be more positive and collaborative in their negotiations and to practice greater empathy. In particular, participants found the case scenario analysis and negotiation role-plays to be highly useful. They also appreciated the many opportunities for sharing and interacting with peers from other hospitals.

**Activity 3:** The scope and methodology of the study to benchmark costs for outsourcing non-clinical services were approved by the MOH in Q4. The Excel-based tool that will be used during data collection to identify the total cost for each outsourced service delivered, cost by facility, and the cost drivers for each service was finalized after review and consultation with MOH stakeholders. Additionally, the data collection team was selected and contracted. The training of data collectors is expected to begin in late September. Data collection is expected to be completed by the end of October. Analysis should be finalized and a report written in late November.

**Activity 4:** A literature review on both clinical and non-clinical outsourcing in Africa and other regions was started to inform and contribute to the documentation process. Information, materials, and lessons learned from the other three activities continued to be compiled into the documentation.

**Challenges** – In Q3, HFG submitted the work plan to the USAID mission for final approval. Despite many attempts to discuss the work plan, final approval is still pending.

**Q4 Additional Information** – In Q4, HFG received a request for additional health financing activities; however, there is no promise of additional funding to complete this work:

1. Support the MOH in convening a three-day stakeholder meeting to build consensus on the Health Financing Strategy. The meeting will solicit inputs from a wide range of stakeholders.
2. Upon completing the stakeholder meeting, provide assistance to produce the final Health Financing Strategy document.
3. Finally, work with the MOH, WHO, and PEPFAR to compile tables and all the available information required to write-up the latest NHA report.

Table 25 provides activity-specific updates.

Table 26 provides the health systems strengthening to HIV links.

**TABLE 25. BOTSWANA ACTIVITY DETAIL**

Y2Q4 Planned Tasks	Y2Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
<b>Activity 1: Strengthening management to improve outsourcing practices in public hospitals</b>		
Deliver formal training to hospital administrators on management of contracts of outsourced services	HFG's second round of hospital outsourcing technical assistance took place July 5-19, 2014, for 28 participants from the MOH and seven regional and referral hospitals. This built off the February workshop, allowing HFG's hospital outsourcing consultant to meet with hospital staff and administrators to discuss current outsourcing issues and help to strengthen hospitals' SLAs.	
Provide ongoing support and advice through remote support to hospital administrators	Other than assistance with SLAs, contracts, and tender documents during the workshop, the hospital administrators have not made any additional request for support for this activity.	
Provide ongoing support to the OSM	Following the July workshop, the PPP unit requested HFG assistance in developing vendor pre-qualification materials.	Due to travel and scheduling conflicts, hospital outsourcing consultant Louise Myers is working with Mr. Buzwani to develop vendor pre-qualification materials starting the last week in September.
<b>Activity 2: Capacity building for the PPP unit</b>		
New Scope: Strengthen hospital administration in contracts	Marsha Slater, our TRG consultant, travelled to Botswana July 26–August 9, 2014, to conduct a highly participatory three-day workshop in <i>Conflict Resolution and Negotiation Skills</i> for 37 hospital managers and MOH personnel.	

Y2Q4 Planned Tasks	Y2Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
<b>Activity 3: Benchmarking costs for outsourcing nonclinical services</b>		
Get MOH approval of scope and costing methodology	<p>The scope and methodology were approved by the MOH this quarter.</p> <p>The Excel-based tool that will be used during data collection to identify the total cost for each outsourced service delivered, cost by facility, and the cost drivers for each service was finalized after review and consultation with MOH stakeholders.</p>	
Collect data in hospitals currently implementing outsourcing and those that have not yet begun implementation	<p>The data collection team was selected and contracted.</p> <p>The hospital in which to pilot test the data collection tool was identified, and the training of the data collectors is expected to begin at the end of September.</p>	Data collection is expected to be completed by the end of October.
Conduct staff surveys of services, including quality indicators	Drafting of this additional survey began in September and is expected to be completed by early October, prior to pilot testing.	
Do costing analysis	<p>Expected to begin in November following the completion of data collection.</p> <p>Completion of the final analysis and report is tentatively planned for the end of November.</p>	
<b>Activity 4: Case study: challenges and opportunities of outsourcing services for Botswana public hospitals</b>		
Conduct interviews with key stakeholders to complement staff surveys and other forms of data collection.	HFG designed a survey for hospital staff to gauge their perception of the quality of outsourced services.	The next step is to pilot and administer the questionnaire to hospital staff (expected in early November).
Submit PowerPoint presentation on a quarterly basis to inform government of progress and intermediate results. Dr. Ndwapi to present PPT to government officials	In place of the PowerPoint, a draft paper was developed around the outsourcing policy evaluation and is undergoing internal review and then will be shared with Dr. Ndwapi.	
Develop and submit a paper for peer review	Currently conducting a literature review on outsourcing of clinical and non-clinical services to contribute to the draft paper on evaluating the Botswana Outsourcing Policy.	

**TABLE 26. BOTSWANA HEALTH SYSTEMS STRENGTHENING TO HIV LINKS**

Activity	Prevention	Diagnosis/ HTC	Referral & Link to Care	Access and Retention	ART initiation	Viral Suppression (Chronic Care and Labs)	Support, Care and Quality
<b>Activity 1:</b> Strengthening management to improve outsourcing practices in public hospitals (near-core)	The Ministry of Health created a five-year Outsourcing Strategy and Programme (2011 – 2016) outlining a plan to outsource non-clinical and clinical services for a total of 28 hospitals throughout the country. However, MOH/PPP unit and hospital administration staff lack the capacity to develop and manage outsourcing contracts. It is expected that by increasing the skills of hospital administrators, the overall quality of care and efficiency of the health services can be increased. All the hospitals included in the capacity building activities provide testing services, counseling and deliver ART services; which could also potentially benefit from information and knowledge gained through the improvement of outsourcing practices, cost savings, and/or being outsourced directly.						
<b>Activity 2:</b> Capacity building for the hospital administration (near-core)	The MOH outsourcing initiative is being rolled out quickly before hospital teams have time to appropriately transition into new roles as contract managers of outside service providers. This activity concluded with active participation of 37 hospital managers and Ministry of Health personnel on Conflict Resolution and Negotiation Skills. It is expected that overall efficiency of services, including HIV interventions across the cascade of care, will be improved by stronger hospital administration capacity.						
<b>Activity 3:</b> Benchmarking costs for outsourcing nonclinical services (near-core)	The MOH currently has no cost benchmark of non-outsourced services to use as a baseline to compare the costs of outsourcing those services (this includes HIV prevention, care and treatment services.). Therefore, the costing of outsourcing services including catering, laundry, cleaning and security is aimed to develop reference costs to improve the operation and delivery of services. This financial knowledge and the capacity developed via the outsourcing and costing exercise can contribute to plans for future outsourcing of clinical services (such as HIV prevention, care and treatment).						
<b>Activity 4:</b> Case study: challenges and opportunities of outsourcing services for Botswana public hospitals (near-core)	In order to successfully expand the MoH's outsourcing strategy to facilities around the country, the challenges, successes, and lessons learned from the initial outsourcing experiences need to be documented in a paper that is accessible for future implementations. This activity includes the assessment of the outsourcing policy and will focus on the impact for general hospital services as well as specific ART services provided in participating hospitals.						

Note: HTC=HIV counseling & testing

### 4.1.5 Burundi

#### Program Objectives –

- Strengthen the organizational capacity of the National HIV/AIDS Programme (*Programme de la Lutte Contre le SIDA et les Infections Sexuellement Transmissibles*, PNLS) to carry out its core functions and, as a result, improve the delivery of HIV/AIDS programs and services.
- Provide costing support to the HIV/AIDS sector in Burundi and improve PNLS's capacity to use cost and financial information in program design and monitoring and evaluation (M&E), especially for Prevention of Mother-to-Child Transmission (PMTCT). In particular, it will inform implementation of the Elimination of Mother-to-Child Transmission (eMTCT) plan and will lead to a more effective national response to HIV/AIDS in Burundi.

**Year 2 Activities** – In Year 1, under the capacity-building activity, HFG conducted an organizational assessment of PNLS and developed an intervention plan to address the gaps. By the end of Year 1, HFG had provided assistance in nearly all of the nine areas identified in the original intervention plan. In continuing to build PNLS capacity in Year 2, HFG focuses on seven distinct areas:

- Continue to develop leadership and management skills of PNLS staff.
- Develop PNLS capacity to develop an annual operational plan and M&E plan to track progress.
- Strengthen PNLS capacity to provide technical supervision at the provincial and district levels.
- Continue to develop PNLS capacity in stakeholder engagement.
- Develop a technical training plan for PNLS staff based on the revised job descriptions and an assessment of the capacity of PNLS staff to carry out their roles and functions specified in the job descriptions.
- Continue to develop PNLS capacity to secure operating resources for basic functioning by developing a 2014 operating budget, which will include additional procurement financed by HFG, and a program budget as part of its annual operating plan.
- Develop a communication plan to increase the visibility of PNLS.

All activities except improving supervision and developing a communication plan build upon Year 1 activities.

In health financing, HFG will continue its focus on costing of HIV/AIDS services, in particular PMTCT. HFG will build upon the eMTCT Plan and Option B+ costing exercises to train PNLS staff on better use of costing data to inform planning decisions. The project will also provide a costing expert, who will be part of a group of consultants leading the mid-term review (MTR) of the National HIV/AIDS Strategy. A National Health Accounts (NHA) advisor will also provide technical assistance to Burundi's NHA team to update their knowledge of the new System of Health Accounts (SHA) 2011 framework and build their capacity to conduct NHA exercises.

**Year 2 Progress** – In Year 2, HFG made significant progress in implementing its capacity-building plan to strengthen the PNLS. HFG has increasingly emphasized the strengthening of core functions – supervision, capacity building, planning, coordination, M&E – in addition to strengthening basic management capacity. There are already signs of the improved organization capacity of PNLS and its staff. External stakeholders have commented on PNLS participation in various forums. For example, PNLS played an increasingly visible role in revising the *Politique Nationale de Sante* (National Health Policy PNS), putting to use the management capacity strengthened over the past year with HFG assistance. They will also be able to apply the skills learned during the upcoming development and costing of the

PNLS operation plan in October, which will include organizing a validation workshop with stakeholders in November.

In health financing, HFG continued to improve the availability and quality of HIV/AIDS data, by completing the costing of the eMTCT Plan and scaling up Option B+. HFG built the capacity of PNLS staff to become better users of costing data. Finally, HFG is supporting the Ministry of Health (MOH) in estimating the 2012 and 2013 NHA, which will be disseminated by Q2 of Year 3.

**PNLS organizational capacity building** – HFG has provided ongoing support to strengthen the organizational capacity of PNLS, including improving the functionality of the seven-person senior management team which was established in Year 1. Individual coaching has been provided on an ongoing basis for each member of this team, including targeted assistance for the Director and Deputy Director.

The organizational assessment conducted in Year 1 indicated that PNLS lacked a strategy and capacity to engage stakeholders and had not established any stakeholder coordination mechanisms. In Year 2, HFG worked with PNLS to identify their key stakeholders and how to prioritize them. A stakeholder engagement strategy was developed, providing PNLS with practical steps on how to better communicate and work with stakeholders to facilitate implementation of key activities and to mobilize additional resources.

In supervision, HFG developed a diagnostic tool that was used to conduct a situational analysis of the supervisory capacity of PNLS of the provinces and districts. The results of the situational analysis were presented at a national-level workshop consisting of 60 representatives from the provincial and district health offices, central ministry staff, the HIV/AIDS Commission, and implementing partners. These stakeholders were consulted for strategic priorities to strengthen the quality of technical supervision of HIV/AIDS activities, which informed the new supervision strategy for PNLS. HFG has supported the development of this plan and will provide assistance in putting it into practice. The national workshop proved to be an excellent opportunity for PNLS to exercise leadership in a critically important area and was very well received by the participants. HFG also assisted PNLS to organize a workshop with implementing partners, donors, and other MSPLS offices to validate the supervision strategy. The workshop was highly successful and reinforced the importance that all parties attach to strengthening supervision. HFG will continue to assist PNLS in implementing the strategy. HFG has also worked with PNLS to update and validate job descriptions for all staff. These job descriptions will be used by PNLS staff to help monitor and improve performance. This activity has been critical in providing greater clarity to PNLS staff about their roles and responsibilities, and provides the basis for greater accountability. The job descriptions were instrumental in develop a training-needs plan for PNLS, also with the assistance of HFG.

To develop PNLS capacity to implement specific activities, HFG conducted an assessment of current project management capacity, developed a project management manual, and then trained staff in basic project management skills.

PNLS staff have a critical role in building capacity at the provincial and district levels and often design and deliver training on a wide range of topics. Yet they have never had any training in how to train effectively. To address this need, HFG delivered a five-day training of trainers (TOT) for 12 PNLS staff who are often called upon to deliver training. The workshop was successful in opening the eyes of the participants to the methodology of training and building basic training skills. HFG will continue to build PNLS capacity in this area. In addition to organizational and management gaps, PNLS staff need technical upgrading in such areas as M&E, epidemiology, biostatistics, and behavior change communication. In Q4, HFG carried out a technical training needs assessment and developed a plan to address these needs. The next step will be to assist PNLS to identify implementing partners and donors that could assist in assist in funding or delivering the training.



**Health financing** – Since April 2014, HFG has been supporting the 2012 and 2013 NHA exercises in Burundi with strong leadership from the MOH's Planning Unit. Assistance has included training on the updated SHA 2011 framework and the NHA Production Tool as well as support in planning and implementing the NHA process. In September 2014, HFG's NHA advisor travelled to Burundi for two weeks to assist the team with NHA data analysis. HFG helped the NHA team to clean all completed questionnaires, develop distribution keys, develop weighting keys for non-respondents, and code all expenditure data for the NHAs. With HFG's assistance, an NHA team consisting of five staff members from the MOH Planning Unit and the Statistics Bureau has been established. HFG's training and technical assistance has deepened NHA knowledge and experience and thereby helped to create more sustainable NHA capacity. The stronger national team will be able to use the new methodology and produce the NHA estimates with reduced technical assistance and external support in future exercises.

Following discussions with in-country stakeholders and OGAC-Washington, the eMTCT Plan and its costing were completed with HFG assistance. The costing of the eMTCT plan showed that, as defined in the plan, there are adequate financial resources to execute the plan for the first three years. HFG developed a costing for scaling up Option B+ in Burundi, using updated epidemiological data from the SPECTRUM model.

HFG also provided critical costing support for the updated PNS. HFG's work on the eMTCT and Option B+ costing were key in updating the plan. The updated PNS is the basis for Burundi's current funding request to the Global Fund (Concept Note) to ensure continued Global Fund support to the country. If successful, the funding will start in January 2015.

HFG developed and facilitated a workshop on costing, and costing consultant/expert management, with optimal results. The workshop exposed PNLS staff to basic costing, economic analysis, and tools for health planning. It also focused on getting optimal results from costing experts through sessions on development of terms of reference, mission preparation, and evaluating deliverables. This exercise will enable PNLS staff to make better use of costing experts and the work that they produce. The PNLS will use these new skills in the costing of the two year operational plan.

**Challenges** – The delay in updating the National Strategic Plan has delayed the development of PNLS's operational plan, which flows directly from the PNS. Now that the PNS is finalized, HFG has scheduled a visit by a planning specialist to assist PNLS in developing and costing its Operational Plan in October 2014.

Table 27 provides activity-specific updates.

Table 28 provides the health systems strengthening to HIV links.

**TABLE 27. BURUNDI ACTIVITY DETAIL**

Y2Q4 Planned Tasks	Y2Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
<b>Activity I: PNLS organizational capacity building</b>		
Continue to develop leadership and management capacity	<ul style="list-style-type: none"> <li>Delivered a three-day course on presentation skills for 12 PNLS staff to develop a key skill that will build PNLS effectiveness in leading the HIV/AIDS response.</li> <li>Provided ongoing coaching to heads of departments to address department-specific issues and help them apply leadership and management concepts.</li> </ul>	Ensure the continued efficacy of the senior management team through coaching and follow-up.

Y2Q4 Planned Tasks	Y2Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
Develop PNLS capacity in operational planning	HFG is strengthening PNLS capacity to develop annual operational plans. Following HFG's operational plan and M&E training earlier this year, the project assisted PNLS in developing its annual operational plan using the skills learned in the workshop. The operational plan was to be based on the revised National HIV/AIDS Strategic Plan, which was delayed. Now that the Strategic Plan is completed, the timing is right to develop the operational plan.	Claude Konan will visit Burundi October 13-31 to work with PNLS in developing and then costing the PNS operational plan. The plan will then be validated with stakeholders in November.
Strengthen PNLS capacity in technical supervision	A national-level supervision workshop was held in May to develop a strategy to improve supervision of HIV/AIDS activities. In August, HFG assisted PNLS to organize a workshop to validate the strategy and agree on how to implement it. The workshop was attended by key implementing partners, other MOH programs, and provincial representatives. All parties see this effort as urgent and high priority. HFG will assist PNLS to draft a document that captures the agreements reached. PNLS's role in this activity is a test of its improved leadership and management capacity.	PNLS is responsible for ongoing coordination to ensure implementation of the supervision strategy. HFG's local coordinator will provide ongoing follow-up with the senior management team.
Continue to develop PNLS capacity in stakeholder engagement	No progress was made this quarter on this activity.	HFG will suggest to PNLS to name a committee to agree on the coordination mechanisms that need to be established.
Complete job descriptions for PNLS staff and use them to develop technical training plan	Job descriptions for all PNLS staff were validated by the senior management team.	HFG will support PNLS to ensure the job descriptions are used to monitor and improve staff performance.
Build PNLS capacity in designing and delivering training	One of PNLS's core functions is training of staff at the provincial and district levels. To enable PNLS to do this, HFG conducted a five-day TOT workshop to build skills in designing and delivering training. 12 PNLS staff who carry out training frequently were trained as trainers. Prior to this TOT, no PNLS staff had received any training in how to train.	Conduct follow-up TOT in Y3Q1 to further develop training skills.
Develop technical training plan	HFG identified a short-term consultant from Kinshasa School of Public Health to develop a technical training plan to strengthen the technical capacity of PNLS staff. The consultant visited Burundi for two weeks in September and developed the plan. The plan identifies six areas of training needs and specific training courses to address the needs.	<ul style="list-style-type: none"> <li>• Validate the technical training plan.</li> <li>• Assist PNLS in identifying other donors and implementing partners to deliver the training. Discussions are already underway with MEASURE Evaluation to strengthen capacity in M&amp;E.</li> </ul>

Y2Q4 Planned Tasks	Y2Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
Continue to develop PNLS capacity to secure operating resources	HFG and PNLS completed procurement for a telephone exchange for the PNLS office and furniture for the PNLS conference room.	<ul style="list-style-type: none"> <li>• Install telephone exchange.</li> <li>• Determine HFG procurement support in Y3.</li> </ul>
Develop communication plan	Communication plan was drafted in Q4 to increase PNLS visibility in leading the HIV/AIDS response.	<ul style="list-style-type: none"> <li>• Validate the communication plan with the Senior Management Team.</li> <li>• Determine HFG financial support in Y 3 in implementing the plan.</li> </ul>
<b>Activity 2: HIV/AIDS costing and financing</b>		
Support 2012 and 2013 NHA in data collection and analysis	Data collection for the NHA began in May. HFG supported the team remotely to develop sampling frames for respondents, identify strategies to increase the response rates, and verify the quality of data in the completed questionnaires. In September, HFG's NHA advisor travelled to Burundi to work with the NHA team to code the expenditure data that were collected. In a 10-day workshop, the team was able to clean all the data collected, develop distribution keys, develop weighting keys, code expenditures for 2012 and 2013, and create NHA tables.	<p>The NHA advisor will support the NHA team remotely to</p> <ul style="list-style-type: none"> <li>• Complete and verify all coding decisions;</li> <li>• Analyze the NHA data in conjunction with other key policy information;</li> <li>• Draft the NHA report;</li> <li>• Validate and disseminate preliminary results.</li> </ul>
Cost Option B+	HFG has completed costing of Option B+ using updated SPECTRUM and costing data.	Activity completed.

**TABLE 28. BURUNDI HEALTH SYSTEMS STRENGTHENING TO HIV LINKS**

Activity	Prevention	HTC/ Diagnosis	Referral and Link to Care	Access and Retention	ART initiation	Viral Suppression (Chronic Care and Labs)	Supportive Care and Quality	Comments
Activity 1: PNLS Organizational capacity building	Costing activities will provide critical financial information to support development of the PNLS operational plan. Such information is critical in ensuring that the resources necessary for prevention interventions, especially those targeting key-risk populations, are known in advance, in order to both plan for services accordingly, and to mobilize for additional funding needs.	Detailed operational plan will include comprehensive costing information that includes the goal of increasing availability and access to HTC, and will support efforts to ensure adequate availability of resources.	1. Strengthening PNLS's stakeholder engagement will ensure better coordination with programs such as TB, reproductive health, and malaria to better integrate HIV/AIDS services 2. Strengthening PNLS's capacity in community mobilization will help support facilities with better outreach services to link more PLHIV to care.	1. Strengthening PNLS's supervision and M&E capacity will help support better supervision of facilities, providing guidance on how to keep HIV patients in care 2. Development of technical training plan is aimed at improving technical capacity of PNLS so they can better train health staff in retaining PLHIV in care.	Developing and costing operational plan will ensure that ART needs are identified and planned for, to support reaching targets for ART scale-up.	Operational plan will include costs associated with laboratory monitoring, including but not limited to costs associated with systematic measurement of viral load.	Strengthening PNLS's supervision and M&E capacity will help ensure better supervision of HIV /AIDS services, thereby contributing to higher quality of care.	Strengthening the government's (PNLS's) ability to steward and lead the national HIV/ AIDS response.
Activity 2: HIV/AIDS costing and financing	Implementation of eMTCT options (including B+) will require additional funding; our costing exercise	1. Costing of PNS will provide accurate information on the cost of scaling up HTC services 2. Costing Option	NHA can help understand the health market and landscape for HIV service provision; help identify roles between the public	Updated costing data for long-term provision of care will make PNLS better informed when mobilizing additional	Costing activity will provide accurate information on funding requirements for scale-up of ART initiation as part of	Costing the PNS will provide accurate data on the resources needed to increase viral load testing and other key laboratory services.	Comparison of NHA data with costing data can help identify where lower spending is affecting quality of care and where	In general, the costing/ health financing activity is helping to provide accurate data on the costs of HIV

Activity	Prevention	HTC/ Diagnosis	Referral and Link to Care	Access and Retention	ART initiation	Viral Suppression (Chronic Care and Labs)	Supportive Care and Quality	Comments
	will help the government to understand and plan for the additional resources that will be required to scale up prevention services.	B+ will help understand the cost of scaling up HTC services to all pregnant women.	and private sector; and provide information that can contribute to improved public resource mobilization.	resources for chronic care/ retention in care.	Option B+.		spending may need to be reallocated.	interventions and the national response, so that the government can be better informed when planning for resources. 1. Costing of the PNS will inform the Global Fund application, which will help mobilize additional resources for HIV/AIDS 2. NHA analysis of HIV spending will increase understanding of the geographical breakdown of spending (and how they align to hot spots) and inform better resource allocation decisions.

Note: HTC=HIV counseling & testing, PLHIV=people living with HIV

#### 4.1.6 Côte d'Ivoire

**Program Objectives** – USAID/Côte d'Ivoire has asked HFG to address three major areas: (1) human resources for health (HRH), including an assessment of the pre-service training institutions for health personnel; (2) health financing; and (3) health governance/decentralization. Côte d'Ivoire activities are entirely funded by PEPFAR and as such contribute to achieving an AIDS-Free Generation goals, and are in line with the PEPFAR Blueprint, which includes health systems strengthening under the pillar “Smart Investment.”

**Year 2 Activities** – In Year 2, activities initiated in Year 1 were planned to be continued or to be completed. Country Operational Plan (COP) 13 funds were received in February, which provided a much-needed boost to activities. These activities are related to the following:

- Updating the HRH Strategic Plan for 2014/2015
- Developing a HRH Performance Management System
- Conducting pre-service training institutional assessment
- Improving health finance
- Improving accountability at national and regional level
- Strengthening decentralization of health delivery
- Mapping health financing flows

#### **Year 2 Progress –**

**Human resources for health:** HFG supported the Ministry of Health and of the Fight against HIV/AIDS (*Ministère de la Santé et de la Lutte contre le SIDA*, MSLS) in developing the HRH Strategic Plan for 2014/2015, which includes a monitoring and evaluation (M&E) plan. The HRH Plan was the result of a participatory process with donors and partners, such as the WHO, which are involved in national HRH policy development. The HRH Strategic Plan focuses on improving capacities and competencies of midwives and nurses to directly address the challenges related to achieving Millennium Development Goals 4 and 5. These midwives and nurses also play a critical role in the care and treatment of people living with HIV/AIDS (PLHIV), and the HRH strategy will assist the MSLS in expanding access to quality care. The preface of the HRH Strategic Plan has been approved and signed by the Minister of Health signaling the validation of the final version. The next step is to edit the document and to produce 250 copies.

HFG assisted the MSLS Human Resources Division (*Direction des Ressources Humaines* (DRH)) in finalizing protocols and tools for an assessment of HRH performance motivators and conducting an opinion survey to identify determinants for career profiles. The project had planned to jointly conduct the surveys on HRH performance motivators, but this was postponed to Year 3. Work continued on the career profile survey. An official validation of the MSLS health position descriptions and HRH skills index for levels 1 and 2 was completed. HFG supported the DRH/MSLS to: (1) hold a workshop to develop tools for implementing a performance management system (April 6-12, 2014); (2) hold a workshop to establish job codification (May 4-9, 2014); and (3) hold a workshop and coaching session for HRH health facilities' managers from the Yamoussoukro health region (June 23-27, 2014). These workshops are vital in standardizing job descriptions, clarifying expectations and responsibilities among health care providers, along with strengthening management at the facility front-line level for the MSLS.

The preservice training institutional assessment was held at all of the National Social Workers Training School (*Institut National de Formation des Agents de Santé*, or INFAS) sites throughout the country. Survey data are being analyzed and the first draft of the report is being prepared. However, based on the

assessment conducted at INFAS, HFG will adapt institutional capacity assessment tools for the two other medical and social sector health pre-service training institutions. With regards to the Bachelors, Masters, and Doctorate (LMD) harmonization process system, HFG assisted INFAS and the National Social Workers Training School (*Institut National de Formation Sociale*, or INFS) to develop a License (Bachelor's) model and University of Medical Training (*Unité de Formation et de Recherches des Sciences Médicales*, or UFR-SM) to also develop LMD models. Through coaching sessions with INFS's LMD team, HFG consultants finalized the syllabus of License courses (April 24, 2014). The project also supported UFR-SM through a workshop to develop Master and Doctorate models and syllabi (May 12-16, 2014) but discontinued the Master and Doctorate support at the request of the USAID PEPFAR team.

HFG supported the MSLS through a political validation process of health reform priorities and activities in the presence of the majority of central actors and relevant stakeholders. Health sector reform is one of the biggest challenges in Côte d'Ivoire so it was necessary to urgently revise and update the country's health reform strategy which was completed during a workshop. The validation of the health sector reform document will allow the implementation of all new HRH policies within the health sector. The health sector reform proposal was presented to the Inspector General's office and the conclusions and recommendations have been presented to the Minister of Health. HFG provided support to working group meetings with key health systems stakeholders and HRH union representatives to review the proposed document.

**Decentralization:** The Côte d'Ivoire government has adopted a process to decentralize health system management along using a results-based management (RBM) approach, which is widely recognized in West Africa as an effective planning tool. HFG assisted the technical working group (TWG) on the decentralization process by organizing four sessions to initiate the planning and development of the Regional Health Development Plans for Guemon, Hautassandra, Belier, and Marahoué based on the RBM approach. The first two sessions were held in July 2014, which gathered stakeholders from two regions in Côte d'Ivoire, Guemon and Hautassandra. Additionally, two other sessions were held in August 2014 for stakeholders from two additional regions: Belier and Marahoué. In September 2014, HFG supported the TWG to organize four other sessions to consolidate the drafting of the different regional plans with a national expert who worked with local teams responsible for compiling the plan in each of the four regions.

**Accountability:** Côte d'Ivoire continues to make progress in addressing corruption and improving transparency in the MSLS. HFG supported the MSLS to develop a governance capacity-building plan through a workshop of key MSLS stakeholders and partners. This workshop was attended by partners such as USAID, Elisabeth Glaser Pediatric AIDS Foundation (EGPAF), Search for Common Ground, Government of Côte d'Ivoire Inspector General's office, National Secretary of Governance and Capacity Building, General Health Unit, the MSLS Inspector General's Office, National Institute of Public Health, University of Bouaké, University of Abidjan, and civil society organizations.

HFG also supported the MSLS in organizing feedback sessions based on the assessment findings in key regions. These feedback sessions started in the regions of San-Pedro, Haut-Sassandra, Béliér, and Gbêké and were led by the MSLS Inspector General's office and continued in N'Zi-Iffou, Boukani-Gontougo, Indenié-Djuablin, and Agneby-Tiassa in July 2014.

In addition, HFG supported the MSLS in organizing a workshop to initiate the development of training modules to address the accountability weaknesses based on the results of the gap analysis. This workshop was attended by partners such as the MSH/LMG, WHO, UNDP, EGPAF, Government of Côte d'Ivoire Inspector General's office, National Secretary of Governance and Capacity Building, General Health Unit, MSLS Inspector General's Office, National Institute of Public Health, University of Bouaké, University of Abidjan, and civil society organizations.



**Health financing:** HFG supported the finalization of National Strategy for Performance-Based Financing (PBF) and supported efforts of the MSLS National Planning and Statistics Office (*Direction de la Prospective, de la Planification et des Stratégies*, or DPPS) to develop institutional arrangements for the implementation of the PBF strategy since this is a relatively new strategy.

The validation workshop of the National Strategy for Performance-Based Financing was held September 30-October 2, 2014. Through the workshop, held in presence of the Minister and including over 80 participants from the national counterpart agencies and donors, the following specific objectives were achieved: determination of the institutional and organizational arrangements required for PBF implementation; identification of the purchasing procedures for service delivery; definition of the modalities for procurement of services; and development of a mechanism for monitoring the implementation of the strategy.

As next steps, the workshop participants recommended: 1) development of the manual of procedures, 2) development of a contracting strategy and guidelines for contracting for health service delivery; and 3) implementation of the PBF pilot phase.

HFG prepared an advocacy document for national and local agencies to support the DPPS' efforts to implement a pilot PBF activity. A first draft of this document, sent to DPPS September 30, 2014, recommends five new institutional arrangements to be negotiated with the Ministry of Economy and Finance and the Ministry of the Budget:

1. Reform of the organizational management and the legal status of health facilities
2. Reform of the financial management of health facilities
3. Reform of the management of human resources in health facilities
4. De-regulation of procurement of drug supplies
5. Formalize the separation of regulation, production, verification, and payment functions for the implementation of PBF

**Challenges** – The project's activities have been carefully designed to both ensure local capacity building and sustainability while also meeting PEPFAR's goals of strengthening HIV care and treatment.

The Ebola Viral Disease (EVD) epidemic in West Africa has become a source of concern for the entire world. While there have not been any confirmed cases in Côte d'Ivoire to date, the uncertain trajectory of the epidemic in neighboring countries has drawn attention away from daily health systems strengthening concerns, particularly for the project's government counterparts.

Should EVD cases be confirmed in Côte d'Ivoire, attendance at health clinics is likely to suffer as both the population and health workers will be fearful of coming into contact with EVD. Côte d'Ivoire has undertaken information campaigns since late 2013 to raise awareness of prevention and treatment of EVD so that vital health services are not interrupted and access is maintained.

**Q4 Additional Information** – The HRH activities have been carefully designed to focus on interventions that support HIV care and treatment.

Nahounou Noël participated in the OneHealth training held in Tunis in July 2014. The training was organized by WHO and the Global Fund. His participation was funded through UNICEF, not by HFG.

HFG supported the MSLS in organizing a OneHealth training workshop for national experts in August 2014. OneHealth is an important planning tool that harmonizes NHA and other training tools into one platform.

Table 29 provides activity-specific updates. Table 30 provides the health systems strengthening to HIV links.

**TABLE 29. CÔTE D'IVOIRE ACTIVITY DETAIL**

Y2Q4 Planned Tasks	Y2Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
<b>Activity 1: Support to elaborate the HRH Strategic Plan (2016-2020)</b>		
Establish an operational plan in preparation for costing of the plan in the next program year	The Minister of Health signed the preface to the Interim Development Plan for Human Resources for Health 2014-2015	<p>There were delays in the political approval process for the HRH Plan.</p> <p>Next steps:</p> <ul style="list-style-type: none"> <li>Organize a one-day workshop to disseminate the 2014-2015 HRH Plan.</li> <li>Contribute to the production and dissemination of the HRH Plan.</li> <li>Organize quarterly meetings to follow up on the implementation of the HRH Plan.</li> </ul>
<b>Activity 2: Development of HRH performance management system</b>		
Conduct an assessment through the performance management TWG to gather information from health care workers, specifically those involved in HIV care and treatment, MSLS, implementing partners, and other key stakeholders and the literature regarding performance motivators, including the causes of absenteeism and poor distribution of health workers to rural/remote posts	<p><u>Health Reform</u></p> <p>National Strategy of Hospital (Health) Reform was validated during a workshop held August 4-8, 2014, involving 64 participants from various health sectors.</p> <p><u>HRH performance motivators</u></p> <p>The planned activities were postponed to the next fiscal year.</p>	<p>Next steps for health sector reform</p> <ul style="list-style-type: none"> <li>Communication during the Ministries Council meeting to present the national strategy of Hospital (Health) Reform</li> <li>Elaboration of legal text and bill on Hospital Reform</li> <li>Adopt legal text and bill on Hospital Reform by members of National Assembly</li> </ul> <p>Next steps in HRH performance motivators activity rescheduled in Y3 will include:</p> <ul style="list-style-type: none"> <li>TWG for HRH performance management system.</li> <li>Development of assessment tools.</li> <li>Implementation of a rapid assessment of performance motivators in the health sector, analysis of survey data and draft of the rapid assessment report.</li> </ul>
Develop a proposed incentive policy for health care workers, specifically those involved in HIV care and treatment, including post-differential payments and nonfinancial incentives, by using data gathered from the performance motivators' rapid assessment and best practices from other countries	Future milestone (planned for Y3).	<p>Next steps:</p> <ul style="list-style-type: none"> <li>Develop terms of reference to hire a team of consultants (statistician, health economics, and sociologist) to conduct an assessment.</li> <li>Develop and validate the assessment protocol.</li> <li>Conduct assessment.</li> <li>Produce the report of the assessment.</li> </ul>

Y2Q4 Planned Tasks	Y2Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
Support MSLS in hosting a stakeholder review with the Performance Management Multi-Sectoral Subcommittee, to include the Ministry of Public Service and Employment, the Ministry of Planning, health care workers, and other stakeholders, to validate the proposed incentive policy for HRH, specifically those involved in HIV care and treatment	Future milestone (planned for Y3 Q2).	Activity is a part of the steps subsequent to incentive policy being proposed (in Y3 Q2).
Prepare the incentive policy for costing and resource mobilization in subsequent program year	Future milestone (planned for Y3 Q2).	This step will be set to take place once the proposed incentive policy is validated (in Y3 Q2).
Revise the career profiles and evaluation criteria to reflect updated MSLS position descriptions	HFG supported DRH and HRH unions by conducting a survey on determinants of career profiles. To achieve this goal, the working session with the investigators (16 people) was organized to train them on assessment tools (September 3, 2014). On September 7-13, 2014, data were collected in 4 Sanitary Regions including Abidjan. Approximately 1,200 health workers were surveyed. A debriefing session with investigators was held on September 16, 2014. On September 22-27, 2014, information and data collected during the survey was transcribed into a computerized database.	Next steps: <ul style="list-style-type: none"> <li>Analyze data and information from the survey.</li> <li>Organize a workshop to finalize the career profile document.</li> <li>Organize a one-day workshop to present the career profile activity.</li> </ul>
Support the MSLS in designing a performance management system using the revised evaluation criteria, including the identification of new tools required for implementation	HFG supported DRH to train and coach (July 1-3, 2014) 15 personnel managers (those responsible for the health staff) within health facilities. The training session focused on capacity strengthening in modern human resource management and developing staff job descriptions. In total 1,312 job descriptions were developed: <ul style="list-style-type: none"> <li>Yamoussoukro: 566</li> <li>Toumodi: 448</li> <li>Tiébissou: 114</li> <li>Didiévi: 117</li> <li>Djékanou: 67</li> </ul>	Next step: <p>Support the DRH/MSLS in organizing a workshop with health regions, district managers, and health facilities managers on the utilization of new HRH tools to evaluate their teams members Support the DRH/MSLS in supervising missions to evaluate the implementation of new HRH tools.</p>

Y2Q4 Planned Tasks	Y2Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
<b>Activity 3: Pre-service training institutional assessment</b>		
Provide technical assistance to the MSLS, Ministry of Higher Education (MHE), and Ministry of Social Affairs (MSA) to design, develop, and/or adapt tools for an institutional capacity assessment for pre-service medical, paramedic, and social sector health pre-service training institutions	Based on the assessment conducted at INFAS, HFG is working to adapt institutional capacity assessment tools for the two other medical and social sector health pre-service training institutions, which is ongoing.	<p>HFG will support the INFS and UFR-SM in finalizing their institutional capacity assessment tools.</p> <p><u>INFS/MSA and UFR-SM/MHE</u></p> <ul style="list-style-type: none"> <li>• Conduct assessment in INFS and UFR-SM; support the analysis of survey data.</li> <li>• Provide support to produce the assessment report.</li> <li>• Hold a one-day workshop to validate the assessment report.</li> </ul>
Support the MSLS, MHE, and MSA to obtain stakeholder buy-in from pre-service training institutions for the institutional capacity assessment, and pilot the assessment tools with one institution	<p><u>MSLS/INFAS</u></p> <p>HFG provided support to develop of the first draft of the assessment report. The draft was shared with key actors at INFAS.</p>	<p>Next steps:</p> <p><u>INFAS/MSLS</u></p> <p>Organize a one-day workshop to validate the assessment report.</p> <p><u>INFS/MSA and UFR-SM/MHE</u></p> <ul style="list-style-type: none"> <li>• Conduct assessment in INFS and UFR-SM; support the analysis of survey data.</li> <li>• Provide support to produce the assessment report.</li> <li>• Hold a one-day workshop to validate the assessment report.</li> </ul>
Support the MSLS, MHE, and MSA to analyze the results of the assessment and provide feedback to stakeholders, in preparation for developing individual institutional capacity-strengthening plans in the subsequent program year	Activity planned to be implemented in Y3.	<p>Next step:</p> <p>Elaborate a capacity building plan for INFAS, INFS, and UFR-SM.</p>
Support INFAS, INFS, and UFR-SMA in the implementation of the LMD policy	This activity has been deprioritized, given its distal relationship to HIV care and treatment. The project is working with counterparts to bring it to a close.	<p>Implement a transition plan to end the process.</p> <p>Next Steps</p> <ul style="list-style-type: none"> <li>• Support INFAS LMD committee to finalize License process (end LMD process).</li> <li>• Support INFS LMD committee to finalize License process (end LMD process).</li> <li>• Support UFR-SM LMD committee to finalize LMD process (end LMD process).</li> </ul>

Y2Q4 Planned Tasks	Y2Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
<b>Activity 4: Health finance</b>		
Assist DPPS with developing a PBF model	At the request of DPPS, HFG prepared and submitted a document to advocate for exceptional measures, in light of the implementation of PBF in the health sector in Côte d'Ivoire.	Next steps: <ul style="list-style-type: none"> <li>• Participate in the validation meeting of the PBF strategy.</li> <li>• Finalize PBF strategy documents in collaboration with DPPS.</li> </ul>
Assist MSLS to identify a plan of action for addressing identified health financing priorities		PBF activity was identified as a key health financing priority for the MSLS.
Closely collaborate with other donors concerning financing and represent PEPFAR at meetings and forums related to health finance		Next step: Continuation in the participation of key meetings by MSLS relating to health financing and finalization of implementation documents.
<b>Activity 5: Improve accountability at national and regional levels</b>		
Assist General Directorate of Health ( <i>Direction Générale de la Santé</i> ) and <i>Inspection Generale</i> to promote and strengthen capacity of managers (at the central level and from eight regions) in accountability practices	HFG supported Inspector General's office in developing training modules to address significant accountability weaknesses (based on the results of the gap analysis).	<ul style="list-style-type: none"> <li>• Support Inspector General's office in developing specific mechanisms (guidelines, systems, procedures) necessary to strengthen systematic accountability.</li> <li>• Support Inspector General's office in finalizing the training modules to address significant accountability weaknesses and organizing the training sessions.</li> </ul>
Analyze findings of the assessment tool and identify priorities	HFG supported the MSLS in organizing feedback sessions based on the assessment findings in some of the surveyed regions. These feedback session tours started in the regions of San-Pedro, Haut-Sassandra, Bélier, and Gbêkê and was went on in the regions of N'Zi-Iffou, Boukani-Gontougo, Indenié-Djuablin, and Agneby-Tiassa in July 2014.	Next steps include: Organize a workshop for wide dissemination of the assessment's findings.
<b>Activity 6: Strengthen decentralization of health delivery</b>		
Assist the TWG with decentralization in health sector with light equipment and technical support	Provided technical support to the decentralization TWG as needed.	HFG decided to continue technical support to TWG, and not to provide help with the light equipment provision.
Collaborate with the eight selected regions to complete costed health development plans	HFG supported the MSLS in the development of the Regional Health Development Plans for Guemon, Haut Sassandra, Belier, and Marahoué	Support the MSLS to finalize the Regional Health Development plans (including the costing).

**TABLE 30. CÔTE D'IVOIRE HEALTH SYSTEMS STRENGTHENING TO HIV LINKS**

Activity	Prevention	HTC/ Diagnosis	Referral and Link to Care	Access and Retention	ART initiation	Viral Suppression (Chronic Care and Labs)	Supportive Care and Quality	Comments
<b>Activity 1:</b> Developing the HRH Strategic Plan 2016-2020		The HRH strategic plan helps the MSLS identify the HRH issues that are impacting HIV treatment scale up. These may include, poorly motivated staff, overworked staff and poor retention strategies. The HRH Strategic Plan contributes to improving decision-making processes, planning coordination, budgeting, and response to problems linked to HRH. The project contributes indirectly to the production and management of HRH from a qualitative and a quantitative perspective, recognizing the needs of the	Increased recruitment and retention of key staff in underserved areas helps strengthen the provider supported links between treatment and care, thus increasing the number of people testing HIV+ who are successfully linked to HIV care through provider interventions and support.	Health workers that are motivated are able to meet increased HIV client demands, thus improving retention in care.	Strategies defined by the HRH Plan aim to increase the capabilities of skilled health workers in performing ART initiation. Improved HRH distribution will also help by increasing the number of providers available/accessible to help initiate greater numbers of patients on ART; e.g., task-sharing roles allowing that nurses and midwives have ART initiation in their scope of practice.	HRH reforms help with better distribution of health workers and as a result, care is improved and provider relationships with patients are strengthened. Increased client satisfaction translates into greater adherence to treatment, which positively impacts success of therapy and reaching viral suppression at the client level.		<p>The HRH Strategic Plan will comprise strategies and policies to increase HRH availability and include recruitment and retention plans, and approaches to assist in the ongoing transition away from donor-funded staff.</p> <p>Addressing staffing challenges will impact the government's ability to respond to challenges or barriers at all points on the HIV care along the cascade of care (i.e., HIV prevention, care, treatment, and quality of HIV care).</p>

Activity	Prevention	HTC/ Diagnosis	Referral and Link to Care	Access and Retention	ART initiation	Viral Suppression (Chronic Care and Labs)	Supportive Care and Quality	Comments
		population. The project also contributes to improving the quality of the HRH that will be used in HIV services (care and treatment, prevention, retention in care).						
<b>Activity 2:</b> Development of HRH performance management system	The performance management system will take into account community health workers (CHWs), who have a key role in improving prevention efforts, and above all in retaining PLHIV in ART.  CHWs also have an important	The implementation of an “HRH performance management tools scale- up plan” will improve efficiency of HRH management. The implementation of the rural- and remote-post health care worker retention strategy in the HRH performance management system will ensure increased recruitment of key staff in underserved areas. That will help to ensure adequacy	The human resource performance management system activity includes advocacy for a plan to integrate CHWs and Data Managers into the public health system via approved civil service roles/jobs. Policy changes will allow CHWs to be formally trained and to do adherence counseling. The trained CHWs will benefit from strengthened supervisory skills of clinic staff. That will increase linkages between CHWs and clinic staff (service delivery) and will	The HRH management system is based on health workers' performance. This fair and objective system proposes a set of motivation mechanisms that can help ensure health workers are motivated and available even in underserved areas. This in turn will improve retention of patients in care.		The human resource performance management system activity includes advocacy for a plan to integrate CHWs and Data Managers into the public health system via approved civil service roles/jobs. Policy changes will allow CHWs to be formally trained and to do adherence counseling. The trained		The human resource performance management system activity includes three components: (1) HRH performance management tools scaling up plan, (2) advocacy policies plan for integrating positions of CHWs and Data Managers as categories of civil servant jobs. and (3) a rural- and remote-post health care worker retention strategy.



Activity	Prevention	HTC/ Diagnosis	Referral and Link to Care	Access and Retention	ART initiation	Viral Suppression (Chronic Care and Labs)	Supportive Care and Quality	Comments
	role in following HIV+ mothers and their infants until weaning. They can encourage the mother to return to health services to ensure that the child has been spared an HIV infection or to very rapidly initiate treatment, should that be necessary.	between workers and health priorities real needs, impacting HIV treatment scale-up.	ideally increase the number of patients successfully reaching appropriate HIV care services.			CHWs will benefit from strengthened supervisory skills of clinic staff. That will increase linkages between CHWs and clinic staff (service delivery) and will ideally increase the number of patients successfully reaching appropriate HIV care services.		
<b>Activity 3:</b> Pre-service training institutional Capacity Building		The Pre-service Training Institutional assessment will guide a capacity-building plan that includes training systems development –	Training systems development focused on HIV/AIDS matters will increase the number of health workers who demonstrate abilities in the provision of HIV/AIDS services.	The newly graduated health care workers (graduated from a pre-service training institution) possessing competencies in	This activity includes the development of a task-sharing focused training program, to ensure nurses and midwives are enabled to perform ART initiation. Ultimately, this will increase the	Increasing HCWs capable to provide HIV/AIDS services at each level of the health system will	The newly graduated health care workers (graduated from a pre-service training institution)	The Pre-service Training Institutional assessment will guide a capacity-building activity that includes training on systems development

Activity	Prevention	HTC/ Diagnosis	Referral and Link to Care	Access and Retention	ART initiation	Viral Suppression (Chronic Care and Labs)	Supportive Care and Quality	Comments
		<p>content related to HIV/AIDS. The support for training and for technical capacity to support HIV /AIDS will contribute to producing new HIV capable health care workers (graduated from a pre-service training institution or program as a result of PEPFAR-supported strengthening efforts). Specifically, this will contribute in increasing HIV/AIDS services providers who are able to provide HIV counseling and testing, as well as linking patients to care.</p>	<p>This will increase referral of newly diagnosed clients to enroll in care, and ideally help strengthen the links between HTC and provider points of care.</p>	<p>HIV/AIDS will help to ensure HIV-positive clients have additional points of care where services are available, helping to retain patients in care due to quality of provider, geographic accessibility, etc.</p>	<p>total number of health providers offering initiation services, can help increase the number of patients being initiated, and increase the number of service points where ART can be accessed long-term.</p>	<p>increase the number of patients enrolled in care, who benefit from ART and adhere to treatment. This contributes to success on therapy and, ultimately, viral suppression.</p>	<p>possessing competencies in HIV/AIDS will help to ensure HIV positive clients have additional points of care where services are available, helping to retain patients in care due to quality of provider, geographic accessibility, etc.</p>	<p>(including HIV/AIDS). The support for training and for technical capacity to support HIV /AIDS will contribute to producing new HIV capable health care workers who graduated from a pre-service training institution or program as a result of PEPFAR-supported strengthening efforts.</p> <p>This will contribute to increasing the total number of HIV/AIDS service providers, improving the overall delivery of prevention, care, and treatment services along the continuum of care.</p>

Activity	Prevention	HTC/ Diagnosis	Referral and Link to Care	Access and Retention	ART initiation	Viral Suppression (Chronic Care and Labs)	Supportive Care and Quality	Comments
<b>Activity 4:</b> Support National PBF Model implementation		<p>The developed PBF model aims to reduce barriers to efficient HIV/AIDS-related service delivery. Ideally, improved health care quality will lead to greater population interest in seeking out HIV testing.</p> <ol style="list-style-type: none"> <li>1. The national PBF strategy will attempt to improve the motivation of health workers, which has been a serious problem in CI for a number of years.</li> <li>2. The PBF work will reintroduce a system of monitoring and will thus allow for adjustments and improvements in HRH decision making.</li> <li>3. Such a strategy will also improve governance and will allow for the reinforcement of the principles of accountability. By improving the HRH, M&amp;E, governance, and financing in synergy with the health insurance mechanism, this strategy contributes greatly to reinforcing the health system in its entirety and in particular access to HIV care and services for seropositive patients. One effect is the quality of the services.</li> </ol> <p>Also, the PBF activity's focus on PMTCT will contribute to achieving an AIDS-free generation through timely provision of HTC, ART intervention, and appropriate follow-up to mothers and their newborns.</p>			Using the number of patients on ART as an indicator-based payment will help increase and incentivize additional ART initiations. The follow-up strategies via CHWs, as was piloted in the Ferke district, could also increase ART provision and coverage.	Through the PBF model which will reduce financial access barriers to service delivery in general and HIV/AIDS services in particular, the number of diagnosed, enrolled and ART-initiated patients will be increased. Ultimately, this will contribute to successful therapy and viral suppression.	The PBF activity aims to strengthen health worker motivation through both individual incentives and improved working conditions. The process can reintroduce M&E to allow for decisions to be made on the basis of facility needs, control, and accountability, that will improve the quality of HIV care and services.	The health finance activity includes support in developing and implementing a PBF model for Côte d'Ivoire, which will reduce barriers to financial access to service delivery, including HIV services, and will help improve the quality of care.
<b>Activity 5:</b> Improve accountability at national and regional levels		Building health actors' capacity in accountability will help reduce risks of corruption (e.g., patients' informal user fees, health workers' absenteeism) that currently limit health service delivery efforts and contribute to HIV commodity stock-outs. This activity aims to increase service access		Health workers who are at their posts in health facilities and perform their work with practices that	Reducing informal drug sales (including ART) and implementing an efficient product commodity management system at	Improved HIV service quality that results from strengthening health actors' capacity in		HFG support in improving accountability at national and regional levels will reduce the likelihood of

Activity	Prevention	HTC/ Diagnosis	Referral and Link to Care	Access and Retention	ART initiation	Viral Suppression (Chronic Care and Labs)	Supportive Care and Quality	Comments
		and utilization, leading to a greater number of people appropriately tested and linked to care.		ensure accountability respond adequately to HIV client demands. Greater utilization of health services and accountable provision of care aims to increase patient retention.	national and regional levels can help reduce HIV commodity stock-outs, and, by strengthening the availability of pharmaceutical supplies, increase the number of patients on ART.	accountability practices can further increase patient retention, supporting their success on therapy and ultimate success in reaching viral suppression.		corruption and waste of HIV/AIDS and other resources. It also will improve efficiency, management, and quality of HIV/AIDS services in health facilities through a decentralization policy.
<b>Activity 6:</b> National policy to strengthen decentralization of health delivery		HFG is assisting the MSLS to develop regional-level Health Development Plans with the participation of civil society and other local stakeholders. The decentralized health development plans, which include sections on HIV/AIDS programs, will help to set clearly defined priorities and expected	Locally developed health plans that include HIV/AIDS can produce a more responsive system that ensures services fill real HIV/AIDS needs. The availability of appropriate resources and geographical/ financial access to health services impact the number of patients who can be effectively linked to and enrolled in HIV care.	A responsive system with plans developed at the local level and within the relevant context are more likely to meet diverse HIV client demands; a better response improves retention in care.	Improved functioning of the health system at national/decentralized levels helps to ensure efficient HRH management, appropriate ART drug stocks, quality of service delivery, and availability of skilled HRH (HIV providers). It helps increase the number of patients successfully initiated on ART.	Improving the quality of the performance management system can also impact the quality of care provided, help patients to succeed on therapy, and ultimately lead to viral suppression.		The support of HFG aims to develop medium- and long-term strategic plans. In Y1 and Y2, HFG provided assistance with decentralized health development plans including HIV/AIDS programs. This guided interventions to improve the function of national/decentralized health system levels and seek a more responsive

Activity	Prevention	HTC/ Diagnosis	Referral and Link to Care	Access and Retention	ART initiation	Viral Suppression (Chronic Care and Labs)	Supportive Care and Quality	Comments
		results. Clear, locally developed plans will build ownership and address bottlenecks in HIV/AIDS programming, including testing.						system. In Y3, HFG will focus its support at the national level, including assisting the MSLS to develop a comprehensive national policy for health delivery decentralization.

Note: HTC=HIV counseling & testing

### 4.1.7 Democratic Republic of The Congo

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

The following results are expected with HFG's support for the two activities:

- Constituency built within MSP that supports and facilitates the MSP reform process. HFG will facilitate ministry efforts to build a constituency for reform and improve coordination of stakeholders within MSP for the MSP reform process.
- Key central MSP Directorates with improved capacity to function under the decentralized system.
- Two provincial health divisions launched as they assume their new roles under the reform process
- KSPH with a financial management system that qualifies for direct USAID funding.

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

**Year 2 Activities** – Because work planning only started in the final quarter of Year 2, no implementation of activities took place in Year 2.

**Year 2 Progress** – In July, HFG fielded a two-person team from the home office to negotiate scopes of work (SOWs) with key MSP stakeholders and KSPH. Following the field visit, the team developed SOWs for support to the MSP reform and for the KSPH financial management activity. The MSP scope was officially approved by the MSP Secretary General, allowing HFG to move forward with drafting the work plan and launching activities in country. The scope for KSPH was also finalized and approved in this quarter.

HFG also made major progress in sourcing potential candidates to fill the five positions of the HFG DRC site office. Interviews were done and HFG selected strong candidates for the Chief of Party/decentralization and organizational development specialist positions. HFG is also recruiting the embedded advisor for the financial management activity with KSPH.

With regards to locating office space and other in country logistics activities, HFG hired an in-country consultant who is gathering quotes for services and identified office space. HFG is currently working with the local legal representative and the Abt contracts team to negotiate a rental agreement.

**Challenges** – Commercial real estate is scarce and the few options that arise do not remain on the market for very long.

Table 31 provides activity-specific updates.

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

Y2Q4 Planned Tasks	Y2Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
<b>Activity I: Work planning</b>		
Work planning	<ul style="list-style-type: none"> <li>• HFG fielded a two-person team to develop SOWs for support to the MSP reform process and strengthening financial management capacity of KSPH. Following the field visit, SOWs were submitted to both KSPH and the MSP for review and comment. Revisions were made and the scopes were subsequently approved.</li> <li>• HFG developed a draft work plan based on the scopes of work and submitted it to USAID/DRC for review and comment.</li> <li>• HFG hired a local coordinator to assist with local logistics such as finding office space, identifying an accounting firm, opening a bank account, and other related activities.</li> <li>• HFG completed job descriptions to recruit local team, posted the job announcements, and interviewed candidates.</li> </ul>	<ul style="list-style-type: none"> <li>• Finalize work plan based on mission comments.</li> <li>• Complete recruitment and hiring of local staff. The aim is to have local staff on board by November 10.</li> <li>• Conduct a start-up workshop for local team in the week of November 10.</li> <li>• Develop a detailed implementation plan for MSP reform activity</li> <li>• Conduct financial management assessment of KSPH and develop capacity building plan.</li> <li>• Complete office set-up.</li> </ul>



### 4.1.8 Ethiopia

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

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

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

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

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

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

**Year 2 Activities** – In Year 1, the HFG project undertook start-up activities to generate evidence on the performance of HF governing boards for policy making, strengthening the EHIA, and building capacity of government institutions to implement HCF reforms.

In Year 2, HSFR/HFG will continue to serve as a bridge program and will continue supporting the government in the four objectives specified above. A wide range of specific activities and sub-activities, described below, are planned.

**Year 2 Progress** – Year 2 is the first year that the USAID bilateral HSFR project fully transitioned to HFG Project. HFG continued providing technical support to the government of Ethiopia at different levels for consolidating and expanding the first-generation HCF reforms as well as implementation of SHI and piloting of CBHI. In the reporting quarter, policy dialogue workshops and consultative meetings

were conducted, training of health officials and HF staff conducted, and different policy, legislative, and implementation documents produced and reviewed. The National Health Accounts (NHA) report was finalized and four documents (the main NHA report, the household health services utilization and health expenditure report, as well as briefs of both reports) were produced and printed. The NHA report was disseminated on April 10, 2014, and over 120 participants from different government offices, donor agencies, NGOs, and other stakeholders attended the event. The FMOH committed to use findings of the NHA report for policy dialogue and budget negotiation to increase domestic financing for health.

CBHI evaluation data were collected from the 13 CBHI schemes and four control woredas; the local subcontractor did data analysis and submitted a draft report, which was reviewed and commented on by the project team. The consultancy team had meeting with the project team to better understand comments from project and other experts, following which the firm produced a revised version of the report that was further reviewed and commented. Currently, the consultancy team is working on addressing the second round of comments and they are expected submit the final report early next quarter. The findings of evaluation will be used for development of a CBHI scale-up strategy. The report will also be submitted to FMOH, EHIA, and other stakeholders and expected to be extensively used for policy decision making on the CBHI program.

Data collection for the health facility governance boards' (FGBs') performance study was undertaken in Year 2. Data were compiled and made ready for analysis. Preliminary findings from Oromia Region were used for a Health Committee/Governance Panel at the Global Symposium on Health Systems Research in Cape Town, South Africa.

CBHI expansion schemes were established and officially launched in a number of new pilot woredas in Amhara and Tigray regions, and encouraging progress was made in Oromia and SNNP regions. The project team in collaboration with health authorities conducted supportive supervision in selected HFs and CBHI schemes; using a checklist, it gathered performance data that are critical to understanding progress and generating evidence at regional and national levels and providing on-the-spot technical support to CBHI schemes and health facility staff. Moreover, supervision data were compiled, analyzed, and submitted to the RHBs and EHIA for management and policy decision making.

**Challenges in implementation of first generation HCF reforms:** Challenges observed in the year include:

1. Weak auditing of HFs: With RRU giving HFs have funds that they manage and spend, regular auditing is critical to ensure that resources are properly used for intended purposes.
2. High turnover of trained financial management staff at the HF level.
3. High turnover of HF board members: One of the continued challenges of the health system is high turnover of permanent and temporary staff (regional core process heads, woreda heads/health office, and scheme staff). This delays decision making and provision of services. As a remedy, the project is working closely with the newly assigned staff as much as possible.
4. Lack of clear guideline on how financial officers will do their tasks during off-work hours, weekends, and holidays especially in health centers (HCs), where their numbers are very few.
5. FGBs fail to support HFs by conducting regular quarterly meeting and on-the-spot random checking the HFs mainly due to the busy schedules of some board members and high turnover of board members and HF heads.
6. Lack of proper implementation of the fee waiver system in some regions and localities including screening of fee waiver beneficiaries, budget allocation, and timely reimbursement of HFs.
7. Absence of evidence-based and timely user fee setting and revision as per the respective regional legal provision.

**CBHI implementation-related challenges:** The task of implementing health insurance has not been without challenges. Some of the challenges faced include the following.

1. **Delay in the procurement of computers:** The project committed to obtain one desktop computer with printer for each of the expansion CBHI schemes. There was delay in the acquisition of computers and printers that was reported as a challenge for the new CBHI pilot expansion schemes, particularly for those in Amhara Region where over 30 CBHI schemes were established early in the year. In the fourth quarter, the project procured half of the computers and printers (80 each) and distributed them to the schemes that are already established and the problem is resolved.
2. **Delay in the procurement of motor bikes:** This has seriously limited establishment and running of CBHI schemes. The peak season for CBHI enrollment, the harvest season, has passed, and the potential for enrollment has not been exploited to the optimum, due to problems in accessing all locations because of lack of mobility among the CBHI schemes officers. In addition, in some of the schemes, renewal times are approaching, which again requires frequent visits to villages by CBHI executive staff. Following approval of the purchase, the project is in the process of procuring the motor bikes and in discussion with the selected supplier on issuing of invoices to make the payment and to receive the motor bikes.
3. **Slowdown in the preparatory activities of SHI implementation:** The preparatory activities required for the implementation of SHI were going at full force until the end of the second quarter. However, the activities are not yet finalized and in some cases there is a sign of a slowdown in undertaking the activities. Apart from the sensitization activities that have to be done on a continuous basis, the collection of data on members, beneficiaries, and employers, ID card production, selection of and contracting with providers, and opening of offices are some of the activities which have to be finalized to kick off SHI.
4. Budget shortage (for ID printing, data cleaning, kebele leaders trainings, furniture for new woreda staff, and travel expenses).
5. Inadequate data recording on health services utilization by CBHI.
6. Delay in woreda scheme executive staff recruitment.
7. Vacant IT post for an extended period in some CBHI schemes,
8. Not understanding that CBHI promotion is continuous. The momentum created at the initial stage does not continue unaided. Continued engagement is needed to prevent low enrollment of additional members and ensure timely renewal of membership.
9. Schemes have financial problem due to imbalance between revenue and expenditure due to over use, over prescription, low level of risk pooling, and absence of a reinsurance mechanism.

#### **Q4 Additional Activities/Information –**

**Center: Comprehensive hospital reform training:** Federal hospitals are lagging behind other government hospitals in initiation and implementation of HCF reforms. HSFR/HFG collaborated with Gondar and Ayder Teaching/University Hospitals and Clinton Health Access Initiative-Ethiopian Hospital Management Initiative (CHAI-EHMI) in conducting comprehensive hospital reform training for 124 participants drawn from the two hospitals (63 from Gondar and 61 from Ayder). The training covered topics related to each of the following reforms: Business Process Reengineering (BPR), Health Care Financing (HCF), Ethiopian Hospital Reform Implementation Guideline (EHRIG), the Balanced Score Cards (BSC), Hospital Performance Monitoring and Improvement (HPMI), Health Management Information System (HNIS), and the Health Development Army (HAD). The objective of the training was to build the capacity of senior hospital management and technical staff by equipping them with the

necessary skills and knowledge on all major hospital reform areas. This training enabled the project to build the capacity of the participants on HCF and hospital governance reforms that hospitals are expected to implement. The training costs were shared by the two universities, CHAI, and HSFR/HFG. The training was an opportunity to discuss and plan the way forward on various issues that have serious implications for improving performance of the respective teaching hospitals.

**Addis Ababa:** A half-day orientation and consultation meeting was organized with sub-city and hospital HCF focal persons on September 16, 2014. Ten sub-city and six hospitals HCF focal persons were expected to attend but only one hospital and three sub-city representatives appeared. The orientation introduced concepts of HCF, achievements at the national and regional levels, the HCF activity plan of Ethiopian fiscal year (EFY) 2007 and on how to complete the data collection template. Due to inadequate attendance, the event will be held again for the absent sub-cities and hospitals.

On June 29, 2014, the FMOH and Addis RHB organized a hospital planning orientation. HSFR/HFG staff provided technical support to the FMOH/Medical Services Directorate and RHB/Curative Care Process Owner and officers to incorporate HCF as priority components with key indicators in the RHB and hospital strategic planning and reporting. Accordingly, RRU, HF governance, fee waiver service, private wing, and user fee revision are incorporated as strategic plan priorities.

The RHB organized a plan alignment meeting for August 21-22 at which sub-cities and HFs came together to harmonize their plans. HCF was incorporated into their strategic and annual plans, and indicators were selected for reporting purposes. More specifically, the priority HCF and governance issues made a priority were RRU, HF governance, fee waiver and exemption systems, private wing, and user fees setting and revision.

**Central:** Two project team members participated in the FMOH and Addis Ababa RHB Joint Annual Hospital Planning Session EFY 2007 (2014/15) organized by the FMOH/Medical Service Directorate on July 4-6, 2014. The conference looked at national hospital reform initiatives and performance bottlenecks, core HCF activities to institutionalize at facility level, and involvement of HCF reform in the hospital planning process.

HSRF/HFG staff attended a two-day Medical Supplies and Auditable Pharmacy Transaction and Services (APTS) workshop held in Addis Ababa on August 14-15, 2014. The workshop was organized specifically for federal referral, university, and Addis Ababa City Administration hospitals. The APTS initiative aims at improving transparency and accountability in pharmaceutical transactions and services. The project participants found the event very useful as pharmaceutical issues are critical for clinical and perceived quality, and the significant portion of RRU is being used for procurement of pharmaceuticals in the HFs.

HSFR/HFG staff supported and participated on the events organized and led by FMOH/ Medical Services Directorate with the objective of improving the quality of services in all university hospitals and thereby the capacity of high- and mid-level managers. We provided on-site support on hospital planning cascading to the case team level for 2007 and training on hospital and HCF reform for 145 male and 88 female hospital department heads, case team leaders, board members, and university staff in four hospitals namely Ayder, Gondar, Asela, and Jimma teaching hospitals. This activity created awareness of hospital reform activities like EHRIG, HPMI, HCFR, and BSC planning. The training was given on site with cost sharing: CHAI paid the participant allowance and the university covered the cost of the training and refreshments. HFG/HSFR covered the cost of four facilitators that FMOH/Medical Services Directorate assigned and provided training materials with two groups of experts established to provide the on-site support and feedback.

The project staff provided support and facilitated data collection organized by the FMOH to serve as input for HCF strategy revision. The project provided support on selection of woredas and HFs. The project also facilitated visits to the study woredas and facilities. The HSFR/HFG team also commented on the draft version of the “Countdown to 2015: Ethiopia’s progress Towards MDG-4” case study.

**Further expansion of CBHI in Amhara:** Amhara region had three CBHI pilot districts initially, and now is expanding to an additional 39 districts. Of these, 35 are already officially established and have launched CBHI schemes, while three are well in progress, and the progress in one of the districts is satisfactory. The region is ahead of the other three CBHI pilot regions in expanding the planned schemes. Currently, the region is in the process of further expanding CBHI schemes to up to 30 additional districts. The RHB received 50 potential new expansion districts and reviewed the list and their readiness, and the Regional Government endorsed expanding CBHI schemes in 30 of the proposed 50 districts.

Table 32 provides activity-specific updates. Table 33 provides the health systems strengthening to HIV links.

**TABLE 32. ETHIOPIA ACTIVITY DETAIL**

Y2Q4 Planned Tasks	Y2Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
<b>Activity I: Improve quality of health services</b>		
Provide training on HCF reform implementation	<p><b>SNNP:</b> On July 24–25, 2014, the HSFR/HFG team conducted parallel HCFR implementation training to 99 (87 male and 12 female) HC heads. In the Mizan Teferi, 50 (47 male and 3 female) training participants drawn from Sheka, Kaffa, and Benchi-Maji zones and in the Yirgalem, 49 (40 male and 9 female) training participants from Siltie, Kembata Tembaro, and Gedio zones were involved. The training topics included an overview of HCF reforms; FGB composition, roles, and responsibilities; fee waiver and exemption system reforms; user fees setting and revision as well as highlights of reforms implementation challenges. Participants were also able to share their experiences on the HCF reforms implementation.</p> <p><b>Amhara:</b> HSFR/HFG staff provided two one-day refresher trainings for woreda and HC staff in East Gojjam zone on August 12 and 14 in collaboration with the zonal health department (ZHD). A total of 257 participants (56 females and 201 males) from 18 woredas and 100 HCs in the zone including the zonal staff participated in these trainings. Topics covered included highlights of HCF reforms including health insurance, RRU, FGB, fee waiver and exemption system, and their implementation. The training was based on feedback of supervision and reviews and it was critical to clarify confusion on the reform implementation. Training was initiated by the zone and it shows their effort to fully institutionalize and lead the HCF reforms implementation in HFs in the zone. The training cost was co-financed by the ZHD. The project covered per diem and lodging cost for facilitators from the project and the RHB.</p>	
Support technical support and collaboration between HFs on financial management.	No progress this quarter.	

Y2Q4 Planned Tasks	Y2Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
Conduct consultative meeting to adapt financial management manual	<b>Benishangul Gumuz:</b> Project staff supported the revisions of the HCF reform implementation directive and manual, copies were printed and distributed to all zones, woredas, HCs, and hospitals. Major changes made were briefed during annual review meetings and woreda planning sessions.	
Advocate for the approval of structure and recruitment of critical finance staff	<p><b>SNNP:</b> In this quarter, 59 HFs were visited through the supportive supervision; the status of human resource fulfillment at HFs was one of the issues covered during the supervision. Each HC is expected to have six Procurement, Finance, and Property Administration (PFPA) staff and one or two auditors based on the HF civil service staffing structure. Type A or level-one HCs, which have relatively better service conditions, are expected to have two auditors. Over 53% of the HFs have three or fewer PFPA staff out of the six required. Only 47.5 % of the HCs have four or more PFPA staff. This implies that the majority of HCs do not have sufficient PFPA staff to accomplish tasks related to financial recording, procurement, and property administration that are crucial for HCF reform implementation. The finding was shared with the RHB and the respective woredas; it will be continuously used for advocacy on filling these positions.</p> <p><b>Benishangul-Gumuz:</b> Based on preparatory activities done during woreda-based planning, follow-up was done to allocate budget to recruit critical finance staff positions. As a result, all HFs proposed budgets for new and vacant posts. Based on these, HCs started the process of recruiting to fill the positions</p>	
Print and distribute Health Sector Development and Administration (HSDA) directive and RRU manual	<b>SNNP:</b> The project supported printing and distribution of 360 copies of HCF documents including legal frameworks as well as HCF reform implementation, RRU manuals, and financial management manuals, and cash management directives. These documents were distributed in the trainings which took place in Yirgalem and Mizan-Aman towns.	
Provide eight-day financial management training	<p><b>Gambella:</b> From September 23 to 27, Gambella and SNNP HCFR/HFG team provide six days of training on Financial Management for HF PFPA staff. A total 19 (14 men and 5 women) participants attended the training.</p> <p><b>SNNP:</b> The regional HSFR/HFG project team in collaboration with the RHB and ZoFED conducted an eight-day financial management training at Fura Institute of Development Studies Center, Yirgalem town from September 16-23, 2014. The training was attended by a total of 49 (43 men and 6 women) Procurement, Finance and Logistics officers drawn from 12 zones. The training focused on officers who had no exposure to such training.</p> <p>The contents of the eight day-long sessions focused on major components of HCF reform, recording financial transactions into journal voucher, payment voucher, and revenue voucher; transferring financial information from a source document into transaction registers; posting journal entries into different ledgers; and producing monthly and annual financial performance</p>	



Y2Q4 Planned Tasks	Y2Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
	<p>reports.</p> <p>The account manual, HCF operational manual, RRU guideline, and cash management directive were distributed to the trainees during the training. The training was conducted by project staff and two senior experts from the Zonal Finance and Economic Development Departments (ZoFED). The trainers presented highlights of HCF reform, basic accounting and financial management concepts and government financial management and procurement procedures and formats. The participants did practical exercises and had discussions among themselves and with the resource people.</p>	
Financial management training for hospital procurement, finance and property officers, and auditors	No progress this quarter.	
Support auditing of HFs	No progress this quarter.	
Conduct HF auditing training	<p><b>Tigray:</b> HSFR/HFG in collaboration with RHB and BoFED provided training July 24–29, 2014 for WoFED auditors on financial management topics. The total participants were 34 (25 male, 9 female) from seven zones (30 woredas), two each from BoFED and from RHB. The purpose of the training was to strengthen the financial management system and auditing practice of the HFs.</p> <p>The topics of the training included HCF progress, experience sharing and discussion on issues of HCF reform implementation, financial management systems, government procurement legal frameworks, property management, and technical procedures of audits and pre-audits, and legal aspects of audits.</p>	
Recognize and graduate HFs that successfully implement HCF reforms	No progress this quarter.	
Increase availability of operational budget at a point of service delivery	No progress this quarter.	



Y2Q4 Planned Tasks	Y2Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
Review of Private Wing Manual.	<p><b>Central:</b> HSFR/HFG supported the federal referral and teaching hospitals' annual review meeting and organized the private wing directive validation workshop. Both events were held in Bishoftu July 8-12, 2014; 45 participants (6 female and 39 male) attended them. The participants were Directors of Directorates, Support Process Owners, and FMOH Department Heads; high-level delegates from the Ministry of Education (MOE) led by the Director General for Higher Education; Deans of Teaching Hospitals, CEOs of Federal Referral Hospitals, Medical Directors, and Planning and Budget Directors from 13 university and medical college hospitals; and Country and Program Directors of CHAI.</p> <p>Directors from the FMOH and MOE emphasized that university hospitals are very peculiar in their organizational arrangement and need considerable attention and efforts to overcome the challenges they face: again, their distinct organizational arrangement; dysfunctional governance structure in many; the private wing guideline was not well developed and the operation has been limited to a very few of these hospitals; inadequate performance in regard to EHRIG standards and management awareness about the reform. The meeting made critical recommendations on initiating and implementing various reforms including HCF and governance.</p>	
Promote health care workers motivational schemes including establishment and operation of the private wings	<p><b>Central:</b> The central team developed a zero draft of a selection guide for recognizing best-performing HFs and hospitals that provide better services to CBHI beneficiaries. The document lists objective criteria that would be used to compare the performance of HCs and hospitals that are contracted to CBHI schemes in the pilot woredas. The guide will be enriched by incorporating comments and will be submitted to the EHIA for review and endorsement.</p>	
<b>Activity 2: Improve access to health services</b>		
Support the revision and issuance of a regional CBHI directive and bylaw for pilot expansion	<p><b>SNNP:</b> In Q4, the CBHI directive was finalized and four copies were distributed to each of the 47 CBHI expansion woredas. Although this is encouraging, the project understands that a lot is yet to be done in the coming months in launching CBHI schemes and running them as stipulated in the regional CBHI directive. A revised draft CBHI bylaw was also prepared; print and electronic copies were distributed to zones for redistribution to the expansion woredas for their adoption and endorsement.</p>	
Support orientation/training of selected regional, zonal, and woreda cabinet members	<p><b>Amhara:</b> A one-round pre-implementation orientation to 30 new woredas was given by members of the regional project team and zonal CBHI coordinators. The orientation includes budget allocation for indigents, salary and running cost for CBHI schemes, and printing costs. The positions of the three critical staff members (coordinator, health officer, and accountant) were endorsed by the regional Civil Service Bureau for the 30 woredas and two positions (M&amp;E and accountant) for the seven</p>	

Y2Q4 Planned Tasks	Y2Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
	<p>zones (North Gondar, Awi, Wag Himira, North Wollo, Oromia, North Shoa, and East Gojjam); each woreda was advised to staff the positions as soon as possible. Procedural documents (Form 14 and 15) to fill the positions were signed by the Civil Service Bureau. Four woredas (Bibugn, Quara, Sekota, and Dhana) are refraining from starting CBHI implementation even though they were selected by the zonal cabinet for implementation.</p> <p>Some of the woredas have started recruiting for CBHI executive positions and others are in the process of announcing the vacancies. Each woreda reported that they have allocated budget for indigents though the sufficiency should again be evaluated after they completed the indigent selection.</p>	
Support the preparation of the design parameters for the scale-up woredas	No progress this quarter.	
Finalize operational/ implementation manual for SHI scheme in consultation with EHIA	No progress this quarter.	
Conduct regular consultation with the EHIA	This is a continuation process and the project team work in collaboration with the EHIA and its branch offices, and the project has regular meetings with the EHIA.	
Support revision of last quarter EHIA plan for EFY 2006 (2013/14)	No progress this quarter.	
Follow up on the recruitment and placement of CBHI executive organs at zone and woreda levels	<p><b>Amhara:</b> Based on the decision by the regional government to add 30 new woredas to CBHI implementation, project staff conducted preparatory work and prepared the necessary documents for the RBH to be endorsed and ratified by Regional Bureau of Civil Service. Following approval, the structure was shared with the zones and selected CBHI expansion woredas so that they can recruit the required staff.</p> <p>According to the approved structure, all zones will have three executive staff members, zonal coordinator, M&amp;E officer, and finance officer, to oversee and backstop schemes. Similar to the three CBHI pilot woredas in the region, the expansion woredas will have three CBHI executive staff: woreda coordinator, finance officer, and health officer /medical auditor.</p> <p>Based on this, zones and woredas are filling these positions. More than half have already recruited at least two staff.</p>	

Y2Q4 Planned Tasks	Y2Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
Provide training for selected regional, zonal, and woreda cabinet members	No progress this quarter.	
Provide training on CBHI financial, administrative, and management systems; and M&E to CBHI executive staff in the expansion woredas	<p><b>SNNP:</b> Training of CBHI Executive Teams: Because of CBHI scheme staff turnover, new staff are being deployed and a significant CBHI knowledge gap is observed among the newly deployed staff. To prepare staff, a two-day training was conducted on September 22-23, 2014, at Hosanna HC. A total of 35 CBHI staff members (27 men and 8 women) took part in the training.</p> <p>The objective of the training was to build the capacity of the trainees on the overall CBHI operational, financial, and administrative matters that need to be performed at scheme level. The following topics were covered during the training:</p> <ul style="list-style-type: none"> <li>• Concepts of health insurance in general and CBHI in particular;</li> <li>• Database management;</li> <li>• Financial Administration and Management System;</li> <li>• Managing contracts with providers;</li> <li>• Major duties and responsibilities of CBHI staff at woreda scheme level.</li> </ul> <p>The training was interactive with a number of practical exercises on handling financial transactions and data encoding. Questions raised by the participants were answered by the trainers.</p>	<ul style="list-style-type: none"> <li>• Delay in information dissemination from ZHDs and woreda administration office;</li> <li>• Limited number of trainees from some woredas;</li> <li>• Failure of woredas to timely send the trainees to the training venues;</li> <li>• Inadequacy of budget to train more executive organs at kebele level;</li> </ul>
Provide training for kebele executive positions in the CBHI expansion woredas	<p><b>SNNP:</b> Building the capacity of kebele executive positions is critical for effective implementation of CBHI schemes. Eight one-day trainings were conducted by the project for selected kebele managers of expansion woredas between August 4 and September 8, 2014. Training was attended by 1,081 trainees (1,015 male and 66 female) from 47 expansion woredas. Budget constraints limited trainees to only kebele managers.</p> <p>The training covered objectives and basic principles of CBHI, community mobilization, membership, registration, premium collection and deposit, and benefit packages of the schemes, as well as roles and responsibilities of kebele executives, i.e., kebele manager, kebele administrator, and finance personnel.</p> <p>The trainees voiced their concerns about the potential workload and administrative hurdles. The ZHD officials who attended some of the training reaffirmed the regional government's unrelenting stance on CBHI implementation. The trainers observed that there was good understanding of the lessons covered because of warm discussions among participants.</p> <p><b>Oromia:</b> A one-day CBHI training was provided to kebele administration leaders (chairpersons and managers) and woreda communication officers in August and September. A total of 2,918 persons (111 female) participated in the training from 1,544 keles of 48 CBHI woredas located in 15 zones.</p> <p>The training focused on basic CBHI concepts, and the</p>	The major issue or gap identified at scheme level was inadequate distribution of ID cards to the members due to absence of photo that could be attached to the ID.

Y2Q4 Planned Tasks	Y2Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
	<p>importance of design parameters stipulated in the regional CBHI directive; organizational structure of CBHI schemes; duties and responsibilities of kebele-level executives; and essential elements of Financial Administration and Management Systems (FAMS) that are applicable at kebele level for the effective implementation of the CBHI scheme.</p> <p>The CBHI coordinator of the respective woreda reported on the performance of CBHI at the woreda level and the variation in performance across keels of the same woreda. The variation is due to the level of commitment of the respective kebele leaders toward CBHI implementation. Moreover, experiences from better-performing woredas were shared. Participants voiced concern about the poor quality of health service in most of the HFs especially with regard to the supply of essential drugs, and the risk involved in cash collection and deposit in remote woredas where bank is not available, etc.</p> <p>Areas of attention include strengthening the CBHI implementation in 2007 EFY especially members mobilization, database management, timely collection and deposition of premium payments, and timely printing and distribution of essential vouchers.</p> <p><b>Amhara:</b> A one-day training on basics of CBHI and the details of regional directive was organized for kebele (managers and administrators), woreda cabinet members, HC heads, and religious leaders at their respective woreda capitals. The training described lessons learned from CBHI pilot woredas. Each training was adjourned after a thorough discussion and agreement on next steps in initiation and implementation of CBHI schemes.</p> <p><b>Tigray:</b> HSFR/HFG in collaboration with the EHIA, RHB, and woreda administrations conducted one-day CBHI trainings between August 31 and September 21, 2014, for kebele leaders (chairmen and managers), woreda cabinets, and HC directors from 13 woredas. The participants totaled 887 (723 men and 164 women). The purpose of the training was: to establish the CBHI schemes in the expansion woredas.</p>	<p>Participants at the workshop agreed to focus on the following activities for the next quarter:</p> <ul style="list-style-type: none"> <li>• Conduct community sensitization.</li> <li>• Support temporary household registration.</li> <li>• Ensure photo readiness for each household.</li> <li>• Selection of 10% community indigents.</li> </ul>
Follow-up on CBHI orientation/training of health care providers at HC level	No progress this quarter.	
Track the enrollment and premium collection in the CBHI pilot woredas	<b>Oromia:</b> A total of 266 new households enrolled in the four pilot CBHI schemes. In addition, a total of 4,831 CBHI member households renewed their membership. A total of ETB 882,748.00 was collected from renewal and newly enrolled households.	

Y2Q4 Planned Tasks	Y2Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
	<p><b>Oromia:</b> In 12 CBHI expansion woredas, 37,125 paying households enrolled into schemes and 38,308 indigent households were also enrolled.</p> <p>The amount of premium collected from paying households in the pilot expansion woredas was 7,074,889.00 ETB while the targeted subsidy transferred into the pilot expansion schemes accounted by the regional government and respective woreda administrations on behalf of selected indigents was 5,100,298.00 ETB. The current banked reserve for all the schemes was ETB 20,849,116.00.</p>	
Support the provision of health care services in the pilot woredas	<p><b>Oromia:</b> With regard to health services utilization in Q4, the number of CBHI beneficiaries served and for whom reimbursement claim was requested was 9,963. The CBHI schemes reimbursed the contracted health care providers ETB 407,318.85 for the services they rendered to the scheme beneficiaries.</p>	
Follow up on the implementation of fee-waiver system	<p><b>SNNP:</b> Out of the supervised 59 HCs where implementation of the waiver system was assessed, 43 (73%) reported that they are implementing the fee waiver system in a hybrid manner (the new and traditional way). The remaining 16 (27%) are not totally providing the fee waiver service to the poor. Of those HFs that are providing services to waiver beneficiaries, 38 (88%) were doing so without having received the lists of certified households from the woreda/ town administrations. Out of all HCs providing services for fee-waived patients, 31 (72%) reported that they were doing so without having entered into a contractual agreement with their woreda/town administration. Six HCs (14%) have not yet received cash/money from the woreda/town administrations for the services they provided even though they submitted their request on time. In addition to on-the-spot feedback to the visited HFs, feedback was also given to district health officials and the RHB. The evidence is being used for advocacy for the full implementation of the fee waiver system in all HFs.</p>	
Follow up on the allocation and transfer of targeted subsidy to the CBHI schemes	<p><b>Amhara:</b> The EHIA released a 4.824 million Birr general subsidy for 12 expansion CBHI schemes based on their performance and biannual report. Finalization of preparatory activities and commencement of providing coverage for accessing health services were major criteria for releasing the subsidy. The general subsidy was transferred to bank accounts of the respective schemes.</p>	
Increase coverage of CBHI and SHI	<p><b>Amhara:</b> CBHI expansion is progressing very well from piloting in three districts that started in January 2011 that expanded to cover 39 woredas last year and early this year. Currently the schemes are being further expanded to an additional 30 districts. The selection of expansion districts as reported by zonal leaders was participatory. First, zonal cabinet members discussed the issue and selected districts that could implement the program. Then each proposed district was contacted by its zone, asked if it was interested in and ready to initiate a CBHI scheme.</p>	

Y2Q4 Planned Tasks	Y2Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
	<p>The three pilot woredas (South Achier, Fogera, and Tehuledere) have been implementing CBHI. The overall performance of South Achier and Tehuledere was quite encouraging while that of Fogera was unsatisfactory. The health service utilization was as usual: members go to facilities and access the service. The project continued supervision and provision of technical support to the schemes.</p> <p>CBHI expansion districts Ibinat, Libo and Estie in South Gondar zone and Takussa in North Gondar were very slow in enrolling new members. In contrast, Abergele district, which had lagged behind until the RHB decided to change it, is progressing well in its preparatory work to launch the CBHI scheme.</p> <p>Out of 39 CBHI schemes, 34 started providing health service for their members and 13 started renewing CBHI memberships for second term.</p> <p>Based on the direction given by the regional government, the HSFR/HFG regional team facilitated selection of additional woredas to further expand the CBHI program. Though the numbers of woredas proposed by zones were around 50, only 30 were chosen by the regional government for additional expansion.</p>	
Facilitate CBHI scheme establishment and general assembly meeting, and operationalization of schemes' boards	<p><b>SNNP:</b> The project team participated in the General Assembly of the Damot Woyide woreda CBHI scheme. As per the CBHI directives and bylaws, participants in assembly included four representatives from each kebele sections (kebele managers, kebele administrator, two individuals nominated by community), and the heads of woredas sector offices (woreda cabinets). The woreda's CBHI board of directors presented the overall performance of the scheme to the assembly based on the evidence compiled by the scheme.</p> <p>Major issues addressed during the meeting were retaining existing members, attracting new members, distributing ID cards to members, collecting premiums, and some problems observed by service providers. Participants reviewed the status and performance of each kebele. Based on their reports, they ranked kebeles into three categories: best performers, medium performers, and poor performers. Participants also observed that some best performers previously were poor performers and vice-versa. Assembly members considered the strength and weakness of each kebele as well as the woreda scheme and jointly agreed to work together to alleviate the existing problems.</p> <p>Moreover, the general assembly also discussed points that need amending in the bylaws as per the recent decisions made by the regional CBHI Steering Committee. The assembly made decisions regarding copayments, timing of collecting contributions from paying members, and penalties for late payers. The assembly approved the revised bylaws as a guiding document for all matters related to the woredas' CBHI operations.</p>	

Y2Q4 Planned Tasks	Y2Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
Strengthen protection mechanism for the poor through waiver, CBHI, and other systems	<p><b>SNNP:</b> In Q4, advocacy on indigents' screening, certification, and provision of health care service was undertaken in seven zones and 33 woredas while supportive supervision by the project team reached ZHDs, WorHOs, and WoFEDs offices. They discussed the need for and procedures of indigent screening, certification, budget allocation, signing of agreements between budget owner and service provider, and overall service provision.</p> <p><b>Amhara:</b> The regional government approved 12 million birr for 72 woredas that have implemented or are in the process of implementing CBHI schemes to cover 70% of indigent's premium that the region is expected to cover as per the regional directive. Thirty percent was allocated by the respective woredas. All the woredas were advised by the regional government to select and certify indigents as per the regional CBHI directive, which indicates up to 5% in food secure woredas/kebeles and up to 10% in food insecure woredas/kebeles. Forty-two woredas selected indigents last year and the 30 new CBHI woredas are in the process of selecting and reporting to the region.</p>	
Increase resource mobilization for the insurance schemes	No progress this quarter.	
Enhance communication and mass media coverage on health insurance	No progress this quarter.	
Support institutionalization of transparent financial management in CBHI schemes through auditing of CBHI scheme	<p><b>Amhara:</b> The regional CBHI directive indicates that there should be at least a one auditing of schemes by responsible bodies. Proper follow-up and control of resources is mandatory to ensure proper use of resources and to protect misuse of funds. It is also critical to build accountability and community trust. Accordingly, Haik and Woreta CBHI schemes were audited while others arranged an audit with their WoFED auditors. The project provided technical support and facilitated auditing of the two CBHI schemes.</p> <p>Technical support has been given to all old and new CBHI pilot schemes to conduct auditing of their funds.</p>	
Management of exempted programs strengthened	As part of the regular supportive supervision, the project team supervised the status of exemption services provision. The team also presented findings and advocated for allocation of budget for this service by the responsible government authority.	



Y2Q4 Planned Tasks	Y2Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
<b>Activity 3: Improve governance of health services and health insurance</b>		
Conduct HF governing body training	<p><b>Gambella:</b> The HSFR/HFG conducted a two-day training on FGB members of new HFs on September 23-24, 2014.</p> <p>The training covered an introduction to HCF, components of HCF, and implementation of the reform to date. It also covered topics related to HF governance and roles and responsibilities of governing board members. Presentations were followed by discussion. The training was closed by the RHB Head who reminded participants that they are expected to improve functioning of HFs and provision of health services. He also urged participants to understand the regional legal frameworks well and strictly adhere to the law.</p> <p><b>Center:</b> Governing board training was provided for the board members of four federal specialized referral hospitals in Addis Ababa on August 28, 2014. Seventeen participants (15 male and 2 female) attended. In addition to presentations by facilitators from the project and FMOH, the HFG short-term consultant Hernan L. Fuenzalida-Puelma made a presentation on organizational arrangements, governance, accountability, service provision, and other matters that are key to the hospitals.</p>	
Organize training of trainers (TOT) on SHI legal frameworks and implementation manual	No progress this quarter.	
Recruit human resources for EHIA	No progress this quarter.	
Organize capacity-building trainings for EHIA support staff	No progress this quarter.	
Improve FGB management capacity	<p><b>Center:</b> The project drafted a system of self-assessment for hospital governing boards with a tool that helps to examine and gauge their performance and weaknesses to draw lessons for continuously improving their functioning. The tool helps the boards review their strengths identify areas that need improvement.</p>	The tool is expected to be finalized next month and will serve as national standard self-assessment tool. It will also enable hospitals to focus their work and performance assessment on their core roles and responsibilities while systematically maintaining accountability for the performance of their CEOs.
Organize networking meeting between EHIA branches	No progress this quarter.	

Y2Q4 Planned Tasks	Y2Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
Increase networking of health insurance schemes and facility boards	No progress this quarter.	
Facilitate CBHI general Assembly meeting	No progress this quarter.	
Conduct experience sharing and review meeting among CBHI schemes and with HFs, and facilitate visits to CBHI pilot woredas	No progress this quarter.	
Hold experience-sharing workshop for health providers, hospitals, and CBHI schemes	No progress this quarter.	
Support zonal-level Biannual Quarterly Review Meeting	No progress this quarter.	
Support CBHI promotion and experience sharing	<p><b>Tigray:</b> A three-day evaluative training/ review meeting was held on CBHI activities July 26-28, 2014 in Wukro town. It was organized by the RHB with help from the HSFR/HFG regional office. The objective of the meeting was to assess the status of the woreda CBHI schemes (old and new), to see the challenges and remedial measures, and to integrate future CBHI direction/ plans with EHIA. Participants totaled 37 (23 male, 14 female), drawn from the EHIA, RHB, old pilot woreda executive staff, and kebele managers. The review meeting and plan preparation was chaired by the head of the RHB.</p> <p>Topics included experience sharing and a visit to the top-performing CBHI scheme in the region, a review of CBHI concepts and directives, and overall CBHI status report, and plans for the coming year.</p>	<p>Lessons learned/next steps:</p> <ul style="list-style-type: none"> <li>• Political leader's attention is needed.</li> <li>• HIA activities should follow woreda level CBHI activities</li> <li>• Maintain high level of involvement of health bureau</li> <li>• EHIA and RHBs need to take responsibility for follow up implementation of CBHI expansion woredas.</li> </ul>
Facilitate woreda-level CBHI review meeting	<p><b>Tigray:</b> A one-day review meeting of the Tahtay-Adiabo woreda CBHI scheme was held in Sheraro town on July 7, 2014, to assess the progress of the scheme, see the challenges, and put in place remedial measures. The total participants were 88 (70 male, 17 female) drawn from zonal and woreda administrations, each kebele leader, WorHO, woreda CBHI schemes, and Sheraro town hospital and HC directors. Low enrollment and renewal rates, delay in HF reimbursement for services they provide to CBHI beneficiaries, and poor health services, especially lack of essential drugs, were identified as challenges. It was agreed that the woreda administration and health office would do serious and regular follow-up to support kebele and</p>	

Y2Q4 Planned Tasks	Y2Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
	HF levels.	
Support biannual providers forum	No progress this quarter.	
Organize regional experience-sharing and networking workshop and facilitate graduation of best model HCs	No progress this quarter.	
Improve capacity of EHIA	<p><b>Central:</b> The project embedded key technical and communication experts who are supporting the EHIA in its day-to-day operation. Major support provided in Q4 includes:</p> <ul style="list-style-type: none"> <li>• Preparation of funding proposals to be submitted to potential funders to the agency and the health insurance program, such as IrishAid.</li> <li>• Preparation of a document that will be used to show the finance gap of the EHIA to the FMOH for financing from the MDG pool fund.</li> <li>• Development of a proposal to the African Development Bank that will be used by the EHIA to solicit bank financing for the procurement of key fixed assets.</li> <li>• Support in the preparation of the Health Insurance Bulletin Draft Editorial Policy and its presentation for approval to the EHIA management committee.</li> <li>• Preparation of 2007 EFY program budget and detailed action plan of the agency to be submitted to MoFED.</li> <li>• Support to the EHIA in aligning its plan with plans of other institutions that are accountable to the FMOH.</li> <li>• Support in the development of terms of reference for the BSC training and preparatory work for undertaking the training such as budget estimation, and liaising with Ethiopian Management Institute at Debrezeit.</li> <li>• Technical support to EHIA during the preparation of periodic reports including consolidated annual performance report to be submitted to the Parliament, MOFED, FMOH, and Board.</li> </ul> <p><b>Tigray:</b> HSFR/HFG in collaboration with the EHIA branch offices conducted two two-day trainings, in Axum and Mekelle branch offices. The training was critical to bring on board the EHIA staff and to develop their capacity and understanding of CBHI activities. The event was also critical to build common understanding of the collaboration between the project team and the branch office staff. Total participants were 47 (20 men and 27 women); 26 and 21 participants were drawn from Axum and Mekelle branch offices, respectively. The training in Axum was held on July 12-13, and in Mekelle on July 15-16, 2014.</p>	Follow-up: EHIA staff recognized that their role in continuing to provide support for CBHI implementation, but with a limited budget, money must be allocated from different sources for the CBHI operational activities the EHIA carries out.
Recruit health insurance technical advisor, communication	No progress this quarter.	

Y2Q4 Planned Tasks	Y2Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
advisor, communication specialists, membership affairs specialist, providers' affairs specialist, and finance specialists		
Sensitize relevant stakeholders on health insurance	No progress this quarter.	
Build capacity of CBHI schemes	<b>Central:</b> The project developed a TOR for developing a medical audit manual and it developed the zero-draft clinical audit manual which is intended to guide CBHI schemes in performing clinical audits to monitor the quality of services provided by HFs that entered into contractual agreement and ensure the provision of services has been justified given the standards and the terms of the contract agreements. The draft manual will be finalized in the coming month by incorporating inputs from relevant personnel – regional health insurance specialists, health professionals working at scheme offices, and technical staff of EHIA. The TOR for the development of the medical audit manual was submitted to the EHIA for review and endorsement.	
Provide technical support on expansion and scale-up of CBHI program	<ul style="list-style-type: none"> <li>• Ethiopia pilot tested CBHI schemes in 13 districts (in four regions). The schemes were evaluated recently and the evaluation report is being finalized. The country is expanding the CBHI initiative to 161 additional districts in the four regions; Amhara Region decided to establish an additional 30 woredas. In addition to providing technical support in the pilot and expansion CBHI woredas, HFG/HSFR is supporting the EHIA and FMOH in developing a comprehensive CBHI scale-up strategy. However, the overall health insurance experience is limited and the project is mobilizing technical assistance to support the effort.</li> <li>• Deployed medium-term CBHI technical advisor: The project deployed one CBHI technical advisor who has similar experience in the region to support the operationalization of expansion and scale-up process. The duration of the assignment is one year.</li> <li>• Short-term technical assistance: The project also had a TDYer to provide capacity-building support (September 13-25) as well as facilitate brainstorming and initial preparatory work for development of the CBHI Scale-Up Strategy. The expert made a presentation, undertook a field visit to one CBHI scheme, and facilitated discussion and brainstorming on next steps and timelines.</li> </ul>	

Y2Q4 Planned Tasks	Y2Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
<b>Activity 4: Improve program learning</b>		
Improve availability of evidence for decision making including routine and beneficiary data	<p><b>SNNP:</b> The backlog routine data from the pilot and control woredas of the region have been collected. The objective of routine data collection is to see the overall performance of the CBHI activities in each woreda and make decisions based on the actual data collected</p> <p><b>Tigray:</b> HSFR/HFG staff have started to review the backlog of beneficiary data in the three original pilot woredas.</p> <p><b>Oromia:</b> The project team conducted supportive supervision in 10 of the 59 CBHI expansion woredas that established the schemes after fulfilling the minimum requirements in the regional CBHI Directive for scheme launch. These woredas were selected purposively so that preparatory activities required for health service provision are identified and necessary actions taken on observed gaps. The supervision was conducted July 30-August 18, 2014, using the CBHI performance assessment checklist. The findings are summarized below:</p> <p><b>Human resources, availability of office and supplies:</b> According to the approved staffing structure of Oromia Region, each woreda CBHI scheme is expected to have three staff: CBHI coordinator, Accountant, and IT/ M&amp;E. The status of staffing in the visited 10 CBHI expansion woredas is 1) all 10 have hired CBHI coordinator and accountant, eight hired the IT person: 69% of hired staff attended CBHI training and half of them have office space within WorHOs.</p> <p><b>Member registration and ID card distribution:</b> All the visited woredas started member's registration and premium collection in all of their respective kebeles and finalized selection of indigents. The highest enrollment rate out of the eligible members is 26% and lowest is 19%; ID card distribution started only in two woredas.</p> <p><b>FAMS:</b> All visited expansion schemes have opened an account at Commercial Bank of Ethiopia; they have started depositing premium collections into their accounts and the targeted subsidy is transferred into the accounts.</p> <p><b>Database management:</b> The supervision revealed that the schemes do not have a well-established database for beneficiaries and contributions. Consequently, progress is not updated and the total number of beneficiaries is not known promptly. Adea, Siraro, and Aleltu woredas are performing better in establishing a database for beneficiaries; a database for premiums was established only in Adea woreda of East Shewa Zone.</p> <p><b>Contracts with health care providers:</b> In all visited woredas, HCs and hospitals to provide health care services for CBHI beneficiaries are identified. But contract agreements were signed only with selected HCs in Dera and Hidhabu Abote woredas. Service provision started at only one HC in Hidhabu Abote woreda.</p>	<p>Challenges in reviewing backlogged data include limited budget and document safety/privacy.</p> <p>In the majority of schemes, organizing updated family members' data is becoming a challenge. Apart from its complexity getting clear data from kebeles, lack of stationery and computers to document files impeded CBHI data management. The regional team strived to get a better data and data management technic through field supportive supervision. This challenge will continue since CBHI data are dynamic and change from day to day and there is no separate responsible body at the kebele level.</p> <p><b>Main Gaps Identified:</b></p> <ul style="list-style-type: none"> <li>• Shortage of office equipment and supplies including computer, printer, filing cabinet, box files and other consumable office supplies;</li> <li>• Majority of kebeles didn't return member application forms and second copy of receipt vouchers which also caused poor data management at scheme level;</li> <li>• Most woredas didn't distribute ID card to members;</li> <li>• Budget allocated for targeted subsidy couldn't finance the selected indigents in all visited woredas; On average, 21% of the premium collected from paying members was not deposited into schemes' bank accounts;</li> </ul>

Y2Q4 Planned Tasks	Y2Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
	<p><b>Oromia:</b> In Oromia, the project team conducted supportive supervision in three pilot CBHI woredas. The report here covered supervision data on September 14-24. Supportive supervision was conducted in Gimbichu, Deder and Limmu Kosa woredas. Major findings are:</p> <ul style="list-style-type: none"> <li>• In Limmu Kosa, the accountant is seconded and hardly engaged in CBHI/ FAMS activities</li> <li>• In Deder, 4296 members did not receive CBHI ID cards. Similarly, in Limmu Kosa and Gimbichu, 1,422 and 3,141 members had not yet received ID cards.</li> <li>• Indigents are selected in all three woredas (Deder=5157, Gimbichu=2195, and Limmu Kosa=925) and the targeted subsidy was transferred to their bank accounts.</li> <li>• Membership renewal for EFY 2006 at Limmu Kosa is 20% of existing members 93% in Gimbichu and 4% in Deder.</li> <li>• Deder and Limmu Kosa woredas schemes did not fully receive the second copy of the receipt voucher from kebele sections with completed member's registration formats. In most cases, the kebele sections only submit bank deposit slips to the schemes.</li> <li>• The audit process was interrupted in all the three woredas as respective kebeles failed to return used pads of receipt vouchers to the schemes.</li> <li>• At Limmu Kosa, the remaining bank balance as of September 24, 2014 is only 122,067.69 ETB. This bank reserve looks very low to cover even reimbursement claim for one quarter.</li> <li>• The paid stamp used for renewal at the kebele level is easily available elsewhere and needs to be replaced to avoid cheating.</li> </ul> <p><b>SNNP:</b> Supportive supervision was undertaken in pilot CBHI schemes Damboya, Damot Woyide and Yirgalem, and selected HFs and kebele sections in those woredas and town administration by deploying two teams August 25-30, 2014 and September 2-5, 2014. The following are highlights of the findings from the supervision visits:</p> <p><b>Human resource and organizational structure:</b> The turnover of IT officers has been frequent and at the Damot Woyide scheme remained vacant for a long time due to shortage of professionals who can fulfill the position requirements of the Regional Civil Service. In this case, discussion with woreda administration and the project office brought the case to the attention of higher officials of the regional government to ensure speedy recruitment and placement. This has made it difficult to clear the backlog data in woreda. The other two woredas have filled the positions and are doing data entry in the computer. The remaining two CBHI scheme positions are filled and staff are equipped with the required skills and are running the schemes.</p>	<ul style="list-style-type: none"> <li>• Most of the schemes did not prepare transaction register and ledger as per FAMS Manual</li> <li>• CBHI database was not established in Dera, Jibat and Digelu Tijo woredas;</li> <li>• Health service provision to CBHI members was not initiated in 43 (83%) HFs;</li> <li>• Limited follow-up of CBHI activities from woreda administrations and health offices;</li> <li>• The collected premium was not fully deposited into CBHI bank account in all the woredas. At Gindeberet 48% (154,338.00) and at Siraro 24% (271,944.00) ETB is still at the hands of kebele cabinet.</li> <li>• In all woredas, the budget allocated for targeted subsidy was not sufficient to finance the targeted indigents.</li> <li>• The highest budget deficit of 36%, 35%, and 34% targeted subsidy are respectively in Dera, Siraro, and Digelu Tijo woredas. Dera Woreda Administration did not allocate budget for indigents.</li> <li>• In Adea woreda, the selected indigents are covered, the proportion of the woreda budget was not as per the 70/30 rule.</li> <li>• About 1648, 1616, and 1162 indigent households respectively in Dera, Siraro, and Digelu Tijo woredas remain unfinanced unless additional budget is allocated.</li> </ul>

Y2Q4 Planned Tasks	Y2Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
	<p><b>Member registration:</b> Membership enrollment in Yirgalem remained strong; in Damboya and Damot Woyde it is less than expected. The supervision teams contacted the respective woreda administrations and provided feedback. The project team has also continued follow-up with the schemes and woreda administrations.</p> <p><b>Premium collection:</b> The performance of the schemes reviewed during the quarter in the supportive supervision was unsatisfactory in Damot Woyde and Damboya.</p> <p><b>Data management:</b> None of the schemes have fully updated their health service utilization and the overall data management remained a challenge partly because of high staff turnover and the vacant IT officer post in Damot Woyde and late recruitment in the remaining two schemes. To give a lasting solution for the problem, the project office is currently extending technical and financial assistance to the schemes.</p> <p><b>FAMS:</b> Although there were improvements in handling financial transactions, some weaknesses were observed including handling financial transactions and producing appropriate financial statements. Noting weaknesses, the supervision team provided on-the-spot technical support to the accountants on improving financial management of the schemes.</p> <p><b>Follow-up on health service providers and reimbursement:</b> Two challenges related to services provision and reimbursement were observed. First, failure of Omo microfinance to issue appropriate supportive documents such as credit advice/receipts of deposit, and delay in the part of HFs submitting service utilization and reimbursement requested for services rendered to CBHI schemes were the major challenges. The second is failure of Yirgalem scheme to reimburse HFs for services rendered to beneficiaries.</p>	
Facilitate timely appropriation of retained revenue	<p><b>Benishangul-Gumuz:</b> Technical support was given to zones, woredas, and HFs on how to compile and submit a retained revenue plan for appropriation. Accordingly, all HCs and hospitals in the region submitted their RRU plan, Birr 23,479,705, to regional finance bureau for appropriation. The requested amount was appropriated by the regional council and disseminated to zones, woredas, HCs, and hospitals for use.</p> <p><b>Amhara:</b> Technical support was provided to zones, woredas, and HFs on how to compile and submit a retained revenue plan. Accordingly, all HCs and hospitals in the region that are implementing HCF reform submitted their RRU plan/budget for the current EFY. A total of Birr 204,941,432 draft budget from 777 HCs and Birr 102,590,004 from 18 hospitals were presented to the regional finance bureau for appropriation. The requested amounts were appropriated by the regional council and appropriation communicated to zones, woredas, HCs, and hospitals facilities for budget execution.</p>	



Y2Q4 Planned Tasks	Y2Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
Produce and finalize NHA reports	<b>Central:</b> Following the dissemination of NHA V findings two additional reports were produced: a PLHIV Services Utilization and Expenditure Survey and a policy brief on the survey. The HSFR/HFG office also printed and distributed additional copies of the NHA V report. Based on the NHA V report a background paper on the NHA institutionalization plan was drafted and circulated among the team for review.	
Support the development of a comprehensive HCF legal framework for federal referral and teaching hospitals	<b>Central:</b> HSFR/HFG deployed one international consultant on hospital governance and management. The consultant made his first TDY in Ethiopia during which he visited teaching and referral hospitals, met with relevant people in the project and FMOH to better understand the country context for making recommendations on the organizational arrangement, governance, supervisory, accountability and functional relations. The consultant also gave a presentation to board members of four federal hospitals.	Another trip has been planned for the consultant to continue to develop the framework, which is being done in conjunction with the local team and stakeholders.
Support the revision of HSDA directives, RRU guidelines, and HCF manual	No progress this quarter.	
Advocate for incorporation of major HCF performance indicators into the integrated checklist	No progress this quarter.	
Conduct regular supportive supervision in HFs	<p><b>Benishangul-Gumuz:</b> The project is providing technical support to the RHB and ZHDs to collect data on HCF reform implementation status as of end of the last EFY. The data collection format on major indicators was revised, and discussed and agreed with the RHB. The form was circulated to the three ZHDs and one special WorHO for collection of the required data. The project has been following up with the ZHDs and WorHOs to clarify the format as well as requesting for submission of the collected/compiled data on time. As a result, data from seven HFs have been submitted to the project satellite office in the region and the remaining facilities are expected to finalize and submit to the office soon.</p> <p><b>Amhara:</b> Based on the lesson learned last year, this year, the regional team outlined a data collection format on key HCF indicators, discussed and agreed it with RHB, and the RHB issued a letter to zones, woredas, and hospitals to provide the required HCF data for the past fiscal year. In Q4, the project team received full data from four zones and one city administration: East Gojjam, North Wollo, South Gondar, South Wollo, Bahir Dar. The data will be compiled and its findings will be shared with the RHB and other key governmental counterparts for future planning and action.</p> <p>The HSFR/HFG regional team compiled and analyzed the synthesis report of supportive supervision conducted in the</p>	<p>Follow-up steps from meetings with FMOH/ Medical Services Directorate (Center):</p> <ul style="list-style-type: none"> <li>• The status of implementation and effectiveness will be carried out by using the same tool used to evaluate the baseline status of EHRIG and key performance indicators.</li> <li>• Regular integrated supportive supervision, key performance indicators, and review meetings will be used to evaluate the performance of the hospitals and project implementation.</li> <li>• Physician engagement and restructuring the organizational structure is a must.</li> <li>• FGBs need refinement and strong mentorship as they are either nonfunctional or lack critical skills for strategic management.</li> </ul>

Y2Q4 Planned Tasks	Y2Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
	<p>region in the last EFY. HCF implementation status was identified and major findings were shared with the RHB, ZHDs, WorHOs, and other officials, and the team also presented findings at the Regional Annual Health Sector Review Meeting.</p> <p><b>Oromia:</b> A total of 49 randomly selected HCs from six zones received supportive supervision in the reporting quarters. The supervision was carried out in collaboration with experts from the respective ZHD and ZoFEDs.</p> <p>The supervision process is that HCs are assessed using the checklist, then discussion is held with and technical advice is provided to the HCs heads and finance staff. Then, findings/feedback of the supervision and outstanding issues are discussed with the respective WorHO, WoFED, and Woreda Administration Office.</p> <p>The following are highlights of the supervision findings:</p> <p><b>RRU:</b> Very few HCs (54%) have secured appropriation of their current FY RRU plan/budget by their respective woreda councils. This is due to late budget appropriation at the woreda level, and some woredas hadn't appropriated woreda-level budget for the entire sectors at the time of the supervision.</p> <p><b>Gambella:</b> The Gambella Cluster Office conducted the regular supportive supervision August 24-30, 2014 in five HFs: Kuergeng, Badhiel, Itang, and Gambella HCs and Gambella Hospital.</p> <p><b>HR/PFPA staff:</b> Out of all the visited HFs, three (Gambella Hospital, and Itang and Kuergeng HC) had good number of PFPA staff. In Gambella, HC PFPA staff are not sufficient to do the work effectively. In Badhiel HC, there was no finance staff, and the RR was being collected by health professionals.</p> <p><b>HF governance:</b> All visited HFs have established a governing board and they were functioning during the visit but Kuergeng and Badhiel HCs said the board did not meet during Q4. Itang and Gambella HCs, and Gambella Hospital reported that their boards usually meet according to schedule (some twice a month and some quarterly).</p> <p><b>Revenue retention:</b> All five HFs started revenue retention during the supervision as per the HCF directive. They retain their revenue in special "A" accounts at the Commercial Bank of Ethiopia. Among the visited HFs, only two have safe deposit boxes; the others mentioned their intention to purchase one soon. Badhiel HC, one among the visited HCs, faces a lot of challenge concerning the PFPA staff and frequent turnover of the HC head, which produces a lack of know-how in planning and using available financial resources. The representative blames the HC board for lack of seriousness in leading the HC and failure to attend board meeting as it is the way forward to solve some minor issues.</p> <p><b>Revenue utilization:</b> The visited HCs are in the process of using their revenue as per the appropriation by the respective woreda councils with the exception of Badiel HC.</p>	<ul style="list-style-type: none"> <li>• Oromia challenges identified in SS: <ul style="list-style-type: none"> <li>• Consumable office supplies</li> <li>• Majority of the kebeles didn't return member application forms and the second copy of receipt vouchers, causing poor data management at scheme level;</li> <li>• Most woredas didn't distribute ID cards to members;</li> <li>• Budget allocated for targeted subsidy couldn't finance the selected indigents in all vested woredas</li> </ul> </li> </ul>

Y2Q4 Planned Tasks	Y2Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
	<p><b>Fee waiver and exempted service:</b> Among the visited HCs, only in Kuergeng and Gambella provided details of their fee waiver beneficiary service. HFs state lack of beneficiary attendance and they are claiming lack of reimbursement from woreda administration. Exempted services are free but Gambella Hospital didn't post this information on the wall while other HFs have posted in all OP waiting areas.</p> <p><b>SNNP:</b> In Q4, the SNNP HCF team conducted supportive supervision at 59 HFs in seven zones in collaboration with the ZHD, WorHOs, and WoFED. During supportive supervision, progress in implementation of all HCF reform components including the status of staffing of the PFP unit, the establishment and operation of FGBs, the procedure as per the directive and implementation status of RRU, the implementation level of fee waiver system and exempted services, and the situation and procedures of user fee setting and revision were assessed using the comprehensive supportive supervision checklist. Below are highlights of the findings and feedback:</p> <p>Of the covered HFs visited, only 14 (23.7%) FGBs met only once in 2006 EFY and more than 54% got support from FGBs only once or twice. The authority to approve the set and revised health service prices is given to FGBs of the respective HFs. Out of the 59 supported HFs in the first quarter of 2007 EFY, about 65.5% of them revised and /or set user fees and used the new price without the knowledge and approval of FGBs. The remaining 30.5% of the HFs have either not set or received FGB approval of revised user fees.</p> <p><b>Status of human resource in HF PFP positions:</b> Each HC is expected to have six PFP staff and one or two auditors based on the HF civil service staffing structure. Type A or Level-I HCs, which provide a broader range of health services, are expected to have two auditors. Over 53% of the HFs visited have three or fewer PFP staff, and only 47.5% have four and more PFP staff. This implies that the majority of HCs do not have sufficient PFP staff to accomplish tasks related to financial recording, procurement issues, and property administration that are crucial for HCF reform implementation.</p> <p><b>Implementation status of FGBs:</b> In the HSDA directive, FGBs are expected to monitor the performance of HFs and provide corrective guidance whenever problems are observed based on data from HFs' quarterly reports, quarterly, on site spot checking and feedback from the public. Among the HFs covered in the quarterly supportive supervision, only 14 (23.7%) HC FGBs met once in the last Ethiopia fiscal year, and more than 54% got support from FGBs only once or twice.</p> <p><b>RRU:</b> RRU is one of the fundamental components of the HCF reform that has been contributing for improving quality and access to health care. All the 59 (100%) HCs reported that they are implementing RRU.</p> <p><b>Revenue retention:</b> Fifty-six (95%) started revenue retention and opened type 'A' bank accounts in the Commercial Bank of</p>	

Y2Q4 Planned Tasks	Y2Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
	<p>Ethiopia and they are depositing their revenue in the account; three (5%) HCs (Koter, Mehal Amba, and Bole in Silte and Guraghe zones) opened accounts in microfinance institutions. Forty (68%) of the visited HFs have safe deposit boxes but 19 (32%) do not. Forty (68%) use functional safe boxes to keep a limited amount of money to finance their petty expenses. Though HCs are expected not to keep cash of more than Birr 5,000 without knowledge or approval of their boards, five (8%) had more than Birr 20,000. Of all 59 HCs visited, 53 that had good record keeping collected a total revenue of Birr 12.85 million and an average retention of Birr 242,623 per HC. In all HCs, the sale of drug and medical supplies were the major source of retained revenues followed by consultations and other medical services.</p> <p><b>Revenue utilization:</b> Fifty-six (95%) of the supervised HCs have already started utilizing their retained revenues. Forty-five that had the required data on average had Birr 291,030 budget appropriated by the responsible authorities from the retained revenues. In terms of actual use of retained revenue, 20 (34%) HCs used more than the amount appropriated by the budget authorities, which is against the finance regulation and directive. The problem was mainly observed in Guraghe and Silte zones. Three (5%) HCs (Zigiti Bakula, Dombe, and Genta Bonke in Gamgofa zone) did not start utilizing their retained revenues mainly due to absence of financial officers to process use as well as inadequate support from the governing body.</p> <p><b>The fee waiver and exempted health services:</b> In SNNP, the fee waiver system is not being implemented uniformly. Of the supervised 59 HCs, 43(73%) were implementing the fee waiver system in both the new and traditional way. Of those implementing fee waivers, 38 (88%) were providing the service without getting the lists of the screened catchment households from the respective woreda and town administrations. Only, 31(72%) of the HCs were providing the service through a contractual agreement with their respective woreda/town administrations. Even among those that entered into a contract, 12% did not submit reimbursement requests to the respective woreda/town administration in a timely manner (quarterly). Of the 59 visited HCs, 16 (27%) HCs were not completely providing the fee waiver service to the poor.</p> <p><b>Implementation status of user fee setting and revision:</b> The SNNP HCF legal framework allows HFs to set new user fees as well as to revise user fees with due consideration of both cost of service provision and willingness and ability to pay their catchment population. Once the HFs take into account all the necessary considerations, they can submit their proposal of revised fees for further review and approval by their respective board. Out of the 59 visited HFs, about 65.5% of them either revised and/or set user fees in the last Ethiopian fiscal year. The remaining 30.5% did not report either fee setting or revision of user fees in the same fiscal year.</p> <p>In summary, the supervision was used to provide on-the-spot</p>	

Y2Q4 Planned Tasks	Y2Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
	<p>feedback and technical support to the visited HFs. In addition, feedback was given to the respective health authorities and administrators, and the evidence will also be used in continuous consultations and advocacy undertakings.</p> <p><b>Amhara:</b> Supportive supervision was conducted in 50 HCs in 20 woredas together with zonal curative health officers using the checklist. On-the-spot feedback was given to each HF. Below are highlights of the findings and feedback:</p> <p><b>RRU:</b> All HFs visited have a detailed RRU budget appropriated and have started utilization. They used retained revenue mostly for procurement of essential drugs, medical equipment, and improved infrastructure. All HFs submit monthly financial reports to WoFED office.</p> <p><b>HF governance:</b> All but five HFs visited (90%) have a functional FGB that is conducting monthly meetings. Of these, 38% of FGBs arranged a community interface program and conducted discussion with the community on how health services are delivered, improvements observed, challenges, and overall community satisfaction with service provision.</p> <p><b>Fee waiver system:</b> The new system was fully implemented in 82% of HCs and 100% of woredas visited. Beneficiaries were getting health services based on agreements entered with woreda administration. Ninety-eight percent of reimbursements to HCs were done on a fee-for-service basis, 2% on the fixed rate payment /capitation mechanism.</p> <p>Exempted health services were provided free of charge and the type of exempted health services were posted in different places in all HCs covered through supportive supervision.</p> <p><b>Addis Ababa:</b> Regular project quarterly supportive supervision was conducted in Ras Desta Hospital and six HCs (Hiwot Amba, Mikililand, Gotera Masalecha, Kolfe, woreda 9, Ras Emiru, and Kebena).</p>	
Support/Participate in integrated supportive supervision (ISS) of the FMOH, RHBs and ZHDs	<p><b>Center:</b> HSFR/HFG central team participated in ISS organized by the FMOH Medical Service Directorate conducted ISS in four federal hospitals (ALERT, St. Paul, St. Peter, and Amanuel). Leadership and governance, financial management, facility management, human resources, and auditing were the focus of this extensive ISS.</p> <p><b>Oromia:</b> The regional project team has participated in the ISS organized by the RHB to visit hospitals in the month of July in collaboration with the relevant partners; i.e., HSFR/HFG and CHAI. A total of eight hospitals (Begi, Gimbi, Nedjo, Shambu, Gidda, Ayana, Dembi Dolo, and Gedo) were visited. The objective of the supervision was to monitor hospital progress in implementation of major health reforms such as the HCF, BPR, BSC, and EHRIG.</p> <p>The supervision team held meetings and discussions with Senior Management Teams and CEOs of the hospitals to review performance. Performance was also assessed using semi-structured questionnaires and performance verification tools.</p>	

Y2Q4 Planned Tasks	Y2Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
	<p>Major findings of the ISS with regard to HCF reform:</p> <ul style="list-style-type: none"> <li>• In all visited hospitals, a governing board was established as per EHRIG standard and community members are well represented.</li> <li>• All of the visited hospitals' governing boards except Gedo's are carrying out regular meetings as per the standard and the plan.</li> <li>• Hospital governing boards except Nekemte Hospital, didn't regularly evaluate the quarterly performance of their hospital and didn't regularly conduct internal supervision.</li> <li>• None of the hospitals conducted internal and external financial audits at least once in the last fiscal year.</li> <li>• None of the hospitals prepared their annual procurement plan.</li> </ul> <p>Following the finalization of each supervision, feedback was given to the senior hospital management team. Then, the supervision team analyzed the data and used it to rank the sample hospitals according to their performance: top, medium, and low-level performance. The team compiled and submitted the report to the senior management team of the RHB. The RHB in turn used the report as an input in the overall regional-level hospital performance review meeting conducted in Batu Town on Sept 19-22, 2014. The objective of this meeting was to discuss the findings of the ISS report, share best experiences among participants, and create a common understanding on how to address observed gaps.</p> <p><b>Addis Ababa:</b> The RHB in collaboration with partners conducted ISS to assess and support the different HF service areas (Leadership and governance, HCF, Emergency, OPD, Laboratory, Pharmacy, etc.). Integrated supportive supervisions visits were conducted in 3 hospitals (Ras Desta, Yekatite 12 Medical and Minilik II Hospitals) and 8 HCs (Mikililand, Kolfe, Kolfe Woreda 9, Hiwot Amba, Toter, Ras Emiru, Arada, Kebena, Feres Meda, and Gotera Masalecha). The supervisory team reviewed HF performance in all areas, and gave feedback with recommendations for improvement with HF heads.</p>	
Provide support for and participate in the RHB annual and bi-annual review meeting	<p><b>SNNP:</b> The Regional Team participated in the RHB's annual review meeting and partners' forum.</p> <p>One project staff participated in Guraghe zone's health sector annual performance review meeting.</p> <p>A project representative also participated in a two-day (August 22-23) Kembata-Tembaro Zonal Health Sector Review Meeting. The participants from the government included heads the zonal sector departments (Zonal Cabinet Members), woreda administrators, WorHO heads, and case team leaders, and heads of all hospitals and HCs in the zone.</p> <p>Participants discussed CBHI's role in the enhancement of the community's health service seeking behavior and its positive impact on HF revenue generation and quality of service provision. In view of this, participants agreed to renew their</p>	



Y2Q4 Planned Tasks	Y2Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
	<p>commitment to provide the necessary leadership and support and to coordinate their effort for CBHI implementation. HSFR/HFG representatives contributed to the discussion.</p> <p><b>Amhara:</b> Project staff participated in the RHB annual review meeting held in Debre Birhan town August 25-29, 2014. More than 300 participants attended the meeting from the FMOH, region, zones, woredas, HFs, and partners. Performance of HCFR and CBHI implementation status was included in the RHB and ZHD reports. Discussions and clarification were made and directions were proposed to pay more attention to the reform implementation so that health service delivery could be accessible, equitable, quality, efficient, and sustainable. The EFY 2007 (2014/15) RHB plan was also presented; it named HCF and CBHI activities as priorities in the year.</p> <p><b>Afar:</b> The regional health sector annual review and regional hospitals review meetings were held at Asaiyita hospital August 4-5, 2014. The hospital review meeting is conducted on a quarterly basis to assess hospital performance against the EHRIG standards and to facilitate best practice sharing among the hospitals in the region. All hospitals except Kelewan attended the meeting.</p> <p>Grouped into two, the participants (hospital CEOs and medical directors, RHB process heads and officers, and representatives from partners) visited the hosting hospital focusing on implementation of the reform. Participants identified the major strengths and areas of improvements, which the groups later presented to the plenary. Subsequently, a representative of each hospital presented their progress report on major Key Performance Indicators, which include governance and leadership and RRU. At the end of the meeting, key lessons learned were highlighted and suggestions made to improve implementation of reforms and performance of hospitals.</p>	
Conduct supportive supervision at scheme and section levels	No progress this quarter.	
Conduct Assessment on the Progress of CBHI Implementation in Expansion woredas of Oromia	<p><b>Oromia:</b> Readiness of HFs to provide all health services covered in the benefit package with acceptable quality is a prerequisite proper functioning of CBHI schemes. In view of this, HFs capacity assessment was conducted in 52 HCs in the 10 expansion woredas that have established CBHI schemes. The assessment was done along with the CBHI scheme supportive supervision to maintain efficiency. The respective zone CBHI scheme staff (the coordinator in most of the cases) were involved in the process. The assessment was made using the HF capacity assessment checklist to capture basic data related to HF human resources; availability of essential medical equipment/instruments; availability of essential drugs or drug stock out tracer; performance in terms of HCF reform implementation especially with regard to the functioning of the</p>	<p><b>Common observations in the visited HFs:</b></p> <ul style="list-style-type: none"> <li>• Shortage of human resources; especially HO, BSc Nurse, laboratory, pharmacy, HMIS, and finance personnel.</li> <li>• Unfair distribution of health professions among HCs within a given woreda itself. For example, in Siraro woreda there are 2 HOs and 4 BSc Nurses in Senbete Sinqeale HC whereas none of these staff are available at Shasha HC.</li> </ul>



Y2Q4 Planned Tasks	Y2Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
	governing board and internal revenue collection and utilization. A report of the assessment findings was shared with the RHB for feedback and decision making. The overall impression is that these HCs can improve their service delivery if RHB and the management of the respective HCs pay due attention to address the observed gaps.	<ul style="list-style-type: none"> <li>There was poor handling of medical equipment/ logistics management in most of the visited HFs. In some HFs, Plumpy nut, medical equipment, and drugs (including expired ones) were stored together.</li> <li>Some of the visited HCs lack room/ adequate space to deliver services.</li> <li>Absence of electric power supply, in 24 of the HCs and, absence of clean water supply in 10 was a huge bottleneck.</li> <li>Neatness was a problem in some HCs such as Shala Bila, Guji, Tijo, and Racho.</li> </ul>
Support annual review meetings in existing CBHI pilot woredas	<b>SNNP:</b> The project facilitated a one-day meeting of the Regional Steering Committee. The committee thoroughly reviewed the performance of the 3 CBHI pilot schemes. Overall, the performance was applauded, but some weaknesses were also noticed. The review noted failure of some woredas/kebeles to live up to the expectation of the regional government in areas of premium collection, service delivery, data management, etc. In this regard, the committee has sent a clear and unequivocal message to all concerned operators to rectify such problems in the forthcoming period as failure to do so will have far-reaching negative repercussions on the overall success of the CBHI in the region. The steering committee passed resolutions to amend the directive for all 50 schemes. Overall, participants at the meeting unanimously agreed to make a better effort and follow a coordinated and integrated approach to realize the full-scale implementation of CBHI in the region.	
Conduct evaluation of CBHI pilot in 13 woredas	The CBHI evaluation team submitted a revised version of the report that addressed comments from HSFR/HFG country team and technical back stoppers. Final comments were given by the project, and the project team had a technical discussion with the team leader of the evaluation team; the report is being finalized based on the final comments.	<p>The final version of the report is expected to be submitted early next quarter and the project team is already discussing dissemination.</p> <p>The report will be submitted to FMOH, EHIA, and other stakeholders. The report findings and recommendations will be extensively used for the CBHI scale-up strategy and other policy discussions and decisions.</p>
Update policy and strategy documents and success stories and improve documentation	<b>Benishangul Gumuz:</b> The project participated in woreda plan preparation held in Assosa in July. During the exercise, we supported woredas in planning HCF activities. Several HCs started HCF reform in the budget year and all necessary budget proposals were made during the planning process.	

Y2Q4 Planned Tasks	Y2Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
	<p>The project team also compiled the detailed HCF annual report of activities in the EFY 2006. Major findings of the data collected on HCF implementation status in EFY 2005 (2012/13), major findings of EFY 2006 (2013/14) supportive supervision at the HF level were included in the report.</p> <p><b>Amhara:</b> The overall HCF reform annual implementation report was compiled. Major activities performed during the just-ended budget year were included with all relevant information. Findings of data collected through supportive supervision on performance of HCF implementation and its major findings were highlighted in the report.</p> <p><b>Central:</b> An abstract was prepared and submitted to the Ethiopia Economic Association's Annual Conference on the Ethiopian Economy. The project prepared a success story summarizing the FMOH's use of NHA findings to advocate for more domestic resources for the health sector and the HIV/AIDS response.</p>	
Establish efficient M&E systems: support/provide training for CBHI executive organs including CBHI M&E	<p><b>Amhara:</b> Organization of CBHI schemes in Amhara region showed that well-organized preparatory work is needed; lack of kick off training for key implementers was a major need. Day-long training on ABCs of CBHI and the details of regional directive was organized for kebele (manager and administrator) and woreda cabinet members, HC heads, and religious leaders in their woreda capitals. The training also presented lessons learned from earlier implementing woredas. Each training was adjourned after discussion and conclusion of the participants on whether they are able to do the initiative or not and unequivocally all woredas agreed and showed their strong commitment to implement the plan.</p>	
Provide technical support to CBHI schemes on their financial management and closing of accounts	<p><b>Amhara:</b> Technical support was given to 22 CBHI schemes to close their accounts so that they would give proper financial report to concerned bodies. Six schemes closed their EFY 2005 accounts and 12 schemes closed their EFY 2006 accounts. These CBHI woredas' accounts are ready for auditing.</p>	
Use mass media and conduct HCF and HI communication and promotion	<p><b>Central:</b> Through its seconded communication staff, the project contributed articles for publication in the EHIA Bulletin on topics covering the background of insurance, concepts of insurance, Ethiopian practice with CBHI, and preparatory activities on SHI.</p>	
Conduct CBHI awareness raising using mass media	<p><b>Central:</b> EHIA-seconded staff coordinated the "Betoch Sitcom" script writing and for final editing and production for broadcasting on EBC focusing on insurance.</p>	

Y2Q4 Planned Tasks	Y2Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
<b>Sub-Activity:</b> Conduct study on performance of HF governing boards.		
Collect data	In the reporting quarter, collected data were fully transcribed and translated.	
Do data analysis and report writing	All qualitative data are being encoded into the Nvivo tool. So far, qualitative data from Oromia region are fully encoded and preliminary results are being generated. In fact, some of the preliminary findings were used for the Health Facility Committee/Governance Board panel in the Global Health Systems Research Symposium held in Cape Town. Encoding of the remaining qualitative data is progressing well and the draft report will be finalized based on analysis of complete qualitative and quantitative data.	
Validate data and disseminate finding	Future milestone.	
<b>Activity 5:</b> Field office program operation and HFG home office support		
Produce publications/reports	<b>Amhara:</b> CBHI working documents/directive and FAMS/ were printed in this quarter and distributed to woredas. A total of 1000 FAMS, 1000 bylaw were printed and distributed. <b>Central:</b> Because of requests for more copies of NHA V reports, the project printed additional copies of the main report, household health services utilization and health expenditure report, and two briefs. It gave additional copies of these reports to FMOH and health sector partners. The project is in the process of finalizing the PLHIV Health Services Utilization and Expenditure Survey and a policy brief of the survey.	
Recruit staff	The project has almost hired all staff planned for program and support positions within the project as well as for seconding key staff to EHIA. Currently, it has a total staff of 92 including one hired in the reporting quarter. Staff hiring is underway for two positions within the project as well as to embed in the EHIA.	
Establish satellite project offices	No progress this quarter.	
Process major procurements	No progress this quarter.	

**TABLE 33. ETHIOPIA HEALTH SYSTEMS STRENGTHENING TO HIV LINKS**

Activity	Prevention	HTC/ Diagnosis	Referral and Link to Care	Access and Retention	ART initiation	Viral Suppression (Chronic Care and Labs)	Supportive Care and Quality
<b>Activity I:</b> Improve quality of health services (Core Activity)	<ul style="list-style-type: none"> <li>RRU strengthens outreach capacity as well as collaboration and referral between HCs and health posts for prevention, care, and support services. RRU enables HFs to improve physical infrastructure. This includes space for HTC (greater privacy) and group education.</li> <li>Perceived improvements in quality put more people in contact with the health system, providing great opportunity for behavioral and clinical interventions to prevent transmission.</li> <li>The various HCF reforms are contributing to staff retention; better working conditions in turn improved availability of</li> </ul>	<ul style="list-style-type: none"> <li>RRU increases availability of the operational budget for HTC resources, laboratory equipment, and essential lab reagents.</li> <li>RRU and other reforms such as establishment and operationalization of private wings improves availability and retention of key health workers including lab staff; and thus improves diagnostic capacity.</li> </ul>	<ul style="list-style-type: none"> <li>Strengthening functional and administrative linkages between HCs and (community-level) health posts facilitates referrals up the system for testing, care, and treatment, minimizing loss to follow-up.</li> <li>Promotion of exempted (free) services including HTC, PMTCT, and ART facilitates provision of comprehensive HIV care at HC level, and referral of patients with more complicated cases. This can increase the number of patients testing positive who subsequently access long-term</li> </ul>	<ul style="list-style-type: none"> <li>Increased availability of operational budget through RRU and incentives through private wings enhance staff commitment to improve retention of patients in the service.</li> <li>RRU allows for increased availability of essential drugs for treatment of opportunistic infections and other co-infections. More reliable service availability will ideally assist in retaining patients in care.</li> <li>Enhancement of two-way referrals enables Health Extension Workers to provide follow-up care for patients on treatment,</li> </ul>	<ul style="list-style-type: none"> <li>Improved diagnostic capacity, health worker retention, and availability of essential drugs facilitates ART services</li> </ul>	<ul style="list-style-type: none"> <li>Improved availability of health workers and of diagnostic and treatment capacity will enable early diagnosis and treatment and thus suppress viral load.</li> </ul>	<ul style="list-style-type: none"> <li>Increased operational budgets in facilities is shown to enhance the overall quality of care, including HIV/AIDS care.</li> </ul>

Activity	Prevention	HTC/ Diagnosis	Referral and Link to Care	Access and Retention	ART initiation	Viral Suppression (Chronic Care and Labs)	Supportive Care and Quality
	<p>preventive services.</p> <ul style="list-style-type: none"> <li>Budgeting for and systemizing exempted (free) services including HTC and PMTCT improves access to these important prevention services.</li> </ul>		HIV care.	<p>leading to better adherence and retention in care.</p> <ul style="list-style-type: none"> <li>RRU and private wings contribute to staff retention through increased job satisfaction and incentives. This in turn strengthens the continuity of patient-client relationships, and thus retention in care.</li> </ul>			
<b>Activity 2:</b> Improve access to health services (Core Activity)	<ul style="list-style-type: none"> <li>Increased enrollment of poor households in health insurance will result in increased enrollment of high risk, vulnerable groups. This in turn will increase their access to information and services, including prevention messaging and HTC services.</li> <li>Enrollment in health insurance has resulted in increased encounters with the health system among</li> </ul>	<ul style="list-style-type: none"> <li>Enhanced access to care through health insurance coverage will enable more PLHIV to be diagnosed and treated for opportunistic infections (which are not normally covered under the exempted services category).</li> </ul>	<ul style="list-style-type: none"> <li>SHI and CBHI in Ethiopia will enable eligible households to join regardless of pre-existing conditions; enrollment is subsidized for the very poor. This will allow for referral for complicated cases requiring higher levels of care</li> <li>In non-CBHI districts, the project is providing</li> </ul>	<ul style="list-style-type: none"> <li>Membership in health insurance schemes or the fee-waiver system enables those in need to access health services in a timely and continuous manner, thereby helping with both access and retention. Coverage for treatment of opportunistic infections and other related conditions enables patients to stay in</li> </ul>	<ul style="list-style-type: none"> <li>Reduced financial barriers encourages early and frequent interface with health care services. This, in turn, will promote accurate patient assessments and timely initiation of ART.</li> </ul>	<ul style="list-style-type: none"> <li>Reduced financial barriers, more timely access to care and treatment of opportunistic infections all function to assist patients to thrive on therapy (i.e., reaching suppression of viral load).</li> </ul>	<ul style="list-style-type: none"> <li>Health insurance schemes increase mobilization and pooling of resources for health from member premium payments, government subsidies, and employers, to improve quality and availability of overall health and HIV care.</li> <li>Health insurance schemes are also able to procure services for their</li> </ul>

Activity	Prevention	HTC/ Diagnosis	Referral and Link to Care	Access and Retention	ART initiation	Viral Suppression (Chronic Care and Labs)	Supportive Care and Quality
	enrolled household members, and increased opportunities for counselling and testing, particularly when common co-infections, such as TB, are identified.		technical support for implementation of the fee-waiver system, which provides financial protection for the very poor. This enables individuals from poor households, including those living with HIV and AIDS, to be referred to higher levels of care if required.	care. <ul style="list-style-type: none"> <li>Health insurance improves the interface between enrolled members and health service providers, i.e., they will have better collective bargaining power to demand services that are included in the contracts between the insurance schemes and facilities.</li> </ul>			members more strategically and advocate for better quality of HIV care and services on behalf of their members.
<b>Activity 3:</b> Improve governance of health services and health insurance (Core Activity)	<ul style="list-style-type: none"> <li>The project supports establishment and operation of FGBs. These boards oversee provision of all services including HTC, PMTCT, and related prevention activities.</li> </ul>	<ul style="list-style-type: none"> <li>FGBs plan for and oversee the use of retained revenue for quality improvements, including diagnostic capacity and services.</li> </ul>	<ul style="list-style-type: none"> <li>FGBs lead implementation of all health financing reforms in their facilities, including RRU. As noted above, retained revenue is widely used for improving availability of essential drugs including those that are used for treatment of HIV-related conditions.</li> </ul>	<ul style="list-style-type: none"> <li>Community representatives on FGBs will be able to serve as the interface between communities and their HFs, bringing priorities and demands from the community to the facility management teams and disseminating information about availability of services, quality</li> </ul>	<ul style="list-style-type: none"> <li>Well-functioning FGBs lead to well-functioning HCs and hospitals. This includes having the diagnostic capability and drug supplies required for timely initiation of treatment for patients in need.</li> </ul>		<ul style="list-style-type: none"> <li>Project interventions improve the capacity of HC governing body members; increase networking of health insurance schemes with facility governing boards; and improve capacity of CBHI scheme managers.</li> <li>Because of their bargaining power and liberty to</li> </ul>

Activity	Prevention	HTC/ Diagnosis	Referral and Link to Care	Access and Retention	ART initiation	Viral Suppression (Chronic Care and Labs)	Supportive Care and Quality
				<p>improvements and related issues, thus facilitating access and retention</p> <ul style="list-style-type: none"> <li>As noted in other sections, good governance of health insurance schemes allows for the schemes to have leverage with the facilities and providers, when acting as the paying agent for collective membership. Scheme managers can communicate the priorities and issues identified by members, including those affected by HIV and AIDS, and demand better care accordingly.</li> </ul>			<p>enter into contracts with HFs of their choice, insurance schemes create pressure on facilities to improve quality of care including prevention, diagnosis, and treatment of HIV.</p>



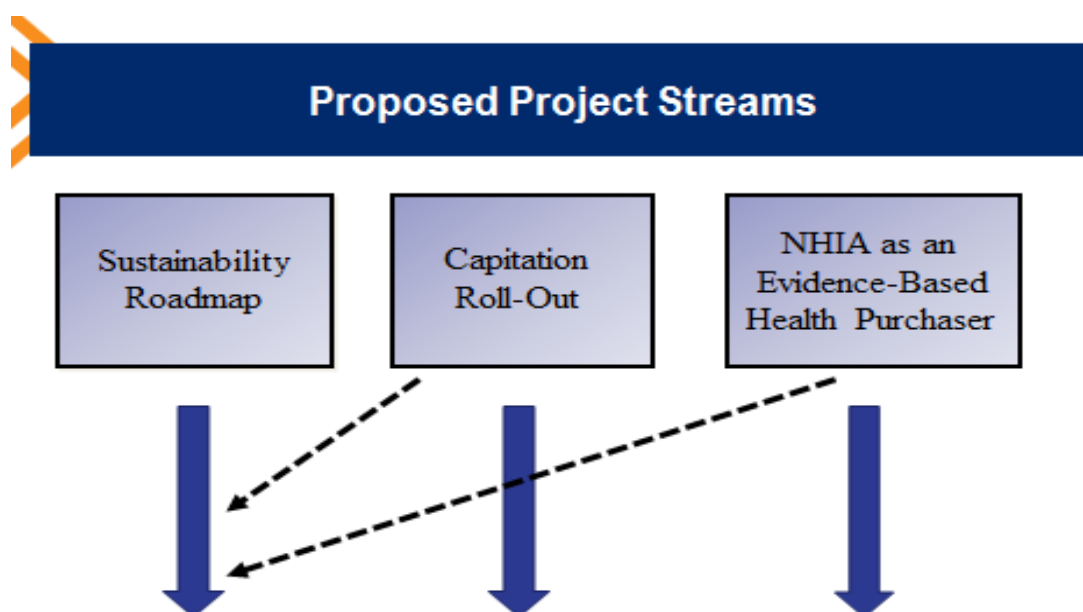
Activity	Prevention	HTC/ Diagnosis	Referral and Link to Care	Access and Retention	ART initiation	Viral Suppression (Chronic Care and Labs)	Supportive Care and Quality
<b>Activity 4:</b> Improve program learning (Core Activity)		<ul style="list-style-type: none"> <li>Supportive supervision data show how much and/or what percentage of RRU is used for improving diagnostic capacity.</li> <li>Strong M&amp;E function enables the project to provide on-the-spot technical support to facility, district, and regional managers of HIV care in generation and use of data for decision making. This includes promotion of exempted services such as HTC and PMTCT.</li> </ul>	<ul style="list-style-type: none"> <li>The "People Living with HIV/AIDS Health Service Utilization and Health Expenditure Survey," which generated evidence for the HIV/AIDS NHA subaccount, shows where people affected by HIV are seeking health care and identifies current and potential financial barriers to care, all important evidence for policy decisions that support linkage and retention in care.</li> </ul>	<ul style="list-style-type: none"> <li>The routine M&amp;E and targeted study findings are generating critical evidence related to increased financing, improvements in the quality of care, and retention of patients in HFs.</li> <li>Routine data are being produced on CBHI membership enrollment, renewal, and health service utilization; this is important data for retaining membership in the schemes as well as keeping patients in care.</li> </ul>	<ul style="list-style-type: none"> <li>The "People Living with HIV/AIDS Health Service Utilization and Health Expenditure Survey" showed that the financial burden of care is much higher for PLHIV than for the general population. This finding is important evidence for advocating for increased access to comprehensive HIV care, including initiation of ART.</li> </ul>		<ul style="list-style-type: none"> <li>Supportive supervision at the facility level; availability of evidence for decision making improved; NHA and other surveys conducted; updated policy and strategy documents, success stories, and documentation improved; efficient M&amp;E systems established.</li> <li>Technical and financial support for Ethiopia's fifth NHA, which included the HIV/AIDS subaccount. The NHA revealed that HIV/AIDS care is highly donor financed (83%), and PLHIV have double the financial burden for health care</li> </ul>

Activity	Prevention	HTC/ Diagnosis	Referral and Link to Care	Access and Retention	ART initiation	Viral Suppression (Chronic Care and Labs)	Supportive Care and Quality
							than the general population. This evidence is being used to advocate for more funding for HIV/AIDS from domestic sources and for budget negotiations at the national level to reduce the financial burden on people and families living with HIV and AIDS.

Note: HTC=HIV counseling & testing

### 4.1.9 Ghana

**Program Objectives** – In Ghana, HFG and the USAID Mission have agreed on the funding level, on the strategic approach, and on the concentration of program activities in three work streams related to improving National Health Insurance Authority (NHIA) purchasing, systems, and operations. USAID technical support to the NHIA is carried out to improve the functioning of the authority as an effective tool in universal health coverage (UHC) and for achieving results under Ending Preventable Child and Maternal Deaths (EPCMD) and AIDS-Free Generation strategies. The three USAID/HFG work streams envisioned to support the NHIA in National Health Insurance Scheme (NHIS) evolution are: 1) sustainability road map (SRM); 2) capitation roll-out; and 3) NHIA as an evidence-based health purchaser. The overall approach is to achieve the objectives of each work stream but also to create synergies between the work streams to magnify the impact on NHIS development and long-term sustainability.



**Year 2 Activities** – Year 2 activities were finalized with the NHIA and Mission and organized into three work streams.

#### I. Sustainability Roadmap Work Stream

The HFG team agreed with the NHIA that the SRM work stream will accomplish two key objectives:

- Serve as an umbrella for NHIS/NHIA evolution, consisting of a balance of revenue increases and expenditure management (e.g., improving health purchasing, efficiency gains, cost containment, direct link to desired service delivery improvements, more effective systems and management).
- Enable focal areas to emerge as priority health purchasing, provider payment, and supporting system activities contributing to both NHIS/NHIA refinement planning and identification of areas for future HFG-Ghana technical assistance.

## 2. Primary Health Care (PHC) Capitation Roll-out Work Stream

HFG proposes to support the NHIA in continuing to phase in the implementation of capitation in several possible ways:

- As a neutral facilitator of the process of synthesis and reflection on the Ashanti capitation pilot experience
- In conducting a qualitative survey of Ashanti stakeholder experience
- In facilitating the design of a revised approach to use capitation as a catalyst for a comprehensive provider payment approach in 1-3 new regions
- In identifying and preparing the service delivery arrangements, support systems, and monitoring and evaluation (M&E) required for a successful pilot

## 3. NHIA as an Evidence-Based Health Purchaser

The HFG team agreed with the NHIA that there are important opportunities for strengthening the NHIA's generation and use of evidence in its operations, especially for its core function of health purchasing. For this work stream, HFG proposes to focus on three components:

- Enhance NHIA's claims data collection and analytic processes to generate evidence for policy and ultimately more efficient and effective health purchasing.
- Support NHIA's broader efforts to strengthen M&E throughout all NHIS operations and in Ghana's health sector more broadly.
- Identify and improve NHIA's internal performance management practices that most affect the generation and use of evidence for health purchasing.

**Year 2 Progress** – Following NHIA's Annual Senior Management meeting in January 2014, NHIA's CEO Sylvester Mensah fully endorsed HFG's Year 2 work plan and urged the team to proceed with implementation of the work streams. He appointed NHIA project teams/working groups for each of three work streams from various departments and senior management. In Year 2, HFG-Ghana continued implementation of planned activities in the three programmatic work streams as described below.

### 1. Sustainability Roadmap

Progress is described below in the following four areas: 1) collaboration and coordination with Ministry of Health (MOH) Health Financing Strategy Implementation Plan (HFS-IP) development; 2) development of the draft Sustainability Roadmap; 3) emergence of key focal areas to support health purchasing improvements obtaining efficiency gains and moving toward UHC; and 4) convergence of Sustainability Roadmap and PHC capitation roll-out work streams as envisioned by the dotted line in the chart above.

#### ***Collaboration, Coordination, and Creating Synergies between MOH Health Financing Strategy Implementation Plan Development and NHIS/NHIA Sustainability Roadmap***

The MOH, NHIA, USAID, and WHO agreed to collaborate to develop the MOH HFS-IP. The collaboration was intended to support Ghana in developing an overarching health financing strategy and plan, and also ensure consistency with NHIS strategic health purchasing plans contained in the draft NHIS/NHIA Sustainability Roadmap. The MOH HFS-IP and NHIS/NHIA Sustainability Roadmap coordination continued throughout Year 2. It appears this collaboration has been successful as the current draft HFS-IP contains an implementation strategy and sequencing consistent with the draft NHIS/NHIA Sustainability Roadmap. In addition, as reported by MOH and other donors, there is a

groundswell of understanding and support building for the MOH HFS-IP and NHIS/NHIA Sustainability Roadmap.

As shown in table 34 below, draft HFS-IP implementation strategy and sequencing consistent with the NHIS/NHIA Sustainability Roadmap is a two-pronged approach for the period 2014-2025; it has four phases: Initiation, Expansion, Deepening, and Solidification. The core of the first prong, shown in the orange boxes, is better expenditure management through strategic health purchasing obtaining efficiency gains to expand coverage and improving service delivery. It is expected that PHC capitation roll-out will “bump up” against or lead to refining diagnosis-related groups (DRGs) for outpatient specialty and inpatient care, which in turn will bump up or lead to drug payment improvements. The second prong, shown in the gray boxes, recognizes that addressing five major policy issues is critical to enabling deepening of strategic health purchasing implementation. The five major policy issues are: 1) government of Ghana revenue; 2) pooling and decentralization; 3) coverage trade-offs; 4) salaries in output-based payment systems; and 5) drug supply chain.

**TABLE 34. HFS-IP IMPLEMENTATION STRATEGY SEQUENCING**

Phase	2014-2016	2017-2019	2020-2022	2023-2025
Initiation				
Expansion				
Deepening				
Solidification				

### ***Development of Draft Sustainability Roadmap***

The NHIA and HFG Sustainability Roadmap team worked to categorize and organize “brainstorming” ideas for the second quarter workshop. These ideas generally define the universe of interventions that can contribute to increasing NHIS financial sustainability. Then from a distance the team developed a first draft of the NHIS Sustainability Roadmap.

The team reviewed this draft in Accra during an April 18-25 TDY. Specific TDY activities consisted of an extensive initial review meeting (NHIA COO Nat Otoo joined the meeting, concurred with general roadmap content and suggested adding road signs), follow-up consultations, and a final review meeting to discuss specific changes to the Sustainability Roadmap chart and draft. Year 2, Quarter 3 progress is summarized as development and review of the first draft Sustainability Roadmap with general consensus on content, agreement to modify the chart to literally look like a roadmap with road signs, and some corresponding revisions or realignment of the draft. The milestone or result development of the draft Sustainability Roadmap is largely met, although revision and review will continue in order to finalize the draft. Final revision of the draft NHIS/NHIA Sustainability Roadmap awaits MOH HFS-IP development as of Year 2 Q4.

### ***Emerging Priority Health Purchasing Focal Areas***

Costing for provider payment system rate setting is emerging as a priority focus area. It initially arose in the PHC Capitation work stream but also emerged in Sustainability Roadmap dialogue, and is one of the first activities in roadmap sequencing. Officially entitled the Unified National Costing System, it is not a broad benefit package or health sector strategy costing, but more micro-level costing or cost accounting, enabling calculation of relative payment weights or other aspects of provider payment system rate-setting. In Year 2 Quarter 3, costing system progress included engaging in dialogue and a costing workshop to initiate development of the unified national costing system in Ghana (see PHC capitation work stream for more detail).

A second emerging priority focus area is refining Ghana Diagnosis-Related Groups (G-DRGs). Part of the reason refining G-DRGs is emerging as a focus is the priority of improving costing for provider payment rate-setting discussed above. In addition, it is emerging as NHIS Sustainability Roadmap dialogue is increasingly identifying areas for strategic health purchasing improvements, cost containment, and efficiency gains, and a number of specific examples raised relate to G-DRGs (e.g., paying an extra 20 percent for additional procedures rather than bundling in DRG payment; readmissions, transfers, or duplicative services; and enhancing relationship to service delivery including reducing incentives for unnecessary services). It is expected that HFG activities supporting G-DRG refinement will begin in HFG Year 3. G-DRG refinement activities will also create synergies with the PHC capitation work stream, as expansion of PHC capitation will likely result in “bumping up” against outpatient specialty and hospital care, such that realignment of the G-DRG payment system becomes more inevitable. Eventually it will lead to growing pressure or creation of demand to improve drug payment, and HFG Year 3 activities may also begin to lay the foundation for drug payment activities.

In Year 2 Quarter 4, DRG refinement and costing for provider payment systems continued to emerge as priority health purchasing focal areas and it is expected that activities for this long and complex task will begin in HFG Year 3.

### ***Convergence of Sustainability Roadmap and PHC Capitation Roll-Out Work Streams***

The dotted line in the chart above envisions potential convergence of work streams as the Sustainability Roadmap strategic planning exercise is completed and activities evolve to intensified NHIS health purchasing technical and operational support consistent with the roadmap. In HFG Year 2 Quarters 3 and 4, this process occurred with the convergence of Sustainability Roadmap and PHC capitation roll-out work streams driven by: 1) successful development of the draft NHIS/NHIA Sustainability Roadmap balancing revenue increases and expenditure management through strategic health purchasing; 2) emergence of cross-cutting topics such as a costing system for provider payment system rate setting; and 3) growing recognition of the important relationship between different health purchasing mechanisms or provider payment systems (e.g., PHC capitation, DRGs) and their impact on service delivery including HFS-IP implementation strategy of PHC capitation expansion bumping up against DRG refinement in turn bumping up against drug payment improvements.

This natural convergence of Sustainability Roadmap and PHC capitation roll-out work streams resulted in their merger as elaborated in the HFG Year 3 work plan. It reflects successful activities to date particularly related to redirecting NHIS strategy to encompass expenditure management and efficiency gains as well as revenue increases, and also averting too rapid PHC capitation roll-out without incorporating lessons learned including the importance of the relationship to service delivery and PHC network structure including provider mapping.

In summary, a Sustainability Roadmap encompassing expenditure management and PHC capitation roll-out contributing to obtaining efficiency gains and enhancing the key relationship between financing/purchasing and service delivery/health provider structure together should enable NHIS/NHIA to move toward financial sustainability and coverage expansion on the road to UHC. Following initial Sustainability Roadmap strategic planning and PHC capitation roll-out design activities relying on targeted technical assistance, the next step is likely a shift in HFG project mode of operation with project inputs supporting implementation, building capacity at all levels of the system, leveraging resources and encompassing both sides of the key relationship between health purchasing and service delivery.

## **2. PHC Capitation Roll-Out**

Similar to the Sustainability Roadmap, progress in PHC capitation roll-out work stream during HFG Year 2 can be characterized by continuation and solidification of activities that were initiated in January 2014. Progress is described below in the following four areas: 1) PHC capitation roll-out payment system design including participation in Technical Steering Committee; 2) provider mapping to support strengthening PHC structure and service delivery capacity through preferred PHC providers; 3) establishment of Regional Implementation Committees; and 4) development of a Routine National Unified Costing System for Provider Payment Rate-Setting.

### ***PHC Capitation Payment System Roll-Out Design***

HFG support to the implementation plan for the nationwide roll-out of capitation resulted in a detailed step-by-step plan for the roll-out that allows sufficient time for the model to be updated and implementation arrangements to be put in place that reflect the experience of the two-year pilot in the Ashanti region. In HFG Year 2 Quarter 4, progress included follow-up activities related to:

- The analytical framework for reviewing the Ashanti pilot experience and recommending revisions to the capitation model and the implementation process including a supplemental qualitative assessment of the Ashanti stakeholder experience with the capitation pilot to answer specific operational questions about the implementation and effectiveness of supporting systems.
- Participation in the national Technical Steering Committee to contribute to the details of PHC capitation roll-out policy decisions and implementation planning. By taking into account Ashanti lessons learned and the need to focus on the service delivery or PHC structure side in addition to the health financing side of PHC capitation, HFG-Ghana technical inputs contributed to development of a more realistic timeframe and thus increased probability of success of PHC capitation roll-out.
- Provision of technical expertise to NHIA PHC capitation roll-out work stream team on the design and development of various aspects of the PHC capitated rate payment system including supporting systems.

### ***Provider Mapping***

HFG has been supporting a mapping of potential preferred PHC providers in the three capitation roll-out regions of Upper East, Upper West, and Volta to inform the revision of the options for preferred PHC provider models, particularly how Community-based Health Planning and Services Initiative (CHPS) compounds will be incorporated, and to inform enrollment guidelines. Terms of reference have been drafted and a local consultant has been contracted by HFG partner Results 4 Development. The local consultant completed the data collection instrument, conducted an initial desk review of the number and capacity of providers in the three regions, and began data collection. The mapping exercise will cover the approximately 1,250 public, Christian Health Association of Ghana (CHAG), and private providers in the three regions, including CHPS compounds, health centers, clinics, polyclinics, district hospitals and regional hospitals.

The extensive and complex provider mapping exercise was progressing well until the tragic death in an automobile accident of the contracted local consultant performing the task. It took time to recover and revise plans but a process is in place and the activity is being restarted.



### **Regional Implementation Committees**

HFG-Ghana continued to support establishment of Regional Implementation Committees (RICs) in the three regions for the capitation roll-out. Local consultant continued activities to: 1) draft terms of reference for the RICs; 2) work with regional leaders to agree on the appropriate composition of the RICs; 3) provide informational meetings and technical support for RICs to build their capacity to manage capitation implementation.

### **Routine National Unified Costing System for Provider Payment Rate-Setting**

To both meet an immediate priority identified by the Minister of Health and generate mutually accepted cost data to develop capitation rates, HFG is supporting the NHIA to develop a national system of costing of health services. This activity will be carried out in coordination with the Joint Learning Network (JLN) Costing Collaborative. The plan for developing the costing system provided by the HFG capitation roll-out work stream in the previous quarter was accepted by the MOH and NHIA. Based on the plan, the MOH convened a steering group, and the launch workshop was held June 24-25, 2014. The purpose of the launch workshop was to launch a participatory process to:

1. Design a routine unified national costing system for health services in Ghana;
2. Conduct and institutionalize training in costing for health care providers and other key stakeholders; and
3. Institutionalize the routine and standardized collection of cost accounting data from a sample of health care providers on an ongoing basis, and institutionalize analysis and use of the routine cost data by the MOH, NHIA, providers, and other stakeholders.

The launch meeting was held at the Alisa Hotel, Accra. The meeting was convened by the MOH, with close collaboration of the NHIA, Ghana Health Service, CHAG, and teaching hospitals. The meeting was sponsored by the HFG project capitation roll-out and Sustainability Roadmap work streams. The JLN Country Core Group provided organizational support. The JLN Provider Payment Initiative provided the materials and technical contribution. There were approximately 25 participants with three HFG/JLN facilitators. Consensus was reached on key points related to the objectives, scope, and costing methods that will be used for the costing system, as well as the institutional structure to oversee and implement the system and a work plan.

HFG Year 2 Quarter 4 costing system activities primarily focused on follow-up to the launch workshop to develop detailed plans and next steps. Follow-up and plans and next steps are expected to be finalized during the October 2014 planning trip.

### **3. NHIA as an Evidence-Based Health Purchaser**

In Year 2 Quarter 2, two comprehensive in-country working sessions, as well as smaller, more targeted meetings, were held. In the first working session, the team identified key issues about which NHIA staff and management needed better information for their decision making. The list of issues was broad and covered multiple functions of NHIA (revenues, purchasing, membership, etc.). A second meeting narrowed the list to issues about the purchasing function – where data will come largely from NHIA's current claims-based data sources. Other accomplishments of the working sessions included:

- Appointment and launch of project (work stream) team
- Agreement on team's overall scope and objectives
- Agreement to work toward a preliminary “dashboard” or equivalent tool/process that synthesizes information on key questions for purchasing-related decision making

- Preliminary list of key questions and indicators for the dashboard, and preliminary mapping of data sources begun (through interviews with key staff handling data)
- Agreement to work toward an exchange learning visit to/from experts in another major health purchaser in a middle-income country

In Year 2 Quarter 3, HFG led a two-day workshop that covered the basics of M&E and the use of dashboards for monitoring purposes. The participants were a group of approximately 20 directors and managers who have been appointed by NHIA management to constitute a committee that will serve as a steering group for the development of a beta version of a dashboard. Through interactive workshop sessions facilitated by the HFG team, the committee developed several potential indicators based on a list of priority questions from senior NHIA management, and completed a framework for the development of the dashboard, including the following for each indicator: formula, data source(s), interpretations/potential future actions, and possible visualization methods. Based on the steps that were deemed essential for the successful development and rollout of the dashboard, the committee created a 12-month work plan for NHIA staff, including a single directorate assigned as lead for each task.

Following the Year 2 Quarter 3 workshop that covered the basics of M&E and the use of dashboards for monitoring purposes, a subcommittee of seven selected NHIA staff from the Claims, Management Information Systems (MIS), Research & Development, and Membership directorates was formed. The subcommittee, which was chaired by Stephen Bewong of the Claims directorate, was tasked with evaluating each of the proposed dashboard indicators. The subcommittee was asked, for each proposed indicator, to complete the following:

1. Identify and examine the data source(s).
2. Assess the quality of data derived from each data source(s) identified in step one.
3. Develop options for visualizing the data so that it is most useful for NHIA management.
4. Based on the feasibility of identifying, and using accurate data, create an initial visualization of each indicator for review by NHIA management.
5. List challenges associated with producing each indicator.

The subcommittee met weekly between June and August and was facilitated by HFG team member Nkem Wellington. Eight of the 11 proposed indicators for the preliminary dashboard were deemed “easy” to produce according to the criteria, which judged each indicator based on clarity, data availability, data quality, visualization, and completion of a sample indicator. The final report based on the subcommittee’s findings has been submitted to NHIA counterparts.

The MIS directorate has identified skills gaps in its use of SharePoint, the Microsoft software that will be hosting the beta version of the information dashboard. HFG has completed a competitive bidding process and chosen a Ghanaian firm which will complete the three priority SharePoint training courses which cover core and advanced solutions and business intelligence. The dates for the trainings will likely be early Year 3 Q1.

A partnership between HFG and the M&E directorate at the NHIA was solidified, and a concept note was finalized detailing the nature of the partnership. HFG is creating a customized two-week workshop in which facilitators will conduct modules focused on the practical application of M&E techniques and the principles of training of trainers (TOT). Approximately 20 M&E managers will attend the workshop. Some of the suggested topics to be covered during the workshop are the following:

- Strategic planning and project management for implementing M&E activities

- Critical thinking skills around M&E conceptual frameworks commonly used by global funders
- M&E for core health insurance activities
- Introduction to program evaluation/research methods
- How to spot data issues and validate data
- Introductory methods for measuring equity
- Adult education and training techniques

The workshop is slated to be held in Year 3 Q2.

During Year 2 Quarter 4, HFG initiated communication with representatives from Taiwan's National Health Insurance Administration (Taiwan NHIA). During a call, the HFG team learned about the Taiwan NHIA's processes for data collection, storage, and use for decision making. HFG has collected documentation about Taiwan NHIA's operations and evidence use and is identifying potential areas where Taiwan NHIA and NHIA can make potential linkages. Collaboration and a potential study tour are planned to take place in Year 3 Q1 and Q2.

**Challenges** – Sustainability Roadmap and PHC capitation roll-out work streams face two major challenges both of which relate to maintaining the positive framing or shift in direction at least partially due to HFG technical assistance. First is the need to solidify understanding and acceptance of the importance of NHIS financial sustainability. Notwithstanding MOH HFS-IP and NHIS/NHIA SRM emphasis on expenditure management, continuous reinforcement and political support is needed to move toward efficiency gains enabling coverage expansion, budget neutrality, cost containment, sharing risk between purchaser and providers, and financial incentives to improve service delivery. Secondly, reinforcement of time as a valuable asset required to enable PHC capitation roll-out design and step-by-step implementation including PHC provider structure and service delivery. Strengthening the most cost-effective PHC sector is on the critical path to improving service delivery, increasing access for the poor and the road to UHC and time is needed for the system to be developed and implemented successfully.

**Q4 Additional Information** – NHIA and the HFG team are confirmed to meet in October 2014 to review and finalize the HFG Year 3 work plan in Ghana.

Table 35 provides activity-specific updates.

**TABLE 35. GHANA ACTIVITY DETAIL**

Y2Q4 Planned Tasks	Y2Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
<b>Activity I: Sustainability roadmap</b>		
Have SRM team categorize, organize, relate “brainstorming” ideas (define universe) and develop draft SRM	Limited follow-up on the draft NHIS/NHIA SRM during the last quarter.	SRM now linked to collaboration on broader MOH HFS-IP. Following development of draft HFS-IP consistent with SRM, team will revise and finalize SRM draft. This is expected to occur in HFG Y3Q1.

Y2Q4 Planned Tasks	Y2Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
Identify focal areas for health purchasing improvement during SRM development	As planned, SRM dialogue is beginning to result in emergence of focal areas for health purchasing improvement. Two initial focal areas are development of unified national costing system for provider payment rate setting that has already been initiated, and potential refinement of G-DRGs.	Plans are to deepen development of costing system and start refine G-DRG activities in HFG Year 3.
Do internal NHIA SRM review and external consultation as determined by NHIA	The internal NHIA draft SRM review has been completed. The content of SRM was accepted by NHIA.	External NHIS/NHIA SRM consultation is now incorporated into MOH HFS-IP consultation. This process has begun and will continue into HFG Year 3.
Initiate development of detailed SRM implementation plan	Agreed to a collaboration that would result in the broader HFS-IP incorporating and coordinating with NHIS SRM. Therefore, SRM implementation plan is generally incorporated into HFS-IP.	There may be a little follow-up on SRM implementation plan, but in general this task now relates to broader HFS-IP.
Communicate and market SRM	This task is now linked to broader MOH HFS-IP. MOH and NHIA have begun the process of HFS-IP communication incorporated into external consultation.	Communication and marketing of HFS-IP and SRM is expected to continue in HFG Year 3.
Initiate development of technical methodologies, implementation plans and sequencing for the selected NHIA focal health purchasing improvement areas including HFG technical assistance	Sustainability Roadmap and PHC capitation roll-out work streams continued to converge in HFG Y2Q4. HFS-IP and SRM detail implementation strategy and sequencing including the relationship between PHC capitation roll-out and other health purchasing or provider payment system refinements such as G-DRGs. In addition, the emergence of cross-cutting topics such as costing system for provider payment rate setting contributes to the convergence. Activities have been successful in balancing revenue increases and expenditure management including efficiency gains in SRM, and helping to ensure a realistic timeframe for PHC capitation roll-out.	The convergence was solidified through merger of the two work streams in HFG Year 3 workplan. The next likely step is a shift in HFG project mode of operation from targeted strategic planning and design technical assistance to project inputs supporting implementation, building capacity at all levels of the system, leveraging resources, and encompassing both sides of the key health purchasing and service delivery relationship.

#### Activity 2: PHC capitation roll-out

Review the Ashanti pilot capitation experience and make recommendations for the next phase of implementation	Synthesis report completed that combines the findings, conclusions, and recommendations of the three main evaluations of the Ashanti capitation pilot	
Support development of the implementation plan for phased roll-out of capitation	During Y2Q4, HFG-Ghana continued to support establishment RICs in the three regions for the capitation roll-out. Local consultant continued activities to: 1) draft terms of reference for the RICs; 2) work with regional leaders to agree on the appropriate composition of the RICs; 3) provide informational meetings and technical support for RICs to build their capacity to manage capitation implementation.	

Y2Q4 Planned Tasks	Y2Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
Support development of the supporting systems for phased implementation of capitation in the next 3 regions	<p>HFG Y2Q4 costing system activities primarily focused on follow-up to the launch workshop in Q3. Progress was made in this follow-up and plans and next steps are expected to be finalized during the October 2014 planning trip.</p> <p>The consultant tasked with the provider mapping exercise was tragically killed. It took time to recover and revise plans but a process is in place and the activity is being restarted.</p>	

### Activity 3: NHIA as an evidence-based health purchaser

Enhance NHIA's claims data collection and analytic processes to generate evidence for policy	<p>A subcommittee of NHIA staff met weekly through July and August to evaluate the list of potential indicators for the dashboard across several criteria. The final report of the subcommittee meetings has been shared with NHIA management.</p> <p>The MIS directorate has identified a capacity gap regarding SharePoint, the Microsoft program that will house the management dashboard. The HFG team is contracting with a Ghanaian firm to give three courses focused on core and business intelligence skills that will allow MIS staff to produce the necessary elements of the dashboard in SharePoint.</p> <p>HFG began communications with Taiwan's NHIA regarding the organization's use of evidence in making health purchasing decisions. Based on these preliminary communications, the HFG team is investigating potential areas where Ghana's NHIA can learn from Taiwan's practices regarding use of evidence.</p>	<p>The SharePoint trainings will occur during Y3Q1.</p> <p>Following the SharePoint trainings, the MIS team will prepare a beta version of the information dashboard during Y3Q1.</p> <p>Further learning exchange/study tour opportunities will be explored during Y3Q1.</p>
Support NHIA's broader M&E strategy	A concept note which describes the nature of HFG's role in an M&E workshop was finalized and agreed upon by NHIA's M&E director. The workshop, which will last approximately 10 days and be attended by 20 M&E managers, will cover the practical application of M&E techniques and the training of trainers.	The M&E workshop will occur in Y3Q3.

#### 4.1.10 Lesotho

**Year 2 Objectives** –HFG is providing technical assistance to the Ministry of Health and Social Welfare (MOHSW) of Lesotho to perform a modified health services assessment (HSA), distinct from the traditional Health Systems Assessment. The request from the MOH was to use this activity to support the primary health care revitalization process and in response to key national strategic plans (e.g., 2011/12 to 2016/17). The MOHSW has established country ownership as an area of emphasis, and in keeping with this mandate, the HFG project will support this country-led process, working in close collaboration with the designated teams and team leads as identified by the MOHSW. HFG will serve as a resource to the MOHSW, providing guidance and critical engagement at key stages along the assessment pathway.

**Year 2 Activities** – HFG will provide technical assistance to the MOHSW in three phases:

- **Health Services Assessment Planning:** HFG will help the MOHSW to facilitate planning for the HSA. It also will provide technical support and facilitation for key assessment launch activities, including the design of stakeholder workshops, identification of the skills needed for the technical team, and technical advice for data collection materials (protocols, instruments, training materials, etc.).
- **Implementation Support/Trouble Shooting:** The HFG activity lead will be available to provide limited in-country support during planned travel to Lesotho. However, she will be available throughout HSA implementation to virtually provide any needed technical support to the assessment lead and the MOHSW team in line with best practices in order to ensure HSA success.
- **Technical and Quality Review of Health Services Assessment Draft Report:** While the MOHSW will conduct the data analysis and prepare the final report, the HFG team will provide technical and quality review on key sections of the draft report.

#### **Year 2 Progress against Objectives -**

The activities described below were conducted progressively in response to MOH needs. Over the course of the activity, HFG assisted the MOHSW to plan, conduct, and finalize the report on a health services availability and readiness assessment.

At the outset, HFG in collaboration with the MOHSW facilitated a workshop to review various health assessment methodologies and to determine the approach that best fit the needs of the MOHSW. Furthermore, the HFG team worked with the MOHSW to complete various tasks essential for conducting a successful and carefully planned assessment: an assessment timeline with key roles and responsibilities and a data collection plan were developed; the assessment tool was reviewed; data collectors and team leads/trainers were identified; and a data analysis plan and final report template were designed. Tools and materials to facilitate the data collection training were developed. The MOHSW conducted a two-day training on the assessment for District Health Management Team (DHMT) representatives from 10 districts. Field data collection schedules were been developed.

The MOHSW teams assumed full responsibility for the data collection, which was conducted using local resources, with the oversight of the respective MOHSW technical program managers. While some of the proposed recommendations for quality data collection were not utilized by the MOHSW teams, data collection was completed at the end of April 2014. Through continued engagement with the MOHSW, HFG provided technical assistance for the subsequent data analysis planning. Working closely with the teams from the local Bureau of Statistics, HFG was able to accomplish the following:

- Through in-country TDYs, worked with the MOHSW and Statistics teams to develop a detailed data analysis strategy that included data cleaning, addressing data gaps, etc. and review of the most appropriate data methodologies.

- HFG provided training to the Statistics team, building their capacity to conduct aspects of the analysis and ensuring external quality assurance.
- HFG worked extensively with the Statistics team to complete the data analysis, incorporating detailed inputs and feedback from the Assessment Lead and his team at the MOHSW.
- Convened meetings with the MOHSW teams to agree on data representations and organization of report sections.
- HFG developed the first draft of the report, which summarized the key findings from the data analysis process. The MOHSW team then developed recommendations and next steps.

HFG provided technical assistance to the MOHSW in developing and pulling together the final report. HFG conducted substantive work on chapter (section) development and reviews, content revisions, editing, and formatting of the report. HFG submitted the final report to the MOHSW along with comments on August 1, 2014, which brought the activity to completion. HFG is working with USAID to explore further areas of MOH support, building on the experiences and findings that emerged through this assessment.

Table 36 provides activity-specific updates.

**TABLE 36. LESOTHO ACTIVITY DETAIL**

Year 2 Q4 Planned Tasks	Year 2 Q4 Progress	Critical Assumptions/ Problems Encountered/ Follow-up Steps
<b>Activity 1:</b> Provide technical assistance to the MOHSW to conduct a health assessment		
Review and finalize assessment report	The HFG team reviewed and provided substantial content revisions, editing, and formatting to the assessment report, which was originally produced by the MOHSW team. A final assessment report was submitted to the MOHSW with suggested comments for their consideration.	The activity was completed in Q4.
Conduct validation workshop on key findings with key stakeholders	HFG offered to support the MOHSW in conducting a validation workshop. However, due to competing priorities, the MOHSW opted not to hold the workshop.	Cancelled due to MOHSW priorities.



#### 4.1.11 Namibia

**Program Objectives** – In anticipation of the reduction in donor funding for HIV/AIDS programming, there is an increasing shift of donor aid from directly supporting prevention and treatment programs to promoting sustainable health care financing models and the ability of country agencies and organizations to implement programs that provide essential health care services or ensure access to these services.

With the continuing transition of PEPFAR activities to the Government of the Republic of Namibia, U.S. Government-funded health systems strengthening work is essential to the success of Namibia's sustainability and country ownership plans. This year, HFG will implement activities to:

- Promote country ownership of the management and domestic financing of the health system overall and HIV/AIDS programs in particular
- Improve the use of key data for decision making (particularly within health finance)
- Enhance the capacity of the Namibian government to sustain the multi-sectoral HIV/AIDS response

**Year 2 Activities** – Following preliminary work planning discussions, USAID/Namibia outlined three specific areas for HFG support in Year 2. These include:

- Conducting a health financing review to inform the government's discussions on promoting Universal Health Coverage
- Costing for evidence-based decision making, and
- Institutionalization of National Health Accounts (NHA) for resource tracking

#### **Year 2 Progress –**

##### ***Activity 1: Implementation and institutionalization of NHA using the updated framework***

In May 2014, two representatives from Ministry of Health and Social Services (MOHSS) attended a training workshop in South Africa on the System of Health Accounts (SHA) 2011 framework and the Health Accounts Production Tool (HAPT). During this workshop, MOHSS representatives, in collaboration with HFG and WHO/Namibia, drafted a work plan for the implementation of the NHA exercise in Namibia. After further work-planning conference calls with the HFG team, the work plan was expanded on and a research protocol was developed. This document details the training, data collection, data analysis and reporting requirements and plans for the NHA exercise, and has been reviewed and updated by HFG based on the SHA 2011 and HAPT requirements. HFG also provided guidance to the MOHSS on the selection of stakeholders to be included in the policy advisory group with the preliminary selection including the MOHSS, Ministry of Finance, National Planning Commission Secretariat, Social Security Commission (SSC), Bank of Namibia, Namibia Financial Institution Supervisory Authority, Namibian Association of Medical Aid Funds, Namibia Chamber of Commerce and Industry, and the Namibian Employers Federation. This list is subject to final approval by the MOHSS.

In Quarter 4, HFG led a five-day in-country training on the SHA 2011 framework and HAPT for the NHA technical working group members drawn from different directorates in MOHSS (policy planning and human resources, special programs, and finance), SSC, Chamber of Commerce, Namibia Medical Aids Fund, Ministry of Finance, and the Polytechnic of Namibia. Following the training, the project supported the NHA technical working group (TWG) to refine the scope and key policy questions of the NHA, customize the production tool, customize the survey instruments, and identify the sample frame and sampling pool for the data collection from primary sources.

The health accounts exercise was officially launched by the Deputy Minister of Health who noted that the MOHSS now intends to conduct the health accounts exercises on a regular basis to ensure continued availability of relevant and up-to-date national health spending information.

HFG then facilitated the MOHSS-led training workshop in September 2014 for data collectors who have been recruited for the health accounts data. Data collection was expected to begin shortly thereafter.

### ***Activity 2: Economic efficiency and effectiveness analysis for sustainable HIV/AIDS financing***

At the request of the mission, HFG prepared a concept note for implementing a costing workshop that would identify the needs for cost and economic analyses to respond to the National Strategic Plan and the National Strategic Framework for HIV/AIDS, both of which call for sustainable financing for HIV/AIDS. HFG submitted the concept note to USAID/Namibia and received feedback that was used to finalize and submit a final version to the mission; this concept note was to be used by the Mission as the basis for discussions with the MOHSS. In Quarter 4, the mission suggested that HFG proceed with arranging a meeting with the MOHSS to discuss the concept note. This proposed meeting between HFG and the MOHSS has not yet taken place due to the unavailability of MOHSS representatives, and this activity cannot proceed before that happens.

### ***Activity 3: Production of health financing review***

In Quarter 1, the HFG Namibia team provided technical support to the SSC and the African Development Bank to organize the first of a series of five stakeholder engagement workshops and a work-planning meeting to consider the development of a committee to promote Namibia's efforts to promote UHC. HFG's Senior Health Finance Technical Advisor, Dr. Carlos Avila, was invited by the SSC to present the UHC approaches and experiences of other countries at the October 2013 workshop. Dr. Avila also presented an overview of health insurance issues that Namibia should consider when planning its UHC-related review, including prioritization of target populations and defining the essential packages of services.

In Quarter 2, Dr. Avila participated in the Inaugural Meeting of the newly formed Universal Health Coverage Advisory Committee for Namibia (UHCAN). In attendance were committee members, including the committee's chairperson, the Deputy Permanent Secretary of the MOHSS. Dr. Avila presented the objectives of the Health Financing Review to be conducted by HFG Namibia, facilitated discussions on the review, and received agreement from the committee on proceeding with the proposed activity (pending Mission approval).

In Quarter 3, the Year 2 work plan was tentatively approved by USAID/Namibia, pending any final comments or feedback. Moving forward with the Health Financing Review for UHCAN, HFG sent a formal request to the Deputy Permanent Secretary of the MOHSS, Dr. Forster, to proceed with data collection from the departments within the MOHSS. The MOHSS then requested that HFG develop a research protocol outlining the specific objectives and data requirements for the Health Financing Review. The protocol was developed and submitted to the MOHSS research committee in June 2014. The HFG team is awaiting approval before proceeding with data collection, although collection of publicly available data has commenced.

In Quarter 4, HFG presented the objectives and some preliminary findings of the Health Financing Review based on publicly available information to the UHCAN at their quarterly meeting. The findings were received with great interest and the UHCAN members are eagerly awaiting the final findings and report. Dr. Avila visited Namibia in Q4 to present on international experiences of achieving UHC at the Namibia Association of Medical Aid Funds (NAMAf) annual meeting. During his visit Dr. Avila also met with various stakeholders to collect information and insights into the health financing situation in Namibia for the Health Financing Review.

**Challenges** – HFG is currently awaiting guidance from the USAID/Namibia Mission on the level and scope of field support funding for Year 3 of the project.

Table 37 provides activity-specific updates. Table 38 provides the health systems strengthening to HIV links.

**TABLE 37. NAMIBIA ACTIVITY DETAIL**

Y2Q4 Planned Tasks	Y2Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
<b>Activity I:</b> Implementation and institutionalization of national health accounts using the updated framework		
Support the Ministry's NHA focal point to identify key stakeholders for an NHA technical working group	In-country training has been provided to the NHA technical working group drawn from MOHSS (policy planning and human resources, special programs, finance), SSC, Chamber of Commerce, Namibia Medical Aids Fund, Ministry of Finance, and University of Polytechnique.	
Train the NHA technical working group on the updated SHA 2011 Framework and use of the HAPT	Scope and policy questions defined by the MOHSS with the NHA technical working group. Scope and questions presented during the official launch of the health accounts.	
Support the NHA technical working group launch the health accounts exercise	Detailed work plan developed and the HAPT customized.	
Support the NHA technical working group in customizing the survey instruments, and identify the sample frame and sampling pool for the data collection from primary sources	Health accounts exercise launched in the presence of key stakeholders led by the Deputy Minister of MOHSS. HFG supported the NHA technical working group in preparing the agenda and presentations.	
Support the NHA technical working group in recruiting and training of data collectors for collecting the necessary primary data	Survey instruments customized. Sample frame and sampling pool for the data collection from primary sources developed and finalized.	

Y2Q4 Planned Tasks	Y2Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
<b>Activity 2: Economic efficiency and effectiveness analysis for sustainable HIV/AIDS financing</b>		
Have work plan approved	The Y2 work plan was approved in June 2014.	
Conduct a costing workshop to help define the HIV/AIDS policy questions that need to be answered through costing studies and identify studies that HFG will support	The mission gave HFG permission to contact the MOHSS to agree on dates for the costing workshop. Absence from the office of our key counterpart at the Policy, Planning and Human Resource Development division and a change in leadership of the Division of Special Programs has made it difficult to get any traction on this activity. The HFG consultant in Namibia continues to seek audience with the ministry but has not succeeded yet.	HFG Namibia is awaiting feedback from MOHSS to proceed with scheduling the workshop.
Do costing studies as determined above	Awaiting feedback from the MOHSS.	
Hold two one-day workshops to disseminate results	Awaiting feedback from the MOHSS.	
Build capacity during costing workshop on the utility and usefulness of costing data for decision making	Awaiting feedback from the MOHSS.	
Transfer skills through active involvement of key MOHSS staff during costing exercises to increase their capacity in areas of costing data collection, collation, analysis, and interpretation	Awaiting feedback from the MOHSS.	
<b>Activity 3: Production of health financing review</b>		
Participate in the consultative stakeholder workshops and give technical support to the UHCAN and SSC	<p>Dr. Carlos Avila and the HFG country program manager, Claire Jones, participated in the UHCAN meeting that took place in March 2014, where Dr. Avila presented the objectives of the Health Financing Review to be conducted by HFG Namibia, facilitated discussions on the review, and received agreement from the committee on proceeding with the proposed activity.</p> <p>Claire Jones participated in the UHCAN meeting that took place in September 2014. She presented the objectives and some preliminary findings of the Health Financing Review based on publicly available information.</p>	The quarterly meeting scheduled for June was cancelled due to the Health Economist not having been hired by the SSC. Although the Health Economist has yet to be hired, it was decided that the meeting in September 2014 should nonetheless take place.

Y2Q4 Planned Tasks	Y2Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
Do data collection and analysis for Health Financing Review	A formal request to the MOHSS was made in June 2014 to proceed with data collection for the Health Financing Review; the answer is pending. HFG Country Program Manager Claire Jones and Dr. Avila submitted a research protocol outlining the specific objectives and data requirements of the Health Financing Review to the MOHSS research committee. Collection of publicly available information has commenced in the interim.	The HFG team is waiting for formal approval of the research protocol from the MOHSS before proceeding with the formal data collection.
Participate in study tours	Awaiting the employment of the Health Economist by the SSC.	
Participate in the evaluation and interviewing of candidates for the Health Economist position	Dr. Carlos Avila and Claire Jones participated in the recruitment and selection of the Health Economist that will be providing technical advisory support to the UHCAN. Telephone interviews were conducted with four candidates and then second round interviews were held for the top two candidates. The Health Economist position will be funded by the African Development Bank. Following approval of the recruitment and selection process by the Social Security Commission's legal team, an offer of employment will be extended to the finalist.	
Develop UHC and health financing communication strategy and products	Awaiting the employment of the Health Economist.	

**TABLE 38. NAMIBIA HEALTH SYSTEMS STRENGTHENING TO HIV LINKS**

Activity	Prevention	Diagnosis / HTC	Referral & Link to Care	Access and Retention	ART initiation	Viral Suppression (Chronic Care and Labs)	Support, Care and Quality	Comments:
<b>Activity 1:</b> <i>Implementation and Institutionalization of National Health Accounts Using the Updated Framework</i>  CORE	SHA 2011 allows the government and their partners to track expenditures on HIV prevention and HTC efforts; providing critical service delivery information such as who is doing what and where, at what level, and where there are service or funding gaps. This will enable government to more “effectively mobilize, coordinate, and efficiently utilize resources” in reaching HIV prevention and HTC target outcomes. By providing necessary foundational information on the magnitude and movement of resources for HIV prevention and HTC, it provides the basis for adequate budgeting and resource allocation to scale-up and strengthen prevention and HTC services.  For example, evidence generated from the health accounts activity will provide the government with key information on the healthcare landscape, such as coverage of prevention and HTC activities in both the public and private sector; thereby providing information that could help more effectively direct resources for maximum impact among diverse health sector providers, key populations, or geographic areas.			The NHA activity will provide integral evidence regarding the extent to which ART is financially supported, as well as assessing whether ancillary services have adequate resources to perform necessary HIV supportive interventions (i.e. laboratory or pharmaceutical services); their distribution (e.g. by level); and foundational financing information to assist in addressing resource gaps for ART linkage, retention, and success. These effectively inform budgeting and resource allocation decisions as well as assist in monitoring implementation progress  It also provides the basic information associated with magnitude of OOP spending on ART; which combined with utilization and overall household spending provides the basis to assess financial vulnerability of PLWHIV’s ability to seek out, and continually access needed care and treatment.			System of Health Accounts provides governments and key counterparts with the necessary evidence for adequate budgeting toward HIV prevention, care and treatment. It provides critical information as to magnitude and flow of HIV resources. Key information includes:  Source and management of funding: basis for gauging sustainability and government ownership  Level of spending: informing value for money (efficiency) and  Spending by facility ownership: informs possibility of leveraging of private sector in improving access  Purpose of spending (prevention, care and treatment): combined with respective resource needs helps identify gaps and resource allocation decisions  Evidence for mobilizing additional resources: e.g. provide the evidence on counter-part financing which is a key precondition on securing funding from Global Fund	

Note: HTC=HIV counseling & testing

#### 4.1.12 Nigeria

**Program Objectives** – The HFG project’s multi-year strategy with the government of Nigeria has two goals. The first goal, which is consistent with PEPFAR’s Road Map for an AIDS-Free Generation, is to mobilize additional government of Nigeria (at all levels) funding for national HIV programming. The objectives of our support in this area are to:

- Generate financial evidence on the costs, impact, and sustainability of HIV programming;
- Use this financial evidence to mobilize additional government resources; and
- Ensure efficient, effective, and equitable use of national HIV programming resources.

The capacity of Nigeria’s National Agency for the Control of AIDS (NACA) to mobilize Nigerian government resources for HIV will lessen the country’s dependence on donor funding. This is important as it contributes to greater country ownership and sustainability of not only the HIV/AIDS response but the whole health system in Nigeria. This goal is consistent with the PEPFAR Road Map for an AIDS-Free Generation, and also with the Nigerian President’s Comprehensive Response Plan for HIV/AIDS in Nigeria.

The second goal is to support the national response to TB programming by improving the diagnosis and treatment of TB through improved supportive supervision at the local government authority level. The use of smartphones is instrumental to the achievement of this goal as the smartphones allow for rapid feedback and improvement of TB services. This goal as well is consistent with the PEPFAR Road Map for an AIDS-Free Generation, and also with the President’s Comprehensive Response Plan for HIV/AIDS in Nigeria. This is because TB is the number-one HIV opportunistic infection and because of the great interrelationship between TB and HIV infections.

**Year 2 Activities** – In Year 2, the HFG project is addressing the HIV/AIDS resource mobilization goal through a number of activities, all of which are interrelated and collectively lead toward the achievement of this goal. One of the activities, using the “one health” tool, models the effects of HIV program funding over past years and analyzes the sustainability of HIV/AIDS programs by estimating the resources required to deliver services up to the year 2020. Its results provide the evidence that will be used to revise and finalize NACA’s resource mobilization strategy. A second activity (within the resource mobilization goal) builds the management and technical capacity of NACA’s Resource Mobilization Department (RMD), using organizational development (OD) approaches. This involves performing an institutional assessment to identify the priority areas for strengthening and using the results to develop and implement an intervention plan aimed at improving the organizational capacity of RMD to carry out its core functions. A third activity (within the resource mobilization goal) is the development of a resource mobilization strategy, which is a roadmap to how the additional resources for HIV will be mobilized. A fourth activity addresses the need for efficient and effective use of resources by developing key performance indicators (KPIs) for the implementation of performance-based budgeting. This will ensure that the additional resources mobilized for HIV will have key performance indicators upon which performance can be monitored.

Regarding TB supportive supervision work (second goal), in Year 2, HFG evaluated the TB supportive supervision activity, which has successfully used innovative smartphone technology to efficiently manage information; improve the quality of feedback; track, diagnose, and treat TB and TB/HIV co-infection; and inform strategic evidence-based actions in TB facilities. The evaluation refines the supportive supervision system and pinpoints areas where the National Tuberculosis and Leprosy Control Program could further benefit from additional sustainability efforts. The evaluation also informs the proposed rollout of this work to additional states in Nigeria.



**Year 2 Progress** – HFG launched HIV/AIDS resource mobilization activities in October 2013 in close collaboration with NACA and other stakeholders. Data collection (using the “OneHealth” tool) to inform the HIV/AIDS financing analysis was first carried out in the 12+1 priority HIV states. Due to the need to get data from all the states, additional data collection was carried out and the project has now collected data from all the states in Nigeria. A report on the analysis of the data has been prepared. As part of capacity building on the “OneHealth” tool, HFG trained NACA staff and key stakeholders on use of the tool to create scenarios for the President’s Comprehensive Response Plan 2013–2015 and beyond (up to 2020), and to demonstrate how this feature can be deployed during priority setting and its implication on costing and cost effectiveness analysis. An organizational and management capacity assessment of NACA’s RMD was conducted in October and found that lack of clarity about job responsibilities and lack of technical skills and knowledge about resource mobilization hinder individual job performance and the overall performance of the RMD. As a result, HFG has developed and started implementing an organizational capacity strengthening plan. A workshop conducted to this effect, with the purpose of introducing the RMD team to the basics of resource mobilization and building common understanding about organizational vision, mission, and objectives as well as functions of the department, was very well received by the participants. This has subsequently been followed up by training on making presentations that are critical to the resource mobilization effort. NACA RMD staff were trained on how to make effective presentations and then required to make individual presentations in front of their peers.

The HFG team has also conducted exploratory interviews with State Agencies for the Control of AIDS (SACAs), the Federal Ministry of Finance (FMOF), and the private sector in Nigeria to inform these stakeholders of the process for the development of a resource mobilization strategy for HIV/AIDS. The idea of setting up a specific and transparent fund which includes private sector contributions emerged from the interviews. Resource mapping from all sources, including government (both federal and state level), donors, and private sector is ongoing. Following consultations with NACA RMD leadership and staff, HFG developed and finalized key performance based-budgeting indicators for all of NACA’s departments.

HFG and NACA RMD agreed on a candidate for Health Finance Advisor who was embedded in NACA’s RMD starting on July 1, 2014. On July 7, 2014, HFG also hired a Chief of Party, who also has an additional technical Health Finance Advisor role, as he has a strong technical background in public sector financing.

For TB supportive supervision work, the design of the quantitative and qualitative evaluation process was completed. An evaluation methodology was developed and shared with the mission. Key indicators for the quantitative evaluation were selected, site selection and survey instruments were finalized, and data collectors were identified and trained. Data collection and analysis have been completed, and an evaluation report has been prepared and submitted to USAID Nigeria for final approval.

**Challenges** – Programming funding for Year 2 under the category of Family Planning/Reproductive Health and MCH has been a challenge. There have been discussions between the mission and HFG on options for potential activities to be implemented under this funding. However, a final decision has not yet been made.

The Health Finance Advisor embedded in NACA has had to shift to work from the HFG office, rather than from NACA offices, as NACA expressed challenges in reporting arrangements of an embedded advisor located in their offices, while also being an employee of HFG. This has created an opportunity to have the embedded advisor spend more time on supporting the HFG HIV/AIDS resources mobilization effort in the four key states (Cross Rivers, Akwa-Ibom, Rivers and Lagos), where he has already provided needed added-value.

**Q4 Additional Information** – The work-planning process for the new funds provided for additional Year 2 HFG funding was underway during this quarter. During discussions with the mission, it was agreed that this be merged into one Year 3 work plan, which has been submitted to the mission for approval. Communications between the mission and HFG are still ongoing to finalize some of the activities to be funded in the work plan. In particular, funds which have been available for Family Planning/Reproductive Health and funding for MCH are still to be programmed as the mission is still consulting internally.

Table 39 provides activity-specific updates. Table 40 provides the health systems strengthening to HIV links

**TABLE 39. NIGERIA ACTIVITY DETAIL**

Y2Q4 Planned Tasks	Y2Q4 Progress	Critical Assumptions/ Problems Encountered/Follow-up Steps
<b>Activity 1: HIV/AIDS financing analysis</b>		
Analyze the results and produce a draft financing analysis for NACA and USAID review	Data analysis has been completed and a report has been written based on the analysis.	The analysis will be the basis for the evidence for recommendations on resource mobilization.
Disseminate findings and conduct a 3-day workshop on turning the findings into action	Findings from the analysis were disseminated in August 2014.	
<b>Activity 2: Building the capacity of NACA's RMD</b>		
Implement organizational capacity-strengthening interventions	Organizational capacity-building workshops were held for NACA RMD in Q2 and Q3. This work is ongoing and is part of the scope of work of the newly hired Health Finance Advisor.	NACA RMD finds these organizational capacity-building interventions to be very useful and has requested that they be extended beyond the RMD.
Implement technical capacity interventions	A technical capacity-building workshop was held for NACA RMD in Q2. This work is ongoing and is part of the scope of work of the newly hired Health Finance Advisor.	
Monitor and evaluate progress and adjust capacity-strengthening plan	HFG continually monitors progress and adjusts the capacity building plan as needed. During the last quarter, HFG started working with the SACAs, to complement the work at national level with NACA.	
<b>Activity 3: Development of a Resource Mobilization Strategy.</b>		
Promote the establishment of a core resource mobilization strategy technical advisory committee (composed of NACA RMD head and representatives of appropriate units in FMOH and FMOF)	The establishment of an advisory committee is the result of discussions that HFG had with NACA and other key stakeholders in country.	This will be part of the final version of the resource mobilization strategy.

Y2Q4 Planned Tasks	Y2Q4 Progress	Critical Assumptions/ Problems Encountered/Follow-up Steps
Map existing and potential sources and mechanisms of HIV/AIDS resource mobilization in Nigeria (including reviewing the fiscal space in consultation with FMOF and other relevant agencies)	Resource mapping from all sources is currently underway.	The resource mapping will serve as an input for revising the draft resource mobilization strategy.
Estimate the total and additional resources that will be mobilized from all sources	Since the data collection and analysis for the finance analysis has been completed, this analysis is now being transferred to be used for the resource mobilization strategy.	This will be part of the final version of the resource mobilization strategy.
Facilitate consultation meeting with the resource mobilization strategy technical advisory committee	This will be done once the committee is in place. The resource mobilization strategy will serve as a critical document for RMD/NACA and Resource Mobilization Committee.	NACA and stakeholders are supportive of the formation of this committee.
Revise the draft resource mobilization strategy	A revised draft resource mobilization strategy will be developed upon completion of the resource mapping and the identification of potential additional funding for the HIV/AIDS response.	The strategy will include support to the Presidential Comprehensive Response Plan for HIV/AIDS in Nigeria.
Present the revised strategy to the core resource mobilization strategy technical advisory committee	See above.	
Hold stakeholder engagement workshop – share with NACA and stakeholders the strategy and total estimates of resources to be mobilized from all sources	See above.	
Refine the strategy and estimated resources based on inputs and feedback from all stakeholders	See above.	
Support/facilitate policy advocacy and consultation workshops to popularize the strategy and secure support from all relevant stakeholders	See above.	
Produce the final resource mobilization strategy	See above.	

Y2Q4 Planned Tasks	Y2Q4 Progress	Critical Assumptions/ Problems Encountered/Follow-up Steps
<b>Activity 4: Development of indicators for performance-based budgeting</b>		
Develop performance-based budget indicators	Completed in Q2.	<ul style="list-style-type: none"> <li>• NACA needs to reflect upon the initial set of performance indicators to assure itself that these are the most important measures of its activities and then begin to establish baseline and targets for the performance indicators.</li> <li>• Additional work may need to be designed (depending on availability of additional funding) to help the Federal Capital Territory Action Committee Against AIDS and the 36 SACAs to develop performance indicators.</li> <li>• HFG has been informed that NACA's Strategic Knowledge Management Department has developed additional indicators that need to be harmonized with the key performance indicators developed with HFG assistance. HFG will review those indicators and recommend next steps.</li> </ul>
<b>Activity 6: Embedded health finance advisor</b>		
Submit health financing policy briefs	The embedded Health Finance Advisor reported to work on July 1, 2014 and has begun working with NACA to develop health policy briefs and conduct advocacy visits at the state level. As a result, 35 million Naira were approved for release in Cross Rivers State and 600 million Naira allocated for approval in the next budget cycle. Additional advocacy visits, using policy briefs have also taken place in Akwa Ibom State, and Rivers State. An Advocacy visit to Lagos state is planned for October 2014.	
Embedded advisor to prepare weekly progress reports (ongoing)	Advisor prepares progress reports on an ongoing basis.	
Embedded advisor to prepare monthly progress reports (ongoing)	Advisor prepares progress reports on an ongoing basis.	

Y2Q4 Planned Tasks	Y2Q4 Progress	Critical Assumptions/ Problems Encountered/Follow-up Steps
<b>Activity 7:</b> TB supportive supervision evaluation		
Clean and analyze data sets and write report	Cleaning and analysis of data has been completed, all comments on the draft evaluation report have been addressed and a final report has been submitted to USAID Nigeria for official approval.	
Disseminate evaluation findings in meetings with key donors, stakeholders and partners	Findings will be disseminated to all stakeholders once official approval of the evaluation report is received.	

**TABLE 40. NIGERIA HEALTH SYSTEMS STRENGTHENING TO HIV LINKS**

Activity	Prevention	HTC/Diagnosis	Referral and Link to Care	Access and Retention	ART initiation	Viral Suppression (Chronic Care and Labs)	Supportive Care and Quality	Comments
<b>Activity 1:</b> HIV/AIDS financing analysis  <b>CORE</b>	The financial analysis provides estimates of numbers of new infections that will be prevented with different levels of financial input.	The financial analysis includes the cost of delivery of HIV services including the cost of scaling up diagnostics and care. Understanding such costs is critical in planning / providing resources for the successful scale-up of HTC services.	The financial analysis includes the cost of human resources for HIV/AIDS care, which is a critical element in ensuring that HRH is adequate in order to link patients between HTC and care.		The financial analysis provides estimates of financial resources needed for provision of HIV/AIDS services for a given number of people at national or state levels. The availability of financial resources is one of the determining factors for the number of clinically eligible people that can be initiated on anti-retroviral therapy. With more financial resources, more clinically eligible people can be started on ART.	Understanding the costs of providing ART long-term is critical in adequately planning for patients to remain in chronic therapy. Patients who are accounted for, and budgets that are adequate/appropriate, can assist in supporting patients to thrive on therapy long-term, thus contributing to their success in reaching viral suppression.		The one health tool that is being used in Nigeria for the financial analysis helps policymakers by providing financial information on the costs of three scenarios of the HIV response: maintain scenario (current levels of service provision); moderate acceleration scenario and; finally an aggressive acceleration scenario. Each scenario is associated with the numbers of HIV infections prevented and the numbers of deaths prevented.

Activity	Prevention	HTC/Diagnosis	Referral and Link to Care	Access and Retention	ART initiation	Viral Suppression (Chronic Care and Labs)	Supportive Care and Quality	Comments
								<p>Polymakers need this analysis to inform their decisions on mobilizing additional resources for the HIV/AIDS response.</p>
<p><b>Activity 2:</b> Build the capacity of NACA's RMD</p> <p>CORE</p>	<p>NACA RMD has the responsibility of coordinating the mobilization of the national HIV/AIDS response, including HIV prevention activities. Capacity building of NACA RMD can therefore improve HIV outcomes by strengthening national capacity to scale-up i) prevention services; ii) links between HTC and care; iii) retention in HIV care, and iv) initiation of ART.</p>							<p>NACA RMD is responsible for mobilization of HIV/AIDS resources necessary for HIV/AIDS prevention and care. Building the capacity of NACA RMD ensures that the necessary resources for HIV/AIDS prevention and care are available for deployment to the HIV/AIDS response.</p>



Activity	Prevention	HTC/Diagnosis	Referral and Link to Care	Access and Retention	ART initiation	Viral Suppression (Chronic Care and Labs)	Supportive Care and Quality	Comments
<b>Activity 3:</b> Development of a Resource Mobilization Strategy.  CORE	The resource mobilization strategy identifies the needs and gaps for resources for the HIV/AIDS response including resources for HIV/AIDS prevention.	The resource mobilization strategy identifies resources needed and the gaps for the HIV/AIDS response including resources for HIV diagnostic services.	The resource mobilization strategy identifies the resource needs and gaps for adequate linkage to, delivery of, and retention in HIV/AIDS care.		The resource mobilization strategy identifies the resource needs and gaps for ART.			The resource mobilization strategy maps existing resources, potential additional resources, and innovative mechanisms of HIV/AIDS resource mobilization in Nigeria. This will help in identifying gaps and potential sources of resources to fill these gaps. That information is vital for mobilization of more financial resources to be utilized for HIV/AIDS prevention and care in Nigeria. More resources mobilized will mean more patients who can receive HIV/AIDS services.

Activity	Prevention	HTC/Diagnosis	Referral and Link to Care	Access and Retention	ART initiation	Viral Suppression (Chronic Care and Labs)	Supportive Care and Quality	Comments
<b>Activity 4:</b> Development of indicators for performance-based budgeting  CORE	The development of key performance indicators for NACA RMD includes NACA performance in HIV prevention				The key indicators include indicators linked to treatment and care as part of monitoring the overall national response.	The key indicators include indicators linked to viral suppression, as part of monitoring the overall national response.		Key performance indicators for NACA RMD link the use of HIV/AIDS financial resources to key indicators. This strengthens accountability for HIV/AIDS resources, and ensures that resources that are utilized are linked to HIV/AIDS-related deliverables.
<b>Activity 6:</b> Embedded health finance advisor  NEAR CORE	The embedded Health Finance Advisor supports NACA RMD in mobilizing resources for prevention.	The embedded advisor supports NACA RMD in mobilizing resources for diagnosis.	The embedded advisor supports NACA RMD in mobilizing resources for treatment and care.		The embedded advisor supports NACA RMD in mobilizing resources for ART.			The embedded advisor is a resource person who ensures that there is technically sound assistance to NACA RMD to help it mobilize additional financial resources for prevention, treatment, and care.

Activity	Prevention	HTC/Diagnosis	Referral and Link to Care	Access and Retention	ART initiation	Viral Suppression (Chronic Care and Labs)	Supportive Care and Quality	Comments
<b>Activity 7:</b> TB supportive supervision evaluation  CORE	TB supportive supervision ensures that HIV prevention interventions are also provided to TB patients.	TB supportive supervision ensures that TB patients receive HIV diagnostic services due to the high risk of TB/HIV co-infection.	TB supportive supervision ensures that TB patients that are eligible for HIV care receive the HIV care.	TB supportive supervision ensures that TB/HIV co-infected patients are retained into both TB and HIV treatment.	TB supportive supervision ensures that TB/HIV coinfectd patients are promptly initiated in the appropriate TB and ART treatment regimens.	TB supportive supervision for TB/HIV co-infected patients ensures that patients receive appropriate care for co-infection, that patients succeed on therapy, and thus reach viral suppression.	TB/HIV collaboration is a key indicator of quality of TB and HIV service delivery. TB supportive supervision ensures that that element of quality of care in TB/HIV collaboration is maintained.	The TB supportive supervision checklist includes questions on TB/HIV coinfection. Effective TB supportive supervision ensures that TB patients receive HIV testing and counseling services and patients that need HIV treatment and care are promptly provided with the services.

Note: HTC=HIV counseling & testing

### 4.1.13 Swaziland

**Program Objectives** – The PEPFAR Partnership Framework on HIV and AIDS 2009-2013 between the Government of the Kingdom of Swaziland and the U.S. Government committed the two countries to work together to address challenges in Swaziland’s health and social welfare (SW) systems to mitigate the impact of HIV/AIDS.

One of the key intervention areas focuses on the development of human and institutional capacity to manage an effective HIV response. Within this key intervention area, the countries plan to “further strengthen human resource capacity in the areas of human resource management, policy reform, recruitment, retention and training, and to build institutional capacity across program areas through management systems strengthening and enhanced infrastructure” (PEPFAR Partnership Framework). HFG’s program activities in Swaziland will support the strengthening of human resource capacity within the system, particularly the capacity of the Ministry of Health (MOH) for human resources for health (HRH) management, policy reform, and retention.

A second key intervention area that HFG’s program will focus on is the mitigation of the impact of HIV/AIDS on vulnerable children and their families. The Partnership Framework prioritizes the development and implementation of national program standards and strategies for quality improvement, enhancement of program monitoring, and scaling up of quality services and support for vulnerable children. HFG will support the strengthening of the Department of Social Welfare (DSW) and regional social service providers to deliver in these strategic areas.

**Year 2 Activities** – In 2012-13, Abt Associates worked as a subcontractor with one of PEPFAR’s implementing partners, the Human Resource Alliance for Africa (HRAA), on technical assistance to the MOH and DSW. The activities in the HFG work plan build upon the work the HRAA and Abt Associates have completed.

Technical assistance in the first and second quarters have been provided primarily through short-term HRH and social work specialists based in the United States and within the southern African region. HFG also worked during this time to establish a site office and hire full-time staff. The site office was fully staffed by May 2014.

In HRH, HFG works with the MOH, mission, and other stakeholders in four areas that were identified as priority by HRH stakeholders: 1) supporting completion and implementation of strategic plans; 2) improving the structure and capacity of human resources management and oversight; 3) strengthening human resource information system (HRIS) and use; and 4) strengthening the professional councils’ capacity for regulatory oversight.

The HFG SW activities complements and builds on prior PEPFAR investments in the Lubombo region to establish a comprehensive decentralized SW delivery system, and to explore potential expansion of the decentralized approach to the Manzini region. In addition, the project will work with the DSW and other SW stakeholders in the country to identify priority barriers to SW service delivery and to develop concrete strategies for addressing them. All HFG SW work in Swaziland is guided by two parameters articulated by PEPFAR/Swaziland: (1) Technical support to strengthen SW systems and human resources should be connected to concrete improvements in service delivery; and (2) Bottlenecks in service delivery should be addressed as a priority, even while restructuring or other large-scale efforts are ongoing.

**Expected results:**

- Strengthened capacity and increased resources within the MOH for implementation of the Human Resources for Health Strategic Plan
- Strengthened human resources for health workforce planning and HRIS data use within the MOH
- Improved capacity within the Swaziland Nursing Council and Swaziland Medical and Dental Council to regulate health workers practicing within the Kingdom
- Strengthened decentralized systems and structures required to provide comprehensive SW services in Lubombo region
- National-level strategies to address systemic barriers to the delivery of efficient, effective, and equitable SW services

**Year 2 Progress** – Quarter 1 of Year 2 was essentially the first quarter of work in Swaziland for HFG, given the receipt of the initial tranche of funding in late August 2013. HFG submitted an updated work plan to USAID/Swaziland in late December 2013 based on the findings of two work-planning trips carried out in the final quarter of Year 1, and the first quarter of Year 2.

Over the course of Year 2, HFG Swaziland undertook the process of opening and staffing a site office, which is now up and running. Steps completed as part of this process included registering with the local government, obtaining a trading permit, applying for tax exemption, procuring equipment, supplies and furniture for the office, and identifying and hiring staff. All legal, administrative, and procurement needs have been completed and the HFG Swaziland office is now fully operational, with a full staff of six Swazis and one Third-Country National. The project's Chief of Party, a former member of the Swazi parliament and former executive director of a prominent Swazi NGO, began in August 2014. Additionally, the HFG Swaziland Office includes a Senior HRH Technical Advisor (who the project relocated from Uganda in March), a Regional Social Welfare Technical Advisor, a Finance and Administrative (F&A) Manager, a Program Associate, and a Driver.

**HRH** – Since the HFG work plan was approved, in Quarter 2 of Year 2, HFG has made significant strides in the implementation of the HRH component of the work plan. Early in 2014, a three-day retreat for the HRH Technical Working Group (TWG) was held to develop a 15-month implementation plan for the HRH Strategic Plan. The plan was designed to support the coordination of the MOH's HRH activities including oversight of partners supporting HRH, and covered three main areas: HRH Planning and Financing, HRH Development, and HRH Management. Subgroups of the TWG were formed in alignment with the three areas, and chairs from the MOH were appointed. The subgroups have been responsible for driving forward the agenda over the course of the year. HFG has participated in the Planning and Financing and Management subgroups, and supports the Human Resources Unit (HRU) in monitoring results and reporting back to the MOH Senior Staff on a monthly and quarterly basis.

Dr. Grace Namaganda, the project's Senior HRH Technical Advisor, has co-located within the HRU three days a week, and has rapidly built rapport with the HRU team, providing effective day-to-day mentorship and targeted training in the technical areas. HFG conducted an assessment of the HRU's HRH technical skills, which will complement an assessment of the HRU's organizational capacity currently underway with the WHO, and will be used to develop a formal capacity-building plan. HFG has already provided training in three areas requested by the HRU: training on human resource Policies and Procedures relating to industrial relations was completed in July 2014, and a compendium of labor laws was given to each staff member for reference. The staff was also trained in collecting data for contracts and operational planning in September 2014. In the area of information technology (IT), one-on-one coaching and mentoring is being provided by the HFG HRH Technical Advisor in the use of MS Excel, Mail, Word, and PowerPoint to address one of the primary skills gaps among HRU staff and MOH managers.

Much of HFG's mentorship work this year has focused on strengthening the HRU team in basic management and administration skills. HFG supported the institutionalization of weekly meetings in HRU designed to improve communication and planning, and in September hosted and facilitated a retreat for HRU staff. The team was guided in prioritizing their tasks and developing a work plan and calendar specific to the responsibilities of the unit. Through the technical assessment, the HRH advisor identified the various tasks and roles HRU staff were performing, and used this information to guide the development of a short-term functional structure that has been proposed to senior MOH staff as a way forward while they grapple with long-term systemic changes within the Unit.

HFG played a significant role in the development of the Swaziland National Health Sector Strategic Plan II (NHSSPII) as rapporteur and writer for the HRH component. The NHSSPII draft is currently under review, and HFG is poised to provide support in finalizing the HRH section. To inform the development of the Plan, HFG conducted an analysis of the data contained within the HRIS to develop the first "Swaziland Human Resources for Health (HRH) Status Report." The report contained up-to-date information on the number and density, distribution, retention and attrition of health workers. The development of this report required intensive manipulation, and in some instances, hand-counting of the data contained within the HRIS.

In addition to informing the NHSSPII, the experience of developing the report informed the identification of HRIS user requirements for the customization of the system. A rapid assessment of the HRIS was conducted to document system use and identify bottlenecks, challenges and areas for improvement. Furthermore, a workshop was held in August, 2014 with operational level MOH human resource managers, and HFG conducted interviews with senior-level MOH planners to determine HRIS user needs. A total of 18 reports were identified as priority, and HFG is working with a WHO-sponsored IT specialist to customize the HRIS to incorporate these reports.

HFG worked closely with the Swaziland Nursing Council and numerous local stakeholders to produce entry-to-practice nursing competencies. Through an intensive process which involved several participatory workshops and meetings with a variety of stakeholders, including representatives from Swaziland's nursing schools and hospitals, nursing competencies were developed and refined in the areas of general nursing, midwifery, community health, and community mental health. This accomplishment advances the project's HRH portfolio by increasing the regulatory capacity of Swaziland's professional councils. In addition, in order to support the Nursing Council's capacity to work productively, HFG procured a prefabricated trailer for the council, which will be used primarily to hold meetings. The trailer was formally inaugurated in a well-attended and successful launch event in September.

Finally, HFG has engaged with the MOH and USAID-Swaziland to determine that establishing a Medical and Dental Council according to the current statute is a high priority, and developed a plan for engaging the Council. As a first step, HFG has supported the MOH in drafting a Scoping Paper to be submitted to the Cabinet.

**Social Work –** HFG initiated SW activities in Swaziland in Quarter 1 of Year 2 in close collaboration with USAID/Swaziland, the DSW, other Ministerial representatives, and Lubombo regional stakeholders. This engagement included the finalization of project work and implementation plans and subsequent approval by USAID/Swaziland. HFG's focus within the SW sector is centered primarily at the regional level in Lubombo, supporting the DSW and the broader child welfare and protection system. In addition, HFG actively coordinates project work with the DSW at the central level as well as other ministerial stakeholders, such as the Ministry of Justice.

Since beginning its work in Swaziland, HFG has been engaged in various capacity building efforts with the DSW in the Lubombo region and the newly established Child-Friendly Court (CFC) in Siteki. HFG's Lubombo Regional SW Advisor supports the Siteki site and Lubombo satellite offices, providing on-the-job training to the DSW social welfare officers. HFG has also conducted more formal training

workshops for the officers in forensic SW, writing court reports, and an orientation to the Child Protection and Welfare Act (CPWA), highlighting its practical relevance and use in the Swazi court system. In addition, the project has identified consultants to deliver trainings on customer service and case management for the officers, two elements vital to the DSW's provision of quality SW services in the region with the training planned for the next quarter.

In Q4, HFG developed and publicly issued two Requests for Applications (RFAs) aimed at enhancing HFG's efforts to strengthen the SW sector in Lubombo. One RFA was designed to identify and provide subawards to SW service-providing NGOs in the region to expand SW services, better define SW practice service delivery models, and enhance the capacity of the regional SW workforce. The second RFA was developed to support the project's work with the Lubombo child protection system by seeking an organization with expertise in the field of child development and law. Under the RFA, the subrecipient will conduct trainings for the Siteki CFC staff. In Q3, HFG carried out a number of targeted procurements to ready the CFC for everyday use, and organized a launch event for the court. The CFC RFA will ensure that those trained to operate the existing "adult" court will understand and follow the procedures and processes inherent in working with child witnesses. Applications for both the NGO and CFC RFA are currently under review by the project. Memorandums of Negotiations will be submitted to USAID/Washington for approval in the beginning of Year 3.

HFG continues to make inroads in strengthening the SW delivery system in Lubombo by supporting the formalization of linkages and coordination mechanisms across and between service delivery partners. This has included engaging in periodic meetings with USG/PEPFAR and the DSW in Lubombo, as well as participating in a stakeholder meeting in the Lower Lubombo region with the DSW and both local and international SW sector partners. The NGO RFA will further cement these linkages by identifying SW service delivery partners in the region and establishing a formal coordination mechanism whereby HFG will support the DSW to convene and chair the stakeholder group.

**Challenges** – The various operational issues surrounding opening and staffing the site office presented the project's greatest challenge this year. The unexpected resignation of the project's initial Chief of Party after only a week on the job made it particularly difficult for project work to move forward. Nonetheless, most of these operational challenges have now been resolved, the site office is fully staffed and running, and program work is moving forward.

Table 41 provides activity-specific updates. Table 42 provides the health systems strengthening to HIV links

**TABLE 41. SWAZILAND ACTIVITY DETAIL**

Y2Q4 Planned Tasks	Y2Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
<b>Activity I: Establish a HFG program office in Mbabane, Swaziland</b>		
Hire consultants/staff to begin program activities	Staff have been hired for all positions, including a COP, 2 technical advisors, an F&A manager, a program associate, a front desk officer, and driver.	
Provide on-boarding training to all key personnel	A two-day onboarding workshop was held in May 2014 and led by HFG's Country Manager. The project's Finance and Contracts analyst travelled to provide additional training to F&A staff in July 2014.	Additional support and training is being provided to program staff on an ongoing basis.



Y2Q4 Planned Tasks	Y2Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
<b>Activity 2: Support completion and implementation of HRH Strategic Plans</b>		
Provide monitoring and evaluation (M&E) support to the HRU	HFG supported the M&E TWG in piloting and refining reporting tools in Q2 and Q3, and is currently supporting the TWG and HRU to use reporting tools to drive the HRU agenda forward, including quarterly and in-depth reviews of the TWG.	Utilization of the tools is still spotty by the component teams, with varying degrees of quality and completeness. New group members are not aware of the TOR, and must be oriented.  HFG will continue to support the different functional groups within the TWG to improve adherence to the new reporting structures, and to work with the HRU to follow-up on findings.
Facilitate stakeholder meetings on the HRH component of the NHSSPII)	HFG provided support to the World Bank consultant identified to lead the process of developing the NHSSPII. HFG assisted the consultant in preparing for the meeting, served as rapporteur.	
Support the MOH in the development and writing of the HRH component of the NHSSPII	HFG led the writing and editing of the HRH component of the HSSP, and submitted the component in August for review by the consultant and MOH senior staff.	The NHSSP HRH section is still under review by the MOH senior staff. HFG will assist with final changes once reviews are received.
<b>Activity 3: Improve the structure and capacity for human resources management and oversight</b>		
Conduct rapid assessment of key skill sets within the MOH HRU staff	A technical capacity assessment was completed in August 2014 with in-depth participation of HFG staff. The draft report was made available to WHO, which is carrying out a companion organizational assessment, in September 2014 and is currently being finalized.	The report will be shared with stakeholders for comments.
Provide training and mentorship of HRU staff in key HRH management areas	The HFG HRH Technical Advisor continued to sit three days per week in the HRU to provide support. Currently capacity development is based upon emergent needs, and has included a broad range of activities.  HFG hosted and facilitated a retreat for HRU staff in Sept 14 in which a work plan and calendar were developed, and weekly meetings with the HRU staff were institutionalized to improve communication and planning in all these areas.	A capacity-development plan will be developed based upon outcomes of HFG and WHO's capacity assessments.
Propose and support the implementation of structural reforms for HRU	The technical capacity assessment completed in August identified the tasks each staff member is currently performing. The HFG Advisor supported the HRU to institute weekly meetings to assist with delineation and coordination of functions.  Advocacy continues for the short-term	The HFG advisor is supporting the HRU to clearly define job functions for the HRU staff.

Y2Q4 Planned Tasks	Y2Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
	functional structure proposed in Quarter 3. However, senior MOH staff have yet to approve it.	
Provide organizational development support, day-to-day mentorship in core functions, and systems-building support	<p>The HFG Senior HRH Technical Advisor continued to sit in the HRU at least 3 days a week and provide extensive mentoring and support to the staff in areas including: preparation for request for posts, development of terms of reference, writing of memo and minutes, use of MS Excel to conduct basic analyses, preparation of presentations, and writing minutes.</p> <p>HFG supported the HRU to develop an annual work plan with clear roles and responsibilities for each staff, and supports weekly meetings to ensure the plan and structure are working appropriately.</p>	Demand for capacity development is extensive within the HRU. For continued effectiveness, HFG, the HRU and USAID need to come to agreement regarding the extent of capacity building appropriate for HFG to be providing. In addition, busy schedules/ inadequate staffing of HRU makes implementation of capacity building activities difficult.
Build HRU capacity in three core functions: IT use, contract management, and industrial relations	<p>A training on human resource policies and procedures relating to industrial relations was completed in July 2014, and a compendium of labor laws was given to each staff member for reference.</p> <p>Training for all HRU staff on collecting data for contracts and operational planning was completed in September 2014.</p> <p>In the area of IT, one-on-one coaching and mentoring was provided by the HFG HRH Technical Advisor in the use of MS Excel, Mail, Word, and PowerPoint, the areas of need identified by a rapid assessment of knowledge of HRU staff and MOH managers.</p>	<p>HFG's HRH Technical Advisor will continue to provide daily follow-up support in these three areas.</p> <p>A decision must be made on how much technical assistance to provide in-house, and when to outsource, such as additional IT training.</p>
<b>Activity 4: Strengthen HRIS and data use</b>		
Adapt and troubleshoot HRIS	In Q3, HFG conducted a rapid assessment of the HRIS to document system use, bottlenecks to use, challenges faced, and areas for improvement. In addition, HFG collaborated with the WHO in the development of a SOW for an IT specialist to modify the system.	
Facilitate stakeholder meeting to determine HRIS functional requirements and HRIS implementation plan	In August 2014, HFG held a workshop with operational level MOH human resource managers and conducted interviews with senior-level MOH planners to determine HRIS user needs. A total of 18 reports were identified as priority, including individual lists that contain employee- or post-specific information and summary reports that provide information in an aggregated form.	The WHO IT specialist is currently customizing the 18 priority reports into the HRIS. In addition, the process of revitalizing the system will be outlined in an HRIS road map to be discussed with and agreed on with relevant MOH and other stakeholders.

Y2Q4 Planned Tasks	Y2Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
Modify existing HRIS in line with stakeholder group inputs	WHO IT specialist will customize HRIS to incorporate 18 reports determined as highest priority during user needs workshop and key stakeholder interviews.	
Support HRU to undertake an analysis and reporting cycle with HRH data sources	<p>The HRH Advisor supported the HRU staff to build capacity to run reports and analyze data. New reports are currently being customized into the HRIS based on determination of HRIS user needs.</p> <p>The HRH Advisor supported the HRU to produce the first "Swaziland HRH Status Report" with data culled from the HRIS.</p>	Future production of reports awaits finalization of the HRIS customization process.

**Activity 5: Strengthen the professional councils' capacity for regulatory oversight**

Host stakeholder meetings to define practice competencies for nurses and midwives	A total of 4 stakeholder meetings and workshops were held in July-August 2014 as part of the process of developing, defining, and building consensus on the nursing competencies.	The Entry-to-Practice Nursing Competencies will be finalized in October 2014 and distributed shortly thereafter.
Provide additional capacity-building support	<p>In order to support the Nursing Council's capacity to work productively, HFG procured a prefabricated trailer for the council in Q4, which will be used primarily to hold meetings. The trailer was formally inaugurated in a well-attended and successful launch event in September, 2014.</p> <p>HFG determined in collaboration with the MOH and USAID-Swaziland that the priority is first establishing the Medical and Dental Council according to the current statute. As a first step, HFG supported the MOH in drafting a Scoping Paper to be submitted to the Cabinet.</p>	Follow up meetings with Medical and Dental Council stakeholders to establish the full board.

**ACTIVITY 6: Support to DSW in the Decentralization of Social Welfare Systems and Services to the Lubombo Region**

Establish HFG regional presence in Lubombo	HFG staff presented the project to regional stakeholders at a meeting held in Lubombo in August. The project will engage in quarterly stakeholder meetings with other actors in the region.	Plans to collaborate with a Peace Corps volunteer in Lubombo to provide targeted support to the DSW office have been put on hold as the proposed volunteer is now unavailable.
Provide technical assistance to Lubombo regional DSW office Case Management System	<p>A rapid assessment of the Electronic Case Management System (eCMS) was completed in Q2. Additional input was obtained from local stakeholders on the system in Q3 and Q4. A draft SOW has been developed for a programmer to modify the eCMS.</p> <p>HFG's Senior SW Advisor (consultant) is currently developing draft guidelines for client assessment and case planning for the DSW.</p>	<p>Following modification of the system, HFG will provide training to the system users.</p> <p>The HFG Senior SW Advisor will likely return to Swaziland in Y3Q2 following finalization of the guidelines to train Lubombo staff on how to use them in their work.</p>

Y2Q4 Planned Tasks	Y2Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
Build capacity of staff integral to the provision of SW services	<p>The HFG Regional SW Advisor provides on-the-job support to the Lubombo DSW office for 3 days per week.</p> <p>HFG developed a SOW and identified a consultant to deliver a training to the Lubombo DSW in customer service and interpersonal communication skills. The HFG Senior SW Advisor will provide input on SW-specific material and scenarios for the training course.</p> <p>HFG delivered a three-day training on Forensic Social Work in July. This was a follow-up to a seven-day training in January, and focused on the writing of court reports by DSW social workers. In addition, HFG conducted a workshop with Swazi court officials to build consensus on the standards and formats for Swazi court reports.</p> <p>An RFA was issued in Q4 to identify an organization to provide trainings for key participants in the PEPFAR-supported child-friendly court in Lubombo. This group includes court role players (e.g., magistrates, prosecutors, judicial officers) and court intermediaries.</p>	<p>Following negotiations with the preferred RFA applicant for the court trainings, a Memorandum of Negotiation will be submitted to USAID/Washington for approval.</p>
Strengthen coordination and referral mechanisms among SW service providers in the Lubombo region	HFG has been actively engaging with SW partners in the Lubombo region.	HFG will work with the DSW to convene and chair a regional SW stakeholder group that will serve as the principal mechanism for improved regional collaboration.
<b>Activity 7: Support to DSW to develop strategies to address systemic barriers to SW service delivery</b>		
Support implementation of Child Protection and Welfare Act	<p>HFG supported an orientation to the CPWA for Social Workers by the Lubombo Crown Counsel in June.</p> <p>An analysis of CPWA is in progress with support from the HFG Senior SW Advisor to determine the consequences of the CPWA's implementation on scopes of practice for social workers.</p>	<p>Depending on the complexity of the CPWA, HFG may need to engage a legal advisor for further analyses.</p>
Develop strategies for enhancing the quantity of degreed social workers in Swaziland	There was no progress under this task, as the intention of the activity was to support the University of Swaziland in the design and creation of a SW degree program. The University initiated a program with USAID support in August.	Discussions will be held with USAID regarding future steps for this task.

Y2Q4 Planned Tasks	Y2Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
<b>Activity 8: Consolidating and Strengthening Social Welfare Delivery System in Lubombo through NGO Subawards</b>		
Issue RFA and select subrecipients	An RFA was issued in July, 2014, to identify organizations in the Lubombo region to strengthen the region's social service delivery system. HFG is currently evaluating applicants' technical and cost proposals.	Following negotiations with the preferred RFA applicant(s), a Memorandum of Negotiation will be submitted to USAID/Washington for approval.
Launch work resulting from NGO RFA, oversight of subrecipient organizations, and support to DSW to lead regional stakeholder coordination	Pending selection of preferred applicant(s) and approval of Memorandum of Negotiation by USAID/Washington	Work resulting from the RFA will be initiated via a subrecipient kick-off meeting to determine organizational and individual roles and responsibilities of the DSW, HFG, and subrecipients. Coordination and communication mechanisms will be established for the duration of the subawards.

**TABLE 42. SWAZILAND HEALTH SYSTEMS STRENGTHENING TO HIV LINKS**

Activity	Prevention	HTC/Diagnosis	Referral and Link to Care	Access and Retention	ART initiation	Viral Suppression (Chronic Care and Labs)	Supportive Care and Quality	Comments
<p><b>High Level Justification:</b> Health workers are integral to the successful delivery of the continuum of HIV prevention, care, and treatment services for HIV.</p> <p><b>Overall Purpose:</b> The HRH Strategic Plan governs the planning, development, and management of Swaziland's entire public sector workforce. The Strategic Plan defines the numbers and mix of health workers needed, the appropriate distribution (including to rural areas), how to recruit them, how to manage them, retention mechanisms, how to ensure quality, how to train for additional skills as needed, among other things. The Strategic Plan guides not only the HRU priorities and actions, but also those of PEPFAR's implementing partners who are supporting service delivery, particularly those who are providing in-service training or trying to attract and retain health workers for HIV service delivery in rural areas.</p> <p><b>Abt's Work:</b> Swaziland's HRH Strategic Plan was developed, but remained unimplemented for nearly 2 years. As a result, in order to rapidly scale up HIV services, PEPFAR implementing partners hired staff and deployed them for HIV service delivery. The training institutions were over-producing some cadres (resulting in unutilized or underutilized qualified health workers), and under-produced others. In addition, without adequate information, the MOH was unable to plan for the appropriate number/mix of new health workers to be requested from the Ministry of Public Service/Ministry of Finance. Abt supported the MOH and PEPFAR (and other donor) implementing partners to come together to review the HRH plan and emerging data, and to develop a specific implementation plan which could be monitored for ongoing assessment and revision of HRH resource utilization.</p>								
1. Establish a HFG program office in Mbabane, Swaziland. (non-core)								
2. Support completion and implementation of HRH Strategic Plans  (Core/Near-Core)	SUPPLY and DISTRIBUTION: The MOH and all implementing partners have a unified implementation plan to increase the number and ensure an appropriate mix of health workers distributed equitably throughout country to deliver clinical prevention	SUPPLY, DISTRIBUTION, TRAINING, MOTIVATION: The MOH and all implementing partners have a unified implementation plan to ensure that qualified health educators, counsellors, nurses, and laboratory technicians are available (equitably distributed	SUPPLY, DISTRIBUTION, TRAINING, MOTIVATION: The MOH and all implementing partners have a unified implementation plan to ensure that community health workers are in place, motivated, and have the skills required to identify and refer	RETENTION, MOTIVATION, TRAINING, SUPPLY, DISTRIBUTION: The MOH and all implementing partners have a unified plan to ensure that the appropriate mix of health workers are: a) trained in the competencies needed to ensure patients remain in care, b) motivated to find lost-to-follow-up patients and reintegrate them	SUPPLY, DEPLOYMENT, DISTRIBUTION, MOTIVATION, RETENTION, TASK-SHARING: The MOH and all implementing partners have a unified plan to ensure that the appropriate mix of health workers are: a) located near the patients' homes so that patients can be easily initiated on ART in a timely manner, b) health	SUPPLY, DEPLOYMENT, DISTRIBUTION, MOTIVATION, RETENTION, TASK-SHARING: The MOH and all implementing partners have a unified plan to ensure that the appropriate mix of health workers are: a) located near the patients' homes so that patients can easily	TRAINING, LICENSURE, PERFORMANCE MANAGEMENT, QUALITY STANDARDS, CLINICAL GUIDELINES: The MOH and all implementing partners have a unified plan to ensure that the health system delivers quality care through health workers	Swaziland's Health Workforce (HRU plans for and manages): Medical Doctors, Nurses, Midwives, Pharmacists, Pharmacy Technicians, Dispensers, Data Processing Clerks, Logisticians, Record Clerks, Lab Technologists, Dental Therapists, Mental Health Officers,

Activity	Prevention	HTC/Diagnosis	Referral and Link to Care	Access and Retention	ART initiation	Viral Suppression (Chronic Care and Labs)	Supportive Care and Quality	Comments
	(treatment as prevention, TasP, counselling as prevention, health educators).	throughout country, including rural areas) and have the skills and motivation to appropriate identify and diagnose HIV positive clients.	individuals to HIV pre-ART care services.	into the program, c) distributed to facilities close to the patients' communities, d) motivated to stay with minimal turnover (disruption of relationships with clients), e) sufficient numbers to ensure the team has time to follow up patients.	workers have the skills to appropriately initiate ART, c) the appropriate practice standards are in place (including for nurses in instances of task shifting), d) health workers are managed and receive the appropriate incentives to stay motivated to stay on the job	access and be retained in care over the long term, b) health workers have the skills to ensure a patient is retained in care/receives the appropriate regimen/receives regular clinical and laboratory monitoring and other necessary interventions to ensure success on therapy, c) health workers are managed and receive the appropriate incentives to stay motivated to remain on the job and thus develop constructive stable patient-provider relationships, d) health workers are motivated to ensure quality of care and follow up patients, e) there are enough health workers in place	who are: a) appropriately trained, b) licensed to practice, c) receive regular focused performance management through a strong system, d) practice standards are up-to-date and support a team-based approach to quality care, e) have clinical guidelines, job aids and other practice support tools at hand, f) receive continuing professional development and meet re-licensure requirements. All health workers have a role to play in ensuring patients thrive on therapy, including workers in supportive or non-HIV specific roles.	Nutritionists, Counsellors, Community Health Workers, Phlebotomist.



Activity	Prevention	HTC/Diagnosis	Referral and Link to Care	Access and Retention	ART initiation	Viral Suppression (Chronic Care and Labs)	Supportive Care and Quality	Comments
						to support patients thriving on therapy through successful viral suppression, f) there are adequate laboratory personnel to successfully monitor viral load.		
3. Improve the structure and capacity for human resources management and oversight	<p>The Swaziland Nursing Council and the Swaziland Medical and Dental Council are responsible for ensuring the quality of the health workforce. The Councils define licensure requirements, assist in holding the MOH responsible for upholding practice standards, define the competencies of their cadres, and ensure production (pre-service training institutions) meets the demands (the service delivery requirements of the health sector). In addition, they govern the requirements for and provision of Continuing Professional Development to ensure the workforce remains up-to-date.</p> <p>HFG is supporting the Nursing Council to develop entry to practice examinations for nurses and midwives. As the first step, HFG is supporting the Council to develop competencies which will guide the development of new standards for the nursing schools and will form the basis of the examination. Abt is also supporting the Medical and Dental Council to perform the role it is expected to perform in overseeing the medical, dental, and allied health professionals. Similar to supporting the development of a comprehensive strategic plan for HRH, this activity can support the MOH in ensuring adequate oversight of HRH at national and local levels, supporting the successful implementation, management, and regulation of HRH resources mobilized as part of the national strategic plan. Ensuring adequate management and oversight of HRH is integral in ensuring that HIV interventions are high quality, and that they lead to desired HRH impact on key HIV targets.</p>							
4. Strengthen human resources management systems and data use	<p>HFG support to the MOH will help improve the accuracy, completeness, and timeliness of data collected within the MOH's HRIS. Such systems are integral in order to generate information (i.e., reports) relevant to the MOH planners and managers (for HIV and other services); and builds capacity on how to use the information in targeting resources and service delivery efforts. As such, the system provides higher quality information to trained planners and managers that will ultimately be used in HRH planning and management (e.g., HRH supply and distribution) that can impact HIV outcomes as described above. This data can be cross-referenced with other sources (e.g., HIV disease burden data within the HMIS) to ensure that the right health care provider with the right skills is in the right place at the right time to provide key HIV prevention, care, and treatment services across the continuum of care.</p>							
5. Strengthen the professional councils' capacity for regulatory oversight								

Activity	Prevention	HTC/Diagnosis	Referral and Link to Care	Access and Retention	ART initiation	Viral Suppression (Chronic Care and Labs)	Supportive Care and Quality	Comments
6. Support to DSW in the decentralization of social welfare systems and services to the Lubombo Region			<p>The availability of social welfare services can be seen as an integral supportive component of ensuring people living with HIV are supported in their access to, retention in, and success with HIV care and treatment. HFG’s SW portfolio focuses primarily on establishing a comprehensive, decentralized SW delivery system in the Lubombo region. This includes: (1) building the capacity of the DSW’s social workers on topics such as case assessment and management; (2) enhancing the functionality and use of the DSW’s eCMS; and (3) assisting the DSW to forge linkages with the broader SW sector in the region, including NGO providers.</p> <p>By better equipping the SW workforce to conduct proper assessments and manage cases, and strengthening coordination within the region, clients with HIV will benefit from referral to appropriate service providers, which will likely improve treatment uptake and retention of individuals utilizing care services. Strengthening the eCMS will provide planners and managers in the sector with data to make decisions that directly impact HIV and related services.</p>					
7. Support to DSW to develop strategies to address systemic barriers to SW service delivery		This activity corresponds to HFG's work in the SW sector at the national level. Within the current implementation plan, as developed in collaboration with USAID/Swaziland, the sole activity is to carry out an analysis of the recently passed CPWA and determine the consequences of the act on social worker scopes of practice. Orientation will then be provided to government social workers on the Act and implications for their practice. Although this activity does not make direct reference to pediatric care and treatment efforts, it is reasonable to expect that pediatric HIV-related components will be included in the scope of practice. Such inclusions can support SWs in linking pediatric clients to HIV services, and supporting their essential and supplementary care needs.						
8. Consolidating and Strengthening the SW Service Delivery System in Lubombo through NGO subawards		In July 2014, HFG issued an RFA for local Swazi NGOs providing social services in the Lubombo region of Swaziland. The goal of the RFA is to strengthen the social service delivery system in Lubombo by awarding up to three subawards to local NGOs to expand social service provision, including support services for those affected by HIV/AIDS (e.g., nutritional support, psychosocial services). The precise activities to be carried out and services to be delivered by subrecipient NGOs under this award are subject to those proposed in subrecipient NGOs' technical applications. The RFA review process is currently underway; successful offerors will be determined in mid-September. It is expected that those selected for the subawards would provide services that result in better access to care and treatment.						

Note: HTC=HIV counseling & testing

#### 4.1.14 Tanzania

**Year 2 Objectives** – The Tanzania USAID Mission is a key donor among a group of development partners who are supporting the Ministry of Health and Social Welfare (MOHSW) to conduct a Mid-Term Review (MTR) of the country’s Health Sector Strategic Plan III. The mission approached HFG to coordinate the MTR activity in collaboration with an in-country steering committee. HFG recruited and managed all consultants for the Joint Review Team of the MTR and assisted with in-country logistics for data collection and report dissemination. HFG also led the health financing section of the report.

**Year 2 Activities** – Present the final report of the MTR to stakeholders.

**Year 2 Progress Against Objectives** – The HFG lead consultant presented the final MTR report to the Joint Annual Health Sector Review conference. The report was very well received, with the lead consultant noting that: *“the comments were that we got the right balance between positive and critical issues. Our overall approach ‘you know what you should do, so get your act together and implement it’ was well accepted.”*

## 4.2 Asia

### 4.2.1 Asia Bureau

**Year 2 Objectives** – HFG’s objectives under USAID’s Asia Bureau focus on supporting and facilitating countries’ progress toward universal health coverage (UHC) to end preventable child and maternal deaths (EPCMD) in the Asia region. Asian nations are at various stages of the trajectory toward achieving UHC with some still in the developing phases and others already implanting financing reforms. In the context of limited time and resources, countries and USAID missions want to pursue steps that are most likely to succeed and benefit from global experience and evidence. The Asia Bureau’s goal is to build local and regional institutional capacity to design and implement smart reforms to expand access to priority services and reduce out-of-pocket health expenditures. HFG and the Bureau are working closely with regional and local partners on two activities that simultaneously advance reforms and build capacity, as described below.

**Year 2 Activities** –In Year 2, HFG will collaborate with the World Bank and Asia Network for Capacity Building in Health Systems Strengthening (ANHSS) to revise the second-year curriculum and course materials for the World Bank Institute’s Flagship course “The Challenges to Advancing Universal Health Coverage (UHC),” in order to adapt materials specifically to the Asia context, and to integrate UHC and the private sector into the course. ANHSS is a network of academic, research, and policy institutions in the Asia Region established with support from the World Bank in response to the need for knowledge sharing on health systems in the region. This activity builds on the successful delivery of the regional Flagship course in March 2014 in Bangkok. After revision, HFG will support the delivery of this course in 2015 in collaboration with an ANHSS partner. Targeted participants include country teams made up of government officials, nongovernment leaders, and senior donor-partner agency staff, including USAID, who can collaborate to facilitate country progress toward UHC. HFG will also support a collaborative capacity-building process for the ANHSS’ Flagship cluster. This process will include skill building in operations, course delivery, and technical expertise in health systems strengthening and UHC. Development of the process will be led by ANHSS to confirm that the correct needs, staff, and skills have been identified.

In addition in Year 2, HFG is conducting implementation research (IR) activities in Indonesia and Myanmar. The overarching goal of implementation research is to institutionalize a continuous learning and problem-solving process for UHC. Research questions will be country-tailored to elicit information on UHC roll-out successes and obstacles.

- **Indonesia:** HFG will establish the foundation to provide technical assistance to build the capacity to conduct implementation research on the scale-up of *Jaminan Kesehatan Nasional (JKN)* in Year 3. Because Indonesia is a large, decentralized, and diverse country, HFG proposes to implement a hub-and-spoke model of implementation research on JKN. Implementation research at the central level of JKN and the single payer insurance administrator, *Badan Penyelenggara Jaminan Sosial (BPJS)*, will be complemented by implementation research in a few districts or municipalities. At the local level, the focus of research will be to determine how JKN is working for providers and beneficiaries with the aim of feeding back lessons to inform implementation at the national level. Together with USAID, HFG will identify the appropriate implementing entity within Indonesia to work with to institutionalize this approach. We will work with the implementing entity to identify key implementation research questions as well as methods and tools for answering them, and to identify the individuals, universities, and survey firms that will implement elements of the approach. The objective will be to provide timely information that can be acted upon to strengthen the implementation of the UHC initiative.

- **Myanmar:** HFG will work closely with the Myanmar Mission to define an approach to implementation research that will contribute to achieving the goal of UHC. Several approaches are being explored: one is to focus on convergence from independent ethnic states to a common national model; the other is to collaborate with a coming World Bank project and with the national authorities to support implementation research on financing and financial management interventions that are being established to set the foundation for UHC. Explorations in Year 2 are paving the way to conduct implementation research in Year 3.

**Year 2 Progress Against Objectives** – In Q2, the Asia Regional Flagship Course on Health Systems Strengthening and Sustainable Financing, *The Challenge of Universal Health Coverage*, was successfully delivered in Bangkok, Thailand March 3-7, 2014. The course was attended by 63 participants from 11 target countries (Cambodia, India, Indonesia, Laos, Myanmar, Nepal, Papua New Guinea, Philippines, Thailand, Timor-Leste, and Vietnam) and six international entities. Participants included USAID mission staff, officials from country Ministries of Health, Finance, and Planning, as well as staff from USAID, World Bank, AusAID, and various universities. Overall participant assessments were very positive, though rich in content, and the faculty will carefully review the feedback to draw lessons for future Flagship workshops.

In Q4, HFG selected the Institute for Health Policy (IHP) to host the Flagship Course in 2015 in Colombo, Sri Lanka and to serve as the logistics sub-awardee to put on the event. The course will take place from April 19-24 with the training of trainers (TOT) sessions to begin 1-2 days prior to the course. HFG along with the Flagship cluster which includes key personnel/faculty from USAID, World Bank, ANHSS, Oxford, Harvard, and University of California, San Francisco, have held several meetings regarding the course curriculum review and capacity-building activities.

HFG presented a proposed work plan for implementation research in Indonesia and presented progress to date and research ideas in a brownbag session to USAID on August 27. Further refinement of the approach will occur in the beginning of project Year 3.

HFG has found it to be challenging to consult with ethnic states without formal memorandums of understanding from the central government in Myanmar. Together with the USAID Mission, HFG is revising the approach to IR so that activities can begin early in Year 3.

**Q4 Additional Information** – Primary challenges in Indonesia have been due to the concurrent change in leadership at the USAID mission and a change in the national government. The new government assumes office in October 2014 and the new USAID mission staff will be in their posting by late October. These changes pave the way for a TDY in November to refine the work program on implementation research.

**Challenges** – As stated previously, the context in Myanmar is challenging. HFG is working closely with the mission to identify a constructive approach that will contribute to national goals of attaining UHC.

Table 43 provides activity-specific updates.

**TABLE 43. ASIA BUREAU ACTIVITY DETAIL**

Year 2 Q4 Planned Tasks	Year 2 Q4 Progress	Critical Assumptions/ Problems Encountered/ Follow-up Steps
<b>Activity 1: World Bank's Universal Health Coverage Flagship Course for the Asia Region</b>		
Revise course materials	A course agenda has been drafted. Several meetings have been held to decide on specific course content to be taught. Key faculty and ANHSS members are being selected to review and develop course materials for each session.	Several sub-awards or contracts to faculty will be granted in order to revise and develop this material.
Award a subcontract for logistics to an ANHSS institution for the organization and delivery of the course and provide ongoing guidance and support to the institution	IHP was selected to be the logistics partner and to deliver the course in Colombo, Sri Lanka.	HFG selected IHP after a reviewing the possible venue's location. The criteria used for selection included cost, ease of travel, quality of facilities, partner experience holding regional events, etc.
<b>Activity 2: Capacity building to support ANHSS</b>		
Collaboratively develop a capacity building process	The dates for the TOT have been determined and faculty to co-teach the courses in conjunction with ANHSS members is being selected	Key international faculty will pair up with ANHSS faculty to develop and review course material.
Support course curricula adaptation as necessary	Several meetings to discuss and determine the content of the courses as well as the development of new material and revision of last year's material have been conducted.	Key international faculty will pair up with ANHSS faculty to develop and review course material.
<b>Activity 3: Implementation research in Indonesia</b>		
Develop scope of IR	A work plan was developed and submitted to the USAID mission. Next steps include a mapping of current and planned research on JKN in order to identify gaps. This will be followed by a TDY in November 2014 to refine the proposed plan.	
<b>Activity 4: Implementation research in Myanmar</b>		
Develop scope of IR	An approach has been developed and agreed with the USAID mission.	Given the delicate political context, each step requires careful consideration. HFG is collaborating closely with the USAID mission to chart the way forward.

## 4.2.2 Bangladesh

**Program Objectives** – In Year 1, it was planned that HFG would continue to work with USAID implementing partner Pathfinder and its NGO Health Service Delivery Project (NHSDP) to support the Smiling Sun NGO network to better achieve its mission related to improving access to health services and improving health outcomes, particularly for girls and young women. The primary objective of USAID support is to enhance sustainability of the network while improving the provision of services to the poor and underserved. The HFG program objective in Bangladesh is to improve Maternal, Neonatal and Child Health outcomes, which is also a goal of Ending Preventable Child and Maternal Deaths (EPCMD) strategy.

HFG also will continue to collaborate with UNICEF, as well as the Ministry of Women and Children Affairs, the Ministry of Social Welfare's Department of Social Services, NGOs, and local Child Protection Services committees, to complete a report summarizing what has been learned about the short-term effects of the cash transfer program on delaying age of marriage and about the presence of social norms around child marriage. In addition to the presentation of findings, this report will provide recommendations to UNICEF to strengthen the monitoring and evaluation approach and the program.

With remaining, uncommitted funding (approximately \$150,000), HFG will undertake additional agreed-upon technical assistance to the Health Care Financing Resource Task Force (HCFRTF) and to the Ministry of Health and Family Welfare (MOHFW) Health Economics Unit (HEU) in its implementation of the Health Care Financing Strategy (HCFS).

**Year 2 Activities** – HFG will provide support through technical analysis that will enhance and complement the primary activities of the NHSDP. In Year 2, HFG will complete the implementation of two activities in support of NHSDP including: 1) An analysis involving a review of existing data from MEASURE's recent impact evaluation of Smiling Sun to assess demographic characteristics of people who access different types of service providers, and provide a partial look at factors that may influence demand; 2) A discrete choice experiment study (DCE) to assess the relative importance of a set of variables, factors, or domains in determining how people decide where to seek health care services.

In Year 1, HFG worked with the Ministry of Women and Children Affairs, the Ministry of Social Welfare's Department of Social Services, UNICEF Bangladesh, NGOs, and local Child Protection Services committees to finalize the design and implementation of a monitoring framework to be used in operation research for an empowerment of adolescents program. In Year 2, HFG will finalize a report that documents this operational research including an analysis on existing social norms in Khulna and Sylhet, issues on the implementation of the subset of UNICEF activities selected for the level 3 monitoring (L3M) pilot, and the implementation of the L3M methodology. This report will be submitted to UNICEF for review and HFG will revise the report in response to comments from UNICEF and submit a final draft for dissemination.

Based on preliminary discussions with USAID/Bangladesh, HFG will undertake additional agreed-upon technical assistance to the HCFRTF and to the MOHFW HEU in its implementation of the HCFS in Year 2. The primary objective of this support will be to effectively harness and align the work to date on the HCFS and further develop a common narrative among stakeholders that works toward a short term (1-3 years) way forward road map that will be appreciated and eventually fully owned and led by the government of Bangladesh.

**Year 2 Progress** – HFG continues to provide technical and analytical support to the NHSDP in its goal of enhancing sustainability of its network while improving the provision of services to the poor and underserved. The final draft of the demographic re-analysis report has been completed and submitted to NHSDP and USAID. The DCE activity has received Internal Review Board approval. BRAC in collaboration with Pathfinder has conducted a full round of expert interviews (NGO, private,



government) to better understand service delivery and population behavior as they relate to utilization of the network, and has conducted focus groups to understand household perceptions of health facility characteristics. In conjunction with a recent HFG TDY, BRAC and NHSDP held a workshop with personnel from the NGOs under NHSDP to finalize health facility characteristics for the DCE, with USAID staff in attendance. Subsequently, data collection at the household level has been completed, and data analysis has begun.

A final round of revisions to the Bangladesh L3M Child Marriage report was completed and submitted to UNICEF for final approval. The report synthesizes recommendations on how to strengthen the overall monitoring approach, which will be routinely replicated by UNICEF. The report has been finalized and disseminated. The team has started working on a technical brief on measuring social norms, based on experiences in Bangladesh.

**Challenges** – Challenges with engaging NHSDP have been noted. Some delays with regards to obtaining site permission/introductions have led to repeated emails and follow-ups being required as well as activity implementation delays.

**Q4 Additional Information** – Following an HFG TDY in February, the USAID Mission in Bangladesh stated its desire for HFG to continue to support the implementation of the HCFS, in a focused way that 1) supports transformational change in health care financing in Bangladesh toward the objective of achieving Universal Health Coverage; 2) is concrete and complementary to the support being provided by other development partners (e.g., World Bank, GIZ, KfW, WHO); and 3) is sufficiently time bound and specific that the work does not represent an open-ended commitment.

HFG traveled to Dhaka to continue the work plan discussion in May. The team met with USAID, potential partners, and the HEU of the MOHFW to discuss progress and the sector needs. In the debrief meeting with USAID Bangladesh, it was agreed that the team will focus on three areas of intervention – plus an activity that USAID Bangladesh requested that HFG undertake:

- Non-profit provider based pre-payment mechanisms: focusing on but not limited to Smiling Sun NGO network providers.
- Formal sector social health insurance: focusing on taking forward the draft of the social health insurance law and possibly complementing the efforts of GIZ, to develop insurance for garment workers.
- A joint analytical work plan with the World Bank: the coordinated effort and discussions have focused on: USAID Bangladesh requested that HFG undertake an analysis of the USAID's contribution to the World Bank managed sector support. The World Bank is administering USAID's contribution in a separate Single Donor Trust Fund (SDTF) account. In addition to the SDTF, the World Bank maintains a Multi-Donor Trust Fund (MDTF) account to which other donors contribute. The SDTF and the MDTF are part of a multi-donor collaborative effort between USAID, the World Bank, and other international donor partners for achievement of the Government of Bangladesh Health, Population and Nutrition Sector Development Program 2011-2016 goals and objectives as implemented under 32 specific "Operational Plans" (OPs). The World Bank PIO grant is a mechanism to provide direct government-to-government assistance from USAID to the government in fulfillment of the goals and objectives of USAID Forward and the first of its kind among USAID missions worldwide. HFG will draft a note explaining the process of contribution and use of USAID funds. HFG will also draft an analysis, following a USAID provided model, of the eight OPs that USAID funding is supporting. In addition, during this period HFG contributed an analysis of a draft of the social protection law establishing a national social health insurance.

A subsequent HFG TDY to Bangladesh was conducted in September to confirm the above areas of implementation and further refine details for the Year3 work plan with USAID, as well as to consult with development and HFG partners and potential partners on activity collaborations. During the visit, meetings were held with the World Bank to discuss World Bank-USAID/HFG collaboration on the joint analytical work. It was determined that the two analytic topics HFG is likely to focus on under this activity would be: 1) secondary analyses of the National Health Accounts and 2) urban health. Through meetings with GIZ and BRAC regarding collaborating with the BRAC insurance scheme for work under the formal sector health insurance activity, likely areas of collaboration identified were: 1) design of an incentive mechanism for scheme providers centering on quality; and 2) design of implementation research for the scheme in collaboration with James P. Grant School of Public Health/BIGH. Lastly, for the nonprofit provider-based prepayment mechanisms activity, the HFG team met with NHSDP and Smiling Sun NGO representatives to present the provider-based prepayment feasibility study and gauge their interest. The aim of the study is to determine if it is possible to introduce or scale up a prepayment scheme as a means to increase NGO sustainability. By the end of the September TDY, working closely with NHSDP, HFG had issued instructions on how to submit an expression of interest to identified Smiling Sun NGOs to conduct the feasibility study. Submissions are anticipated to be received and evaluated in Q1 of Year 3.

Additionally, HFG anticipates that Abt will make a strategic local hire in Bangladesh during Q1 of Year 3. This individual will be tapped to provide senior-level technical health finance and health systems support to the HFG Bangladesh portfolio.

Additional funding to support the implementation of HFG Bangladesh activities was reflected in the field support database in late Q4.

Table 44 provides activity-specific updates.

**TABLE 44. BANGLADESH ACTIVITY DETAIL**

Y2Q3 Planned Tasks	Y2Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
<b>Activity 1: Technical support for the NGO health services delivery project</b>		
Conduct DCE study	Data collection at household level has been completed. Data analysis has begun, and preliminary results for review by NHSDP/USAID targeted to be available by the end of Q4.	Data cleaning has proved challenging with respect to delayed receipt of the double entry data (second set). BRAC and HFG are working together to address issues around the socio-economic variables which are key to understanding Smiling Sun's catchment population.
<b>Activity 2: M&amp;E assistance to an adolescent empowerment program using conditional cash transfer program to raise age of marriage</b>		
Finalize report with UNICEF inputs	Report finalized.	
Disseminate report	Dissemination was on line and virtual. No dissemination activities are planned in country.	

Y2Q3 Planned Tasks	Y2Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
<b>Activity 3:</b> Health care financing strategy implementation support		
Development of Y3 work plan	In September, further work-planning meetings between HFG, USAID, and partners in Dhaka confirmed the areas of intervention for HFG YR3 activities in Bangladesh, and advanced next steps for joint activity implementation.	
World Bank USAID PIO OP funding analysis	<p>A draft PIO flow of funds analysis was completed and shared with USAID Bangladesh. A revised version based on anticipated feedback from USAID Bangladesh is targeted for submission by the end of Q4.</p> <p>Recruited and hired a consultant to analyze the 8 PIO-funded OPs.</p>	HFG will respond to USAID comments on the draft report, potentially combining the analysis and an earlier Fund Flow and Allocation note (June 2014), to be finalized in Y3Q1.

### 4.2.3 India

**Program Objectives** – Under the Ministry of Health and Family Welfare (MOHFW) Reproductive, Maternal, Child and Adolescent Health (RMNCH+A) strategy, USAID is the lead partner in six north Indian states, and has been tasked with strengthening program management and service delivery of various RMNCH+A-related programs and activities.

To augment its efforts, USAID asked HFG to explore potential technical assistance areas in the six states where USAID is the lead partner, especially in HFG's technical domain areas of health financing, human resources for health (HRH), and Data for Decision Making (DDM).

Moreover, HFG will support the institutionalization of National Health Accounts (NHA) in India by supporting 1 or 2 states in undertaking the NHA exercise and then using their experiences and the materials developed for replication in other states and at the national level. The teams that will be trained and conduct the state-level health accounts (SLHA) will be able to serve as resources to train and support other state teams in collecting and analyzing health financing and expenditure data to support decision making and health-planning processes, with the aim of reducing inequalities and improving health conditions among women, poor, and young populations. HFG will strengthen the country's capacity for managing the health workforce. In addition, HFG will conduct an assessment of the National Rural Health Mission (NRHM) health information systems (HIS) data quality and provide a synthesis of the current state of HIS in the country, with a road map for key priorities to strengthen the health system. A work plan will be developed to strengthen the reporting of health data through the HIS portal to support program managers in planning and decision making. Another objective is a country-owned partnership for health system research (HSR) that improves research quality and engages in policy dialogue and discussions with decision-makers.

**Year 2 Activities** – In addition to the activities outlined in the project's work plan, the USAID client has asked HFG to provide input and support the development of evidence-based Project Implementation Plans in six states and 30 District Health Action Plans where USAID is the State Lead Partner.

Ongoing HFG program work will continue, including work with the Haryana Government on SLHA, Data Quality Audit (DQA), and HRH activities as agreed upon with USAID. At the national level, the landscape analysis on HRH will also continue.

A request for applications is currently being developed to identify an Indian organization to partner with on the project's technical activities, including its work in DQA and national- and state-level health accounts.

#### Year 2 Progress

**Health Finance/National Health Accounts** – Based on guidance from the mission of using support to one or two SLHAs to draw lessons and provide input to the institutionalization effort at the national level, the HFG team has begun work with the NRHM of Haryana State on preparation of its health account exercise. HFG also refined the SLHA action plan based on inputs from state-level officials.

A multi-stakeholder Steering Committee has been constituted under the leadership of the Additional Chief Secretary of Health to the Government of Haryana. In Q4 (July 2014), HFG supported the first steering committee meeting, which discussed and refined policy questions to be answered by the SLHA and also finalized the action plan on SLHA. The training of the technical team was delayed by state-level elections. Materials including Health Accounts Briefs, a Policy Primer, and a presentation for the steering committee meeting were prepared. Key NRHM worked on finalizing their overall program implementation plan. Activities to finalize training materials to provide the first round of training to the SLHA team are underway.

In addition, the HFG team provided orientation to the senior Haryana Department of Health officials on what health accounts are, their use, and overall steps associated with conducting them. Following the orientation, the Department of Health designated the Haryana State Health Resource Center (HSHRC) to house the state health accounts activity. Accordingly, the project is working closely with HSHRC to analyze the public expenditure review (PER) as an initial step to undertaking the state health accounts and in the interim providing further understanding of both the magnitude and flow of public expenditure. The project has also provided senior teams of HSHRC similar orientation on the State Health Accounts.

**Universal Health Coverage in Haryana** – HFG received a request from Haryana to provide technical assistance in developing a road map and identifying strategies for achieving Universal Health Coverage (UHC) in Haryana. HFG developed a broad outline for the road map and shared it with the state. Moreover, in collaboration with the Post Graduate Institute of Medical Education and Research (PGI, Chandigarh) and the Public Health Foundation of India (PHFI), HFG is coordinating the overall UHC road map for the state. The broad areas covered under this activity are: essential health package, access to medicine and diagnostic services, health financing, HRH, HIS, governance, and social determinants of health.

**Tibetan Medicare System (Central Tibetan Administration)** – HFG completed a study on claims analysis for the Tibetan Medicare System (TMS), a community-based health insurance scheme, and provided recommendations for redesigning the scheme's benefit package. The scheme also requested USAID and HFG assistance in conducting an enrollment study to understand beneficiaries' perspectives with the overall aim to design communication and marketing strategies to increase scheme enrollment rates.

## **Human Resources for Health**

**Technical assistance to four of the six priority states** – HFG has been actively engaged with four out of the six USAID priority states which have identified a specific need for HRH technical assistance. The HFG India HRH specialist supported these states in developing technical concept notes for the requested interventions, which are listed below:

### **HARYANA**

- HFG, in collaboration with the USAID CapacityPlus Project, is supporting the implementation of a comprehensive Human Resource Information System (HRIS) with the iHRIS suite of open-source software. The state has formed a Technical Working Group (TWG), of which HFG is a part, to steward the process. CapacityPlus will lead the activity and carry out the bulk of the work until the project's work in India ends, in September 2014. During the quarter, the following activities were taken up:
  - Consultation workshop to feed into the Requirement Study, and finalization and presentation of the study to the state
  - Training of eight officials from National Health Mission (NHM), Directorate General Health Services (DGHS), Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homoeopathy (AYUSH) and State Institute of Health & Family Welfare (SIHFW) on iHRIS administration and customization
  - Customization of iHRIS software by CapacityPlus
  - Finalization of data collection form
- Support for building the capacity of the human resource cell (subdepartment) in Haryana, including technical assistance for the following HRH subsystems:
  - Recruitment system

- Performance appraisal system
- Training strategy
- Job descriptions and an human resource manual

During the quarter, the following activities were taken up:

- Finalization of 208 job descriptions of contractual health workers. These have been submitted for review to the respective program officers, subsequent to which the same will be officially released.
- Preparation of salary rationalization/banding systems to address the variance of salaries for similar skill sets.

## **PUNJAB**

During the quarter, the following activities were taken up:

- TWG on HRH was formed. The group is chaired by the NHN Mission Director.
- First meeting of the TWG was held, and three subgroups were formed, for Training, Supportive Supervision, and HRH Management Systems.
- These subgroups have developed their work plans and submitted them to the main TWG for approval.

## **UTTRAKHAND**

- Developed and built capacity to use a new supportive supervision system as part of the larger performance improvement process
- Strengthened the human resource cell in the NHM through creation of scopes of service, standard operating procedures, and skill matrices

## **JHARKHAND**

- HRH technical assistance in Jharkhand has been put on hold pending further discussions with the state and USAID India.

**HRH Landscape Assessment** – The assessment report has been completed and submitted to the mission. The preparatory work for the workshop of national HRH experts is underway to determine which HRH interventions are best suited for scale-up and replicability. A consultant has been hired for this task and the draft approach note has also been shared with the mission.

**Challenges** –A change in state-level housing of health accounts<sup>5</sup> and the ensuing change in focal points for SLHA activity in Haryana led to delays in moving forward with the health accounts activities especially in establishing the technical team with the speed originally envisaged. The project has been working with the HSHRC senior management in quickly taking over the activities and moving forward with the health accounts activity while flexibly adjusting the order of some of the activities such as working on the public expenditure review (PER) to accommodate the priorities of HSHRC. At the national level, the MOHFW handed over the health accounts activity to NHSRC. HFG has contacted NHSRC to identify areas of support it requires and is awaiting the response to put together a list containing possible areas of support it requires to fulfill the mandate of institutionalizing health accounts at the national level.

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<sup>5</sup> From NHM-Haryana to HSHRC

Table 45 provides activity-specific updates.

**TABLE 45. INDIA ACTIVITY DETAIL**

Y2Q4 Planned Tasks	Y2Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
<b>Activity 1: Haryana State Health Accounts</b>		
Support launch of the 1 <sup>st</sup> SLHA for Haryana	First steering committee meeting was held, during which policy questions were discussed and finalized. The Department of Health decided to house the SLHA exercise. HSHRC has been designated by the state to house health accounts.	
Orient senior staff of the Haryana Department of Health and HSHRC on health accounts	Orientation completed for the Senior team from the two institutions on what health accounts are, their use and overall steps associated with conducting them.	
Conduct a PER as an initial step to the SLHA	Ongoing; activity taken on following the reordering of activities by HSHRC which indicated the need for a PER and afterwards transition into the remaining sources of financing to complete the health accounts exercise for Haryana.	
Customize training materials to Indian context	Ongoing.	Will be completed in Y3Q1.
<b>Activity 2: National Health Accounts</b>		
Organize NHA introductory meeting with key stakeholders at the national level (with initial key discussions of what it takes for its institutionalization)	Awaiting activity scope finalization by NHSRC (organization designated by the MOHFW to house health accounts as to when to hold a national-level stakeholder engagement.	
Develop a road map for NHA institutionalization	Pending, as NHSRC would like to undertake the initial attempt at drafting the road map and will identify areas for HFG to support in the preparation/finalization of the road map.	



Y2Q4 Planned Tasks	Y2Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
<b>Activity 3: HRH landscape analysis</b>		
Finalize and submit desktop review	Report finalized and shared with the mission.	
Complete the preparatory work for the workshop for national HRH experts A consultant hired for this task	Workshop preparations are underway. A consultant has been hired for this task and the draft approach note has been shared with the mission.	Identifying and hiring the consultant took longer than expected. Also, with major Indian festivals in October, the workshop may be delayed.
<b>Activity 4: Provide support to the MOHFW to identify, analyze, and operationalize key HRH reform</b>		
Contribute to subworking group on performance-based incentives for health workers	The project was invited to be part of a sub-working group and has contributed to drafting the national guidelines for PBIs.	
<b>Activity 5: Provide HRH support to the state of Haryana</b>		
Hold consultation workshop to feed into the Requirement Study, and finalize and present the study to the state.	Workshop conducted. Draft Requirement Study report submitted.	
Training of 8 officials from NHM, Directorate General of Health Services, AYUSH and NAYUSH, and SIHFW on iHRIS administration and customization	Training completed successfully.	
Customize iHRIS software by CapacityPlus	Customization is underway.	
Finalize data collection form	Draft data collection forms have been sent for final review by various departments involved.	
Develop recruitment system	Consultant identified.	
Develop performance appraisal system	Consultant on board.	
Develop job descriptions and a human resource manual	208 job descriptions were drafted and have been sent for approval from the relevant government officials.	
<b>Activity 6: Provide HRH support to the state of Uttarakhand</b>		
Develop and build capacity to use a new supportive supervision system as part of the larger performance improvement process	Initial consultation meetings held. HFG consultant identified and has started work on tools for supportive supervision. State is waiting for financial approvals from national ministry.	

Y2Q4 Planned Tasks	Y2Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
<b>Activity 7:</b> Provide HRH support to the state of Punjab		
Support development of a Training Strategy, Supportive Supervision, and improved HRH Management Systems	<p>TWG on HRH was formed. The group is chaired by NHM Mission Director.</p> <p>First meeting of the TWG was held, and 3 subgroups were formed: Training, Supportive Supervision, and HRH Management Systems.</p> <p>These subgroups developed their workplans and submitted them to the main TWG for approval.</p>	
<b>Activity 8:</b> Synthesize existing HMIS assessments to inform design and implementation of technical assistance for strengthening HMIS		
Identify and engage national- and state-level stakeholders for HMIS strengthening	USAID India is planning to engage with the MOHFW to discuss the report's recommendations.	The MOHFW is undergoing staffing changes in the wake of the change in national government leadership.
Develop HMIS strengthening road map	<p>Pending meeting between USAID India and MOHFW.</p> <p>HFG India HIS team has drafted a concept paper on engagement with the national MOHFW based on the HMIS synthesis report.</p>	
<b>Activity 9:</b> Assess and develop capacity building plan to improve HMIS data quality and data use		
Identify DQA training teams	HFG recruited and hired two consultants to become routine DQA (RDQA) and information use advisors to the NHM Haryana.	Identification of a local partner by USAID/India is still pending. Until this partner is identified and introduced to the HFG India team, it will be impossible to incorporate them into the capacity-building efforts of the HMIS team.
Engage with five additional states to identify HMIS technical support needs	Outreach has been made to Punjab, Jharkhand, Uttarakhand, Himachal Pradesh, and Delhi to assess interest in HMIS technical support from HFG India.	As noted below, a revised methodology for conducting state-level HIS assessments is being proposed.
Carry out DQA in target states, districts	Two RDQA consultants have been deployed in Haryana and are now conducting data quality trainings and exercises across priority districts in Haryana.	Based on USAID/India feedback regarding the DQA exercise, HFG India was asked to propose a revised approach to conducting rapid, state-level HIS assessments in the six USAID priority states/union territories.
Develop revised approach to conducting state-level HIS assessments	HFG India HIS team has been reviewing the data outputs from the Punjab PRISM assessment exercise.	Anticipate completion of the PRISM Punjab draft report and initiation of the validation workshop with the Punjab NHM team in next quarter.

Y2Q4 Planned Tasks	Y2Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
<b>Activity 10:</b> Technical assistance to support the MOH in the areas of health financing, HRH, and using data for decision making		
Activity being developed with guidance from the USAID mission	Updates on the technical assistance being provided are incorporated into the new and existing activities listed above.	

#### 4.2.4 Vietnam

**Program Objectives** – Vietnam’s HIV/AIDS response is financed mainly by external sources, with 73 percent of spending on HIV funded by international donors in 2008-2010. In order to help the Government of Vietnam to become self-sufficient in managing and funding the HIV/AIDS response, the inclusion of HIV/AIDS into social health insurance (SHI) has been proposed as a key strategy. HFG has proposed key activities to achieve this. The broader objective is to increase the ability of the Government of Vietnam to manage and fund the SHI system, in order to achieve a fair and effective coverage of current and future HIV/AIDS health needs. To achieve the objective, HFG has broadly agreed to:

1. Contribute to the implementation of a new capitation system for payment of health care providers in four pilot provinces;
2. Contribute to the efforts currently in place to estimate the additional costs involved in including HIV services in SHI;
3. Do a comprehensive assessment of procurement capacity and gaps to plan for the Government of Vietnam taking charge of the centralized supply chain of HIV and TB drugs, diagnostics, and supplies.

**Year 2 Activities** – The activities to be carried out in Year 2 are the following:

1. Provide ongoing coordination and implementation support to the capitation pilots
2. Assess capacity of reporting and monitoring systems to deliver data to monitor SHI performance
3. Support costing of HIV/AIDS services to inform integration into SHI
4. Carry out an assessment of current supply chain systems and evaluate potential mechanisms for centralized procurement of public commodities (ARVs, methadone maintenance treatment (MMT), Lab, TB)
5. Evaluate appropriate points of entry for support of integrated management for Year 2
6. Develop capacity-building plan for MOH and other partners

**Year 2 Progress** - The HFG team moved very quickly and successfully during the first quarter of activities (Apr–Jun) along three parallel lines of work:

- Set up a project office (needed in country to support operations) in a limited amount of time;
- Recruit the necessary short-term staff to quickly start technical activities;
- Engage and support counterparts to establish a visible and energetic presence in country and to encourage future government cooperation and buy-in.

By the end of May, the office was fully functional, with full- and part-time administrative staff able to support technical assistance activities in a very short amount of time. An official memorandum of understanding (MOU) between the Ministry of Health (MOH) and HFG was established early on. Following approval of HFG's Year 2 work plan by the MOH, the HFG team has been continuously engaged with the MOH's Provider Payment Unit and the Vietnam Administration of HIV/AIDS Control (VAAC). The last quarter of the year consolidated all the preparatory work of the previous three months and saw the achievement of three key deliverables:

1. A rapid review of the implementation of the revised capitation payment system in four pilot provinces, which had begun in Q3, was completed. The review culminated with the presentation of the results and recommendations to over 150 stakeholders from central and provincial MOH levels;
2. An assessment of the procurement and supply chain of ARVs, methadone, and anti-TB drugs in Vietnam was completed and resulted in the presentation of findings and recommendations for moving toward government-led centralized procurement. The report has been officially submitted to all relevant stakeholders.
3. The implementation of a model to estimate health insurance liability for treatment of people living with HIV/AIDS (PLHIV) in Vietnam was also completed through remote and in-country short-term technical assistance. The report is currently in final draft format, pending validation by the relevant stakeholders and will be presented to a wider audience during year 3.

HFG's technical assistance activities have been relevant to the current priorities of the MOH, which has shown keen interest in the contribution of the HFG team by repeatedly inviting HFG staff to relevant meetings with the intent to solicit technical feedback in health financing related matters. The planned Year 3 activities are the natural continuation of the efforts so far expended in the health sector of Vietnam, and the health financing arena in particular.

**Challenges** – The language barrier between the US-based technical staff and the local counterparts continues to be a challenge, but the rapid achievements of Year 2 have contributed to the establishment of a more trusting and cooperative relationship between the HFG/Vietnam team and the government counterparts.

**Q4 Additional Information** – In light of PEPFAR's renewed focus on direct service delivery, HFG is facing the additional challenge of uncertain funding for future planned activities, which rely entirely on PEPFAR funds. To respond to unexpected decreases of planned funding, HFG/Vietnam had to quickly cut back on activities and hiring plans and to refocus on essential operations and technical activities to ensure the sustainability of the program. HFG/Vietnam is working closely with its USAID and PEPFAR counterparts in country to gauge the optimal level of engagement the project can deploy given the new funding environment. Activities 5 and 6 have been deemed non-essential by USAID in Vietnam and were discontinued in Q4. Activity 3 has been modified in coordination and agreement with VAAC and USAID to better respond to the needs of counterparts in the HIV/AIDS administration and control unit of the MOH.

Table 46 provides activity-specific updates. Table 47 provides the health systems strengthening to HIV links.

**TABLE 46. VIETNAM ACTIVITY DETAIL**

Y2Q4 Planned Tasks	Y2Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
<b>Activity 1:</b> Provide ongoing coordination and implementation support to the capitation pilots		
Conduct 2-day training for Department of Planning & Finance (DPF) and Vietnam Social Security (VSS) staff	This activity was completed in Q4. HFG conducted training in Hanoi and Da Nang with the purpose of introducing the audience to specific monitoring forms.	
Provide ongoing coordination and technical assistance to DPF and VSS	Provided throughout the quarter and currently ongoing.	
<b>Activity 2:</b> Assess capacity of reporting and monitoring systems to deliver data to monitor SHI performance		
Develop assessment plan with inputs from VSS and DPF, including provincial selection	Plan developed and validated by MOH/DPF.	VSS has not actively participated in the development of the plan. HFG has not found the right entry point to entice VSS to become a more active contributor for this specific activity/task.
Conduct assessment	Assessment conducted in May in two provinces. One more province was assessed during Q4 and a report prepared with the interviews and responses collected.	
Report findings to VSS and MOH	This activity was completed during the Capitation Pilots workshop conducted August 6-7, 2014.	
<b>Activity 3:</b> Support costing of HIV/AIDS services to inform integration into SHI		
Convene meetings to build consensus on appropriate methods	Activity discontinued as such.	In agreement with VAAC and USAID/Vietnam, HFG has modified the original scope to provide short-term technical assistance and remote support for the definition of a model to estimate health insurance liability for treatment of PLHIV in Vietnam. This work involved the direct cooperation with VSS and has been an extremely well received contribution to the government's efforts in HIV and health financing. The model was introduced and illustrated in a report, currently in draft and being circulated for comments and validation.
Develop data collection plan for costing analysis	Activity discontinued as such.	
Conduct training for data collectors and conduct data collection	Activity discontinued as such.	
Analyze data and prepare final report	Activity discontinued as such.	

Y2Q4 Planned Tasks	Y2Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
<b>Activity 4:</b> Carry out an assessment of current supply chain systems and evaluate potential mechanisms for centralized procurement of public commodities		
Analyze ARV costs under alternative procurement scenarios	The activity has been completed. Report submitted to counterparts and relevant stakeholders.	HFG will follow up on uptake of recommendations.
Develop options for financing and financial flows to support centralized procurement of ARVs	The activity has been completed. Report submitted to counterparts and relevant stakeholders.	HFG will follow up on uptake of recommendations.
<b>Activity 5:</b> Evaluate appropriate points of entry for support of integrated management for Year 2		
Facilitate the identification and evaluation of options and priorities through discussion and review of available studies	Activity discontinued.	In light of decreased funding planned for HFG/Vietnam, this activity has been deemed non-essential and discontinued.
Assess potential provincial-level activities	Activity discontinued.	In light of decreased funding planned for HFG/Vietnam, this activity has been deemed non-essential and discontinued.
<b>Activity 6:</b> Develop capacity building plan for MOH and other partners		
Run skill gaps assessment at VSS	Activity discontinued.	In light of decreased funding planned for HFG/Vietnam, this activity has been deemed non-essential and discontinued. HFG had to terminate the contract with a local consultant who had been engaged to help carry out this activity/task. The consultant had started the collection of individual training plans, but no further work is planned on this activity.
Run skill gaps assessment at MOH (DPF, Department of Health Insurance (DHI), and VAAC)	Activity discontinued.	
Run collaborative sessions to define capacity-building plan	Activity discontinued.	



**TABLE 47. VIETNAM HEALTH SYSTEMS STRENGTHENING TO HIV LINKS**

Activity	Prevention	Diagnosis/ HTC	Referral & Link to Care	Access and Retention	ART initiation	Viral Suppression (Chronic Care and Labs)	Support, Care and Quality
<b>Activity 1:</b> Provide ongoing coordination and implementation support to the capitation pilots (NEAR CORE):	This activity will help to strengthen a mechanism by which social health insurance can pay for HIV/AIDS and other health services, which in turn is intended to transition responsibility for HIV/AIDS services to VSS and increase coverage of HIV prevention.	This activity will help to strengthen a mechanism by which social health insurance can pay for HIV/AIDS and other health services, which in turn is intended to transition responsibility for HIV/AIDS services to VSS and increase coverage of HIV diagnosis / counseling and testing.		This activity will help to strengthen a mechanism by which social health insurance can pay for HIV/AIDS and other health services, which in turn is intended to transition responsibility for HIV/AIDS services to VSS and increase coverage of HIV treatment.			
<b>Activity 2:</b> Assess capacity of reporting and monitoring systems to deliver data to monitor SHI performance (NEAR CORE)	This activity will provide recommendations to improve the monitoring and reporting capacity of social health insurance, allowing it to track expenditure and utilization information for HIV/AIDS and other health services, which will inform resource mobilization and enable SHI to increase coverage of HIV prevention.	This activity will provide recommendations to improve the monitoring and reporting capacity of social health insurance, allowing it to track expenditure and utilization information for HIV/AIDS and other health services, which will inform resource mobilization and enable SHI to increase coverage of HIV diagnosis / counseling and testing.		This activity will provide recommendations to improve the monitoring and reporting capacity of social health insurance, allowing it to track expenditure and utilization information for HIV/AIDS and other health services, which will inform resource mobilization and enable SHI to increase coverage of HIV treatment.			

Activity	Prevention	Diagnosis/ HTC	Referral & Link to Care	Access and Retention	ART initiation	Viral Suppression (Chronic Care and Labs)	Support, Care and Quality
<b>Activity 3:</b> Support costing of HIV/AIDS services to inform integration into SHI (NEAR CORE)	This activity will provide information on the cost of HIV/AIDS services, allowing those services to be eventually funded through SHI, and thus transitioning responsibility for HIV/AIDS services to domestic funding sources, and enabling an increase in the coverage of HIV prevention.	This activity will provide information on the cost of HIV/AIDS services, allowing those services to be eventually funded through SHI, and thus transitioning responsibility for HIV/AIDS services to domestic funding sources, and enabling an increase in the coverage of HIV diagnosis / counseling and testing.		This activity will provide information on the cost of HIV/AIDS services, allowing those services to be eventually funded through SHI, and thus transitioning responsibility for HIV/AIDS services to domestic funding sources, and enabling an increase in the coverage of HIV treatment.			
<b>Activity 4:</b> Carry out an assessment of current supply chain systems and evaluate potential mechanisms for centralized procurement of public commodities (CORE)	This assessment will provide guidance for a successful transition toward government-led, financially sustainable procurement and supply chain systems for ARVs, methadone and anti-TB drugs. The assessment will provide recommendations for reaching the GVN target of covering 81,047 patients with MMT by 2015, which will result in a significant increase in HIV prevention.			This assessment will provide guidance for a successful transition toward government-led, financially sustainable procurement and supply chain systems for ARVs, methadone and anti-TB drugs. The assessment will provide recommendations for reaching the GVN target of covering 105,000 patients with ART by 2015, which will result in a significant increase in HIV treatment.			

Activity	Prevention	Diagnosis/ HTC	Referral & Link to Care	Access and Retention	ART initiation	Viral Suppression (Chronic Care and Labs)	Support, Care and Quality
<b>Activity 5:</b> Evaluate appropriate points of entry for support of integrated management for Year 2 (NEAR CORE)	This activity will provide information and guidance on integrating HIV/AIDS services, which will result in efficiency gains and therefore enable an increase in the coverage of HIV prevention.	This activity will provide information and guidance on integrating HIV/AIDS services, which will result in efficiency gains and therefore enable an increase in the coverage of HIV diagnosis / counseling and testing.		This activity will provide information and guidance on integrating HIV/AIDS services, which will result in efficiency gains and therefore enable an increase in the coverage of HIV treatment.			
<b>Activity 6:</b> Develop capacity building plan for MOH and other partners (NEAR CORE)	This activity will enable DPF and VSS to analyze alternative payment mechanism for HIV services that ensures sustainability for SHI. This mechanism is expected to result in efficiency gains and therefore increase coverage of HIV prevention.	This activity will enable DPF and VSS to analyze alternative payment mechanism for HIV services that ensures sustainability for SHI. This mechanism is expected to result in efficiency gains and therefore increase coverage of HIV diagnosis / counseling and testing.		This activity will enable DPF and VSS to analyze alternative payment mechanism for HIV services that ensures sustainability for SHI. This mechanism is expected to result in efficiency gains and therefore increase coverage of HIV treatment.			

Note: HTC=HIV counseling & testing

## 4.3 Eastern Europe and Eurasia

### 4.3.1 Eastern Europe and Eurasia Bureau

**Year 2 Objectives** - There is a critical need to build the capacity of local NGOs serving injecting drug users (IDUs) and men who have sex with men (MSM) populations in Eastern Europe and Eurasia (E&E). These NGOs provide essential HIV prevention, treatment, and support services that are not currently available through government programs, yet the sustainability of these NGOs is threatened by poor financial viability, weak governance and management capacity, insufficient advocacy and constituency-building efforts, and inadequate networking and referral systems.

The geographic target of this activity will be the Caucasus countries of Armenia, Azerbaijan, and Georgia. The E&E Bureau program will strengthen local NGOs serving IDU and MSM populations in these three countries across key areas of organizational capacity, including financial management, internal management and governance, advocacy and constituency building, and networking and partnerships. Bilateral USAID health activities will be phased out in each of these three countries over the next few years. The proposed activity provides a regional mechanism through which some final technical assistance and support can be provided to enhance the sustainability of NGOs in these three countries. At the end of this program, indigenous NGOs working with key populations will be in a stronger position to continue to provide services for and advocate for the needs of the target populations after USAID assistance phases out.

Outcomes of the program will include:

- Technical assistance, training, and support provided for local HIV/AIDS NGOs
- Capacity-building subgrant(s) awarded to local HIV/AIDS NGO(s) in Armenia, Azerbaijan, and Georgia
- Network of HIV/AIDS NGOs strengthened within and across countries in the region

**Year 2 Activities** - Activities for the E&E Bureau program include capacity development and strengthening of country-based NGOs.

**Year 2 Progress Against Objectives** - HFG began activities on the E&E Bureau program in the second quarter of Year 2. The project received the concept for the activity from the bureau in late May, and submitted a full work plan to the bureau in September 2014; the plan is currently pending bureau approval. HFG completed a literature review and key informant interviews in order to map the status of NGOs working with HIV/AIDS key populations in the region, their core competencies, and current and potential funding sources for their activities. In September, HFG issued a request for Expressions of Interest (EOI) as a first step in the process of procuring a regional organization capable of providing capacity development technical assistance to NGOs in the region. HFG is also identifying a local consultant to assist with identifying targeted technical assistance needs for the capacity-building NGO or firm as well as the status and technical assistance needs of the nationally located NGOs.

Table 48 provides activity-specific updates. Table 49 provides the health systems strengthening to HIV links.

**TABLE 48. EASTERN EUROPE AND EURASIA BUREAU ACTIVITY DETAIL**

Year 2 Q4 Planned Tasks	Year 2 Q4 Progress	Critical Assumptions/ Problems Encountered/ Follow-up Steps
<b>Activity 1:</b> Capacity development technical support		
Do desktop review and key informant interviews to map local NGOs	This task was completed in Q4.	The summary of the findings including the list of potential NGOs to receive technical assistance will be included in the forthcoming RFA.
Solicit and select subrecipient	A call for EOIs was distributed in Q4.	EOIs will be reviewed, the RFA developed and a winning bidder will be selected in the first quarter of Year 3.
<b>Activity 2:</b> Strengthening country-based NGOs		
Do National NGO Capacity Assessment	Activity is planned to start in Y3Q2.	

**TABLE 49. EASTERN EUROPE AND EURASIA BUREAU HEALTH SYSTEMS STRENGTHENING TO HIV LINKS**

Activity	Prevention	HCT/Diagnosis	Referral and Link to Care	Access and Retention	ART initiation	Viral Suppression (Chronic Care and Labs)	Supportive Care and Quality
<p><b>Overview:</b> Eastern Europe and Central Asia is the only region in the world where HIV prevalence continues to rise. The highly concentrated nature of the epidemic in marginalized populations such as IDUs and MSMs has created significant barriers to HCT, care and treatment service access (i.e. stigma, unknown location). As such, NGOs and CSOs play a critical role in reaching these populations through advocacy, outreach, and the direct provision of care and treatment. Static and declining donor funding for HIV, in a context of insufficient government funding to sustain or scale-up service provision, poses a significant risk to these important service providers. Capacity development, networking and strategy work is needed to help these organizations through this transition from USAID support over the next few years.</p>							
<p><b>Activity 1:</b> HFG Capacity Development Technical Support</p> <p>(Core)</p>		<p>HFG will provide capacity development support to an NGO or private firm location in the region in order to ensure it has the skills and resources to be a provider of capacity building TA to NGOS that work with most at risk populations in the region.</p> <p>This support will be essential to help them transition from USAID support and to continue to offer the essential advocacy (to ensure access and quality), outreach (to link to testing and care, and promote adherence), and care (many of these NGOs directly provide testing, counselling, and ART services.)</p>					
<p><b>Activity 2:</b> Strengthening Regional NGOs</p> <p>(Near Core)</p>		<p>HFG will provide capacity development support to an NGO or private firm location in the region in order to ensure it has the skills and resources to be a provider of capacity building TA to NGOS that work with most at risk populations in the region. This support will be essential to help them transition from USAID support and to continue to offer the essential advocacy (to ensure access and quality), outreach (to link to testing and care, and promote adherence), and care (many of these NGOs provide testing and counseling and distribute ARTs.)</p>					

### 4.3.2 Ukraine

**Program Objectives** – HFG in Ukraine will work closely with country counterparts to test new ways of managing and financing basic HIV services that are fully aligned with the government’s current health reforms. The piloted activities will include HIV testing and counseling, as well as basic HIV care, through their integration into the primary health care (PHC) centers in selected towns and districts in Chernigiv Oblast.

Given the current reforms in Ukraine aimed to improve health services, the purpose of this work is to explore the following questions:

- What are the costs and benefits of providing integrated HIV testing and treatment at PHC centers, as compared to the current vertical model of provision based on specialized trust/AIDS centers?
- What are the impacts of the integrated HIV care model on HIV testing rates, counseling uptake, and timely AIDS treatment?

**Year 2 Activities** – Work will move forward in all of HFG Ukraine’s activities in Year 2. The working group for the implementation of the project will be established and meet regularly to oversee the development of the program model and its implementation (Activity 1). The project will develop local capacity by training PHC physicians and nurses in the use of HIV rapid test kits and doing basic HIV test counseling and non-specialist care. The supervision protocol for the services will be finalized and test kits and related supplies delivered to the four pilot districts early in Year 2. The health financing framework for integrating HIV care into the PHC system will progress with the assessment of the use of incentives in the reform regions, and recommendations for integrated financing of HIV/AIDS at the regional level. The team will finalize the research protocol and associated data collection instruments and conduct the baseline survey for the cost-effectiveness assessment.

**Year 2 Progress** – In the first quarter of Year 2, the project made significant progress in putting into place the pilot model of integrating HIV services into PHC. The project’s most notable accomplishment was successfully completing the first round of trainings for PHC physicians and nurses in November and December, which was the result of months of extensive planning and logistical preparation. The project steering committee was established and the memorandum of understanding among regional officials, the State Services for HIV, TB and Other Socially Dangerous Diseases, and HFG Ukraine was signed in October. The model for the integration of HIV testing and counseling services (HTC) at the PHC level, including new referral pathways, was developed and discussed at the national level with the Head of the Oblast AIDS Center, and other local stakeholders. The team completed the research protocol and associated data collection instruments for the economic evaluation of the model.

In Q2, HFG Ukraine continued to make progress with implementing its pilot model of integrating HIV services into PHC in Ukraine. Training of health workers and delivery of necessary supplies of HIV rapid tests, gloves, etc. for the model implementation were completed in February 2014. PHC center-delivered HTC began in Q2. All of the 65 doctor and nurse pairs trained continued to provide HTC throughout the year.

Operational data from PHCs on delivered HTC services continues to be collected on a monthly basis, including data on the number of tests undertaken and the number of positive results. Since the beginning of the intervention (January 2014), 3,903 HIV tests have been conducted and 33 positive results were detected as of September 1, 2014.

The project has continued to coordinate with Ukrainian health officials and representatives from PHC facilities. Coordination meetings were held in January, February, and April, with participation from 14 project stakeholders, including representatives from the Health Administration, the Chernigiv Oblast AIDS Center, Clinton Health Access Initiative, and head doctors from PHC centers.



Supportive supervision visits began in March 2014 and continue to be conducted at all PHC centers. Observations of the team and operational data suggest that the HTC provided through the PHC ambulatories are well accepted by the catchment population, including most at-risk populations, and teams of physicians and nurses who provide these services recognize their importance and are eager to provide them using rapid tests in the future.

Baseline cost data for 2013 have been collected from all four Trust Cabinets in pilot regions and the AIDS Center Lab Services Unit. These baseline cost data have been matched with 2013 Trust Center and AIDS Center output data to generate preliminary incremental cost-effectiveness ratios for the Trust Center/AIDS Center Lab voluntary counseling and testing (VCT) related outputs.

In Q4, HFG met with representatives from Ukraine's State Services in Kiev to discuss the State Services' interest in HFG modeling performance-based incentives for PHC providers and exploring the possibility of separating HTC and encouraging the use of HIV self/home tests. State Services is interested in the project expanding to offer care as well as HTC. HFG project is taking these ideas into consideration depending on the availability of Year 3 funding for Ukraine.

Finally, the HFG Ukraine team completed its country Gender Strategy and Performance Monitoring Plan in Year 2 and shared them with the mission.

**Challenges** –The project has continued to monitor the ongoing political situation in Ukraine. Despite the violence and instability experienced in the east of the country and some changes in political appointments, including project counterparts such as the Minister of Health, the director of the State Services for HIV, TB and other Socially Dangerous Diseases, and the Director of the Chernigiv Oblast Health Administration, the project's work has continued with only minor interruptions. Nonetheless, the intended discussion of the possible incentives for the PHC staff engaged in the provision of HTC services cannot be conducted given the political and economic crisis in Ukraine.

Operational challenges experienced implementing the project have included unexpected fees for training the physicians at the National Medical Academy for Post Graduate Education. These fees were required, and the training was essential to put the model in place, but necessitated a budget realignment and the paring down of other activities, such as the planned health financing technical briefs and the extensiveness of the planned study dissemination. USAID/Kyiv has been consulted regarding these changes and cuts in some program activities. Other operational challenges included lengthy recordkeeping requirements mandated by the Ukrainian government for PHC centers, as well as a shortage of reagents for the production of confirmatory HIV tests. The shortage of some ARV drugs is expected as the Ministry of Health has not yet conducted procurement of drugs to cover 2014 needs.

Table 50 provides activity-specific updates. Table 51 provides the health systems strengthening to HIV links.

**TABLE 50. UKRAINE ACTIVITY DETAIL**

Y2Q4 Planned Tasks	Y2Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
<b>Activity 1:</b> Develop a model for managing and delivering integrated HIV services at PHC clinics		
Do situational analyses on management structures, supervision, terms of reference, and the use of incentives	HFG has developed modified algorithms for the distribution of functions between PHC centers, Trust Cabinets, and the Oblast AIDS Center, and discussed these algorithms with the State Service, Oblast Health Administration, Trust Cabinets, PHC managers, and other project stakeholders. The algorithms are currently being tested at all levels of HIV care.	Piloting of the current algorithms is ongoing. Analysis and suggestions to improve algorithms will be included in the project's final report in 2015.

Y2Q4 Planned Tasks	Y2Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
Provide ongoing support for steering committee	HFG's clinical advisor has been in communication with project stakeholders throughout Q4. No meeting was held due to summer holidays and a plan to conserve budget funds.	One additional meeting will be held in Year 3.
Provide written documentation of pilot project design, management, and scale-up	Program documentation continued to be developed and refined in Q4, including a summary report of the results of supportive supervision visits to date. The report outlined the main challenges faced as well as suggestions to address these challenges.	
<b>Activity 2: Develop institutional and human resources capacity for providing HIV/AIDS services at PHC facilities</b>		
Train trust offices and AIDS Center staff on supervision protocols and rapid testing	Short instructions have been developed and distributed among participating PHCs. Refinement and piloting of the draft supervision protocol has been ongoing throughout the year and the protocol is now finalized.	
Provide oversight in the roll-out of supervision protocols	Complete; ongoing site-level supervision continued in Q4 via site visits and telephone communication.	
<b>Activity 3: Propose health financing framework for the integration of HIV services into PHC</b>		
Draft situational analysis for incentives for PHC	This activity has been cancelled.	
Provide ongoing technical assistance to identify, with the steering committee, new funding opportunities and analyze the feasibility of the options	This activity has been cancelled.	
<b>Activity 4: Economic evaluation of an innovative model of integrated HIV/PHC services</b>		
Develop sampling frame and begin study design for cost-effectiveness study	The team drafted the design of the cost-effectiveness study, which was finalized in Q3.	The cost and effectiveness baselines for Trust Center provided VCT (with blood referral to AIDS Center lab) have been completed. VCT data from PHC sites is being collected on a monthly basis with concurrent supervision by the AIDS Center, Trust Centers and the HFG project.
Provide data collection of costs, utilization, access, and output data at PHC centers	Routine data collection is ongoing; data are being collected monthly and reported to partners on a quarterly basis. An initial Inventory of PHC sites including number of personnel, type of personnel, types of services offered, etc., is being	PHC cost and utilization data collection will happen in early 2015 after one year of the pilot is completed.

Y2Q4 Planned Tasks	Y2Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
	undertaken during PHC and HIV voluntary and counseling supervision visits.	
Collect trust center-based costs, utilization, access, and output data	The cost and effectiveness baselines for Trust Center provided VCT (with blood referral to AIDS Center lab) have been complete. The baseline cost data for the Trust Cabinets were collected in April-May 2014.	
Analyze data	Baseline data have been analyzed. Baseline ICERs (incremental cost-effectiveness ratios) for the performance of the Cabinets of Trusts in 2013 have been calculated.	The next stage of analysis will occur early in 2015.

**TABLE 51. UKRAINE HEALTH SYSTEMS STRENGTHENING TO HIV LINKS**

Activity	Prevention	HTC/Diagnosis	Referral and Link to Care	Access and Retention	ART initiation	Viral Suppression (Chronic Care and Labs)	Supportive Care and Quality
<b>Activity 1:</b> Develop a model for managing and delivering integrated HIV services at PHC clinics (Core)		By developing a comprehensive and adaptable HIV service delivery model, in conjunction with Ukraine's State Services and other local stakeholders, for providing HTC services, HFG can demonstrate to governments new ways of rapidly increasing the provision of HTC services (with the ultimate goal of improving access and uptake). Within the existing healthcare system, HTC is often approached as a vertical and specialized service. Integrating HTC into a package of PHC service provision will i) increase points of HTC access ii) provide	Linking PLHIV to care is a major challenge in Ukraine. The model HFG is testing focuses on strengthening provider abilities to immediately link PLHIV to ongoing care following administration of a rapid test. As the majority of PLHIV are 'lost to follow up' during the period between testing and care uptake, a focus on strengthening this referral process may assist in ensuring those testing positive successfully reach care. This is particularly important for key populations/MARPs in Ukraine such as sex workers, men who have sex with men, and IV drug users.	The current service delivery model focuses on HTC but it is laying the foundation for the addition of other HIV and AIDS services (i.e. pre-ART and ART). At present AIDS Centers and Trust Offices only distribute ARVs, are centrally located; few in number; and are considered specialized. ART refills and ongoing pre-ART/ART care offered via PHC facilities can increase potential points of access for long-term HIV care, and support ongoing retention of patients who can access HIV care closer to their homes and in a normalized PHC environment.	According to WHO, coverage of HIV care in Ukraine is insufficient, with 22% of the estimated number of PLHIV are in need of ART. (HIV Treatment and Care Evaluation Report, April 2013). By expanding access to HTC services and strengthening the links between testing and care, this activity can support efforts seeking to ensure PLHIV receive care and are appropriately/timely initiated on ART.	By laying the groundwork for integration of HIV and ART services into PHC points of access, this activity seeks to ensure that PLHIV receive long-term access to appropriate HIV services. Thus, increasing their success on therapy, and ultimate success in reaching viral suppression.	

Activity	Prevention	HTC/Diagnosis	Referral and Link to Care	Access and Retention	ART initiation	Viral Suppression (Chronic Care and Labs)	Supportive Care and Quality
		opportunities for provider counselling, HIV symptom identification, and PITC; and iii) may assist in reducing the stigma related to HIV specific facilities (thereby increasing HTC uptake) as HTC and subsequent linkage to care become part of the "normal" health care system.					
<b>Activity 2:</b> Develop institutional and human resources capacity for providing HIV/AIDS services at PHC facilities		HFG provided training to health workers at 35 sites, and facilitated provision by Global Fund and Clinton Health Access Initiative (CHAI) HTC rapid tests, gloves, and other equipment to support the introduction of PITC and VCT at 35 PHC facilities.	HFG introduced HIV counselling and testing protocols to the workers at these 35 PHC sites. This counselling capacity can now assist in linking PLHIV to care, in particular those who required counselling interventions and who might not otherwise have been tested and/or were at risk for loss to follow up.	Now that health workers in PHC sites are trained in anti-stigma and discrimination practice, (facilitated by HFG), PLHIV may feel more comfortable accessing care in these conveniently located PHC facilities. This instead of traveling to city centers for specialist clinics for routine care and/or stigmatized HIV	According to WHO, coverage of HIV care is not sufficient in Ukraine and 22% of the estimated number of PLHIV are in need of ART. (HIV Treatment and Care Evaluation Report, April 2013). By expanding access to rapid tests, the new service delivery model may decrease the number that are "lost" after a positive diagnosis and increase the number	Increasing access to counselling and testing and more effective links to care should result in increased ART coverage, sustained care in a PHC environment, with the goal of long-term success on therapy and resulting viral suppression.	HFG has trained trust office physicians and AIDS Center staff on supervision protocols for HTC so they may provide supportive supervision to PHC sites, ensuring quality, and promote more effective service delivery efforts across the cascade of care.

Activity	Prevention	HTC/Diagnosis	Referral and Link to Care	Access and Retention	ART initiation	Viral Suppression (Chronic Care and Labs)	Supportive Care and Quality
				only facilities.	of newly diagnosed that quickly access care and ART as needed. Health workers in 35 sites have been trained by HFG to recognize early signs of AIDS and in PITC in order to link patients to care and treatment as soon as needed/possible.		
<b>Activity 3:</b> Propose health financing framework for the integration of HIV services into PHC		Currently, HTC, and HIV care and treatment services are vertically funded and managed through a limited number of facilities throughout Ukraine. While this funding structure has in the past served to protect donor sources of HIV/AIDS funding from conflicting regional and local budget demands, the current structure is duplicative and does not take full advantage of existing health facilities or human resources in Ukraine. By integrating HIV and AIDS into the PHC service and financing structure, including adding HIV indicators (as recommended by HFG) to the package of services for which health workers receive incentives, this may serve to lower costs and increase quality and access to HIV diagnosis, care and treatment across the cascade of care.					
<b>Activity 4:</b> Economic evaluation of an innovative model of integrated HIV/PHC services		HFG is conducting a comparative cost effectiveness analysis of the current model of Trust Center provided VCT (with blood referral to AIDS Center lab) and the HFG piloted model of decentralized, integrated access	As part of the cost effectiveness study, HFG is assessing the number of HIV positive people identified, and the numbers among those who enter into care (register at AIDS Centers). This will assist government at the national level to tackle the widespread problem of "losing" PLHIV between diagnosis and treatment uptake. In addition, those who are successfully linked and retained in care will be more likely to access and benefit from early and appropriate initiation of ART.			Patients who are successfully linked to care and initiated on ART are more likely to receive a stable treatment pathway of long-term care. By assessing the number of people who are successfully linked to care,	HFG is assessing not just the cost of the new service delivery model, but its effectiveness. In particular, HFG will seek to assess whether the new model is successfully reaching MARPS as an indicator of quality of care. Findings of the study will be provided to the Government of

Activity	Prevention	HTC/Diagnosis	Referral and Link to Care	Access and Retention	ART initiation	Viral Suppression (Chronic Care and Labs)	Supportive Care and Quality
		to HTCwith rapid tests at the PHC level. This analysis will help policy makers determine the most cost effective means of delivering HTC and ground truth the proposed PHC integration model				the cost effectiveness study can also speak to the efficiencies gained in helping people access care in a normalized PHC environment, thus improving their retention and success on therapy to viral suppression.	Ukraine in order to inform the ongoing process of policy reform.

Note: HTC=HIV counseling & testing



## 4.4 Latin America and Caribbean

### 4.4.1 LAC Bureau

**Program Objectives** – In 2012, the governments of the United States, Ethiopia, and India, along with UNICEF, convened A Child Survival Call to Action to help refocus the efforts of governments and organizations worldwide in addressing preventable child and maternal mortality. Participants, including USAID, committed to supporting maternal and child health (MCH) globally and to deliver on existing commitments to child survival. This commitment became recognized as A Promise Renewed. In September 2013, a regional conference called A Promise Renewed in the Americas was convened in Panama City, Panama. The conference recognized the regional improvements of maternal and child mortality rates in the Americas region, but also the fact that gaps persist, especially due to inequality and a lack of universal access to appropriate care. The conference focused specifically on MCH challenges in the region and the way forward, recognizing diminishing donor funds for MCH and the need to mobilize local resources to focus on sustainability of existing programs and services. Countries and donors cited the specific problem of policymakers introducing new reforms to achieve Universal Health Coverage (UHC) that do not adequately protect or promote MCH services and goals. USAID was part of the region-wide commitment at the conference to help reduce the equity gaps for MCH in the region and eliminate preventable maternal and child mortality by 2035.

In Latin America and the Caribbean (LAC), the HFG project is supporting national, regional, and local government organizations and health facilities in initiating and implementing a wide-range of health finance and governance projects. As countries in LAC graduate from bilateral assistance in health, USAID's LAC Regional Bureau seeks to help transitioning countries ensure MCH programmatic sustainability. To achieve this goal, the LAC Bureau's program focuses primarily on health systems strengthening and capacity building to ensure that reforms to achieve UHC reflect the latest evidence and incorporate MCH services. In order to implement reforms and affect broader policy decision making, there is a strong need for the generation and use of evidence to provide policymakers with the information they need to make sound policy and operational decisions. The lessons learned and research findings from within LAC countries can also be shared in regional global forums.

**Year 2 Activities** – In Year 2, HFG will work with subawardee Bitran y Asociados to ensure the successful delivery of the four-day course “The Challenges to Advancing Universal Health Coverage,” in close collaboration with the World Bank Institute (WBI). Through HFG, the LAC office at USAID is collaborating with the WBI to host The Challenges to Advancing Universal Health Coverage, for government officials and USAID staff. The course will be based on the WBI's three-week flagship course that uses a practical framework for understanding health systems and their performance, and a structured approach to developing health system reform policies to improve systems performance. The course will provide a unique opportunity for participants to explore key issues in health financing, payment systems, organizational change, regulation, and influencing provider/client behavior. Sessions will include a closer look at the reality of political/ethical trade-offs, leadership challenges, and ensuring quality to progress toward UHC.

**Year 2 Progress** – The sub-award with Bitran y Asociados has been finalized. The invitations have been sent out to potential participants from the Dominican Republic, Haiti, Guatemala, Honduras, El Salvador, Peru, and Guyana, and we will confirm the final participant list by the end of September 2014. The venue in Panama City, Panama, is being finalized. Travel arrangements are being organized and will be finalized once we have travel approval and a confirmed participant list. Course logistics and travel arrangements are being finalized and curriculum and course material preparation is underway, with a draft of materials to be submitted to our LAC Bureau client by October 10, 2014. The course will take place in Quarter 2 of Year 3.

**Challenges** – There has been some difficulty confirming participants from target LAC USAID transition countries. We are working aggressively with Bitran y Asociados and our LAC Bureau client to confirm all intended participants.

Table 52 provides activity-specific updates.

**TABLE 52. LAC BUREAU ACTIVITY DETAIL**

Y2Q4 Planned Tasks	Y2Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
<b>Activity I: World bank's universal health coverage flagship course for Latin America and Caribbean Region</b>		
Support course curricula adaptation as necessary	Development of course materials is underway.	Draft materials will be ready for review in mid-October, 2014, and will be finalized before the course is held.
Deliver UHC Flagship Course	No progress made – this is scheduled for March 2015.	

## 4.4.2 Barbados and the Eastern Caribbean

**Program Objectives** – The HIV/AIDS epidemic is the leading cause of death for adults aged 25 to 44 years in the Caribbean region. With an HIV prevalence rate of 1 percent, the Caribbean is the hardest hit region after sub-Saharan Africa. Multiple factors, such as leveled donor funding, the global economic recession, and increased prevalence of non-communicable diseases have placed more weight on the importance of sustainability in health programs. As external aid for HIV programs decreases across the Caribbean, investments in health financing systems are necessary to enhance sustainability of and access to HIV programs. The seven countries where HFG is working – Antigua and Barbuda, Barbados, Dominica, Grenada, St. Kitts and Nevis, St. Lucia, and St. Vincent and the Grenadines (SVG) – have made great strides in their HIV response, and have an achievable goal to end mother-to-child transmission in the next three years. Careful management and investments in the face of declining external funding will be important to sustain the momentum and gains that have been achieved.

The overall objective of HFG's activities in the Caribbean is to build country capacity in core health system components – financing, governance, and operations – enabling health systems and HIV programs in particular to function more sustainably and efficiently. Our anticipated results include:

- Increased use of health and HIV expenditure data and unit cost information to inform resource allocation decisions, health sector reforms, financial sustainability planning, and advocacy, including among both public and private sector health stakeholders
- Strengthened Ministry of Health (MOH) financial management capacity, including the ability to conduct costing analyses and utilize costing data for strategic and operational planning
- Strengthened regional institutional capacity to provide health financing technical assistance, specifically in National Health Accounts (NHA) and resource tracking for HIV
- Strengthened capacity within the Pan Caribbean AIDS Partnership (PANCAP) to provide sustainable strategic leadership for the regional HIV response in the Caribbean
- Increased long-term sustainability of HIV programs throughout the region
- Increased capacity of civil society to engage in the HIV response, particularly on issues of governance and the financing of the response

**Year 2 Activities** – USAID/Barbados and Eastern Caribbean provided a budget of \$1,219,000 for the Caribbean region in March 2014. In August 2014, USAID/Barbados and the Eastern Caribbean has directed HFG to spend against that budget up to \$1,159,132 in order to reflect new programming guidance from PEPFAR.

In Year 2, HFG will begin operations in the region and implement and complete a number of activities, most of which will be completed in the first quarter of Year 3. As a follow-up to the UNAIDS and PEPFAR supported “2<sup>nd</sup> Caribbean Regional Meeting On Strategic HIV Investment And Sustainable Financing (January 2014)”, in Year 2 HFG Caribbean will offer support to the development of HIV Investment Cases in six of the Organization of Eastern Caribbean States (OECS) nations: Antigua and Barbuda, Grenada, Dominica, St. Kitts and Nevis, St. Lucia, and SVG. The goal of an Investment Case is to outline strategic HIV investments to maximize available resources and achieve the greatest impact on the epidemic. Each case will be used to inform planning, resource allocation decisions, and funding applications for the HIV responses in these countries. The development of the cases will include participation from the governments, civil society, the private sector, and development partners. The individual Investment Cases could also be used to support the development of a concept note that the OECS Regional Coordinating Mechanism is currently preparing to apply for a multi-country Global Fund grant.

HFG will support NHA estimations in Barbados and St. Vincent and the Grenadines in Year 2. The NHA methodology quantifies health spending and tracks expenditures from financing sources (such as households, donors, and Ministries of Finance) to funds' managers (such as Ministries of Health and insurance companies) that allocate and manage health care funds, and ultimately to health care providers and health functions. Under the latest version of the NHA methodology, called the "System of Health Accounts (SHA) 2011" framework, all expenditures are allocated to disease categories, including HIV. The results provide stakeholders with a comprehensive map of resource flows funding the HIV response and the entire health system. Mirroring the approach used under the Health Systems 20/20 and Health Systems 20/20 Caribbean projects, HFG will support the NHA estimations in close collaboration with the University of the West Indies (UWI)-Health Economics Unit (HEU). To the extent feasible, we will rely on MOH staff to assist with data collection and analysis as well. We will use the updated Health Accounts Production Tool (HAPT) software that incorporates the new SHA 2011 framework to facilitate and streamline the data analysis process.

The process will begin with a stakeholder launch workshop, followed by data collection on health expenditures from donors, NGOs, insurance companies, and employers. The project will also complete a survey among people living with HIV (PLHIV) in order to capture out-of-pocket spending for HIV prevention, treatment, and care. In Barbados, the NHA will include a household expenditure survey in order to get a good sense of out-of-pocket spending on health in that country. These surveys on their own are a good gauge of health priorities and vulnerabilities to catastrophic health expenditure. The team will analyze the data; write reports summarizing and synthesizing findings; and disseminate and promote the use of the results via in-country validation and dissemination workshops.

Other activities planned for Year 2 include:

- Capacity-development assistance for PANCAP and UWI-HEU to strengthen their role as regional resources for the HIV response. This technical assistance includes both technical inputs, such as training in SHA 2011 methods for HEU staff, and costing of a regional operational plan for PANCAP in support of a Global Fund application, as well as organizational development technical assistance to be provided to PANCAP only.
- Technical inputs in support of a regional multi-country Global Fund application including financial impact modelling
- Development of technical briefs including:
  - Publication of an article on the lessons learned from USAID's transition from family planning programming that can be applied to the transition from donor funding for the HIV response in the region.
  - A technical brief on Satellite Account estimations versus NHA that can be a resource for countries in the region that have implemented or are considering implementing one or both expenditure analysis techniques.

**Y2 Progress** – HFG has been an active participant supporting planning for sustainable financing of the HIV response in Barbados and the six countries of the OECS. Starting with participating in a January 2014 UNAIDS- and PEPFAR-sponsored “Second Caribbean Regional Meeting on Strategic HIV Investment and Sustainable Financing” with senior leaders from eight Caribbean countries who are engaged in HIV program planning and financing, including Permanent Secretaries of Health, Ministry of Finance representatives, National AIDS Program coordinators, and civil society and private sector representatives, HFG has helped to



Health workers in St. Kitts and Nevis talk to the HFG Project about their services in the HIV response and resource needs.

define an approach for Investment Case development for these small states, including a method to use existing data to suit the countries’ multiple needs, and to aggregate results for a combined regional contribution to the regional Global Fund application as well as an OECS Regional HIV Strategic Framework. In Year 2, HFG facilitated and provided technical content for HIV Investment Case validation meetings in St. Lucia, St. Kitts and Nevis, and St. Vincent and the Grenadines, country dialogue meetings in Grenada and Antigua and Barbuda, and a National Strategic Planning meeting in Dominica. At these meetings, HIV programming priorities, scale-up scenarios, and funding need estimations were discussed and agreed upon with a broad range of stakeholders, allowing for the finalization of the HIV Investment Case Briefs in each of these countries. This task will be completed for the six OECS countries by the end of October 2014.

HFG delivered training in the SHA 2011 method of conducting an NHA on June 2-6, with more than 20 participants from the UWI-HEU staff, and the Ministries of Health of SVG and Barbados. NHA launch workshops were held for Barbados (June 18) and SVG (June 26). Each was well attended by health sector leaders and stakeholders, NHA committees were established, and the priorities for NHA estimations, including health and non-health HIV spending, were established. Data collection in both countries has been initiated and is ongoing.

The rapid assessment to develop a capacity-building plan for UWI-HEU and PANCAP were completed in Year 2 and submitted for review to both organizations. HFG supported the development of PANCAP’s Regional Operational Plan and has initiated the costing of this plan in support for a regional Global Fund application being led and submitted by PANCAP.

HFG participated in and presented at PANCAP Executive Board Meeting and Regional Coordinating Mechanism (RCM) for Global Fund Projects meetings in April 2014 (PANCAP Executive Board and OECS RCM) and in June 2014 (OECS RCM). HFG provided update on HFG support to PANCAP and shared information related to country-level health financing data availability, needs, and planning for Investment Case development and global fund applications.

The technical brief on SHA 2011 NHA methodology v. Satellite Accounts has been completed and disseminated. The technical brief on lessons learned in transition from USAID funding is being finalized.

**Challenges** – The seven countries are engaged and committed to the HFG-supported activities, but each has limited human resources capacity to work together with HFG to implement the NHAs and Investment Case data collection and development. HFG is working with UWI-HEU to provide targeted technical support to these governments. The project is also coordinating carefully with other development partners such as the OECS RCM, PEPFAR and other PEPFAR implementers, UNAIDS,

PANCAP and the Pan American Health Organization so as not to duplicate efforts or place excessive demands on country counterpart participation. PANCAP and UWI-HEU also have limited capacity to work with HFG but the project has managed to accommodate these organizations' schedules and needs accordingly.

**Q4 Additional Information** – In Q4, HFG received news from PEPFAR via USAID that programming priorities for the Caribbean Region were changing. As a result, HFG provided an updated work plan of activities directly supporting Global Fund applications (supporting PEPFAR's priority of helping to leverage other funding sources for the HIV and AIDS response) and those activities that were very far along and could be completed by the end of December 2014. The reprogramming process included a brief order to stop activities, which was lifted after about two weeks, but which caused some delays in activities. The project expects all activities to be completed on time by the end of December despite the minor set-back.

Table 53 provides activity-specific updates. Table 54 provides the health systems strengthening to HIV links.

**TABLE 53. BARBADOS AND EASTERN CARIBBEAN ACTIVITY DETAIL**

Y2Q4 Planned Tasks	Y2Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
<b>Activity 1: Investment Case development (OECS countries)</b>		
Investment Case development: Literature review, data collection, and development of annotated outline for Investment Case, GOALS Modeling, and analysis (Antigua and Barbuda, Dominica, Grenada, St. Kitts and Nevis, St. Lucia, and SVG)	Data collection and modelling was completed for all six countries.	Significant difficulties were experienced in some countries to extract needed data for the modelling. HFG, using multiple sources and methods depending on the country, managed to get the required data to complete the modelling.
Validation meeting and finalization of investment case inputs	Stakeholder meetings were held in each of the six countries to validate HIV investment case scenarios, resource availability, and programming priorities.	Investment cases for all six countries and the draft national strategic plan for Dominica will be complete by the end of October.
<b>Activity 2: HIV/AIDS-focused health accounts estimations (Barbados and SVG)</b>		
Launch workshops held for NHA estimations in Barbados and SVG	The activity was completed in this quarter. Both workshops were well attended and achieved objectives of defining priorities, establishing an NHA implementation committee, and launching the exercise.	
Conduct primary data collection and analysis	This task was initiated in Q4 and is ongoing.	In the next quarter (Q1 of Year 3) HFG will work with MOHSW and stakeholders to analyze findings, draft reports, and disseminate NHA results.



Y2Q4 Planned Tasks	Y2Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
<b>Activity 3:</b> Capacity development support for UWI-HEU		
Rapid assessment to develop capacity building plan	Rapid assessment was initiated in June 2014 and HFG developed a proposed menu of capacity building activities. However, HEU decided it was not interested in HFG capacity development assistance at this point. They determined that it conflicts with a strategy planning process and management review already underway.	No further capacity building support is planned.
<b>Activity 4:</b> Capacity development support for PANCAP		
Rapid assessment and development of organizational capacity building plan	Organizational capacity assessment was completed in Q4 and approved by PANCAP. The assessment included a proposed capacity-building plan. This plan was then revised due to the request by USAID/Barbados to complete all capacity-building activities by 12/31/14.	
Implementation of capacity-building plan	HFG completed initial planning to implement the plan in compressed time period. HFG assistance will consist of 1) clarifying the role of the Priority Areas Coordination Committee, which provides leadership to PANCAP, 2) development of orientation/sensitization packages for PANCAP members, the Caribbean Community (CARICOM), an Executive Board, 3) conducting interviews with CARICOM on how PANCAP can operate more effectively under CARICOM umbrella, and 4) development of a resource mobilization plan	
Support Development of Regional Operational Plan	HFG agreed with PANCAP to focus on the costing of the operational plan. The plan was developed by PANCAP, but needed to be revised based on the PEPFAR focus on care and treatment. This delayed the costing of the plan.	Complete the costing once HFG receives the revised operational plan.
<b>Activity 5:</b> Regional HIV response sustainability planning		
Participation in PANCAP Executive Board Meeting and Regional Coordinating Mechanism for Global Fund Projects meetings	Attended both meetings in Q3.	HFG will participate in the PANCAP Annual General Meeting in Q1 of Year 3 in support of the development of the PANCAP resource mobilization plan and coordination of the regional Global Fund concept note.



Y2Q4 Planned Tasks	Y2Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
Develop Investment Case process guidance	This activity is complete. HFG worked with UNAIDS and country counterparts to determine data availability and country needs for Investment Cases and developed an approach to meet needs given regional and country data availability and objectives of the Investment Case modeling and process.	
Publish technical brief on SHA 2011 NHA methodology v. Satellite Accounts	Disseminated in Q4.	
Publish technical brief on lessons learned in transition from USAID funding	Brief is ready for peer review.	
Participate in regional meetings as requested by USAID/Caribbean	HFG participated in the USAID Partners' Meeting in July 2014.	
Support development of regional multi-country Concept Note for OECS Global Fund application	Collected financial, demographic, programmatic, and behavioral data from each of the six OECS countries in support of the Concept Note.	In Year 3, HFG will aggregate data from the six countries on programming priorities, anticipating spending needs and financial gaps as an input into the regional multi-country Concept Note.

**TABLE 54. BARBADOS AND THE EASTERN CARIBBEAN HEALTH SYSTEMS STRENGTHENING TO HIV LINKS**

Activity	Prevention	HTC/Diagnosis	Referral and Link to Care	Access and Retention	ART initiation	Viral Suppression (Chronic Care and Labs)	Supportive Care and Quality	Comments
<b>Activity 1: HIV Investment case development (Core)</b>	Investment case will include segment impacts of investment in prevention services versus costs of care and treatment. Enhanced information on investments needed to avert infections and save lives will assist government (and others) make evidence-based decisions on investment in prevention activities. These decisions could include resource mobilization, budgeting, resource allocation, and policy.	Will assist governments and donors to make evidence-based decisions on where HTC investments will be most cost-effective in reaching most at risk / key populations with HTC services and approaches. This information is integral in providing governments with information necessary to take key decisions in reaching key populations with HTC services. For example, Investment Case information has helped governments to amend incongruities between funding and needs for specific populations (Jamaica 2013).	Investment cases can consider population-specific behaviors when assessing the impact of investments on linking and retaining key populations in HIV care (i.e., differential costs associated with addressing health-seeking behavior of commercial sex workers v men who have sex with men v general population). Such information can assist in evidence-based decision making and program design to ensure financial investments are targeted to linking and retaining HIV positive clients from key populations.		Investment Cases provide information on differential approaches to scaling up the supply of ART services. Adequate knowledge of the costs and investment impacts of ART efforts can support decision making targeting rapid ART scale-up.	Investment Case modelling can support decision makers in lobbying for increased/amended resource allocation that targets patients at risk for loss-to-follow-up (or other key populations at risk of treatment default). Resources specifically designated to supporting treatment adherence can assist patients in reaching stable therapy / viral suppression.	Investment Cases can provide information on the costs of investments in supportive services (i.e., nutrition or lab monitoring), which can help patients thrive on treatment.	Investment Cases outline country commitments to the HIV response, and possible impact of investments, as part of an application for a Global Fund grant. Leveraging PEPFAR funds to attract more funding "shared responsibility" with Global Fund and counterparts.

Activity	Prevention	HTC/Diagnosis	Referral and Link to Care	Access and Retention	ART initiation	Viral Suppression (Chronic Care and Labs)	Supportive Care and Quality	Comments
<b>Activity 2:</b> NHA estimations with HIV focus (Core)	Abt has adapted the SHA 2011 methodology to include elements of National AIDS Spending Assessment (NASA) - that is, tracking expenditures on HIV prevention so that government can adequately segment the health market. Understanding levels of spending on prevention to provide evidence for adequate budgeting and resource allocation to scale-up and strengthen prevention services.	Market segmentation evidence helps MOH and other decision makers to target investments in HTC and testing access. In many Caribbean countries, patients may not have/choose not to access public sector services. NHAs can reveal private sector coverage/segmentation, and opportunities to invest in private sector services where populations may feel more comfortable due to stigma and privacy issues.	Evidence of out-of-pocket spending from NHA estimations help understand financial vulnerability which could impact PLHIV ability to seek and retain needed care and treatment.		NHAs provide market segmentation information (geographic, by sector), which can assist in targeting efforts and investments at scaling up supply and access to ART services.	Evidence of out-of-pocket spending from NHA estimations help understand financial vulnerability which could impact PLHIV ability to seek and retain needed care and treatment, and/or financial barriers to supporting patients in reaching viral suppression.	NHAs can support health system market segmentation; reveal public-private partnership or private sector opportunities; and/or reveal areas of supportive care that could be strengthened via differential resource allocation / use.	NHA - provide data for evidence-based budgeting for prevention, care, and treatment including 1) public v private sector leveraging; 2) increasing access - reducing financial barriers/risk, geographic, type of facility (public v private); adequate budgeting for care and treatment; 4) evidence for applications to Global Fund, others for financial contributions.

Activity	Prevention	HTC/Diagnosis	Referral and Link to Care	Access and Retention	ART initiation	Viral Suppression (Chronic Care and Labs)	Supportive Care and Quality	Comments
<b>Activity 3:</b> Capacity development support for PANCAP (Near Core)	PANCAP plays an important and unique regional role in resource mobilization, information sharing, and advocacy. Reducing stigma and providing outreach are important components of prevention in this region where the epidemic is concentrated in key populations. Sustaining and strengthening this organization therefore assists in strengthening the response throughout the region, which has a highly transient population.		Civil society organizations are important members of PANCAP and their ability to have a voice on the executive board allows a mechanism for feedback on barriers that may impact key populations' ability to get into care once diagnosed. For example, there is a regional youth representative who has pointed out that there are legal and social barriers impacting the youth in the region's ability to seek care.	As a successful vehicle to mobilize and manage resources from outside the region (such as Global Fund grants), PANCAP has helped ensure education, social services, and advocacy programs are sustained, which encourage key populations to stay in care.	Information sharing and strategy development among the Caribbean nations through the PANCAP vehicle helps with resource sharing, learning from policy and resource allocation decisions of other nations, so that individual countries may strive to make continual improvements in their ART (and other HIV) service delivery.			Development and costing of Regional Operational Plan feeds into Global Fund Concept Note. As part of the PEPFAR Road Map, this activity supports the shared responsibility for the response by leveraging other donor funds. The capacity-development work, including the development of a RMP, supports PANCAP's sustainability in a time of declining donor funding.

Activity	Prevention	HTC/Diagnosis	Referral and Link to Care	Access and Retention	ART initiation	Viral Suppression (Chronic Care and Labs)	Supportive Care and Quality	Comments
<b>Activity 4:</b> Regional HIV Response Sustainability Planning (Near Core)		Supporting the development of regional sustainability plan for the regional HIV response will assist multiple stakeholders in identifying, planning for, and addressing financial and service delivery requirements for long-term sustainability. Information in this area assists stakeholders by providing information on country-level health financing data availability, financial needs assessments, and planning for sustainable service provision/scale-up.						
<b>Activity 5:</b> Antigua and Barbuda Public Private Health Sector Task Force (Policy Mechanism/Near Core)		Engaging the private health sector can expand the government's ability to reach key populations with prevention and HTC efforts. The task force provides a platform through which private sector engagement initiatives can be explored, lessons shared, and multiple stakeholders can be involved in developing PPP options.	With private sector engagement (that didn't exist before the task force) the government can increase communication with private providers currently not included in the government's HIV response. For example, appropriately engaged private providers treating HIV patients can ensure more effective links between public and private sources of	Task force provides a forum for private and public sector to share lessons learned/strategies to keep PLHIV in care. Information on important programs that need support can be shared more easily, which could lead to problem solving and resource sharing. (Example of Caribbean HIV/AIDS Alliance being defunded, seeking government support for essential services post-PEPFAR funding.)	New guidelines for ART initiation can be more easily communicated to private providers via task force mechanism, to support compliance with government and WHO guidelines, and increasing the number of private sector sources of care and treatment.		Through the task force, private and public sector stakeholders are developing facility regulation policy (including labs, health care facilities, and pharmacies), which should have the effect of quality standards for patients in both public and private facilities. Of particular concern are currently unregulated labs that conduct tests for HIV.	

Activity	Prevention	HTC/Diagnosis	Referral and Link to Care	Access and Retention	ART initiation	Viral Suppression (Chronic Care and Labs)	Supportive Care and Quality	Comments
			care, ensuring continuity of referral and improving treatment access throughout the health system.					
<b>Activity 6:</b> Technical brief on Lessons for Transitions (Near Core)		This brief outlines lessons learned in programming during the years previous to and during a transition from USG support. It draws lessons from USAID's experience in funding family planning advocacy, awareness, supplies, and care and withdrawing that funding in countries that have "graduated." Lessons can be considered by donors, governments, and regional stakeholders as they navigate declining donor funding for HIV in the region with a goal of maintaining and improving on the gains made over the past 20 years in treatment and care. Compiling and disseminating this knowledge will be critical in preparing regional HIV stakeholders for long-term program sustainability. Such information can provide stakeholders with options / lessons in expanding HIV services along the full cascade of care.						

Note: HTC=HIV counseling & testing

### 4.4.3 Haiti

**Program Objectives** – At the start of HFG, USAID Haiti asked that the project work closely with the Haitian Ministry of Public Health and Population (*Ministère de la Santé Publique et de la Population*, MSPP) with the objective of strengthening the ministry’s capacities in human resources for health (HRH) management and in health financing, enabling it to carry out its role as an effective steward of the health sector. In response, HFG developed a country strategy to address the mission’s request. In order to execute this strategy, HFG planned to work directly with five MSPP units – *Unité d’Appui à la Décentralisation Sanitaire* (UADS) (decentralization unit), *Unité d’Evaluation et Programmation* (UEP) (planning and evaluation unit, formerly called the UPE), *Direction de l’Administration et du Budget* (DAB) (budget and administration directorate), *Direction des Ressources Humaines* (DRH) (human resources directorate), and *Direction de Formation et Perfectionnement de Sciences de la Santé* (DFPSS) (training) on institutional and technical capacity building as well as technical implementation support.

**Year 2 Activities** – In Year 2, HFG continued its country strategy to support its five focal units. With the DAB, the focus of the activities is strengthening public financial management (PFM) at both the central and department<sup>6</sup> levels. Working with UEP, HFG continues to strengthen MSPP’s capacity to effectively plan its activities and track resource flows through the health sector. HFG continues to build the capacity of UADS to strengthen the decentralized functions of the departments, particularly with respect to financial management and some HRH management activities. HFG will be supporting DRH with strengthening the Human Resources Information System and use of the data in addition to improving career and performance management processes. Finally, the DFPSS is receiving support from HFG to design and implement effective processes to ensure minimum standards across Haiti’s private nurse training institutions.

In addition to these activities, HFG will carry out a costing exercise for the Partners in Health-supported teaching hospital facility at Mirebalais to support its financial planning.

**Year 2 Progress** – HFG Haiti has continued to make steady progress on its original three-year country strategy with most activities being on track. Year 1 focused on project set-up and building relationships with the project’s five counterpart units within MSPP and understanding the ministry’s needs and priorities. In Year 2, HFG has strengthened its collaboration with MSPP beyond the five focal units by working with the office of the Minister’s cabinet (e.g., for developing scopes of work for additional staff) and the office of the Director General (DG) of MSPP. This process aims at ensuring that the cabinet is kept up to date with the activities that the HFG project is implementing in the ministry. HFG has produced activity briefs, in French and English, that describe the project’s work to date as well as policy briefs where appropriate to describe the key findings and next steps of the projects work, for example the Haiti National Health Accounts (NHA) Brief. HFG has also collaborated with non-MSPP arms of the Haitian Government that are critical to the success of the health sector; for example by coordinating activities between MSPP’s UEP and the Ministries for Finance (MEF) and for Planning and Donor Coordination (MPCE). A clear demonstration of the benefit of this collaboration can be observed from the NHA exercise where the MSPP has leveraged the MPCE’s NGO database to come up with the NGO’s contribution in the national health expenditures for NHA activity. In so doing, a data quality assessment (DQA) and recommendations for improving the database were provided to the MPCE. A further demonstration of this collaboration includes the development of a hospital financial reporting process that aligns with MEF line items and nomenclature in coordination with MSPP’s DAB.

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<sup>6</sup> Haiti is divided into 10 geopolitical regions called “departments.”



To date, the HFG project has made important progress working within the five MSPP focal units and below is a summary of the progress made in each of the units:

**Unité d'évaluation et de Programmation (UEP)** – HFG began its support of the UPE with costing of the operational plans and *plan directeur* of MSPP. HFG worked with all 10 MSPP departments as well as 22 strategic units to review their activities in order to ensure alignment with unit functions as described in the *loi organique* and then to cost their operational plans. This process was completed for 30 out of 32 operational plans including all 10 departments (geo-political sub national levels) of the country and most of the national level operational units of MSPP. The remaining two will be completed in Year 3 once those operational plans have been developed by their respective units; however, they are considered to be 'sub-units' of other higher level units and their costs will be included within the original 30 units for this fiscal year. HFG produced a complete database of the costs of approximately 4,000 activities within the MSPP operational plan framework and has mapped each of these activities to the *plan directeur*, which is the implementation plan of Haiti's National Health Policy. This database and the fully costing report were completed for three years and are under review by MSPP at the time of the writing of this report.

**Accomplishment:** *For the first time, as a result of USAID support, all the activities of MSPP and their costs have been collated together in a single database and report. This database links directly to the implementation plan of Haiti's national health policy – the plan directeur allowing future expenditure tracking against the plan directeur's performance along with a straightforward, updatable way to estimate annual costs of MSPP that can in the future be used to estimate gaps between available resources and required needs.*

HFG has also supported the UEP in conducting a health financing situation analysis of Haiti that will be used to draft the national health finance strategy in Year 3. During Y2Q4, the HFG project was requested to organize a national health financing conference by the Minister of Health. The objective of this conference will be to raise the profile of health financing in Haiti, particularly with partners, lawmakers, and other key ministries within the Haitian government. The concept note for this conference is currently under review by MSPP and it is anticipated that both the health financing situational analysis and the 2011/2013 NHA data will be heavily leveraged to set the Haitian context during this conference. Finally, HFG has supported the UEP in conducting the 2011/2012 NHA using the Systems of Health Accounts (SHA) 2011 methodology for the first time in Haiti. HFG has collaborated with the World Bank's Living Standards Measurement Survey (LSMS) project in obtaining the household expenditure data; however, all other data were collected from secondary sources allowing the activity to complete NHA data collection in six months – a very short timeframe and significant achievement. By using a process that leveraged existing data, HFG has made significant strides in ensuring that Haiti can conduct future NHA estimations with minimal donor support, in a sustainable and consistent manner.

As per the country strategy, the project has supported a functional capacity assessment of the UEP as part of the broader government initiative to align and strengthen the planning and evaluation units of each of its ministries. The recommendations of this report that have been reviewed and accepted by the Minister of Health and will be implemented in Year 3 of the project.

**Direction de l'Administration et du Budget (DAB)** – HFG has made some progress in the work with the DAB by hiring two consultants who are building the capacity of DAB staff in certain aspects of accounting and financial reporting that relate to aligning MSPP's financial reporting process to the MEF requirements. The project also provided Quickbooks software to the DAB staff at the central level and at the three pilot hospitals for which it developed templates in Quickbooks that align with the nomenclature required by the MEF accounting manual to ensure that financial reporting by MSPP aligns

with MEF requirements. These financial reporting processes were piloted in three public hospitals including the University of Haiti Teaching Hospital upon request by the Minister of Health. Related to this activity, the project also developed financial reporting training materials that will be used by DAB central-level staff to train the hospitals' finance staff in improving their financial reporting activities (see challenges below regarding next steps). As per the country strategy alongside these technical activities, the project has worked with the DAB's directors to identify and address organizational issues, including an in-depth functional assessment of the DAB and its 120+ staff. This assessment, which will be available in October 2014, will be used as the basis for moving forward with the development and implementation of an institutional capacity-building activity in Year 3.

**Unite d'Appui a la Decentralisation Sanitaire (UADS)** – During its first year, HFG conducted an assessment of the organizational capacity of UADS and developed an intervention plan aimed at strengthening the unit and its relationships/interactions with other units and the 10 departments. HFG has made steady progress in implementing the planned activities. HFG assisted UADS to develop an organizational vision, identify the organizational values to guide its work, and determine the strategies needed to implement its vision. HFG also conducted training aimed at building specific skills in performance management to improve internal functioning; for example, UADS initiated the practice of regular staff meetings. In the second year of the project, HFG assisted UADS to finalize its vision, values, and functions document and conducted training on key skills required by UADS to effectively work with the departments. These included consulting approaches and skills, coaching skills and their usefulness for motivating and building capacity, and increased self-awareness of personal styles in working with others. Following a ministerial request, a re-alignment of UADS with the minister's expectations and directives from the Office of Management and Human Resources (*Office de Management et des Ressources Humaines*, or OMRH) will be supported by HFG over the course of Years 3 and 4. This work will dovetail with the specific skills-building work already supported by the project.

**Direction des Ressources Humaines (DRH)** – HFG has embedded an HRH advisor in the DRH in order to support unit staff with the implementation of their HRH strategic plan. This year, the advisor has supported the DRH in conducting a DQA of the *Système d'Information et de Gestion des Ressources Humaines* (SIGRH) in order to obtain high-quality, complete data that can be used for prioritizing and implementing the national HRH strategy. The DQA revealed several opportunities for optimizing SIGRH functioning and strengthening the quality and use of the data: for example, in the first five departments where the DQA was completed, staff lists showed a total of 5,103 employees, but 2,079 (40 percent) of these were not entered in the SIGRH. Data collection has now been completed in all 10 departments. These data are being used by HFG as baseline data to support the design of HRH planning and management indicators that the unit can use in future to track (on a quarterly basis) and demonstrates its own improved HRH management capacity. The preliminary data and findings from the DQA have been shared and reviewed by the DRH and other relevant stakeholders at the *l'Evaluation des Ressources Humaines des Institutions Sanitaires du secteur public* (ERHIS-I) workshop in August 2014. Subsequently a final report is being completed and will be under review by the ministry and USAID in October 2014.

**Accomplishment:** USAID has supported the first DQA of the information system used to monitor Haiti's human resources for health leading to the availability of up-to-date, accurate information that can be used to identify where HRH gaps are so that evidence-based retention and redistribution policies can be developed to address these issues.

In addition to HRH information systems, HFG is addressing a key concern raised by the Minister of Health at the beginning of the project: that the staff within units, across MSPP are not clear on the expectations of MSPP and the rules and regulations that govern how the units work. To address this, HFG has developed orientation-training modules that have been reviewed and validated by the director of the DRH. This orientation will be carried out in Year 3 by MSPP with support from HFG.

**Direction de la Formation et du Perfectionnement des Sciences de la Santé (DFPSS)** – This year, HFG has made significant progress working with the DFPSS on improving and implementing the reconnaissance process for improving and maintaining the quality of private nurse training institutions. In September 2013, the HFG Project contracted the Canadian Association of Schools of Nursing (CASN) to serve as technical experts and an ongoing resource for the DFPSS. CASN travelled to Haiti to begin discussions about improving the system of reconnaissance. From this initial meeting, CASN designed a study tour at their headquarters for four MSPP staff. In October 2013, the Haitian delegation travelled to Ottawa, Canada, to explore how programs of evaluation and the development of standards to evaluate the quality of professional schools can foster capacity building. While in Canada, the Haitian delegation met with multiple universities, accreditation experts, and hospitals to learn about approval and accreditation from multiple perspectives and discuss how Canadian processes could be adapted to the Haitian context.

Following the tour, the HFG project and CASN began work with the DFPSS to develop a toolkit for the strengthened reconnaissance system, including the development of standard norms to which nursing schools must adhere and a guidebook on reconnaissance procedures. The reconnaissance pilot was launched in April 2014 with the goal of reaching 90 schools. The DFPSS has sent the auto-evaluation tool to 90 schools and has finished the evaluation process for 45 schools. The independent jury has already completed the evaluation of 40 schools with the remaining five to be completed in October. The jury has approved 37 out of the 40 schools and those 37 schools will be awarded a reconnaissance logo. It should be noted that DFPSS staff and identified MSPP staff are conducting the evaluations and the jury assessments. HFG is providing logistical support to the evaluation process itself and the tracking of the process but is not participating in any of the technical evaluations or jury activities.

**Accomplishment:** *As a result of USAID support through the HFG project, Haiti has a functioning system for recognizing the attainment of minimum standards for its private nursing schools. As a result of this work, prospective students will be able to identify nursing schools that have been recognized through the process and, in turn, should be able to obtain a quality nursing education leading to an improved pass rate of the national nursing exam and an increased availability of nursing skills within the country.*

**Hospital Costing and Financing** – In addition to the work being conducted to directly support MSPP, HFG has been requested by the mission to participate in strengthening the sustainability and management of hospital financing. In Year 2, a costing of the Hôpital Universitaire de Mirebalais was completed. The preliminary results of this exercise were shared with the Minister of Health and the Assistant Director of USAID's Global Health Division, Dr. Ariel Pablos-Mendez, at a high-level meeting facilitated by the HFG project. As follow-on to this work, HFG will be developing business plans for the hospital, along with services costing analyses at two additional tertiary level health facilities in Year 3.

### **Challenges –**

**Need for realistic and achievable targets** – The original target set by MSPP for the reconnaissance process (discussed above) was 90 schools, which HFG thought would not be feasible in the time period because there would be a need to first have a pilot application that could be reviewed to ensure that the process worked as planned. However, MSPP insisted upon this target. Upon reviewing the data from the

first few site visits and auto-evaluation forms, this number was reduced to 43, a more manageable number that has been cleared at the higher level of MSPP by the DFPSS director. Re-aligning these expectations has allowed HFG and the DFPSS to ensure that the process produces high-quality data and defensible results that ensure the validity of the reconnaissance concept.

***Need to maintain regular contact with MSPP above the unit director level*** – Despite initial plans for HFG and other USAID projects to check in with the Minister and Director General of MSPP on a regular basis, these meetings have not occurred. As a result, although HFG has attempted to maintain communication through the production of briefs, there have been occasions during the year when it has been made clear that higher levels of the ministry are not as aware of the project's activities as would be ideal. The project and the mission are currently working to address this issue, hopefully with the re-instatement of quarterly debriefs.

***Hospital financial reporting and PFM: unclear next steps*** – There remains a lack of clarity around how HFG can move the hospital financing reporting process forward for implementation and scale-up. This is because, although the process was requested by the Minister of Health, there is a lack of clarity with regards to exactly where this activity should sit within MSPP. Although the project works with the DAB, it appears that the tertiary public hospital report to the office of the Director General and not the DAB. Therefore it is unclear exactly who needs to be trained on the process at the national level and who should be responsible for rolling it out across health facilities. The mission is currently working to set up the necessary meetings to obtain clarity on this and the PFM requirements that the DAB is required to meet. It is necessary to understand USAID's vision on PFM, which is larger than MSPP, in order to work with the DAB to develop a scope of work and then hire an embedded advisor to support PFM within MSPP.

***Overburdened, limited MSPP staff*** – The limited progress made on health financing is partly due to the absence of an embedded health financing advisor but is also as a direct consequence of the lack of appropriately skilled staff in terms of numbers, to serve as focal points for HFG's work. The focal point for the health financing activity was also the focal point for the NHA activity and it is likely to remain the same for Year 3. Similarly, after beginning implementation in a timely manner, the limited number of DFPSS staff had to switch focus to the implementation of the national nursing exam, stalling somewhat the progress on the reconnaissance activity toward the end of the project year.

***Q4 Additional Information*** – In Y2Q2, the health financing advisor embedded in MSPP resigned and the process of replacement has been drawn out in part by the lack of candidates for the position as well as the lack of prioritization of this work by the UEP focal point. This focal point was primarily working on finalizing the NHA for the better part of the year making repeated reviews of the health financing advisor scope of work and advertisement a particularly long process. However, a candidate for the health financing position was identified and accepted by the mission in Y2Q4. Also in Y2Q4, the HFG Chief of Party resigned from the project. A prospective candidate for the position was identified by the end of Y2Q4.

Table 55 provides activity-specific updates. Table 56 provides the health systems strengthening to HIV links.

**TABLE 55. HAITI ACTIVITY DETAIL**

Y2Q4 Planned Tasks	Y2Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
<b>Activity 1: Supporting PNS target setting with a needs and outcomes analysis</b>		
Conduct skills building with UEP/data needs identification	<ul style="list-style-type: none"> <li>In Q3 the costing of 30 out of the 32 units' operational plans was completed. The remaining 2 units did not have an operational plan. Their costing will resume once they develop operational plans.</li> <li>During this process, capacity was built with the staff of UEP, as they were directly involved in collecting the data, doing the costing exercise and writing the final report. HFG and the health economics unit head are confident that the team will be able to carry out a similar activity for the following years.</li> <li>After the costing process, HFG worked remotely with country team on developing the plan directeur de santé classification called "nomenclature des activités issues du plan directeur de santé". After getting comments from UEP on the classification document, HFG has completed the data coding and the first draft of the costing report. The first draft has been sent to MSPP for their review. Currently available documents for this activity are the <i>nomenclature des activités issues du plan directeur de santé</i>, the operational plan activity database and the first draft of the costing report.</li> </ul>	The majority of the work with the UEP on target setting has been carried out using technical assistance from the HFG home office in Bethesda, Md. While this support has been well received by MSPP, the project recognizes the need to have more flexible, locally available support and it is in the process of identifying candidates who can work from the local office in coordination with the Bethesda office.
Capacity building in the use of OneHealth	<ul style="list-style-type: none"> <li>On August 11-22, 2014, HFG's Andre Zida conducted training with MSPP to build capacity on the use of the OneHealth tool for the costing of the health system strategic plan (<i>Plan directeur de santé 2012-2022</i>). Zida organized two training sessions, the first with 16 technical workers and the second with 8 policymakers.</li> <li>As a result of this activity, there is significant interest in using the OneHealth tool across MSPP, which bodes well for Year 3 implementation.</li> </ul>	
<b>Activity 2: Health financing strategy development and resource mobilization capacity building</b>		
Development of situation analysis	<ul style="list-style-type: none"> <li>The activity team continues to revise the situation analysis document for content and language.</li> <li>A final candidate has been selected for the health financing advisor position.</li> </ul>	
Develop health financing strategy document	<ul style="list-style-type: none"> <li>In June, the Minister of Health/MSPP expressed renewed interest in the development of the health financing strategy. The recent prioritization of the work has driven MSPP to identify a team within the UEP to focus specifically on this project. In response, the UEP team plans to convene various partners and stakeholders for broader discussion of the health financing strategy.</li> </ul>	<ul style="list-style-type: none"> <li>HFG continue will to plan this high-level conference in Y3Q1/Y3Q2.</li> <li>The World Bank's participation in this event is envisaged but specific roles and responsibilities are yet to be defined.</li> </ul>

Y2Q4 Planned Tasks	Y2Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
	<ul style="list-style-type: none"> <li>The Minister of Health requested HFG's help to convene a high conference in health financing in Haiti in Y3Q2.</li> <li>The HFG team developed a concept note and tentative agenda for this conference.</li> </ul>	
Develop recommendations for restructuring UEP	MSPP has requested that the local consultant, Dr. Junot, be engaged by HFG to implement the recommendations in his report. The consultant has submitted a proposal that has been approved by HFG and the USAID mission and has started implementation.	
<b>Activity 3: Strengthening PFM/budget preparation and execution</b>		
Assess PFM/ budget preparation and execution capacity in the health expenditure	<ul style="list-style-type: none"> <li>HFG has developed templates in Quickbooks that align with the nomenclature required by the MEF accounting manual to ensure that financial reporting by MSPP aligns with MEF.</li> <li>HFG has completed pilots of the hospital financial management reporting process in three hospitals.</li> </ul>	Two pilot reports and the training materials were submitted to the DAB for review but feedback has been very slow forthcoming (3+ months) despite repeated follow-up. The mission is engaging the DAB directly with regards to this issue.
Conduct institutional capacity building Y3	The primary focus of the institutional capacity building assistance to the DAB continued to be the technical capacity assessment of all five DAB divisions. In this quarter, data collection was completed, the data were analyzed, and the report drafted. HFG is reviewing and finalizing the draft report for DAB review.	Submit the report for DAB review.
<b>Activity 4: Resource tracking /NHA.</b>		
Reporting	The NHA results dissemination event took place in July and the report has been disseminated.	
Use the World Bank's LSMS to estimate household health expenditure	The World Bank has still not shared the final dataset/ results of the household survey; however, the data that was needed for the NHA was received and validated by MSPP.	The final household dataset will be invaluable to the health financing activity because it will provide tremendous detail around health expenditure behavior of Haitian households. At this time it is unclear why the results and data have not yet been cleared by MSPP/Government of Haiti.
<b>Activity 5: Development of MSPP UADS's capacity to strengthen department-level health directorates</b>		
Develop vision and strategy for UADS	UADS has requested that HFG organize a half-day workshop in October with DG department directors in Nippes, Centre, and Nord-Est, directors of other parts of the DG, especially the UEP and the Legal Unit. The objectives of this workshop will be to validate the vision, values, and functions document and discuss the UADS structure in light of the functions.	This work will need to be carefully coordinated with USAID's Leadership, Management and Governance (LMG) project. The mission is currently organizing meetings to ensure that this coordination happens.



Y2Q4 Planned Tasks	Y2Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
Identify gaps in the organizational structure and staff	<ul style="list-style-type: none"> <li>The Minister has requested that the same local consultant who did the restructuring plan for UEP, Dr. Junot, develop a similar plan for UADS.</li> <li>To clarify the role of Dr. Junot, HFG prepared a detailed summary of HFG assistance to UADS to date and in September presented that summary to the Minister and DG. As a result of the meeting, it was agreed that HFG will support Dr. Junot, who will work on the restructuring while HFG staff will continue to build capacity of UADS.</li> </ul>	<ul style="list-style-type: none"> <li>Scope of work is being discussed with the local consultant.</li> <li>Coordinate HFG assistance with LMG.</li> </ul>
Develop a rational organizational structure to carry out its core functions	See above.	See above.
Build coaching and consulting skills	No action on this in Q3.	Monitor application of coaching and consulting skills previously taught.
Build management skills of UADS staff	No action on this in Q3.	Change management will be a theme in the planned October workshop.
Improve performance management	No action on this in Q3.	Now anticipated for Y 3.
Strengthen capacity to engage MSPP stakeholders	Plans underway to roll out financial reporting tool for departments of MSPP. Plans include a training of trainers to train financial staff in over 100 facilities.	See challenges noted above explaining why roll-out has not yet been implemented.
<b>Activity 6:</b> Support institutional capacity building of the MSPP DRH to implement, manage, and monitor civil service reforms, and conduct workforce capacity assessments		
Conduct data quality control in 10 departments with focus on availability and quality of human resource data from online database (SIGRH)	<ul style="list-style-type: none"> <li>Completed DQA of SIGRH data in all departments, central office, and university hospitals</li> <li>Presented preliminary results from the audit</li> </ul>	<ul style="list-style-type: none"> <li>Draft of report submitted to stakeholders for review.</li> <li>Submit final report.</li> <li>Follow up with corresponding audit and evaluation of the private sector health workforce.</li> </ul>
Support to be provided to the DRH to assist with the implementation of the draft process for the development of a training plan (provided to MSPP by OMRH).	<ul style="list-style-type: none"> <li>Met with OMRH to review five modules designed to orient new staff to working at MSPP.</li> <li>OMRH agreed that the information in the modules was sufficient and comprehensive.</li> <li>OMRH provided the following suggestions: <ul style="list-style-type: none"> <li>Make presentations more interactive by incorporating exercises for participants.</li> <li>Include more information on the importance of the training modules to the everyday operations at the MSPP.</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>Develop an additional set of modules that incorporate participant exercises.</li> </ul>



Y2Q4 Planned Tasks	Y2Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
Conduct technical capacity assessment of DRH	HFG will support Dr. Junot, who will review the DRH structure in Year 3.	
Review and revise stakeholder analysis and communications plan	Navigation Group has been on hold with a new director.	Discuss with new DRH Director the future role of Navigation Group.
Support managers in implementing improved performance management	The focus of HFG assistance will be Dr. Junot's work.	
Continue to support team leadership skills among managers including the use of participatory and creative problem-solving and decision making	The focus of HFG assistance will be Dr. Junot's work.	
Support all staff through the transition to new space and to a new organizational structure (if approved)	On hold pending Dr. Junot's work.	

#### Activity 7: Accreditation of HRH training institutions and professional bodies

Support the DFPSS unit in the design and validation of a nursing school accreditation process	<ul style="list-style-type: none"> <li>• DFPSS finalized accreditation tools with support from the HFG project, and distributed the auto-evaluation form to 90 schools to complete.</li> <li>• The evaluators visited and assessed 45 nursing educational institutions.</li> <li>• 40 out of the 45 schools were evaluated by the Jury and only 3 of those 40 schools have been rejected. This means that 37 schools have been confirmed to receive the logo.</li> <li>• The design of the logo has been finalized and the logos are currently being printed.</li> </ul>	<ul style="list-style-type: none"> <li>• The logo award ceremony will take place in early Y3Q1.</li> <li>• The jury still has 56 more schools that were sent the auto-evaluation form to evaluate, however the entire staff of the DFPSS has been busy working on the national nursing exam (see challenges discussing this issue). This final evaluation meeting will take place in Y3Q1.</li> </ul>
Translate nursing competencies to accreditation standards through the development of an accreditation manual	The manual was shared with DFPSS, and used during the first phase of implementation. HFG has been collecting documentation on the strengths and weaknesses of the manual based on its practical application.	After phase one is complete, the DFPSS will reconvene with HFG and CASN to update the manual based on lessons learned. This is expected to take place Y3Q1.
Assist DFPSS to organize its space and staff for better efficiency and effectiveness	No action in Y3Q4.	

Y2Q4 Planned Tasks	Y2Q4 Progress	Critical Assumptions/Problems Encountered/Follow-up Steps
Strengthen institutional capacity of DFPSS	Work on the technical capacity assessment was initiated in Q3 with most administrative staff having completed their self-assessments. Evaluation criteria for evaluating technical staff have been developed and a local team assembled. However, the DFPSS has not given HFG the go ahead to proceed and as a result the activity has been on hold.	Continue to follow up with DFPSS Director as the unit has been overwhelmed by the nursing examination activity.
Build skills of managers in performance management	No action in Q4 but under discussion.	Continue to follow up with DFPSS Director as the unit has been overwhelmed by the nursing examination activity.
<b>Activity 8:</b> Costing of services at the Hôpital Universitaire de Mirebalais for Partners in Health/Zanmi Lasante		
Do costing report	<ul style="list-style-type: none"> <li>• New data related to drugs and medical supplies has been included in the total cost.</li> <li>• The analysis will be updated in 2014 in order to have current information for drafting the business plan.</li> </ul>	Discussion on the business plan development is underway.

**TABLE 56. HAITI HEALTH SYSTEMS STRENGTHENING TO HIV LINKS**

Activity	Prevention	HTC/Diagnosis	Referral and Link to Care	Access and Retention	ART initiation	Viral Suppression (Chronic Care and Labs)	Supportive Care and Quality
<b>Activity 1:</b> EHRIS-1 and EHRIS-2 (HRIS DQA)  (Near Core)	Improving HRH information: <ul style="list-style-type: none"> <li>• The limited availability of adequate data sources to assist in strengthening human resource management remains a major obstacle (bottleneck) to the Haitian government's ability to provide appropriate HIV/AIDS care and treatment (C&amp;T) services. In order to address this need in scaling up the provision of key HIV services, HFG will build on the work completed through the data quality and audit of the public sector human resources information system (Evaluation of the Human Resources Information System for Health, EHRIS-1) with EHRIS-2, a data quality audit and evaluation of the data on the private sector health workforce.</li> <li>• Human Resource Information audited and evaluated will include 1) numbers, 2) location and 3) job titles (with corresponding training on C&amp;T) of staff in the private sector. This work leverages HFG's work on EHRIS-1: of all the facilities that deliver care and treatment in Haiti, only a small percentage are public; the majority of HIV Care &amp; Treatment (C&amp;T) is delivered by faith-based organizations or for-profit institutions.</li> <li>• By identifying the distribution and skills of staff in the public and private sectors we will have an understanding of the gaps in numbers and skills by location to identify where HRH resources and training can be directed to strengthen HRH availability and quality. This in turn can assist in scaling up the number of patients who receive care and treatment interventions across the cascade of care. EHRIS 1 and 2 will also enable MSPP to identify remuneration issues such as whether or not facility staff receives salary support from donor sources; this is a critical piece of information for sustainability planning as donor-funding for HIV remains static or continues to decline.</li> </ul>						
<b>Activity 2:</b> HRH retention strategy development  Near Core	Improving HRH retention: <p>The MSPP has had difficulties keeping remote, rural health facilities appropriately staffed. HFG is supporting the development of a retention strategy to ensure that adequate HRH resources are available in challenging, rural communities so that the HIV affected women and children in these areas (who tend to be particularly poor and vulnerable) can have access to PMTCT, care and treatment services. Improving the retention of health workers increases the points of access available to patients for HTC, care and treatment services, and increases the likelihood of patients being retained in care by improving and sustaining patient/client relationships.</p>						
<b>Activity 3:</b> HRH performance management  Near Core	Improving HRH quality: <p>HFG is supporting the MSPP (through the OMRH) to improve staff morale and performance. This is being accomplished through the development of a performance management system aimed at strengthening the link between remuneration, career progression and performance – so that health staff are motivated to do their jobs well, knowing that their performance will result in tangible rewards. It is anticipated that improved motivation will lower absenteeism, lower attrition and increase productivity and quality of care at the health facility level.</p>						

Activity	Prevention	HTC/Diagnosis	Referral and Link to Care	Access and Retention	ART initiation	Viral Suppression (Chronic Care and Labs)	Supportive Care and Quality
	Performance will be evaluated based upon updated job descriptions which will include skills and activities related to data collection and reporting which will improve understanding of HIV prevalence rates and geographical hot spots in addition to different levels of HIV/AIDS C&T. This activity aims to increase the number of patients receiving high quality HIV interventions across the continuum of care as a result of improved service quality, motivation of health providers, and retention of staff for long-term patient interaction.						
<b>Activity 4: NHA and health financing strategy development</b>  Core		<p>HFG is providing support to conduct the national health accounts using the SHA 2011 approach which will provide a necessary, statistical description of the Haitian health sector. Specifically, the NHA provides the government with the sources and amount of health expenditure for all public health programs including health spending by disease categories such as HIV/AIDS. The ministry can use that information to advocate for more funding from the government itself and from donors in order to be able to fully fund or increase funding to the programs.</p> <p>Improved allocation of resources (for example reallocating from tertiary/secondary to primary) will allow scale-up of HIV/AIDS related treatment programs at primary care facilities in order to improve access to care for rural/vulnerable populations. HFG's NHA support also allows for a geographic breakdown of expenditure that can be combined with utilization rates to see if there is alignment between expenditures and HIV hot spots, therefore highlighting opportunities to improve resource allocation within Haiti's HIV program.</p> <p>HFG's NHA support has quantified the low level of government spending on HIV programs in relation to donor spending, and this data can be used to advocate for increased government spending which in turn will increase the overall level of resources available to use for retaining in care and initiating treatment for people living with HIV. HFG is working to strengthen PFM systems within MSPP, which can ensure that resources allocated to HIV are fully expended and accounted for (for example ensuring that HIV funds flow down to facility level where they can be used for non-drug sundries like gloves, gauze etc.).</p>					

Note: HTC=HIV counseling & testing



## 5. INDICATORS

The HFG attribution indicators are listed in Table 57.

**TABLE 57. ATTRIBUTION INDICATOR TABLE**

Result	Performance Indicator	Year 2					
		Year 1	Q1	Q2	Q3	Q4	Total
Linkages	Indicator						
All IR	Number of organizations contributing to HFG-supported work (cumulative)	79	80	80	89	89	89
All IR	Number of HFG-supported partnerships (cumulative)	5	7	7	7	9	9
All IR	Number of participants at HFG-supported events	1,531	2,344	3,733	9,896	6729	24,233
All IR	Number of HFG-supported technical resources	139	105	75	187	141	647
IR1.3, 3.3	Number of HFG-supported PBI schemes	0	0	0	0	0	0
IR 2.2	Number of HFG-supported mechanisms established to improve transparency and/or accountability	0	0	0	0	0	0
All IR	Number of organizations where HFG-supported technical resources are used (cumulative)	5	5	5	5	5	5
All IR	Management capacity to perform core functions in country institutions (score)	N/A	N/A	N/A	N/A	N/A	N/A
All IR	Technical capacity to perform core functions in country institutions (score)	N/A	N/A	N/A	N/A	N/A	N/A
IR1.3	Country capacity to perform NHA estimations (score)	-	-	-	-	-	-
IR2.2, 2.3, 4.3	Use of evidence-based information to perform core functions in country institutions (score)	-	-	-	-	-	-

N/A: Not appropriate at aggregate level "-": Not measured





## 6. FINANCIAL UPDATE

The financial overview for Year 2 is presented in Table 58.

**TABLE 58. FINANCIAL OVERVIEW**

Client	USAID
Project Director	Ann Lion
Total Potential Worth	\$199,702,730
Obligated to Date	\$64,062,019.42
Expensed to Date	\$36,763,009 (thru September 2014)
Funded Backlog Remaining	\$29,299,010.42
Project End Date	09/29/2017

### **Cost Share**

Through the end of September 2014, the HFG project has obtained \$1,778,459.34 in actual cost share contributions. Sources of cost share contributions include the Namibia Social Security Commission, the Benin Ministry of Health, the Health Systems Board, the Department for International Development, the Tanzania Ministry of Health and Social Welfare, Abt Associates, the World Bank Haiti Living Standards Measure Survey, Results 4 Development Ghana, and the Africa Bureau.



## 7. KNOWLEDGE MANAGEMENT/ COMMUNICATIONS UPDATE

**Knowledge Management:** During Q4, HFG worked diligently to produce the first complete draft of the technical report, Synthesis of available evidence on HSS impact on health. This activity entailed managing and coordinating a team of 12 technical experts to review 667 systematic reviews from the McMaster Health Systems Evidence Database, conduct an Inclusion/Exclusion review, extract key findings from the 135 included reviews, develop an outline in coordination with USAID, conduct additional searches on PubMed to address evidence gaps, and then write the draft report based on the strongest evidence. The complete draft was submitted to USAID for review on September 26, 2014.

**Website:** As the HFG project grows, the website ([www.hfgproject.org](http://www.hfgproject.org)) continues to add strong content to reflect the project's achievements and contributions to health systems knowledge. Google analytics show a low bounce rate; that is, the percentage of visitors who come to the site and then leave after visiting one page. The home page bounce rate is 42%, which is considered excellent by industry standards (40%-60% is the ideal). Other pages have a bounce rate average of 66% which is also good for a non-news site such as HFG's. Another indicator – the length of the average session – is also strong. The average visitor stays on the website for 1:58 minutes.

Given the sharp escalation in the number of website visitors and sessions this fall, however, the KM Director asked Abt's IT team to investigate. They identified that much of the increase was actually due to automated hits by the Abt server checking security and functionality at regular intervals. As a result, HFG added a new filter to Google Analytics to remove the automated hits and count only actual human visits. As a result, the overall numbers of visitors (1,366) and sessions (1,814) are lower this quarter, but they reflect more accurate analytics.

The top pages according to number of page views were:

- Health Systems Database = 379 views
- About HFG = 327 views
- Resources/Publications = 300 views
- News/Announcements = 290

In Q4, HFG added three feature stories, bringing the total number of success stories to 15 since the website launch in September 2013. HFG also added 10 announcements, which highlight new documents, tools, brown bags, and presentations, bringing that total up to 30.

In addition, HFG successfully remediated security vulnerabilities in response to a poor vulnerability scan from USAID/CIO.

**Brown Bag Lunch series:** In coordination with the Office of Health Systems, HFG launched its brown bag lunch (BBL) discussions at the Ronald Reagan Building this year. HFG and OHS organized five BBLs, attracting a wide range of staff from USAID.

- National Health Accounts: New and Improved! ( A.K. Nandakumar, Chief Health Economist, USAID, Scott Stewart, Health Economist and AOR for the HFG Project, and Tesfaye Dereje, HFG) – April 23rd, 2014. “NHA provides extremely powerful information that should be used increasingly for policymaking ... The power of the [NHA] evidence is that they trigger discussions about how to allocate resources,” said A.K. Nandakumar during the event.
- Results-Based Financing: Promising Results from Mozambique – was held in May 2014. HFG and DELIVER shared results and analysis of the FARA with the Mozambique Central Medical Store or CMAM (Central de Medicamentos e Artigos Medico).
- Three HFG Chiefs of Party shared lessons learned in strengthening health finance and governance systems in their countries – Côte D'Ivoire, Ethiopia, and Haiti. – June 2014
- Investing in Universal Health Coverage in Indonesia (Joe Naimoli, USAID, Kristina Yarrow, USAID and Rena Eichler, HFG)-August 2014
- Measuring Progress toward Universal Health Coverage (Bob Emrey, USAID and Laurel Hatt, HFG) – September 2014.

HFG looks forward to working with OHS to schedule more BBLs discussion in year three.

**HFG E-Newsletters:** HFG also launched its e-newsletter in May. It featured success stories on how HFG is supporting Haiti to re-build its health system four years after the earthquake, scaling up CBHI in Ethiopia, and the Financing in Africa report. Using MailChimp, HFG designed the newsletter and sent it out to 3,995 people, of which 902 or 25% opened it. The industry average is 18%, so we were pleased with its successful launch. During the last quarter, HFG sent out the second edition of its e-newsletter. It featured: HFG's participation in the Cape Town Health Systems Research Symposium; the USAID/HFG workshop on the state of the evidence on governance contributions to health outcomes; the brown bag lunch discussion on measuring progress toward UHC; and Ukraine's new HIV service integration model.

The e-newsletter was sent to 3,744 people, of whom 815 opened it, for an open rate of 24%.The total opens was 1,408, meaning some of those 815 then forwarded it to others.

Also, this year the mobile money team launched their e-newsletter, and sent out three editions. The third edition of the Mobile Money e-newsletter was sent out in early September. The theme of this edition was mobile microinsurance in the context of health.

### **Conferences:**

HFG was pleased to participate in the third Health Systems Global Symposium in Cape Town, South Africa.

#### **Satellite Sessions:**

On Monday, September 29, HFG's Daniela Rodriguez presented a satellite session with Joseph Naimoli, Health Systems Research Advisor for USAID's Office of Health Systems, *Enhancing patient-centered care: translating knowledge into action for improved CHW performance*.

Catherine Connor and Jeremy Kanthor participated in The Third Global Governance for Health Roundtable, September 29-30. **The HFG Project collaborated with the Leadership, Management & Governance (LMG) Project and the Health Policy Project (HPP)** on the Roundtable.

Dr. Elaine Baruwa moderated the satellite session, *The Bridge from Research to Action*, on Monday, September 29. This session was co-hosted by the Translating Evidence into Action Thematic Working Group (TWG) and Abt Associates. This TWG is one of eight approved by the HSG Board. Co-chaired by HFG's Kate Stillman and Heather Cogswell, the TWG focuses on the translation of health systems evidence into action through knowledge exchange of best practices, lessons learned, and practical guidance and tools. The aim is to help reduce the gap between health systems knowledge and policy action.

**Presentations:**

- Nathan Blanchet et al. – *Building on community-based health insurance to expand national coverage: The case of Ghana*
- Jeremy Kanthor et al. – *Strengthening internal health system accountability: Insider and outsider insights on building capacity, forging partnerships and marshaling research for more effective and responsive government services*
- Asha George – *Building collaborative and equitable governance mechanisms: Experience strengthening health committees in diverse health systems contexts*

**Posters:**

- Marianne El-Khoury et al. – *Opening the Black Box: Process evaluation of results-based financing in Senegal*
- Alison Comfort et al. – *Increasing access and financial protection: Evaluation of an innovative microinsurance partnership in Lagos, Nigeria*
- Elizabeth Ohadi and Stephen Musau – *So you have WISN calculations, what's next? Using cost data to evaluate HRH policy options to meet the WISN required staffing levels*

In addition, HFG's submission to the *Prince Mahidol Award Conference 2015* "Global Health Post 2015 – Accelerating Equity" was accepted. The title is Domestic Resource Mobilization: A Strategy for Achieving Sustainable Health Systems in Developing Countries, and the authors are Eunice Heredia-Ortiz and Jeremy Kanthor.

**Social Media:** The number of HFG's Twitter followers continues to grow, reaching 153 this quarter, up from 99 in Q3. Similarly, HFG's followers on Facebook increased from 42 to 61. HFG is in the process of actively trying to migrate followers of the Health Systems 20/20 Project to the HFG project. It appears social media is helping to drive more users to the HFG website given the big increase in visits to the website.



## 8. GENDER UPDATE

In Quarter 4, the Gender team continued to work with country teams to develop gender strategies, supporting teams to articulate plans to mainstream gender considerations into their technical assistance, in line with USAID's Gender Equality and Female Empowerment Policy. To date, the team has worked with 19 country teams. The country teams for Bangladesh, Benin, Burundi, the Caribbean, Ethiopia, India, Lesotho, Swaziland, and Ukraine have completed and submitted their gender strategies. The gender strategies for Ghana, Botswana, Namibia, and Nigeria have been drafted but not yet finalized. Additional HFG country teams have begun working on their gender strategies: Côte d'Ivoire, Haiti, and Vietnam. The Gender team has also met with Angola, Tanzania, and the DRC. These teams will develop their gender strategies once greater clarity has been achieved on the scope of the technical assistance programs.





## 9. M&E UPDATE

For the M&E program, Year 1 was focused on establishing the program direction and protocol, developing plans, creating templates, collaborating with missions, and profiling activities. Year 2 continued to build on this foundation with the introduction of the new online M&E system MandE and the organization of project progress and deliverables.

Country PMP development and updating continued to progress, with both updating Year 1 PMPs with FY2013 results and with new PMP development. In addition to the HFG attribution and contribution indicators, PEPFAR indicators were introduced to the scope of PMPs where PEPFAR funding is involved. The following changes occurred this year:

- PMPs updated with FY2013 results and submitted to respective missions: Angola (Q1), Bangladesh (Q1), Ethiopia (Q1), Burundi (Q1), Namibia (Q1), Tanzania (Q1)
- PMPs developed/updated and distributed to respective missions: Haiti (Q4), Nigeria (Q4), Côte d'Ivoire (Q4), Ukraine (Q2), Benin (Q3), Lesotho (Q2)
- PMPs under development: Swaziland (Q2-Q4), Botswana (Q4), Ghana (Q2-Q4), Namibia (Q4), Barbados and Eastern Caribbean (Q4)
- PMPs to be developed: India, Vietnam, Democratic Republic of Congo, Peru

The new web-based HFG M&E system (MandE) was launched on the project. The system contains the following components for the project:

- Work plan – all HFG activities will have space to accommodate the work plan, results framework connection, staff, organizations, and task progress
- Deliverables and supporting evidence – all HFG deliverables and supporting evidence will be associated with the activity and related task
- Indicators – access to all HFG project-wide and country-specific indicators, with links back to respective activities
- Reporting – access to various HFG-related reports, such as results framework-related activity progress, results/lessons learned
- Dashboard - central page for users to access their activities, indicator results, project calendar, and other key metrics
- Resources – lists of organizations, deliverables, and supporting information will all be easy to access

MandE status to date includes:

- Quarterly Reports - All past Y1 and Y2 quarterly reports have been integrated into the system
- Work plans - All past Y1 and Y2 work plans have been integrated into the system
- Indicators and reports will be established in Q1 of Year 3.
- Training - HFG team member training concluded in Q4. To date, approximately 60 team members have been trained on using MandE. Training will continue throughout the project on an as needed basis.

- Quarterly reporting - One of the features of MandE is the ability to generate quarterly reports (first draft quality). This will allow the team to move from an environment each quarter where approximately 30 Word templates are created/updated by the respective HFG teams, to just having all teams enter their submission directly in MandE. The quarterly report feature was piloted in Q3 (3 HFG teams) and Q4 (10 additional teams). The lessons learned from the piloting went back into the MandE development process, to prepare for a final pilot (10 additional teams) in Q1 of Year 2.
- Data/deliverable loading - Deliverable and supporting data loading in MandE occurred in the 2nd half of Year 2. To date the following programs have their deliverables and supporting data integrated in MandE: Cross Bureau, Africa Bureau, Angola, Asia Bureau, Barbados & the Caribbean, Benin, Haiti, Lesotho, Swaziland, Tanzania, Malaria, Population and Reproductive Health, Maternal and Child Health, HIV/AIDS, Gender, Knowledge Management/Communications, Monitoring & Evaluation. Historical data loading will continue in the first half of Year 3.

Quarterly reporting continued each quarter, with the project-wide quarterly report submitted to the AOR team and 16 country reports submitted to their respective mission. Also, the team is involved with ADS 253 (Participant Training) compliance, which includes participant document collection and TraiNet reporting. Reporting in TraiNet continued as well.

During Year 2, an M&E site visit trip occurred to the Haiti office, where deliverables and supporting evidence was reviewed and collected, M&E updates provided to team members and a monthly results meeting occurred with the team and mission staff, where a demonstration of MandE was provided.

The NHA capacity assessment tool development, being led by the NHA team, was completed. While the tool will help the NHA team develop a baseline measure for countries that they work with on NHA, it won't always be applicable to every NHA engagement, depending on when the team is brought into the NHA process.

The team completed the draft of the mid-term review concept paper. After review and discussion with the AOR Team, it was determined that there would be no mid-term review conducted in year 3 as there will likely be an external evaluation conducted in Year 4. The AOR Team will be looking into confirming this direction.

Data quality audits (DQA) were initiated in the 2nd half of Year 2, on reported accomplishments, on the programs noted above on data loading in MandE. Once MandE is up to date for all programs, then more focused DQAs will be conducted.

## 10. MANAGEMENT UPDATE

Q4 has seen a strong emphasis on linking HFG activities and programs funded by PEPFAR with service delivery, especially care and treatment. With more than \$63 million in total project obligations – over 60 percent of which were PEPFAR funds – such linkage becomes a huge project effort. As a first phase, we carried out a two-hour, all-staff workshop on 1) what is included in HIV/AIDS care and treatment? 2) How do HFG activities relate to care and treatment? and 3) we asked each country manager to practice making the connections in front of a mock USAID team. This exercise proved two things: it was extremely important to do, and we were not very good at it. As a second phase, we asked our small (Abt) HIV team to sit with each country manager and their full team in an individual country meeting. The HIV team went through every single activity (HFG now has over 140, many of these PEPFAR funded) and outlined the connection with care and treatment. For all countries with PEPFAR funding, activity tables which include the care and treatment connection are included in this report at the end of each respective country section. A third phase included our Abt HIV team being made available to review all country work plans and help our HFG teams with the connections on an as-needed basis. This intensive sensitization effort has proved very useful. In countries where the USAID teams were ready to significantly reduce the HFG portfolios, they have been only minimally affected. This overall effort has been adopted by Abt as a best practice, and is being rolled-out to other global projects and bilaterals.

In addition to the above example of "fast-response management," we have been making sure that we have the systems in place to ensure the growth typical of a global project in the third year. This includes ensuring that the overall results reporting is a streamlined and efficient as possible, that the subaward processes are clear and functional, that the contracting (human resources) function is responsive to rapid growth and that we have the right staff hired. As of the end of Q4, all these systems are in shape and we have no key positions vacant. In addition, we now have a governance leader who is sitting in our HFG offices and committed to ensuring that the connections with governance are made through as many of our activities as make sense. Overall, it has been a strong performing quarter and we are ready for further growth in Year 3.

In Q4, we experienced no significant global management challenges. We have strong systems, people and adequate financial resources. In countries where we experienced management challenges at the country level (Haiti, Nigeria and Swaziland), we quickly identified new Chiefs of Party who were all in place by the end of this reporting period. In countries where the PEPFAR funding was threatened (Caribbean, Vietnam, Swaziland, Nigeria), our work with the country offices and missions (with USAID/AOR support!) has resulted in workable solutions for all. Senior leadership is now checking in with all missions with significant scopes, on a regular basis.

Internally, we continue to carry out cost-saving efforts for travel, share staff where feasible, and involve core partners as much as possible as this allows us to carry out our work without the expansion of full-time staff. Where feasible, we co-locate with SHOPS, and share staff, offices and other costs. This is resulting in important savings for HFG and the USG. We also continue to meet regularly with partners that have potential overlap with our work to ensure that scopes are clearly synergistic and complementary. Part of the HFG philosophy is to increase involvement by others, with a priority for core partners, and ensure the widest bandwidth possible for the project.

Earlier this year we also rolled out an initiative internally to ensure that all our research efforts receive additional quality oversight. We have created a position and identified a research coordinator (Ben Johns, PhD), who ensures the research rigor we expect. As part of this initiative, he has trained the HFG

staff on when and how to access the research quality expertise. He is helping each activity lead with criteria to help identify what is research and what is not, as well as what the role expectations are for the activity lead, research advisor, and quality oversight. This will continue to ensure that the research on HFG is done following the highest standards.

As stated in previous progress reports, we have been aware that the demand for health financing work is greater than for governance work. Our vision is that governance activities be both stand alone and integrated into all our activities; however, that is not enough. To spotlight and emphasize our governance work, every program and country manager was asked to report on how they are improving health governance in their activity and how they will ensure these efforts over the coming year. The results were reported on in the November 2013 quarterly meetings and documented. The newly formed Governance Working Group meets regularly and will continue to identify paths to ensure a strong governance portfolio within HFG.

## II. COLLABORATION WITH OTHER COOPERATING AGENCIES

During Year 2, HFG met with the following projects to ensure that HFG is coordinated with others and that synergies for working together are identified and carried out:

- Africa Indoor Residual Spraying (AIRS): HGF is collocated with AIRS in Burundi, ensuring value for money for both projects and the U.S. Government.
- ASSIST, a key OHS global project: HFG met with the ASSIST Project Director to share overall scopes, countries we are working in, and where we might be able to identify joint work and synergies. Both ASSIST and HFG agreed that attending each other's quarterly meetings will be an important opportunity to hear what the other is doing and identify further opportunities to work together and ensure efficiency.
- ASSIST, Maternal and Child Health Integrated Program, Alliance for Health Policy and Systems Research, WHO Department of Child and Adolescent Health, Johns Hopkins School of Public Health, and multiple local Indian NGOs – In Y2Q3, the HFG India team collaborated with a diverse array of stakeholders to implement the Data Usage and Implementation Research Workshop in Panchkula, Haryana (India). The objectives of the workshop were to support the National Health Mission, Haryana, in engaging with district health teams to use a research questions approach to address locally relevant health issues.
- Association for Reproductive and Family Health (ARFH) – Global Fund principal recipients in Nigeria: HFG has leveraged its relationship with the national TB program to collaborate with the Global Fund to support the objective of the national program to scale up the activity nationwide. HFG has supported the ARFH in developing a scale-up plan, and will provide technical advice to Global Fund scale-up to additional states.
- Capacity Plus
  - In order to collaborate with the CapacityPlus project and address any potential overlap, HFG and CapacityPlus leadership decided to review each country on a case-by-case basis and to coordinate with USAID before travel. This has been done for both Haiti and Côte d'Ivoire. A meeting was held in early December to further share our scopes for HRH.
  - In Y2Q2, HFG seconded an HRH technical advisor to the CapacityPlus/ Namibia team to facilitate completion of Workload Indicators of Staffing Needs (WISN) activities before closeout.
  - In Y2Q3, an HFG HRH technical advisor continued to work with the CapacityPlus/ Namibia team on training Namibian Ministry of Health staff on the Workload Indicators of Staffing Needs (WISN) methodology.
- Caribbean HIV/AIDS Alliance (CHAA) – HFG is communicating program activities to CHAA to help ensure that this organization, which is a key actor in providing prevention, testing, and ongoing support for vulnerable populations in Barbados and Eastern Caribbean, is informed and engaged in regional HIV strategy and funding application initiatives as the organization is going through a leadership transition.

- Clinton Health Access Initiative (CHAI) – HFG Ukraine is collaborating closely with CHAI on its pilot to integrate HIV testing and counseling into primary care. HFG collaborated with CHAI as well as government counterparts in the development of a supervision protocol for the pilot. CHAI has facilitated the donation of HIV Rapid Test kits for the project, and participates in project coordination meetings. HFG invited CHAI to attend project site visits in April, along with the USAID mission representative. Also, HFG collaborated with the CHAI Ethiopia office in conducting integrated supportive supervision and review meetings in hospitals to assess the status of hospital reform and discuss the way forward.
- DELIVER Project – Through PRH funding, we collaborated with DELIVER on the evaluation of the performance-based FARA grant program in Mozambique.
- Department for International Development – HFG collaborated with the DFID-funded PATHS2 project to complete the baseline survey of the microinsurance evaluation in Lagos, Nigeria.
- Doctors Without Borders - As part of the OHA work, HFG is coordinating with MSF to assess the costs and cost-effectiveness of conventional and POC-VL and early infant diagnosis technologies. The HFG team met with MSF at HQ offices in Paris to review and collect costing information of conventional and POC-VL and early infant diagnosis technologies. MSF is supporting the POC pilot testing of the Simple Amplification Based (SAMBA) nucleic acid test and conducting operational research using this novel SAMBA technology in Uganda and Malawi.
- Family Health International 360/SIDHAS Project – The SIDHAS team is to be involved in relevant HFG-conducted workshops by contributing any of their relevant reports as well as providing technical input during the workshops. Be a part of the advocacy team to provide joint access to key stakeholders at the federal and state levels (Cross Rivers, Akwa-Ibom, Lagos and Rivers); HFG Nigeria and SIDHAS have a written plan of collaboration between the two projects.
- Governance - HFG's July 23, 2014, workshop on Generating Evidence for Governance Contributions to Health Outcomes involved participants from other health implementing partners (LMG, HPP, Capacity Plus, System for Improved Access to Pharmaceuticals and Services, MEASURE Evaluation), governance partners (Social Impact, Management Systems International, DAI) and other international partners (WHO and World Bank).
- Governance - HFG participated in the LMG 3rd Governance Roundtable in Cape Town, South Africa, on September 29-30. In advance of the meeting, HFG's Governance team participated in meetings with LMG and HPP colleagues to design and plan the Roundtable. HFG also organized and moderated Session 1: Measuring the Value of Health Sector Governance: Insights, Interventions and Impacts, and it presented its experience during Session 2: Transparency, Trust and Accountability: Bridges to More Equitable Access to Services.
- Government Mass Media Agencies – HFG is collaborating with the Ethiopian mass media agency regional offices in organizing capacity building trainings on health insurance for mass media agency staff, to enable them to comprehend the significance of health insurance and to advocate to the public.
- Health Policy Project (HPP) – We provided technical support to HPP in a two-day consultation on Gender-Responsive Health Governance. We also provided technical support to HPP on expenditure tracking for family planning.

- Health Policy Project & LMG - HFG is working with both the LMG and HPP projects to facilitate inter-project knowledge sharing and coordination, and to brainstorm broader contributions of interest to the governance community. Leaders from the three projects met two times in Q2 to share new governance activities, and discuss ways that the projects are already collaborating and how to better coordinate work in overlapping countries and technical areas. The group also planned a brown bag event at USAID, focused on evidence generation for governance, in Q3.
- HIV Reform in Action Project, in Ukraine – HFG Ukraine is collaborating with this USAID project implemented by Deloitte Consulting by sharing information and coordinating work on program activities in conjunction with USAID Ukraine.
- International Center for AIDS Care and Treatment Program (ICAP) – Côte d'Ivoire HFG is collaborating with ICAP on the development of the LMD (License, Master Doctorate) system at INFAS. HFG supported in developing the License program models, while ICAP worked on the content of these models related to HIV/AIDS.
- International HIV/AIDS Alliance – Alliance Ukraine has provided HFG Ukraine with Rapid Test kits for HIV testing through the Global Fund Rd10 HIV grant. Alliance has also collaborated with and assisted HFG Ukraine in other aspects of its program activities.
- International Training & Education Center for Health (I-TECH) – At the request of HFG Ukraine and the Chernigiv Region AIDS Center, the I-TECH Project conducted a three-day training workshop on HIV testing and counseling, with an emphasis on counseling for Most At Risk Populations and post-test counseling for HIV positive patients. The HFG project's clinical advisor helped lead the training of primary health care workers who are working with the HFG project.
- Joint Learning Network – In Ghana, HFG collaborated with the Joint Learning Network for UHC. JLN contributed to HFG staff's May 2014 trip with colleagues from PATH and PharmAccess to present in the National Health Insurance Agency workshop on Monitoring and Evaluation. Also, for the UHC pathways cross-bureau activity, HFG initiated discussions on UHC with the Rockefeller Foundation-funded JLN to plan for collaborative research that will focus on how countries choose which benefits to cover through national insurance schemes.
- Leadership, Management, and Governance (LMG) project:
  - HFG participated in a roundtable event hosted by LMG that resulted in greater clarity on how we need to jointly develop and use governance indicators.
  - HFG continued to coordinate with LMG activities at the country level in Haiti.
  - HFG staff participated in planning discussions for LMG's 3rd Governance Roundtable. The discussion focused on the agenda, potential participants, and how to link the Roundtable with broader HFG and LMG activities.
- LMG & HPP – On April 23, HFG hosted a governance coordination meeting between the LMG, HPP and HFG projects. Leaders from all three projects participated in a meeting that reviewed the projects' current governance activities and discussed opportunities for field-based collaboration (in Kenya for LMG and HPP, and in Côte d'Ivoire for LMG and HFG). HFG also engaged the projects in a discussion regarding joint efforts at generating evidence for governance in line with Cross Bureau activity 16.
- LMG, European Funds for Development (FED/PARSSI), Elisabeth Glaser Pediatric Aids Foundation (EGPAF) HFG projects leaders – In Côte d'Ivoire HFG is coordinating with LMG, EFD, and EGPAF. These agencies are participating in the technical working groups, sponsored by HFG with the Ministry of Health (MSLS), which are organized around decentralization.



- Maternal and Child Health Integrated Program - In Y2Q2, the HFG India team coordinated with the program's JSI team to ensure that efforts to train members of the India NRHM in the Performance of Routine Information Systems and Management (PRISM) methodology were complementary and not duplicative.
- MEASURE Evaluation: This program is collaborating with HFG on the health systems strengthening indicator activity.
- National Agency for the Control of AIDS/HIV, Federal Ministry of Health – Department of Planning Research & Statistics & HIV Division, National Planning Commission, Federal Ministry of Finance, Budget Office of the Federal, OSSAP-MDG office, 12 + 1 SACA states, USAID, UNAIDS, WHO, World Bank, CCM – Global Fund, NHIS, FHI, NEPWHAN, NANTS, Action Aid, DFID, and private partners (NIBUCCA) – Data collection visits to obtain socio-demographic, epidemiologic and program data to populate the one health tool and map planned HIV resources; validation and finalization to generate consensus for reports/strategies developed; training to institutionalize use of tool; facilitate operationalization of reports / strategy / tools.
- Network of People Living with HIV (PLHIV) – HFG Ukraine is working with the Network for PLHIV in its pilot of integrating HIV testing and counseling into primary care. In addition to other areas of collaboration, the Network for PLHIV is developing a five-day course on anti-stigma and care for PLHIV, and has agreed to share the materials/outline once the course is accredited so that HFG may use the materials for the project's anticipated expansion in the next project year.
- Organization of Eastern Caribbean States (OECS) – HFG is supporting the development of a Regional Strategic Plan for HIV with inputs to the economic section as well as feedback on the outline and other content. This support is also being coordinated with UNAIDS.
- OECS Regional Coordinating Mechanism (RCM) – HFG is coordinating closely with the RCM, as the financial planning and modelling supported by HFG in six OECS countries will feed into the country dialogue process and other inputs to a regional concept note for a Global Fund application.
- Pan American Health Organization (PAHO) – Coordination of assistance to Barbados and the Eastern Caribbean states in support of financial sustainability planning and applications to the Global Fund.
- Pan Caribbean HIV/AIDS Partnership (PANCAP) – HFG is working with this partnership, housed in the Caribbean Committee (CARICOM) secretariat, to build PANCAP's organizational capacity. We are also coordinating with PANCAP to support regional applications for Global Fund grants.
- Partners for Health – Coordination with P4H on our HFG UHC activity in Benin.
- Population Reference Bureau – We are collaborating with PRB to finalize a brief on insurance and family planning.
- Providing for Health (P4H) Social Protection Network – Coordination with P4H on our HFG UHC activity in Benin.
- RESPOND Project – HFG Ukraine is working with the USAID RESPOND project in Ukraine. Collaboration has included conferring on the current status of the reform agenda, coordination between projects, and developing strategies for supporting health reform at the national and regional levels.
- Rockefeller Foundation - For the UHC pathways cross-bureau activity, HFG initiated discussions on UHC with the Rockefeller Foundation-funded JLN to plan for collaborative research that will focus on how countries choose which benefits to cover through national insurance schemes.

- Strengthening Health Outcomes through the Private Sector (SHOPS) project: HFG is in close contact with the Abt-led SHOPS project and is sharing office space in Côte d'Ivoire, Bangladesh, and India.
- UNAIDS - HFG worked with UNAIDS as we presented and facilitated country working groups at the January 2014, 2nd Caribbean Regional Meeting on Strategic HIV Investment and Sustainable Financing.
- UNAIDS – In collaboration with UNAIDS, we presented at the June 2014 OECS Regional Coordinating Mechanism Meeting to discuss an upcoming regional Global Fund grant application. HFG is using the UNAIDS Investment Framework approach with six countries in their financial planning of their HIV response.
- Urban Institute – On June 6, HFG staff and partners participated in an Urban Institute-sponsored roundtable on Local Health Systems. HFG was the only USAID project represented in a wide-ranging discussion about governance and health at the local level. Participants from various bureaus at USAID and the World Bank also participated.
- USAID, EGPAF and Search For Common Ground –HFG collaborated with USAID, EGPAF and Search For Common Ground to develop the health sector's governance Capacity Building Plan in Côte d'Ivoire (April 21-28, 2014).
- World Bank – HFG is participating in World Bank organized meetings on Performance Based Funding that is seeking to develop a national model for PBF in Côte d'Ivoire. Our consultant presented an overview of the history of PBF, the previous PBF experience under HS 2020 and is continuing to participate in partner discussions with the MSLS around PBF.
- World Bank Institute - Under Asia Bureau direction, we worked with the WBI and ANHSS (Asia Network for Capacity Building in Health Systems Strengthening) to deliver the WBI Flagship course in UHC.
- World Bank, UNFPA, French Agency for Development (AFD/C2D), European Funds for Development (FED/PARSSI); Leadership, Management & Governance (LMG) project – In Y2Q3, Côte d'Ivoire HFG held separate technical meetings with the different cooperating agencies to (1) identify relevant gaps of technical areas in Governance, Financing and HRH to support, and (2) develop strategic interventions for next FY.
- World Bank – HFG is working with the World Bank in Ukraine. Collaboration has included conferring on the current status of the reform agenda, coordination between projects, and developing strategies for supporting health reform at the national and regional levels. Also, HFG in collaboration with the World Bank and Ethiopian Health Insurance Agency (EHIA) organized a workshop to review types of health services incorporated in the benefit packages of health insurance, financial sustainability study and the performances of the agency in the last two years. It also conducted supportive supervision with the health insurance agency branch office (Dessie branch, Amhara region) in five selected Community Based Health Insurance pilot expansion woredas.
- World Bank, USAID (through HFG) and the Asia Network for Capacity Building in Health Systems (ANHSS) – Collaborating to hold a flagship course on UHC in 2015, including reviewing and revising the curriculum of the flagship and undertaking capacity building of the ANHSS. This builds on a successful collaboration last year.

- World Health Organization – In Y2Q3, an HFG senior technical advisor worked with the African Development Bank to identify and interview candidates for a Health Economist position to be seconded to the Namibian Social Security Commission. The Health Economist will be supporting Namibia's efforts to develop a strategy for promoting universal health coverage.
- World Health Organization - In Y2Q2, an HFG senior technical advisor facilitated discussions and work planning of the Universal Health Coverage Advisory Committee of Namibia, which includes among its members representatives from WHO, Management Sciences for Health/SCMS and the African Development Bank. Also, HFG is collaborating with WHO on resource tracking and SHA2011.
- World Health Organization – In Y2Q4, HFG worked with WHO and the Global Fund to facilitate a WHO-supported training for consultants who will participate in the Global Fund New Funding Model concept note process. HFG team members Andre Zida and Rachel Sanders facilitated group sessions on the costing of malaria and HIV programs using the OneHealth Tool for the purpose of concept note submissions. More broadly, the participants benefitted from HFG experience in the concept note and costing process.
- Zambia Integrated Systems Strengthening Program – In planning the microeconomic study on the impact of malaria control scale-up, HFG linked with the ZISSP project.



