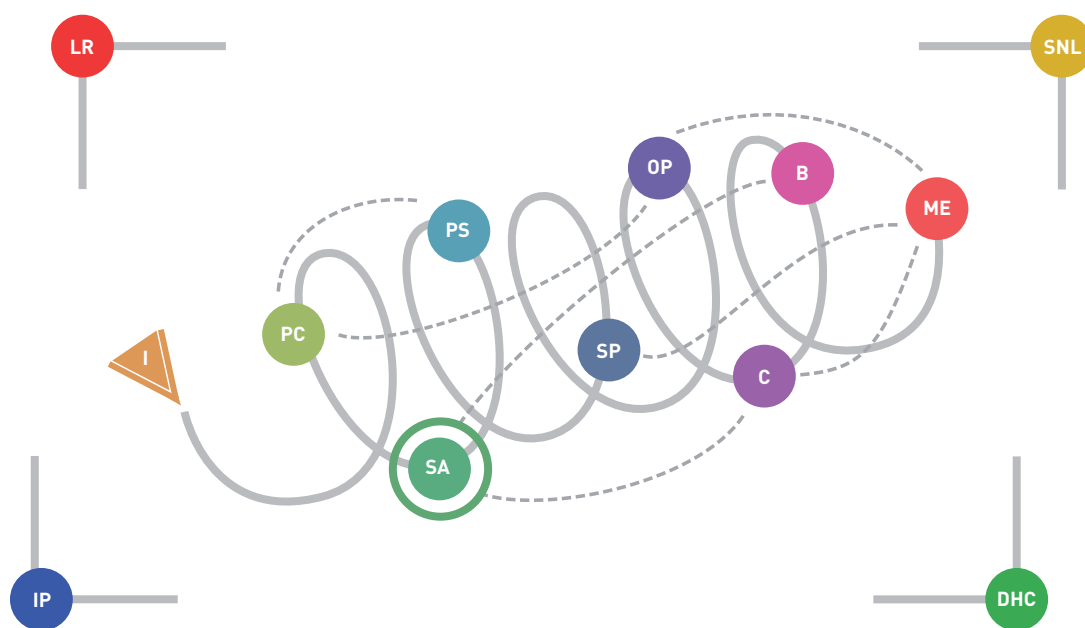


Strategizing national health in the 21st century: a handbook
Chapter 3

Situation analysis of the health sector

Dheepa Rajan





| | |
|-----------|---|
| I | CHAPTER 1 Introduction: strategizing national health in the 21st century |
| PC | CHAPTER 2 Population consultation on needs and expectations |
| SA | CHAPTER 3 Situation analysis of the health sector |
| PS | CHAPTER 4 Priority-setting for national health policies, strategies and plans |
| SP | CHAPTER 5 Strategic planning: transforming priorities into plans |
| OP | CHAPTER 6 Operational planning: transforming plans into action |
| C | CHAPTER 7 Estimating cost implications of a national health policy, strategy or plan |
| B | CHAPTER 8 Budgeting for health |
| ME | CHAPTER 9 Monitoring and evaluation of national health policies, strategies and plans |

Cross-cutting topics relevant to national health planning

| | |
|------------|--|
| LR | CHAPTER 10 Law, regulation and strategizing for health |
| SNL | CHAPTER 11 Strategizing for health at sub-national level |
| IP | CHAPTER 12 Intersectoral planning for health and health equity |
| DHC | CHAPTER 13 Strategizing in distressed health contexts |

Situation analysis of the health sector

Dheepa Rajan





WHO Library Cataloguing-in-Publication Data

Strategizing national health in the 21st century: a handbook / Gerard Schmets ... [et al].

Contents: 13 individual chapters

1.Health Policy. 2.National Health Programs. 3.Health Planning. 4.Handbooks. I.Schmets, Gérard. II.Rajan, Dheepa. III.Kadandale, Sowmya. IV.World Health Organization

ISBN 978 92 4 154974 5

(NLM classification: WA 540)

© World Health Organization 2016

All rights reserved. Publications of the World Health Organization are available on the WHO website (<http://www.who.int>) or can be purchased from WHO Press, World Health Organization, 20 Avenue Appia, 1211 Geneva 27, Switzerland (tel.: +41 22 791 3264; fax: +41 22 791 4857; email: bookorders@who.int).

Requests for permission to reproduce or translate WHO publications – whether for sale or for non-commercial distribution – should be addressed to WHO Press through the WHO website (http://www.who.int/about/licensing/copyright_form/index.html).

The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted and dashed lines on maps represent approximate border lines for which there may not yet be full agreement.

The mention of specific companies or of certain manufacturers' products does not imply that they are endorsed or recommended by the World Health Organization in preference to others of a similar nature that are not mentioned. Errors and omissions excepted, the names of proprietary products are distinguished by initial capital letters.

All reasonable precautions have been taken by the World Health Organization to verify the information contained in this publication. However, the published material is being distributed without warranty of any kind, either expressed or implied. The responsibility for the interpretation and use of the material lies with the reader. In no event shall the World Health Organization be liable for damages arising from its use.

The named editors have overall responsibility for the views expressed in this publication. The named authors alone are responsible for the views expressed in each chapter.

The document has been produced with the financial assistance of the European Union and the Grand Duchy of Luxembourg. The views expressed herein can in no way be taken to reflect the official opinion of the European Union nor the Grand Duchy of Luxembourg.

Graphic design by Valerie Assmann.

Suggested citation: Rajan D. Chapter 3. Situation analysis of the health sector. In: Schmets G, Rajan D, Kadandale S, editors. Strategizing national health in the 21st century: a handbook. Geneva: World Health Organization; 2016.

Contents

| | |
|---|----|
| Acknowledgements | iv |
| Overview | v |
| 3.1 What do we mean by “situation analysis” of the health sector? | 1 |
| 3.1.1 What is a situation analysis? | 1 |
| 3.1.2 The spectrum of a situation analysis | 2 |
| 3.2 Why do we want to undertake a situation analysis? | 3 |
| 3.2.1 It is a crucial step in the planning cycle | 3 |
| 3.2.2 In order to give a voice and a platform to all health sector stakeholders, including the population | 3 |
| 3.2.3 In order to increase accountability and transparency | 4 |
| 3.2.4 In order to support and strengthen monitoring and evaluation | 7 |
| 3.2.5 It contributes to concretizing roles and responsibilities | 8 |
| 3.2.6 It helps to establish consensus on the status of health in the country | 10 |
| 3.3 When should the situation analysis take place? | 11 |
| 3.4 Who should be involved in the situation analysis? | 12 |
| 3.4.1 Ministry of health (MoH) | 13 |
| 3.4.3 Civil society, including professional associations and special interest groups | 13 |
| 3.4.4 Private sector | 14 |
| 3.4.5 Parliament | 14 |
| 3.4.6 Media | 15 |
| 3.4.7 Development Partners | 15 |
| 3.5 Methodology: how should a situation analysis be organized and conducted? | 17 |
| 3.5.1 Organization of the situation analysis | 17 |
| 3.5.2 Three streams of analysis | 26 |
| 3.5.3 How long does a truly participatory situation analysis approximately take? | 34 |
| 3.5.4 Link between Streams 2 and 3 | 36 |
| 3.5.5 Link between situation analysis and priority-setting | 38 |
| 3.6 Some issues to consider | 39 |
| 3.6.1 Factors of success | 41 |
| 3.6.2 Dissemination of situation analysis results | 40 |
| 3.7 What if ...? | 41 |
| 3.7.1 What if your country is decentralized? | 41 |
| 3.7.2 What if fragmentation and/or fragility is an issue in your country? | 43 |
| 3.7.3 What if your country is highly dependent on aid? | 44 |
| 3.8 Conclusion | 47 |
| References | 48 |
| Further Reading | 49 |

Acknowledgements

We would like to give special thanks to Agnes Soucat for overall guidance. Thanks are also due to Alyssa Muggleworth Weaver for overall background research support.

WHO interns who supported this chapter were Olaitan Awonusi and Romain Oguey.

Frank Terwindt provided information for Table 3.2, Box 3.6, Box 3.12 and Fig. 3.3.

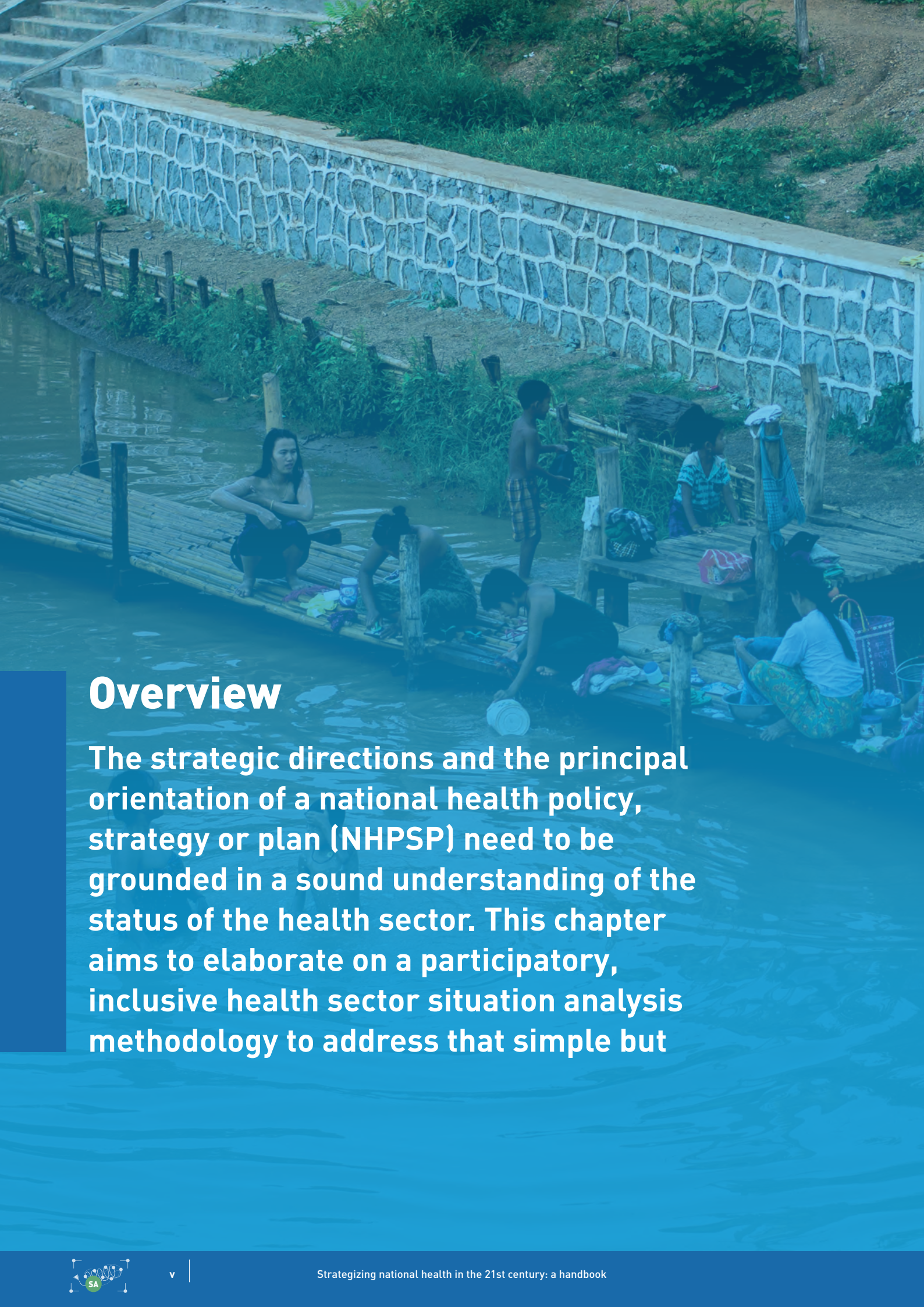
Elisabeth Paul provided information for Boxes 3.1 and 3.2.

This document was reviewed by Frank Terwindt, Gerard Schmets, Qaiser Pasha and Humayun Rizwan.

The following participants of a retreat in August 2015 provided valuable input into a revised draft of the chapter: Olaitan Awonusi, Maryam Bigdeli, David Clarke, Casey Downey, Sowmya Kadandale, Thomas O'Connell, Denis Porignon, Finn Schleimann, Gérard Schmets, Archana Shah, Karin Stenberg, , Frank Terwindt, and Kavitha Viswanathan.

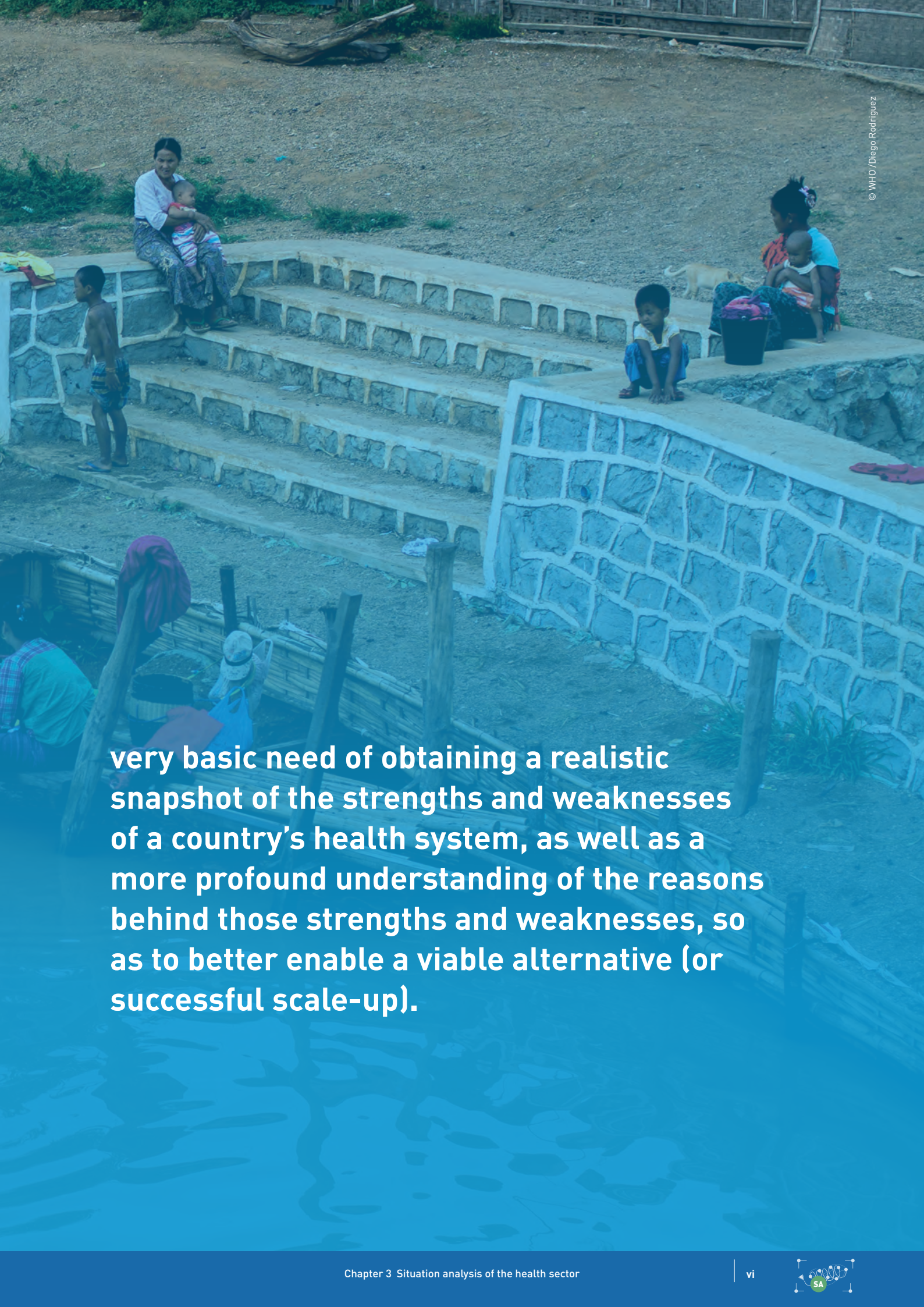
English language editing was provided by Dorothy van Schooneveld and Thomson Prentice. We gratefully acknowledge financial support from the European Union and the Grand Duchy of Luxembourg.





Overview

The strategic directions and the principal orientation of a national health policy, strategy or plan (NHPSP) need to be grounded in a sound understanding of the status of the health sector. This chapter aims to elaborate on a participatory, inclusive health sector situation analysis methodology to address that simple but

A photograph of a rural community scene. In the foreground, there are stone steps leading up to a higher level. A woman is sitting on the steps, holding a baby. Another woman is sitting on the steps to the right, also holding a baby. A young child is standing on the steps. In the background, there is a well with a wooden frame and a bucket. The scene is set in a dry, hilly area. The image is overlaid with a blue gradient and white text.

very basic need of obtaining a realistic snapshot of the strengths and weaknesses of a country's health system, as well as a more profound understanding of the reasons behind those strengths and weaknesses, so as to better enable a viable alternative (or successful scale-up).

Summary

What is a situation analysis of the health sector?

A health sector situation analysis should aim:

- (a) to realistically assess the current health sector situation, with all its strengths, weaknesses, opportunities and threats, including their root causes and effects;
- (b) to provide an evidence-informed basis for responding to health sector needs and expectations of the population;
- (c) to provide an evidence-informed basis for formulating future strategic directions for the health sector.

Several characteristics are recommended to ensure a sound health sector situation analysis. These are further detailed in this chapter:

- ▶ participatory and inclusive;
- ▶ analytical;
- ▶ relevant;
- ▶ comprehensive;
- ▶ evidence-based.

Why should a situation analysis be done?

A whole-of-sector situation analysis is important because:

- ▶ It is a crucial step in the planning cycle.
- ▶ It gives a voice and a platform to all health sector stakeholders, including the population.
- ▶ It increases accountability and transparency
- ▶ It supports and strengthens monitoring and evaluation.
- ▶ It contributes to concretizing roles and responsibilities.
- ▶ It helps to establish consensus on the status of health in the country.

When should a situation analysis take place?

It should be done as a key initial step in the development of a NHPSP. Ideally, it should be undertaken at least once during the health policy and planning cycle, and updated every few years, because an updated, in-depth technical analysis that includes stakeholder viewpoints is an invaluable resource for the whole health sector.

Who should be involved in a health sector situation analysis?

When examining the roles and responsibilities of the various health sector stakeholders, it is important to keep in mind the three main functions which are needed for a successful situation analysis: active and inclusive multi-stakeholder participation, decision-making, and organization and coordination. Some health actors will be active on all three fronts, while others will only be involved in one or another function, as described in more detail in this chapter.

How should it be conducted?

It is recommended to go for an approach which is as participatory and inclusive as possible, with a core team coordinating working groups. The working groups should consist of relevant experts and health stakeholders who are given adequate space and time for dialogue. This process is a crucial investment, whose potential to unite together those who have a stake in health into a common understanding of health sector challenges and solutions should not be underestimated. This methodology is elaborated upon in more detail in this chapter.

Anything else to consider?

- ▶ Decentralized setting;
- ▶ Fragile environment;
- ▶ Aid-dependent environment.



3.1 What do we mean by “situation analysis” of the health sector?

3.1.1 What is a situation analysis?

No one disagrees with the fact that the strategic directions and the principal orientation of a national health policy, strategy or plan (NHPSP) need to be grounded in a sound understanding of the status of the health sector. However, a myriad of options exist on how to go about the situation analysis, depending on the setting and objectives. In this chapter, the focus is on a situation analysis of the full health sector for purposes of developing a NHPSP. However, even for this same purpose, it may be necessary to go more in-depth into certain key areas – for example, health financing or human resources for health – depending on the country setting. The principles and approach as described in this chapter can still be used, although we specifically address an overarching whole-of-sector situation analysis here.

This chapter aims to elaborate on a participatory, inclusive methodology to address that simple but very basic need of obtaining a realistic snapshot of the strengths and weaknesses of a country's health system, as well as a more profound understanding of the reasons behind those strengths and weaknesses, so as to better enable a viable alternative (or successful scale-up).

WHO defines a health-specific situation analysis as “an assessment of the current health situation ... [that] is fundamental to designing

and updating national policies, strategies and plans”.¹ The World Bank proposes the term “health systems analysis” with the following definition: “Health systems analysis includes evidence on health system inputs, processes, and outputs and the analysis of how these combine to produce the outcomes. It considers politics, history, and institutional arrangements. Health systems analysis proposes causes of poor health system performance and suggests how reform policies and strengthening strategies can improve performance.”²

Based on the above definitions, the objectives of a situation analysis in this handbook are:

- (a) to realistically assess the current health sector situation, with all its strengths, weaknesses, opportunities and threats, including their root causes and effects;
- (b) to provide an evidence-informed basis for responding to health sector needs and expectations of the population;
- (c) to provide an evidence-informed basis for formulating future strategic directions for the health sector.

A health sector situation analysis can begin as a one-off activity, but parts of the analysis can be updated and revisited on a regular basis for programming and monitoring purposes.

This chapter elaborates on a participatory, inclusive methodology to obtain a realistic snapshot of the strengths and weaknesses of a country's health system.



3.1.2 The spectrum of a situation analysis

Several characteristics are recommended to ensure a sound health sector situation analysis.

- ▶ **Participatory and inclusive**—include all relevant stakeholders in the health sector, including the population.
- ▶ **Analytical**—base it on a causal framework of how inputs, processes, and outputs interact with each other and with other important environmental factors. It is critical to make a distinction here between being descriptive, i.e. narrating the state of the current situation, and analytical, i.e. attempting to understand the current situation based on past decisions, choices, and plans, as well as underlying causal factors.
- ▶ **Relevant**—focus on issues that ultimately affect the health status of the population, and consider solutions to ongoing challenges.
- ▶ **Comprehensive**—cover all aspects related to the health sector, including health systems, programmes, the full range of (personal and non-personal) health services, intersectoral action for health, etc.
- ▶ **Evidence-based**—utilize a wide range of information and data, both quantitative and qualitative, as well as, where relevant, other countries' experiences.³

A situation analysis can happen:

- (a) at any stage of the national planning process, from priority-setting to monitoring and evaluation;
- (b) at any level of the state (national, province/region, district);
- (c) on varying themes and scopes (i.e. for the health sector in general or for health financing in particular, for example);
- (d) with the lead taken by ministry of health (MoH).

Please note that for the purposes of this chapter, the focus will be an overall health sector situation analysis.

3.2 Why do we want to undertake a situation analysis?

3.2.1 It is a crucial step in the planning cycle

Coherent and needs-oriented health sector planning cannot take place without an adequate base of information, data, and evidence on the current state of the health system. Is the health system responding to population needs? Is the health status of the population improving? Is the current national health plan being implemented well? What are the challenges faced? These are just some of the crucial queries whose answers are imperative to better plan for and orient the future. Taking stock of existing knowledge is the first step towards decision-making.

3.2.2 In order to give a voice and a platform to all health sector stakeholders, including the population

(a) Stakeholder buy-in can lead to better policy implementation

Even the most ingeniously-designed health policies will not be implemented without the buy-in from health sector stakeholders (which includes stakeholders from other sectors who work in and with health), because they are precisely the ones who will be involved in the launching and practical implementation of the policy. In order to have adequate buy-in, stakeholders must be involved in all crucial steps of the planning cycle, starting with the situation analysis.

(b) A wide range of expertise and view-points, in particular the views of citizens, leads to better-designed policies

Policy-makers at central level may not be aware of all the details and challenges faced in other sectors and at the level of implementation – therefore, the input of those who are in other sectors and those who are close to the “field” is necessary in order to ensure that a situation is reflecting the true status of the health system.

It is important to note here that “input” may not solely be from technical experts. Policy-making is a complex process that clearly should be guided by scientific knowledge and experts’ views. However, the views and opinions of end-users and the population at large add a demand-side dimension that highly influences success in implementation. For instance, experts are well-placed to identify high-mortality diseases in the country and the most cost-effective ways to reduce their incidence. However, the most cost-effective ways may be ignoring some dire realities and barriers to access at the population level, which will only emerge when hearing population views.¹ Examples include some ethnic groups’ beliefs preventing women from delivering in health facilities because health staff do not respect traditional rituals; social norms which are contrary to health experts’ message for health prevention; health centres not being used because the opening hours are not convenient for the local population’s schedules. These few examples evince the bias that a situation analysis can take if populations’ points of view are not taken into account.

The first step towards decision-making is taking stock of existing knowledge about the health sector.

¹ Please see Chapter 2 “Population consultation on needs and expectations” in this handbook.



Experience shows that if stakeholders' well-founded critical views are taken into account in the situation analysis, their willingness to align, harmonize and contribute resources increases. On the other hand, if a sector analysis is perceived to be biased, obscuring obvious system weaknesses, the MoH may have difficulties obtaining a consensus with stakeholders.

Box 3.1

Expert views and population opinion in West Africa: two sides of the same coin

If one asks most health staff in rural West Africa what are the major problems impeding the performance of health services, they will probably mention the following: lack of sufficient and timely resources; poor staff motivation due to low salaries and no recognition of merit; and poor working conditions. At the same time, a socio-anthropological study performed in five of these countries shows that the main complaint of patients about the local health system is the bad reception and rude behaviour of health staff towards them.⁴ The two are very likely interconnected, but the latter would certainly not have emerged as a major problem if the situation analysis only took into account views of experts and health professionals. Thus the solutions to the first set of problems alone (e.g. raising salaries and upgrading equipment) would probably not be an appropriate solution to the problem in its full complexity.

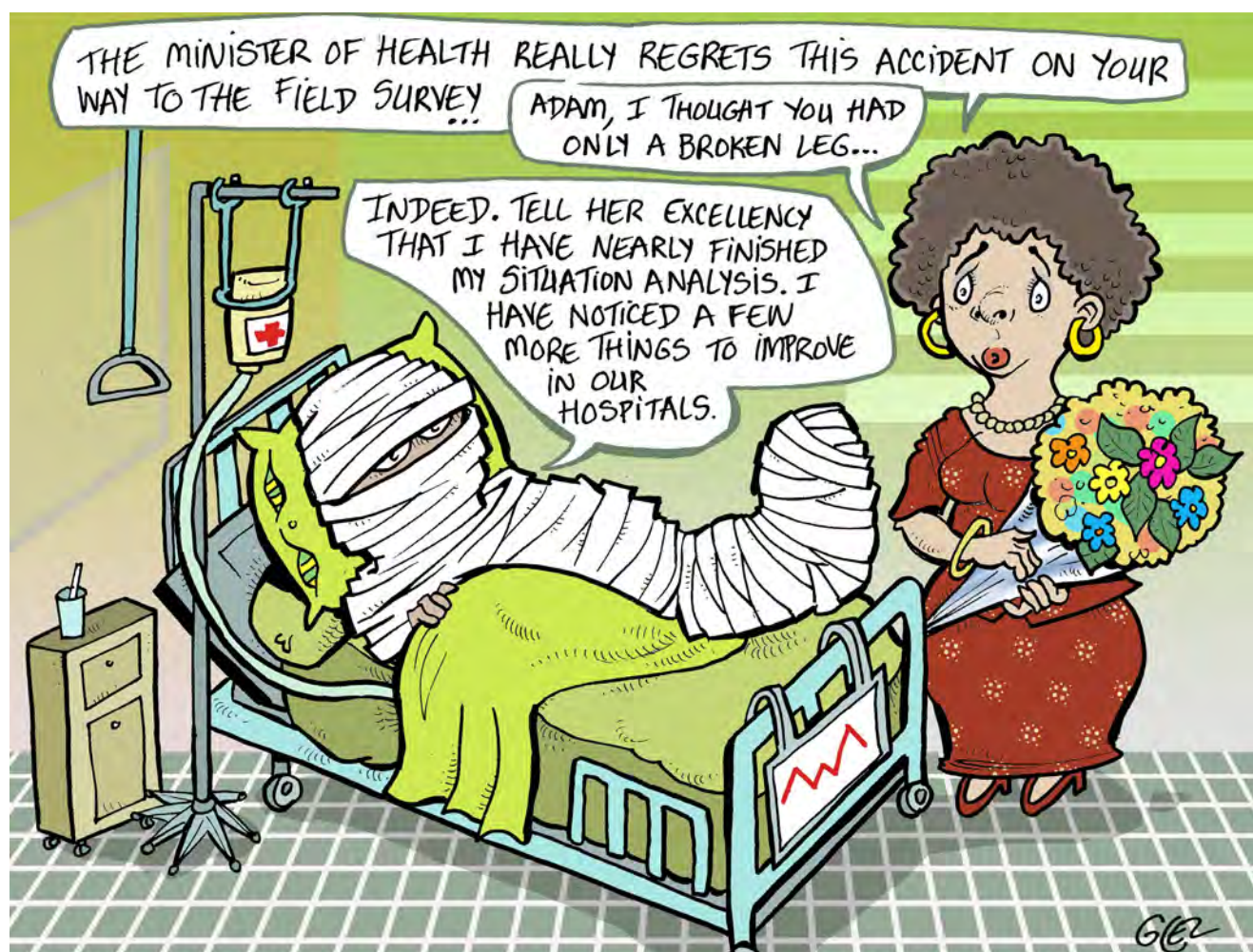
3.2.3 In order to increase accountability and transparency

A situation analysis done properly, with the characteristics mentioned above, allows governments to account for health sector activities and results in a transparent way. The more participatory and honestly open the situation analysis is, the more accountable and transparent the government shows itself to be. This is not to say that the types of participation and representativeness of those participating should not be thought through in detail and care given to practical considerations for fair participation (see Boxes 3.2 and 3.4).

Conducting a situation analysis in a participatory manner implies making data and information available and accessible to different health sector stakeholders who may not have the opportunity to look at, discuss, and understand this information otherwise – thus promoting transparency. Transparency also means giving stakeholders a voice by providing information and explanations on issues that matter to them most and affect them directly. Accountability entails enabling stakeholders to influence decision-making and hold those making decisions to account. A participatory situation analysis is the first step to joint decision-making and monitoring progress on those decisions.

In some settings, the MoH may fear that if a sector analysis is done in a genuinely participative way, the outcome may point out weaknesses at their level which can become politically burdensome. However, experience shows that

Fig. 5.1 Situation Analysis: getting a good understanding of a country's health system



Damian Glez; scenario by Bruno Meessen.

if stakeholders' well-founded critical views are taken into account in the analysis, their willingness to align, harmonize and contribute resources increases. On the other hand, if a sector analysis is perceived to be biased,

obscuring obvious system weaknesses, the MoH may have difficulties obtaining a consensus with stakeholders. Subsequently, overall adherence to new policies may end up being weak.

Box 3.2

What do we mean by “voice and accountability” and by “participation”? What are some of the common challenges to ensuring widespread participation?

“Voice and accountability” is a driving concept in strategizing for health in the 21st century. It signifies that those in charge of developing national health plans need to include all concerned stakeholders, giving them the space and opportunity to freely express their views. In particular, the population (and their representatives) should be explicitly included as “concerned stakeholders” in the debates that lead to strategies which affect them.

The word “participation” in the context of a health sector situation analysis implies a meaningful participation, i.e. the stakeholder who is requested to participate is prepared and informed in an objective way and is allowed an adequate platform to express his/her voice. Participation by a greater number of people and a wider cross-section of society can be reached by linking a participatory situation analysis to a population consultation. Many countries may not conduct a population consultation with every situation analysis due to time and cost constraints but it is necessary to capture population demands and expectations with some level of periodicity.^{II}

Ensuring widespread participation often necessitates good and early preparation – this is because, depending on the political context of the country, dialogue and consensus must be sought at an early stage. This often means reaching out to actors one is less comfortable with, and potentially facing confrontation. This is an extra effort and its importance is

not to be underestimated in view of achieving broad adherence and alignment.

Ideally, the stakeholders who participate in a situation analysis should have sufficient understanding of the issue, have sufficient communication skills so as to claim their voice (including being socially “allowed” to speak), and be representative of all the categories of population that should participate. In practice, however, it is not always easy to identify those representative stakeholders and enable them to participate. The following dilemmas require careful consideration but should not be seen as deterrents – rather, by thinking these issues through beforehand, they can be more easily resolved:

- ▶ The greater the number of participants there are in the consultative event, the more difficult it is to allow fair participation of all points of view, to reach a consensus on situation analysis, and to take decisions. It is important to strike a balance between casting the net wide to include as many stakeholders as possible and having a fair number of participants who are really able to have a say.
- ▶ Even when all relevant categories of stakeholders have been identified (e.g. civil society, religious communities, women, labour unions, other line ministries, etc.), it is not easy to identify those organizations or individuals which are most appropriate and legitimate to represent

^{II} For more information, see Chapter 2 “Population consultation on needs and expectations” in this handbook.

those stakeholders. In many countries, civil society organizations (CSOs) are federated into national platforms, but these are not always viewed as legitimate by all organizations. It can thus be extremely difficult to know who constitute adequate representatives of the whole. A similar situation can be found with non-profit organizations: there may be hundreds of them, varying greatly in size, coverage and expertise, while effective coordination, and therefore representativity, can be unclear.

- ▶ A careful analysis and understanding of stakeholder groups, as well as engagement with them, can help to identify the right people. As for representatives of other sectoral line ministries the MoH may wish to involve, it is not straightforward whether the “right” representatives will be sent by their ministry. Very often, ministries send medium-grade staff, who do not have decision-making power (and sometimes even do not know the issues to be discussed). Specifying the person who should attend the event may be against protocol (but if it is not, this is one way to overcome this challenge). In countries where official “health focal points” have been nominated in non-health ministries, this problem occurs much less frequently.
- ▶ Even when the appropriate stakeholders are represented, they may not feel empowered to effectively participate in the dialogue – be it due to lack of technical skills or due to social norms. Particular

care should be given to supporting the participation of representatives from rural and hard-to-reach populations. It may even be appropriate to organize separate consultative events to allow these groups to freely express their opinions.

- ▶ In the case of NHPSPs, it is important that the government leads the consultative process, especially in aid-dependent contexts where donors may unduly influence debates (see section 3.7.3).

3.2.4 In order to support and strengthen monitoring and evaluation

A health sector situation analysis is an in-depth look at all aspects related to inputs, processes, and outputs of the health sector, i.e. a full snapshot of the sector. This information is extremely relevant and useful to compare and contrast with existing data and information, to assess trends, and monitor progress. If existing data and information is sparse, a situation analysis can serve as a baseline to inform future monitoring and evaluation rounds.^{III} In addition, sector situation analyses provide essential and accessible documentation in a concise, analytical format for all stakeholders interested in the health system, giving a common overview of the situation, using the same language and definitions for all, thus improving the quality of policy dialogue.

A situation analysis can serve as a baseline to inform future monitoring and evaluation rounds.

^{III} Please see Chapter 9 “Monitoring, evaluation and review of national health policies, strategies and plans” in this handbook.



3.2.5 It contributes to concretizing roles and responsibilities

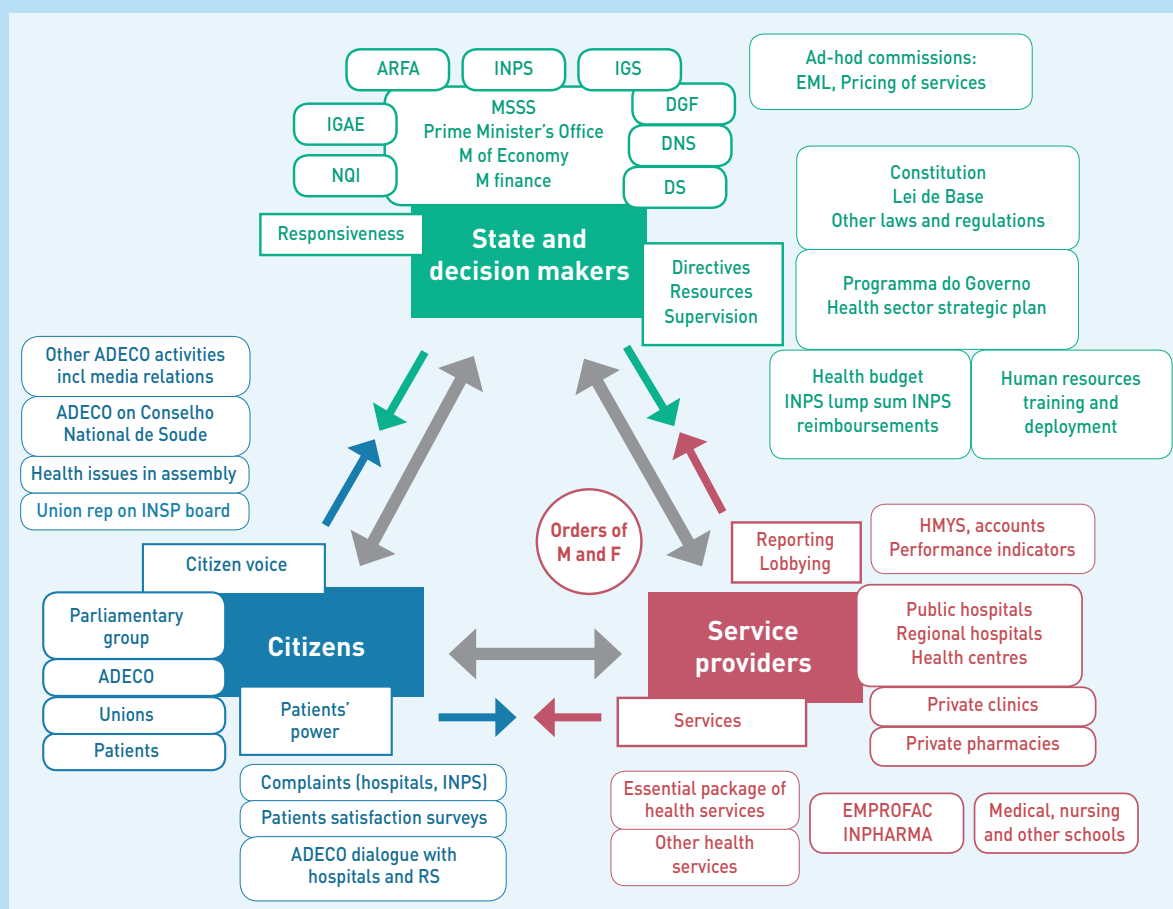
A situation analysis is the basis for planning health sector activities, often making it the first step towards a new national health plan or health sector reform.

A situation analysis is often the first step towards a new national health plan or health sector reform. It is the basis for planning of activities which will take place in the health sector over the following few years. Successful implementation of these activities is highly dependent on a clear definition of roles and responsibilities between all types of stakeholders, especially including those who are on the ground, in districts, in more remote areas, and closer to or representing the population, the citizens and/or the patients. A situation analysis is a key step for all relevant stakeholders to understand which strategic orientations and linked activities need

to happen in the health sector – and based on this, which concrete roles and responsibilities each stakeholder has.

It is highly recommended that a stakeholder analysis forms an integral component of the health sector situation analysis (see Box 3.3). Such an analysis can help elucidate how the characteristics of the various stakeholders influence the NHPSP development process. By better understanding the stakes of each actor, roles and responsibilities can be better distributed and managed to the benefit of all.

Analysis of health sector actors, their relationships and interests, in Cabo Verde



adapted by Bigdeli M and Clarke D, from World Development Report 2004: Making services work for poor people. World Bank; 2004. and Brinkerhoff D, Bossert T. Governance: concepts, experience and program options. Bethesda: Health Systems 20/20 Project; 2008

Box 3.3

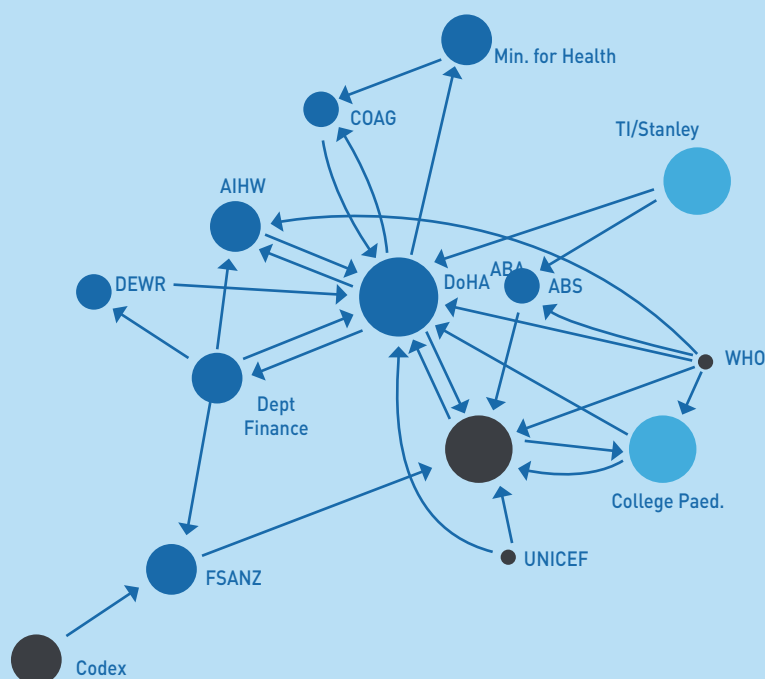
Stakeholder analysis

A stakeholder analysis is frequently used in health system management, development, and health policy-making.⁵ It aims to evaluate and understand stakeholders from the perspective of a certain organization or their relevance to a specific policy or project based on information from stakeholder surveys and interviews, supplemented by in-country experiences, literature reviews, expenditure data, and reports or publications.⁶ Stakeholder analyses can address important questions such as: Who are the key players, formal and informal, in this field? What are the relationships between the actors? Who has the power or influence in this situation? How do the actors influence the policy process? (see example of an analysis of health actors, their relationships and interests, from Cabo Verde)

One of the results of a stakeholder analysis is a net map or a stakeholder movement map. A net map visually displays the actors in the health field and their relationships to each other using labels and arrows indicating the flow of resources versus action. A stakeholder movement map, on the other hand, can visually display a comparison of past, present, and future projected influence of a stakeholder, graphing level of influence in the health sector versus level of support over time. Visual representation of stakeholder analysis results provides an easy way to grasp a wealth of information about stakeholders' relative positions – i.e. in support, neutral, or opposed – to policy goals.

Knowledge of the actors present in the health system, their interests, and positions can allow policy-makers to interact more effectively with key stakeholders for health reform.⁷ In

Net map



Source: Thow AM. Stakeholder analysis for health policy research. Sydney Health Policy Network and Qualitative Health Research Collaboration Forum; May 2013 (<http://sydney.edu.au/health-policy-network/news-events/Thow.pdf>, accessed 14 October 2016).

the health sector, a stakeholder analysis can be used as a tool to inform project planning, implementation, and evaluation and is most useful when incorporated into a larger policy analysis process.⁸ For instance, the role of CSOs and donors in health policy is vast – through stakeholder analysis, policy-makers can best understand which ones have the largest stake in a policy and be prepared for future funding opportunities or for potential barriers to passing a policy. While this specific type of analysis is useful in managing actors in the health field and identifying opportunities for stakeholder support or mobilization, a degree of caution is necessary in applying analysis results due to biases or uncertainties in data retrieved from stakeholders.⁹



3.2.6 It helps to establish consensus on the status of health in the country

Different stakeholders will probably have diverging interests and varying points of view. This is precisely why information sharing and a jointly-undertaken situation analysis are essential to building trust between different players and negotiating a consensus among them. A situation analysis is often the principal first step in establishing trust by having stakeholders work together to agree upon the health sector status quo.



© UN Photo/JC McIlwaine

3.3 When should the situation analysis take place?

A health sector situation analysis should be done as a key initial step in the development of a NHPSP. Ideally, it should be undertaken at least once during the health policy and planning cycle, and updated every few years, because an updated, in-depth technical analysis that includes stakeholder viewpoints is an invaluable resource for the whole health sector.

That being said, taking stock of the situation, especially for particular thematic areas that may not be covered in complete depth in an overarching health sector situation analysis, is an activity which may be necessary during any stage in the policy cycle. It is an activity which is worth investing in, as it forms a basis and is a part of good programming and monitoring.

A health sector situation analysis need not always be undertaken on a large scale – it depends solely on the scale of the objective. If, for example, a malaria programme is considering reprogramming small funds, without interfering with the overall health sector strategy and targets, a quick technical analysis on malaria can potentially fulfil this objective. On the other

hand, if, for example, a reorientation of the national health plan objectives is foreseen as a consequence of the development of a new national health financing strategy, a more substantial and in-depth situation analysis of the health financing situation and its linkage and potential impact on the health sector as a whole would need to take place.

Thus, the timing is linked to the specific objectives of the situation analysis, the topic in question, and the scope of the situation analysis (full health sector, a sub-sector, a programme).



3.4 Who should be involved in the situation analysis?

There are three main functions taken on by stakeholders for a successful situation analysis: active and inclusive multi-stakeholder participation, decision-making, and organization and coordination.

When examining the roles and responsibilities of the various health sector stakeholders (see Box 3.4), it is important to keep in mind the three main functions which are needed for a successful situation analysis: active and inclusive multi-stakeholder participation, decision-making, and organization and coordination. Some health actors will be active on all three fronts, while others will only be involved in one or another function, as described in more detail below.

Box 3.4

A health sector situation analysis typically brings together some or all of the following stakeholders

Population/beneficiaries

- ▶ Population and community representatives
- ▶ Civil society, including nongovernmental and faith-based organizations
- ▶ Special interest groups

Government and government-affiliated entities

- ▶ Various central-level MoH departments
- ▶ Other ministries whose work is pertinent to health
- ▶ Regional MoH departments
- ▶ Other institutions and agencies linked to the MoH (e.g. parastatals)
- ▶ Development partners

Health providers

- ▶ Public services providers and in particular local health systems authorities
- ▶ Professional associations
- ▶ Private for- and not-for-profit health services providers

Other

- ▶ Research institutions
- ▶ Think tanks

3.4.1 Ministry of health (MoH)

In an overall health sector situation analysis, the leader should be the MoH, especially if the objective is the formulation of a new national health plan. The MoH leads the coordination, organization and decision-making of the situation analysis exercise, and besides participating itself, ensures meaningful participation of others. There may be cases where certain preparatory steps, such as the population consultation, or the analysis of health data, are better conferred to outside parties in order to be independent and unbiased in their recommendations. Nevertheless, the MoH is the entity that takes the final decision on how to use the recommendations and results of various analyses and consultations and translates them into a national plan.

A situation analysis needs to be as impartial and objective as possible – ensuring this is a crucial role of the MoH, whether the analysis is actually conducted externally or not. One way to do this is to ensure that no single stakeholder or stakeholder group dominates the discussions and the process. A range and variety of stakeholders should be represented adequately and everyone given a voice and role. Of course this is easier said than done because often, in reality, the interest levels, funding and availability of different participants are not equal – this is where the MoH must make an extra effort to pique participants' interests, to incentivize participation if necessary, and ensure a fair balance in the voices.

3.4.2 Sub-national health systems authorities^{IV}

Sub-national health authorities and services providers have an important role in providing data and information as well as in synthesizing this information in a format that is understandable to the vast majority of stakeholders. Their main role thus lies in “active participation”; however, it is advisable to have at least one regional or district health authority in the core team, as much of the knowledge that will be synthesized and analysed for the situation analysis comes from the field. The core team member will certainly contribute to the organization and decision-making of the situation analysis exercise.

District and especially regional authorities have a good overview of the challenges and bottlenecks faced in their local health sectors – their role in a situation analysis is thus to ensure that this message from the ground is brought across with the appropriate supporting evidence, in an understandable and clear way.

A situation analysis needs to be as impartial and objective as possible – ensuring this is a crucial role of the MoH, whether the analysis is actually conducted externally or not.

^{IV} Often called “regional” or “district” health authorities.



3.4.3 Civil society, including professional associations and special interest groups

The private sector is comprised of both for-profit and non-profit entities.

Their role in the situation analysis is to actively participate at the very least. In situations where they make up a substantial proportion of health services, it would be wise to include them in the core team and definitely in relevant technical working groups.

Civil society's role is crucial, as these are the organizations which are most often closest to the populations. A CSO representative can also be in the core team, and if not, should certainly actively participate and be transparent in providing relevant data and information. It is essential for CSOs to ensure that legitimate representatives are engaging in the situation analysis process. Where a plethora of CSOs exists working on similar topics, it may not be possible for all of them to participate in the situation analysis process – in this case, CSOs as a group would have the responsibility to ensure legitimate representation.

3.4.4 Private sector

In most countries, the private sector contributes to providing health services and health system inputs such as pharmaceuticals, health technology and human resources for health. It is thus relevant and necessary to bring the private sector into the situation analysis discussion, even though it is often difficult to do so. A complete and accurate understanding of a country's health sector is really not possible in some settings without the private sector angle.

The private health sector comprises “all providers who exist outside of the public sector, whether their aim is philanthropic or commercial, and whose aim is to treat illness or prevent disease”.¹⁰ This comprises for-profit and non-profit entities, including faith-based organizations. It also includes the informal health sector such as traditional healers, traditional birth attendants, indigenous systems of medical providers, and market drug sellers. Their role in the situation analysis is to actively participate at the very least. In situations where they make up a substantial proportion of health services, it would be wise to include them in the core team and definitely in relevant technical working groups. Their insights into the realities on the ground are unique, and they have knowledge and experience with the same issues but from a different angle – therefore, huge efforts should be undertaken to ensure their meaningful participation in the situation analysis process.

3.4.5 Parliament

Ideally, a parliamentary health committee representative would be a part of the thematic working groups or – at the very least – follow the analyses and discussions by keeping in touch with the core team. Health committee parliamentarians will ultimately be involved in approving the national health budget that will be based on the NHPSP; the NHPSP is based on the situation analysis, so ensuring a link between the legislative focal points for health and the technical situation analysis work is beneficial to both sides. During the budget hearings in parliament, it would be extremely useful for health committee members to have the background knowledge of the situation analysis to better defend the health budget.

3.4.6 Media

The media is a special actor, since it is omnipresent and aims to provide information and reflect population opinion in an objective way. In a situation analysis, its role is chiefly to disseminate and inform the population on the situation analysis exercise, thereby ensuring that the analysis process and results are transparent and understandable. The media's role is thus critical and keeps the national health planning process dynamic.

3.4.7 Development partners

Development partners can be represented in the core team, where they would take on more of an organization/coordination as well as co-decision-making role. Where they are not in the core team, their active participation is important, as they have relevant data and information on the projects and programmes that they are involved in and which could add value to the situation analysis discussions. The information should also be made available in as palatable and understandable a format as possible.

In aid-dependent contexts, development partners should be careful not to skew or over-influence the debates. MoH and country health sector needs should always be in the forefront of the discussions, rather than partner priorities.

During the budget hearings in parliament, it would be extremely useful for health committee members to have the background knowledge of the situation analysis to better defend the health budget.





© UN Photo/JC McIvaine

3.5 Methodology: how should a situation analysis be organized and conducted?

A situation analysis can be conducted in different ways but there are key elements which must be in place to ensure that all the chief characteristics (see section 3.1.1) are fulfilled:

- ▶ participatory and inclusive;
- ▶ analytical;
- ▶ relevant;
- ▶ comprehensive;
- ▶ evidence-based.

In the following sections, organizational aspects of a situation analysis (steering committee, core team, working groups) are detailed, as well as the streams of work which need to be examined by health planning stakeholders.

3.5.1 Organization of the situation analysis

There are two main ways of organizing the situation analysis of the health sector, and it will partly depend on the amount of time and funds at MoH's disposal. The first might be necessary when the analysis must be done quickly; here, international and national expert consultants come and review documents, carry out interviews with key informants, examine existing data and draw conclusions within a few weeks. This will be useful in producing a published analysis rapidly, but it will neither build country capacity nor allow adequate understanding and buy-in from all relevant stakeholders, especially those in the field, such as local NGOs and communities. The second way is through working groups involving relevant experts and health actors with

adequate space and time for dialogue. It is true that when the analysis involves a wide array of stakeholders as is advocated in this handbook, it can become heavy and time-consuming. Nevertheless, it is a crucial investment, whose potential to unite those who have a stake in health into a common understanding of health sector challenges and solutions should not be underestimated. The latter methodology is elaborated upon in more detail in this section.

A situation analysis must be participatory and inclusive, analytical, relevant, comprehensive, and evidence-based.

Establishment of a “steering committee”

The creation of a formal “steering committee” (or whatever name chosen by the country), representing the community of stakeholders involved in the exercise, may or may not be necessary; it depends on the scope of the situation analysis and the core team's access to higher-level decision-makers in the government. If it is decided to form one, it would be important to have MoH department heads as well as heads of CSOs or other line ministry directors who are closely linked to health sector activities. In any case, clarity is needed as to who will finally sign off on the situation analysis and formally accept its contents.

Nomination of a “core team”

The nomination of a “core team” (this can go by any other title, depending on the country context) is essential to ensure effective coordination of the situation analysis exercise. This team should have the skills to organize well, have



A participatory situation analysis is mainly organized through thematic working groups, coordinated by a core team. The working group reports should then be submitted to a policy dialogue which includes a broad range of stakeholders, including community and citizen representatives.

relational skills to be able to reach out to the right people for constitution of working groups, and also possess strong technical capabilities to actively participate in and support the working groups. The team should be led by the MoH but its constitution does not need to be exclusively MoH staff. In fact, representation from key donors, CSOs, professional associations, sub-national health authorities or any other relevant bodies (especially relevant for NHPSP implementation) for the particular country setting is explicitly recommended.

The core team's tasks include (but are not limited to):

- ▶ preparing the situation analysis, including obtaining official approvals and a budget;
- ▶ constituting working groups;
- ▶ making available relevant documentation; informing and sensitizing relevant stakeholders;
- ▶ organizing workshops and meetings between relevant actors and/or working groups on cross-cutting topics;
- ▶ technically supporting working groups;
- ▶ ensuring that the three streams of work as described below are done well and accurately, and that they are adequately linked.

WHO health systems taxonomy: a tool

In order to ensure comprehensiveness of the aspects covered under the different working groups that will be conducting the situation analysis, WHO has put together a taxonomy for health systems (see Box 3.5), or exhaustive list of subjects which can be covered on health systems-related matters. The taxonomy is organized in a set of health sector categories based on the health system building blocks; most principal country health programme areas come under the "service delivery" building block. Under each category, a series of sub-headings has been developed with the corresponding experts so that an analysis of each area is comprehensive. An annotated taxonomy explains which information is expected for each sub-heading of the taxonomy. Using a comprehensive taxonomy to describe the way the system and programmes function is a good starting point and can help the working groups ensure that all important aspects of the health system in the country are well covered in the situation analysis.

Examples of other situation analysis tools are described in Table 3.1.

Box 3.5

An example of a taxonomy for health workforce¹¹

Health workforce

- 1 Analytical summary
- 2 Organization and management of human resources for health
 - 2.1 Overview of the organization and management of human resources for health
 - 2.2 Specific regulatory framework
- 3 Modes of remuneration
 - 3.1 Salaries and other financial rewards
 - 3.2 Performance appraisal and non-financial incentive schemes
 - 3.3 Problems and negotiation around remuneration issues
- 4 Stock and distribution of human resources for health
 - 4.1 Numbers and distribution of health workers
 - 4.2 Specific stock and distribution information
 - 4.3 Estimated unemployment rates among health-care professionals
- 5 Education and training
 - 5.1 Training courses
 - 5.2 Educational institutions by type of training programmes
 - 5.3 Number of graduates
 - 5.4 Standards setting for professionals and educational institutions
- 6 Planning for human resources for health
- 7 Career path
 - 7.1 Doctors' and health professionals' career path
 - 7.2 Migration of health workers
- 8 Priorities and ways forward
- 9 Others



Table 3.1 Examples of situation analysis tools

| SITUATION ANALYSIS TOOL | WHAT IS IT? | WHO RUNS IT? | TARGET AUDIENCE | EXAMPLE COUNTRIES WHERE APPLIED |
|--|---|--|---|--|
| Health systems in transition, health system reviews (HiTs) ¹² | “Country-based reports that provide a detailed description of each health care system and of reform and policy initiatives in progress or under development” | WHO Regional Office for Europe | Countries of the WHO European Region; some additional OECD countries | Albania, Australia, Canada, Estonia, Hungary, Portugal, Slovenia, Turkey, United States, Uzbekistan |
| Health System Assessment Approach (HSAA) ¹³ | <p>Technical Modules used to “produce a comprehensive assessment of an entire health system or parts of the health system”</p> <p>“Widely used in the developing world to diagnose health systems performance and to capture system-wide information”</p> | United States Agency for International Development (USAID) | Policy-makers and analysts Health system planners, policy-makers, practitioners, and program managers | Angola, Azerbaijan, Benin, Viet Nam |
| Organizational Assessment for Improving and Strengthening Health Financing (OASIS) ¹⁴ | “An analytical approach and framework for undertaking a systematic review of a health financing system including a performance assessment” | WHO | Health financing policy-makers of ministries of health, finance, planning and labour, or other ministries, health insurance organizations, other actors in health financing | Benin, Cambodia, France, Jordan, Mali, Morocco, Nicaragua, Pakistan, Republic of Korea, Rwanda, Sudan, Tunisia, Uganda, Viet Nam |
| Human Resources for Health Toolkit ¹⁵ | “Toolkit brings together a set of existing tools that are in use for various aspects of country level HRH [human resources for health] development, including situation analysis, planning, implementation, monitoring and evaluation” | Global Health Workforce Alliance | Various levels stakeholders and policy-makers involved in health planning | |

Establishment of “working groups”

Ideally, the stakeholders can be organized into working groups, with the aim of balancing out technical input from different levels of the health system, different institutions involved in the topic, and simply, different viewpoints which need discussion and debate. For example, a working group on human resources for health can include representatives from: MoH, from the department dealing with health workforce; a researcher from an academic institution working in this area; health professional association (health worker representative); donor agency if they are interested in or fund this area; and a CSO that may be providing health services and must manage staff. In addition, this group would call upon a wider group of actors to consult them ad hoc on specific issues (sometimes termed a “community of practice”) – this could be ministry of labour; district health authorities; community leaders, etc.

Working groups should not only be mixed teams, with experts and experienced actors from various stakeholder groups, but also cover all main aspects of expertise on the topic attributed to them. The WHO taxonomy already gives an idea of the various aspects to be analyzed, but as it is very comprehensive, it would not be practical to nominate a member for each section.

Table 3.2 can be used as a checklist for expertise that needs to be covered in working groups on common situation analysis topics. It allows the core team, which is responsible for establishing the working groups, to verify that, together, each group has sufficient expertise and experience to ensure a comprehensive analysis of their topical area.



Table 3.2 Expertise needed for common situation analysis topics

| WORKING GROUP | PRIORITY FOR DEVELOPMENT OF AN IMPROVED EVIDENCE BASE |
|---|---|
| Service delivery | <ul style="list-style-type: none"> ▶ health service levels, service packages, referral system ▶ quality of care: continuity, care, drugs ▶ (universal) coverage, primary health care, outreach, health-seeking behaviour, health service demand ▶ role of various private sector providers ▶ traditional medicine |
| Pharmaceutical and medical supplies | <ul style="list-style-type: none"> ▶ needs projection, procurement, supply ▶ drugs, material, blood bank, contraceptives |
| Equipment and infrastructure, logistics | <ul style="list-style-type: none"> ▶ asset planning and management, norms and standards ▶ health facility mapping (existing and projected) ▶ maintenance |
| Human resources | <ul style="list-style-type: none"> ▶ needs projection, production, distribution, registration, supervision, training ▶ technical assistance |
| Financing | <ul style="list-style-type: none"> ▶ costing, medium-term expenditure framework, resource allocation (criteria) ▶ cost-sharing policy/practices, financial accessibility ▶ resource projection/budgeting process, mobilisation (National Health Accounts) ▶ financial management, expenditure tracking, internal control ▶ auditing arrangements |
| Governance/management | <ul style="list-style-type: none"> ▶ administrative legislation and regulation ▶ implementation and administrative arrangements ▶ planning processes and procedures ▶ procurement |
| Coordination and leadership and reforms | <ul style="list-style-type: none"> ▶ International Health Partnership (IHP+) compact development ▶ institutional development ▶ multisectoral cooperation ▶ international cooperation ▶ health sector decentralization ▶ public/private partnership |
| Information systems | <ul style="list-style-type: none"> ▶ monitoring and review mechanism ▶ knowledge management ▶ research |
| Sector policies and context | <ul style="list-style-type: none"> ▶ process of strategy and policy development, validation and review ▶ gender, equity, human rights ▶ alignment with overall government directives/processes ▶ international commitments, initiatives |
| Health outcomes (health status) | <ul style="list-style-type: none"> ▶ trends of main health indicators (compare with region) ▶ epidemiological profile ▶ results of priority health programmes ▶ results re international commitments (MDG, ...) ▶ analysis of factors and causes |

The working group's principal tasks are to collect, examine and interpret relevant data, knowledge and information around the topic at hand, and through preliminary internal expert discussions, come to joint conclusions which would be the object of policy dialogue. The group's analysis and conclusions should be drafted into a thematic report which can be disseminated to all stakeholders for review and comment, and discussion and debate.

Working groups can be organized along the health systems building blocks,¹⁶ along strategic directions of the current NHPSP, or along cross-cutting topics such as universal health coverage (see Tables 3.3 and 3.4). In practice, the topics of the working groups will depend also on the way the health sector, and the MoH, is organized.

Table 3.3 Situation analysis working groups by health system building block

| Examples of working group topics by building block | Issues to consider |
|---|---|
| <ul style="list-style-type: none"> ▶ Human resources for health ▶ Pharmaceuticals and medical products ▶ Health technologies and infrastructure ▶ Service delivery ▶ Health governance and leadership ▶ Health financing ▶ Health information system | <p>This grouping might reinforce silo thinking. Service delivery working group ends up taking on all programme-related information which can make this group's workload very high compared to other groups. Overlaps must be thought through to ensure joint meetings between overlapping topics. Labelling one group to look only at governance and leadership may be politically sensitive in some settings -- it must thus be easier to integrate governance issues into other topics.</p> |

Table 3.4 Situation analysis working group by cross-cutting health sector topics

| Examples of working groups by cross-cutting topics | Issues to consider |
|--|---|
| <ul style="list-style-type: none"> ▶ Universal health coverage ▶ Social determinants of health ▶ People-centred service delivery ▶ Governance for health | <p>Can support thinking out of the box. Can foster collaboration across existing departments, institutions and sectors. If the sector is not organized in this cross-cutting way, it can be difficult to incentivize full participation during the situation analysis. Understanding of cross-cutting topics may be from the point of view of the expertise of each working group member -- an initial investment in explaining and clarifying the definition and content of cross-cutting topics may be necessary.</p> |

Meetings, workshops and communication

Individual working groups can organize their reading, debate and writing work for the analysis in ways that suits them. If team members are doing this work on top of their routine duties, most of the exchanges can take place by email or online. These channels are also useful when some members are based at a decentralized level, or elsewhere.

It is useful to adopt a clear schedule of meetings and workshops that all working group members have agreed upon, for both individual working groups as well as meetings between different working groups on overlapping or cross-cutting topics. These meetings can be the forum where working groups report on the progress in their work, give and receive feedback, receive advice from other experts and a community of practice (who may not necessarily be in the working group) and harmonize content with other groups, especially on cross-cutting topics. They also serve to link the different streams of work together and ensure data and knowledge sharing.

The working groups should agree on text formatting, management of feedback and comments and on procedures for communication. Some groups may decide to organize formally, with a chair and formal roles for members. Others may be more loosely formed, especially if the group is small and the members know each other well.

Box 3.6

Working groups: proposed sequencing of work

1. Review the taxonomy: subheadings and possible key words.
2. Identify main issues and aspects for the working group report.
3. Formulate the identified issues in strength-weakness-opportunity-threat (SWOT; see Box 3.11) bullet points and discuss root causes and effects.
4. Identify key sources of information and assure their availability.
5. Verify if each of the identified aspects is evidence-based, and can be referenced.
6. Identify information and analysis gaps and search for complementary documentation.
7. Based on feedback, especially from other working groups and the Streams 1 and 2 focal points, revise the first SWOT version.
8. Start writing a concise working group report, with quotes and references.

Situation analysis report

Each working group must submit their individual thematic reports, which must then be consolidated into a final report. Writing the first draft of the report may be done jointly in a workshop format, but finalization of it will usually end up being the responsibility of a small group of people or an individual from the core team, or a hired (consultant) by the core team.

Each working group's report, as well as the final report, should summarize key issues and recent developments, relating them to the objectives and plans of the NHPSP. The most important strengths and weaknesses and their underlying causes – as well as determining factors – should be highlighted. The report should be well referenced, especially on issues which are contentious or heated in stakeholder debates. The working group thematic reports, which will go more in-depth onto the topic at hand, may be lengthier, but the final report should focus on a concise analysis and summarize the working group reports and address cross-cutting issues. For a sample outline of the situation analysis report, please see Box 3.7.

Box 3.7

Sample outline of a situation analysis report

- Table of Contents
- Executive summary
- Introduction/Background
- Objectives
- Methodology/Approach
- Limitations
- Team members/Coordination
- Findings (this can be divided by working group topics, strategic directions of the current NHPSP, cross-cutting topics, or any mix of the above; it can also potentially follow the WHO taxonomy)
- Discussion
- Conclusion
- Annex (list of documents reviewed, field visit reports, list of people interviewed, etc.)



3.5.2 Three streams of analysis

Three distinct streams should be examined by the situation analysis working groups: analysis of health data and measuring health sector performance; analysis of the implementation of sector activities and finances; and policy dialogue on the effectiveness of NHPSP activity areas.

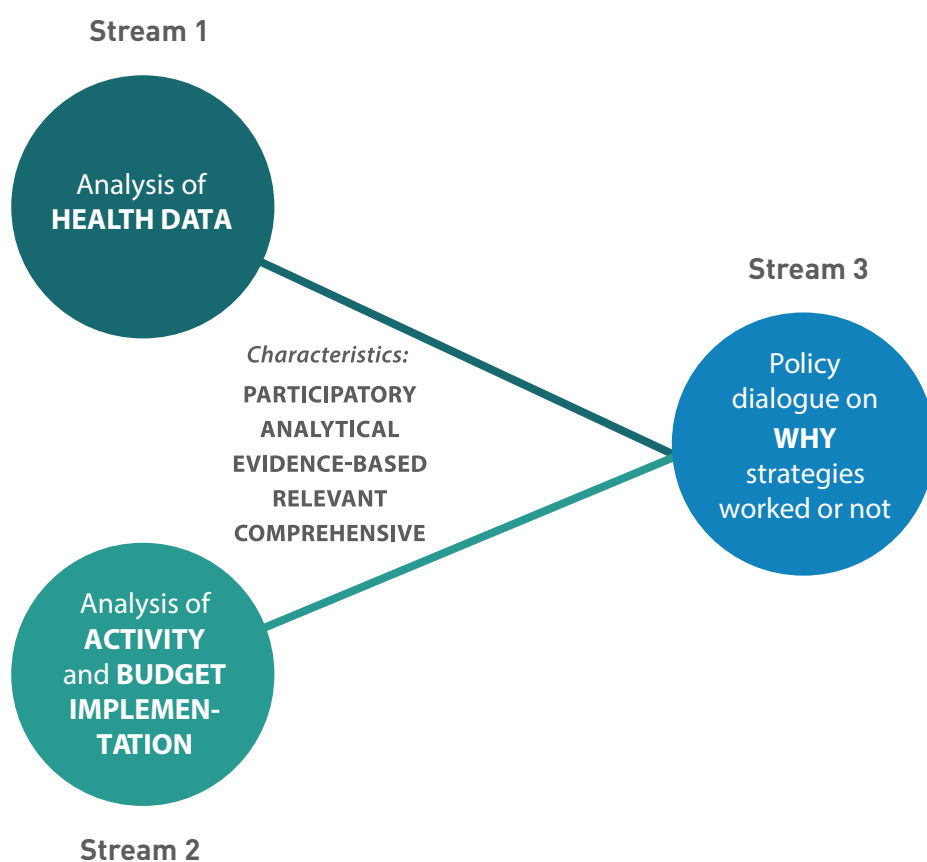
To ensure solid results, three distinct streams should be examined by the situation analysis working groups (see Fig. 3.1):

- (i) analysis of health data and measuring the performance of the health sector as per its indicators;
- (ii) analysis of the implementation of health sector activities, budgets and finances;
- (iii) analysis of the effectiveness of NHPSP activity areas: policy dialogue with a wider stakeholder group on the strengths and

weaknesses of the health system (health workforce, pharmaceuticals, health financing, service delivery, etc.) and health programmes (HIV, noncommunicable diseases, nutrition, maternal health, immunization, etc.), their causes and effects, and cross-cutting issues.

Ideally, a focal point or several people acting as a focal point group would be responsible for streams 1 and 2 respectively, liaising with all the working groups as needed.

Fig. 3.1 Three streams of work in a health sector situation analysis



(a) Stream 1: analysis of health data

An in-depth analysis and synthesis of all relevant health data is crucial to assess performance and better comprehend priority problems, main challenges, and urgent needs to be covered in the health sector. Beyond data sets that capture a snapshot of the health sector at a given time point, this step should try to elicit trends and developments over time, especially with regard to the major causes of morbidity and mortality in the country.

The health data analysis should be focused on the priority areas of the NHPSP if that is the objective of the situation analysis. In many countries, health sector indicators tend to focus on service delivery performance (output) and outcome, whereas very important, sometimes more qualitative, reform aspects are ignored (and not captured in a routine monitoring and evaluation system). Even if attainment of reform phases are used as a milestone indicator, the actual effects and impact of the reforms can be easily missed.

Similarly, the effects of unforeseen environmental changes (external to the health care system) sometimes need special attention. For example, unexpected large migrations due to civil unrest can overburden a health system and merit a specific evaluation; decentralization efforts can lead to an increase in the number of administrative districts, which often leads to an increase in the number of health districts. Targeted studies or targeted data/information gathered to evaluate these types of circumstances may be necessary.

Ensuring a wide variety of data types and data sets allows for critical triangulation between the different data and information to get a more complete and realistic picture of the health sector.

Box 3.8

What can a good data analysis report include?

It includes:

- ▶ assessment of progress against targets for key indicators (core NHPSP indicators, as well as additional programme specific indicators);
- ▶ equity analysis by key stratifiers;
- ▶ comparative analyses with peer countries;
- ▶ customer satisfaction surveys/health facility exit surveys;
- ▶ performance and efficiency analysis comparing inputs and outputs at the sub national level;
- ▶ computation of lives saved through interventions;
- ▶ data quality assessment.



First and foremost, existing data sets should be collected, analysed and synthesized, including primary data sets, reports of data collection efforts, existing reviews as well as published and grey literature. Here follows a (non-exhaustive) selection of key questions to ask and issues to appraise. Is data coverage complete, geographically and time-wise? Do existing indicators allow for a comprehensive analysis? Do the existing thematic reports and evaluations allow for a comprehensive analysis? Is there likelihood of contradicting information/data? If so, how can one clarify this? How reliable is the routine data? Should facility-based data be complemented with other sources, like exit surveys?

If a data gap has been identified, a country may choose to do additional surveys or research studies to close that gap (if time permits).

It is to be highlighted that a wealth of data and information may exist which have not been validated, or disseminated, or stored. The task of identifying and centralizing this documentation should not be underestimated: it takes considerable time and effort, but is of course a useful investment.



Box 3.9

Examples of data sources for health data analysis

1. National health plan
2. Population health surveys
 - ▶ Reproductive, maternal, neonatal child health and other issues: Demographic Health Surveys
 - ▶ HIV/AIDS: AIDS indicator surveys, sero-behavioural survey
 - ▶ Malaria indicator survey
 - ▶ National household survey
 - ▶ National service delivery surveys
 - ▶ Sub-national surveys
3. National health information system data, including trend data
4. Performance reports
 - ▶ Annual health statistics report
 - ▶ Annual health sector performance reports:
 - ▶ HIV/AIDS epidemiological surveillance reports
5. Facility assessments
 - ▶ Service Availability Readiness Assessment (SARA)
 - ▶ Client satisfaction surveys
6. Administrative data
 - ▶ Financing: National Health Accounts, progress reports on public sector management/finance reforms
 - ▶ Human resources: Human Resources Information System, professional council databases, training institutions records, progress reports on civil service reforms
 - ▶ Infrastructure: Health facility inventory, vehicle inventory, equipment inventory of health facilities (public)
7. Mortality and causes of death
 - ▶ Hospital reports, Health Management Information System (HMIS)
 - ▶ Maternal perinatal health review reports
8. Research/Evaluation studies
 - ▶ Health systems assessment
 - ▶ Programme evaluations – e.g. Malaria Programme review report
9. Data sets/documents from other ministries (planning, education, local government, finance, etc.)
10. Data sets/documents from civil society – reviews, analyses, evaluations, case studies, etc.

Often, due to time and resource constraints, health sector situation analyses draw heavily from internal, or government, documentation. These are usually data sets and documents which the MoH is familiar with and can easily access. It takes a concerted extra effort to go and find out about the existence of, and obtain, other non-sectoral, non-government material. A solid situation analysis, however, depends on this, since changes in health status are sometimes better explained by other “external” health determinants and activities in which the government may not be directly involved.

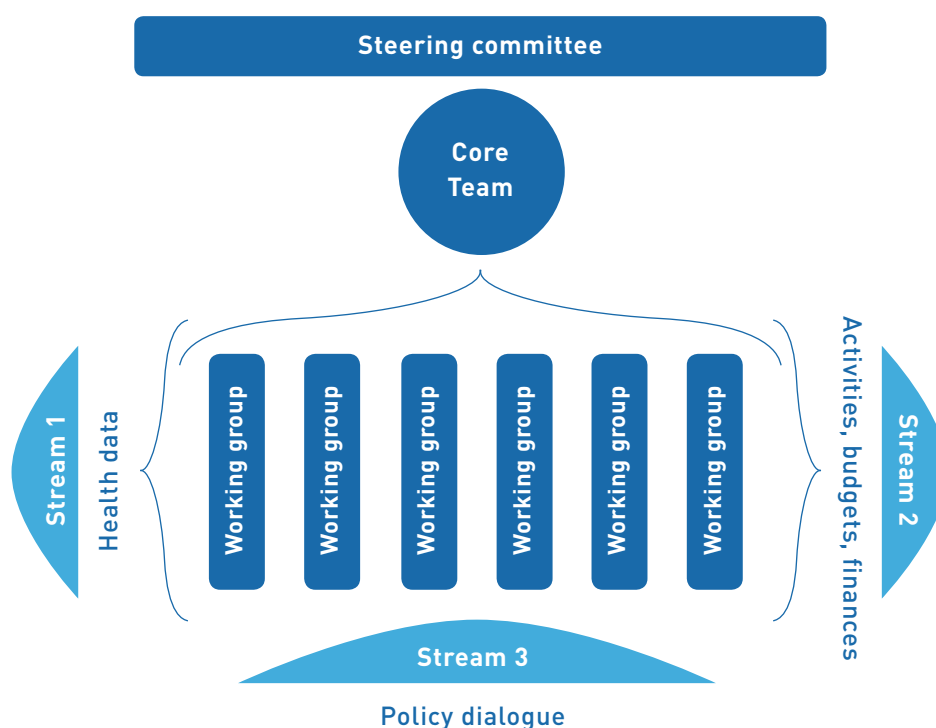


Normally, health data analysis is done largely by technical experts who are familiar with the data sets and/or who are trained to analyse data sets. For the interpretation of the data, it is important to collaborate with those who are familiar with health sector activities as well as non-technical experts (see below section 3.5.5).

The technical experts will most likely be the focal points for Stream 1 of the situation analysis. Since health data analysis is relevant and

cross-cutting across all working groups, these focal points will be liaising and working closely with all working groups (see Fig. 3.2) – this is the crucial link needed for understanding the numbers and making sense of the data. For the working groups, the input from the health data analysis will be indispensable for understanding if and how health status and indicators have evolved over the medium term and how it potentially correlates with activity implementation on the ground.

Fig. 3.2 Interaction between situation analysis working groups and streams



(b) Stream 2: Analysis of the implementation of health sector activities, budgets and finances

The analysis of the implementation of NHPSP activities should be organized around the budget and planning cycle: beginning with the costed NHPSP, the links to the actual health sector budget and health sector expenditures should be assessed. A study of the national health budget and sector finances should be undertaken to better understand whether budget formulation and implementation have adequately reflected the NHPSP objectives. In addition, an assessment of whether the NHPSP has been adequately funded, and if activities have been implemented as per plan, must take place. To this end, a review of public expenditure over the previous years will be necessary, along with an in-depth look at activity reports from districts. The analysis of the implementation of the health sector budget is a necessary link between performance and activity progress. It will be essential to link in with the health data analysis when reviewing clinical activities in health facilities and progress made on performance indicators – this linkage should happen at the level of the working groups, depending on the specific topic at hand.

Box 3.10

Examples of data sources for the analysis of activity, budget, and financial implementation

1. Activities

- ▶ National HMIS data
- ▶ Periodic activity reports from the different levels of various ministries involved in health sector activities
- ▶ Social audits
- ▶ District and regional sector review reports
- ▶ Donor mapping exercises

2. Finances

- ▶ NHPSP costing
- ▶ Ministry of finance reports
 - National health insurance or private insurance reports
- ▶ MoH administration and finance reports (including sub-national entities financial reports)
- ▶ Private sector reports
- ▶ National Health Accounts
- ▶ Public expenditure review
- ▶ External donors financial reports if relevant
- ▶ All other relevant reports, data, papers and grey materials from other ministries, partners, nongovernmental organizations, private sector, etc.



Usually, this type of analysis is done with a large range of mainly technical stakeholders, principally from the health sector but also, where necessary, with input from other sectors. The working groups will be responsible for a more in-depth interpretation of the data beyond the technical analysis, as will the work done in Stream 3.

(c) Stream 3: Analysis of the effectiveness of NHPSP activity areas through policy dialogue

Stream 3 is based on a policy dialogue on the strengths and weaknesses of the different elements of the health system and health programmes not only by technical experts, but also by service providers, representatives of the population and beneficiaries, national and international partners and CSOs.

This analysis aims at assessing and analyzing what works and what does not work in the health system as well as in programmes, sub-policies and strategies. It is based on a participatory assessment of strengths and weaknesses of the different elements of the health system and health programmes not only by technical experts, but also by service providers, representatives of the population and beneficiaries, national and international partners and CSOs. The key to this analysis is bringing together experts' views with non-technical opinions of community members who are using the health system on a day to day basis. Health strategies and plans should not be solely based on experts' views, but also on populations' perceptions, opinions, preferences and expectations – so as to help demand meet the supply of health services. Also, contextual issues play a key role in the success of NHPSP implementation – people's views and opinions can be decisive in putting the best-laid plans into context.^V

In principle, this step should take place after the two other streams, when the stakeholders have a better understanding of what works

well and less well through the Stream 1 (data and indicators performance assessment), and Stream 2 (has the implementation taken place as per planned activities and budgets?). Stream 3's objective is to collectively assess if the strategic directions and activity areas adopted have indeed led to expected results, to examine strengths and weaknesses, and deliberate on whether a change in strategies should be recommended to reach higher levels of effectiveness.

Moreover, policy-making is clearly a highly-political process and decisions are rarely done on the sole basis of objective reasons. Consulting population representatives is a critical means to involve them in the political decision-making process in order to avoid a bias in the situation analysis towards the point of view of policy-makers, or any other minority or elite group, only. A situation analysis should go beyond the descriptive stage to where stakeholders can draw adequate lessons from the past. The identified weaknesses and threats should not be a mere repetition of what had been found already in earlier analyses; instead, a serious effort is necessary to learn why an improvement has not, or insufficiently, taken place in order to be able to rectify the issue at hand.

In practice, the Stream 3, fed by Stream 1 and Stream 2 assessments, is organized following the Strengths-Weakness-Opportunities-Threats (SWOT) approach (see Box 3.11). The exercise requires the organization of working groups that will review the different health topics using the SWOT terminology and ultimately assess the overall health sector strategy. The final product will consist in a set of conclusions and recommendations.

^V Please also see Chapter 2 of this handbook, "Population consultation on needs and expectations".

Box 3.11

SWOT analysis

SWOT (strengths, weaknesses, opportunities, threats) analysis is a popular method used to compare internal capabilities, in the form of strengths and weaknesses, to external developments, in the form of opportunities or threats. A SWOT analysis can provide a strong and broad base for NHPSP situation analysis and sets the stage for strategic planning, especially because of its unique ability to illuminate new strategic options via evaluating the balance between internal and external factors.¹⁷

SWOT analysis in its most basic form can be broken down into four steps. The first step is the collection and evaluation of key data and information, including but not limited to population demographics, sources of

health-care funding or the status of medical technology. Step 2 is to sort data into the four key categories, where strengths and weaknesses typically stem from internal organizational factors and opportunities and threats from external factors. The following table demonstrates how these four categories are defined and sorted.

The third step involves development of a SWOT matrix that compares different alternatives for consideration following an in-depth data analysis. The fourth step incorporates SWOT analysis into the broader situation analysis and decision-making process. Ideally, SWOT-analysis also includes a comprehensive literature search and qualitative input from stakeholders and sector experts.

Examples of SWOT-analysis factors:¹⁸

| | DEFINITION | EXAMPLES |
|--------------------------|--|--|
| S (strengths) | Factors that have stimulated strong sector performance | State-of-the-art medical equipment, investments in health-care informatics |
| W (weaknesses) | Factors that increase health-care costs or reduce healthcare quality | Ageing health care facilities, lack of standard clinical practices, duplication of programs |
| O (opportunities) | New initiatives and areas of growth available to the health sector | New development partners for health-care programmes, introduction of standard clinical protocols, increased sector funding |
| T (threats) | Factors that negatively affect sector performance | Political or economic instability, funding deficits, growing uninsured population |



3.5.3 How long does a truly participatory situation analysis approximately take?

A truly participatory and inclusive situation analysis will take at least 3-5 months, ensuring adequate time for real policy dialogue.

From start to finish, a truly participatory and inclusive situation analysis, with adequate room for real policy dialogue, will take approximately 3–5 months at least. Most working group members will do this work in parallel with their routine duties. If it is possible to free up stakeholders' schedules from their more routine duties, the situation analysis could be considerably faster. On the other hand, if they are overburdened with too many other tasks, it could take longer as well. In addition, if the participatory approach and methodology are new, time will be needed to explain, clarify and justify it.

Please note that some of the working groups will engage separately with the Stream 1 and 2 focal points. The workload for the three streams will overlap in time so they are not explicitly mentioned in the approximate timeline.

The proposed timeline also assumes that all data and information is available and needs to be found and brought into one place. If collecting additional data is considered indispensable, the necessary time for integrating the results of such small surveys/studies is additional. Also, if heavy input from sub-national levels is deemed necessary, it may require a longer timeline.

Fig. 3.3 Example of a timeline of situation analysis activities

| Activities/ Time Frame | Month 1 / Weeks | | | | Month 2 / Weeks | | | | Month 3 / Weeks | | | | Month 4 / Weeks | | | | Month 5 / Weeks | | | |
|--|-----------------|---|---|---|-----------------|---|---|---|-----------------|---|---|---|-----------------|---|---|---|-----------------|---|---|---|
| | 1 | 2 | 3 | 4 | 1 | 2 | 3 | 4 | 1 | 2 | 3 | 4 | 1 | 2 | 3 | 4 | 1 | 2 | 3 | 4 |
| Inception phase (3 days) -- meeting of all working groups + stream 1 and 2 focal points to discuss content delineation, report structure, modus operandi | | | | | | | | | | | | | | | | | | | | |
| Working group sessions: start content development, discuss specifics of working group organization and work schedule | | | | | | | | | | | | | | | | | | | | |
| Groups meet to examine initial evidence and interview key stakeholders. Streams 1 and 2 focal points liaise with all groups | | | | | | | | | | | | | | | | | | | | |
| 1st version feedback with all groups (1 day) | | | | | | | | | | | | | | | | | | | | |
| Groups meet individually, potentially do field visits, continue content development. | | | | | | | | | | | | | | | | | | | | |
| Feedback from core team and concerned department heads | | | | | | | | | | | | | | | | | | | | |
| Workshop with all groups for peer-review of reports (2 days) | | | | | | | | | | | | | | | | | | | | |
| Re-work reports based on workshop feedback | | | | | | | | | | | | | | | | | | | | |
| Each group meets with steering committee for feedback | | | | | | | | | | | | | | | | | | | | |
| Groups write pre-final version of reports | | | | | | | | | | | | | | | | | | | | |
| Core team does compilation and last corrections | | | | | | | | | | | | | | | | | | | | |
| MoH approves pre-final version | | | | | | | | | | | | | | | | | | | | |
| Stream 3: policy dialogue workshop with wide stakeholder group on pre-final version | | | | | | | | | | | | | | | | | | | | |
| Editing final version situation analysis report | | | | | | | | | | | | | | | | | | | | |
| MoH endorses the report and disseminates / publishes | | | | | | | | | | | | | | | | | | | | |

3.5.4 Link between Streams 2 and 3

In Stream 2, the core team's Stream 2 focal point(s) have the main responsibility for the centralization and validation of all progress and financial reports, audits and evaluations. The main challenge is to:

- ▶ centralize plans, data and reports (financial and implementation) from various levels and actors;
- ▶ appraise reliability, identify gaps, contradictions, overlaps;
- ▶ assist working groups to synthesize data and capture the essence in concise tables and graphs;
- ▶ assist working groups to extract key issues from reports (progress, evaluations, surveys);
- ▶ assist working groups to comment on features, trends, unexpected developments.

It is vital that the Stream 2 focal point(s) work with and across all working groups, as activity implementation and activity expenditure needs to be adequately examined and analyzed on all health sector topics.

Stream 3 is a collective effort of the core team, working groups, the wider community of experts and the wider community of resource persons (the latter two are sometimes deemed "community of practice"). It involves engaging in real dialogue

with all stakeholders, including those with diverging or different views, including non-technicians and non-experts, to discuss, exchange, interpret and nuance the results coming out of the situation analysis working groups. Stream 3 draws from the results of the other streams, and takes place sequentially afterwards. In the analysis of overall strategic developments and reforms (Stream 3), it is necessary to have a good assessment of how activities and finances were implemented (Stream 2) (see Box 3.12).

For the analysis of overall strategic developments and reforms (Stream 3), it is necessary to have a good assessment of how activities and finances were implemented (Stream 2).

Box 3.12

Interconnection between the three streams: a hypothetical example from the area of medical equipment maintenance

Stream 1: An assessment of health service readiness revealed that in hospitals, 40% of the medical equipment was not operational and that in dispensaries, 50% of the latrines were out of order. Stream 1 focal points' discussions with the health technology working group revealed that many of the after-sales equipment needs as well as the preventive maintenance needs had not been addressed. Common reasons were: no universal reporting system, responsibilities not clearly attributed, non-availability of technicians and/or a functional workshop and budget insufficiency.

Stream 2: Of the planned activities and investments for strengthening the area of maintenance, only a limited number were implemented. While several regional workshops for maintenance of medical equipment were renovated or constructed, an insufficient number of new technicians and engineers

were trained. Moreover, several of them left for jobs in the private sector. The supply of spare parts remained erratic due to procedural and budgetary insufficiencies. Only few of the planned new public-private partnerships (for outsourced maintenance) were actually established.

Stream 3: Policy dialogue with the full range of health stakeholders, including facility-level managers and health workers, showed that, on the plus side, the new database for asset management facilitated the strategic shift to a more centralized system of maintenance for medical equipment. However, on the negative side, the lack of a health technology policy, medical equipment norms and standards and clear technical specifications for equipment standardization were all strong limiting factors for more efficient and needs-based procurement, supply and repair management.



3.5.5 Link between situation analysis and priority-setting

Priority-setting processes the recommendations and insights coming from the situation analysis and accords them a specific priority level.

As elaborated upon above, the health sector situation analysis process is where the health system's strengths, weaknesses, opportunities, and threats, including their root causes and effects, are analysed and debated upon among all relevant stakeholders. Of course, a discussion on what has worked well and less well is not completely disconnected from potential solutions and recommendations to overcome health sector challenges; thus those very suggestions, which have already been debated upon, discussed, and sorted through by a broad stakeholder base during the situation analysis, form the starting point for the priority-setting exercise. Priority-setting is where the recommendations and insights coming from the situation analysis are "processed" and examined in view of according them a specific priority level.

The analysis of the sector thus provides the foundation for priority-setting, and greatly determines the quality of priority-setting results. The challenges identified during the situation analysis process, and the debate around potential strategies to overcome those challenges, help make the best possible choices regarding the focus and distribution of means, in order to improve the performance and impact of the health system in an efficient and fair way. The choices made during the priority-setting process will profit from the quality of evidence and the quality of dialogue during the situation analysis

process – if one is sound, the likelihood is that the other will be, as well.

Those choices, or priorities, drive the decisions on the key goals and objectives of the health sector for a given period, and will be expressed in the NHPSP. So, in the context of strategizing for health, it is the identified important need from the situation analysis, and reflections on how this need can be addressed, which paves the way for the priority-setting process.

Normally, future challenges – such as an ageing population, climate change, or increasing health inequalities – are issues which will have emerged both during population consultations and a health sector situation analysis. During the priority-setting phase, the consequences of these expected eventualities will be contemplated. The process of setting priorities is the opportunity for policy-makers and health sector stakeholders to pre-empt foreseeable health problems raised during the situation analysis and ensure that their negative impact on health outcomes is mitigated.

Since priority-setting is a trade-off, and trade-offs are difficult, a robust reasoning and justification must be offered. The situation analysis, by examining challenges and possible solutions, is the knowledge base which provides this to health sector stakeholders and the population.

3.6 Some issues to consider

3.6.1 Factors of success

Success of a situation analysis is judged against its stated objectives. As mentioned previously, the objectives of a health sector situation analysis are:

- (a) to realistically assess the current health sector situation, with all its strengths, weaknesses, opportunities, and threats;
- (b) to provide an evidence-informed basis for formulating future strategic directions for the health sector;
- (c) to provide an evidence-informed basis for responding to real health sector needs of the population.

Accordingly, the main factors of success would be achieving each of the above objectives.

- ▶ The situation analysis adequately captures a broad range of the stakeholders' views and opinions in a balanced way. It would be especially useful if these views and opinions were formulated such that they could be easily converted into operational steps for future (or adjusting existing plans).
- ▶ More importantly, those very stakeholders have accepted, or "bought into", the situation analysis conclusions, even on controversial issues. It is important to note here that accepting conclusions is not equal to being

in agreement with them. If the situation analysis presents all major viewpoints in an unbiased way, throwing light on the pros and cons of the different perspectives, it can be seen as "balanced", which can then be accepted by all.

- ▶ In addition, the situation analysis can be seen as successfully undertaken if results are the drivers behind health sector priority-setting as well as embodied in the strategic directions of the health sector.

A successful situation analysis realistically assesses the current health sector situation, provides an evidence-informed basis for formulating future strategic directions for the health sector and for responding to a population's real health sector needs.



3.6.2 Dissemination of situation analysis results

Containing a wealth of information, the full situation analysis should be published, promoted, and distributed widely to guide stakeholders during the rest of the strategic planning process.

A situation analysis is in essence a very technical piece of work whose results and conclusions are relevant for the whole population. Therefore, a significant effort to translate the technical into simple population-friendly language is imperative. For that purpose a concise summary of the situation analysis can be written, with illustrations and graphs where necessary, which can be distributed in communities and at districts and regions. The concise summary should clearly highlight the principal challenges and trends, major issues of debate, possible solutions and reasoning. Using various forms of traditional and social media can be an effective way of communicating the key findings of the situation analysis. For example, partnering with the media and collaborating on disseminating

and simplifying messages has been used as a successful strategy in many countries.

The full situation analysis report is a wealth of information which should be published, promoted and distributed widely to guide the contributions of all stakeholders during the rest of the strategic planning process. Dissemination includes not just distribution of a hard-copy document; instead, it implies explaining the document to relevant communities and stakeholders, holding special meetings and presentations, making it available online, etc. In effect, it involves a whole communication strategy linked to the NHPSP as a whole, which might require additional resources to be budgeted.



3.7 What if...?

3.7.1 What if your country is decentralized?

A decentralized^{VI} setting requires looking more closely at a country's constitutional background and legal framework. If health is a mandate for a sub-national entity, the full health policy and planning cycle, from situation analysis to monitoring and evaluation will fall under that authority. In this case, close cooperation with other decentralized entities and/or a central authority may be necessary on topics that are not confined to one area or region.

A situation analysis at a regional/sub-national level has the distinct advantage of being closer to the reality of health services. This means that a bottom-up approach does not have very far to go to become translated into policy. This is to be taken advantage of, and efforts to disseminate and feedback results of a situation analysis to the population should be easier to undertake. Also, a decentralized system means that those spearheading the health sector situation analysis may have a better knowledge of local realities such as language and customs that can help tailor the situation analysis for maximum results and use in policy-making.

A sub-national health sector situation analysis will also be useful for central level policy- and decision-making, especially since national policies and plans need to include concerns and be adaptable to sub-national levels. More detailed information, data, and views from specific population groups or remote areas is extremely valuable when designing policies, setting priorities, and allocating resources. It can even merit national-level involvement in the sub-national process – and in some cases, other regional/sub-national levels whose concerns may overlap. A caveat for the national level is to ensure coherence and comparability among sub-national entities – without which it will be extremely difficult to draw more generalized conclusions for the rest of the country.

The table below gives an indication on issues to consider when undertaking a health sector situation analysis in a decentralized context, following the “factors of success” for a situation analysis in 3.6.1.

A situation analysis in a decentralized setting requires looking more closely at a country's constitutional background and legal framework to understand the authority of certain stakeholders and ensure cooperation between entities at various levels.

^{VI} This includes including political decentralization (federal system) as well as geographical decentralization (e.g. islands).



Table 3.5 Factors of success: situation analysis in a decentralized system

| DID WE DO A GOOD JOB ... | ... IN A DECENTRALIZED SYSTEM? |
|--|---|
| <p>1. The situation analysis adequately captures a broad range of the stakeholders' views and opinions in a balanced way</p> | <ul style="list-style-type: none"> ▶ Inclusiveness of national as well as sub-national levels in the design of the methodology is ensured even if the actual situation analysis may only be conducted at sub-national level. Both levels can benefit greatly from the situation analysis results and the cross-linkage between the two. ▶ Stakeholders which only exist at sub-national (e.g. state MoH, grass-root organizations, professional associations), or only at national level (e.g. federal MoH, parliamentary groups, ministries of finance and planning, professional associations) are informed and adequately included where useful and necessary. For example, the central/federal MoH should especially be included (potentially in large numbers) in a sub-national situation analysis if a new national health plan is being drafted – input from sub-national level is crucial for this. ▶ All types of stakeholders, even those with diametrically opposing views, have been included and involved and a balanced outlook is presented in the situation analysis report. Please note that this is not specific to a decentralized system; however, it may be even more difficult to present a balanced viewpoint in a localized system where the actors know and interact with each other more closely. |
| <p>2. And more importantly, if those very stakeholders have accepted, or “bought into”, the situation analysis conclusions, even on controversial issues.</p> | <ul style="list-style-type: none"> ▶ Stakeholders who were less present or engaged before have an increasingly active role in policy formulation and implementation. ▶ Roles and responsibilities for NHPSP implementation between national and sub-national levels, and between stakeholders, have been clarified. ▶ National and sub-national levels are adequately represented during the preparation and follow-up of the situation analysis. ▶ Especially more marginalized stakeholder groups have a clear role in and accept the conclusions of the health sector situation analysis. |
| <p>3. In addition, if the situation analysis results are the drivers behind health sector priority setting as well as embodied in the strategic directions of the health sector, it can be seen as successfully undertaken.</p> | <ul style="list-style-type: none"> ▶ The results of the situation analysis were made available to all concerned levels. ▶ Priorities which were raised in sub-national situation analyses can be found in local district/regional operational plans as well as the strategic and/or operational plans at national level. ▶ Follow-up to the results should be demonstrated by national as well as sub-national levels – with a clear understanding of which level will be responsible for implementation of the follow-up plan. |

3.7.2 What if fragmentation and/or fragility is an issue in your country?

Fragility refers to a country that includes certain areas of limited statehood, “where the state does not have the administrative capacity (either material or institutional) to exercise effective control over activities within its own borders”.¹⁹

When the state does not have effective administrative capacity, its governance and steering capacities are also severely hampered. This can lead to various stakeholders in the health sector working in an uncoordinated way with duplications in procedures, funding streams, and parallel institutions. In this context, a stronger emphasis must be placed on strengthening coordination for planning, funding, and implementation. A joint situation analysis with a comprehensive and solid stakeholder input, bought into by all, can be a very good start.

Especially in post-crisis settings, there is often a tension between those desiring to do a rapid situation assessment with a humanitarian aid focus and those wanting to ensure an overarching policy framework based on a more comprehensive situation analysis to prevent further fragmentation and verticalization. It is key here to enter into dialogue with actors on both sides to come to a common understanding; without it, any situation analysis work, where all stakeholders’ input is necessary, will be difficult. In reality, much of the situation analysis itself will be conducted by these very stakeholders anyway, which renders the dialogue beforehand even more critical.

Logistical issues can pose a particularly difficult challenge in a fragile setting and can put into question the feasibility of the exercise in the first place. These issues must be carefully considered with all relevant stakeholders before coming to a decision.

Despite the myriad problems associated with conducting a situation analysis in a fragile setting, this exercise can actually be a huge opportunity to gauge what the new status quo of the health sector is after a difficult conflict/struggle/natural disaster/revolution. It can be the start of gathering relevant information to introduce reforms that may have been necessary before the fragile situation began but were unlikely to go through. It can be seen as the beginning of a clean slate to rebuild the health sector to a state that will be better than it was before.

1. *The situation analysis adequately captures a broad range of the stakeholders’ views and opinions in a balanced way*

In a fragile or fragmented context, where steering capacity is diffused and held by those with the most money or power, getting a balanced view on the health sector situation is a challenge. It is all the more important to spend time and effort to build MoH governance capacity in targeted areas as quickly as possible so that it can adequately take on its lead role in ensuring a balanced situation analysis. Development partners can play their part by participating and giving input into a situation analysis exercise, and aligning with the MoH agenda.

2. *And more importantly, if those very stakeholders have accepted, or “bought into”, the situation analysis conclusions, even on controversial issues.*

In fragile, post-conflict, or post-emergency settings, a situation analysis will be largely conducted by those involved in emergency relief as well as health sector development professionals. Often, there is a tension between the two groups due to differing views on the



In an aid-dependent context, a situation analysis should be used as an opportunity to rally donors and aid agencies around the same priorities.

objectives and scope of a situation analysis – short-term data and information to feed into humanitarian aid planning, or more in-depth longer-term trends, taking into account the recent or current emergency, for longer-term health system development? Managing this tension will not be easy but the measure of success will be if both sides have truly accepted the situation analysis conclusions.

It is important to note here that accepting conclusions is not equal to being in agreement with them. If the situation analysis presents all major viewpoints in an unbiased way, throwing light on the pros and cons of the different perspectives, it can be seen as “balanced” which can then be accepted by all. A good way of assuring a balanced view of a subject in a fragile setting is to actively ensure the meaningful participation and representation of both types of stakeholders into the analysis, even if it might mean that debates and discussions are particularly heated or even conflictual. The conclusions may present the majority view but should take into account other views as well.

3. In addition, if the *situation analysis results are the drivers behind health sector priority setting as well as embodied in the strategic directions of the health sector*, it can be seen as successfully undertaken.

As mentioned in previous chapters, the disconnect between existing policies and plans and realities on the ground is particularly high in fragile settings. A well-done and well-balanced situation analysis can help address this deficiency and support the priority-setting process in a constructive yet realistic way. A direct link between the situation analysis results and the core set priorities in any health sector reform/health sector plan is particularly imperative here.

3.7.3 What if your country is highly dependent on aid?

A country that heavily depends on external aid might also be dependent on external funding and expertise to conduct the situation analysis in the first place. This could imply undue influence of those who are funding or providing expertise. Unless government stewardship is strong, the situation analysis might end up reflecting external – rather than domestic – priorities or vision. External priorities might imply that certain programmes or project topics receive more prominence than necessary in the situation analysis. It can be a vicious cycle where the situation analysis results find themselves in the national health plan with the same priorities, which are not really the ones the government would like to focus on.

A situation analysis in an aid-dependent context should rather be seen and used as an opportunity to rally donors and aid agencies around the same priorities. If the situation analysis is done correctly with a balanced vision of the strengths and weaknesses of the health system, key problems can be collectively addressed and priorities given funding by donors. A well-done situation analysis could raise the credibility of the MoH and government and give donors confidence to support activities that have been deemed important by the situation analysis.

Table 3.6 Factors of success: situation analysis in an aid-dependent context

| WHEN UNDERTAKING A SITUATION ANALYSIS... | ... THIS IS WHAT WE NEED TO CONSIDER ADDITIONALLY IF OUR COUNTRY IS HEAVILY DEPENDING ON EXTERNAL AID |
|--|--|
| <p>1. The situation analysis adequately captures a broad range of the stakeholders' views and opinions in a balanced way</p> | <ul style="list-style-type: none"> ▶ When setting up the methods and deciding on who to be involved (stakeholders), it is important to explicitly recognize and ensure that every stakeholder is considered equally; a categorical effort should be made to create a sense of joint commitment and collective benefit to all. Keep in mind that often, those stakeholders who provide funding (donors) may be perceived as more important than others. The big risk here is the tacit establishment of a certain hierarchy of stakeholders which can create tension, resentment and frustration. The consequences can include the withdrawal of some stakeholders, from the process altogether – with its accompanying loss of “champions” (and the evident possibility of negative propaganda) as well as a group of stakeholders (often donors) taking over the situation analysis to influence it in their own interests. ▶ Linked to the above, it is crucial to clarify in no uncertain terms the roles and responsibilities of each stakeholder, taking into account their respective added value. |
| <p>2. And more importantly, if those very stakeholders have accepted, or “bought into”, the situation analysis conclusions, even on controversial issues.</p> | <ul style="list-style-type: none"> ▶ Donor engagement in consultation processes might change the dynamics and reception, and the subsequent results, of the situation analysis. ▶ The technical team coordinating the situation analysis should make a specific effort to ensure that all stakeholders in a sensitive aid-dependent environment feel as if their matters have been adequately considered and its pros and cons weighed up. The aim of any situation analysis result is for it to be balanced and fair. |
| <p>3. In addition, if the situation analysis results are the drivers behind health sector priority-setting as well as embodied in the strategic directions of the health sector, it can be seen as successfully undertaken.</p> | <ul style="list-style-type: none"> ▶ In an aid-dependent context, it is especially vital to ensure that the results of the situation analysis are immediately translated into either an operational plan or a strategic plan while the momentum and dynamic is still in place. A long gap between the situation analysis and plan development will allow various actors to potentially intervene and influence the plan to their interests, thus creating a disparity between the situation analysis and the plan. ▶ Linked to the above, an adequate follow-up and monitoring body must be set up to see through the implementation of the situation analysis results. A fine balance must be found in enabling the right monitoring body, as it should be a high enough level for decision-making purposes but operational enough for day-to-day follow-up. ▶ Inadequate follow-up can lead to different interpretations of review results by different stakeholders – these varying interpretations may manifest themselves again in the country's health sector vision and priorities |



© Shutterstock

3.8 Conclusion

The strategic directions and the principal orientation of a NHPSP must be firmly grounded in an analysis of the current state of the health sector. A situation analysis helps to provide an evidence-informed basis for the NHPSP strategic directions to respond to real health sector needs of the population. In this chapter, the situation analysis methodology proposed is one that adequately captures not only expert analysis but also stakeholder input that actively includes citizens' voices and population demand.

A situation analysis of the health sector should ideally feed directly into the priority-setting process, as it is the knowledge base for health challenges, potential solutions, what has worked well in the past and what has not. However, regardless of whether it is technically undertaken by external parties or not, the lead and overall coordination should be provided by the MoH.

A health sector situation analysis is a crucial step in the health policy and planning cycle. It is a key platform to give voice to stakeholders in order to obtain their buy-in for better policy design and implementation, and ensure mutual accountability between them.

Methodologically, a situation analysis should include an analysis of health system performance and an analysis of the implementation of health sector activities, budgets and finances. These should then be brought into an overarching policy

dialogue on strengths and weaknesses of health system components and health programmes as well as cross-cutting health topics that bring expert views and end user/community opinion together.

A situation analysis should be participatory and inclusive, comprehensive and analytical in nature. This last point is to be emphasized as it is easy to stop at a *description* of the health sector status quo (already useful in and of itself) and not delve adequately enough into the root causes and comprehension of *why* certain activities or programmes worked well or less well. But precisely understanding the root causes and effects will help lead to finding longer-term sustainable solutions or scale-ups.

A situation analysis can be judged as successful if it adequately captures a broad range of the stakeholders' views and opinions in a balanced way; if those very stakeholders have accepted, or "bought into", the situation analysis conclusions; and if the situation analysis results are the drivers behind health sector priority-setting and the strategic directions of the health sector.

Finally, if your country has particular specificities such as a decentralized setting, a distressed health context, or is highly aid-dependent, there may be unique issues to heed when conducting a situation analysis, as has been elaborated upon in this chapter.



References

- 1 Situation analysis and priority setting. In: National health policies, strategies and plans [website] Geneva: WHO; 2016 (<http://www.who.int/nationalpolicies/processes/priorities/en/>, accessed 13 October 2016).
- 2 Berman P, Bitran R. Health systems analysis for better health system strengthening. Washington [DC]: World Bank; 2011 (HNP Discussion Paper; <http://siteresources.worldbank.org/HEALTHNUTRITIONAND-POPULATION/Resources/281627-1095698140167/HealthSystemsAnalysisForBetterHealthSysStrengthening.pdf>, accessed 13 October 2016).
- 3 Adapted from: Ibid.
- 4 Jaffré Y, Olivier de Sardan JP. Une médecine inhospitalière. Les difficiles relations entre soignants et soignés dans cinq capitales d'Afrique de l'Ouest. Paris: Apad Karthala; 2003.
- 5 Brugha R, Varvasovsky Z. Stakeholder analysis: a review. *Health Policy Plan.* 2000;15(3):239–46 (<http://heapol.oxfordjournals.org/content/15/3/239.long>, accessed 13 October 2016).
- 6 Schmeer K. Guidelines for conducting a stakeholder analysis. Bethesda (MD): Partnerships for Health Reform, Abt Associates Inc.; 1999 (Health Reform Tools Series; <http://www.phrplus.org/Pubs/hts3.pdf>, accessed 13 October 2016).
- 7 Ibid.
- 8 Brugha R, Varvasovsky Z. Stakeholder analysis: a review. *Health Policy Plan.* 2000;15(3):239–46 (<http://heapol.oxfordjournals.org/content/15/3/239.long>, accessed 13 October 2016).
- 9 Thow AM. Stakeholder analysis for health policy research. Sydney Health Policy Network and Qualitative Health Research Collaboration Forum; May 2013 (<http://sydney.edu.au/health-policy-network/news-events/Thow.pdf>, accessed 13 October 2016).
- 10 Mills A, Brugha R, Hanson K, McPake B. What can be done about the private health sector in low-income countries? *Bull World Health Organ.* 2002;80(4):325–30 ([http://apps.who.int/bulletin/archives/80\(4\)325.pdf](http://apps.who.int/bulletin/archives/80(4)325.pdf), accessed 13 October 2016).
- 11 CHPP taxonomy can be found at healthsituation.org [registration required]. See: CHIP annotated table of content. Second draft. October 2, 2009.
- 12 Health system reviews (HiT series). In: European Observatory on Health Systems and Policies [website] Copenhagen: WHO Regional Office for Europe (<http://www.euro.who.int/en/about-us/partners/observatory/publications/health-system-reviews-hits>, accessed 7 October 2016).
- 13 Health system assessment approach: a how-to manual. Bethesda (MD): Abt Associates Inc.; 2008 (Health Systems 20/20 Brief; http://healthsystemassessment.org/wp-content/uploads/2015/03/Health-Systems-Assessment-Approach-How-To-Manual_Brief.pdf, accessed 13 October 2016).
- 14 Health financing for universal coverage: health systems financing review. Geneva: WHO; 2016 (http://www.who.int/health_financing/tools/systems_review/en/, accessed 13 October 2016).
- 15 Human Resources for Health Toolkit. Global Health Workforce Alliance. [website] Geneva: WHO; 2016 (<http://www.who.int/workforcealliance/knowledge/toolkit/hrhtoolkitpurposepages/en/index3.html>, accessed 13 October 2016).
- 16 World Health Organization: Everybody's business: strengthening health systems to improve health outcomes. WHO's Framework for Action. 2007, Geneva: World Health Organization, (http://www.who.int/healthsystems/strategy/everybodys_business.pdf, accessed 16 October 2016)
- 17 van Wijngaarden JD, Scholten GR, van Wijk KP. Strategic analysis for health care organizations: the suitability of the SWOT-analysis. *Int J Health Plann Manage.* 2010;27(1): 34–49 (<http://onlinelibrary.wiley.com/doi/10.1002/hpm.1032/full>, accessed 13 October 2016).
- 18 Harrison JP. Chapter 5: Strategic planning and SWOT analysis. In: Harrison JP. *Essentials of strategic planning in healthcare*. Chicago (IL): Health Administration Press; 2010 (http://www.ache.org/pdf/secure/gifts/Harrison_Chapter5.pdf, accessed 13 October, 2016).
- 19 Krasner SD, Risse T. External actors, state-building, and service provision in areas of limited statehood: introduction. *Governance.* 2014;27(4): 545–67.

Further reading

Berman P, Bitran R. Health systems analysis for better health system strengthening. Washington (DC): World Bank; 2011 (HNP Discussion Paper; <http://siteresources.worldbank.org/HEALTHNUTRITIONANDPOPULATION/Resources/281627-1095698140167/HealthSystemsAnalysisForBetterHealthSysStrengthening.pdf>, accessed 13 October 2016).

Harrison JP. Chapter 5: Strategic planning and SWOT analysis. In: Harrison JP. Essentials of strategic planning in healthcare. Chicago (IL): Health Administration Press; 2010 (http://www.ache.org/pdf/secure/gifts/Harrison_Chapter5.pdf, accessed 13 October, 2016).

Health system assessment approach: a how-to manual. Bethesda (MD): Abt Associates Inc.; 2008 (Health Systems 20/20 Brief; http://healthsystemassessment.org/wp-content/uploads/2015/03/Health-Systems-Assessment-Approach-How-To-Manual_Brief.pdf, accessed 13 October 2016).





