World Health Organization

CASE STUDIES

Applying a PHC Lens to Global Health Initiative Proposals and Health Program Design

PHC-GHI Toolbox

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INTRODUCTION

Primary Health Care (PHC) / Global Health Initiative (GHI) Case Studies

The following set of case studies were developed in 2021 and 2022 for inclusion in the PHC-GHI Toolbox. The case studies are designed to provide examples of how PHC concepts, strategies and investments can be applied for PHC and GHI program design in different country settings. The case studies were either derived from existing WHO publications or were developed through consultations with WHO headquarter technical leads and the GHI Task Team, and with Regional Levels and GHI project advisers in different countries. Regional advisers from the Eastern Mediterranean Region of WHO also provided substantial input to product developments.

The case studies follow a similar two-page format of main objectives and activities and lessons learned for useful practices, as well as links to specific references for follow up information, and are organized by the levers of the PHC Operational Framework. This document also provides a template for development of case studies in other countries and regions [Refer to PHC Toolbox Data Base and User Guide]. A summary of the case studies is included below, after which a two-page description of each of the case studies follows, with links to the main case study resources for further information.

SUMMARY LIST OF CASE STUDIES

No.	PHC Operational Framework Lever	Case Study Title	Case Study Description
1	Political Commitment	A profile of Health Law in relation to Universal Health Coverage in Kenya	Describes the main findings of a Health and Law profile in Kenya. It covers legal recognition of access rights to essential health services, medicines, and vaccines in the context of implementation and access barriers.
2	Funding and Allocation of Resources	A cross-programmatic efficiency analysis in Ghana	Describes a cross-programmatic efficiency analysis in Ghana that was conducted to identify and analyse critical areas of functional overlap, misalignment, or duplication across the country's tuberculosis (TB), HIV/AIDS, malaria, EPI, and MNCAH programmes
3	Funding and Allocation of Resources	Applying PHC framework to GHI support to strengthen budget planning and formulation using example of C19 vaccine introduction	Explores Budget planning and formulation, using example of C19 vaccines. PFM becomes highly relevant as it supports the last mile distribution of a predominantly publicly funded and managed public good.
4	Funding and Allocation of Resources	Applying PHC framework to GHI support to strengthen budget execution using example of C19 vaccine introduction	This case study explores Budget execution and spending modalities using example of C19 Vaccine Introduction and indicates that indicates that PFM bottlenecks, regularly encountered in the health sector during normal times, are also affecting COVID-19 vaccination plans.

No.	PHC Operational Framework Lever	Case Study Title	Case Study Description
5	Funding and Allocation of Resources	Applying PHC framework to GHI support: Example of Public Financial Management (PFM)	This case study explores Expenditure tracking and accountability using example of C19 Vaccine Introduction
6	Governance & Policy	Applying PHC framework to "Health-in-All" policies in China, Thailand, Zambia and Sudan	Highlights the range of applications and processes of Health in all Policies (HiAP) from China, Thailand, Zambia, and Sudan.
7	Governance & Policy	Establishment of an effective Coordination Mechanisms for Global Fund Grants in Georgia	Describes the level of CCM alignment and integration with government processes and systems.
8	Governance & Policy	Building capacity to manage health system strengthening donor funding through Ministry of Health and Global Fund investments in Kenya	Describes how Kenya implementers worked with the Global Fund Country Team during grant-making to propose a responsible entity at the Ministry of Health tasked to coordinate implementation of RSSH interventions
9	Governance & Policy	Leadership, Management and Coordination at Sub-National Level (Decentralization) in Ethiopia	Supporting leadership, management and coordination functions at regional level to improve data use for decision making and supervision in immunisation

No.	PHC Operational Framework Lever	Case Study Title	Case Study Description
10	Engagement of communities and other stakeholders	Development of community engagement mechanisms for PHC in India and Madagascar	Presents different case studies to reflect on platforms for direct population engagement, engagement mechanisms at community level, and engagement with civil society organizations (CSOs).
11	Models of Care	Models of integrated communicable disease screening in Georgia	Describes introduce a system of integrated screening services for eliminating hepatitis C and controlling the HIV and TB epidemics.
12	Models of Care	Immunisation and Health Services Integration in Malawi	Describes evaluation of a model of services integration in primary care in Malawi and identifies enablers and challenges for quality and coverage of service integration.
13	Models of Care	Health Service Integration in Senegal	Describes design features, challenges, success factors and M & E requirements for integration of primary care package of services in Senegal
14	Models of Care	Piloting and scale up of integration of hygiene communication and immunisation in Nepal	Describes steps towards development of an integration pilot of immunization and health promotion in Nepal, including research, development and evaluation stages that culminated in national scale up of the approach.

No.	PHC Operational Framework Lever	Case Study Title	Case Study Description
15	Purchasing & Payment Systems	Applying PHC frameworks to GHI support of Strategic Purchasing	Summarizes the key purchasing instruments that could help countries make their purchasing more strategic for UHC
16	Engagement with Private Sector providers	Public Private Partnerships for Immunization Services in the Sudan	Describes the rationale, policy and regulatory actions and lessons learned from government collaborations with private providers (both non-profit and for profit) in expanding immunization coverage and equity.
17	Engagement with Private Sector providers	Engagement with private sector providers in 5 countries	Describes approaches from countries on actions taken to engage the private sector around PHC
18	Digital technologies for health	Use of mHealth Technologies for Vital Registration and Health Information Reporting in Uganda	Describes how mobile technologies are being used in Uganda to report birth and deaths and weekly reporting and surveillance information. Discussed in context of development of a national eHealth Strategy.
19	PHC Oriented Research	Implementation of Embedded Research initiatives to address barriers to immunisation in Pakistan	Describes the main characteristics and implementation steps in an embedded implementation research approach

No.	PHC Operational Framework Lever	Case Study Title	Case Study Description
20	Quality of Care Systems	Applying PHC framework to systems for improving Quality of Care in Namibia	Describes the national quality policy and its accompanying strategic plan. This work builds on a long history of quality improvement within Namibia's HIV programme.
21	Quality of Care Systems	Improving quality of care through integration of ANC and PNC in Health Care Facilities in Togo	Describes applied interventions aimed at strengthening capacity of healthcare providers to improve quality and integration of ANC and PNC in Health Care Facilities in Togo.
22	Medicines & Other Products	A global coalition to support and build capacity of health supply chain leaders and managers	Describes the initiative of a global coalition to develop capacity of health supply chain managers and leaders.
23	Health Workforce	Human Resources for Health Planning in Ethiopia	Describes a political economy analysis of HRH in Ethiopia, and the strategies adopted by that country to support scale of health workforce densities.
24	Health Workforce	Multidisciplinary Health Workforce for community-based care in Thailand	Describes the operations of multidisciplinary health care teams and community-based care givers to provide coordinated care at community level in Thailand

No.	PHC Operational Framework Lever	Case Study Title	Case Study Description
25	Health Infrastructure	Rapid Assessment of Primary Care Health Infrastructure in Tanzania	Describes the methods and lessons learned from application of a rapid assessment methodology to assess seven components of primary care infrastructure in Tanzania
26	Monitoring and Evaluation	Health Profiles of the Urban Poor in 10 Cities of Pakistan	Describes methods and results of using urban health profiles and coverage surveys to quantify scale of unreached populations, availability of health services, and reasons for non uptake of vaccinations in 10 cities.
27	Engagement of communities and other stakeholders; Governance and policy	Community dialogues to identify health needs and priorities in Sudan	Describes methods and outcomes of process of community dialogues for identify health needs and priorities in remote and conflict affected populations in Sudan.

Case Study 1

Example of Legal Access to Health Care in Kenya

Country or Region	**Global Health Initiative**
Kenya	All GHIs and Development Partners

PHC Operational Framework lever

Political Commitment, Governance & Policy

Context

Kenya has developed a long-term development strategy for economic, social, and political planning. Along with food security, manufacturing, and affordable housing, the achievement of Universal Health Coverage by 2022 is one of the "Big Four Agenda" development priorities of the country. Kenya's National Health Policy 2014-2030 includes a provision of essential health services s as a key objective. In addition to frontline medical services, the essential care package incorporates disaster risk management, non-communicable disease prevention and other preventive and promotive services and nutrition. The question therefore arises as to how the constitutional, legal, and rights-based declarations ensure legal access rights to essential health services are fulfilled.

What were the specific objectives/activities?

A Legal Access Rights to Health Care profile was undertaken by WHO in Kenya in 2019. This case study examines main findings of the profile with regards to legal recognition of access rights to essential health services, medicines, and vaccines as well as anti-discrimination provisions applicable to health care. The Profile also examined implementation and access barriers in the Kenya context.

The Legal Access to Health Care Profile was undertaken through review of key national documents and declarations including the Constitution of Kenya, the Health Act, Health Policies on UHC, the National Health Insurance Fund Act and Anti-Discrimination provisions applicable to health care.

Main legal and rights-based instruments reviewed include the following:

> **The Constitution of Kenya** stipulated that every person has the right to health care services. The constitution also stipulates rights to reasonable standards of sanitation, adequate housing, clean and safe water and food and social security, and includes non-discrimination provisions for the protection of marginalized groups and other ethnicities or cultural groups.

The Health Act enshrines the Right to Health, including progressive access to promotive, preventive, curative, palliative, and rehabilitative care, including reproductive and emergency care. Based on the Health Act, everyone has the right to lodge a complaint about the way they have been treated.

Based on the National Hospital Insurance Fund Act, the National Hospital Insurance Fund (NHIF) provides social health Insurance to Kenyans in the formal and informal sector that defines an essential services package covered by the insurance system (including maternal and child health care, immunization, chronic disease management and preventive and promotive services). Anyone is eligible to join the national scheme who possesses Kenyan citizenship. Salaried persons pay contributions based on income, and self-employed and informal sector workers as well as retirees can purchase cover for a fixed monthly rate.

National anti-discrimination provisions and complaint mechanisms are enshrined in the Kenyan Constitution. There is a non-discrimination clause that protects from discrimination based on race, sex, pregnancy, marital status, health status, ethnic or social origin, color, age, disability, religion, conscience, belief, or language. Children's rights to health care (including nutrition and shelter) are stated along with the requirement of the State to support affirmative action programs for minorities. The Health Act also contains a non-discrimination clause to protect health care providers from discrimination based on the same factors outlined above in the Kenyan Constitution.

Ratification of International Rights Instruments by Kenya includes the ratification of the Convention on the Rights of the Child and on Economic, Social and Cultural Rights.

Key lessons learned, or useful practices

• Developing a legal access to health care profile enables policy makers, planners, and development agencies to be aware of their legal and rights-based obligations towards ensuring the fulfillment of the health care rights of the population.

• Developing a legal access to health care profile enables policy makers, planners, and development agencies to identify gaps in laws, declarations and policy instruments that have the potential to impact on the right to essential care for sectors of the population.

Examples of implementation and access barriers highlighted in the profile include:

• Lack of specification or accountability for development of a detailed procedure on a complaints process.

• The contracting model of the National Health Insurance scheme has multiple provider payment mechanisms and rates, meaning incentives to treat patients vary based on financial rewards.

- Undocumented migrants cannot enroll for insurance cover under the National Insurance Scheme and must pay out of pocket for care or seek care through non-government organizations.

- Undocumented migrants avoid health care due to mistrust of authorities and fear of deportation, stigma, language barriers and lack of health literacy.

- Although insurance has been increasingly rising, a significant proportion of the population is still not covered. Premiums are rising and insurance is biased heavily toward the formal sector. In 2017, although 83% of the population are employed in the informal sector, just 24% of the insurance membership were informal workers.

- Although the essential health care benefits package is comprehensive, access of beneficiaries is limited by non-availability of services and essential medicines at some locations.

- Identifying legal access to health care strengths, gaps and limitations provides policy makers, planners, and development partners the opportunity to design pro-equity and rights-based programs to fulfill   national and international legal and rights-based obligations on essential health services.

Acknowledgements and Links to relevant resources, references, expertise

Legal access rights to health care country profile: Kenya. Geneva: World Health Organization; 2019 (UHC law in practice).

Kenya Health Policy 2014–2030

Acknowledgment

We acknowledge the inputs of Katja Rohrer-Herold and Benjamin Rouffy-Ly in reviewing this case study.

Case Study 2

A cross-programmatic efficiency analysis in Ghana

Country or Region Ghana	**Global Health Initiative** All GHIs and Development Partners

PHC Operational Framework lever Funding and allocation of resources, PART A

Context

With Ghana's reclassification as a middle-income economy, support from GHIs such as Gavi, Global Fund, PEPFAR, as well as other bilateral donors will decline over the next five years. Limited fiscal space will also constrain the domestic capacity to fund these health services. With a constrained resource envelope and largely vertically designed and programme-specific service delivery architecture, the impact of declines in support from GHIs and partners will be felt acutely by disease programmers. Thus, diagnosing cross-programmatic efficiencies and identifying ways to overcome them is more important than ever.

What specific objectives/activities were funded?

A cross-programmatic efficiency analysis was conducted (2017 to identify and analyse critical areas of functional overlap, misalignment, or duplication across the country's tuberculosis (TB), HIV/AIDS, malaria, Expanded Programme on Immunizations (EPI), and Maternal, Newborn, Child, and Adolescent Health (MNCAH) programmes, and with the overall health system. The study was motivated both by a need for increased efficiency, as well as impending donor transitions.

Key lessons learned, that could be replicated in other countries eligible for GHI support

A "System-wide approach to analysing efficiency across health programmes" approach equips countries with a framework to identify and correct inefficiencies that compromise governments' ability to improve, or at the very least sustain, the delivery of priority health services. More specifically, the aim is to look across the array of health programmes that are part of each country's health system in order to detect "cross-programmatic" gaps, duplications, overlaps and misalignments. Once these have been identified, there is a foundation to address them through changes to specific aspects of how programmes are configured and operate within the context of a country's overall health system and strategy for Primary Health Care (PHC).

Five key findings are summarised below, with potential policy options underneath each to address the inefficiency:

1. Lack of coordination across institutions within the health sector.

There are multiple uncoordinated co-financing targets set by individual disease programmes (specifically HIV, TB, malaria, and EPI) in response to upcoming declines in donor support. This jeopardizes coverage gains made over the past decade as current fiscal space constraints make meeting these co-financing targets difficult.

Policy options include:

- Governance review of structure, roles, and responsibilities of health sector-related agencies to minimize duplications and overlaps in mandates

- Coherent and well-coordinated medium-term plan for budgeting will aid in sector-wide plan coordination

2. Heavy reliance on donor support and lack of general, non-programmatic funds.

There are multiple uncoordinated co-financing targets set by individual disease programmes (specifically HIV, TB, malaria, and EPI) in response to upcoming declines in donor support. This jeopardizes coverage gains made over the past decade as current fiscal space constraints make meeting these co-financing targets difficult.

Policy options include:

- Redirect funds for HIV/TB personal services into the national health insurance fund (NHIF) or establish system for these funds to go directly to facilities as part of an essential services package, while maintaining core public health functions at programme level

- Implement a coordinated approach around donor transition and sustainability practices (e.g. funding flows analysis)

- Provide and allow for greater regional/district autonomy and discretion to allocate funds

- Review of health financing strategy to implement previously accepted plans

3. Duplication and lack of coordination of services across levels of care.

There is a complex delivery structure leading to overlap between multiple levels of care providing the same services without proper referral mechanisms, jeopardizing quality coverage of key services and integrated care and delivery. This also leads to underutilized capacity at facilities, and a mismatch between need and distribution of staff.

Policy options include:

- Capacity building and some service delivery restructuring to facilitate better integrated programme-related services into general delivery platforms (e.g. ARVs in ANC clinics).

- Rationalize health worker and facility distribution to improve equity, access, and efficiency through New Human Resource for Health Policy that is being developed

4. Un-coordinated supply chains and heavy reliance on private market procurement.

There are multiple, overlapping supply chains (especially pharmaceutical-related) that lead to an overly complex system for financing, warehousing, and distribution, that are even fragmented on a programmatic level. Furthermore, without a central medical store that incorporates programmatic supplies and in the inability of the MOH to strategically procure essential medicines, the health system has to rely on the private market without negotiating prices.

Policy options include:

- Continue efforts to rationalize and integrate supply chain and procurement systems

- NHIS reform, including more strategic purchasing, benefit package review, assessment of pharmaceutical payments Policy options include:

5. A high reporting burden due to lack of centralized and consolidated data systems.

There is a significant amount of data being collected and generated across different levels of the health system. This is due in part to uncoordinated data demands by different disease programmes. Most officials also tend to only use their own programme's data for decision-making purposes, without looking at

6. How their programme fits within the broader health sector.

- Work towards putting into place an integrated information sharing system platform

- This platform can be accessed by providers, facility, district, regional, and national managers

Acknowledgements and Links to relevant resources, references, expertise

POLICY BRIEF : Ghana: Cross-Programmatic Efficiency Analysis

A system-wide approach to analysing efficiency across health programmes

Universal health coverage: WHO Fact Sheet

WHO Operational Framework for Primary Health Care

Acknowledgment

We gratefully acknowledge the inputs from Susan Sparkes for this case study

Case Study 3

Strengthening budget planning and formulation for C19 vaccine introduction[1]

Country or Region	Global Health Initiative
Global Level	GAVI

PHC Operational Framework lever	
Health Financing: Budget planning and formulation, PART A	

Context

Public Financial Management (PFM) strategic approaches to support successful introduction of new health interventions, such as introduction of Covid-19 vaccines. The question of "How" to budget, is as vital to answer as is determining "How much" to budget for the costs of C19 vaccine introduction. PFM becomes highly relevant as it supports the last mile distribution of a predominantly publicly funded and managed public good. This case study explores Budget planning and formulation for C19 vaccines

What were the specific objectives/activities?

Figuring out how to channel necessary funds towards the vaccine roll-out is as important as determining the cost of the roll-out itself. For this, Public Financial Management (PFM) becomes highly relevant as it is what supports the last mile distribution of a predominantly publicly funded and managed public good.

Key lessons learned, or useful practices

Preliminary country evidence indicates that PFM bottlenecks, regularly encountered in the health sector during normal times, are also affecting COVID-19 vaccination plans. Some of the key issues include determining How are vaccines and vaccination delivery costs formulated in budget structures?

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[1] Adapted from: "Why PFM is Key for the Effective Roll Out of COVID-19 Vaccines" by Hélène Barroy, Federica Margini, Triin Habicht, Tomas Roubal, Peter Cowley and Joseph Kutzin

Budget planning and formulation

Budget estimates: Uncertainties around the cost of COVID-19 vaccines, their availability and their uptake exacerbate the disconnect between costing and budgeting. While most countries have a costed deployment plan, very few regular budgets for 2021 include provisions for COVID-19 vaccination. Adoption of supplementary budgets can include vaccination related expenditures; other countries, like Ghana, postponed the adoption of the 2021 budget, so as to include C19 vaccine procurement and operational costs.

For recommendations and guidance on general costing for HR and operational costs for vaccination campaigns, there is detailed advice in the National Deployment and Vaccination Plan for COVID-19 vaccines (NDVP) which lists the items needed to be included in the costing. And in the COVID-19 Vaccine Introduction and deployment Costing tool (CVIC tool) there is also a step-by-step guide on the costing. The HR cost is also linked to the delivery modality. For more information, email to CVICosting@who.int

Budget planning: Most countries struggle to define a medium-term vision for budget planning and to align allocations with longer-term vaccine deployment needs and other priority health needs. To reduce fragmentation, South Africa consolidated COVID-19 vaccination spending in the Medium Term Expenditure Framework (MTEF) for FYs 2021-2023, while the country pursues a flexible scenario-based budgeting approach for annual updates.

Budget structure: If routine immunization allocations are any indication, input-based budgeting may create rigidities for COVID-19 vaccination resource management, with separate line-items for vaccines, cold chain and support staff. Several countries have created a temporary program line that groups all inputs related to COVID-19 vaccination together. In Georgia, for instance, costs related to vaccination are included in the state budget as part of a new COVID-19 budgetary program to make resource management for COVID-19 vaccination more flexible (re-allocations are made possible within the program envelope) and provide a clear audit trail.

Budget holders: To enable full budget execution, each budget holder in the multi-stakeholder response must be clearly defined and their vaccine-related expenditure properly coordinated and tracked. In South Africa, the COVID-19 vaccination budget allocations are clearly split between national budget holders (primarily the National Department of Health) for vaccine procurement and provincial departments of health for implementation-related expenditures. In other countries, budget is, sometimes, allocated to the main purchasing agency – the national health insurance fund – for the reimbursement of the full distribution costs (Czech Republic), or to cover provider-related costs only (Korea), while other central departments (e.g. defense, education) and agencies (e.g. centers for disease control) may receive subsidies to support additional spending related to vaccination campaigns. Clarity on budget holders is critical for a coordinated response, as well as for financial accountability.

Acknowledgements and Links to relevant resources, references, expertise

Why PFM is Key for the Effective Roll Out of COVID-19 Vaccines

Mapping PFM for Covid-19 Vaccine rollout

For more information on costing of C19 vaccine rollout, please email to CVICosting@who.int

Case Study 4

Strengthening budget execution for C19 vaccine introduction[2]

Country or Region	Global Health Initiative
Global Level	GAVI

PHC Operational Framework lever	
Health Financing: Budget execution and spending modalities, PART B	

Context

Public Financial Management (PFM) strategic approaches to support successful introduction of new health interventions, such as introduction of Covid-19 vaccines. PFM becomes highly relevant as it supports the last mile distribution of a predominantly publicly funded and managed public good.

This case study explores **Budget execution and spending modalities for C19 Vaccine Introduction.**

What were the specific objectives/activities?

Preliminary country evidence indicates that PFM bottlenecks, regularly encountered in the health sector during normal times, are also affecting COVID-19 vaccination plans.

Some of the key issues include:

1. How will funds flow to health service providers to cover operational costs?

2. What are the rules for hiring and contracting temporary vaccinators?

3. How will providers be incentivized for vaccination services?

The below reviews some PFM "stress points" in each phase of the budget cycle may arise throughout the vaccine roll-out.

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[2] Adapted from: "Why PFM is Key for the Effective Roll Out of COVID-19 Vaccines" by Hélène Barroy, Federica Margini, Triin Habicht, Tomas Roubal, Peter Cowley and Joseph Kutzin

Key lessons learned, or useful practices

Budget execution and spending modalities

Budget overlaps: In some countries, budget overlaps are a common occurrence. This is when the provisions of the last year's budget are moved to the next budget cycle as a result of non-implementation. This often results in poor project execution due to the lack of clear-cut decision. The best way forward is to improve implementation of the budget in the same year of its adoption. We know that improving health budget execution means to address some generic PFM aspects (e.g., rigidities in budget and disbursement structure that can contribute to reduce level of execution), as well as some health-related issues (e.g., delays in procurement that may impact level of budget execution).

Central and subnational spending authorization: Cumbersome and multilayered spending authorization processes, across administration levels, can hamper efficient health spending. Prior to the vaccine roll-out, several countries, like India, adjusted modalities to allow public funds for COVID-19 goods and services to be disbursed more readily upon appropriation. The same procedures continue to apply, in several countries, for vaccination-related spending to accelerate funds disbursement. In Ukraine, authorities have also simplified procedures for budgetary transfers to subnational levels and purchasing entities in charge of vaccination, to allow for the rapid deployment of resources for vaccination.

Procurement rules: Procurement processes can sometimes stand in the way of efficiently procuring COVID-19 vaccines and other related products. Most countries use emergency procurement processes to purchase vaccines and some non-vaccine-related items (e.g. medical supplies, cold chain). These emergency processes generally allow for direct negotiations with vaccine manufacturers and remove the competitive bidding process. When emergency procurement provisions were not comprehensive enough, some countries like Morocco and the Philippines, adopted further regulations for these emergency purchases to allow sole source contracting and advance payments to vaccine manufacturers. However, when these contracts and payment amounts are kept secret, the process has raised concerns with regards to financial transparency and accountability.

Provider contracting modalities: Rigid personnel recruitment and contracting policies can hamper the efficient roll out of vaccines. In many cases, there are rigid frameworks—or in some cases, no frameworks at all—for contracting private providers in the health sector. Some countries are updating their regulatory frameworks to make tendering easier while ensuring that contracted providers are still held accountable for outputs. In Estonia, additional private providers have been contracted to vaccinate front-line workers. The Estonian Health Insurance Fund held an open call to identify new providers and developed a new contract template to ensure their work aligned with vaccination requirements.

Payment and incentives to providers: A lack of or inconsistent incentives for providers may alter how effectively vaccines are deployed. Revising payment methods to support vaccine delivery can help mitigate the problem. In Ukraine, the government added a vaccination performance fee to the current capitation payment for primary care providers. In other countries, an extra fee-for-service was introduced to incentivize the supply; in Estonia the fee-for-service goes to family doctors while in Italy it goes to pharmacists.

Rules for resource use by providers: Front-line health workers are often handcuffed by a lack of direct access to operational funds, as well as cumbersome authorization and reporting rules (generally by the consumption of specific inputs) when resources are made available. Several countries have started to update their PFM frameworks to allow front-line workers to receive and manage public funds directly, including for the vaccine roll-out and COVID-19 related goods and services. For instance, the Philippines implements the Bayanihan to Heal as One Act which allows for prospective payments by the main purchasing agency, Philhealth, to more than 700 eligible facilities. Other countries that do not rely on separate purchasing agencies are also considering a revision of regular PFM mechanisms to empower the frontlines and allow them to receive and manage public funds directly.

Acknowledgements and Links to relevant resources, references, expertise

Why PFM is Key for the Effective Roll Out of COVID-19 Vaccines

Mapping PFM for Covid-19 Vaccine rollout

Case Study 5

Example of Public Financial Management (PFM)[3]

Country or Region	Global Health Initiative
Global Level	GAVI

PHC Operational Framework lever
Health Financing: Expenditure Reporting and accountability, PART C

Context

Public Financial Management (PFM) strategic approaches to support successful introduction of new health interventions, such as introduction of Covid-19 vaccines. PFM becomes highly relevant as it supports the last mile distribution of a predominantly publicly funded and managed public good.

This case study explores **Expenditure tracking and accountability for C19 Vaccine Introduction**

What were the specific objectives/activities?

Preliminary country evidence indicates that PFM bottlenecks, regularly encountered in the health sector during normal times, are also affecting COVID-19 vaccination plans. Some of the key issues include:

How can reporting mechanisms ensure financial accountability for vaccination-related expenditures?

Key lessons learned, or useful practices

Tracking vaccination expenditure

Weak reporting systems, multiple reporting processes, and a narrow or incomplete view of vaccination-related spending can create challenges for financial accountability. Policy options to manage this:

> Some countries, like Ghana, have started to assign special codes for COVID-19 vaccination expenditure in their Financial Management Information System (FMIS). In other countries, when a program structure allows, budget tagging systems are used to track vaccination-related activities and spending. In Estonia, budget tagging for COVID-19 vaccination expenditure helps to identify relevant expenditures in the government's budget system and, ultimately, to ensure financial accountability.

Large volume of spending not accounted for in Financial Management Information Systems (FMIS)

Countries can be challenged when spending on external resources is monitored through separate or parallel processes, verification systems and audits. Policy options to manage this:

> Streamlining reporting modalities to avoid duplications and parallel reporting processes; Strengthening domestic financial information systems and audit functions.

Lack of incentives for accountability by health service providers

Poor and fragmented accountability systems undermine the efficient use of resources. Another problematic issue is the case in which countries only track the consumption of inputs instead of assessing the quality and effectiveness of outputs and performance. Policy options to manage this:

> Refining contracts with service providers and performance agreements to ensure transparency in use of resources, to establish clear lines of accountability and to carefully define the roles and responsibilities of all partners and entities.

Note> "IF" a 3rd dose ('booster dose') is being considered

• On August 10th, WHO issued a statement, with support of the Strategic Advisory Group of Experts (SAGE) on Immunization and its COVID-19 Vaccines Working Group (link). It concluded that "In the context of ongoing global vaccine supply constraints, administration of booster doses will exacerbate inequities by driving up demand and consuming scarce supply while priority populations in some countries, or subnational settings, have not yet received a primary vaccination series.

- The focus for the time being remains on increasing global vaccination coverage with the primary series (either one or two doses for current EUL vaccines).

- Introducing booster doses should be firmly evidence-driven and targeted to the population groups in greatest need. The rationale for implementing booster doses should be guided by evidence on waning vaccine effectiveness, in particular a decline in protection against severe disease in the general population or in high-risk populations, or due to a circulating VOC.

- To date, the evidence remains limited and inconclusive on any widespread need for booster doses following a primary vaccination series. WHO is carefully monitoring the situation and will continue to work closely with countries to obtain the data required for policy recommendations.

- Should a country choose to introduce booster dose to their plan, then the costing and budgeting for C19 vaccine introduction would need to be updated based on revised plan, including the full costs of procuring, storing and managing the vaccine.

Acknowledgements and Links to relevant resources, references, expertise

Why PFM is Key for the Effective Roll Out of COVID-19 Vaccines

Mapping PFM for Covid-19 Vaccine rollout

Case Study 6

Applying PHC framework to multi-sector actions on "Health-in-All" policies

Country or Region	**Global Health Initiative**
Thailand, Zambia, Sudan	All GHIs, Development Partners

PHC Operational Framework lever
Governance and Policy

Context

Health-in-All policy (HIAP) is an approach proposed by WHO to systematically consider health policy design and implementation across different sectors (multi sectors) through synergy building. It acknowledges that population health is impacted by wider economic, political, cultural and social environment, i.e. the social determinants of health.Public policies and decisions made in all sectors and at different levels of governance significantly impact population health and health equity.

What were the specific objectives/activities?

The Health in All Policies Approach (HiAP) was endorsed at the 8th Global Conference on Health Promotion in Helsinki in 2013 as the following:

> "Health in All Policies is an approach to public policies across sectors that systematically takes into account the health implications of decisions, seeks synergies, and avoids harmful health impacts in order to improve population health and health equity. It improves accountability of policymakers for health impacts at all levels of policy-making. It includes an emphasis on the consequences of public policies on health systems, determinants of health and well-being."

The WHO defines Health in All Policies as referring to "taking health implications of decisions systemically into account in public policies across sectors, seeking synergies, and avoiding harmful health impacts, in order to improve population health and health equity through assessing consequences of public policies on determinants of health and well-being and on health systems." (WHO WHA 67.12 2014). Categories of action through HiAP include fiscal measures, such as taxes and subsidies, laws and regulations, changes in the built environment, and education, and communication campaigns. (PHC Vision and Strategy, 2018)

In 2017, an international conference on HiAP was convened to report on progress in implementing HiAP approaches in different countries. The case studies highlighted the range of applications and processes of HiAP, some of which are featured in this document (see case examples below of China, Thailand, Zambia, Sudan).

Key lessons learned, or useful practices

Four characteristics have been identified as being important for implementation success. These include good governance, development of partnerships based on co-design and co-delivery, dedicated capacity and resources, and the use of evidence and evaluation. Good governance in HIAP refers to engaging authority for action from the high-level political and executive leadership to leadership at all levels of the social system.

China developed the "Healthy China 2030 " strategy in 2016 , which made inclusion of "Health in All Policies" an official government mandate for all future governmental policy making. Key drivers of success in this initiative were high political commitment to PHC for UHC, increased health financing, piloting reforms to assess feasibility and identify any adverse effects before national scale-up. Over 20 government departments were involved in drafting the 2030 plan. A main component of Healthy China 2030 is the promotion of healthy lifestyles and physical fitness and the development of Healthy Cities. This illustrates how the HIAP approach assist health and other sector planners to ensure a greater focus on prevention rather than treatment.

Thailand passed a National Health Act in 2007 which embodied a whole of society approach to health, has now been active for 15 years. The Act involved setting up a National Health Commission chaired by the Prime Minister and with representation from other Ministers in the Government. The NHC has proved to be a useful mechanism for engaging with other sectors on health and wellbeing. This NHC is supplemented by a National Health Assembly (NHA) which engages with a wide range of stakeholders (government agencies, academia, civil society, health professionals, the private sector) to adopt resolutions to guide national health policy. It has proved to be a viable mechanism and process by which to engage the public and other sectors in public policy making.

Zambia revised the national development plan to recognise that the determinants of health lie outside the control of the health sector. It created a new division on health promotion, social and environmental determinants (2017) with multi sectoral approach as a key principle informing its operations. It also had a policy analysis and coordination role hosted in the Presidency. It was found that the establishment of a Policy Analysis and Coordination Division in the Office of the President was critical in supporting coordination and facilitating participation of other sectors. The Sustainable Development Agenda also provides a rationale for embedding HiAP as an established approach for improving health and promoting sustainability.

Sudan conducted an assessment in 2013 on the National Health Policy. This review found that there was no clear guidance on how intersectoral collaboration should happen. A National Health Sector Coordination Council (NHSCC) chaired by the President was established. This led to the development of a Health-in-All policy (2015) roadmap facilitated cross-sectoral policymaking on health, with the UHC partnership (2022) currently providing ongoing support to HiAP programme improvement and roll out at sub-national levels. 12 ministries have signed commitments to work with the Sudanese Ministry of Health on joint policy making.
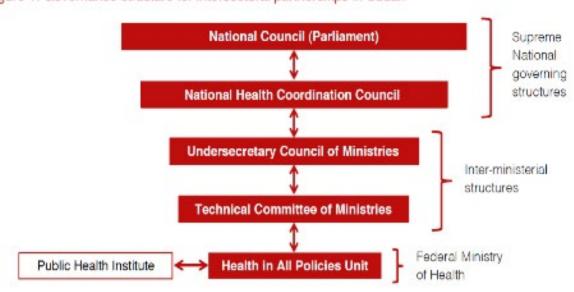
Figure 1. Governance structure for intersectoral partnerships in Sudan

These commitments included for example commitments by Agriculture in food security, commitments by the Ministry of Social Welfare for provision of health insurance, commitments by the Ministry of Finance for social and financial protection for poor families, and commitments by the Ministry of Interior for improving civil registration and population protection during conflicts and emergencies. Some of the main success factors in establishing the approach was the high level of commitment to health by political leadership, a shared recognition of the necessity of multi sector engagement for attainment of SDG goals, and a consensus amongst stakeholders on the need for more collaboration to achieve these goals. More country case studies on multisector collaboration are found in the links below.

Acknowledgements and Links to relevant resources, references, expertise

Progressing the sustainable development goals through Health-in-All policies: Case studies from around the world

Health in All Policies: a WHO training manual

The Helsinki Statement on Health in All Policies

Health in All Policies Roadmap Sudan

National Health Assembly Thailand

PHC Vision and Strategy, 2018

Acknowledgment

We would like to acknowledge Benjamin Rouffy-Ly for his review of this case study

Case Study 7

Example of the Country Coordination Mechanism in Georgia

Country or Region	**Global Health Initiative**
Georgia	Global Fund

PHC Operational Framework lever
Governance and Policy

Context

Country Coordination Mechanisms (CCMs) are committed to local ownership, stakeholder collaboration and participatory decision-making. A Global Review of Country Coordination Mechanisms (CCM) found in 2016 that Country Coordination Mechanisms have limited integration with national systems and tend to function as parallel entities.

The Country Coordination mechanism of Georgia was established in 2003 to coordinate Global Fund programs for prevention and control of HIV, TB and Malaria. The Government of Georgia in 2012 passed a resolution that established the Country Coordination Mechanism (CCM) of the Global Fund as the national authority for addressing public health issues of HIV and TB. The government made the CCM accountable for coordinating and sustaining the response to the public health challenges posed by HIV and TB. The Government of Georgia through this resolution CCM through this resolution delegated to the CCM the authority to monitor public and private partnerships, and to mobilise and utilise program funding through both external and domestic resources. The level of alignment and integration with government processes and systems was also reinforced through both the CCM role in advising on legislation relevant to HIV and TB prevention and control, and also through the obligations of CCM to the government to act according to Georgian Laws and Agreements.

What were the specific objectives/activities?

The Health in All Policies Approach (HiAP) was endorsed at the 8th Global Conference on Health Promotion in Helsinki in 2013 as the following: The G-CCM in 2016 participated in a CCM Integration Study funded through GIZ Backup, which found that the G-CCM was well integrated through both policy and practice. As a result of this finding, there was a consensus reached in the country that the CCM should not only continue past Global Fund support but could also act as a model of good governance for the Ministry of Health and the Georgian Government more generally. Some of the activities that resulted in this outcome included the following:

> **Transition Planning:** Given the positive outcome of the aforementioned integration study, the country took the opportunity to utilise a program of technical assistance (2016-2019) to strengthen the G-CCM's linages and preparing from Transition post Global Fund support. The transition plan delivered provided important outcomes in terms of a timeline for transition, an analysis of future budgetary needs, a vision of how the G-CCM could function in the future and the production of a Governance manual and other administrative standard procedures.

Key lessons learned, or useful practices

Management and Coordination Capacity

Several factors have been associated with high standard of G-CCM functioning in Georgia. Along with the previously mentioned program of Technical Assistance on Transition planning, there is a competent senior leadership with recognition and strong management skills, with acknowledgement and engagement of the Minister of Health in G-CCM policies and requirements. Additionally, there is a highly participatory and collaborative G-CCM with an efficient and effective CCM secretariat. The secretariat has low turnover which serves to maintain institutional memory. It is also the focal point for G-CCM leadership and membership on policies and procedures of the Global Fund.

Representation and Technical Support

Another factor in the successful functioning of the G-CCM is the support it receives from a Policy Advisory and Advocacy Council. (PAAC). This Council (PAAC) is composed of the main HIV and TB key populations, people living with these diseases, as well as of government and non-government organizations working in the HIV or TB fields. The PAAC plays a critical role in technical assistance, transition planning, and advising on National Strategic Plans and grant proposals. The PAAC also has the critical role of ensuring there are specific mechanisms for increasing engagement with people living with the disease and with civil society organizations.

Membership Networking & Trust

In addition to these strengths in planning, management, representation and technical support, the strength of the G-CCM rests on the foundation of its membership and its capacity for networking. There are several factors that support this networking. Most members of the G-CCM interact frequently not only on the G-CCM, but also on other health sector bodies. There is a spirit of trust, consensus building and national commitment from the members in the G-CCM, which facilitates frank and open discussions on program design and implementation.

There are important outcomes from these lessons learned on governance of the G-CCM. A recent evaluation conducted through document review, key informant interviews and an on line survey has confirmed that the G-CCM scored highly across the four responsibility domains of oversight (92%), engagement (75%), positioning (92%) and operations (92%).

Acknowledgements and Links to relevant resources, references, expertise

Global Fund

The Georgian Country Coordination Mechanism: Factors Supporting its successful links with other public institutions and its high level of functionality. 2021

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Case Study 8

Transitioning Governance of Health System Strengthening in Kenya

Country or Region	Global Health Initiative
Kenya	Global Fund

PHC Operational Framework lever
Governance and Policy

Context

Significant Resilient and Sustainable Systems for Health (RSSH) investments under the Global Fund (GF) grants have been made in Kenya over the years. Key amongst these is strengthening of laboratory systems and PSM (procurement & supply chain management) for health products; strengthening data systems to promote interoperability of existing platforms; strengthening of community systems; and supporting integrated service delivery approaches.

In the context of Kenya, all donor funding through the government is mandated to pass through the National Treasury (i.e., Ministry of Finance), making it the default government PR (principal recipient) of Global Fund grants. The Ministry of Health national HIV, TB and malaria disease programs, and the NACC (National AIDS Control Council) are sub recipients (SRs) and lead implementation of HIV, TB, and malaria interventions under the 3 Global Fund grants to the government. Additionally, each disease has one grant implemented by a Civil Society Organization (CSO) PR – Kenya Red Cross Society for HIV and AMREF Health Africa for TB and malaria.

Historically, RSSH interventions were housed under the government TB grant and implemented by the National TB program, even though they are cross-cutting in nature. This resulted in inadequate ownership for the cross-cutting RSSH interventions and led to implementation bottlenecks such as challenges in coordination, slow implementation of activities, and suboptimal absorption of funds.

In 2020, the Technical Review Panel (TRP) of the Global Fund reviewed Kenya's funding request for the implementation period 2021-2024 and raised the concern that despite sound investments proposed for RSSH, the issue of stewardship and governance needed to be addressed. The TRP found that there was no clear governance or coordination structure proposed for the implementation of the different RSSH investments, and encouraged the country to find an adequate implementation arrangement which would facilitate better coordination and utilization of funds for RSSH interventions.

What were the specific objectives/activities?

The Health Sector Partnership and Coordination Framework of Kenya aims to "align partner support towards a joint strategy and investment plan that is led by the Government." Aligned with this National Framework and the TRP recommendations, Kenya implementers worked with the Global Fund Country Team during grant-making to propose a responsible entity at the Ministry of Health tasked to coordinate implementation of RSSH interventions, in collaboration with the national disease programs. As a result, the MOH Department of National Health System Strengthening (DNHSS) was included as a new SR under the government TB grant to carry out this role.

To support the DNHSS in becoming ready to take on their new role coordinating GF RSSH investments, the GF Country Team provided several recommendations to the new SR focused on strategies for enabling the DNHSS to strengthen key linkages, ensuring timely monitoring, and maximizing the impact of their role and the interventions under their purview. These recommendations included:

- Development of an RSSH-specific M&E and operational plan (to be integrated into the existing HSS NSP) that would document the key processes for data management for cross-cutting interventions.

- Establishment of monthly coordination meetings between relevant departments/ programs (in the case of Kenya, the DNHSS, HMIS Department and HIV, TB and malaria disease programs).

- Establishment and operationalization of an RSSH working group; and

- Guidance for ensuring sufficient staffing, and training on GF policies and processes.

RSSH investments in Kenya support health sector governance. These relate mostly to capacity building as well as other activities to facilitate better integration of DNHSS into the health policy-making space. This makes DNHSS a functional participant of health sector governance rather than being only an implementer of a Global Fund grant.

Key lessons learned, or useful practices

One of the main challenges in health system strengthening grants through Global Health Initiatives is related to managing and coordinating cross cutting health systems strengthening programs through vertical program management structures.

The case from Kenya illustrates the feasibility of cross programmatic management of health system strengthening initiatives, through coordination, joint operational planning, and monitoring of health system strengthening. The main driver of change (along with the TRP recommendation) has been the realisation that coordinated implementation of HSS can reduce bottlenecks and increase pace of both program implementation and budget utilisation.

Coordination of these grants through cross cutting structures also demonstrates the potential for the following:

- Reducing workloads of managers already dedicated to vertical programmatic management

- Increasing efficiencies in programming by taking opportunities for sharing of system costs and reducing overlap in operational funding

- Improving quality in programming through building synergies between programs by coordinating implementation of shared health system strategies

- Increasing synergies in RSSH program investments in national health information systems and M&E, laboratory systems, procurement and supply chain systems for medicines and related commodities, financial management systems, human resources for health, and community systems strengthening (TRP, 2021)

It is important to note that investing in an overarching health sector coordination department need not impact the community system strengthening component of the RSSH investments. As has historically been the case in Kenya, such investments have been implemented under grants managed by the CSO principal recipients (AMREF Health Africa and Kenya Red Cross Society) to facilitate implementation with community level organizations.

Acknowledgements and Links to relevant resources, references, expertise

Technical Review Panel Issue and Recommendation Requiring Strategic Action, Kenya July 2021

The Health Sector Partnership and Coordination Framework Kenya 2018-2030

Kenya Global Fund Funding Request Form Allocation Period 2020-2022

Acknowledgement

We gratefully acknowledge the contributions by Soukeyna Sylla, Lisa Butler, Regis Choto, John Ochero, Erin Ferenchick and George Shakarishvili from the Global Fund.

Case Study 9

Example of Leadership Management Coordination at Sub-National Level (Decentralization) in Ethiopia

Country or Region	Global Health Initiative
Ethiopia – Afar, Oromia and Addis Ababa Regions	GAVI

PHC Operational Framework lever
Governance and Policy

Context

Since September 2018, Gavi has provided support to improve leadership, management and coordination of the national EPI programme with focus on sub-national levels. In the last year, the expanded partner team accelerated implementation of the activities at scale across the country with the objective to drive systemic improvements in immunisation and other PHC services.

What were the specific objectives / activities?

1. Scaling LMC interventions across three regions (>800 health centers)

2. Launching new management reports to improve oversight, decision-making, and follow-up through Data packs, woreda scorecards, dashboard analysis

3. Introducing new management strengthening routines to review performance data through new performance management meetings in regions and a "Traffic Light" system to track the timely completion of key activities

4. Improved coordination, and accountability between managers and partners

Key lessons learned, or useful practices

Improving performance in Afar Region

Improvements have been seen in Afar in several key areas since the team scaled the approach to all 34 woredas in July 2019. Supervision performance in the region reached an average of 63% in 2020. In addition, 85% of facilities in Afar facilities have been visited at least 5 times since July 2019, with every facility visited at least once during this time. As supervision began to improve, the team put more emphasis on improving the key drivers of EPI performance, e.g. improving static and outreach sessions, increasing the availability of vaccines, increasing the availability of micro-plans, etc.

In doing so, managers quickly put additional focus on these areas in monthly review meetings and their day-to-day activities.

As a result of this, the average number of static sessions per facility has increased from 14 per month in July 2019 to 19 per month in April 2020. Similarly, the average number of completed outreach sessions per facility has increased significantly from 1.5 sessions per month in July 2019, to almost 3 sessions per month in April 2020. In addition to this, Acasus has worked hard to improve ARHB-EPSA coordination through improving communication, holding meetings attended by both parties, and through working to jointly resolve identified issues.

These improvements have been driven by new management routines, improved follow-up, and increased visibility on performance. The launch of new monthly regional review meetings has been highly impactful. These meetings are focused on reviewing performance data, identifying problems and developing solutions, and following-up on previously agreed actions. Meetings are facilitated by the Acasus team using focused presentations, comprised of targeted analysis and recommendations. Meetings are attended by representatives from regional MCH and EPI teams, EPSA hub managers, and key regional partners such as JSI, Path, and Amref, ensuring improved communication and coordination. Outside of these meetings, the team also follows up with managers at regional and Woreda-level each week to review progress, problem-solve, and drive performance. The introduction of new dashboards has also enabled managers and partners to monitor supervision and progress against other KPIs (e.g. stock availability, presence of fridges, etc.) in real-time. This now takes place as part of day-to-day management activities, independent of Acasus support.

Improving performance in Oromia Region

In May 2019, Acasus launched a proof of concept in four woredas in two zones in Oromia. As of May 2020, the team had successfully implemented the intervention across 58% of zones in Oromia, covering 45% of the 40 million population residing in the region. This comes despite political changes, conflict and insecurity, and the onset of COVID in March 2020. As the intervention has scaled to include more facilities, the absolute number of facilities supervised each month has also increased, from 76 in November to 239 in April. This is highly encouraging, especially since most of this improvement took place during sustained campaign activities, internet blackouts, and security issues. Significant expansion was completed in April (new zones tend to take 1-2 months to fully adopt the intervention). In addition to increasing supervision compliance, the team has been working with ORHB and zonal managers to improve static sessions and vaccine availability. Static session have improved from 36% in November 2019 to 83% in April 2020. This improvement is largely due to weekly follow up with managers at different levels to review progress and problem solve.

Improving performance in Addis Ababa Region

The team launched the intervention across all sub-cities in Addis Ababa in October 2019. Thanks to strong collaboration with managers, 100% of health centers were supervised during the first round of quarterly supervision (Oct - Dec 2019). The team continued to make good progress in the following quarter, but the onset of COVID in March saw performance decrease to 82%. The impact of COVID continues to be significant in Addis, with the outbreak prompting AARHB to completely shift its frontline staff - including EPI supervisors - to assist in the response. The team continues to work with managers to ensure routine immunization and governance is maintained in facilities that have not been designated as COVID treatment or isolation centers. The team has also established monthly performance reviews with EPI, logistics teams, and EPSA, in which performance data is reviewed, problems identified, and solutions developed. This is the first time such monthly meetings have taken place in Addis and was also the first example of joint performance meetings with EPI and EPSA (this has since been replicated in Afar and is about to be replicated in Oromia). Both supervisors and logistics teams attend to these issues, enabling them to work together to raise issues and problem solve. As a result of these interactions, logistics staff attend almost half of all supervisions with EPI supervisors to address facility-level cold-chain and logistics issues. Overall, these meetings have had a significant impact on the quality of coordination and communication between regional actors.

Overall, the intervention has been scaled across all 5 zones covering 34 woredas and 91 health facilities in Afar, 23 zones covering 132 woredas and 605 health facilities in Oromia and all 10 sub-cities covering 101 health facilities and 12 hospitals in Addis Ababa. The team is also exploring the possibility of either scaling to SNNPR or Amhara in future, once the impact of COVID diminishes.

Acknowledgements and Links to relevant resources, references, expertise

Gavi Documents Measles Second Dose (2019)

Ministry of Health Ethiopia, Health Sector Transformation Plan II, (2021)

Ethiopia Comprehensive Vaccine Preventable Disease Surveillance Review

Case Study 10

Increasing Social Participation in Health in India and Madagascar

Country or Region	Global Health Initiative
Global, including examples from India and Madagascar	All GHIs, Development Partners

PHC Operational Framework lever
Community Empowerment

Context

As outlined in Voice, agency, empowerment - handbook on social participation for universal health coverage, social participation is at the core of strengthening health system governance and thus fosters people´s trust in government and public institutions. The main objective of social participation mechanisms is to bridge the gap between policy-maker perspectives and the experiences and needs in communities.

"Participatory spaces" are participation techniques, modalities, instruments, or methods that allow meaningful dialogue and debate between the population, communities, & civil society and policy makers. A premise underlying the concept of a participatory space is that relationships between people and policy makers are shaped by power-relations and uneven levels of influence. Hence, understanding and actively diminishing power relations is essential for creating effective strategies to shape participatory spaces for community dialogue.

The Handbook on Social Participation presents different case studies to reflect on platforms for direct population engagement, engagement mechanisms at community level, and engagement with civil society organizations (CSOs). While recognising that all three of these modalities for engagement inter-act, this short report focuses on lessons learned from community engagement models from India and Madagascar.

What were the specific objectives / activities?

The aim of the Madagascar Study was to assess how communities were able to influence district-level and national policy making processes, including challenges and obstacles for meaningful community engagement. The study focused on a community health system strengthening approach, facilitated through the NGO Action Contre La Faim (ACF) in two Malgèsh districts. This approach built on the district health committee structure and sought to strengthen capacities through training programmes, consultative workshops, and technical support for community health workers.

Key lessons learned, or useful practices

Findings

In Madagascar obstacles to meaningful community engagement were related to manifested social and traditional hierarchies that impeded community representatives to speak freely. Additionally, a perceived lack of community capacity hindered community members to enter dialogue with policy makers and local authorities. A general sense of mistrust in elites and fear of repercussions from decision-makers if the community raised sensitive issues. Established norms of engagement restricted community members on commenting on their personal experiences with the health system.

Success Factors

Efforts by the international NGO in Madagascar to strengthen participation capacities clearly showed that it is possible to diminish power imbalances. This outcome was achieved by (a) increased recognition of the relevance of community input to national planning (b) supporting the creation of a level playing field between stakeholders through use of local language, convenient meeting venue for community members, and no direct exposure to hierarchies.

Findings

In the India case study, the effectiveness of community platforms for engagement was limited by leadership, political intent, and capacities. In India, the scope for community voices in planning, governance and feedback was limited by the fact that the platforms for participation were restricted to service delivery issues, with limited inputs into decision making. Additionally, models of social participation implemented through vertical programs did not always result in mainstreaming of the approach into the wider health system.

Success Factors

The governance spaces and structures for participation made available by the National Rural Health Mission increased people's participation in health and were enabling factors for engagement. This was especially the case where leadership, political intent and capacity were evident. The ASHA cadre acted as a relay between communities and the health system. Where civil society organizations had established operations, they were able to boost ASHAs' role and amplify community voice.

Given contextual factors of culture and local power structures and imbalances, there is no "one-size-fits-all approach" for expanding social participation. As these two cases demonstrate, format & design of the participatory space as well as strengthening capacities serve to balance power relations between communities and policy-makers and can be seen is as enabling factors for meaningfully increasing community voice in health.

For further references to case studies and conceptual frameworks for Social Participation in Health, refer to the Handbook on Social Participation for Universal Health Coverage listed below.

Acknowledgements and Links to relevant resources, references, expertise

Voice, agency, empowerment - handbook on social participation for universal health coverage

Acknowledgement

We would like to acknowledge the inputs of Katja Rohrer-Herold for advice and input to this case study.

Case Study 11

Example of Integrated screening for infectious diseases in Georgia

Country or Region	**Global Health Initiative**
Georgia	Global Fund

PHC Operational Framework lever
Models of Care, Monitoring & Evaluation

Context

Chronic hepatitis B and C, HIV and TB are significant public health problems in eastern Europe and central Asia. Coinfection of these diseases are high in Georgia. Up to 22% of people living with HIV had active TB and up to 32% had latent TB. Among people with TB, 21% had hepatitis C infection. Detecting and managing coinfections has proven to be a challenge when each disease and testing strategy falls under a separate health programme.

What were the specific objectives/activities?

The objective was to introduce a system of integrated screening services for eliminating hepatitis C and controlling the HIV and TB epidemics.

Main activities included developing an integrated screening protocol, raising awareness, and training primary health care physicians, including village doctors and nurses. Many primary health care clinics also offered integrated HCV, HIV and TB screening to individuals being testing for COVID-19. Finance for the initiative was mobilised through the Global Fund and through municipal budgets.

After the pilot project was implemented in 2018, screening coverage increased by 60% in the 7 months of the pilot compared to the 3 years prior. The model was subsequently expanded from the pilot area across the country using State support.

What were the specific objectives/activities?

• Testing for priority infectious diseases along specific programme lines can lead to missed opportunities for detecting other infectious diseases

• It is feasible to test simultaneously for several infectious diseases in primary health care settings.

• This integrated approach to testing demonstrates the potential for reducing the burden of chronic hepatitis C, HIV, sexually transmitted infections (STIs) and tuberculosis (TB).

Acknowledgements and Links to relevant resources, references, expertise

Integrated screening for infectious diseases: a success story from Georgia

For further information: Irma Khonelidze I.khonelidze@ncdc.ge

Acknowledgement

We would like to acknowledge the work of Irma Khonelidze in reviewing this case study

Case Study 12

Immunisation and Health Services Integration in Malawi

Country or Region	Global Health Initiative
Malawi	All GHIs, Development Partners

PHC Operational Framework lever
Models of Care, Governance and Policy, PHC Oriented Research

Context

In Malawi, the Malawi Ministry of Health (MOH) in 2004 established health service priorities for universal health coverage in the form of an Essential Health Package (EHP). The EHP was reviewed in 2016, and has been updated in the most recent Health Sector Strategic Plan II (2017-2022). The list of interventions includes vaccine preventable diseases, HIV, TB and malaria, reproductive maternal and child health (including integrated management of childhood illnesses, nutrition, non-communicable diseases and for oral health. A process of priority setting was undertaken to design the EHP which included expanding coverage for all but ensuring disadvantaged groups such as rural populations and low-income groups are not left behind.

The EHP is designed to be implemented at every level of the health system from community to health centre and to hospital level. Malawi's health system is organized at community, primary, secondary, and tertiary levels. At the community level, health services are provided by a form of community health worker referred to as health surveillance assistants (HSAs), with each HSA being responsible for a catchment area of 1,000. The role of the HSAs is to provide services at the community level in an integrated way, with roles including health education activities, distribution of mosquito nets, provision of family planning services and antenatal support, and providing case management and referral services.

Health Services Integration has been defined by WHO as: "health services that are managed and delivered so that people receive a continuum of health promotion, disease prevention, diagnosis, treatment, disease-management, rehabilitation and palliative care services, coordinated across the different levels and sites of care within and beyond the health sector, and according to their needs throughout the life course."

In support of this direction towards health services integration in Malawi, a development assistance project referred to as the "Support for Service Delivery Integration of Services" worked with the Ministry of Health in Malawi to integrate family planning HIV, maternal and child health, and nutrition into community-based health service delivery.

What were the specific objectives/activities?

The purpose of this study was to document the changes required within the health system to make service integration a reality with the support of such implementing partners as SSDI. The study also aimed to document how the monitoring and evaluation (M&E) systems have been or could be strengthened to better monitor and evaluate integration, including documentation of indicators and information sources in use.

Under age 5 and antenatal care (ANC) clinics in each of these 10 facilities were chosen in which to conduct client (n=762) and provider (n=75) interviews and time studies. Districts and zones representing these facilities were also included in the study. Focus group discussions were held with health surveillance assistants who served in both facilities and communities in Central Region. Representatives from policy, programming, and M&E from the MOH and international implementing partners at the national, regional, zonal, and district level were invited to participate in key informant interviews regarding the inputs, processes, and expected outputs of the study, as well as provide information on how integrated service delivery is monitored and evaluation.

Integration inputs included policy and governance; information systems and planning and management functions; human resources; and demand creation. The outputs and results integration were coherent integration of services and increased coverage, acceptability, quality, efficiency, and use.

Key lessons learned, or useful practices

Enabling factors for integration and lessons learned from implementation were as follows:

- **Expanded Service Delivery Access:** An end of project report in 2017 found that – integrating health services increased access to and coverage of multiple essential health services at each client visit. Based on triage and counselling at the facilities, clients presenting to the facility were able to access other essential EHP services. HIV services were also integrated into maternal and child health, TB, sexually transmitted infection, and family planning services. Community health workers could provide a range of health services through integrated family health outreach clinics, which enabled the provision of multiple EHP services in one location and at one time. One assessment found that most patients seen in ANC and under age 5 clinics received more than one EHP service.

- **Increased Patient Satisfaction:** Providers and clients reported greater satisfaction with integrated services, even if integrated service provision required a longer waiting time.

- **Improved Efficiency:** Integration of services improved efficiency of service delivery by providing "one-stop shopping" in contrast to a model based on availability of services only on certain days or in specific facility wards.

- **Policy and Governance Enablers:** The establishment of policy and guidelines and mandating the provision of the EHP in all public health facilities provided a framework for provision of other inputs including human resources, infrastructure, technology and commodities and supplies. Supportive supervision was critical for assuring provision of integrated services.

- **Monitoring and Evaluation Enablers:** There were also challenges reported with integrated service delivery implementation. Stakeholders at all levels reported gaps in availability of equipment and supplies and inadequate availability of referral services. It is critical to maintain and strengthen a responsible national level coordinating body to provide oversight of the initiative, and to have readily available monitoring and evaluation tools and core indicators that all facilities can report on to track progress on integration of services.

Acknowledgements and Links to relevant resources, references, expertise

Integration Service Delivery in Malawi - A Case Study

Ministry of Health Malawi The Essential Health Package (EHP)

Ministry of Health Malawi: The National Health System

Support for Service Delivery Integration of Services

Working together: an integration resource guide for immunization services

Case Study 13

Health Service Integration in Senegal

Country or Region	Global Health Initiative
Senegal - Health Service Integration in Senegal: A Case Study	All GHIs, Development Partners

PHC Operational Framework lever
Models of Care

Context

Integrated health services refers to the management and delivery of services so that people receive a continuum of care through their access to the different functions, activities and sites of care within the health system (PHC Operational Framework). Integrated service models should provide comprehensive services across the life-course, be designed according to the population health needs and be delivered by multidisciplinary teams across settings and levels of care (Integrated Care Models).

In Senegal, the Ministry of Health and Social Action (MSAS) introduced an essential package of health services for the reduction of maternal, newborn and child morbidity and mortality, with the model of care based on a community health approach as developed through a Government of Senegal National strategic Community Health Plan (2014-2018). At the community level, health activities are conducted by a volunteer team that includes a community health worker (responsible for the treatment of patients on site and referral of cases), a matrone (responsible for monitoring pregnancy and assisting with childbirth, and a relais (responsible for raising awareness about health issues). These community level health services assist to make primary health care accessible to rural populations where access to health centres and health posts are limited. Achievement of equitable access to health care is challenged in Senegal by limited human resource quality and distribution, weak referral systems, stock outs of essential commodities and challenges related to costs of services.

To respond to these challenges, services integration has been promoted in Senegal is intended to support improvements in availability and accessibility of health services in communities. The main approach for improving accessibility and availability of services was through the implementation of a minimum package of services offered by community health workers at primary care centres and in the community.(Health Services Integration in Senegal).

What were the specific objectives / activities?

The wider purpose of the integration approach was to improve accessibility, and effectiveness of services and to improve resource efficiency through reduction of service duplication by all stakeholders. A case study was conducted in Senegal to document how systems could be strengthened to better monitor and evaluate integration (Health Services Integration in Senegal).

The critical inputs for supporting integration of services were defined as including policy and governance, information systems, planning and management, human resources management and demand creation. The monitoring and evaluation of integration required several steps to undertake integration assessment. Interview discussions at each health system level and in communities were conducted in relation to management and the monitoring and evaluation of integrated services using integration indicators. Indicators were selected based on existing data collection and information needs for integration. Integration indicators included the following: (Health Services Integration in Senegal).

- Total number and percentage of health huts offering a minimum package of services

- Number of HIV service delivery points that have integrated at least one non-HIV service (coverage and access)

- Number of maternal, newborn, and child health service delivery points that have integrated at least one other type of service (coverage and access)

- Number of clients who have received two or more services during a single visit to a service delivery point (uptake)

Information on the first indicator (number and percent of health centers offering a minimum package of services) was collected during supervision. In addition to these indicators, further modifications were made to the M & E system that included the following:

- The design of a " supervision grid" to monitor the package of services being offered at the community level.

- The introduction of an annual work plan process for integrated services. When supervision is implemented, assessments are based are based on information in the prepared action plans and budgets.

- Monitoring of provider performance through periodic meetings and documented integrated supervision.

Key lessons learned, or useful practices

The case study demonstrated that Integration inputs resulted in wider ownership and collaboration between health teams both within the health systems and within communities. Success factors associated with integration of services and successful M & E of integration were as follows:

- **Leadership** is required for resource allocation and human resource placements in local community health services. Integration also resulted in more engagement by local leaders in budgeting and planning.

- **Planning and Coordination:** Integration clarifies roles and responsibilities of stakeholders including community groups in planning and financing. Integrated services planning enables shared platform for investment. The establishment of joint annual work plan processes was an important process for shared investment, monitoring, and evaluation

- **Human Resources Management:** Expansion of the service package and HR training and task shifting were important factors for expanding service integration.

- **M & E and Supervision:** Performance of providers engaged in the provision of integrated services is monitored though regular meetings and supervision that is reinforced and documented. Regions and districts work with implementing NGOs to monitor program implementation and assess the quality of services provided.

- **Communication** was a key strategy to increase demand for integrated services. A mobile workforce and home visits were important for expanding the reach of integrated services for areas not covered by health facilities.

Acknowledgements and Links to relevant resources, references, expertise

Global Operational Framework of Primary Health Care

WHO Integrated Care Models: An Overview

Health Services Integration in Senegal

Case Study 14

Piloting and scale up of integration of hygiene communication and immunisation in Nepal

Country or Region	Global Health Initiative
Nepal	All GHIs, Development Partners

PHC Operational Framework lever	
Models of Care, Community Engagement	

Context

In Nepal, diarrhoeal diseases is the leading cause of child mortality, and along with undernutrition, remains a major development challenge for this country (Water Aid, 2019). Major environmental factors contributing to this situation are lack of access to safe drinking water, improved sanitation, and good hygiene practices. Vaccination against rotavirus also provides an opportunity to address disease burden due to diarrhoea, with this disease contributing to a large proportion of severe gastroenteritis in children. Programs addressing diarrhoeal diseases prevention and control and management therefore requires a comprehensive package of protective, preventive and curative interventions.

A partnership was established between WaterAid and the Nepal Ministry of Health and Population to support the integration of hygiene communication and immunisation. A one-year pilot project through hygiene promotion activities were delivered in all routine immunisation clinics in four districts of the country in 2016. This case study summarises the main findings from a project on integration of Hygiene Promotion through Routine Immunisation (2016).

What were the specific objectives/activities?

The project aimed to address these key questions:

- Is it feasible to integrate hygiene promotion into a regular service-delivery mechanism?
- Does this approach effectively change five key hygiene behaviours of new mothers and their families?
- Does this approach increase the effectiveness of immunisation efforts?
- Is this approach cost-effective?
- Is the model scalable across the whole country?

The intervention targeted multiple hygiene behaviours including exclusive breastfeeding, handwashing with soap, and food hygiene. Opportunity was taken to implement the program through attendance at all five immunization sessions. The sessions were conducted at the start of each immunisation session. Target participants included 35,000 mothers/caregivers with children under 12 months of age. The intervention also involved mobilizing 2,200 trained Family Community Health Volunteers (FCHVs) across four districts. [included package of tools]. The following steps were undertaken to implement and scale up the program:

Feasibility Study: The program commenced with a feasibility study which concluded that integrating hygiene promotion interventions into immunisation programmes was acceptable to stakeholders (2012).

A pilot project was implemented by the Nepal Ministry of Health and Population, within the Expanded Programme on Immunisation in four districts of the country.

Formative research was undertaken to better understand behavioural determinants, motives, barriers and socio-cultural variability of the target population. (2014)

A hygiene promotion intervention package was developed which was based on the formative research that assisted in prioritising five key behaviours. The package promotion interventions were then pretested and finalized and endorsed by the National level to implement through the routine immunization programme. (2015)

Capacity building programs on the intervention were then conducted for national, regional, districts and local level staffs including with female community health volunteers in four districts.

Post intervention evaluation was then conducted (by a third-party group) to assess the final outcomes of the pilot project, with inputs from districts, female community health volunteers and discussions among the other stakeholders. Representatives from the Ministry of Health and Population, Child Health Division, and the other stakeholders including WaterAid then reached consensus on a nation wide scale up of the intervention.

Key lessons learned, or useful practices

• The Evaluation demonstrated that hygiene promotion interventions were effective in improving all key hygiene behaviors (from 2% during baseline to 53% after one-year of implementation). There were also improvements in immunisation coverage, reduced drop out and vaccine wastage rate. Period prevalence of diarrhea was 5% during the follow up survey among the intervention group, compared to 15% during baseline. The program also assisted to reach the unreached population as secondary outcomes.

• The capacity of the health workers and female community health volunteers to run innovative hygiene promotion was increased.

• The results from the pilot initiative demonstrated that it is a feasible, viable and it is an effective approach to integrate hygiene promotion into routine immunization.

• Integrated female community health volunteer programs have the potential to combine roles in various community-based maternal and child health programs.

• Integrated programming provides the potential to link fragmented activities of community-based health programs into an integrated services model of care.

Acknowledgements and Links to relevant resources, references, expertise

Water Aid Hygiene promotion through immunisation

Water Aid Hygiene Promotion through Routine Immunization

Female Community Health Volunteers in Community-Based Health Programs of Nepal: Future Perspective

WHO: Working together: An integration resource guide for planning and strengthening immunization services throughout the life course

Case Study 15

Strategic Purchasing and Payment Methods

Country or Region	Global Health Initiative
Multiple countries	All GHIs, Development Partners

PHC Operational Framework lever	
Purchasing and payment systems	

Context

Purchasing refers to the allocation of pooled funds to healthcare providers for the delivery of health services on behalf of certain groups or entire population. "Strategic purchasing means aligning funding and incentives with legal entitlements to health services and must therefore be guided by detailed information on the performance of providers and the health needs of the population served." (1). Strategic purchasing therefore aims to equitably distribute resources, to improve coverage and quality of health services and is therefore vital for making progress towards achievement of universal health coverage goals (1).

Strategic purchasing is based on the principal-agency relationship, which relies for its effectiveness on the expectation that the agent behaves in the way the principal wants the agent to behave. The principal achieves this objective through provision of the right incentives, by specifying the interventions to be purchased by the agent, and finally by the principal monitoring performance and resource allocation.

There are different types of purchasing agencies. These can include for example, Ministries of Health, local health authorities, health insurance agencies, community-based health insurance organisations or a non-governmental organization.

In many countries and in countries with mixed health care systems, purchasing is becoming more complex due to the existence of multiple purchasers and diverse private sector of health care providers. Due to this growing diversity and complexity, there is a consensus that more attention needs to be put on purchasing of health services and how to make it more strategic if countries are to make progress towards UHC.

What were the specific objectives/activities?

A WHO Policy Brief on Strategic Purchasing (2017) summarizes the key purchasing instruments that could help countries make their purchasing more strategic for Universal Health Coverage. The following five core areas should be jointly addressed and aligned with each other:

1. Specifications of health services and interventions ("What to buy").

2. Making choices on the levels and types of providers (From whom to buy").

3. Provider payment mechanisms and contractual arrangements ("How to buy")

4. Building integrated or inter-operable information management systems for purchasing

5. Establishing strong governance arrangements for purchasing

Provider payment mechanisms are a common support area of Global Health Initiative grants, which is why particular attention is placed on provider payment in this brief here.

The main provider payment methods include line-item budgets, per diem payments, case-based payments, global budgets, fee-for-service, and capitation payments. Each of these provider payment methods has their advantages and disadvantages as well as each creating its own set of incentives. The health system's objectives, challenges, services to be paid for and contextual factors (such as the level of provider autonomy), will determine the appropriateness of each provider payment method.

There is growing evidence and increased consensus that "purposive alignment of payment methods – balancing the undesirable incentives of a single payment method and harmonizing the range of incentives – is the optimal approach to improving the payment system" (1).

Contracting is a key policy instrument for strategic purchasing and effective payment systems by putting greater focus on the achievement of measurable results. A growing number of countries are implementing payment arrangements in combination with contracting methods to address concerns about quality and to set performance targets. Sufficient managerial and financial autonomy and capacity for providers is also required to enable the providers to respond effectively to incentive payments.

Key lessons learned that are relevant in other countries eligible for GHI support

The WHO policy brief on strategic purchasing outlines a number of key lessons:

Administrative control mechanisms are needed to ensure that payments are setting the right incentives for providers. This may include for example financial or technical audit, fraud control measures and claims review, as well as updating services and essential medicines covered, and reviewing of provider behaviours to ensure the right incentives are being set.

Policy makers need to carefully think through the sequencing of strategic purchasing reforms for successful implementation. Country experience with strategic purchasing illustrates that getting the incentives right for provider payment and service provision is essential before raising more revenue through large scale financial system reforms. The reforms do not have to be sudden major changes but can be gradual. The health sector has the capacity to undertake these reforms through the guidance of Ministries of Health as illustrated in the examples from Egypt (2019), Kyrgyzstan (2020), and Tunisia (2020). Country experience also demonstrates that those countries with large informal economies and limited fiscal capacity can implement purchasing reforms in such a way as to gradually progress the country towards UHC.

It is important to consider the political economy that lies behind "technical" issues such as payment methods and rates. Issues of political and institutional feasibility need to be understood and addressed, which includes making assessments of the effectiveness of governance arrangements and mixed provider payment systems to support moves towards strategic purchasing. Understanding of political economy can also assist to ensure that strategic purchasing policies are considered and aligned with existing health system and health financing policies (1).

Finally, there are important issues regarding the alignment of purchasing policy with other health financing policies and health system functions, such as revenue raising, pooling, public financial management, service delivery and devolution that must be addressed. Examples of assessments of strategic purchasing and their governance arrangements are detailed in examples from Egypt (2019), Kyrgyzstan (2020), and Tunisia (2020) in the links below.

Acknowledgements and Links to relevant resources, references, expertise

WHO Policy brief on strategic purchasing

Governance for strategic purchasing: an analytical framework to guide a country assessment. Geneva: World Health Organization; 2019 (Health Financing Guidance No 6)

Analytical guide to assess a mixed provider payment system

Implementing the Universal Health Insurance Law of Egypt

Governance of health financing and strategic purchasing of services in Kyrgyzstan

La gouvernance de l'achat et des méthodes de paiement : comment aller vers un achat stratégique pour la Couverture Sanitaire Universelle en Tunisie ?

Case Study 16

Public Private Partnerships for Immunization Services in the Sudan

Country or Region	Global Health Initiative
The Sudan	All GHIs, Development Partners

PHC Operational Framework lever
Private Sector Partnerships

Context

The private sector has expanded its role in immunisation service delivery in recent decades. In Malawi, 27% of all vaccinations are delivered through the private sector and in Benin the figure is 8%. One of the main challenges with private sector immunisation is how Ministries of Health manage, regulate and supervise facilities to ensure quality and affordable services (Levin et al, 2019). Similar challenges of management and regulation of the private sector have been experienced in the Sudan, where in 2017 it was estimated that 16% of the third dose of pentavalent vaccine for children was provided through the private sector in 2017. In the capital city Khartoum was estimated in 2019 to have 382 private sector primary care clinics, with 64% operated by NGOs and 36% by for profit providers. (Ahmed et al, 2019)

The context of Sudan also provides additional rationale for closer relationships with the private sector. A Multiple Indicator Cluster Survey in Sudan also showed wide disparities in coverage by wealth quintile and between States. These disparities have been exacerbated by internal conflicts and economic downturns, which have constrained the governments capacities to support imunisation in hard to reach areas. In the Darfur Region of the country, NGOs have played a major role in providing immunisation services for children. In Northern Darfur State, NGOs have also been managing and supporting public health facilities and establishing health centres in IDP camps. (Yagub et al, 2015). Internationally, studies have shown that the likelihood of children being immunized regardless of household wealth is increased in areas where services are delivered by contracted NGOs (WHO Guidance Note). An additional rationale for public private partnerships in immunisation is to support safeguarding and improving the quality of immunisation services in the private sector and specially to ensure the integrity of cold chains, safe administration of vaccines, conformance with national immunisation policies and vaccination schedules, and to facilitate reporting by the private sector of coverage and vaccine preventable diseases. (WHO Guidance Note). In summary, private sector collaborations provide opportunities for extending the coverage, equity, and quality of immunisation services.

What were the specific objectives/activities?

This case study, based mainly on the study of Ahmed et al in 2019, describes the regulation and planning interventions undertaken by Sudan to support the coverage and equity of immunisation services. Min activities to support this objective were:

- **Regulation:** The Ministry of Health of Khartoum state established a regulatory framework for immunisation services by NGOs. These regulation supported integration of the NGO providers into the State's Immunisation program.

- **Registration and Agreements:** All service providers must be registered by the state-level MoH before they can deliver immunisation and other primary care services.

- **Standards:** To obtain and maintain a license all health facilities must meet certain quality standards and are required to sign a memorandum of understanding (MoU) with the state MoH.

- **Vaccine Supply:** Vaccine supplies are provided to health facilities by the government along with the required reporting forms (to report vaccine doses administered, vaccine preventable diseases and adverse events).

- **Human Resource Capacity:** Private sector staff take part in regular immunisation trainings and District review meetings.

- **Accountability Measures:** In return for government support, accountability measures are included in agreements that require compliance on administering all vaccines free-of-charge; following the national policies and vaccination schedule; timely reporting and agreeing to receive regular supervisory visits to ensure that quality standards are met in such areas as vaccine and cold chain management, vaccine administration. Lack of compliance with such measures can result in a revocation of licence to provide services.

- **Incentivising the Private Sector:** Vaccine and cold chain supply and provision of government vaccinators (on occasions) incentivises the private sector to collaborate. Engagement of private health facilities in planning and services mapping also promotes ownership and partnerships between public and private sectors.

Key lessons learned, or useful practices

• **Increasing Coverage and Reducing Inequities:** Private providers contribute significantly to Sudan's immunisation programme goals for coverage and equity, especially by filling service gaps in hard-to-reach areas. This is especially the case in areas with high levels of insecurity, where national and international NGOs have also conducted immunisation campaigns in collaboration with district managers.

• **Regulation and Quality:** Monitoring programs have detected suboptimal quality standards and of cases of charging of user fees for vaccination. An important lessons is that a licencing process for private facilities and a quality assurance system are essential for ensuing compliance with standards and policies.

• **Ownership and Cost Sharing:** Models of cost sharing operate through private sector supply of locations and human resources, and through public supply of vaccines and in some cases cold chain systems. Both cost sharing and engagement of private providers in planning and training promotes the accountability and ownership by providers of the policies of the National Immunisation program.

Acknowledgements and Links to relevant resources, references, expertise

Ahmed N, DeRoeck D, Sadr-Azodi N. Private sector engagement and contributions

to immunisation service delivery and coverage in Sudan. BMJ Glob Health

2019;4:e001414. doi:10.1136/bmjgh-2019-001414

Levin A, Munthali S, Vodungbo V, et al Scope and magnitude of private sector financing and provision of immunization in Benin, Malawi and Georgia. Vaccine. 2019 Jun 12;37(27):3568-3575. doi: 10.1016/j.vaccine.2019.05.023. Epub 2019 May 20. PMID: 31122855; PMCID: PMC6573791.

Engagement of private/nongovernmental health providers in immunization service delivery: Considerations for National Immunization Programmes. Geneva, Switzerland: World Health Organization; 2017.

Case Study 17

Engagement with private sector providers on PHC

Country or Region	**Global Health Initiative**
Multiple countries	All GHIs, Development Partners

PHC Operational Framework lever
Engagement with private sector providers

Context

The private health sector is generally defined as all non-state providers including hospitals, doctors, pharmacies, traditional healers, faith-based organizations, private health insurance mechanisms. (Engaging the Private Sector, 2016) Engagement between public and private health sectors has been described as involving "deliberate, systematic collaboration of the government and the private health sector according to national health priorities, beyond individual interventions and programs." (Engaging the Private Sector, 2016)

Public and private health delivery systems exist in most countries, yet government health systems coordination role sometimes lack basic information needed effectively to engage with private sector providers around primary health care service delivery including information concerning the supply of services, the quality of those services, and the profile of their users. In Tamil Nadu state, India, and Upper East Region, Ghana, preventive or promotive services are typically not provided due costs, human resource gaps and lack government incentive or support. In Malaysia, although the government is the main health provider, the need has been identified for better coordination with the public health sector. In Vietnam, engagement of the private sector in the provision of preventive and promotive services is low. (Engaging the Private Sector, 2016).

What specific objectives/activities were funded?

Engaging the Private Sector in Primary Health Care to Achieve universal health coverage: Advice from Implementers, to Implementers (2016) is a practical manual that contains step-by-step guidance along with real-world examples and case studies to help facilitate public-private sector engagement around primary health care (PHC). The manual was developed by the Joint Learners Network (JLN) and provides practical guidance on initial communications and partnership around PHC and provider mapping. It also illustrates the guidance with case studies from around the world on implementers experiences with public/private partnerships.

Key lessons learned, that could be replicated in other countries eligible for GHI support

A few lessons/ approaches from countries on actions taken to engage the private sector around PHC are summarized below;

1. Malaysia [2013]

- Malaysia recognized that public - private sectors providing primary care services in partnership will make for more efficient use of health resources, and improve access to towards PHC to achieve UHC

- Conducted a provider mapping exercise to determine where health care providers are located in the country, especially private sector providers

- This mapping, provided evidence for policy making and health planning, including better integrating private providers into delivery of PHC

2. Benin [2015]

- The Ministry of Health of Benin hosted a high-level workshop on regulation of the private sector

- Workshop brought together public and private leaders to identify the benefits of and constraints to regulation of the private sector, and to produce a strategic and operational plan for improving regulation

- Key participants included the Minister of Health, other key Ministry personnel, the Director of USAID/Benin, the President of the Association of Private Clinics, and leaders of private health professional orders and associations.

- This high-level stakeholder workshop resolved to review texts and laws, review organization of regulatory services, establish public-private partnerships, and adopt measures to ensure providers are in compliance with regulations

3. Lesotho [2013]

- The Government of Lesotho worked with the private sector to improve and privately operate the low-quality public clinics

- Netcare, South Africa's largest private health care provider, led a consortium of private sector stakeholders to renovate and equip clinics, train staff, and expand services to improve public health efforts

- This example from Lesotho demonstrates the potential for the private sector to partner with the public sector to support health infrastructure development

4. Pakistan [2008-2013]

- A public-private partnership in Northern Pakistan between the Government of Khyber Pakhtunkhwa, Chitral district, and Aga Khan Health Service, Pakistan (AKHS,P) to improve the quality of services in a government owned rural health center. The partnership authorized AKHS,P to take over the management of the rural health center Shagram, add staff, and provide a full complement of care

- The main lesson was that partnering the resources of government and a private entity can improve health services, especially in remote locations, and also assist to prevent duplication of investment and operations. The case study also illustrated that involvement of the community (especially in relation to reviewing the cost of services) is critical to sustaining services through a public private partnership

5. The Philippines [2013-   ]

- Private electronic medical record (EMR) and electronic prescription providers were involved in the creation of a health information system for primary care that will be interoperable with both public and private EMRs

- A private drug outlet was contracted to provide medications for non-communicable diseases diagnosed by accredited PHC providers

- A private communications group was subcontracted and funded through technical assistance to create a communications strategy for marketing the enhanced primary care benefit once for roll-out

- Networks of DOTS referring private physicians were established through implementation of certification trainings, with the intention of making PhilHealth's TB/DOTS outpatient benefit package a possible source of funding for sustaining the program

- The lesson from the Philippines is that there are multiple partner types multiple ways of utilising public private partnerships to improve quality and coverage for UHC

Acknowledgements and Links to relevant resources, references, expertise

Engaging the Private Sector in Primary Health Care to Achieve universal health coverage: Advice from Implementers, to Implementers

The private sector, universal health coverage and primary health care

Engaging the private health service delivery sector through governance in mixed health systems: strategy report of the WHO Advisory Group on the Governance of the Private Sector for Universal Health Coverage

Country Connector on Private Sector Resources for Health

Case Study 18

Use of mHealth Technologies for Vital Registration and Health Information Reporting in Uganda

Country or Region	Global Health Initiative
Uganda	All GHIs, Development Partners

PHC Operational Framework lever
Digital Technologies for Health

Context

Digital health interventions are one means by which to accelerate progress towards universal health coverage, especially when facilitating engagement by frontline health workers and communities in reporting and receiving essential health information. The Government has developed a National eHealth Strategy (2017) and includes areas relating to eHealth governance and regulatory frameworks, Electronic Medical Record systems, health provider and patient registries, electronic healthcare planning and financial management systems, electronic Logistics and Supplies Management Information System (LSMIS) and health management information system (HMIS), and systems for improved access to continuous professional development through e-learning.

Two of these innovations in ehealth include civil registration and surveillance and health information reporting. Although 72% of the population lives within five kilometres of a primary health facility in Uganda, most of the population lives in rural areas that are distant from hospitals specialist care. (National eHealth Strategy Uganda, 2017). However, there is a rapidly growing mobile communication network in Uganda, with an estimated 65% of the population have access to mobile technologies in 2015 (UNICEF). The National eHealth Strategy reports that mHealth technologies can improve accessibility to services, and also empower patients and communities to make informed decisions about health care. Uganda has introduced several mobile mHealth technologies that are intended to improve births registration (Mobile Vital Records System - Mobile VRS) and a mobile technology known as mTRAC which enables health facility workers to report routine and surveillance data by SMS.

What were the specific objectives and/or activities?

Mobile Vital Records System

There are around 1.4 million babies are born every year in Uganda, and the country is reported to have a total fertility rate of 4.8 in 2020 (World Bank, 2022). Registration at birth advances children's rights through ensuring legal identity, improving access to health, social and child protection services. It also provides an essential input to national level development planning. (NIRA, 2019) .

Access to birth certification requires a three-step process of notifications (issuance by appropriate authority), registration (Civil registration Office) and certification (issuance of legal document by civil authority). (UNICEF). The purpose of the Mobile Vital Records System (Mobile VRS) is to ensure timely access to birth registration and certification. The Mobile VRS was developed under a public private partnership to address the bottlenecks in a paper-based system and for the purpose of simplifying and decentralizing delivery of births and deaths registration. The Mobile VRS uses web-based application and mobile phones to register births and deaths in health facilities and in communities. When deliveries occur outside health facilities, notifications are sent from community level via mobile phone USSD to a central Mobile VRS at the National Identification and Registration Authority.(NIRA Uganda Mobile VRS). This information is also accessible to local registration offices who can verify notifications for completeness and accuracy. When deliveries occur in hospitals, web-based systems on site enable issuance of notifications and uploading of notifications into the central Mobile VRS server.

Mobile Health Reporting (mTRAC)

mTrac forms part of the electronic health management information system of Ugnada which merges mTrac and DIHS2. Health workers use SMS to submit routine, weekly health surveillance data using their own mobile phones. The system reports on health indicators that indicators include notifiable diseases, essential medicines stock levels and maternal and neonatal deaths. This data is automatically integrated into the DHIS2 District Health Information platform which is then used for analysing facility and community health information. There are a number of other functions that the digital health information system incorporates that includes: or facilitates:

- SMS alerts when a threshold of disease outbreak case numbers is reached which are transmitted to all members of the District Health management team for mobilisation of a response.

- The system has enables development of a data base of health workers and their numbers which enables prompt communications by local governments, as well as the conducting of polls and surveys by the Ministry of Health and District officials.

- Toll free SMS complaints hotlines enables reporting of service delivery problems by citizens.

Key lessons learned, or useful practices

• The application of mHealth Tools in Uganda mHealth tools has the potential to improve population enumeration and Civil registration and vital statistics (CRVS) information systems in remote areas in Uganda (Mehl et al).

• There is some evidence from field projects that birth registration services are being scaled up using an upgraded Mobile Vital Records System (MVRS) with increasing numbers of under 5 year old children having their birth registered at decentralized NIRA offices. (UNICEF Annual Report 2021). There are still challenges with scaling up however. Children born in communities where there are no registrars are not receiving their birth certificates in time. Nationally, certification is estimated at one third of children under 5 years of age. (UNICEF).

• Reporting on the experience of mTRAC, weekly reporting rates have continued to rise, and more rapid feedback is being received at facilities from the Ministry of Health, District Health Offices and from UNICEF

• The National eHealth Strategy reports that multiple applications and products from different agencies and development partners are not always interoperable and compatible. Information is not shared and the services are not integrated. There is a tendency for some of the innovations to stop when development partner funding ceases. National eHealth Policies and Strategies require a well-defined governance structure to ensure coordination and sustainability of digital innovations. (National eHealth Strategy Uganda).

Case Study 19

Embedded Research on Immunisation in Pakistan

Country or Region	Global Health Initiative
Pakistan	All GHIs, Development Partners

PHC Operational Framework lever
Primary health care-oriented research

Context

The most recent Pakistan Demographic and Health Survey, although identifying some gradual immunisation coverage improvement in recent years, nonetheless has identified large numbers of partially immunised and zero dose children. Urban poor and remote areas are especially at risk of large numbers of zero dose children, and Union Councils across the country have been identified as being at "Super High Risk" for polio transmission. An Urban Coverage Survey in urban poor areas in 10 cities identified a range of service gaps and social determinants that were associated with zero dose vaccination.

A program of Embedded Implementation Research [Reference 1] was commenced in 2016 to explore the health system bottlenecks contributing to low and inequitable coverage, as well as examining potential solutions to address the challenges of inequities in immunisation. Some of the thematic areas examined by this program included immunisation supply chain and performance management systems, demand side factors at community level, and human resources and service delivery bottlenecks and solutions.

What were the specific objectives/activities?

The objective is to describe the main characteristics and steps in an embedded implementation research approach. In line with the principles of implementation research, implementers were involved as principal investigators for each project. These implementers included policy makers, health workers and health managers. The other principle of implementation research applied is that the research topic is relevant to EPI barriers or challenges, and that involvement of the policy makers, managers and workers in setting research priorities and implementing research activities is more likely to result in translation of research findings into practice.

Some of the key steps in the implementation research process were as follows:

- Contracting research partners. This also involved technical collaboration with research institutes

- Research prioritisation through literature review and engagement of implementers and partners in selecting research topics and questions

- Call for proposals based on identified questions: 10 proposals were selected through this process (e.g., involvement of community health workers to improve immunisation coverage in hard-to-reach , community barriers to immunisation)

- Research Protocol workshop with 10 research teams agreeing on protocols and research methods

- Data Collection and Analysis and Report Synthesis

- Research dissemination workshop with policy makers and with implementers

Key lessons learned, or useful practices

Research Capacity Building: Provision of continuous and high-quality TA support by in-country researcher partners made the intervention feasible. IR coordination and partnerships are essential for successful implementation. Partners need to be aware of their roles and responsibilities

Effective Research Management, Coordination and Planning: The study of the embedded research initiative found that there could be clear roles and responsibilities amongst partners involved in the research, there should be a dedicated strategy or guideline which ensure effective coordination among all partners involved.

Translation of findings into practice can be facilitated the research teams' capacity to utilise research findings in their practice. By involving implementers and communities in priority setting research topics and questions, approach ensured that research was relevant, and the recommendations were practical and actionable. Organising sub-national dissemination activities to share practical recommendations with provincial- and district-level EPI policy makers was one more important strategy to ensure take up of implementation research findings into practice.

Acknowledgements and Links to relevant resources, references, expertise

Case Study 20

Systems for Improving the Quality of Care

Country or Region	Global Health Initiative
Namibia	All GHIs, Development Partners

PHC Operational Framework lever
Systems for improving the quality of care

Context

WHO, World Bank and OECD have called on countries to improve quality of care across the health system through a clearly articulated national strategic direction on quality. The WHO Handbook for national quality policy and strategy (2018) highlights the need for integration of strategies, policies and operational efforts with those of disease and population-based programmes.

In 2015, Namibia Ministry of Health and Social Services (MOHSS) started the process of drafting its national quality policy and strategy. This process was revisited in 2019 to strengthen areas related to unpacking a national definition of quality of care, updating the situational analysis and developing a quality measurement framework. These efforts culminated into finalising and validating the national quality policy and its accompanying strategic plan. This work builds on a long history of quality improvement within Namibia's HIV programme.

What specific objectives/activities were funded?

Finalisation of the national quality policy and strategy, including stakeholder engagement; drafting and consultation for the policy and strategy documents; costing of implementation activities; and development of a quality of care measurement framework. This was a coordinated activity with multiple funding streams involving WHO technical support, CDC-Namibia financial support, and domestic input from Ministry of Health and Social Services (MOHSS.)

Key lessons learned, that could be replicated in other countries eligible for GHI support

National strategic direction as a foundation for system-wide action on quality

Although Namibia had established quality management expertise and infrastructure, much of this was only centred around specific programmes (e.g., HIV) and specific interventions (e.g., maternal mortality audit). As such, there were still significant gaps in capacity at different health system levels in quality planning, assurance, and improvement. The effort to set national strategic direction through multi-stakeholder inputs into a national quality policy and strategy was embraced by the MOHSS and partners as an important step in coordinating the multiple existing initiatives, identifying key gaps and creating a fertile environment for sustainable quality improvements to thrive. System-wide action was emphasized throughout for quality efforts to be integrated rather than being in a silo.

In the recent process to refine and finalise the national quality policy and strategy, the MOHSS utilised the approach set out within the WHO Handbook for national quality policy and strategy, placing attention on eight inter-related elements: national health goals and priorities; local definition of quality; stakeholder mapping and engagement; situational analysis; governance and organizational structure; improvement methods and interventions; health management information systems and data systems; quality indicators and core measures. Of particular note was the use of a 5-day multi-stakeholder workshop to bring together stakeholders from the national, sub-national and facility levels to forge a common understanding of quality challenges and co-develop strategies to address these. This committed approach to involvement of stakeholders both enriched the strategy content and provided a foundation for ongoing engagement in strategy implementation. Internally within the MOHSS there was a strong focus on engagement of key leaders beyond quality management programme, to foster shared ownership of the policy and strategy; for example, this included the MOHSS executive director as well as the directorates responsible for PHC and health information and research.

The pathfinder role of the HIV programme

The long history of successful work on quality of care within the Namibian HIV programme was a critical foundation both for development and implementation of the national quality strategy. The expert quality management capacity built by the HIV programme meant that there were well-trained quality champions and established organisational structures for quality management at the facility, sub-national and national levels, as well as local expertise and technical resources for application of quality improvement methods at the point of care. Many facilities also had trained data clerks and QI teams with experience of collecting and using data to identify variation and drive improvements. The long experience of the programme provided significant local learning on quality management that was fed into strategy development, highlighting known implementation challenges and local solutions.

The existing quality structures that were built as part of the HIV programme are intended to be leveraged to support roll out of the national strategy, for example through utilising existing facility teams and refining HIV programme tools and systems to support broader quality objectives.

Critical role of data on quality of care

In the strategy development process, there was consensus among stakeholders on the need for better use of data, and better quality of data, to improve quality of care. The situational analysis for the national quality policy and strategy identified that the data collection system was mainly paper-based and using forms that had not been updated to reflect current data needs, and that there was relatively low confidence in the reliability and comparability of much of the data collected by health providers. Commonly, health providers were involved in collecting and reporting data but very rarely received any feedback on key indicators that could inform changes in their procedures and practice. Few mechanisms existed to systematically review data at different health system levels and feed the findings into decision-making processes. Implementation of the national quality strategy provides an opportunity to address data use so that data can be used to identify variations in practice, increase accountability, and drive improvement processes at national, sub-national and facility levels.

The national strategy committed to developing a quality measurement framework that would focus on robust monitoring of a pragmatic and concise set of indicators that could support quality improvement processes. Within the effort to strengthen measurement of quality of care, linkages with system-wide efforts were again emphasized as key. For example, the MOHSS identified an opportunity to utilise data on quality of care within the health sector performance management process, proposing that improved measurement of a selection of quality indicators would allow integration of selected measures within the performance assessments of workers at all levels, promoting accountability for quality care from senior MOHSS leadership right through to staff at the point of care.

Acknowledgements and Links to relevant resources, references, expertise

WHO-World Bank-OECD report Delivering quality health services

WHO Handbook for national quality policy and strategy

Case Study 21

Quality Improvement of Integrated HIV, TB and Malaria Services in Antenatal and Postnatal Care (ANC-PNC) Facilities in Togo

Country or Region	**Global Health Initiative**
Togo	Global Fund

PHC Operational Framework lever
Quality of Care, Models of Care

Context

The maternal mortality ratio remains unacceptably high in Togo, and there is limited access to quality maternal and child health services. Pregnant women and newborns are also a high-risk group for many conditions including HIV, TB and malaria. Essential interventions for reproductive, maternal, new-born, and child health are designed to be implemented as a continuum of integrated care. Evidence from a healthcare facility survey in Togo in 2017 demonstrated that although there was a relative consistency in service provision, there were concerns raised over missed opportunities for identifying infectious diseases including HIV, TB, malaria, and syphilis, in addition to missed opportunities for Ante Natal Care (ANC)- Post Natal Care (PNC) screening for pre-eclampsia and anaemia.

What were the specific objectives/activities?

The Global Fund, in partnership with the Liverpool School of tropical Medicine (LSTM), the University of Lome (UL), the Togolese Ministry of Public Health and Hygiene and Universal Access to Care (MSHPAUS), applied interventions aimed at strengthening capacity of healthcare providers to improve quality and integration of ANC and PNC in Health Care Facilities in Togo. The quality improvement interventions described below were adapted following a baseline assessment in 62 healthcare facilities across three regions in 2017 [See reference 1]. Additionally, several studies were implemented a) a large stepped-wedge randomized controlled trial to assess the effectiveness of interventions on the quality and availability of care [See reference 2], b) a study of perceptions of mothers of respectful care in 2020 [See reference 3] and c) a mapping of ANC-PNC health providers (2020) [See reference 4]

The first intervention was the implementation of a Standards-based audit cycle (StBAs) for ANC-PNC. By selecting relevant standards to improve care, health care providers were equipped with the means to improve quality of care based on their facility's priorities. The standards are clustered into seven categories of women's and baby friendly care, organisation of care, antenatal care, management of obstetric complications, HIV, TB, malaria and other infections, postnatal care for the baby and finally postnatal care for the mother. The audits applied a 3-month cycle of (1) "pre-action" data collection month, (2) an "action" month with root-cause analysis and coordinated action led by HCPs at facility level and (3) a "post-action" data collection month to assess the potential improvement obtained.

The second intervention covered competency-based training for health care providers providing ANC-PNC services in healthcare facilities (HCF). The two focus areas for the training were on developing knowledge and skills on the ANC-PNC package of services and on integrating care for HIV, TB, and malaria. Based on preliminary data analysis, important outcomes of these interventions included both sharply increased compliance with standards (50% change from baseline in the in the post action phase), as well as improved screening rates for HIV, TB, malaria, and pre-eclampsia. The sustainability of these processes and outcomes are being promoted through a supportive supervision package, simple and efficient use of data for quality improvement, and facility and provider led change through establishment of permanent quality improvement committees.

Key lessons learned, or useful practices

• Prioritization of this work for support in GF grants was the result of a multistakeholder consultative process in country at all administrative levels, and including the MoH, National programs, the CCM (that includes technical partner representation) and within the Global Fund Secretariat

• The success of the implementation of the program was due to the continuous collaboration between LSTM and UL with the Directorate for Mother-Child Health and the Directorate of Health and Readaptation Facilities at MSHPAUS

• The focus of the initiative was on availability and quality of interventions for HIV/TB/ Malaria and MNCH in an integrated way with each stakeholder being motivated by their programmatic indicator of interest (e.g. IPTp for malaria program and MNCH, PMTCT for HIV and MNCH).

• The catalytic approach involved generating local evidence for the key interventions and other characteristics of the health system through learning, documentation, and dissemination.

• The intervention has demonstrated the capability of health care providers to auto-assess and improve health care provider availability, performance, and quality of care (e.g. skills and competency improvement package, mapping exercise).

• The quality improvement strategy has resulted in both improved integration of health care screening and introduction of a quality improvement process at facility level.

Acknowledgements and Links to relevant resources, references, expertise

Case Study 22

Medicines and other health products, linked to "Governance and Policy"

Country or Region	Global Health Initiative
Multi-country	All GHIs, Development Partners

PHC Operational Framework lever
Medicines and other health products, linked to "Governance and Policy"

Context

Lack of professional educational standards and a lack of a formal career path undermines the authority of Supply Chain professionals in many countries. In a bid to support the critical role that health supply chain leaders and managers play in ensuring the availability of vaccines and health commodities, a global coalition was established to support and build capacity of health supply chain leaders and managers established a new partnership with a Strategic Training Executive Program, known as STEP 2.0. This seeks to increase supply chain efficiency to improve health outcomes.

Managed by People that Deliver (PtD) – a global coalition hosted by UNICEF Supply Division – STEP 2.0 is jointly offered by Gavi, the Vaccine Alliance, the Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund) and the United States Agency for International Development (USAID). STEP 2.0 was designed for health supply chain managers and leaders, many of whom face the challenges with supply chain.

What were the specific objectives/activities?

To increase supply chain efficiency and consequently improve health outcomes for many in lower- and middle-income countries struggling to access medicines or other health commodities

What is the challenge?

Health supply chain leaders and managers play a pivotal role in ensuring the availability of critical vaccines and health commodities but all too often these managers and workers lack the appropriate skills and training. The human resource training prevalent in low- and middle-income countries tends to emphasise technical and operational-level competencies (hard skills) over strategic competencies (soft skills). As a result, health supply chains are often limited in their ability to meet existing demands. This jeopardizes the health of individuals, the health goals of countries and the major investments in health supplies made by governments and partners.

What is the solution?

A well-performing health system relies on well-trained and motivated health workers. The health supply chain worker is often overlooked, but it is precisely this worker that is responsible for ensuring that health commodities reach patients.

This is where STEP 2.0 comes in. STEP 2.0 combines traditional learning with on-the-job training to give health supply chain managers guidance in people management, problem-solving, communication, project management and professional development competencies. It is these kinds of skills that could hold the key to many health supply chains reaching their potential and becoming well-oiled machines.

Crucially, it blends elements of self-paced learning, facilitator-led training, on-the-job application of leadership skills and coaching support.

Key lessons learned, or useful practices

The coalition leverages the technical strengths of each organization's supply chain leadership programs, creating greater consistency and coherency of the Technical Assistance provided. This STEP 2.0 presents a unique opportunity for harmonising partners' efforts to strengthen in-country supply chain systems align efforts to national planning and budgeting processes and ensure lifesaving health products are delivered where they are needed most." The example and lessons learned of Dagoretti sub-county, Kenya are described below:

- They have addressed poor data quality through a new computerised logistics management system (LMIS) for the sub-county depot, and they now have seamless information flows and data visibility. In addition, they now have scheduled data quality assessments, while for decision-making they have adopted micro planning and immunisation performance monitoring.

- In addition, they have begun monitoring reach every community and reach every child (REC) interventions: this has all resulted in improved service delivery.

- Another example is their new vaccine distribution system pilot: at six public health facilities a direct delivery approach is being tested, removing the need for facilities to collect vaccines and other health commodities. The aim is to improve access to health delivery posts and minimise any service disruptions.

- The direct deliveries approach has helped the MCH supply chain manager and team to overcome the obstacles of weak infrastructure and limited transportation. It has also provided them with extra opportunities to monitor stock control processes as well as provide supportive supervision to health facility staff on effective vaccine and other logistics management issues during delivery visits. They are now working to upgrade their cold chain equipment and have already delivered new, modern and efficient refrigerators to 37 facilities.

Acknowledgements and Links to relevant resources, references, expertise

Gavi, the Global Fund and USAID announce innovative collaboration to support supply chain leaders

Strategic Training Executive Programme (STEP 2.0)

STEP brochure 6 May.pdf (peoplethatdeliver.org)

Empower School of Health training on Global Health Procurement and Supply Chain

Chartered Institute of Procurement & Supply offers resources and trainings

Case Study 23

Human Resources for Health Planning in Ethiopia

Country or Region	Global Health Initiative
Ethiopia – Human Resource for Health Planning	All GHIs, Development Partners

PHC Operational Framework lever
Health Workforce

Context

Globally, political instability, weak health systems, poor working conditions, and migration of health workers have all been factors associated with lower health workforce densities. In reviewing past efforts for human resources for health planning, the Global Strategy for Human Resources for Health (2016) has noted that the main challenge for HRH planning is in mobilizing sufficient political will and financial resources for longer term action.

Action in Human Resources for Health (HRH) policy and planning is further complicated by the range of interests that have a stake in HRH policy and planning. These include Ministries of Education, Health, Finance, and Public Service, training institutions, professional boards and associations and development partners. The struggle for consensus from this wide range of interests is further complicated by the fact that policy makers often view HRH expenditure as a cost rather than an investment, and that there is an insufficient advocacy effort from relevant political leaders, civil society or professional actors. These factors contribute to reduced pressure for scale up of workforce densities. (Fieno et al,2016)

This was the situation in Ethiopia in the early 2000s, after which a "disruptive" process was introduced which challenged the status quo. Based on the account of Fieno et al 2016, the idea that HRH was the crucial factor in scaling up health services in the country provided the required momentum for shifting priorities in the development agenda towards longer term planning for improved health workforce densities in the country.

What were the specific objectives and/or activities?

This case describes a "political economy" analytic approach to an understanding behind the rebuilding of the health workforce in Ethiopia and elsewhere. The rationale for this approach stems from the recognition that the solution to health workforce shortages requires much more than a technical response. It also relates to factors related to power in terms of how "how policy is made, how leaders are accountable, how WHO and foreign donors encourage (or distort) health policy, and how development objectives are prioritized in these countries." (Fieno et al,2016). Three categories of intervention are described for accelerating development of human resources for health. These are political will, building of state institutions and capabilities, and effective development cooperation.

Political Will

In Ethiopia, political commitment was expressed through planning for the long term development of the health workforce in that country from the mid-1990s. This was a 20 years strategy For health service development based on the recognition that the country was starting from a very low level of health workforce density. Given the pressure of other development priorities in the country, the development of HRH required to be linked with other development objectives and was therefore integrated into the Health Sector Development program (HSDP) of Ethiopia.

State Building

There were two aspects of "State Building" that were of relevance to the rebuilding of the health workforce in Ethiopia. These were HRH planning and institutional strengthening for HRH management.

Planning: Ethiopia developed a HRH plan within the HSDP (2005-2009). The aim was to address health coverage issues through deployment of health extension workers (a form of community health workers). It was subsequently planned to develop a more skilled categories of health workers. Ethiopia also adopted the initiative of introduction of a new cadre of health workers referred to as "the health officer." The main role of this new cadre was to support expansion of basic public health services. The subsequent HRH Plan to 2020 focussed more on development of higher skilled workforce and particularly of medical doctors, with a plan to Increase numbers from less than 5000 in 2009 to 50,000 trained by 2020. The most recent available data confirms that the medical doctor to 10,000 population ratio has increased from .25 per 10,000 population in 2009 to 1.06 per 10,000 population in 2020. In the same period nursing and midwifery personnel had increased from (Global Health Observatory 2022)

Institution Building: Ethiopia implemented a process of "Business Process Reengineering (BPR)" in all of its Federal and Regional Departments. This involved introduction of a results-based management approach to the public sector. Although there would be reporting of "mixed results" for this initiative, the Ministry of Health demonstrated its increased capacity in the areas of strategic planning in both health sector and in health workforce planning and in development partners coordination. (Fieno et al, 2016)

Resource Mobilisation

The above-mentioned planning and institution building activities were contributing factors to the mobilisation of resources for HRH. A significant proportion of the development assistance resources were allocated for HRH including HRH production. The strategic health plans developed and implemented by the Ethiopian government provided promoted country ownership of the initiative and also provided a rationale for support from overseas development assistance. Careful planning for increased workforce densities facilitated coordination with donors. Successful outcomes were promoted through development partners working through policies, frameworks and an aid management platform of the national government, which promoted openness, accountability and planning for results.

Key lessons learned, or useful practices

The main lessons learned from development and implementation of the HRH strategy in Ethiopia were as follows:

- Development of a comprehensive approach to HRH management and planning that includes political leadership, institutional capacity building for policy and planning and governance including for effective aid management are important success factors associated with improving health workforce densities and facilitating the long-term development of the health workforce.

- The case of Ethiopia illustrates that if countries can develop the leadership and technical capacity in HRH planning, development partners will be willing to invest in such plans. The capacity for governments and development partners to demonstrate openness, accountability and results are important ingredients for more effective implementation of development assistance programs.

Acknowledgements and Links to relevant resources, references, expertise

Case Study 24

Multidisciplinary Teams for Community Based Care in Thailand

Country or Region	Global Health Initiative
Thailand	All GHIs, Development Partners

PHC Operational Framework lever
Models of Care, Human Resources, Integrated Health Services

Context

There are several demographic, epidemiological and health system factors in Thailand which are increasing pressure for development of a community-based health care workforce. The population is rapidly ageing in Thailand, with the aged population expected to increase to an expected 26.6% of the population by 2030, with a significant proportion of this population reliant on long term care services. Life expectancy is 75, and non-communicable diseases are on the rise, with diabetes and hypertension prevalence at 8.5% and 22.3% respectively (PHCPI). Health care costs are projected to increase significantly, given the ageing of the population and rise in prevalence of NCDs.

There are shortages of the health workforce in rural Thailand. Despite 54% of the population residing in rural areas, only 19% of doctors are working in these areas, and by 2026, it is projected there will be a shortage of 47,000 nurses. These shortages of the health workforce in rural areas are a major obstacle towards development of a community-based model of health care. (Pagaiya N, et al 2021). Sustaining and expanding a community-based health workforce has been identified as a "necessary foundation" for universal health coverage as health priorities shift towards prevention and management of NCDs. (Potempa et al, 2022).

Based on this context and these demographic and epidemiological trends, a study was undertaken to assess the projected frontline personnel requirements for a multidisciplinary health workforce including paid community care givers to deliver home health care in rural Thailand. (Pagaiya N, et al 2021)

What were the specific objectives and/or activities?

The policy objective of the government announced in 2016 was to deliver long term care in communities through home health care services supported by multidisciplinary health teams and paid care givers. The main members of the multidisciplinary health workforce involved in home health care were nurses, doctors, and physiotherapists. The paid care givers were trained village health volunteers (not professional staff of the government) who provided a combination of support services, personal assistance, and health services to the elderly in their homes. Main activities associated with this strategy were as follows:

- The multidisciplinary health teams conducted patient assessment and case conferences, development of a care plans, home visits, and supervision of care givers. Team members also has distinct but complementary roles in the continuum of care, with nurses involved in assessments, doctors in case conferencing and physiotherapists in rehabilitation. All team members were engaged in development of care plans and home visits.

- The care givers assisted in the community with activities of daily living, basic health services, and support for patients and relatives.

- In addition to providing technical support, the multidisciplinary team provided training for care givers in areas such as personal care, disease-specific care, medications, nutrition, mental health, health promotion, and basic rehabilitation.

Key lessons learned, or useful practices

Health Workforce Shortages

The assessment found that teamwork between the members of the multidisciplinary health team and the care givers for community-based care is an appropriate solution to the problems of workforce shortages.

Increasing accessibility to health care services

The assessment found that, by care givers working closely with professional multidisciplinary health teams, it is possible to expand accessibility to integrated social and medical services to community level as well as to improve health outcomes.

Multi-disciplinary Team Skills Mix

The dependent elderly needs a range of services that includes activities of daily living, health services including prevention, medical and rehabilitation services and improved access to other social services. This complex set of needs means that various professionals in the multidisciplinary team are required to provide patient support. This means that the optimal skill-mix between the mainstream health professionals and the paid care givers needs to be clearly defined so that the health and social care needs can be appropriately met.

Coordinated Care

The assessment found that care managers (most often nurses in this case) were a success factor in ensuring effective management of multidisciplinary health teams for community care. This role assisted to reduce fragmentation of services and improve communication between care providers and patients.

Continuum of Care

The complex care needs of patients with chronic health conditions can be best supported through a multidisciplinary health team that has the skills mix to provide integrated services across a continuum of care extending from prevention, diagnosis, treatment, promotion, rehabilitation and palliative care (PHC Operational Framework).

Containing Health Care Costs

Care givers who are based in the community can increase the accessibility of care while at the same time reducing health care costs. Given the demographic and epidemiological trends in middle income countries, mobilizing community resources in this way may be the most viable policy option for building a long term care system that is sustainable.

Acknowledgements and Links to relevant resources, references, expertise

Case Study 25

Rapid Assessment of Primary Care Health Infrastructure in Tanzania

Country or Region	**Global Health Initiative**
Tanzania - Rapid assessment of infrastructure of primary care facilities	All GHIs, Development Partners

PHC Operational Framework lever
Infrastructure

Context

The physical infrastructure lever of the Global Operational Framework for Primary Health Care (2018) defines this lever as the provision of "Secure and accessible health facilities to provide effective services with reliable water, sanitation and waste disposal / recycling, tele communications connectivity and a power supply, as well as transport systems that can connect patients to other care providers." The framework points out that infrastructure needs are often "overlooked or neglected", especially in primary care settings. The physical infrastructure of health facilities also has important an impact on the safety, quality, and acceptability of health care services, especially in primary care facilities. Health facility assessments are also essential for information on the supply and quality of health services as well as for health systems management, and monitoring, and evaluation purposes. (WHO, SARA, 2015) The provision of safe water, hand washing facilities, latrines, and hygiene and cleaning practices at health facilities are necessary for improving maternal, newborn and child health outcomes, for infection prevention and control (IPC) and for prevention of antimicrobial resistance (AMR). (WASH FIT, WHO UNICEF, 2017).

Facility infrastructure can be defined as the "total of all physical, technical and organizational components or assets that are required for the delivery of health care services." (Scholz et al, 2015) . This case study summarizes the application of a rapid assessment tool for assessment of infrastructure needs for primary health care facilities in Tanzania in 2015.

What were the specific objectives and/or activities?

The main purpose of application of the rapid assessment method for health infrastructure was to provide an evidence-base for health policy decision-making through provision of fast and reliable knowledge on the condition of health care infrastructure. It was proposed that collection and analysis of data on facility infrastructure by using the rapid assessment would enable health decision makers to achieve the following:

- Improve health system performance through detection and elimination of infrastructural deficiencies.

- Improving reporting on facility infrastructure and related problems;

- Improving accessibility, availability, and quality of health services through development and maintenance of quality facility infrastructure.

The seven major components of health facility infrastructure that were assessed included:

- The facility and its management,

- The physical infrastructure

- The supply facility system,

- The disposal system,

- Technical medical equipment,

- Information and communication technology, and

- Outreach services.

The rapid assessment tool comprises a total of 101 data queries in 7 infrastructural components as outlined above. Ratings in the rapid assessment are grouped and then used for the calculation of indicators, after which the infrastructural indicators are merged in indices, the main three of which are the general facility index, the buildings index and the assets index. The rapid assessment tool is available in excel spreadsheet version that can be integrated into software that is used for data collection in existing health information systems. The rapid assessment is comprehensive and collects information on the seven components of health infrastructure, and is designed for yearly data collection for integration into health information systems.

Key lessons learned, or useful practices

The main lessons learned from application of this rapid assessment methodology for health care infrastructure were as follows:

- The rapid assessment of facility infrastructure has the potential to operate as a management tool for district level facility infrastructure management.

- To be effective for management decision making, data should be collected on all the seven components of infrastructure as outlined above

- Assessments of infrastructure should become a routine management process. To become routine, assessment data collection, recording and reporting should be easy to perform by health and administrative staff at facilities, and should be not too time consuming.

- To enable uptake of the information into decision making and resource allocation, the data collection process should be standardized so that results are comparable.

The standardization of data collection should also enable integration of infrastructure data and indicators into the National Health Information System. This will be a means by which to overcome neglect in the assessment of primary care health infrastructure, by ensuring that this data becomes a " natural component" of annual routine HIS data reporting, and thereby providing an evidence base for improving the supply, quality and acceptability of health care services. (Scholz et al, 2015)

Acknowledgements and Links to relevant resources, references, expertise

Rapid assessment of infrastructure of primary health care facilities – a relevant instrument for health care systems management (Scholz et al, 2015)

Operational Framework for Primary Health Care (2018)

Service availability and readiness assessment (SARA) (WHO,2015)

Water and Sanitation for Health Facility Improvement Tool (WASH FIT). WHO UNICEF 2017

Case Study 26

Health Profiles of the Urban Poor in 10 Cities of Pakistan

Country or Region

Pakistan – 10 Major Cities: (These include the two main cities of Sindh Province (Karachi and Hyderabad), the five main cities of Punjab Province (Faisalabad, Gujranwala, Lahore, Multan, and Rawalpindi), Quetta in Balochistan Province, Peshawar in Khyber Pakhtunkhwa (KPT) Province, and Islamabad Capital Territory.

Global Health Initiative

Gavi, other GHIs and Development Partners

PHC Operational Framework lever

Monitoring and Evaluation and PHC Orientated Research

Context

Almost one billion people are estimated to live in urban slums globally (UNHABITAT. Sustainable Urban Development (2020). In Pakistan it was estimated that 46% of the urban population lived in slums (UNHABITAT, 2022). These slums which are referred to as "Kachi abadis" were initially informal settlements located in both urban and peri urban areas of the 10 major cities of Pakistan. Studies in Pakistan had previously confirmed high incidence of communicable diseases and low immunisation coverage in many of these slum areas, with low access related to low numbers of Lady Health Workers, transport barriers and internal migration linked to conflict and humanitarian emergencies. (Khawaja Aftab Ahmed, 2022), The major factor constraining effective planning to improve services in the slums was lack of data and information on locations and populations of slums, including information about barriers to access and level of service availability (CHIP, UNICEF 2020). Given these challenges of low immunisation coverage and health inequities, a series of urban slum profiles were conducted between 2017 and 2019 in urban poor areas of 10 cities. This case study summarises the main activities and outcomes of the urban health profile method, based on published reports (CHIP, UNICEF 2020), analyses of the health system coverage and access (Khawaja Aftab Ahmed, 2022), and findings on the gender and social determinants of health care access in these locations (Ahmed, KA, 2022)

What were the specific objectives and/or activities?

The main objective of the urban slum profile study was to prepare in-depth profiling of slums with specific objectives of collecting socio-demographic information of slum residents, assessing availability of EPI facilities and health resources located in the slums and determining childhood immunization coverage rates in these locations. The studies were conducted by a partnership between national and sub national Governments, international organisations, an independent civil society organisation and local health managers in Union Councils.

The main types of assessment conducted were:

- Physical verification of slums and underserved areas

- Assessment of vaccination facilities and services

- Mapping of health resources in the union councils

- Qualitative discussion with residents of slum areas.

- Immunisation Coverage Survey in Urban Poor areas of 10 cities

Key lessons learned, or useful practices

Urban Slum Profile Findings

The urban slum profile findings demonstrate a complex mix of health system, gender, and social determinants of low health service access and zero dose vaccination. -

- Of the 41 million people in the 10 cities, nearly half (48%) were living in slums or in areas classified by local authorities as being underserved

- Of the 14,531 children surveyed, 53% were fully immunised (n=5774), with rates of zero dose vaccination [no vaccinations] was greater than 15% in six of the ten cities.

- Facility surveys (n=422 facilities) demonstrate insufficient availability of vaccination, social welfare, and nutrition services. Most of the slums are without public health facilities.

- Knowledge of the benefits of vaccination is low, and with lack of autonomous decision making by women being a main reason why children are not being vaccinated

- Levels of zero dose for vaccination were associated with low incomes, poor environmental conditions, low levels of opportunity for social networking, low rates of employment outside the home, and high levels of illiteracy

- Knowledge by mothers about the work of Lady Health Workers proved to be a significant predictor of a child's vaccination status.

- Few opportunities participation in health by community-based organisations reinforces social marginalization and lack of access to information on health care and other social services.

A combination of social and health system determinants of health means that the problem of zero dose vaccination cannot be resolved by health program or health systems solutions alone. It requires an integrated urban health and social services approach to address the environmental, socioeconomic and gender-based drivers of low public health service availability and utilization.

Urban Slum Profile Method

- The mixed method approach of the Urban Slum profiles proved to be well designed to deepen understanding of the health system, environmental and socio-economic determinants of low health service utilization and zero dose vaccination.

- The multiple determinants of Zero dose vaccinations highlights the importance of using both social and epidemiological data for learning and decision making. Such methods of inquiry should be integrated into needs assessments, survey methodologies and routine monitoring wherever possible.

Case Study 27

Community Dialogues for Setting Health Priorities in Sudan

Country or Region	Global Health Initiative
Sudan, West Darfur	UHC-Partnership and WHO

PHC Operational Framework lever
Engagement of communities; Governance & Policy (decentralised decision-making)

Context

In Sudan, community dialogues empower disadvantaged populations to decide on their health priorities. In the war-torn Darfur region of Sudan, communities are taking an active role in rebuilding their health services and advancing universal health coverage. Through regular community dialogues, they are empowered to identify, prioritize and propose solutions for their health needs, to hold local health authorities accountable, and to act as an early warning system in times of crisis such as the COVID-19 pandemic.

What were the specific objectives and/or activities?

A team from WHO, the Ministry of Health, the local health authority and the United Nations African Union Hybrid Operation in Darfur (UNAMID) visited four West Darfur communities (Kreinik, Mornie, Serba and ElGeneina) in November 2020.

Methods: Team held in-depth guided interviews with each community, using a questionnaire to identify gaps in all PHC services across the lifecourse. Critically, sustainably was addressed by providing Technical Assistance to institutionalise such dialogues and related follow up assessments within local health authorities. This includes support to re-establish and build up the capacities to community health committees, and working collaboratively to design a feasible and credible package of incentives to support and retain local health workers.

Expected results: Communities and local health authorities are given capacity building and other technical assistance, to set their own health priorities through collaborative, sustainable and feasible methods. This permits local health authorities to work with their community members and partner to find solutions appropriate to their local problems as they work closely with local health authorities.

Key lessons learned, or useful practices

1. **Inclusive engagement:** Community health dialogues bring together communities, local authorities, local health partners such as non-government organizations and community-based organizations to discuss health priorities and concerns, and envisage a way to prioritize and plan for better health outcomes.

2. **Impact:** local communities can meaningfully contribute to addressing health system bottlenecks. For example, communities helped local officials address the inequitable distribution of frontline health workforce by helping design locally appropriate and feasible workforce retention packages.

3. **Sustainability:** Institutionalizing dialogues. via regular participatory meetings between communities and local health authorities, provided those authorities with greater capacities to collaborate with community members in setting the health agenda and monitoring its implementation.

4. **Replicability:** In the communities in Darfur, the team and the community members discussed health challenges, epidemics and crises in the area, as well as the response and performance of the health team and coordination mechanisms. The communities made suggestions to improve the performance of the health team. In turn, the health team proposed what the community could do to contribute to better health outcomes in the locality. With future funding and support, this community engagement process will be replicated in ten other states in Sudan.

Acknowledgements and Links to relevant resources, references, expertise

UHC-Partnership Case Study, Sudan, pp 42-49 https://uhcplaunch.com/sites/default/files/2022-02/Stories-from-the-field_EMRO_issue-1_FINAL-1-December-2021%20%282%29.pdf

WHO Press release https://www.who.int/news-room/feature-stories/detail/sudan-s-community-dialogues-empower-disadvantaged-populations-to-decide-on-their-health-priorities

World Health Organization. (2022). The work of WHO in the Eastern Mediterranean Region: annual report of the Regional Director 2021. https://apps.who.int/iris/bitstream/handle/10665/363496/9789292740214-eng.pdf?sequence=1