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Maternal and Child Survival Program

Health Systems Strengthening in MCSP Country Programs

A Review of MCSP's Work to Strengthen Health Systems for Improved RMNCH

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MCSP is a global USAID initiative to introduce and support high-impact health interventions in 25 priority countries to help prevent child and maternal deaths. MCSP supports programming in maternal, newborn, and child health, immunization, family planning and reproductive health, nutrition, health systems strengthening, water/sanitation/hygiene, malaria, prevention of mother-to-child transmission of HIV, and pediatric HIV care and treatment. MCSP will tackle these issues through approaches that also focus on household and community mobilization, gender integration, and digital health, among others.

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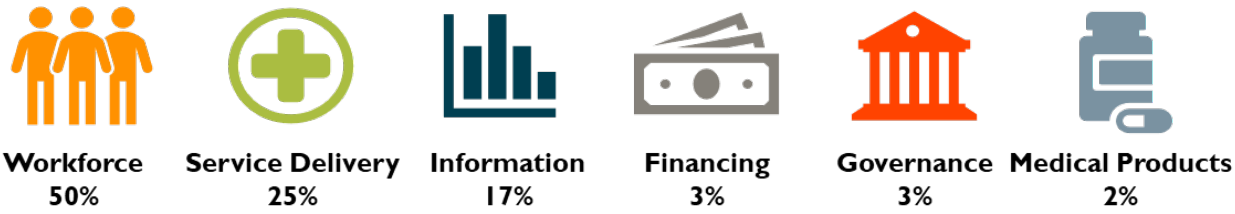
Acronym List

AIDS	Acquired immunodeficiency syndrome
AOTC	Acting on the Call
CHW	Community health worker
DHIS2	District Health Information System 2
GOR	Government of Rwanda
HIS	Health information system
HIV	Human immunodeficiency virus
HMIS	Health management information system
HSS	Health systems strengthening
HW	Health worker
IMNCI	Integrated management of neonatal and child illness
LARC	Long-acting reversible contraceptive
MCSP	Maternal and Child Survival Program
MOH	Ministry of Health
PPFP	Postpartum family planning
PY	Program year
QI	Quality improvement
RMNCH	Reproductive, maternal, newborn, and child health
USAID	United States Agency for International Development
USG	United States Government
WASH	Water, sanitation, and hygiene
WHO	World Health Organization

Executive Summary

USAID's flagship Maternal and Child Survival Program (MCSP) has worked in over 40 countries to improve coverage and quality of high-impact interventions in nine technical areas—family planning, maternal health, newborn health, child health, immunization, nutrition, malaria, HIV/AIDS, and water, sanitation, and hygiene (WASH). To support MCSP's reproductive, maternal, newborn, and child health (RMNCH) mandate, the program's approach to health systems strengthening (HSS) focuses on addressing barriers that directly affect service delivery and supporting institutionalization and scale-up of high-impact interventions. MCSP moves beyond providing system inputs to driving system performance improvements by purposely managing interactions between different parts of the system and changing policies, organizational structures, and behaviors that drive performance to improve equity, coverage, quality, and efficiency. To understand the breadth of MCSP's HSS work within country programs, the Health Systems Strengthening and Equity team conducted a comprehensive review of country program workplans active during the fourth program year (October 2017 – September 2018), mapping activities to the HSS strategies identified in USAID's 2017 *Acting on the Call* (AOTC) report to provide documentation of MCSP's HSS efforts that contribute to USAID's maternal and child mortality reduction targets.

The outputs of the mapping analysis showed that MCSP strengthens health systems in all of its country programs. On average, half of all activities within country workplans included HSS-focused strategies identified in the AOTC 2017 report. Of MCSP's HSS activities, half fall under workforce, with one-quarter devoted to service delivery, and approximately one-fifth to information systems. Financing, governance, and medical products functions comprise a comparatively smaller portion of MCSP's HSS activities:



MCSP HSS activities were further disaggregated by activities that provide direct inputs to support critical health system functions and activities that undertake comprehensive strengthening of health system performance drivers. While inputs are critical ingredients for functionality, they can be short-term and narrowly focused, whereas performance drivers fundamentally change *how* the system operates. Approximately one-third of MCSP's activities across country programs strengthen health system performance drivers.

Based on these conclusions, MCSP offers three primary recommendations to inform future programming: 1) continue and deepen programming that integrates multiple HSS strategies to improve coverage and quality of RMNCH services; 2) identify opportunities to incorporate financing strategies demonstrated to improve RMNCH outcomes; and (3) incorporate more activities aimed at strengthening health system performance drivers to deliver sustainable RMNCH improvements. Strong health systems are more efficient, resilient, and sustainable; only through comprehensive changes to how the system operates will countries be able to achieve sustainable improvements in RMNCH, thereby saving the lives of millions of women and children worldwide.

Introduction

The Maternal and Child Survival Program (MCSP) is a global, USAID Cooperative Agreement to improve coverage and quality of high-impact health interventions to address the leading causes of maternal, newborn, and child mortality. MCSP incorporates health systems strengthening (HSS) approaches to support programming along nine technical areas—family planning, maternal health, newborn health, child health, immunization, nutrition, malaria, HIV/AIDS, and water, sanitation, and hygiene (WASH).

USAID's *Acting on the Call* (AOTC) report provides annual updates on country progress toward achieving global targets for reducing maternal and child mortality. In its fourth edition, AOTC 2017 identified 29 HSS interventions that have been shown to save lives. AOTC further demonstrated the value of investing in HSS by providing quantitative estimates of the number of lives that would be saved through a set of evidence-based HSS interventions. It estimated that the scale-up of evidence-based HSS activities across 25 priority countries would save the lives of 5.6 million children and 260,000 women from 2016 to 2020 (Figure 1 below).

While MCSP incorporates HSS approaches across its country programs, MCSP's midterm evaluation found that HSS activities at country level were not well documented. To understand the breadth of MCSP's HSS work within country programs, the Health Systems Strengthening and Equity team conducted a comprehensive review of country program workplans active during the fourth program year (October 2017–September 2018), mapping activities to the HSS strategies identified in the 2017 AOTC report. The review was designed to assess alignment between MCSP's HSS activities and the AOTC HSS strategies and provide documentation of MCSP's HSS efforts that contribute to USAID's maternal and child mortality reduction targets.

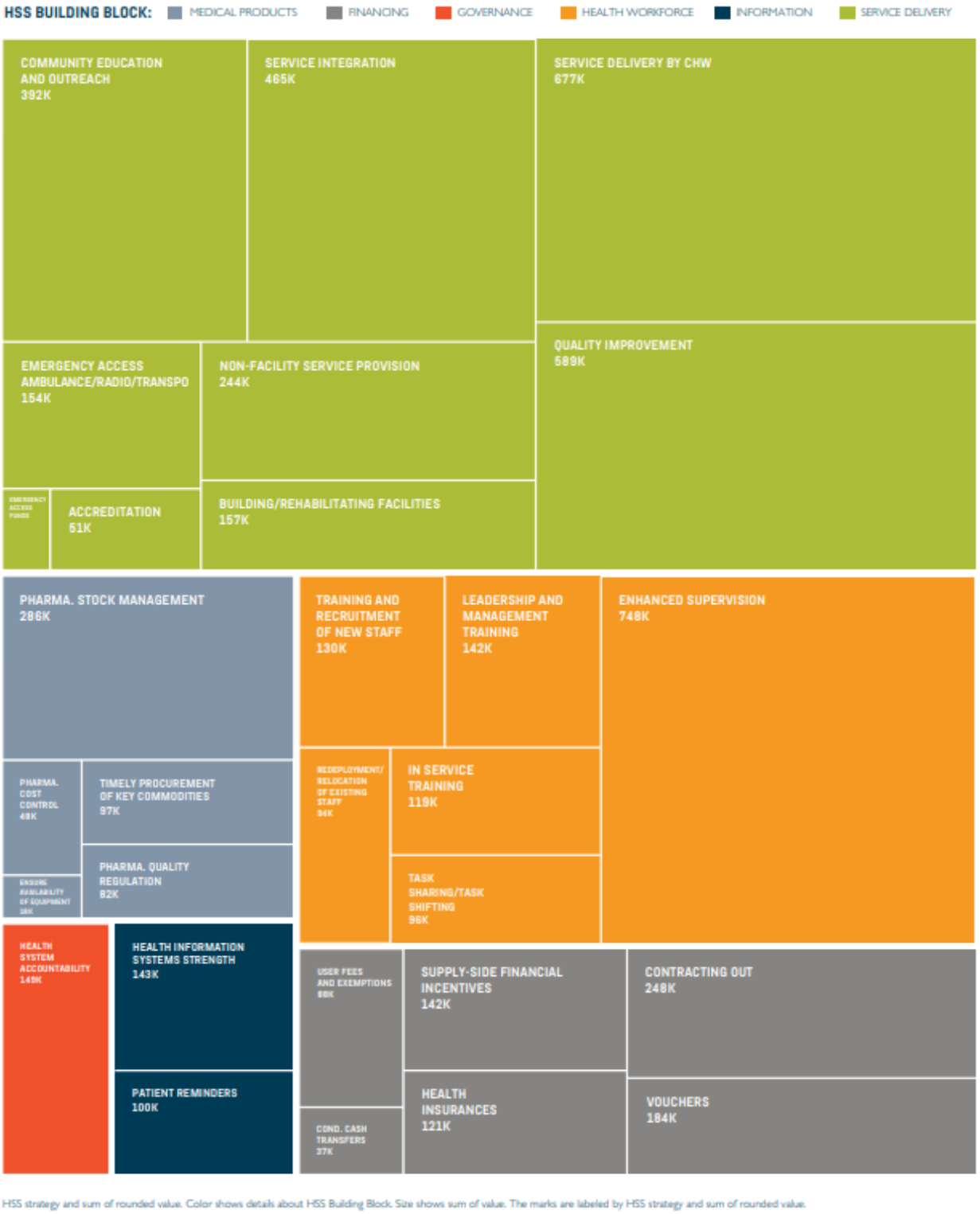
MCSP's Mandate and Approach for Health Systems Strengthening

MCSP aims to improve coverage and quality of high-impact interventions and is guided by three strategic objectives:

1. Support countries to increase coverage and utilization of evidence-based, high-quality reproductive, maternal, newborn, and child health (RMNCH) interventions at the household, community, and health facility levels.
2. Close innovation gaps to improve health outcomes among high-burden and vulnerable populations through engagement with a broad range of partners.
3. Foster effective policymaking, program learning, and accountability for improved RMNCH outcomes across the continuum of care.

To support its RMNCH mandate, MCSP's approach to HSS focuses on addressing barriers that directly affect service delivery and supporting institutionalization and scale-up of high-impact interventions. MCSP seeks to undertake HSS efforts that move beyond providing system inputs to driving system performance improvements, as well as going beyond individual health system building blocks to recognize the interconnectedness between health system functions and improving multiple functions in a complementary way to achieve performance improvements. Addressing gaps in human capacity throughout the system is a core strategy for MCSP, ranging from medical professionals to community health workers (CHWs) to health system managers. Complementing efforts in human capacity development, MCSP also supports improvements in health information systems (HIS) and data use so managers can better identify problems and gauge progress, as well as financial analysis to support planning and advocacy for scaling up high-impact interventions.

Figure 1: USAID AOTC 2017 estimate of maternal and child lives saved by 29 evidence-based HSS strategies (2016–2020)



Source: USAID 2017.

Methodology

Overview

All program year four (PY4) MCSP country workplans—including life-of-program and previous program year workplans with overlapping PY4 timelines—were included in the review; already completed programs were excluded. Workplans were reviewed and coded from October 2017–February 2018. Not all workplans had secured USAID approval at the time of assessment; in these instances, the most recently submitted workplan was included. In total, 32 country programs were included in the review.[1]

Each workplan was reviewed and coded at the sub-activity level, resulting in the mapping of approximately 1,400 activities. Each activity was coded according to the 29 HSS strategies identified in the AOTC report, which spanned the World Health Organization's (WHO's) six health system building blocks of service delivery, medical products, health workforce, health governance, health information, and health financing. Using the definition for each strategy provided in the AOTC report as guidelines (Appendix I), each workplan activity was assessed to see whether it applied an HSS strategy. The majority of activities were coded to only one HSS strategy, although they could be coded to a maximum of three strategies. Activities that were ancillary to an active intervention (e.g., documentation or learning activities) were not included.

Following the completion of the first round of mapping, the primary coder re-reviewed all workplans to ensure consistent application of the abovementioned guidelines. The team then engaged and trained a consultant to independently code all the workplans. The first and second mappings were then compared for discrepancies, which were resolved by a final reviewer.

Approach to Coding

The initial phase of the analysis was iterative, with two coders reviewing separate workplans, and frequent internal review of coding and clarification of AOTC strategy definitions. After the initial five to 10 workplans, the primary coder completed the first round of coding, and re-reviewed all workplans for consistency. An independent consultant then completed a second round of coding. The first and second round of coding results were compared for discrepancies, with a third reviewer resolving inconsistencies. To ensure consistency, the mapping team developed a set of guidelines that were continually refined during the coding process (Appendix II).

This process resulted in the inclusion of three additional HSS strategies not included in the AOTC report that were of particular importance within MCSP: strengthening the referral system under the service delivery building block, policy development under the governance building block, and financial planning and management under the financing building block.

The team's iterative process resulted in a tightly defined understanding of how common activities were coded. For example, an activity was only coded as "Quality Improvement" (QI) if it specifically mentioned the institutionalization of a QI approach; technical capacity building in itself was not coded as QI, even though an ultimate goal would be improved quality.

Human capacity development is a core component of MCSP's approach across country programs, with activities across five HSS strategies:

- In-service training – building capacity of existing health workers (HWs)
- Training and recruitment of new staff – strengthening pre-service education system, building capacity of new HWs

[1] Two MCSP country programs were not included in the analysis because their scopes of work included targeted activities (e.g., planning of evidence summit) that were atypical of MCSP country programs.

- Leadership and management trainings – building capacity of district/regional managers and health facility managers
- Enhanced supervision – mentoring and supportive supervision activities
- Service delivery by CHWs – building capacity of CHWs
- HIS strengthening – building capacity for compiling, analyzing, and using health data

Activities were not coded as pharmaceutical stock management if they solely involved MCSP-based stock management and procurement of health commodities. Only activities working to improve management of medical supplies within public supply chain systems (from national or subnational medical stores) were coded as HSS.

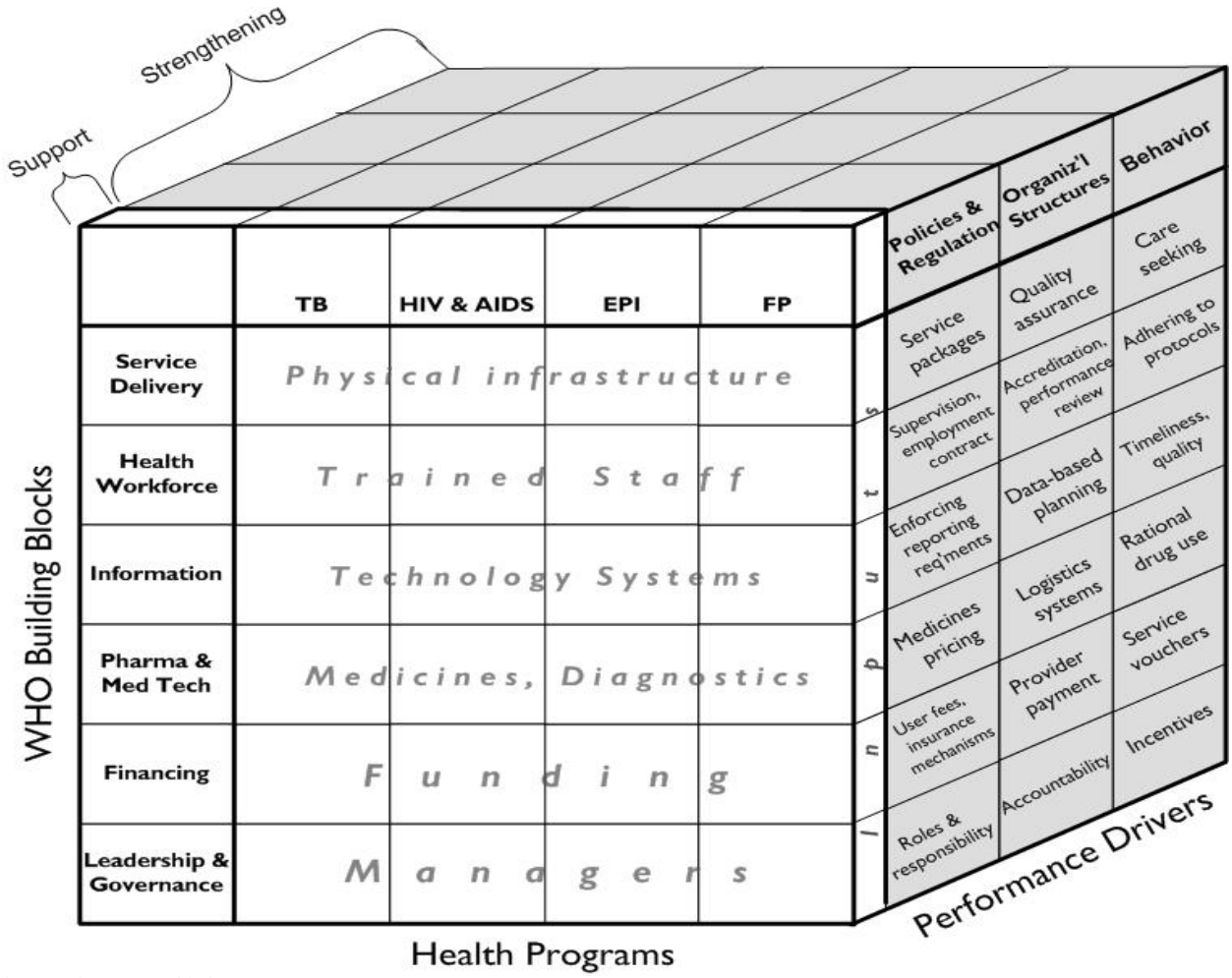
The mapping team also developed guidelines for the three HSS strategies not included in the AOTC report. Only activities involving large-scale policy changes were coded as the "Policy Development" category. For example, the development of a national health financing strategy would have been coded as policy development, but revisions to clinical guidelines for one intervention would not have been counted. General support to convene technical working group meetings that may discuss policy were not coded as policy development. "Strengthening the Referral System" was coded for activities that included improvements to referral networks. For example, an activity described as "link facilities with CHWs for referral" or "facilitate development of a strategy to include private sector in referral" would have been coded to this strategy. Finally, "Financial Planning and Management" included costing, cost-effectiveness, or facility business plan development activities, such as supporting a Ministry of Health (MOH) to develop a costed integrated management of neonatal and child illness (IMNCI) implementation plan or building the capacity of local actors to use a costing tool.

Distinguishing between System Inputs and Performance Drivers

MCSP HSS activities were further disaggregated by activities that provide direct inputs to support critical health system functions and activities that undertake comprehensive strengthening of health system performance drivers. This analysis was based on the framework outlined in Chee et al., 2013, which conceptualizes the health system as a cube consisting of the WHO core health system building blocks, health programs that provide needed services, and performance drivers (Figure 2).[2] HSS strategies can take the form of health system *inputs* that improve system functionality though may be short-term and narrowly focused (e.g., topping up salaries for target staff or supporting community volunteers). In contrast, HSS strategies that strengthen *performance drivers* involve more comprehensive and lasting changes to policies and regulations, organizational structures, and relationships across the health system building blocks that motivate changes in behavior, and/or allow more effective use of resources to improve multiple health services. To illustrate the difference using the "service delivery by CHW" strategy, *inputs* would include providing training, materials, medicines, and supplies for CHWs. Comparatively, strengthening *performance drivers* includes rationalizing CHW responsibilities (scope of work and households covered) and creating processes to improve linkages between CHWs and health facilities. While inputs are critical ingredients for functionality, performance drivers fundamentally change *how* the system operates.

[2] Chee, et al. (2013). "Why differentiating between health system support and health system strengthening is needed." *International Journal of Health Planning and Management* 28: 85–94.

Figure 2: Health system cube distinguishing system input and performance driver activities



Source: Chee et al., 2013.

To understand how MCSP HSS strategies were distributed among these input and performance driver dimensions, the mapping team categorized the 29 HSS strategies as inputs versus performance drivers; for those HSS strategies that may include both inputs and performance drivers, the team further defined the types of activities that would be strategies that provide inputs versus strengthening performances drivers.

Analysis

After the coding was completed, two adjustments were made: 1) to adjust for activities coded to more than one HSS strategy; and 2) to adjust for variation across workplan size and detail. Activities coded to two or three strategies, for example, would only count as one-half or one-third of a point under each strategy, respectively. This adjustment prevented over-counting of HSS activities in calculating the proportion of the workplan's activities containing at least one HSS strategy, or the number of activities incorporating various HSS strategies. Less than five percent of all workplan activities were coded to more than one HSS strategy.

The mapping team used workplan budgets to adjust for differences in size and detail across workplans. The workplan budget was used as a proxy for level of effort. Before aggregating totals across workplans, activities in each workplan were weighted by the size of the total workplan budget, assuming equal distribution across all workplan activities. For example, if two workplans each had a USD 1 million budget, but one had 10 activities and the other 100, then there would be different values assigned to each activity across the two workplans. Similarly, if two workplans both had 10 activities, but one had a USD 1 million budget and the other a USD 10 million budget, then each activity in the two workplans would be assigned a different value. This adjustment only affects the aggregated findings, ensuring small workplans with more detail at the activity level (i.e., larger number of activities) would not disproportionately influence the findings across MCSP.

After initial data analysis, the results at the country program levels were presented and validated with the MCSP country support team.

Limitations

The methodology and analytical approach were designed to allow for more apt comparisons across MCSP's workplans; however, the following limitations have been identified:

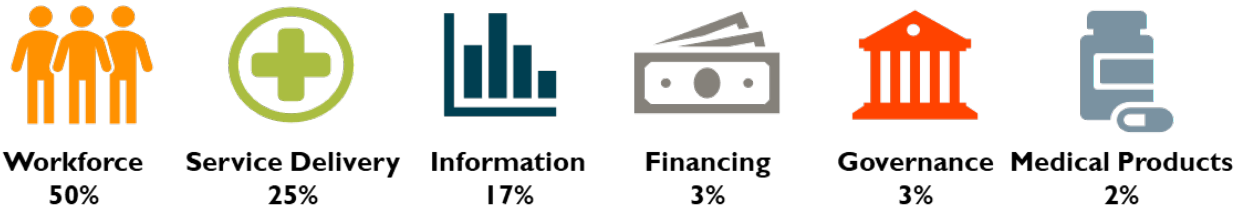
- **Definition of HSS:** This analysis used the AOTC 2017 evidence-based HSS strategies identified through its systematic review process to define HSS activities.
- **Program workplan period:** The analysis was limited to one program year (unless a program only submitted a life-of-program workplan,) although country program strategies do not tend to shift dramatically from year to year. Nonetheless, the analysis is not reflective of previous work conducted in each country that may have been needed to prepare for current activities.
- **Reliance on workplans:** Given variation in the level of detail in country workplans, it is possible that some small activities were not included in the analysis if they were not included in the workplan or included below the "sub-activity" level. It is also possible that there are activities included in workplans that are not fully implemented.
- **Interaction among HSS strategies:** Reviewing each sub-activity individually also does not capture the interactions among strategies; activities that may appear siloed to a particular health system building block may serve to reinforce other aspects of the health system, therefore more comprehensively strengthening the health system than one might recognize through an activity-by-activity review.
- **Interpretation of analytical outputs:** Budget is an imperfect proxy for level of effort. While budget allows for more accurate comparison across programs with different scopes, it nevertheless does not perfectly gauge the size of a set of activities given other relevant variables such as geographic scope, size of population served, varying expense of interventions, etc. Therefore, the analytical approach only allows for estimation of the *proportion* of MCSP work addressing health system constraints; the data is not reliable for estimation of budget or level of effort devoted to MCSP's HSS work.

Findings

Incorporating HSS in Country Programs

All MCSP country workplans incorporate HSS activities, with many incorporating multiple health systems strengthening strategies (Figure 3). Among the six core health system building blocks, the majority of MCSP's HSS activities focus on health workforce strengthening efforts, followed by service delivery and HIS strengthening:

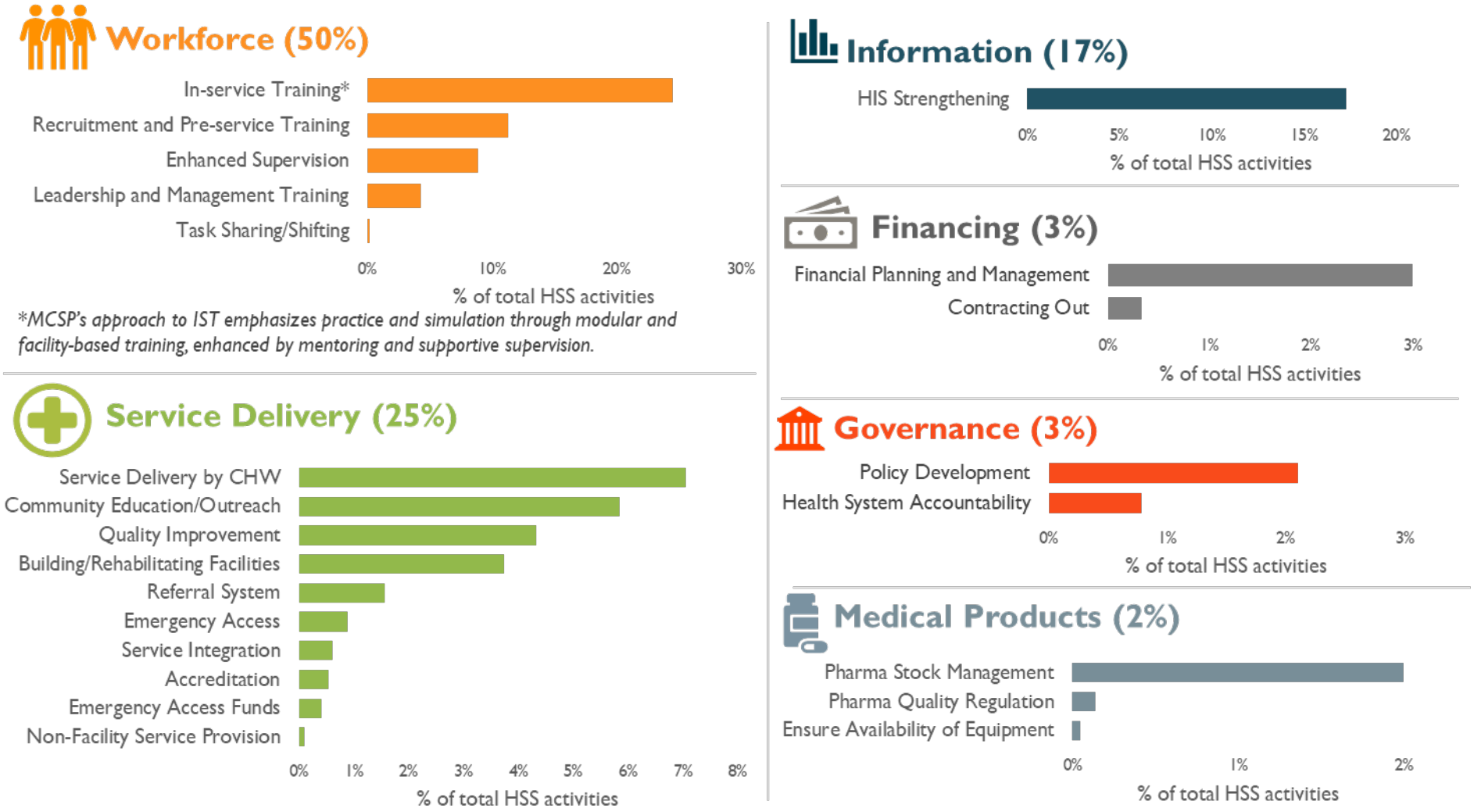
Figure 3: Distribution of MCSP HSS activities across health system building blocks



HSS Strategies in Country Programs

Figure 4 shows the proportion of country program HSS activities, each building block, as well as specific HSS strategies pursued (Appendix III presents an alternative visualization of Figure 4). Health workforce HSS activities comprise half of all MCSP country programs' HSS activities. Within the workforce building block, in-service training comprises the greatest share of MCSP's total HSS activities at 25 percent, followed by recruitment and pre-service education at 11 percent, and enhanced supervision (including supportive supervision and mentoring) at nine percent. Service delivery strengthening activities comprise one-quarter of MCSP's HSS activities, with the strategies pursued distributed across several of the AOTC strategies, including service delivery by a CHW at seven percent, community education and outreach at six percent, and institutionalization of QI approaches at four percent. Almost one-fifth of MCSP's HSS activities focused on HIS strengthening (17 percent). Comparatively fewer focused on strategies within the financing, governance, or medical products building blocks; however, financial planning/management and policy development comprised three percent and two percent of all HSS activities, respectively.

Figure 4: Detailed breakdown of MCSP HSS activities by HSS strategies



Note: Nine of the AOTC HSS strategies were not applied within MCSP country programs as reported in reviewed workplans.

The 10 most common HSS strategies across MCSP's country programs are shown below in Table 1. These strategies span the workforce, service delivery, information, and financing system building blocks.

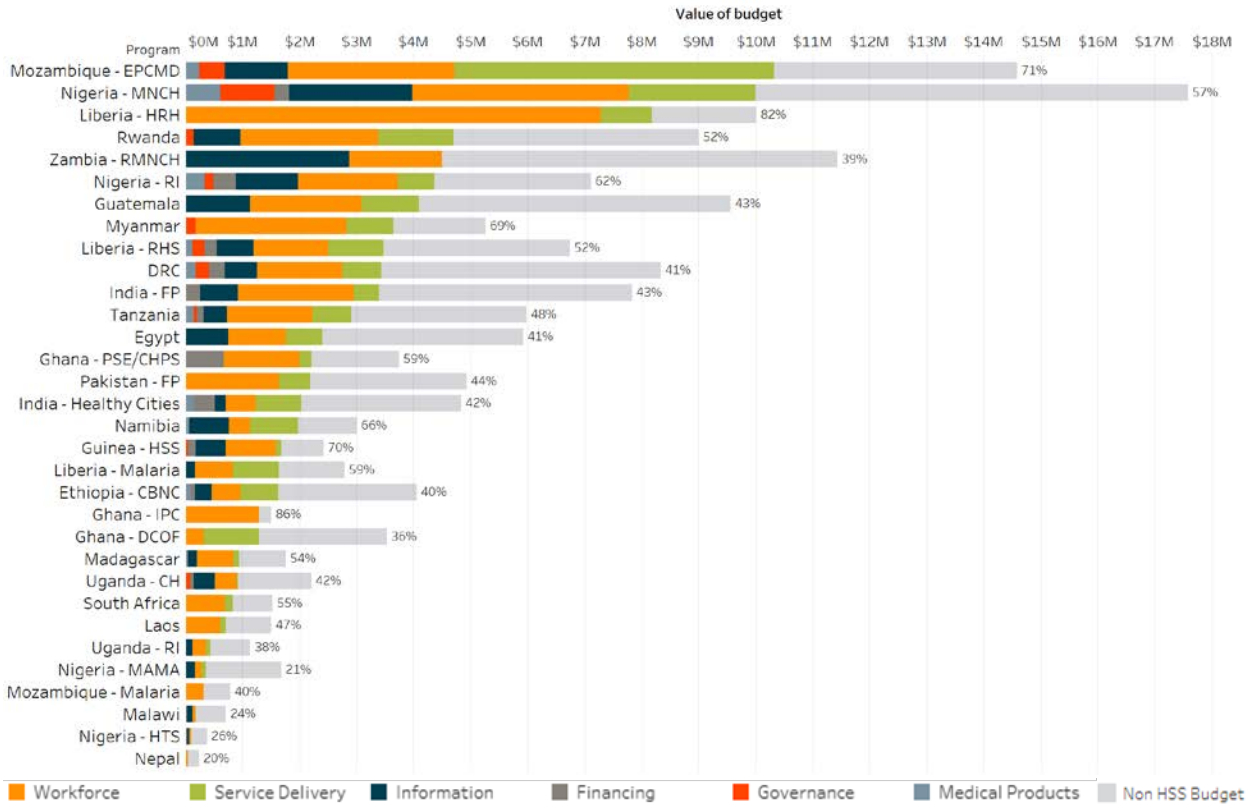
Table 1: Ten most common AOTC HSS strategies in MCSP programs

HSS Strategy	Proportion of MCSP Program Activities Incorporating Strategy
In-service training	25%
Health information systems strengthening	17%
Recruitment of new staff and pre-service education	11%
Enhanced supervision	9%
Service delivery by community health worker	7%
Community education and outreach	6%
Quality improvement	4%
Leadership and management training	4%
Building and rehabilitation of facilities	4%
Financing planning and management	3%

HSS as a Proportion of Country Program Activities

At the programmatic level, on average, half of all activities within country workplans included HSS-focused strategies; however, the range of HSS-focused activities as a proportion of a program's total workplan ranged from 20 percent to 86 percent. Figure 5, below, provides a portrait of each country program's HSS activities broken down by health system building blocks, and relative to the program's overall budget ceiling; the programs are presented in decreasing order by the weighted budget value of a program's HSS activities. For example, 71 percent of MCSP Mozambique's PY4 activities incorporated AOTC HSS strategies across the workforce, service delivery, information, governance, and medical products building blocks. Additional detailed treemaps on the breakdown of each country program's HSS activities by AOTC HSS strategies can be found in Appendix IV.

Figure 5: HSS activities as proportion of workplan activities, by system building blocks, in decreasing order by weighted budget value of HSS activities



Note: Text labels represent the proportion of a program's budget dedicated to HSS activities.

Integrating Multiple HSS Strategies

MCSP country programs worked across the health system building blocks, integrating an array of HSS strategies. All MCSP country programs incorporated at least one health workforce HSS strategy, and 88 percent incorporated HSS strategies in both the workforce and service delivery building blocks. Across all 32 country programs, five programs included strategies in all six health system building blocks (16 percent), five programs in five building blocks (16 percent), four programs in four building blocks (13 percent), nine programs in three building blocks (28 percent), six programs in two building blocks (18 percent), and three programs in one building block (nine percent) (Figure 6).

Figure 6: Breakdown of country programs by breadth of health system activities

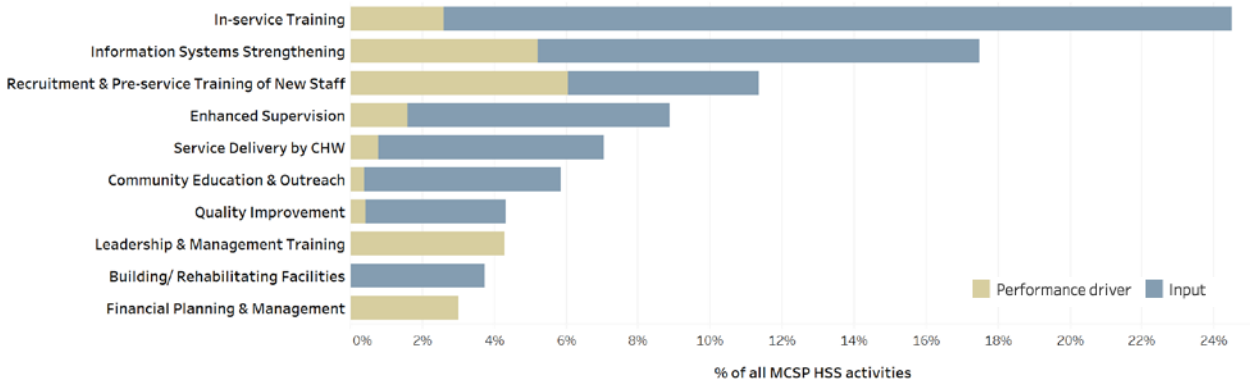
Within the workforce dimension, pre-service education, in-service training, and enhanced supervision were the most common AOTC HSS strategies across MCSP country programs. These three strategies were frequently incorporated into the same program: nine programs incorporated all three strategies, 12 incorporated in-service training and enhanced supervision, and three incorporated pre-service education and in-service training activities. Among those programs that only included pre-service education or in-service training strategies, the majority included other AOTC HSS strategies, such as service delivery and information system strengthening strategies.

Health System Inputs and Performance Drivers

While health system inputs are critical ingredients for functionality, they can be short-term and narrowly focused, whereas performance drivers fundamentally change *how* the system operates.[3] To illustrate the difference between inputs and performance drivers using in-service training as an example, an *input* could be a training on a new vaccine introduction while strengthening a *performance driver* could entail capacitating a regional training unit to use adult training techniques. Another example of this distinction using service delivery by CHW is that a critical system *input* could entail revising and disseminating CHW training curricula and materials, while strengthening a *performance driver* could include improving linkages and referral systems between facilities and CHWs.

Across all programs, 67 percent of MCSP's HSS activities were focused on providing *inputs* while 33 percent focused on comprehensively strengthening health system *performance drivers*. Across the 10 most common HSS strategies (Figure 7), those that included relatively more activities targeting performance drivers were recruitment and pre-service education of new staff and information systems strengthening.

Figure 7: Breakdown of 10 most common HSS strategies by input and performance driver



The following sections feature examples of how these HSS strategies are implemented across different MCSP country programs, and how they can be integrated within one country program, such as in Rwanda.

[3] Refer to Figure 2 for additional context on the distinction between inputs and performance drivers.

HEALTH SYSTEMS STRENGTHENING IN ACTION IN MCSP-SUPPORTED COUNTRIES

Workforce

MCSP strengthens health worker performance through health professions regulation, **pre-service education systems**, and innovative approaches for capacity development for the existing health workforce, focusing on cadres most essential for RMNCH services. MCSP strengthens pre-service education systems in Ghana, Kenya, Liberia, Madagascar, and Tanzania. MCSP develops the capacity of the existing workforce through a combination of **in-service training, mentoring, and supportive supervision**. MCSP uses evidence-based in-service training approaches, including low-dose, high-frequency training and modular, facility-based, and integrated training to emphasize practical experience and minimize disruption of service.

Financing

MCSP's financing work focuses on **generating practical cost estimates** to empower decision-makers to better analyze and advocate for their programs **to achieve financial sustainability and scale-up**. Once disseminated, this information can be used to compare costs of alternative approaches and inform future donor and governments investments in RMNCH. MCSP incorporates financial analysis to support long-term planning for primary health services in Ghana, essential newborn care and postpartum family planning in Rwanda, and the roll-out of an essential package of child health services in Uganda.

Service Delivery

MCSP **strengthens service delivery** by improving RMNCH services across the continuum of care. MCSP has supported 17 countries to increase coverage of high-impact RMNCH interventions at household and community levels by **task shifting service delivery** to community health workers and supporting **community education and outreach**. MCSP also works in 13 countries to institutionalize QI approaches for RMNCH services, tailoring a core set of QI principles to a country's context, needs, and systems. Additionally, MCSP strengthens vertical referral, integrated service delivery, and patient tracking to increase access to emergency services and utilization of routine services to reduce maternal and child mortality in eight countries.

Governance

MCSP strengthens governance structures for RMNCH services to make countries' health systems **more transparent and responsive**. MCSP increases community-level accountability through data use to improve the quality of RMNCH services. MCSP also works with subnational health managers to develop **accountability mechanisms** within district health management teams to improve health outcomes. MCSP's RMNCH policy work spans costing to **support advocacy** (e.g., DRC, Ghana, Madagascar, Rwanda), **strategic planning** (Egypt, India, Kenya, Mozambique, Nigeria, Rwanda, Tanzania), and **integrating new and updated RMNCH evidence into global and national policy** (Burma, Guinea, Liberia, Nigeria).

Medical Products

Across the globe, MCSP empowers health workers and district managers to monitor drug and vaccine availability, address stockouts when they occur, and prevent future stockouts through **training in stock management and use of logistics data**. In Liberia, Mozambique, Nigeria, and elsewhere MCSP successfully advocates for the inclusion of evidence-based products
(i.e., chlorhexidine, amoxicillin DT, LARCs) **on national essential drug lists and in sufficient quantities in government and donor budgets**. In Nigeria, MCSP links private medicine vendors to pharmaceutical distributors to improve their access to low-cost, high-quality products for the treatment of childhood illness.

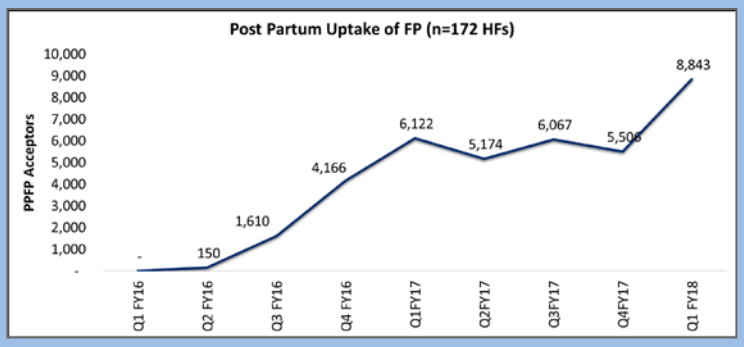
Information Systems

Together with MOH partners, MCSP strengthens the content of national HMIS and **collection, analysis, and utilization of data** at all levels of the health system to support decision-making and continuity of care for RMNCH services. In Tanzania, MCSP is developing the Health Information Mediator, which allows multiple HIS systems to communicate with each other and share data about individual clients, regardless of when and where care is received. In countries such as DRC, Namibia, Nigeria, and Rwanda, MCSP supports the implementation of DHIS2, strengthening the capacity of facility, district, and national managers to utilize and analyze health data, and adding community-level indicators and community-based data entry for **more complete RMNCH data**.

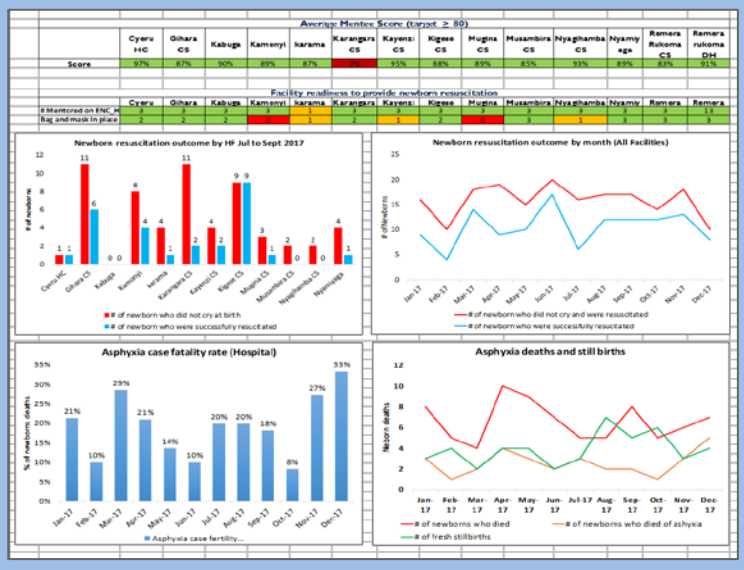
Integrating HSS Strategies for Improved RMNCH through MCSP Support in Rwanda

The goal of MCSP's program in Rwanda is to strengthen the capacity of the Rwandan MOH to manage and scale up high-impact RMNCH and malaria interventions. To support this objective, MCSP has worked to improve the quality and equity of services along the continuum of care, mobilize communities, and increase data use for decision-making. In tandem with its work across multiple RMNCH technical areas, the program has developed a cross-cutting HSS approach comprising more than half of its PY4 workplan activities. Specific HSS strategies include: 1) support for revised policies, strategies, and clinical guidelines; 2) targeted capacity building to address provider skills through in-service training and mentorship; 3) capacity development for scale-up planning and development of financial analyses to advocate for the scale-up of high-impact interventions; 4) strengthening of Rwandan professional associations to assume greater leadership in improving the quality of care, 5) quality assurance approaches to strengthen health services for gender-based violence, and 6) institutionalization of data system strengthening approaches for increased collection, reporting, and use of data at national, district, and facility levels. Collectively, MCSP Rwanda's HSS approach covers all health system building blocks and incorporates 10 evidence-based AOTC HSS strategies.

The Rwanda program has had significant success in its HSS efforts. Major achievements include: 1) institutionalization of DHIS2 dashboards for planning in all MCSP supported facilities; 2) increased uptake of postpartum family planning (PPFP) methods in 10 districts and Government of Rwanda (GOR) commitments to scale up nationally; 3) a multi-faceted mentorship program, including mentorship of CHWs; 4) increased clinical skills, supervision, and mentorship by GOR district-based mentors for maternal care, essential newborn care, and PPFP services; 5) increased access to high-quality health services for survivors of gender-based violence, and 6) mentorship, alternative training approaches, PPFP, use of dashboards, and QI systems adopted/included in key national strategies, policies including the Health Sector Strategic Plan (HSSP IV).



MCSP's approach for clinical training and mentorship for PPFP has shown a marked increase in uptake of PPFP methods in MCSP-supported districts.



MCSP supported the development of facility dashboards to improve data use for planning for essential newborn care and PPFP in MCSP-supported districts.

There has been a strong enabling environment for HSS in Rwanda, including strong political commitment to accelerated progress toward the Sustainable Development Goals and USAID alignment with GOR RMNCH priorities. In the long term, MCSP HSS efforts will leave a legacy of: enhanced supervision as a key strategy to sustain clinical skills for improved RMNCH outcomes, a strengthened data system infrastructure and culture of data use for decision-making at all system levels, empowered and experienced professional associated able to strengthen the health workforce and RMNCH service delivery models, and increased GOR capacity to plan and scale up high-impact RMNCH interventions to reduce maternal and child deaths.

Conclusions and Recommendations

Through its country programs, MCSP has supported a range of HSS strategies identified by AOTC 2017 to prevent maternal and child deaths. Aligned with MCSP's mandate to improve coverage and quality of high-impact RMNCH interventions, the majority of HSS investments in MCSP's country programs have centered on health workforce and service delivery strengthening strategies, such as enhanced supervision and QI. Activities to strengthen HIS also represent a significant portion of MCSP's HSS activities. On average, half of all activities in country programs included HSS strategies; in six of 32 programs, more than two-thirds of activities incorporated HSS strategies.

MCSP implemented relatively fewer HSS activities to address medical products, governance, and financing. Both MCSP's mandate and the AOTC-identified HSS strategies contributed to this result. Under medical products, four of the five AOTC HSS strategies are outside the mandate of MCSP (equipment to support supply chain logistics, pharmaceutical quality regulation, pharmaceutical cost control, and timely procurement of pharmaceutical) and supported by other USAID projects. AOTC only identified one strategy under governance—accountability, or policies and strategies to encourage transparency and hold actors to answer for their actions. Although the mapping team added policy development as a HSS strategy, ultimately only two HSS strategies were considered under governance. Regarding financing, the majority of MCSP's work focused on improving financial planning and management, including generating evidence to scale up and sustain high-impact RMNCH interventions. However, the AOTC-identified HSS strategies for financing include additional interventions that help to increase the demand for and quality of essential RMNCH services (e.g., voucher programs, supply-side financial incentives).

Although primarily a service delivery program, MCSP took advantage of opportunities at country level to address multiple health system barriers. In 23 of 32 programs, HSS activities integrated strategies across three or more building blocks. More concerted efforts to address cross-cutting issues like quality and HW performance from multiple synergistic dimensions may be useful—for example, supplementing HW capacity building with mechanisms for holding them accountable, and financial incentives for strong performance.

While addressing all parts of the health system, MCSP HSS activities have focused on providing critical health system *inputs*, with fewer activities aimed at comprehensively strengthening system *performance drivers*. This result may be driven by the short timeframes of country programming and USAID mission interests. Nonetheless, only by changing how the system operates will countries be able to achieve sustainable improvements in RMNCH.

Based on these conclusions, MCSP offers the following recommendations for future programming:

- **Continue and deepen programming that integrates multiple HSS strategies to improve coverage and quality of RMNCH services.** Thoughtful program design that incorporates interventions across the health system to address multiple causes of weak performance in a synergistic way helps to extend and reinforce potential benefits of individual interventions.
- **Incorporate more activities aimed at strengthening health system performance drivers to deliver sustainable RMNCH improvements.** While health system *inputs* are indeed important, their effects can be short-term and narrowly focused. Comprehensive changes to policies and regulations, organizational structures, and relationships across the health system building blocks are necessary to sustainably improve health outcomes over the long term.

- **Identify opportunities to incorporate and collaborate with partners on financing strategies demonstrated to improve RMNCH outcomes.** Particularly in the area of maternal health, there is a body of evidence that supports the use of financing interventions including conditional cash transfers, vouchers, contracting, and supply-side performance-based financing to improve health outcomes.[4, 5, 6, 7] Incorporating these interventions as appropriate, collaborating with other partners leading health financing interventions, and documenting their outcomes can contribute to achieving larger RMNCH goals.

"USAID invests in HSS to promote country ownership and sustainability, scale up solutions, and promote greater efficiencies in investments."[8] MCSP has contributed to stronger health systems in all its program countries to improve the coverage, quality, and sustainability of RMNCH services. Stronger health systems are more efficient, resilient, and sustainable, providing better health, and saving the lives of millions of women and children worldwide.

[4] Hatt, et al. (2015). *Impact of Health Systems Strengthening on Health.* Health Finance & Governance Project, Abt Associates. At: https://www.hfgproject.org/wp-content/uploads/2016/03/Impact-of-Health-Systems-Strengthening-on-Health-7-24-1.pdf.
[5] USAID. (2012). *USAID Evidence Summit on Enhancing Provision and Use of Maternal Health Services Through Financial Incentives*. At: https://www.usaid.gov/sites/default/files/documents/1864/mh_financing_concept_paper.pdf.
[6] Wiysonge, et al. (2017). "Financial arrangements for health systems in low-income countries: an overview of systematic reviews." *Cochrane Database of Systematic Reviews* 9. At: http://cochranelibrary-wiley.com/doi/10.1002/14651858.CD011084.pub2/full.
[7] Herrera, et al. (2017). "Governance arrangements for health systems in low-income countries: an overview of systematic reviews." *Cochrane Database of Systematic Reviews* 9. At: http://cochranelibrary-wiley.com/doi/10.1002/14651858.CD011085.pub2/full.
[8] USAID. (2015). *USAID's Vision for Health Systems Strengthening 2015–2019*. At: https://www.usaid.gov/sites/default/files/documents/1864/HSS-Vision.pdf.

Appendices

Appendix I: AOTC 2017 Glossary of Terms

Critical Health Systems Constraints, or bottlenecks, are issues in a health system that reduce the ability of the population to access quality care.

They include:

Availability of Commodities

Availability of Human Resources

Financial Affordability

Geographical Access

Sociocultural Acceptability

These bottlenecks may be more or less critical depending on the setting in which care is delivered. For the purposes of the analysis in this report care delivery settings are grouped into four categories:

Community based practices (WASH, bednets, breastfeeding);

Preventive Care (family planning, antenatal care, immunization);

Delivery Care (normal and emergency obstetric and neonatal care); and

Care for Childhood Illness (treatment for child illness including pneumonia, diarrhea, malaria, neonatal sepsis, etc).

Health Systems Activities[v] improve some, or all, of the constraints:

Health Financing *helps countries mobilize sufficient resources to pay for health needs and aim to reduce catastrophic health costs to individuals, thereby improving access to and availability of services that improve and save lives.*

Conditional cash transfers are cash payments made to individuals or households for medical spending and are contingent upon certain behaviors (i.e. school attendance) or use of particular services (i.e. immunization).

Contracting out refers to governments establishing contracts with health care providers to offer publicly-funded health care services to a specified population.

Health insurance collects regular and predictable payments from large numbers of people to "pool" resources and disburse payments to eligible individuals for health care when it is needed.

Supply-side financial incentive programs—including performance-based financing, performance-based incentives, and pay-for-performance programs—provide rewards to providers or facilities that are based on the achievement of specific health outcomes, increased service use and/or improved service quality.

User fees are point-of-service charges patients pay to receive care. User fee exemption policies aim to reduce the financial burden on vulnerable patients and increase access to health care services by reducing or eliminating fees for certain services (i.e., delivery care) or certain groups (i.e., pregnant women or under-five children).

Vouchers provide coupons to individuals, based on eligibility criteria, to receive free or reduced-price access to care.

Health Workforce *interventions aim to improve the availability and accessibility of qualified health care providers to a population in order to save lives through adequate and appropriate service delivery.*

Enhanced Supervision is a broad set of supervisory interventions that improve provider performance through team-based, learning approaches, including supportive supervision, the use of checklists and in-person visits.

Leadership and Management Training is the provision of training of health workers and facility managers in management and leadership skills to improve care delivery.

Relocation of Existing Staff is the process of redistributing the existing health workforce to optimize population access to health care services, especially in rural and underserved areas.

Task sharing / Task shifting is the redistribution of duties for health care workers as a way to increase patient access to service delivery.

[v] Developed by the EQUIST Expert Review Panel

Training and Recruitment of New Staff is the action of increasing the supply of qualified health workers.

Health Information *interventions aim to improve the collection, analysis, dissemination, and timely use of health data in evidence-based decision making at all levels of the health system in order to save lives.*

Health Info Systems Strengthening is the effort to improve the organizational, behavioral and technical capacity of the health information system so that decision making at the national and subnational levels is informed by timely, complete and accurate data.

Patient Reminders are electronic communications sent to patients to increase compliance with appointments and adherence to treatment.

Health Governance *interventions help improve the responsiveness of health systems to their populations, thus addressing perceptions of poor quality or mistreatment which may impede populations from accessing health services.*

Health System Accountability is the existence of appropriate policies and strategies to promote transparency in the health system and encourage that all actors answer for their actions.

Medical Products *interventions aim to ensure that people have sustained access to and make appropriate use of safe, effective, and quality medical products to improve their health status and save lives.*

Ensure Availability of Equipment is the procurement of all necessary equipment within the supply chain, from the central medical store to a health facility, necessary to safely and effectively deliver medication and supplies.

Pharmaceutical Cost Control is the practice of managing or reducing costs for medicines and supplies required by the health system, while maintaining quality.

Pharmaceutical Quality Regulation is the set of rules or policies that ensure the quality and integrity of pharmaceuticals.

Pharmaceutical Stock Management is the effort to maintain a continuous and sufficient stock of appropriate drugs and supplies in facilities and other patient serving settings.

Timely Procurement of Medical Products is the selection and purchasing of appropriate medications and supplies to prevent shortages and stock-outs.

Service Delivery *interventions aim to ensure access to safe, effective, and high-quality services by individuals and populations when they need them in order to sustain health and well-being and to prevent illness and death.*

Building/Rehabilitation of Facilities is the constructing and renovating of health facilities in order to improve access to and/or quality of health care services.

Community Education and Outreach encompasses all learning activities conducted collaboratively with individuals and groups in a community to raise awareness, transfer knowledge and skills and catalyze behavior change.

Emergency Access Interventions are programs and structural interventions designed to facilitate access to medical care in emergencies, including ambulances, radio communication, accompaniment, and maternity waiting homes.

Facility Accreditation is a process by which an independent body evaluates compliance with an established set of norms and standards that are meant to optimize the quality of services provided at the facility level.

Quality Improvement consists of systematic and continuous actions that lead to measurable improvement in health care services and the health status of targeted patient groups.

Service Delivery by Community Health Workers are services performed by a non-medical professional who is trusted in the community and trained to support, diagnose, and/or deliver culturally-competent basic health services.

Service Integration refers to a broad array of service delivery activities meant to enable patients to receive multiple needed health services in a coordinated and convenient fashion.

Service Provided Outside Facility is the provision of priority services by medical practitioners to improve access to care outside of a standard fixed health facility site.

Improvements in Care Come in Stages.

As country health systems improve and develop more facilities are able to offer evidence based standards of care to broader swaths of the population. While all people may not have access to quality services, more people are consistently able to access services of higher quality than were available to them before the systems strengthening interventions.

Improvements in Basic Health Services refers to the percentage of a population that is able to access any health care at all for key maternal and child health interventions. Depending on the care delivery setting, this may include: ownership of a net, partial breastfeeding, beginning immunization series, receiving one ANC visit, delivering in a basic health facility, or treating diarrhea with oral rehydration therapy.

Improvements in Improved Health Services refers to the percentage of a population that is able to access care that meets basic standards for maternal and child health interventions. Depending on the care delivery setting, this may include: ownership of an ITN, predominant breastfeeding, use of contraception, receipt of full immunization series, four ANC visits, delivering in a health facility capable of handling basic emergency care.

Improvements in Quality Health Services refers to the percentage of a population that is able to access high quality care, represented by correct implementation of evidence based maternal and child health interventions when and where they need them. Depending on the care delivery setting, this may include: exclusive breastfeeding, use of modern methods of contraception, ANC which includes recommended diagnostic tests, delivery in facilities capable of performing comprehensive emergency care, or treatment of diarrhea with scientifically formulated oral rehydration solution.

Source: USAID 2017.

Appendix II: HSS Strategy Coding Guidelines

Strategy	Input or Performance Driver	Definition Based on AOTC Italicized Criteria Developed by MCSP in Bullets
Service Delivery		
Community Education and Outreach	Input	*Activities to raise awareness, transfer knowledge and skills, and catalyze behavior change* • Include community education activities like church services, theater presentations, and other community events that describe health practices to community • Include supporting community agents, liaisons, and volunteers
	Performance Driver	• Include integrating community outreach within government plans and budgets • Include training and systems to support HW outreach to communities
Service Integration	Performance Driver	*Activities that enable patients to receive multiple needed services in coordinated and convenient fashion* • Include service delivery protocols or standard operating procedures • Include new integrated reporting forms • Exclude integrated training
Service Delivery by Community Health Worker	Input	*Services provided by non-medical professional who is trusted in the community and trained to support, diagnose, and/or deliver culturally competent basic health services* • Include training for CHWs and materials, medicines, supplies, transport, and incentives for CHWs
	Performance Driver	• Include support to rationalize CHW roles and responsibilities • Include support to improve linkages between CHWs and health facilities
Emergency Access Interventions	Input	*Programs and structural interventions designed to facilitate access to medical care in emergencies* • Include ambulances, radio communications, accompaniment, and waiting homes
	Performance Driver	• Include establishing transport systems (e.g., identifying village vehicles, private vehicles) • Exclude vouchers for transport (e.g., vouchers) • Include changes to emergency access procedures (e.g., calling ahead, access to non-health government vehicles) • Include establishing community mobilized and managed funds for emergency transport
Emergency Access Funds	Input	*Funds to support emergency access* • Exclude funds that are community mobilized and managed

Strategy	Input or Performance Driver	Definition Based on AOTC Italicized Criteria Developed by MCSP in Bullets
Non-Facility Service Provision	Input	*Provision of priority services by medical practitioners outside a fixed facility site* • Include funds for outreach and per diem • Include vehicles and equipment to support outreach
	Performance Driver	• Include processes for planning and coordination to identify locations and services requiring outreach • Include integrating outreach into government plans and budgets
Quality Improvement	Input	*Systematic and continuous actions to improve health services* • Include training in QI processes • Exclude HW clinical training not focused on QI processes
	Performance Driver	• Include integrating QI indicators into existing reporting and performance review systems • Include integrating QI activities into government plans and budgets
Facility Accreditation	Performance Driver	*Independent body certifies compliance to standards to optimize quality at facilities* • Exclude MCSP-based certification processes, like Model Maternity
Building/Rehabilitation of Facilities	Input	Constructing or renovating health facilities in order to improve access to and/or quality of health care services • Include additions to existing facilities
Referral System (added by MCSP)	Performance Driver	• New tools to improve referrals (HW tools and job aids, referral and counter-referral forms, reporting systems, and indicators)
Medical Products		
Pharmaceutical Stock Management	Performance Driver	*Maintain continuous and sufficient stock of drugs and supplies in facilities and other patient serving settings* • Include training for quantification and ordering, improving ordering processes • Include advocacy for government funding of critical medicines, including new drugs/formulations in essential drug lists • Exclude MCSP reviews of stocks or MCSP-based stock management
Pharmaceutical Cost Control	Performance Driver	*Managing or reducing cost for medicines while maintaining quality*
Timely Procurement of Medical Products	Performance Driver	*Selection and purchasing of medicines and supplies to prevent shortages or stockouts*
Pharmaceutical Quality Regulation	Performance Driver	*Rules or policies to ensure quality and integrity of pharmaceuticals*

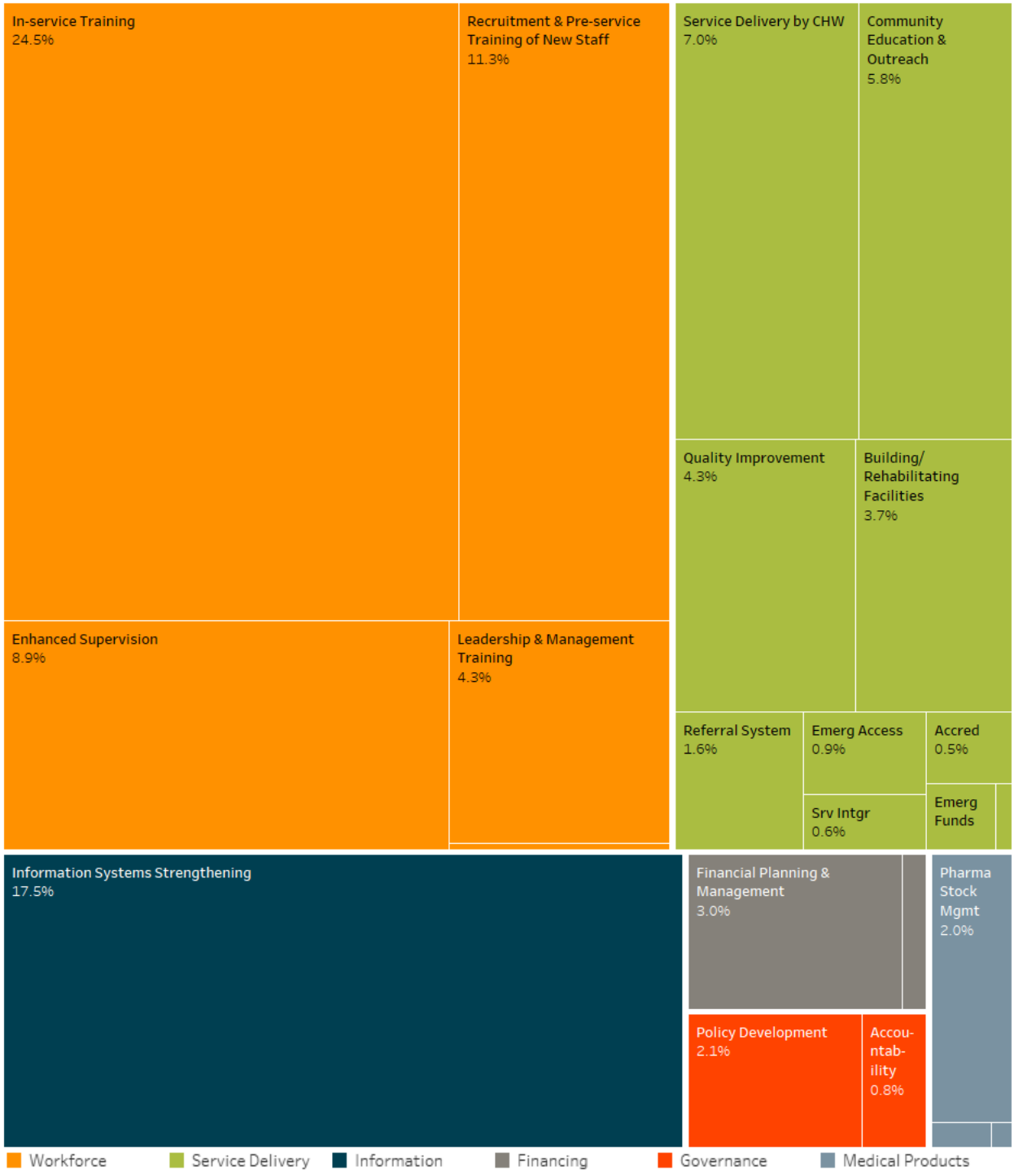
Strategy	Input or Performance Driver	Definition Based on AOTC Italicized Criteria Developed by MCSP in Bullets
Ensure Availability of Equipment	Performance Driver	*Procurement of necessary equipment within the supply chain from the central medical store to a health facility to safely and effectively deliver medicines and supplies* • Exclude if no mention of national or subnational public medical store
Workforce		
Training and Recruitment of New Staff	Input	*Increasing supply of qualified HWs* • Include pre-service education for new HWs • Include MCSP financing new staff salaries
	Performance Driver	• Include review and revision of training materials and approaches used in pre-service education • Include revision of recruitment policies, including recruitment at subnational levels, new staff incentives, etc.
Leadership and Management Training	Performance Driver	*Training HWs and facility managers in management and leadership skills to improve care delivery* • Include new incentives to improve management and/or leadership
Enhanced Supervision	Input	*Improving supervision systems to strengthen quality and performance through team-based learning approaches* • Include mentorship or supervisory visits • Include funding for supervision • Include vehicles for supervision
	Performance Driver	• Include new supervision checklist or procedures • Include district planning and budgeting for supervision
Redeployment/Relocation of Existing Staff	Performance Driver	*Redistributing existing HWs to optimize population access to health care services, especially to rural and underserved areas*
In-Service Training	Input	*Clinical training for existing HWs to introduce new interventions or improve quality of existing interventions* • Include development of training materials, training of trainers, clinical training for HWs
	Performance Driver	• Include in-service training activities integrated into government plans and budgets • Include strengthening local training institutions to conduct in-service training
Task Sharing/Task Shifting	Performance Driver	*Redistribution of duties for health care workers as a way to increase patient access to service delivery (such as from doctors to nurses)*
Governance		
Health System Accountability	Performance Driver	*Policies and strategies to promote transparency and encourage all actors to answer for their actions* • Include support to community health committees that have coordination and communication function with facilities • Include data use by patients/communities to hold facilities accountable

Strategy	Input or Performance Driver	Definition Based on AOTC Italicized Criteria Developed by MCSP in Bullets
Policy Development (added by MCSP)	Performance Driver	*Large-scale policy changes at the national level to improve health outcomes across the country* • Include activities such as development of a national health financing strategy • Exclude smaller-scale efforts focused on guideline revisions or program-specific policies, such as an update to an immunization policy
Information		
Health Information Systems Strengthening	Input	*Improve organizational, behavioral, and technical capacity of HIS so that decision-making at the national and subnational levels is informed by timely, complete, and accurate data* • Include hardware purchases, training, and technical assistance on design and implementation • Include quarterly/annual reviews of progress on indicators
	Performance Driver	• Include indicator revisions for HIS • Include training for managers on data analysis • Include incentives for data reporting • Include establishment of new dashboards/databases for collecting and displaying health data
Patient Reminders	Input	*Electronic communications to patients to increase compliance with appointments and adherence to treatment* • Include MCSP-generated reminders
	Performance Driver	• Include reminder systems established within government (originating from government health facilities and government records)
Financing		
User Fees and Exemptions	Performance Driver	*User fee exemption policies that reduce or eliminate fees to increase access to health services*
Conditional Cash Transfers	Performance Driver	*Payments to individuals or households for health spending contingent on certain behaviors (e.g., school attendance, immunization, delivering at facility, etc.)*
Supply-side Financial Incentive	Performance Driver	*Performance-based financing, pay-for-performance, performance-based incentives; provide incentives (usually cash) to individuals or facilities based on service targets*
Health Insurance	Performance Driver	*Collect regular and predictable payments from large numbers of people to pool resources and disburse payments to eligible individuals for health care when it is needed*
Contracting Out	Performance Driver	*Government enters into contracts with non-government health providers to provide services with public funds*

Strategy	Input or Performance Driver	Definition Based on AOTC Italicized Criteria Developed by MCSP in Bullets
Vouchers	Performance Driver	*Coupons provided to individuals for free or reduced fee to access health services*
Financial Management and Planning (added by MCSP)	Performance Driver	*Costing or cost-effectiveness analyses, and/or facility business plan development to facilitate planning and sustainability analysis*

Appendix III: Breakdown of MCSP HSS Activities by AOTC HSS Strategies

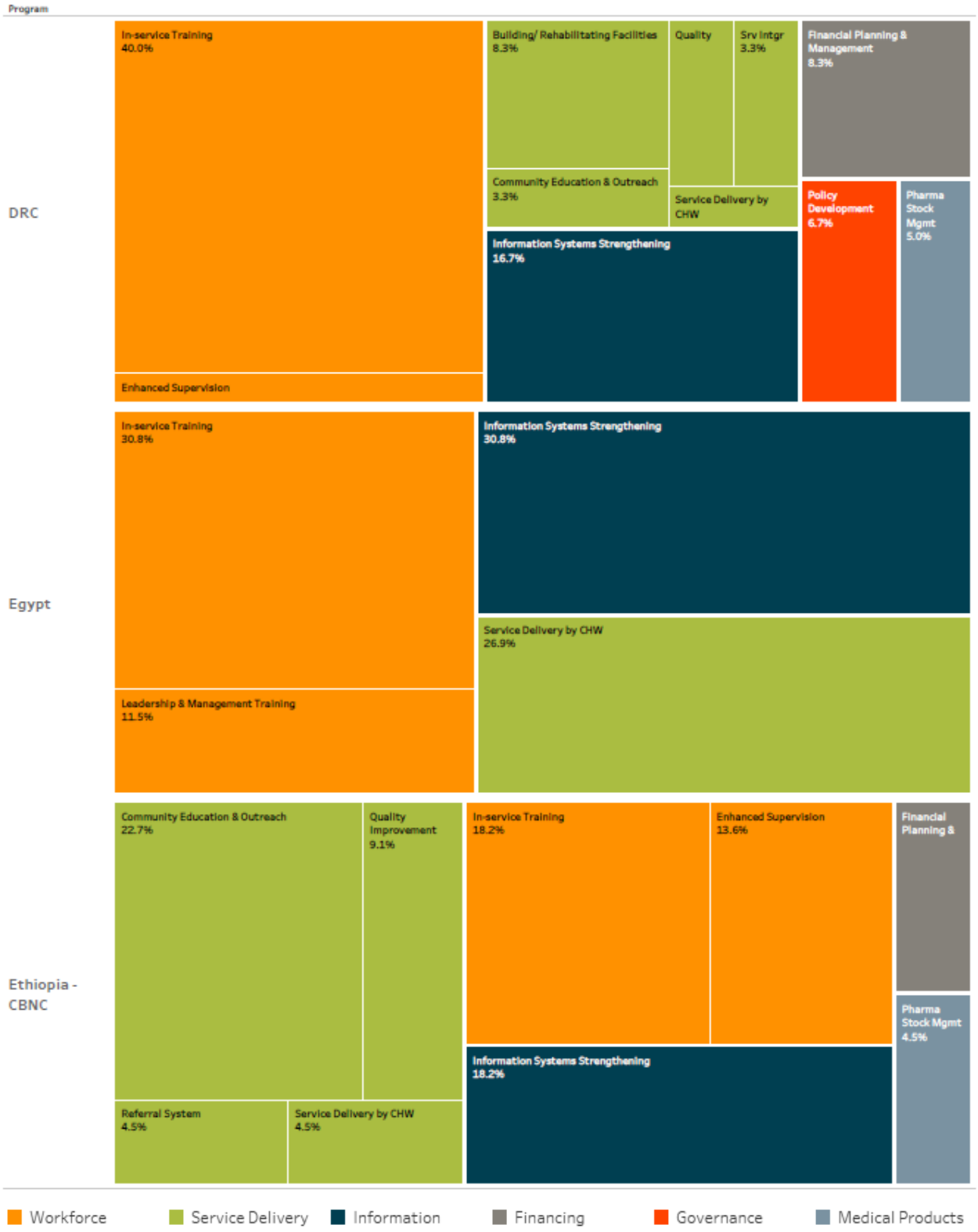
This view aligns with similar information displayed in AOTC 2017, but represents the same information visualized in Figure 4. The percentages represent the proportion of all HSS activities across all mapped country programs.[9]

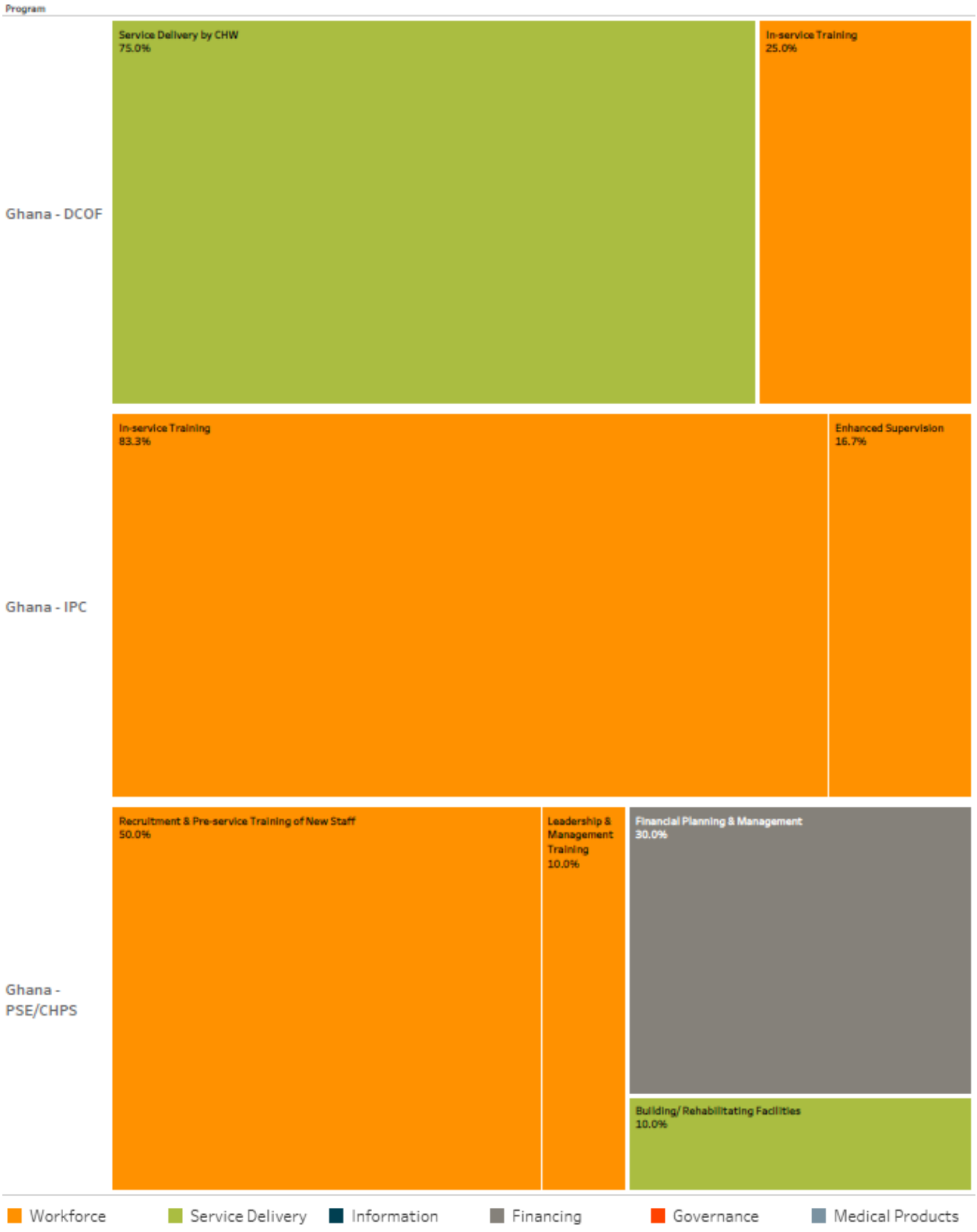


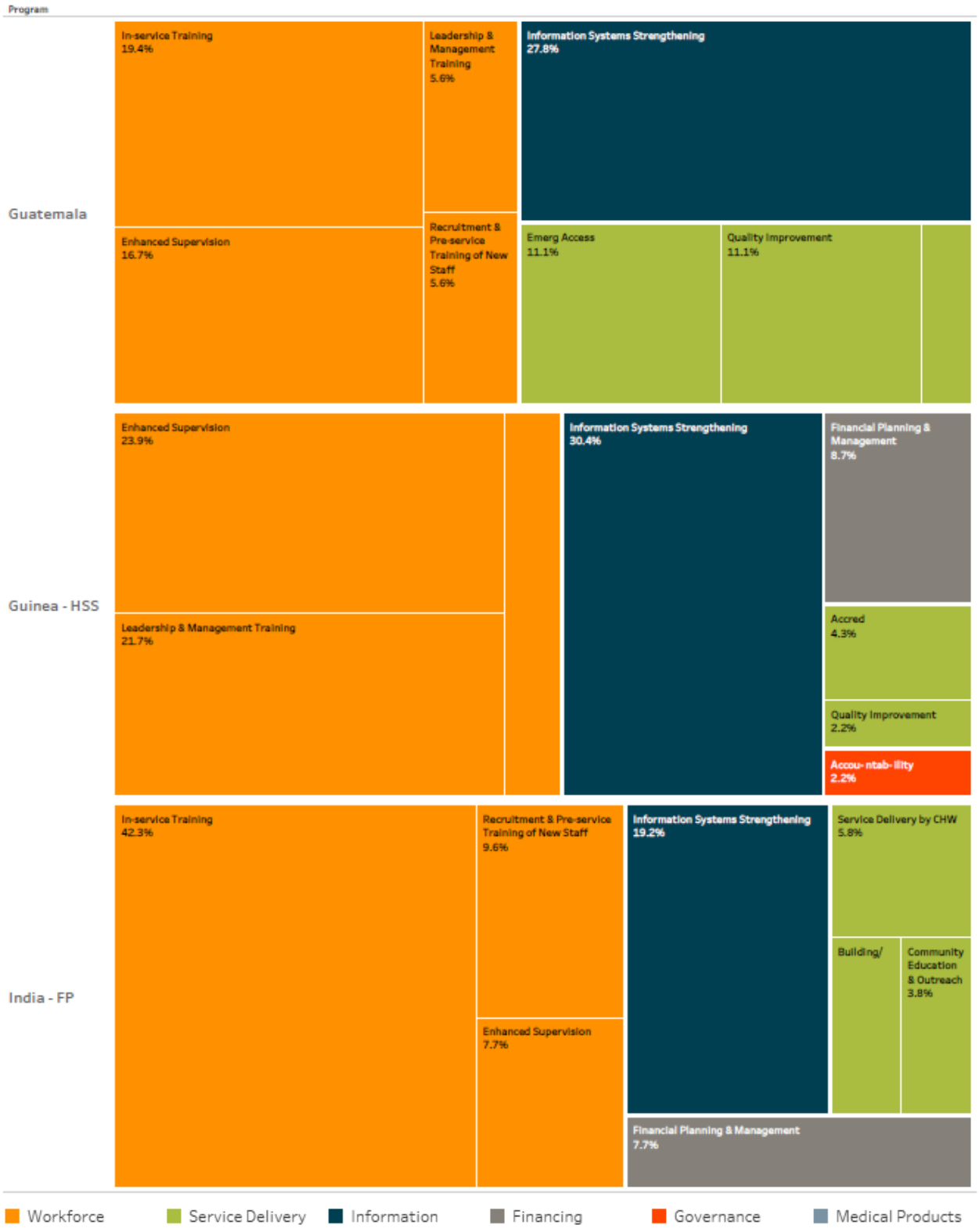
[9] HSS strategies comprising less than 0.5% of HSS activities are unlabeled. They include: 1) task-shifting (0.1%) under workforce, 2) non-facility service provision (0.1%) under service delivery, 3) contracting out (0.3%) under financing, and 4) pharmaceutical quality regulation (0.2%) and equipment redistribution (0.01%) under medical products.

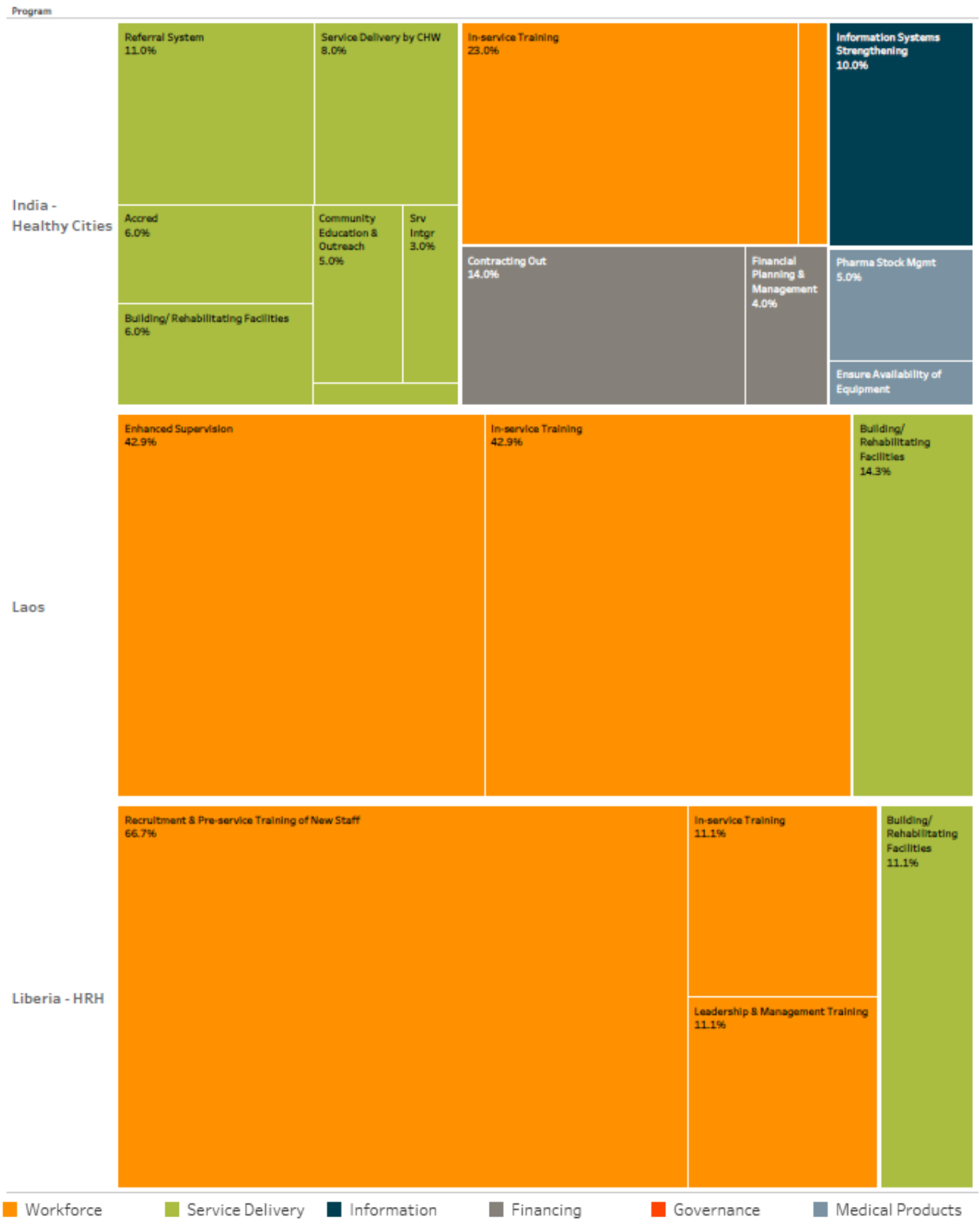
Appendix IV: Breakdown of HSS Activities by AOTC HSS Strategies for Each MCSP Country Program

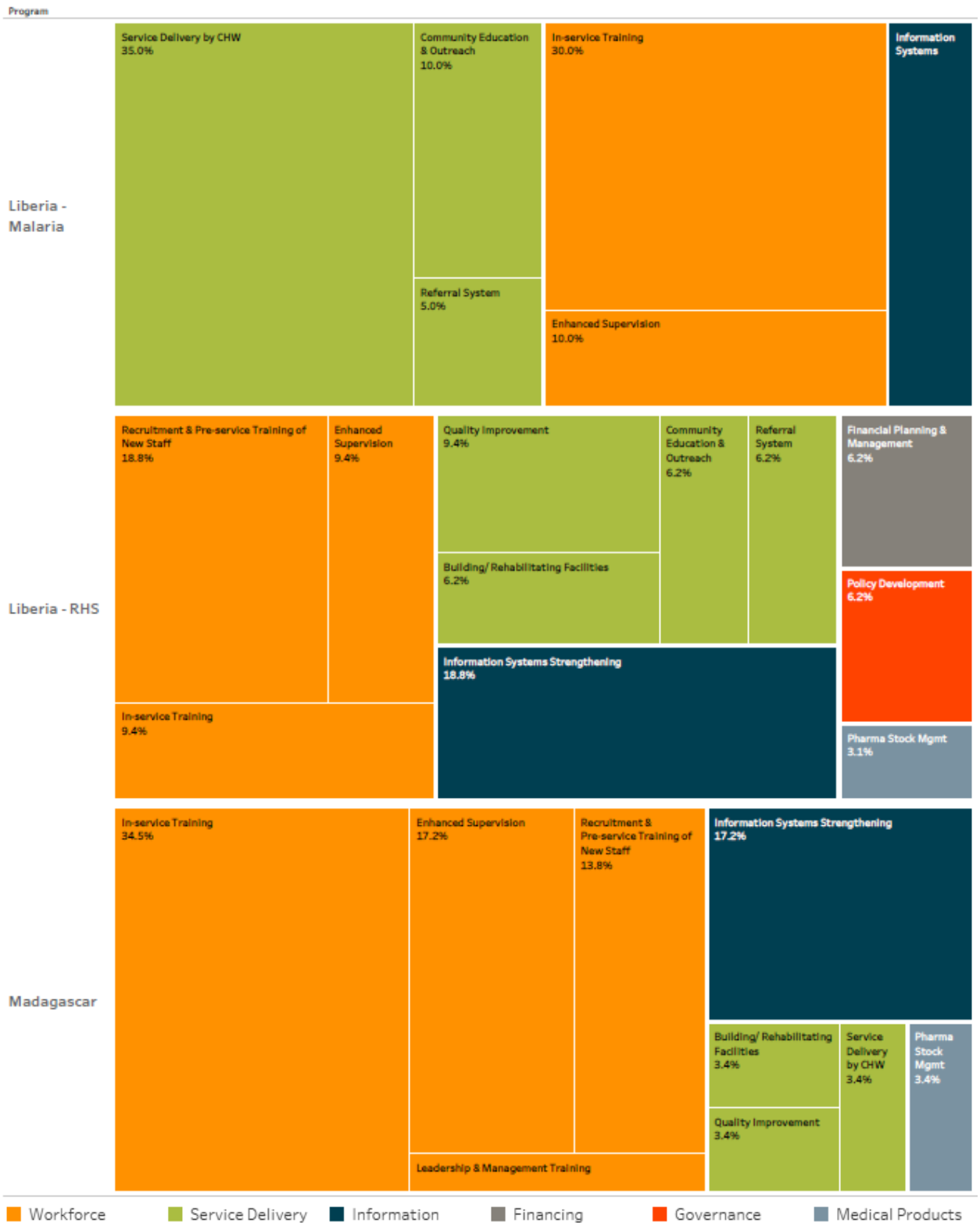
Note: Displayed percentages represent the proportion of a program's HSS activities—not all programmatic activities—dedicated to that AOTC HSS strategy.

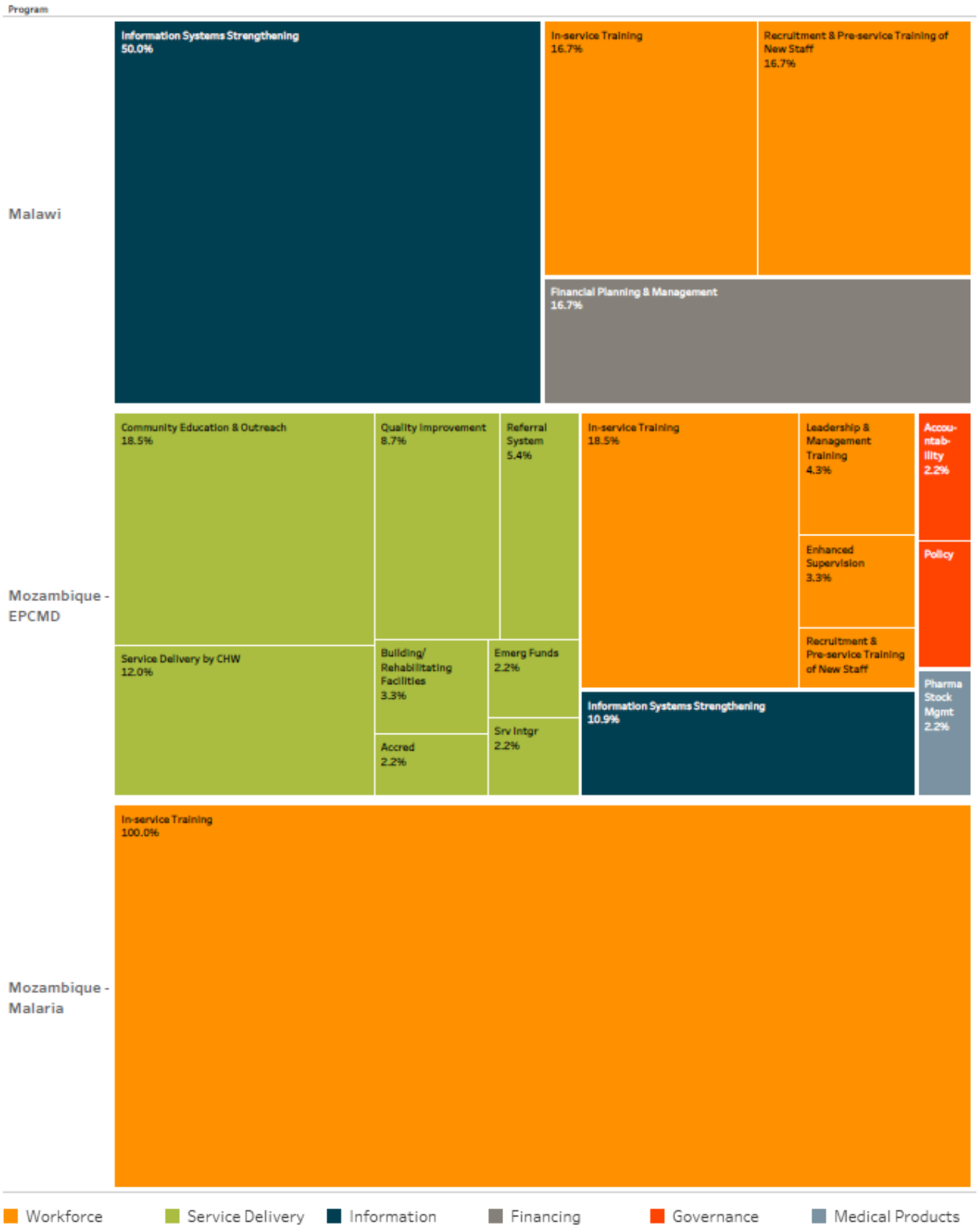


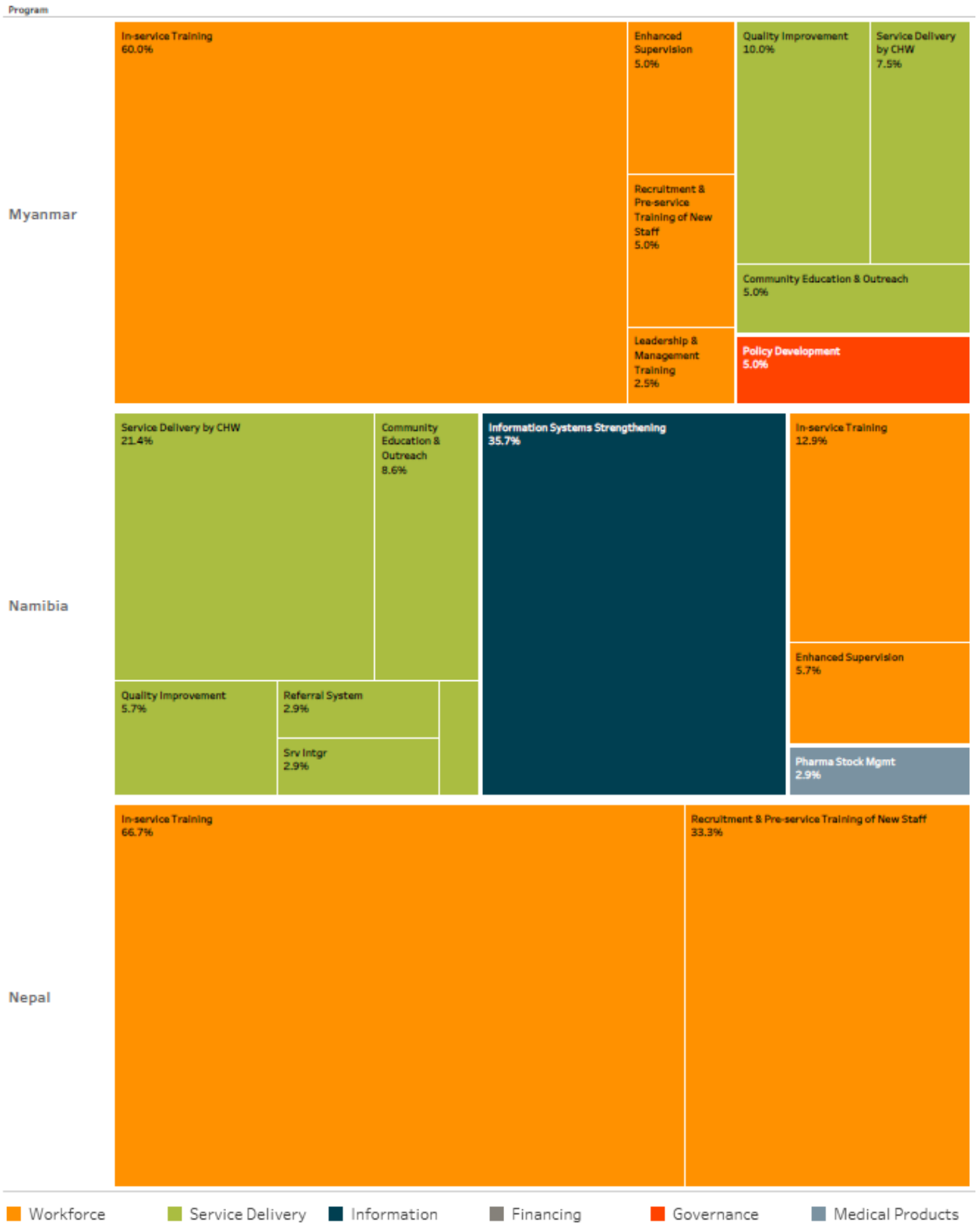

Program
Ghana - DCOF
Service Delivery by CHW
75.0%
In-service Training
25.0%
Ghana - IPC
In-service Training
83.3%
Enhanced Supervision
16.7%
Ghana - PSE/CHPS
Recruitment & Pre-service Training of New Staff
50.0%
Leadership & Management Training
10.0%
Financial Planning & Management
30.0%
Building/ Rehabilitating Facilities
10.0%
Workforce
Service Delivery
Information
Financing
Governance
Medical Products

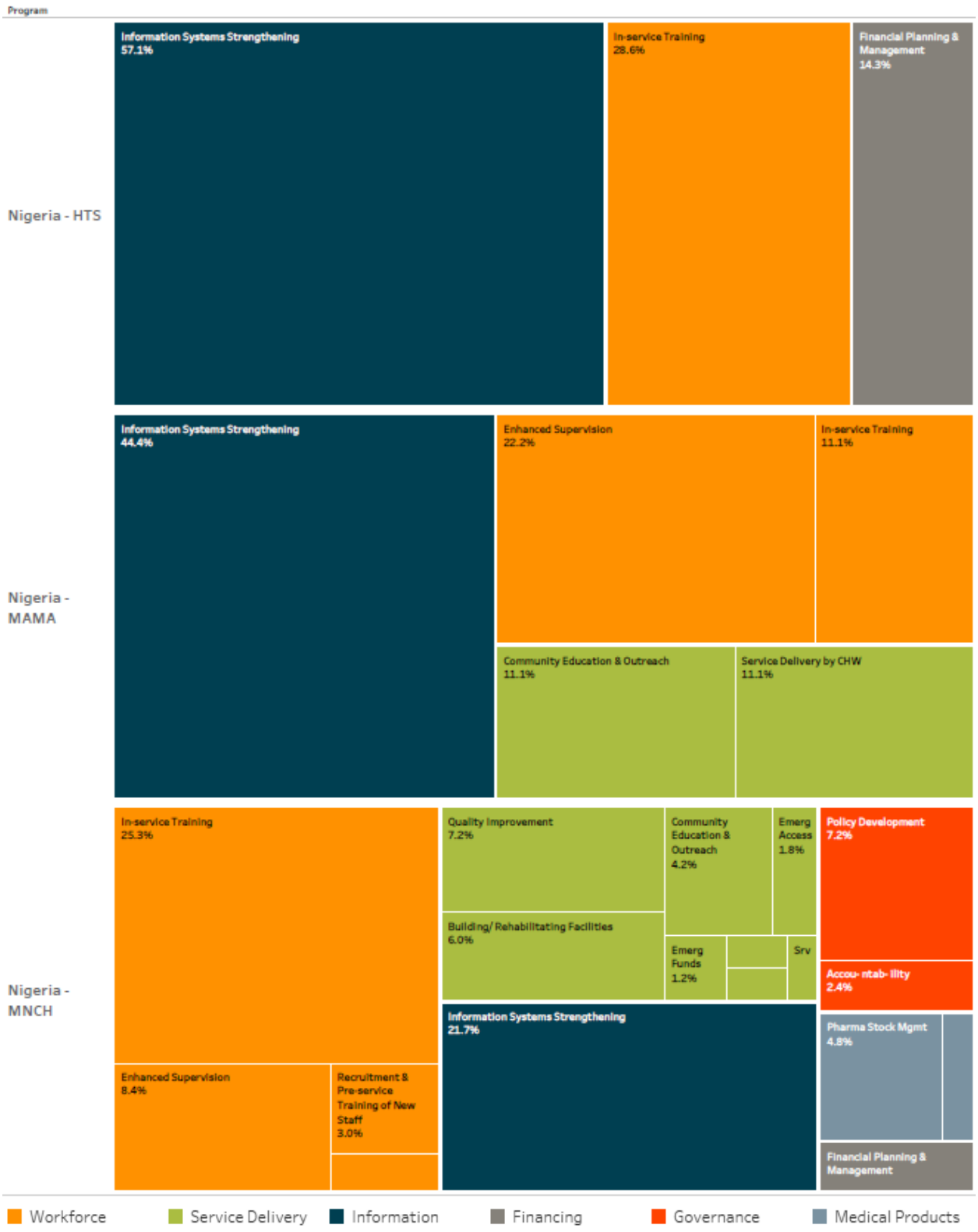

Program
Guatemala
In-service Training
19.4%
Leadership & Management Training
5.6%
Information Systems Strengthening
27.8%
Enhanced Supervision
16.7%
Recruitment & Pre-service Training of New Staff
5.6%
Emerg Access
11.1%
Quality Improvement
11.1%
Guinea - HSS
Enhanced Supervision
23.9%
Information Systems Strengthening
30.4%
Financial Planning & Management
8.7%
Leadership & Management Training
21.7%
Accred
4.3%
Quality Improvement
2.2%
Accou- ntab- ility
2.2%
India - FP
In-service Training
42.3%
Recruitment & Pre-service Training of New Staff
9.6%
Information Systems Strengthening
19.2%
Service Delivery by CHW
5.8%
Building/
Community Education & Outreach
3.8%
Enhanced Supervision
7.7%
Financial Planning & Management
7.7%
Workforce
Service Delivery
Information
Financing
Governance
Medical Products

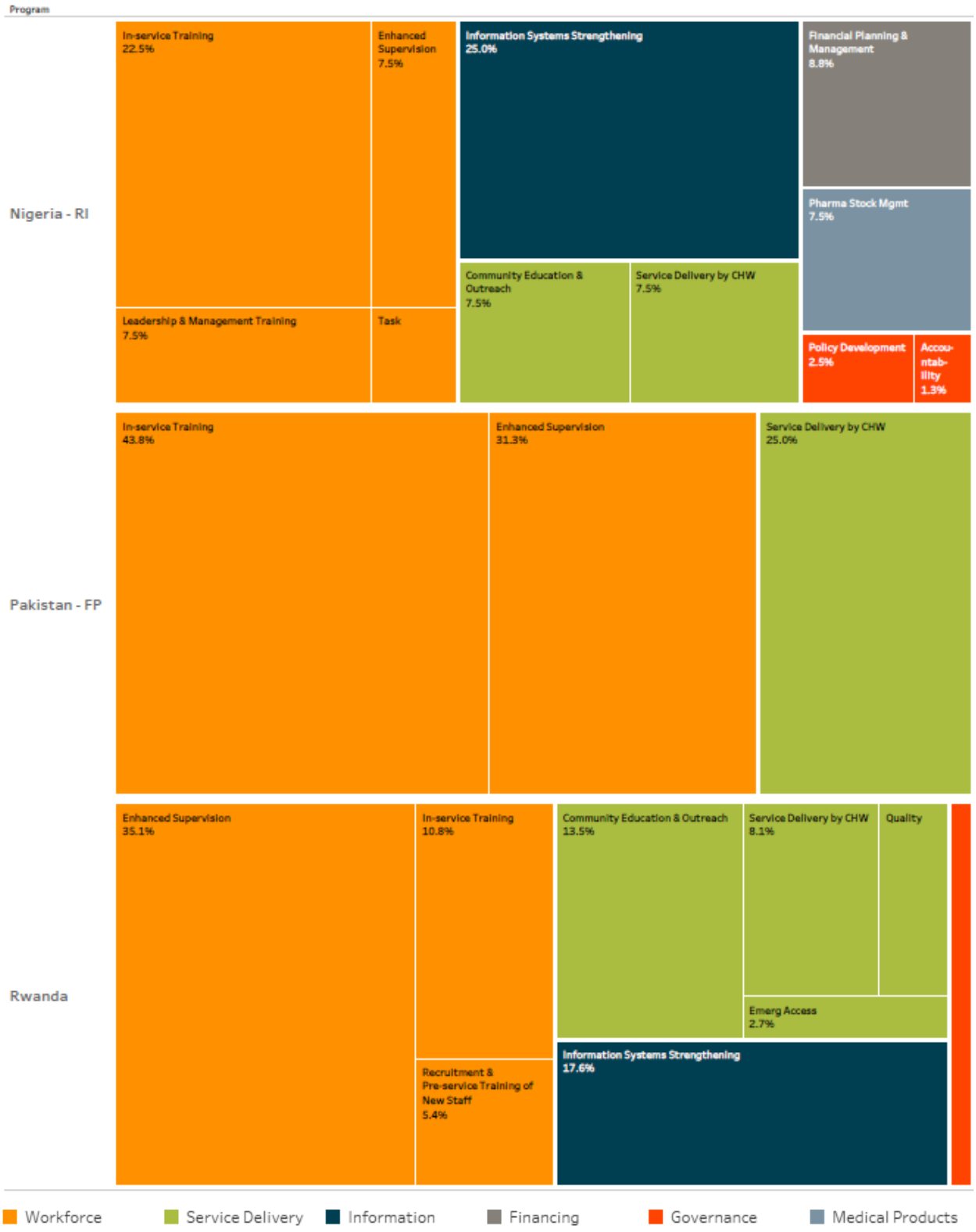

Program
India - Healthy Cities
Referral System 11.0%
Service Delivery by CHW 8.0%
In-service Training 23.0%
Information Systems Strengthening 10.0%
Accred 6.0%
Community Education & Outreach 5.0%
Srv Intgr 3.0%
Contracting Out 14.0%
Financial Planning & Management 4.0%
Pharma Stock Mgmt 5.0%
Building/ Rehabilitating Facilities 6.0%
Ensure Availability of Equipment
Laos
Enhanced Supervision 42.9%
In-service Training 42.9%
Building/ Rehabilitating Facilities 14.3%
Liberia - HRH
Recruitment & Pre-service Training of New Staff 66.7%
In-service Training 11.1%
Building/ Rehabilitating Facilities 11.1%
Leadership & Management Training 11.1%
Workforce
Service Delivery
Information
Financing
Governance
Medical Products

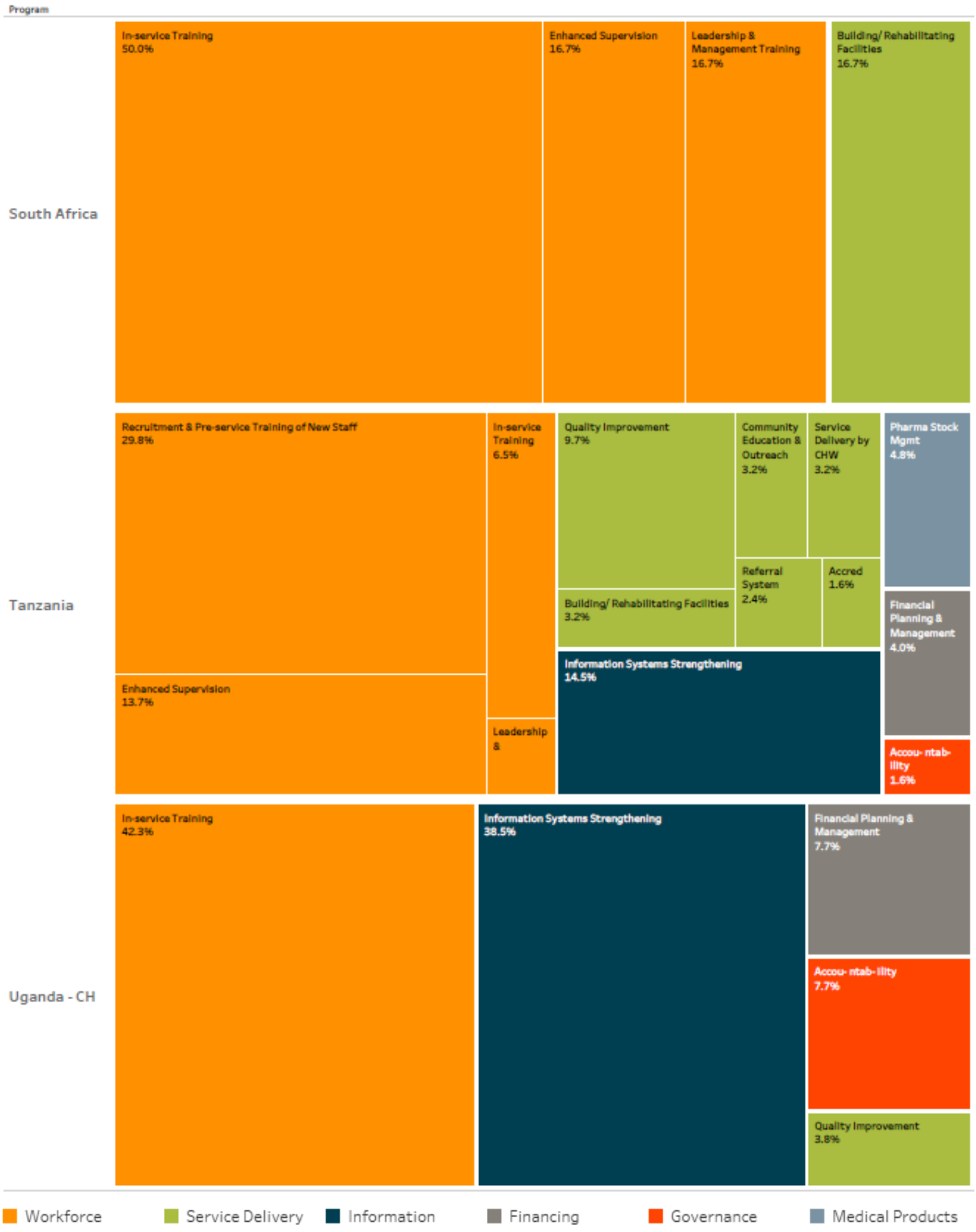

Program
Liberia - Malaria
Service Delivery by CHW 35.0%
Community Education & Outreach 10.0%
In-service Training 30.0%
Information Systems
Referral System 5.0%
Enhanced Supervision 10.0%
Liberia - RHS
Recruitment & Pre-service Training of New Staff 18.8%
Enhanced Supervision 9.4%
Quality Improvement 9.4%
Community Education & Outreach 6.2%
Referral System 6.2%
Financial Planning & Management 6.2%
Building/ Rehabilitating Facilities 6.2%
Policy Development 6.2%
Information Systems Strengthening 18.8%
In-service Training 9.4%
Pharma Stock Mgmt 3.1%
Madagascar
In-service Training 34.5%
Enhanced Supervision 17.2%
Recruitment & Pre-service Training of New Staff 13.8%
Information Systems Strengthening 17.2%
Building/ Rehabilitating Facilities 3.4%
Service Delivery by CHW 3.4%
Pharma Stock Mgmt 3.4%
Quality Improvement 3.4%
Leadership & Management Training
Workforce
Service Delivery
Information
Financing
Governance
Medical Products


Program
Malawi
Information Systems Strengthening
50.0%
In-service Training
16.7%
Recruitment & Pre-service Training of New Staff
16.7%
Financial Planning & Management
16.7%
Mozambique - EPCMD
Community Education & Outreach
18.5%
Quality Improvement
8.7%
Referral System
5.4%
Service Delivery by CHW
12.0%
Building/ Rehabilitating Facilities
3.3%
Emerg Funds
2.2%
Accred
2.2%
Srv Intgr
2.2%
In-service Training
18.5%
Leadership & Management Training
4.3%
Enhanced Supervision
3.3%
Recruitment & Pre-service Training of New Staff
Information Systems Strengthening
10.9%
Accou-ntab-ility
2.2%
Policy
Pharma Stock Mgmt
2.2%
Mozambique - Malaria
In-service Training
100.0%
Workforce
Service Delivery
Information
Financing
Governance
Medical Products


Program
Myanmar
In-service Training
60.0%
Enhanced Supervision
5.0%
Quality Improvement
10.0%
Service Delivery by CHW
7.5%
Recruitment & Pre-service Training of New Staff
5.0%
Community Education & Outreach
5.0%
Leadership & Management Training
2.5%
Policy Development
5.0%
Namibia
Service Delivery by CHW
21.4%
Community Education & Outreach
8.6%
Information Systems Strengthening
35.7%
In-service Training
12.9%
Quality Improvement
5.7%
Referral System
2.9%
Srv Intgr
2.9%
Enhanced Supervision
5.7%
Pharma Stock Mgmt
2.9%
Nepal
In-service Training
66.7%
Recruitment & Pre-service Training of New Staff
33.3%
Workforce
Service Delivery
Information
Financing
Governance
Medical Products


Program
Nigeria - HTS
Information Systems Strengthening
57.1%
In-service Training
28.6%
Financial Planning & Management
14.3%
Nigeria - MAMA
Information Systems Strengthening
44.4%
Enhanced Supervision
22.2%
In-service Training
11.1%
Community Education & Outreach
11.1%
Service Delivery by CHW
11.1%
Nigeria - MNCH
In-service Training
25.3%
Quality Improvement
7.2%
Community Education & Outreach
4.2%
Emerg Access
1.8%
Policy Development
7.2%
Building/ Rehabilitating Facilities
6.0%
Emerg Funds
1.2%
Srv
Accou- ntab- ility
2.4%
Information Systems Strengthening
21.7%
Pharma Stock Mgmt
4.8%
Enhanced Supervision
8.4%
Recruitment & Pre-service Training of New Staff
3.0%
Financial Planning & Management
Workforce
Service Delivery
Information
Financing
Governance
Medical Products


Program
Nigeria - RI
In-service Training
22.5%
Enhanced Supervision
7.5%
Information Systems Strengthening
25.0%
Financial Planning & Management
8.8%
Pharma Stock Mgmt
7.5%
Community Education & Outreach
7.5%
Service Delivery by CHW
7.5%
Leadership & Management Training
7.5%
Task
Policy Development
2.5%
Accou-ntab-ility
1.3%
Pakistan - FP
In-service Training
43.8%
Enhanced Supervision
31.3%
Service Delivery by CHW
25.0%
Rwanda
Enhanced Supervision
35.1%
In-service Training
10.8%
Community Education & Outreach
13.5%
Service Delivery by CHW
8.1%
Quality
Emerg Access
2.7%
Information Systems Strengthening
17.6%
Recruitment & Pre-service Training of New Staff
5.4%
Workforce
Service Delivery
Information
Financing
Governance
Medical Products


Program
South Africa
In-service Training
50.0%
Enhanced Supervision
16.7%
Leadership & Management Training
16.7%
Building/ Rehabilitating Facilities
16.7%
Tanzania
Recruitment & Pre-service Training of New Staff
29.8%
In-service Training
6.5%
Quality Improvement
9.7%
Community Education & Outreach
3.2%
Service Delivery by CHW
3.2%
Pharma Stock Mgmt
4.8%
Referral System
2.4%
Accred
1.6%
Building/ Rehabilitating Facilities
3.2%
Financial Planning & Management
4.0%
Enhanced Supervision
13.7%
Information Systems Strengthening
14.5%
Leadership &
Accou- ntab- ility
1.6%
Uganda - CH
In-service Training
42.3%
Information Systems Strengthening
38.5%
Financial Planning & Management
7.7%
Accou- ntab- ility
7.7%
Quality Improvement
3.8%
Workforce
Service Delivery
Information
Financing
Governance
Medical Products


Program
Uganda - RI
In-service Training
36.4%
Leadership & Management Training
18.2%
Information Systems Strengthening
27.3%
Community Education & Outreach
9.1%
Service Delivery by CHW
9.1%
Zambia - RMNCH
Information Systems Strengthening
63.6%
In-service Training
27.3%
Leadership & Management Training
9.1%
Workforce
Service Delivery
Information
Financing
Governance
Medical Products

Bibliography

Chee, et al. (2013). "Why differentiating between health system support and health system strengthening is needed." *International Journal of Health Planning and Management* 28: 85–94.

Hatt, et al. (2015). *Impact of Health Systems Strengthening on Health*. Health Finance & Governance Project, Abt Associates. At: https://www.hfgproject.org/wp-content/uploads/2016/03/Impact-of-Health-Systems-Strengthening-on-Health-7-24-1.pdf.

Herrera, et al. (2017). "Governance arrangements for health systems in low-income countries: an overview of systematic reviews." *Cochrane Database of Systematic Reviews* 9. At: http://cochranelibrary-wiley.com/doi/10.1002/14651858.CD011085.pub2/full.

MCSP. (2018). "Scaling up practice improvement for labor management and immediate newborn care in Rwanda." At: https://www.mcsprogram.org/resource/scaling-up-practice-improvement-for-labor-management-and-immediate-newborn-care-in-rwanda/

MCSP. (2018). "Scaling Up Immediate Postpartum Family Planning Services in Rwanda." At: https://www.mcsprogram.org/resource/scaling-up-immediate-postpartum-family-planning-services-in-rwanda/

USAID. (2012). *USAID Evidence Summit on Enhancing Provision and Use of Maternal Health Services Through Financial Incentives.* At: https://www.usaid.gov/sites/default/files/documents/1864/mh_financing_concept_paper.pdf.

USAID. (2015). *USAID's Vision for Health Systems Strengthening 2015–2019*. At: https://www.usaid.gov/sites/default/files/documents/1864/HSS-Vision.pdf.

USAID. (2017). *Acting on the Call: Ending Preventable Child and Maternal Deaths: A Focus on Health Systems*. At: https://www.usaid.gov/sites/default/files/documents/1864/USAID_2017_AOTC_final.pdf.

Wiysonge, et al. (2017.) "Financial arrangements for health systems in low-income countries: an overview of systematic reviews." *Cochrane Database of Systematic Reviews* 9. At: http://cochranelibrary-wiley.com/doi/10.1002/14651858.CD011084.pub2/full.