HEALTH SYSTEMS STRENGTHENING ACCELERATOR


# Institutional Architecture for Health Systems Strengthening:

## Summary Report on a Framework for Application

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## About the Accelerator

The Health Systems Strengthening Accelerator (Accelerator) is a global health system strengthening initiative, funded by the United States Agency for International Development (USAID) with co-funding from the Bill & Melinda Gates Foundation (BMGF) that supports local partners as they find their own pathways to meaningful and lasting health systems change.

The Accelerator is led by Results for Development (R4D) with support from Health Strategy and Delivery Foundation (HSDF, headquartered in Nigeria), and ICF. Additional global, regional, and local partners will be selected in partnership with USAID/OHS and USAID Missions based on demand.

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# Introduction

In October 2018, the United States Agency for International Development (USAID) launched the Health Systems Strengthening Accelerator (Accelerator) to support countries in addressing complex health systems challenges. The Accelerator seeks to build local expertise and strengthen institutions and processes to enable health systems to function efficiently, perform well, weather shocks, and continuously strengthen themselves. Through health systems investments in USAID partner countries, the Accelerator activities aim to sustain and expand progress toward global health outcomes such as Ending Preventable Child and Maternal Deaths, Creating an AIDS Free Generation, and Protecting Communities from Infectious Diseases.

The purpose of this document is to summarize work to date on the Accelerator's framework for the institutional architecture for health systems strengthening (HSS) (Year 1, Activity 2) and options for future application of the framework.

Overview

# Strengthening Countries' Capacity to Drive Health System Change

## What is Institutional Architecture for Health Systems Strengthening?

**Institutional Architecture for health systems strengthening (HSS) is** the **actors, processes, and resources** that interact—or fail to interact—to perform a set of **functions** that produce health system improvements.

In many low- and middle-income countries (LMIC), HSS efforts have often involved partnerships between domestic institutions, international donors, and external providers of technical assistance. As donor funding declines, countries are seeking to build capacity for HSS independent of international support. This objective aligns well with the overall goal of the Accelerator program, which aims to connect locally driven health system innovation with global knowledge, improve the institutional architecture for evidence based and sustainable HSS, and accelerate countries' journeys to self-reliant health systems.

The Accelerator has developed an institutional architecture framework to assess and build capacity for self-reliant, continuous HSS in LMICs. The framework will enable country leaders to self-assess strengths and weaknesses in their HSS capacity, deliberately plan for capacity building, and track progress toward self-reliance. In addition, it is hoped that external assistance providers will be able to better prioritize how to complement existing capabilities to implement activities and strategically invest in building additional capabilities. The result will be accelerated progress on key health systems challenges and a faster path to self-reliant HSS.

The term institutional architecture has a solid foundation in literature across multiple sectors and with some key health system strengthening thought leaders. It resonated especially well in two Francophone settings (Togo and Guinea) during initial the Accelerator's scoping visits. However, it may be useful to adapt the terminology to facilitate understanding and utilization of the framework in a way that is responsive to the local context. In this report, we use both the formal term and the more informal expression "countries' capacity to drive health systems change."

"Institutional Architecture" has been used in diverse sectors such as food security, global forestry, and marine fisheries. The term was first used in reference to the health sector in a 2008 commentary by Frenk and Gonzales-Block, who suggested that national public health institutions are key components of the "institutional architecture for improving health system performance." The concept is defined broadly in the literature and refers to much more than just fixed, formal organizations. Rather, it refers to the roles and relationships among varied public and private sector actors and institutions, and the

norms, regulations, and decision-making procedures governing them (Martin and Chileshe 2014, Biermann et al 2009, Orsini, Morin, and Young 2013, Quinn 2015, Raustiala and Victor 2004).

Following this literature, we define institutional architecture for HSS to be the **actors, processes, and resources** that interact—or fail to interact—to perform a set of **functions** that produce health system improvements. The functions are distinct from current health systems *performance* elements, such as those often categorized according to the health systems "building blocks," and for which well-validated measurement tools already exist (HFG project 2017, see also Annex 2). Instead they refer to a *capacity for change* leading to both one-time changes and—ideally—continuous system improvement over time.

An institutional architecture approach to HSS recognizes the regulative, normative, and cultural-cognitive dimensions of the institutionalization of the roles and relationships of actors, processes and resources that must occur for countries to have the capacity to drive health system change (Koon et al 2017). The relationships among actors, processes and resources that support the institutional architecture of continuous HSS are defined by norms, incentives, rules, and standards, and are codified into regulations or laws so that they occur in an automated and mandated way as an established mode of practice rather than being ad-hoc or "one-off."

Our theory of change is that helping a country to strengthen its institutional architecture—that is, the way that actors, processes and resources underpinning key health system functions interact—will accelerate its progress towards a stronger, more resilient, and more self-reliant health system.

## Approach

The Accelerator conducted a literature review to further understand and develop the concept of institutional architecture and how it relates to HSS, and in turn, how assessing institutional architecture could support countries to better understand and solve complex health challenges. Google and Google Scholar were searched using the key terms and variations of the terms. Donor and implementer websites, such as USAID and the World Health Organization (WHO) were searched using the website's own search engine or site navigation. Annex 1 lists the literature reviewed, organized by key terms.

To inform development of the framework, the Accelerator reviewed 28 HSS progression models and related tools. These tools were identified through the broader literature review as well as recommendations from colleagues. We categorized the tools in relation to type and focus area and analyzed each tool to understand their purpose and use. Annex 2 summarizes this mapping of relevant tools.

Next, we conducted a preliminary desk review to document country experiences undertaking health system change. Japan, Mexico, Thailand, and Turkey were selected because each country was illustrative of either some or all the components of institutional architecture that enable continuous HSS. Annex 3 summarizes these experiences. Annex 4 details how the concept of institutional architecture for HSS is related to other relevant concepts in the literature, such as governance, stewardship, and resilience.

Following this initial reading, review, and discussion phase, the team developed a preliminary institutional architecture for HSS framework. The Accelerator:

- Identified a preliminary set of high-level core functions (or domains)
- Discussed various options for further categorization to facilitate measurement (e.g., operational elements such as people, institutions, processes, resources and tools; technical areas; sub-functions and sub-technical areas)
- Identified preliminary distinctions in relation to progression levels for institutional architecture for HSS
- Discussed various options for a graphic representation of the model, giving attention to conveying that the model reflects systems thinking and incorporates, but also moves beyond the WHO health systems building blocks

The Accelerator organized a series of consultations with internal and external experts. The aim of the consultations was to solicit feedback and strategize possible framework development options. The most significant determination from this feedback was that a conceptual framework should be applied and iterated through in-country use cases prior to deciding whether and how to develop a detailed, metrics-based progression model. The team summarized the preliminary conceptual model and options for application in the report that follows below.

## Functions and Components: Institutional Architecture for Health Systems Strengthening Framework

Figure 1 shows the five main functions and three components (actors, processes, and resources) that make up the framework. The visual highlights how the functions are part of a continuous cycle of change and improvement and emphasizes the cross-cutting role of stakeholder engagement across all functions. Table 1 provides definitions for the functions, actors, processes, and resources.


*Figure 1: Institutional Architecture for Health Systems Strengthening Framework*

**Table 1: Definitions of the Components and Functions of Institutional Architecture for Health Systems Strengthening**

| | |
|---|---|
| **Components** | |
| **Actors** | The organizations and people responsible for driving forward continuous HSS, including how their roles are defined and relationships among them. *Examples:* government bodies, businesses, health service administrators and providers, academic institutions, civil society organizations, and international stakeholders. |
| **Important note**: Institutional architecture for HSS is not solely focused on formal or public institutions or entities; it includes a range of individuals and organizations from both public and private sectors that play a role in the functioning of the health system. The concept also underscores the importance of relationships between diverse stakeholders across multiple sectors that are involved in the functions that produce health system improvements. These relationships include formal platforms for engagement but may also occur informally, for example through clientelism and patronage. | |
| **Processes** | The various activities that contribute to HSS. These are defined by rules, norms, informal practices, and standards—some codified into regulations or laws. *Examples:* annual health sector forums, public sector budget formulation, legislative procedures, public procurement, and informal networking and advocacy. |
| **Resources** | The financial and non-financial inputs, including funding, training, tools and technologies, necessary for actors and organizations to effectively and efficiently implement HSS processes. *Examples:* budgets of public health institutions, research grants, financial management tools, statistical modeling software, and IT infrastructure. |
| **Functions** | |
| **Generate HSS Evidence** | The capacity to generate usable evidence that facilitates evidence-based decision making. This includes producing new data to meet specific needs, producing high-quality routine data, and integrating new measurements into analytic processes. |
| **Analyze Data and Diagnose Problems** | The capacity to analyze, interpret, and use data to identify issues that need action. This includes monitoring programs and policies, evaluating the effects of policy changes, recognizing that a problem warrants action, and diagnosing root causes. |
| **Formulate Solutions** | The capacity to curate and develop solutions to identified problems. This includes cultivating domestic and international innovations (from public and private sectors), identifying existing approaches that can be translated from other contexts, designing new approaches, generating proposals, and iteratively refining solutions. |
| **Manage Adoption of Solutions** | The capacity to maneuver, within a given political economy context, from proposed solutions to the adoption of new policy or some other change in practice. This includes building consensus to take action, prioritizing among proposals, building winning coalitions, formalizing strategies and policies/practices in statutes or organizational mandates, advocating for resources, and communicating strategically about the selected change. |
| **Cross-Cutting Function** | |
| **Engage Stakeholders and Ensure Accountability** | The capacity to enable a diverse set of stakeholders to participate in the above functions and to integrate stakeholder feedback. This includes the ability to conduct stakeholder analysis; seek and facilitate input; monitor, adapt, design, and redesign as needed to reflect input; and hold leaders and implementers accountable for action. |

## Applications: Institutional Architecture for Health Systems Strengthening Framework

The Institutional Architecture for HSS framework reflects the core principles of the Accelerator and other emerging global health programs that emphasize health system sustainability. It provides a systematic way to think about long-term engagement with country stakeholders to build sustainable capacity for health systems change. The framework could add value to many HSS activities but will need to be tailored in its application to specific contexts and country needs. In general, the Accelerator plans to apply the framework to help country leaders and development partners in three ways:

1. **Take stock** (whether descriptively or evaluatively) of the existing actors, processes, and resources needed for each function in relation to an identified health system challenge;

2. **Strategize and plan** by identifying components of the institutional architecture for HSS that could be strengthened through new or ongoing activities; and

3. **Learn** by tracking progress and best practices in strengthening institutional architecture for HSS over time (likely in a qualitative manner).

The Accelerator is adopting this framework as part of its model for country engagement, in order to inform scoping, mapping, formal assessment, and work planning; and will use the framework for its global monitoring, evaluation and learning (MEL) goals, synthesizing findings across countries and activities.

We describe the three general options for application of the framework below. These options are not mutually exclusive and build progressively on each other; the selection of an approach and the intensity of Accelerator engagement can vary based on country need and resource availability. Annex 5 includes a table showing illustrative applications within some of the Accelerator's current activities.

### Take Stock: Three options from low to high intensity

**Low intensity: Facilitation guide for country engagement scoping efforts**

Use the framework as an orienting document for engaging stakeholders during the Accelerator's initial scoping efforts. Central to a scoping visit is asking questions, listening, and learning about health system challenges and successes in the country. The framework's components and functions provide a systematic structure to guide that listening and discussion process, relative to whichever health system challenge is under consideration. In particular, the framework could help scoping teams consider not just "How can we support this country to solve its current health system problems?" but more holistically, "How can this country build the functions needed to address this kind of health system challenge both now and in the future?"

For this purpose, the application of the framework would be relatively informal and flexible. The core functions could be used to guide initial identification of relevant actors and organizations for engagement, and questions could be tailored to these respondents both in advance of the visit and as the visit proceeds. The framework could then be integrated into work planning, influencing how project activities are implemented and providing framing for monitoring, learning and evaluation efforts.

### Medium intensity: Systematic mapping exercise within a focus topic area

Conduct a somewhat more in-depth, descriptive mapping of a country's current institutional architecture for HSS within one or more focus areas. This would also likely take place early in an engagement with a given country. The objective would be to systematically document what institutional architecture exists today for a focus area prioritized by country stakeholders, map the associated actors, processes, and resources supporting each function within that focal topic, and collectively identify areas of strength and weakness.

For example, the entry points for these mapping efforts could be defined as "strengthening community health systems" or "strengthening institutional architecture for UHC." Sometimes, it may be more tractable to engage initially around narrower focus areas that have immediate urgency to country stakeholders. Specific technical areas could be defined as a "problem statement" or "objective statement" by country stakeholders–for instance, a technical objective might be to "build the institutional architecture needed to ensure financial sustainability of a country's universal health coverage (UHC) scheme." Whether the initial focus is narrow or broad, the effort will intentionally build longer-term capacity for underlying system change. The mapping could be accomplished through a participatory process, possibly in the context of a facilitated workshop and associated expert interviews and document review. Such an application would be descriptive, though more structured than the scoping exercise described above in the low intensity scenario. The exercise could lead to developing a road map for strengthening capacity for more robust performance of institutional architecture functions in the future.

### High intensity: Structured assessment tool, such as a progression model

A third application modality would be a more formal, standardized assessment of a country's institutional architecture for HSS. This could take the form of a progression model (a type of benchmarking exercise illustrating where a health system should be placed along a spectrum of institutional architecture strength and demonstrated via a series of illustrative conditions and indicators) or other structured, metric-driven assessment tool. Domains, sub-domains, and quantitative or qualitative assessment metrics would be collected through secondary data, interviews, and facilitated workshops. The detailed indicators and illustrative conditions, along with specific interview questions for respondents, would need to be developed.

Various options for sub-categorizing the key functions – disaggregating them to address different levels of a system, different aspects of a problem, or different sectors or institutions – could be considered in developing the standardized assessment tool, depending on the needs of a given context and audience. For instance, each core function could be sub-categorized into 2-3 related sub-domains or sub-capacities needed to optimize implementation of the broader function. "Analyze data" might include a sub-capacity around data visualizations and data translation; "Formulate solutions" might have sub-capacities around multi-sectoral engagement and cultivating innovation; and "Build Consensus to Adopt Prioritized Solutions" might include sub-capacities related to coalition building and advocacy for resource allocation.

One advantage of building out this type of formal progression model assessment is that it could enable comparisons across countries, and possibly tracking of country improvements to their institutional

architecture for HSS over time. A disadvantage is the substantial level of effort necessary to construct and validate such progression model indicators, as well as practical difficulties in standardizing measurement indicators across varied and diverse contexts. Expert feedback on this idea emphasized that it would be essential to assess the level of country demand for a formal assessment process of this nature prior to the investment of significant time and resource to develop and validate a detailed progression model.

### Strategize and Plan: Prioritization Tool for Country Strategy or Road Map Development

This application would focus on supporting country stakeholders to develop a road map or strategy for strengthening prioritized components of a country's institutional architecture for HSS (whether broadly or narrowly defined). The institutional architecture functions and associated components (actors, processes, resources) would form a framework for developing such a strategy. A country might already have clearly defined and prioritized areas needing investment, or these could be identified through one of the assessment modalities described above, and the Accelerator could facilitate the priority-setting process.

### Learn: Agenda and Framework for Learning Best Practices

Use the framework as a multi-country, multi-partner, and/or multi-project learning agenda. Any country, partner, or project involved would use the framework in at least a light-touch way (e.g., option 1a above), creating a basis for peer-to-peer exchange on how countries compare in current capacities and how they plan to build capacity. Communities of practice could form, or experience could simply be shared in occasional webinars or forums. Over a 4-5-year period, the Accelerator (and others) could produce and disseminate global knowledge goods based on this systematic learning across many activities.

**Box 1: Application of Institutional Architecture framework in Togo**

The Accelerator conducted a scoping visit to Togo in October 2019 to gain a better understanding of what institutional architecture would most effectively support Togo's journey toward UHC and enable sustainable improvements in health outcomes at the community level. A wide range of stakeholders agreed that the current institutional architecture is not fit-for-purpose to help Togo deliver on its UHC goals, and that further analysis is needed to understand what changes are required in relation to the roles and responsibilities of different actors, the processes through which they interact, and the resources required to fulfill the necessary functions.

An initial mapping identified a significant number of actors with some role in the broader UHC landscape. There is a lack of clarity about who is responsible for which functions, a lack of well-defined processes through which they interact, and an absence of clearly defined mechanism to coordinate the actions of different actors.

The key questions identified during the scoping mission and validated by stakeholders at the debrief session include:

- What distribution of roles and responsibilities across institutions and levels would most effectively support Togo's UHC goals?
    - Political leadership: sponsorship and oversight (where does the mandate come from?)
    - Technical leadership
    - What other functions need to be fulfilled, and by whom?
    - To what extent do key actors have the capacity to deliver what is expected of them?
- What existing or new coordination mechanisms would enable Togo to most effectively coordinate efforts across a range of actors in support of coherent and efficient delivery of the UHC goals?
- What legal and regulatory framework would most effectively support Togo's UHC goals?
- What mechanism would be most fit-for-purpose in ensuring that different actors are accountable for delivering what is expected of them? What is the best way to ensure responsiveness to the needs and perspectives of communities?
- Who has responsibility for leading the change management process? Who supports? What are the expectations of different stakeholders?

The institutional architecture framework was used during the scoping process to help formulate key questions, enhance understanding of the issues, and inform the initial mapping exercise. These key questions will be further validated with key stakeholders who were not present during the debrief meeting, revised where needed, and used to help inform future workplans. It is anticipated that during the implementation period regional coaches will help facilitate a country-led co-creation process to address the key questions and identify prioritized actions and additional support that Togo needs to strengthen its institutional architecture for UHC. In doing so, they will draw on innovation and learning from across the region and beyond as relevant.

## References


- Biermann, Frank, Philipp Pattberg, and Harro van Asselt, and Fariborz Zelli. 2009. “The Fragmentation of Global Governance Architectures: A Framework for Analysis.” Global Environmental Politics. 9(4): 14-40. Link
- Frenk, Julio and Miguel Angel Block. 2008. “Institutional Development for Public Health: Learning the Lessons, Renewing the Commitment.” Journal of Public Health Policy. 29(4): 449-58. Link
- Health Finance & Governance Project. 2017. Health Systems Assessment Approach A How-To Manual. Version 3.0. Bethesda, MD: Health Finance & Governance Project, Abt Associates Inc. Link
- Koon, Adam, Lauren Windmeyer, Maryam Bigdelli, Jodi Charles, Fadi El Jardali, Walter Flores, Jesse Uneke, and Sara Bennett. 2017. *A Scoping Review of the Uses and Institutionalization of Knowledge for Health Policy in Low- and Middle-Income Countries*. Marshalling the Evidence for Health Governance Thematic Working Group Report. USAID Health Finance and Governance Project. Link
- Martin, Jerry and Christian Chileshe. 2014. Zambia Food Security Policy Assessment: Institutional Architecture for Food Security Policy Change. Link
- Orsini, Amandine, Jean-Frédéric Morin, and Oran Young. 2013. "Regime complexes: A buzz, a boom, or a boost for global governance." Global governance 19: 27. Link
- Quinn, David. 2015. Institutional Architecture for Food Security Policy Change: Cross Country Study. The Enabling Agricultural Trade (EAT) project, funded by the United States Agency for International Development (USAID), and implemented by Fintrac Inc. Link
- Raustiala, Kal, and David G. Victor. 2004. "The regime complex for plant genetic resources." International Organization 58(2): 277-309. Link
- USAID. 2016. Technical Note The 5Rs Framework in the Program Cycle. Link

# Annex 1: List of All Resources Reviewed

This Annex provides a list of the resources reviewed, organized by the following key terms:

- Institutional Architecture
- Health System Strengthening
- Universal Health Coverage
- Measurement of health system performance and systemic change
- Governance and Health Governance
- Stewardship
- Health System Resilience and Resilience
- Institutional and Organizational Capacity Building
- Sustainability and Transition
- Country Experiences

## Institutional Architecture


Arnau, Sergi, Kristian Kristensen, Oscar Widerberg, and Philipp Pattberg. 2017. Mapping the Institutional Architecture of Global Marine Fisheries and Aquaculture Governance. Institute for Environmental Studies. CONNECT project (Coping with Fragmentation: Assessing and Reforming the current Architecture of Global Environmental Governance), funded by the Netherlands Organization for Scientific Research. Link

Biermann, Frank, Philipp Pattberg, and Harro van Asselt, and Fariborz Zelli. 2009. “The Fragmentation of Global Governance Architectures: A Framework for Analysis.” Global Environmental Politics. 9(4): 14-40. Link

Brown, Katrina, and Sergio Rosendo. 2000. "The institutional architecture of extractive reserves in Rondonia, Brazil." Geographical Journal 166, no. 1: 35-48. Link

Frenk, Julio and Miguel Angel Block. 2008. “Institutional Development for Public Health: Learning the Lessons, Renewing the Commitment.” Journal of Public Health Policy. 29(4): 449-58. Link

Gomes, Raqual. 2018. “Institutional Architecture: Huh?” *Agrilinks*. USAID Feed the Future. Link

Gueera, Flávia Dias, Marija Isailovic, Oscar Widerberg, and Philipp Pattberg. 2015. “Mapping the Institutional Architecture of Global Forest Governance.” Technical Report R-15/04. CONNECT project (Coping with Fragmentation: Assessing and Reforming the current Architecture of Global Environmental Governance), funded by the Netherlands Organization for Scientific Research. Link

Hage, Jerald and Joseph J Valadez. 2017. Institutionalizing and sustaining social change in health systems: the case of Uganda. *Health Policy and Planning*, Volume 32, Issue 9:1248–1255. Link

Hearns, Glen S., Richard K. Paisley, and Taylor W. Henshaw. 2013. "Institutional Architecture and the Good Governance of International Transboundary Waters." Link

Koon, Adam, Lauren Windmeyer, Maryam Bigdelli, Jodi Charles, Fadi El Jardali, Walter Flores, Jesse Uneke, and Sara Bennett. 2017. *A Scoping Review of the Uses and Institutionalization of Knowledge for Health Policy in Low- and Middle-Income Countries*. Marshalling the Evidence for Health Governance Thematic Working Group Report. USAID Health Finance and Governance Project. Link

Martin, Jerry and Christian Chileshe. 2014. Zambia Food Security Policy Assessment: Institutional Architecture for Food Security Policy Change. Link

Menocal, Alina Rocha, Marc Cassidy, Sarah Swift, David Jacobstein, Corinne Rothblum, and Ilona Tservil. 2018. Thinking and Working Politically Through Applied Political Economy Analysis: A Guide for Practitioners. USAID. Link.

Meyers, Marcia. 2007. "The institutional architecture of antipoverty policy in the United States: Looking back, looking ahead." Focus 25, no. 1: 58-62. Link

Orsini, Amandine, Jean-Frédéric Morin, and Oran Young. 2013. "Regime complexes: A buzz, a boom, or a boost for global governance." Global governance 19: 27. Link

Pattberg, Philipp, Oscar Widerberg, Maira Isailovic, and Flavia Dias Guerra. 2014. Mapping and measuring fragmentation in global governance architectures. Institute for Environmental Studies. Link

Quinn, David. 2015. Institutional Architecture for Food Security Policy Change: Cross Country Study. The Enabling Agricultural Trade (EAT) project, funded by the United States Agency for International Development (USAID), and implemented by Fintrac Inc. Link

Raustiala, Kal, and David G. Victor. 2004. "The regime complex for plant genetic resources." International Organization 58(2): 277-309. Link

Tarantino L, Laird K, Ottosson A, Frescas R, Mate K, Addo-Cobbiah V, Bannerman C, Pacheco P, Burssa D, Likaka A, Rahimzai M, Massoud MR, Syed S. 2016. Institutional Roles and Relationships Governing the Quality of Health Care: Country Experiences, Challenges, and Lessons Learned. Bethesda, MD: Health Finance & Governance Project, Abt Associates and USAID Applying Science to Strengthen and Improve Systems Project, URC. Link

USAID. 2016. Technical Note The 5Rs Framework in the Program Cycle. Link

## Health Systems Strengthening

Chee, Grace, Nancy Pielemeier, Ann Lion, and Catherine Connor. 2013. “Why differentiating between health system support and health system strengthening is needed.” The International journal of health planning and management. 28(1): 85–94. Link

Forest, Pierre-Gerlier, Jean-Louis Denis, Lawrence D. Brown, and David Helms. 2015. "Health reform requires policy capacity." International Journal of Health Policy and Management 4(5): 265–266. Link

Hafner, Tamara, Helena Walkowiak, David Lee, and Francis Aboagye-Nyame. 2017. "Defining pharmaceutical systems strengthening: concepts to enable measurement." Health Policy and Planning 32, no. 4: 572-584. Link

ICF. 2018. *Subnational organizational capacity metrics for Mozambique: Results of assessments of the provincial metrics tool in the Cabo Delgado, Gaza, and Zambezia provinces of Mozambique*. Project funded by PEPFAR/CDC. Unpublished report.

ICF. 2019. *District performance management standards for Uganda: Results of a quantitative and qualitative analysis from the implementation of the district performance management tool in Uganda in 2015 and 2017*. Project funded by PEPFAR/CDC. Unpublished report.

Peters, David H., Ligia Paina, and Sara Bennett. 2012. "Expecting the unexpected: applying the Develop-Distort Dilemma to maximize positive market impacts in health." Health Policy and Planning 27, no. suppl_4: iv44-iv53. Link

Melanie Morrow, William T Story, Katharine D Shelley, D Shanklin, Minal Rahimtoola, Alfonso Rosales, Ochiawunma Ibe, Eric Sarriot. 2019. “Beyond the building blocks: integrating community roles into health systems frameworks to achieve health for all.” BMJ Global Health: 3. Link

Schuftan, Claudio. 2013. "The emerging sustainable development paradigm: a global forum on the cutting edge of progressive thinking." Health and Sustainable Development: Visions on Health and Sustainable Development: 27-35. Link

Topp, Stephanie M & Chipukuma, Julien. 2016. “How did rapid scale-up of HIV services impact on workplace and interpersonal trust in Zambian primary health centres: a case-based health systems analysis.” BMJ Global Health. 1. Link

PEPFAR Site Improvement through Monitoring (SIMS) tool – Link

World Health Organization. "Joint external evaluation tool: International health regulations (2005)." (2018). Link

USAID. USAID’s Vision for Health Systems Strengthening, 2015-2019 Link

USAID / Health Systems 20/20. 2012. New Perspectives in Health Systems Strengthening: Lessons Learned for Building Stronger, Smarter Systems. Link

World Health Organization. 2009. *Systems thinking for health systems strengthening*. de Savigny, Don and Taghreed Adam (Eds). Alliance for Health Policy and Systems Research, WHO. Link

## Universal Health Coverage

Atun, Rifat, Luiz Odorico Monteiro De Andrade, Gisele Almeida, Daniel Cotlear, Tania Dmytraczenko, Patricia Frenz, and Patrícia Garcia, Octavio Gómez-Dantés, Felicia M. Knaul, Carles Muntaner, Juliana

Braga de Paula, Felix Rígoli, and Pastor Castell-Florit Serrate. 2015. "Health-system reform and universal health coverage in Latin America." The Lancet 385, no. 9974: 1230-1247. Link

Ruiz, Antonio Chemor, Anette Elena Ochmann Ratsch, and Gloria Araceli Alamilla Martínez. 2018. "Mexico's Seguro Popular: achievements and challenges." Health Systems & Reform 4, no. 3: 194-202. Link

Frenk, Julio. 2015. "Leading the way towards universal health coverage: a call to action." The Lancet 385, no. 9975: 1352-1358. Link

Harris, Joseph. 2015.""Developmental capture" of the state: explaining Thailand's universal coverage policy." Journal of Health Politics, Policy and Law 40, no. 1: 165-193. Link

Nigenda, Gustavo, Veronika J. Wirtz, Luz María González-Robledo, and Michael R. Reich. 2015. "Evaluating the implementation of Mexico's health reform: the case of Seguro Popular." Health Systems & Reform 1, no. 3: 217-228. Link

Reich, Michael R., Joseph Harris, Naoki Ikegami, Akiko Maeda, Cheryl Cashin, Edson C. Araujo, Keizo Takemi, and Timothy G. Evans. 2016. "Moving towards universal health coverage: lessons from 11 country studies." The Lancet 387, no. 10020: 811-816. Link

Sparkes, Susan Powers, Jesse B. Bump, and Michael R. Reich. 2015. "Political strategies for health reform in Turkey: Extending veto point theory." Health Systems & Reform 1, no. 4: 263-275. Link

Stuckler, David Andrea B Feigl, Sanjay Basu, and Martin McKee. 2010. The political economy of universal health coverage." Background paper for the global symposium on health systems research. 16-19 November 2010, Montreux, Switzerland. Link

## Measurement of Health System Performance and Systemic Change

Alva, Soumya, Eckhard Kleinau Amanda Pomeroy Kathy Rowan. 2009. Measuring the Impact of Health Systems Strengthening: A Review of the Literature. Link

Diana, Mark, Valeria A. Yeager, and David R. Hotchkiss. 2017. Health Systems Strengthening: A Compendium of Indicators. Link

Fowler, Ben and Elizabeth Dunn. 2014. Evaluating Systems and Systemic Change for Inclusive Market Development: Literature Review and Synthesis. USAID Leveraging Economic Opportunities (LEO), Report No. 3. Link

Fowler, Ben and Tim Sparkman. 2016. Testing Tools for Assessing Systemic Change – Synthesis Paper. USAID Leveraging Economic Opportunities (LEO), Report No. 41. Link

Fowler, Ben, Tim Sparkman, and Erin Markel. 2016. Disrupting System Dynamics: A Framework for Understanding Systemic Changes. USAID Leveraging Economic Opportunities (LEO), Report No. 47. Link

Hargreaves, Margaret B. 2010. Evaluating System Change: A Planning Guide. Mathematica Policy Research Reports. Link

Latham, Nancy. 2014. A Practical Guide to Evaluating Systems Change in a Human Services System Context. Center for Evaluation Innovation. Link

Murray, Christopher JL, and Julio Frenk. 2008. Health metrics and evaluation: strengthening the science. Lancet; 371: 1191–99. Link

Mutale, Wilbroad, Peter Godfrey-Fausset, Margaret Tembo Mwanamwenge, Nkatya Kasese, Namwinga Chintu, Dina Balabanova, Neil Spicer, Helen Ayles. 2013. Measuring Health System Strengthening: Application of the Balanced Scorecard Approach to Rank the Baseline Performance of Three Rural Districts in Zambi. PLOS One. Volume 8, Issue 3. Link

## Governance and Health Governance

Abimbola, Seye, Joel Negin, Alexandra L. Martiniuk, and Stephen Jan. 2017. "Institutional analysis of health system governance." Health policy and planning 32, no. 9: 1337-1344. Link

Balabanova, Dina, Anne Mills, Lesong Conteh, Baktygul Akkazieva, Hailom Banteyerga, Umakant Dash, Lucy Gilson, Andrew Harmer, Ainura Ibraimova, Ziaul Islam, Aklilu Kidanu, Tracey P Koehlmoos, Supon Limwattananon, VR Muraleedharan, Gulgun Murzalieva, Benjamin Palafox, Warisa Panichkriangkrai, Walaiporn Patcharanarumol, Loveday Penn-Kekana, Timothy Powell-Jackson, Viroj Tangcharoensathien, and Martin McKee. 2013. "Good Health at Low Cost 25 years on: lessons for the future of health systems strengthening." The Lancet 381, no. 98833: 2118-2133. Link

Balabanova, Dina, Martin McKee, Anne Mills, Gill Walt, and Andy Haines. 2010. "What can global health institutions do to help strengthen health systems in low income countries?" Health Research Policy and Systems 8, no. 1: 8-22. Link

Barbazza, Erica, and Juan E. Tello. 2014. "A review of health governance: definitions, dimensions and tools to govern." Health policy 116, no. 1: 1-11. Link

Brinkerhoff, Derick W and Thomas J Bossert. 2014. “Health governance: principal–agent linkages and health system strengthening.” Health Policy and Planning, 29:685–693. Link

Chhotray, Vasudha, and Gerry Stoker. 2008. Governance theory and practice: A cross-disciplinary approach. Springer. Link

Frenk, Julio, and Suerie Moon. 2013. "Governance challenges in global health." New England Journal of Medicine 368, no. 10: 936-942. Link.

Gostin, Lawrence O., and Emily A. Mok. 2009. "Grand challenges in global health governance." British Medical Bulletin 90, no. 1: 7-18. Link

Greer, Scott L., and Claudio A. Méndez. "Universal health coverage: a political struggle and governance challenge." American journal of public health 105, no. S5 (2015): S637-S639. Link

Greer, S, M. Wismar, and J. Figueras. 2016. “Strengthening Health System Governance,” Strengthening Health System Governance Better policies, stronger performance.” European Observatory on Health Systems and Policies Series. Link

Kickbusch, Ilona and David Gleicher. 2012. *Governance for health in the 21st century*. Copenhagen: WHO Regional Office for Europe. Link

Lebel, Louis, John M. Anderies, Bruce Campbell, Carl Folke, Steve Hatfield-Dodds, Terry P. Hughes and James Wilson. 2006. “Governance and the capacity to manage resilience in regional social-ecological systems.” Ecology and Society 11(1): 19. Link

Pyone, Thidar, Helen Smith, and Nynke van den Broek. 2017. "Frameworks to assess health systems governance: a systematic review." Health Policy and Planning 32, no. 5: 710-722. Link

Siddiqi, Sameen, Tayyeb I. Masud, Sania Nishtar, David H. Peters, Belgacem Sabri, Khalif M. Bile, and Mohamed A. Jama. 2009. "Framework for assessing governance of the health system in developing countries: gateway to good governance." Health Policy 90, no. 1: 13-25. Link

USAID. 2017. "Health System Assessment Approach, Version 3.0" Health Finance and Governance Project. Link

## Stewardship

Londoño, Juan-Luis, and Julio Frenk. 1997. "Structured pluralism: towards an innovative model for health system reform in Latin America." Health Policy 41, no. 1: 1-36. Link

Saltman, Richard B., and Odile Ferroussier-Davis. 2000. "The concept of stewardship in health policy." Bulletin of the World Health Organization 78: 732-739. Link

Travis, Phyllida, Dominique Egger, Philip Davies, and Abdelhay Mechbal. 2002. *Towards better stewardship: concepts and critical issues*. World Health Organization: Geneva. Link

Veillard, Jeremy Henri Maurice, Adalsteinn Davidson Brown, Enis Bariş, Govin Permanand, and Niek Sebastian Klazinga. 2011. "Health system stewardship of National Health Ministries in the WHO European region: concepts, functions and assessment framework." Health Policy 103, no. 2-3:191-199. Link

World Health Organization. 2018. “Stewardship.” Link.

## Resilience and Health System Resilience

Blanchet, Karl, Sara L. Nam, Ben Ramalingam, and Francisco Pozo-Martin. 2017. “Governance and Capacity to Manage Resilience of Health Systems: Towards a New Conceptual Framework.” International Journal of Health Policy Management 6(8), 431–435. Link

Kruk, Margaret E., Michael Myers, S. Tornorlah Varpilah, and Bernice T. Dahn. 2015. "What is a resilient health system? Lessons from Ebola." The Lancet 385, no. 9980: 1910-1912. Link

USAID/Promoting Resilience. Link

Kapoor, Neelesh, Dewesh Kumar,and Nivedita Thakur. 2014. “Core attributes of stewardship; foundation of sound health system.” International Journal of Health Policy Management, 3(1), 5–6. Link

Karanikolos, Marina, Philipa Mladovsky, Jonathan Cylus, Sarah Thomson, Sanjay Basu, David Stuckler, Johan P. Mackenbach, and Martin McKee. "Financial crisis, austerity, and health in Europe." The Lancet 381, no. 9874 (2013): 1323-1331. Link

Kruk, Margaret E., Emilia J. Ling, Asaf Bitton, Melani Cammett, Karen Cavanaugh, Mickey Chopra, Fadi El-Jardali et al. "Building resilient health systems: a proposal for a resilience index." BMJ 357 (2017): j2323. Link

Thomas S1, Keegan C, Barry S, Layte R, Jowett M, Normand C. 2013. “A framework for assessing health system resilience in an economic crisis: Ireland as a test case.” BMC Health Services Research 13:450 Link

Venton, Courtenay Cabot. 2018. Economics of Resilience to Drought: Somalia Analysis. USAID Center for Resilience. Link

UNDP. 2011. Towards Human Resilience: Sustaining MDG Progress in an Age of Economic Uncertainty. “Governance Principles, Institutional Capacity and Quality.” Link

USAID. 2018. Resilience Evidence Forum Report. USAID Center for Resilience. Link

## Institutional and Organizational Capacity Building

Baser, Heather, and Peter Morgan. 2008. Capacity, Change, and Performance: Study Report. Discussion Paper No.: 59B. European Centre for Development Policy Management. Link

Bennett, Sara and Fred Rosensweig. 2018. Building Institutional Capacity for Stronger Health Systems. HFG Series: Advances in Health Finance & Governance. Link

Espejo, Raúl, and Antonia Gill. 2011. The viable system model as a framework for understanding organizations. Link

LaFond, Anne K., Lisanne Brown, and Kate Macintyre. 2002. "Mapping capacity in the health sector: a conceptual framework." The International Journal of Health Planning and Management 17, no. 1: 3-22.

## Sustainability and Transition

Espejo, Raul and Antonia Gill. 2011. The Viable System Model as a Framework for Understanding Organizations. Link

Espejo, Raul. 1990. “The Viable System Model”. Systemic Practice and Action Research. 3: 219-221. Link

George, Asha, Amnesty Lefevre, Meike Schleiff, Arielle Mancuso, Emma Sacks, Emma, and Eric Sarriot. 2018. “Hubris, humility and humanity: Expanding evidence approaches for improving and sustaining community health programmes.” BMJ Global Health. Link

Oberth, Gemma and Alan Whiteside. 2015. “What does sustainability in the HIV and AIDS response?” African Journal of AIDS Research. 15(1):35-43. Link

Naimoli, Joseph F., Sweta Saxena, Laurel E. Hatt, Kristina M. Yarrow, Trenton M. White, and Temitayo Ifafore-Calfee,. 2017. “Health system strengthening: Prospects and threats for its sustainability on the global health policy agenda.” Health Policy and Planning. 33(1): 85-98. Link

Peters, David, Ligia Paina, and Sara Bennett. 2012. “Expecting the Unexpected: Applying the Develop-Distort Dilemma to maximize positive market impacts in health.” Health policy and planning. 27 Suppl 4: iv44-iv53. Link

Raj, Baldev. 2016. “Directed and Systematic Approaches Towards Sustainability in the Twenty-first Century.” The Mind of the Engineer. Edited by Ghosh, P. Pp-11-18. Link

Sarriot, Eric, Anne Langston, Ilona Varallyay, Sharon Arscott-Mills, Helen Coelho, Soumya Alva, Jennifer Yourkavitch, Natasha Wad, Kiersten Johnson. 2011. Ownership, Partnership, Capacity, Transition and Sustainability: A Literature Review. Unpublished report.

Savigny, Donald de and Taghreed Adam. 2009. Systems Thinking for Health Systems Strengthening. World Health Organization. Link

Schuftan, Claudio. 2003. “The Emerging Sustainable Development Paradigm: A Global Forum on The Cutting Edge of Progressive Thinking.” Link

Topp, Stephanie M. and Julien Chipukuma. 2016. “How did rapid scale-up of HIV services impact on workplace and interpersonal trust in Zambian primary health centres: A case-based health systems analysis.” BMJ Global Health. Link

Jennifer Yourkavitch, Lwendo Moonzwe Davis, Reeti Hobson, Sharon Arscott-Mills, Daniel Anson, Gunther Baugh, Salim Sadruddin, Jean-Caurent Mantshumba, Bacary Sambou, Jean Tony Bakukulu, Pascal Ngoy Leya, Misheck Luhanga, Leslie Mgalula, Gomezgani Jenda, Humphreys Nsona, Santos Alfredo Nassivila, Eva de Carvalho, Marla Smith, Moumouni Absi, Fatima Aboubakar, Aminata Tinni Konate, Mariam Wahab, Joy Ufere, Chinwoke Isiguzo, Lynda Ozor, Patrick B Gimba, and Ibrahim Ndaliman. 2019. “Integrated community case management: planning for sustainability in five African countries.” Journal of Global Health. 9(1). Link

## Country Experiences

Atun, R., Aydın, S., Chakraborty, S., et al. 2013. “Universal health coverage in Turkey: enhancement of equity.” *The Lancet*, *382*(9886), 65-99. Link

Culyer, A. J., Phōthisitā, C., & Santatiwongchai, B. 2016. *A star in the east: a short history of HITAP*. Health Intervention and Technology Assessment Program. Link

Frenk, J., González-Pier, E., Gómez-Dantés, O., et al. 2006. "Comprehensive reform to improve health system performance in Mexico." *The Lancet,* 368(9546), 1524-1534. Link

Fundación Mexicana para la Salud A.C. (FUNSALUD). 2019. Universal Coverage of Health Services. Link

Fundación Mexicana para la Salud A.C. (FUNSALUD). 2019. Link

Hashimoto, H., Ikegami, N., Shibuya, K., et al. 2011. "Cost containment and quality of care in Japan: is there a trade-off?" The Lancet, 378(9797), 1174-1182. Link

Ikegami, N. 1992. "Japan: maintaining equity through regulated fees." *Journal of Health Politics, Policy and Law*, *17*(4), 689-714. Link

Ikegami, N., & Anderson, G. F. 2012. "In Japan, all-payer rate setting under tight government control has proved to be an effective approach to containing costs." *Health Affairs*, *31*(5), 1049-1056. Link

Ikegami, N. 2014. Universal health coverage for inclusive and sustainable development: lessons from Japan. The World Bank. Link

Juan, M., Moguel Ancheita, A., Valdes Olmedo, C., et al. 2013. Mexican Health Foundation working group. Universal Coverage of Health Services in Mexico Salud Publica Mex 2013; 55: EEI-EE64. SALUD PUBLICA DE MEXICO, 55, E3-E64.

McGann, J. G. 2019. 2018 Global Go To Think Tank Index Report. Link

Poder. 2016. Funsalud, the entrepreneurs who set the health policies in Mexico. [Published: April 7 2016]. Link

Sparkes, S. P. 2015. *The Political Economy of Health Reform: Turkey's Health Transformation Program, 2003-2012* (Doctoral dissertation). Link

Tantivess, S., Teerawattananon, Y., & Mills, A. 2009. "Strengthening cost-effectiveness analysis in Thailand through the establishment of the health intervention and technology assessment program." *Pharmacoeconomics*, *27*(11), 931-945. Link

Yardim, M. S., Cilingiroglu, N., & Yardim, N. 2013. "Financial protection in health in Turkey: the effects of the Health Transformation Programme." *Health Policy and Planning*, *29*(2), 177-192. Link

# Annex 2: Mapping of Comparable Tools

The team reviewed 28 HSS progression models and related tools. Table 2 presents definitions for types of tools and focus areas. Table 3 presents the types of tools and focus areas in comparison. Table 4 summarizes the 28 identified tools, with 11 tools presented in more detail.

**Table 2: Definitions for Types of Tools and Focus Areas**

| Category Definitions | | |
|---|---|---|
| **Type of Tool** | **Definition** | **Number (Total = 28)** |
| **Foundational Framework** | The WHO building blocks is the framework that the progression model sought to break away in order to describe the factors or linkages between these blocks that contribute to a continuously improving health system. | 1 |
| **Framework** | A framework is a starting point. A way to conceptualize an idea or the basic structure of something. From a framework, tools, action plans, or roadmaps can be created. | 5 |
| **Scorecard** | A scorecard is a tool / methodology for ranking or judging X. Often fairly static, to give a score on topics at one point in time. That said, some scorecards are more dynamic and work similar to an assessment or progression model | 8 |
| **Assessment** | An assessment is a tool / methodology for ranking or judging X. Often, there is a mix of quantitative and qualitative data as well as primary and secondary data. | 10 |
| **Progression Model** | A progression model is a tool or methodology for ranking or judging X. | 4 |
| **Functions** | **Definition** | **Number (Total = 28)** |
| **Health System Performance** | Tool or model looks at how effectively a health system is able to improve health outcomes of its population, remain responsive to the needs of its population, and ensure equitable geographic and financial access of health services, all of which contribute to performance. | 3 |
| **WHO Building Blocks** | Tool or model that is described or organized according to a health system that is made up of six blocks – service delivery, health workforce, health information systems, access to essential medicines, financing, and leadership/governance. | 2 |
| **Topic-specific (health service)** | Tool or model that seeks to assess or understand an aspect of a specific health service such as HIV/AIDS, malaria, or VMMC. | 2 |
| **Topic-specific (capacity)** | Tool or model that seeks to assess or understand the underlying and cross-cutting capacities that contribute to the management or delivery of health services. | 17 |
| **Sustainability and Transition Planning** | Tool or model that seeks to delineate or assess progress made towards sustaining outcomes during a transitional period when funding shifts are occurring. | 4 |

## Findings

In terms of type of tool, most fell into the assessment category (10), followed by the scorecard (8), framework (5), progression model (4), and foundational framework (1) categories. Across the focus areas, the majority of the tools reviewed relate to the capacity of the health system focus area (17), followed by the sustainability and transition planning (4), health system performance (3), topic-specific for a health service (2), and WHO building blocks (1) focus areas.

Table 2 provides a summary of the types of tools and focus areas. Only three tools relate to health system performance, including WHO's health system building blocks framework (categorized as a foundational framework). The two additional health system performance tools the team categorized as assessment tools, which includes USAID's Health Systems Assessment Approach (HSAA) developed under the Health Finance and Governance (HFG) project. The small number of health system performance tools reviewed is logical given our prioritized interest in exploring the potential value added of institutional architecture related tools over health system performance related tools. The four progression models fall in the WHO building blocks (2) and the health service (2) focus areas. This concentration of progressions models potentially suggests increasing interest in the HSS field around the value added of progression model tools.

Most tools (17) align to the focus area of understanding underlying capacities behind providing health services, whether in the form of a framework (3), scorecard (7), or assessment (7). The team was unable to find progression models in the capacity of the health system and the sustainability and transition planning focus areas. This lack of tools in these two focus areas potentially suggests a gap in terms of the types of progression models that are being developing in the HSS field.

**Table 3: Types of Tools and Focus Areas in Comparison**

| | | Focus Area of Tool (n = 28) | | | | | |
|---|---|---|---|---|---|---|---|
| | | Health System Performance | WHO Building Blocks | Topic-specific (health service) | Topic-specific (capacity) | Sustainability and Transition Planning | TOTAL |
| Type of Tool (n = 28) | Foundational Framework | 1 | | | | | 1 |
| | Framework | | | | 3 | 2 | 5 |
| | Scorecard | | | | 7 | 1 | 8 |
| | Assessment | 2 | | | 7 | 1 | 10 |
| | Progression Model | | 2 | 2 | | | 4 |
| | TOTAL | 3 | 2 | 2 | 17 | 4 | 28 |

## Summary of Tools Reviewed

Table 4 presents a list of all 28 tools reviewed, including the focus area along with a brief summary for each tool. The table organizes the tools in this order: Foundational Framework (1), Framework (5), Scorecard (8), Assessment (10), and Progression Model (4). The asterisk (*) denotes the eleven tools that are reviewed in Table 3.

**Table 4: Summary List of Tools Reviewed**

| | Tool Reviewed | Focus Area | Summary |
|---|---|---|---|
| **Foundational Framework** | | | |
| 1 | WHO Building Blocks | Health System Performance | Shows how health inputs and processes (e.g. health workforce and infrastructure) are reflected in outputs (e.g. interventions and available services) that in turn are reflected in outcomes (e.g. coverage) and impact (morbidity and mortality). |
| **Framework** | | | |
| 2 | * USAID / Maternal and Child Survival Program (MCSP) Viable, Integrated Community Health Platform | Topic-specific (capacity) | Describes the essential elements of community health strategies to systematically address and improve the comprehensiveness of services, sustainability, and scale. Building a Community Health Platform (CHP) requires a coherent alignment of functions, structures, and resources as represented through the model. |
| 3 | * Sustainability Planning Framework for the WHO Rapid Access Expansion Program (RAcE) for integrated community case management (iCCM) | Sustainability and Transition Planning | Organizes thinking about sustainability and informs planning, management, and evaluation of activities related to iCCM in order to improve and maintain health outcomes for children under 5. |
| 4 | ICF Sustainability Framework | Sustainability and Transition Planning | Organizes thinking about sustainability and informs planning, management, and evaluation of activities in order to improve and maintain health outcomes at a population level. |
| 5 | USAID Pharmaceutical Systems Strengthening (PSS) Insight | Topic-specific (capacity) | Measures pharmaceutical systems strengthening. Includes an indicator-based monitoring tool called PSS Insight. |
| 6 | * USAID Thinking and Working Politically Through Applied Political Economy Analysis (PEA) | Topic-specific (capacity) | Helps USAID think and work in politically aware ways, i.e. "thinking and working politically" (TWP), through use of applied political economy analysis to understand power dynamics and economic and social factors influencing development. |
| **Scorecard** | | | |

| | | | |
|---|---|---|---|
| 7 | USAID Community Health Worker (CHW) Assessment and Improvement Matrix | Topic-specific (capacity) | Examines programmatic components that CHW programs should consider as important to successfully supporting CHWs. |
| 8 | * USAID Journey to Self-Reliance | Topic-specific (capacity) | Describes a country's ability to plan, finance, and implement solutions to address its own development challenges, using an approach that fosters stable, resilient, prosperous, and self-reliant countries. |
| 9 | * Institutional Architecture Assessment for Food Security Policy Change | Topic-specific (capacity) | Analyzes a country's capacity to undertake food security change. It examines the key systems, processes and relationships that shape the development of food security policy while trying to factor in the broader socioeconomic context. |
| 10 | WHO Joint External Evaluation (JEE) Tool | Topic-specific (capacity) | Assesses a country's capacity to prevent, detect, assess, and notify on all public health risks and emergencies of international concern through a voluntary, external assessment of these core-capacities built on a variety of technical frameworks and regional and global strategies. |
| 11 | * USAID Collaborative Learning Approach (CLA) Maturity Tool | Topic-specific (capacity) | Helps USAID Missions think deliberately about how to plan for and implement CLA approaches that fit the Mission's context and assist them to achieve their development objectives, through a self-assessment, establishment of a vision, development of an action plan, and tracking progress. |
| 12 | USAID Knowledge Management (KM) Maturity Model | Topic-specific (capacity) | Depicts the characteristics and key focus areas of the different levels of KM maturity, from ad hoc (very low) to optimized (very high), in order to help organizations determine where they fall on the scale and identify processes for achieving increased KM structures. |
| 13 | * PEPFAR Sustainability Index and Dashboard (SID) | Sustainability and Transition Planning | Sharpens understanding of each country's sustainability landscape for HIV/AIDS programming and assists PEPFAR and others to make informed investment decisions related to HIV/AIDS. |
| 14 | * Pan American Health Organization (PAHO) Assessment (Steering Role of the National Health Authority (NHA): Performance and Strengthening) | Topic-specific (capacity) | Defines and maps out a NHA in a country in order to identify its strengths and weaknesses and generate recommendations on how to strengthen the NHA steering role function. |
| **Assessment** | | | |
| 15 | * USAID / Health Finance and Governance (HFG) Health System Assessment Approach (HSAA) | Health System Performance | Diagnoses and assesses a country's health system at a point in time through an approach that can be adapted depending on the focus area and goals of the individual country assessment. |

| | | | |
|---|---|---|---|
| 16 | USAID Health System Benchmarking Tool (HSBT) | Health System Performance | Contains a database of health indicators for low- and middle-income countries with standardized answers for policy and programmatic questions. |
| 17 | Guidance for Analysis of Country Readiness for Global Fund Transition | Sustainability and Transition Planning | Provides guidance for countries that must take on ownership of management and financing for HIV, TB, and malaria programs previously funded by the Global Fund, by identifying financial, programmatic and governance gaps, bottlenecks and risks in the health system that might affect transition. |
| 18 | WHO Service Availability and Readiness Assessment (SARA) | Topic-specific (capacity) | Fills critical data gaps in measuring and tracking progress in health systems strengthening specific to service delivery. |
| 19 | Joint Learning Network's (JLN) Health Benefits Policies Assessment | Topic-specific (capacity) | Takes a system's approach to evaluating how well health benefits packages are constructed and implemented. |
| 20 | JLN Costing of Health Services for Provider Payment | Topic-specific (capacity) | Provides step by step guidance through tools, resources, and an online course, on the different methods that can be used to cost a set of provider services specific to LMIC. |
| 21 | JLN Universal Health Care (UHC) – Primary Health Care (PHC) Self-Assessment Tool | Topic-specific (capacity) | Identifies practical policy opportunities in the health system to improve relationship between health financing and PHC efforts globally. |
| 22 | JLN Assessing Health Provider Payment Systems | Topic-specific (capacity) | Helps countries find answers to provider payment policy questions through a country-led participatory process, and practitioner experiences with designing, implementing and managing payment systems. |
| 23 | JLN Using Data Analytics for Provider Payment | Topic-specific (capacity) | Uses data analytics to monitor heath provider payment systems and track whether payment systems are supporting health system objectives toward achieving UHC. |
| 24 | World Bank Universal Health Coverage Assessment Tool (UNICAT) | Topic-specific (capacity) | Assesses the strengths and weaknesses of country and partner capacities in implementing UHC policies. Following piloting of the tool in 15 countries, the World Bank did not move forward with the tool. |
| **Progression Model** | | | |
| 25 | * USAID / MEASURE Evaluation Health Information System (HIS) Stages of Continuous Improvement | WHO Building Blocks | Provides a scale that can be used to develop a roadmap for HIS improvement that is aligned with a national HIS strategic plan or a health systems plan. |
| 26 | USAID / MEASURE Evaluation Health Information System (HIS) Interoperability Maturity Matrix | WHO Building Blocks | Supports ministries of health, their implementing partners, and other stakeholders to identify the key domains for interoperability and the required levels of maturity to achieve HIS interoperability goals. |

| | | | |
|---|---|---|---|
| 27 | WHO Voluntary Medical Male Circumcision (VMMC) | Topic-specific<br>(health service) | Provide a framework for advancing voluntary male circumcision programs in HIV prevalent countries. |
| 28 | * The Primary Health Care Performance Initiative (PHCPI) / Primary Health Care (PHC) Progression Model | Topic-specific<br>(health service) | Brings together stakeholders with varying and complementary knowledge of how the PHC system functions in a country to yield an objective, comparable assessment of PHC capacity. |

## Detailed Review of 11 Tools

This section presents the detailed review of 11 tools, including summaries of the overall strengths and weaknesses of the tools as well as the pros and cons of the metrics used as part of the tool. The process to select 11 tools for detailed review was largely purposeful and considered factors such as insights from the larger literature review, discussion among the team about which tools appeared most relevant to institutional architecture for HSS, familiarity with tool based on past or parallel work experience, and suggestions from colleagues, including USAID. Table 5 presents the 11 tools review in detail. Following Table 5, we include summary statements for each of the 11 tools reviewed in detail.

**Table 5. Tools Reviewed in Detail**

| | Tool | Type | Focus Area |
|---|---|---|---|
| 1 | USAID / Maternal and Child Survival Program (MCSP) Viable, Integrated Community Health Platform | Framework | Topic-specific (capacity) |
| 2 | Sustainability Planning Framework for the WHO Rapid Access Expansion Program (RAcE) for integrated community case management (iCCM) | Framework | Sustainability and Transition Planning |
| 3 | USAID Thinking and Working Politically Through Applied Political Economy Analysis (PEA) | Framework | Topic-specific (capacity) |
| 4 | USAID Journey to Self-Reliance | Scorecard | Topic-specific (capacity) |
| 5 | Institutional Architecture Assessment for Food Security Policy Change | Scorecard | Topic-specific (capacity) |
| 6 | USAID Collaborative Learning Approach (CLA) Maturity Tool | Scorecard | Topic-specific (capacity) |
| 7 | PEPFAR Sustainability Index and Dashboard (SID) | Scorecard | Sustainability and Transition Planning |
| 8 | Pan American Health Organization (PAHO) Assessment (Steering Role of the National Health Authority (NHA): Performance and Strengthening) | Scorecard | Topic-specific (capacity) |
| 9 | USAID / Health Finance and Governance (HFG) Health System Assessment Approach (HSAA) | Scorecard | Health System Performance |
| 10 | USAID / MEASURE Evaluation Health Information System (HIS) Stages of Continuous Improvement | Progression Model | WHO Building Blocks |
| 11 | The Primary Health Care Performance Initiative (PHCPI) / Primary Health Care (PHC) Progression Model | Progression Model | Topic-specific (health service) |

## 1. USAID Maternal and Child Survival Program (MCSP)

## Viable Integrated Community Health Platform

| Overview | |
|---|---|
| Type | Framework |
| Focus Area | Topic-specific (capacity) |
| Summary Statement | Describes the essential elements of community health strategies to systematically address and improve the comprehensiveness of services, sustainability, and scale. Building a Community Health Platform (CHP) requires a coherent alignment of functions, structures, and resources as represented through the model. |
| **The Tool in General** | |
| Strengths | • Aims to accelerate the institutionalization of community health as a central component of country health strategies.<br>• Provide a common direction that also respects program and country differences. |
| Weaknesses | • Inconsistent language—Community health is defined differently by different people and organizations. Definition can encompass services delivered by diverse cadres of CHWs, from sharing knowledge and information on health promotion to delivering lifesaving drugs and organizing communities for targeted health and nutrition improvements or infrastructure work on health systems issues.<br>• Multiple contexts—MCSP is already engaged in important community health work in response to requests from USAID Missions and countries; but all MCSP countries are at different stages of development and implementation in their own community health strategies. |
| **The Metrics of the Tool** | |
| Pros | • Five Domains (Lenses): interventions and outcomes (health promotion, prevention and curative services); CHW workforce/community organizing (social infrastructure); local learning and adaption; institutionalization, governance and partnerships; support services and functions<br>• Broad and overarching, encompasses a wide array of CH principles |
| Cons | • Can be so broad that it is not necessarily useful.<br>• Overall objective of the framework is unclear.<br>• Unclear how all the domains interact with each other. |
| Link | https://www.mcsprogram.org/resource/moving-toward-viable-integrated-community-health-platforms-to-institutionalize-community-health-in-national-strategies-to-end-preventable-child-and-maternal-deaths/ |

## 2. WHO Rapid Access Expansion Program (RAcE)
## Sustainability Planning Framework for the for Integrated Community Case Management (iCCM)

| **Overview** | |
|---|---|
| Type | Framework |
| Focus Area | Sustainability and Transition Planning |
| Summary Statement | Organizes thinking about sustainability and informs planning, management, and evaluation of activities related to iCCM in order to improve and maintain health outcomes for children under 5. |
| **The Tool in General** | |
| Strengths | • Multi sectoral and participatory process for sustainability planning in support of country-level planning, implementation, and assessment of iCCM activities.<br>• Allows for emergence of linkages that were not considered previously by bringing together diverse stakeholders.<br>• Takes a systems lens to thinking through iCCM management and implementation.<br>• Can result in roadmap or transition plans |
| Weaknesses | • Requires external facilitation.<br>• For ideal implementation, at least 2-3 days is needed. |
| **The Metrics of the Tool** | |
| Pros | • N/A |
| Cons | • N/A |
| Link | http://www.jogh.org/col-race.htm |

## 3. USAID: Thinking and Working Politically Through Applied Political Economy Analysis (PEA)

| **Overview** | |
|---|---|
| Type | Framework |
| Focus Area | Topic-specific (capacity) |
| Summary Statement | Helps USAID think and work in politically aware ways, i.e. "thinking and working politically" (TWP), through use of applied political economy analysis to understand power dynamics and economic and social factors influencing development. |
| **The Tool in General** | |
| Strengths | • Framework provides guide to tailor at country and sectoral level and provides example discussion questions for USAID Missions. |
| Weaknesses | • Targeted at USAID Missions and requires their engagement to make findings actionable<br>• Requires several months to implement. |
| **The Metrics of the Tool** | |
| Pros | • N/A |
| Cons | • N/A |
| Link | https://www.usaid.gov/sites/default/files/documents/1866/PEA2018.pdf |

## 4. USAID Journey to Self-Reliance

| Overview | |
|---|---|
| Type | Scorecard |
| Focus Area | Topic-specific (capacity) |
| Summary Statement | Describes a country's ability to plan, finance, and implement solutions to address its own development challenges, using an approach that fosters stable, resilient, prosperous, and self-reliant countries. |
| **The Tool in General** | |
| Strengths | • Accompanying material explains the purpose and rationale behind moving towards a "self-reliant" approach.<br>• Self-reliance indicators are not health program specific and are a series of indicators that evaluate a country's economic development and commitment to lowering donor finance. |
| Weaknesses | • Relies on the concept of system resilience for self-reliance, even though resilience is about how well a system can respond to an ecological crisis instead of how well a system can improve itself over time.<br>• It is not health system specific and does not have indicators that are a good measure for health system development. |
| **The Metrics of the Tool** | |
| Pros | • Clearly articulated metrics that allow countries to be benchmarked against each other. |
| Cons | • The framework's composite scores rely on indicators that do not appear to be causal to self-reliance or better health system outcomes. |
| Link | https://www.usaid.gov/selfreliance |

## 5. USAID
## Institutional Architecture Assessment for Food Security Policy Change

| Overview | |
|---|---|
| Type | Scorecard |
| Focus Area | Topic-specific (capacity) |
| Summary Statement | Analyzes a country's capacity to undertake food security change. It examines the key systems, processes and relationships that shape the development of food security policy while trying to factor in the broader socioeconomic context. |
| **The Tool in General** | |
| Strengths | • Few "domains" and no "subdomains" makes the framework less cumbersome to work with - i.e. would be less time consuming to assess than a framework with 5 domains and 15 subdomains. |
| Weaknesses | • Lack of "subdomains" may ignore complexity of assessing each component.<br>• Does not provide description of attributes for each level that are specific to the component. Only provides overall description of the component and overall description of what each of the three tiers broadly mean. |
| **The Metrics of the Tool** | |
| Pros | • Simple to assess on a three color-grade/tiered system. |
| Cons | • Scoring approach is not intended to capture progression but rather a snapshot in time.<br>• The qualitative nature of the indicators introduces bias from the assessment team. Need to ensure that the team or stakeholders interviewed covers the full range of expertise needed to accurate and fully assess food security policy change.<br>• Lack of description of the attributes for each of the color tiers can introduce subjectivity in interpretation. May work better if provided cutoff for number of "yes" or positive answers to map to each color. |
| Link | https://www.agrilinks.org/post/institutional-architecture-assessment-food-security-policy-change |

## 6. USAID
## Collaborative Learning Approach (CLA) Maturity Tool

| Overview | |
|---|---|
| **Type** | Scorecard |
| **Focus Area** | Topic-specific (capacity) |
| **Summary Statement** | Helps USAID Missions think deliberately about how to plan for and implement CLA approaches that fit the Mission's context and assist them to achieve their development objectives, through: a self-assessment, establishment of a vision, development of an action plan, and tracking progress. |
| **The Tool in General** | |
| **Strengths** | • A good example of a maturity model toolkit that comes in many different languages.<br>• The CLA maturity tool has an instruction video, facilitation guide, and an action planning template that enables users to arrive at a tangible next step for implementation. |
| **Weaknesses** | • CLA tool is not a health systems specific tool.<br>• Intent is not to evaluate a health system, but only a specific project, and there is an unclear applicability to the institutional architecture model. |
| **The Metrics of the Tool** | |
| **Pros** | • Domain specific progressions are well designed and visually appealing.<br>• The toolkit and the benchmarking exercise are meant to be a facilitation device to ensure there is evaluation and learning throughout the life of the project |
| **Cons** | • Self-scoring on the progression model is fairly subjective and therefore the self-assessment exercise will need to have a strong facilitator with content knowledge. |
| **Link** | https://usaidlearninglab.org/library/cla-framework-and-maturity-tool |

## 7. PEPFAR
## Sustainability Index and Dashboard (SID)

| Overview | |
|---|---|
| **Type** | Scorecard |
| **Focus Area** | Sustainability and Transition Planning |
| **Summary Statement** | Sharpens understanding of each country's sustainability landscape for HIV/AIDS programming and assists PEPFAR and others to make informed investment decisions related to HIV/AIDS. |
| **The Tool in General** | |
| **Strengths** | • Multi sectoral and participatory process – the SID includes the partner government (all relevant ministries, including Ministry of Health and Ministry of Finance, and parliamentarians) and key stakeholders, including civil society, private sector, and other bilateral and multilateral (i.e., Global Fund, World Bank) donors.<br>• Framework provides summary data as contextual information for understanding the overall SID score for each country. This includes HIV financing and health indicators, such as population and fertility, GNI per capita, demographic, and HIV care management.<br>• Scores are publicly available<br>• Prior year data is summarized to enable analyses of trends |
| **Weaknesses** | • Tool has been implemented in many countries with varying degrees of success.<br>• Tool is complicated and requires a large amount government support to complete. |
| **The Metrics of the Tool** | |
| **Pros** | • Tool assesses the country capacities across four domains and fifteen elements.<br>• Each domain and element provide guiding questions and lists to assist with scoring an element.<br>• The tool allows for implementers to provide comments to provide context for individual scores.<br>• Each domain has both definitions and illustrative examples of a country with a high degree of maturity to improve objectivity of assessment.<br>• Scores are auto-filled based on the assessment point-based scoring system. |
| **Cons** | • There are no requirements on data sources, meaning data might not be standardized making cross-country comparisons difficult.<br>• Country reports lack stakeholder citations making findings difficult to assess.<br>• Unclear methodology on how data is aggregated or different scores are allocated. |
| **Link** | https://www.pepfar.gov/countries/cop/sids/index.htm |

## 8. Pan American Health Organization (PAHO) Assessment
## Steering Role of the National Health Authority: Performance and Strengthening

| Overview | |
|---|---|
| **Type** | Scorecard |
| **Focus Area** | Topic-specific (capacity) |
| **Summary Statement** | Defines and maps out an NHA in a country in order to identify its strengths and weaknesses and generate recommendations on how to strengthen the NHA steering role function. |
| **The Tool in General** | |
| **Strengths** | • Detailed activities within functional areas are laid out to enable discussion at each level of health system that can allow comparison between the levels. |
| **Weaknesses** | • Assessment process is not clear. |
| **The Metrics of the Tool** | |
| **Pros** | • Broken into functional areas and activities, with qualitative assessments done through interviews or workshop format. |
| **Cons** | • Limited guidance on how to score each functional area (for example, is it yes/no questions, or based on discussion?) |
| **Link** | http://www1.paho.org/hq/dmdocuments/2010/Steering_Role_NHA.pdf |

## 9. USAID / Health Finance and Governance (HFG) Project Health System Assessment Approach (HSAA)

| Overview | |
|---|---|
| **Type** | Assessment |
| **Focus Area** | Health System Performance |
| **Summary Statement** | Diagnoses and assesses a country's health system at a point in time through an approach that can be adapted depending on the focus area and goals of the individual country assessment. |
| **The Tool in General** | |
| **Strengths** | • Highly comprehensive and a thorough review of the health system performance<br>• Health system improvement recommendations are backed by an ample amount or research |
| **Weaknesses** | • Highly comprehensive nature requires an extensive data collection and long implementation<br>• Takes a building blocks approach to health system performance |
| **The Metrics of the Tool** | |
| **Pros** | • Measures are a mix of qualitative and quantitative information, and are a comprehensive way for evaluating health system performance and overall governance |
| **Cons** | • Large number of measures requires extensive staff time and data to properly collate and aggregate<br>• Creating a cohesive strategy with this amount of data across the entire system is an onerous task |
| **Link** | https://hsaamanual.org/ |

## 10. USAID / MEASURE Evaluation Project
## Health Information Systems (HIS) Interoperability Maturity Matrix

| Overview | |
|---|---|
| **Type** | Progression Model |
| **Focus Area** | WHO Building Blocks |
| **Summary Statement** | Supports ministries of health, their implementing partners, and other stakeholders to identify the key domains for interoperability and the required levels of maturity to achieve HIS interoperability goals. |
| **The Tool in General** | |
| **Strengths** | • Attributes defined for each of the 18 subdomains that can be used to map the domain levels and to determine the overall maturity level for HIS interoperability<br>• Stakeholder driven and country-owned: the assessment team draws from MOH representatives and representatives from other key line ministries and other stakeholders (e.g., development and implementation partners, private sector, donors, CSOs, academia).<br>• Criteria-based: In addition to the metrics for assessing maturity this tool offers guidance on the selection of the assessment team to ensure that tool can be accurately and fully assessed.<br>• Flexibility of the tool: recognizes that partial achievement of some levels is a possibility and provides guidance on how to deal with those scenarios (e.g., shade in yellow if partially achieved and green if fully achieved). |
| **Weaknesses** | • Relative to broader HSS challenges, this tool is highly specialized to one narrow health system challenge (data interoperability) |
| **The Metrics of the Tool** | |
| **Pros** | • Simple scoring system that uses a scale of 1-5 to score each subdomain based on a set of questions. The responses to question can be mapped to a level.<br>• Flexibility of the scoring system to indicate both current level as well as achievement (partial or full) of other levels |
| **Cons** | • Subjective nature of the scoring methodology relies on the expertise and knowledge of the assessment team. The accuracy of the scores may be biased by the composition and expertise of the team.<br>• Although the scoring methodology allows for partial levels or completion of levels higher than the current level, it does not provide a cutoff or threshold for partial completion (e.g., 2 of 3 etc.) |
| **Link** | https://www.measureevaluation.org/resources/tools/health-information-systems-interoperability-toolkit |

## 11. The Primary Health Care Performance Initiative (PHCPI) Primary Health Care (PHC) Progression Model

| | |
|---|---|
| **Overview** | |
| **Type** | Progression Model |
| **Focus Area** | Topic-specific (health service) |
| **Summary Statement** | Brings together stakeholders with varying and complementary knowledge of how the PHC system functions in a country to yield an objective, comparable assessment of PHC capacity. |
| **The Tool in General** | |
| **Strengths** | • Well organized and displayed tool to help users understand function and use of the tool |
| **Weaknesses** | • Still under construction so unsure of findings from implementation of model. |
| **The Metrics of the Tool** | |
| **Pros** | • Scoring methodology provides minimum threshold in order to meet requirements of a given level. This approach is a simplified way to deal with the fact that a health system may possesses a mix bag of attributes for a given domain (e.g., more advanced on some and less advanced on others). Elsewhere, levels are mapped to a metrics such as percentages or proportions reflecting the extent of performance or capacity.<br>• The use of quantifiable cutoffs is helpful to remove subjectivity in what constitutes "a lot" or "little" |
| **Cons** | • The mapping of levels to the number of questions answered "Yes" assumes that each of the attributes that the questions are assessing are equally important and this may not be the case.<br>• It may be difficult to assess a particular subdomain even if a quantifiable minimum threshold or range is provided because it may be difficult to measure, or the country may not have this data or may add to the burden of data collection and reporting. |
| **Link** | https://improvingphc.org/primary-health-care-progression-model |

# Annex 3: Country Experiences

This annex illustrates how the framework of institutional architecture for HSS applies to specific country experiences with health system change in Japan, Mexico, Thailand, and Turkey.

In each of these countries, an interaction of particular actors (public and private), processes, and resources led to a change in the country's health system via one or more of the framework's functions—generating critical evidence related to the health system, identifying health system gaps and challenges, managing the adoption of solutions, and/or operationalizing and implementing changes to address these challenges.

## Japan

Japan introduced a system of revision to the fee schedule that has been put in place as a method of cost containment in its fee-for-service system. The country has institutionalized each of the core functions of the institutional architecture for HSS framework while engaging critical actors in the health system to achieve health systems strengthening goals. This includes the generation and analysis of evidence-based drug and device rates, proposing new fee schedules based on analyses, allowing for broad stakeholder input, and managing changes in the new payment structure when necessary.

Every other year, data from the MOH's national survey of claims (filed regularly by the providers) and the MOH's national report on provider cost and revenue is generated and analyzed to see if costs need to be adjusted. This process involves several levels of government, including the Prime Minister and their cabinet, and the Ministries of Finance and Health, Labor and Welfare. Pertinent officials review the fee schedule and update drug and device pricing based on marketing research surveys and total volume.

In the bi-annual process, the government, as well as representatives of the public, payers and providers, review the fee schedule and update drug and device pricing based on marketing research services and total volume of use. Updates also occur outside of the biannual process when necessary in which billing conditions are set and revised by the MOH to ensure health sector cost containment while maintaining quality (Hashimoto, 2011).

The institutionalization of a fee schedule revision system represents a significant enhancement in the country's ability to drive change within the system. The fee schedule revision system allows for cost-containment in a fee-for-service structure that would typically incentivize the increased utilization of services. In doing so, the government is able to avoid rationing, unnecessary use of technology and the maintenance of insurance plans for its aging population (Ikegami, 2014).

## Mexico

In Mexico, FUNSALUD is a civil, private, non-profit organization that generates evidence and proposes policy solutions meant to develop the field of health, two of the functions of the institutional architecture for HSS framework. The organization also engages critical government and health policy stakeholders through institutionalized processes throughout its process.

The organization continues to present new policy proposals that generate evidence, analyze data and present solutions to multiple health challenges in Mexico. Beyond that, proposals also outline means by which political and organizational stakeholders can take steps to pass reforms and implement them

once mandates are defined and resources have been allocated. The organization works closely with government, so they have a strong sense of the stakeholders involved and can communicate their findings to those who are in position to influence the policy change process. to those necessary. In 2014, the think tank produced a new initiative which would work towards the university of health services, building on the operationalization of SSPH and Seguro Popular (Juan, 2013; FUNSALUD, 2019).

Through the process of the generation and analysis of evidence and formulation of policy solutions, FUNSALUD has been a critical component of the health system strengthening of Mexico. FUNSALUD was instrumental to the advocacy for and design and implementation of the System of Social Protection (SSPH) and its operational arm, Seguro Popular, a large-scale health systems reform that expanded health insurance to the informal economy (Frenk 2006). Because the organization interacts with government through well institutionalized processes and defined feedback loops, it contributes to significant enhancement of Mexico's ability to drive health systems change in a timely manner.

## Thailand

In Thailand, the Health Intervention and Technology Assessment Program (HITAP) was created in 2006 as a semi-autonomous research unit under the Thai Ministry of Health. HITAP provides a mechanism to review and provide recommendations on benefit package revisions for each of the three government sponsored coverage schemes—the general public, formal sector employees, and civil servants. The unit publishes guidelines on drugs, medical devices, procedures, disease prevention, health promotion measures, and benefit packages to assist health policy decision making (Cuyler, 2016). Its work has enabled the country to continually reassess benefits package offered under the different government-subsidized insurance schemes and make improvements to coverage as needed. For example, by 2008, the inclusion criteria for essential benefits were modified to include evaluations on safety, quality, cost-effectiveness, and total fiscal impact (Tantivess, 2009).

The core principles of HITAP reflect three core attributes of the IA for HSS framework—generating evidence, influencing policy, and capacity building. Stakeholder engagement is central to the organization's strategy, both for building the analytic capacity of individuals and facilitating an evidence-based approach to benefit package revisions (Tantivess, 2009). Through HITAP, the institutionalization of these domains with well-defined links to the country's decision-making process has led to an evidence-based allocation scheme for the country's limited public resources, in contrast to allocation that may be arbitrary or favor special interest groups (Culyer 2016). This process – and the actors and resources which support it – has been foundational to Thailand's Universal Health Coverage program.

## Turkey

Turkey's implementation of the Health Transformation Program (HTP)—a national insurance scheme—is emblematic of two of the functions of the institutional architecture for HSS framework: managing adoption of solutions and operationalizing and implementing change, as well as the cross-cutting function of engaging stakeholders and ensuring accountability. This example illustrates how a process and the actors involved can contribute to long term and institutionalized HSS.

From a political perspective, the Ministry combined both visible and rapid changes to the health system with longer-term, major structural reforms that needed legislation. Decrees—such as elimination of involuntary incarceration in hospitals of patients who could not meet medical expenses and expansion

of Green Card benefits to outpatient services and drugs—helped the ministry build public support even as they took time to build consensus for longer-term, more wide-reaching reforms (Yardim 2013).

The MOF and Undersecretary of the Treasury were opposed to the reform, as they were focused on addressing government deficit (many of the UHC reforms that had been attempted in the 1990s had stalled due to economic volatility in the country). In response, the MOH worked with the World Bank, OECD and WHO to created models that showed how HTP would improve the efficiency of the health system. In the meantime, the MOH expanded benefits and coverage in areas, which were under its own authority and did not require MOF approval. The Ministry also undertook a comprehensive study from 2002-03 (the National Health Accounts Study) to establish a baseline of health financing and expenditures to measure the impact of new programs and informed its program by evidence in other countries, such as Belgium, Cuba, Denmark, Thailand and the UK, which increased receptivity across other agencies (Atun 2013).

Over this ten-year period, health system changes to population coverage were implemented systematically, over a series of reforms, with a flexible and responsive approach based on the stakeholders involved and receptivity to the what was introduced (Sparkes 2015). The process of implementing the HTP in Turkey illustrates how actors, such as the Ministry of Health and Finance, engaged in the political change process, and how a series of programs, such as the Green Card benefits program, were implemented in such a way that they led to strengthening of Turkey's institutional architecture for HSS.

## References


Atun, R., Aydın, S., Chakraborty, S., et al. 2013. “Universal health coverage in Turkey: enhancement of equity.” *The Lancet*, *382*(9886), 65-99. Link

Culyer, A. J., Phōthisitā, C., & Santatiwongchai, B. 2016. *A star in the east: a short history of HITAP*. Health Intervention and Technology Assessment Program. Link

Frenk, J., González-Pier, E., Gómez-Dantés, O., et al. 2006. “Comprehensive reform to improve health system performance in Mexico.” *The Lancet,* 368(9546), 1524-1534. Link

Fundación Mexicana para la Salud A.C. (FUNSALUD). 2019. Universal Coverage of Health Services. Link

Fundación Mexicana para la Salud A.C. (FUNSALUD). 2019. Link

Hashimoto, H., Ikegami, N., Shibuya, K., et al. 2011. “Cost containment and quality of care in Japan: is there a trade-off?” The Lancet, 378(9797), 1174-1182. Link

Ikegami, N. 1992. “Japan: maintaining equity through regulated fees.” *Journal of Health Politics, Policy and Law*, *17*(4), 689-714. Link

Ikegami, N., & Anderson, G. F. 2012. “In Japan, all-payer rate setting under tight government control has proved to be an effective approach to containing costs.” *Health Affairs*, *31*(5), 1049-1056. Link

Ikegami, N. 2014. Universal health coverage for inclusive and sustainable development: lessons from Japan. The World Bank. Link

Juan, M., Moguel Ancheita, A., Valdes Olmedo, C., et al. 2013. Mexican Health Foundation working group. Universal Coverage of Health Services in Mexico Salud Publica Mex 2013; 55: EEI-EE64. SALUD PUBLICA DE MEXICO, 55, E3-E64.

McGann, J. G. 2019. 2018 Global Go To Think Tank Index Report. Link

Poder. 2016. Funsalud, the entrepreneurs who set the health policies in Mexico. [Published: April 7 2016]. Link

Sparkes, S. P. 2015. *The Political Economy of Health Reform: Turkey's Health Transformation Program, 2003-2012* (Doctoral dissertation). Link

Tantivess, S., Teerawattananon, Y., & Mills, A. 2009. “Strengthening cost-effectiveness analysis in Thailand through the establishment of the health intervention and technology assessment program.” *Pharmacoeconomics*, *27*(11), 931-945. Link

Yardim, M. S., Cilingiroglu, N., & Yardim, N. 2013. “Financial protection in health in Turkey: the effects of the Health Transformation Programme.” *Health Policy and Planning*, *29*(2), 177-192. Link

## Annex 4: How "Institutional Architecture" for Health Systems Strengthening Relates to Other Concepts

Institutional architecture relates to numerous concepts in global health and system strengthening literature and programming, including governance, stewardship, and resilience. As part of our literature review, we considered these three terms in broad strokes and in relation to institutional architecture. This section briefly defines governance, stewardship, and resilience in the context of building a health systems strengthening-specific definition for institutional architecture.

**GOVERNANCE**

Governance is defined by the WHO as "a wide range of steering and rule-making related functions carried out by governments/decisions makers as they seek to achieve national health policy objectives that are conducive to universal health coverage" (WHO 2019).

In addition to the WHO definition, of governance, the UNDP defines governance as "the exercise of political, economic and administrative authority in the management of a country's affairs at all levels, comprising the complex mechanisms, processes, relationships, and institutions through which citizens and groups articulate their interests, exercise their rights and obligations and mediate their differences" (UNDP 2011).

Similar in each definition is the conceptualization that governance relates to the core functions and rules—both formal and informal—that are integral to how a health system functions. Wide in its scope, health governance can also incorporate capacities involving regulatory frameworks, policy processes, accountability, and government effectiveness, transparency and accountability. While governance is a function of the state, it involves a disparate set of actors across the health system and beyond, including civil society, public and private providers, researchers, membership organizations, investment partners, and more (Siddiqi 2009).

Institutional architecture for HSS incorporates this model of the formal and informal relationships that govern a health system into its framework, recognizing that a range of actors, processes and functions are necessary for the continued functioning of a health system.

**STEWARDSHIP**

Stewardship is an aspect of governance, referring to the ability of the system to work towards its policy goals and foster equity, access and quality while still meeting the demands of country stakeholders.

The WHO defines stewardship as “the institutions by which authority in a country is exercised for the common good, including the processes by which authority is exercised for the common good, including the processes by which those in authority are selected, monitored and replaced; the capacity of the government to effectively manage its resources and implement sound policies; and the respect of the citizens and the state for the institutions that govern economic and social interactions among them” (WHO 2019).

Stewardship involves a vision and direction for the health system, as institutions and authorities that decide what how and where resources should be allocated. This process can involve strategy formulation and policy development, health system governance and regulation and data analysis and generation (Veillard 2011).

The institutional architecture for HSS framework incorporates aspects of stewardship as well, in that it is directed towards the specific aim of continuous health system improvement. This vision may involve specific country goals in the area of procurement, financing or human resources for health, for example. Institutional architecture for HSS identifies parts of existing health system architecture that can be strengthened or areas that should be built that should meet these national policy aims.

**RESILIENCE**

Resilience is the capacity for a health system to respond to inevitable external shocks. Systems are considered highly sustainable and resilient when they are able to mobilize and allocate sufficient resources to meet these shocks, while still not disrupting the functioning of the rest of the system.

Institutional architecture incorporates resilience into its framework with the understanding that as health systems seek to build or strengthen the institutional architecture for continuous health system strengthening, these actors, processes, and resources (however they are ultimately identified and organized) should be able to absorb shocks, financial, structural, epidemiological or otherwise. Additionally, as architecture is built and/or strengthened to contribute to continuous HSS, this institutional architecture should not only be improving its performance, but improving its ability to mitigate against, adapt to, and withstand shocks and stressors to the system as well.

## References

Siddiqi, Sameen, Tayyeb I. Masud, Sania Nishtar, David H. Peters, Belgacem Sabri, Khalfi M. Bile, and Mohamed A. Jama, 2009. "Framework for assessing governance of the health system in developing countries: gateway to good governance." Health policy 90(1): 13-25. Link

UNDP. 2011. Towards Human Resilience: Sustaining MDG Progress in an Age of Economic Uncertainty. “Governance Principles, Institutional Capacity and Quality.” Link

Veillard, Jeremy Henri, Adalsteinn Davidson Brown, Enis Baris, Govin, Permanand, Niek Sebastian Klazinga. 2011. "Health system stewardship of National Health Ministries in the WHO European region: concepts, functions and assessment framework." Health Policy 103(2-3): 191-199. Link

World Health Organization (WHO). 2019. Stewardship. Link

# Annex 5: Potential Applications of an Institutional Architecture for Health Systems Strengthening Framework

Table 6 presents potential, illustrative applications of the framework across several of the Accelerator's current activities. These preliminary ideas will be considered for integration into activity implementation.

**Table 6: Illustrative Applications of the IA for HSS Framework**

| Identified HSS Challenge | Potential Applications of Framework |
|---|---|
| **Ghana** | |
| ▪ Need for clear UHC roadmap at key inflection point for Ghana's health system and multiple health agencies<br>▪ Despite relatively rich (but fragmented) domestic HSS expertise, system seems paralyzed and unable to drive change on longstanding challenges like NHIS financial sustainability and universal access to basic quality care at community level. | ▪ **Take Stock and Learn:** Participatory, systematic mapping and assessment of Ghana's institutional architecture related to NHIS reform and/or PHC-strengthening by GHS. Identify institutional architecture for HSS-related gaps, weaknesses, or bottlenecks. Re-assess certain elements at 3-year and 5-year point.<br>▪ **Strategize and Plan (Local Partner):** Build explicit capacity building on high-priority HSS institutional architecture for HSS gaps into HSSA workplan. Could be basis of sub-award to local actor to do a needed task in way that strengthens institutional architecture for HSS for related tasks in future.<br>▪ **Strategize and Plan (MOH/GHS Knowledge Translation Platform (KTP)):** Support KTP to develop skills to contextualize and package local and global evidence to inform advocacy, decision- and policy-making efforts.<br>▪ **Strategize and Plan (MOH):** Enable MOH to create evidence-based strategy for stronger stewardship of multiple health agencies (a need recognized by many stakeholders), especially through a proposed multi-stakeholder Technical Working Group on health financing issues.<br>▪ **Strategize and Plan (Development Partners):** Use initial mapping to identify opportunities for "status-quo breaking" donor investments—e.g., training for health journalists to sharpen media effectiveness, strategic communications capacity building for civil society actors, etc. |

| Liberia | |
|---|---|
| ▪ One of Liberia's key G2G health revenue streams (USAID's FARA) at risk due to inadequate costing basis and dissatisfaction with payment mechanism<br>▪ New gov't struggling to launch health financing initiatives that would visibly help population and progress toward NHI/UHC vision | ▪ **Take Stock:** Limited and rapid baseline assessment of Liberia's institutional architecture for HSS related to *health financing* evidence generation, data analysis, and solution formulation[1]<br>▪ **Strategize and Plan (GOL):** Institutionalize use of new costing model by Costing Technical Working Group<br>▪ **Strategize and Plan (Development Partners):** Identify priorities for USAID/Liberia and new HSS bilateral implementing partner to strengthen institutional architecture, with baseline and proposed 5-year targets |
| **USAID/OHS Activity 1 – Togo and Guinea** | |
| ▪ **Activity Level:** Countries in West Africa face many common health systems challenges impeding improved community health outcomes, including within governance, financing, and service delivery. Links between health systems and communities are often weak.<br>▪ **Togo** faces challenges in stewardship and coordination as it seeks to design and implement its UHC roadmap. Togo lacks a coordinating body to advance feasible UHC efforts in the short- and long-term.<br>▪ In the post-Ebola context, **Guinea** struggles with coordination and strategic communications between actors at the national level. Guinea's system is decentralized, but the implementation of decentralization remains incomplete and ineffective. | ▪ **Take Stock and Strategize (Togo):** Conduct a participatory, systematic mapping and assessment of Togo's institutional architecture for HSS related to UHC reform, incorporating elements of PEA and needs assessment. Prioritize and support institutional architecture capacity development needed for UHC reform (e.g., clarifying institutional roles, enhancing key skills needed, filling gaps in accountability processes).<br>▪ **Take Stock and Strategize (Guinea):** Conduct rapid assessment of Guinea's institutional architecture for HSS for coordination at the central level, complemented by assessment of institutional architecture at regional or district levels for decentralized health system management. Prioritize and support institutional architecture capacity development at central and subnational levels (e.g., for improved coordination across gov't actors and development partners, multi-sectoral collaboration, social accountability and community engagement, etc.)<br>▪ **Learn:** Identify relevant opportunities for cross-country exchange and learning on institutional architecture for HSS challenges and capacity development efforts. Develop global public goods around new evidence generated for improved institutional architecture for community health in West Africa, including institutional architecture for social accountability and community engagement. |

[1] Some of this rapid assessment done informally during HSSA's initial scoping visits—led to recommendation of forming a Costing Technical Working Group.

**USAID/Asia Bureau – Support Asian HSPRIs**

- Health system and policy research capacities are relatively high in Asia (but less so in low-income countries). However, a common challenge across research institutions is their staff's and organization's limited ability to prioritize HSS innovations and translate knowledge into policy.
- Despite the range of health systems research capacities in the region, there is limited regional collaboration and engagement among country-level institutions on how to translate research from one context into another.

- **Take Stock:** Consultations with health research institutions within Asia region will help to reveal institutional architecture challenges related to bridging the gap between research and policy (in countries and possibly regionally as well)
- **Strategize and Plan:** Create plans and processes for stronger regional collaboration among research institutions to support each other on HSS research and knowledge translation
- **Learn:** Generate recommendations on whether and how to strengthen regional exchange among HSPRIs, including how to scale up or institutionalize promising knowledge translation practices to improve institutional architecture for HSS at country level

**USAID/DCHA/DRG – Mental and Rehabilitative Services**

- Mental health and disability represent a growing burden of disease in LMICs but are rarely integrated into countries' UHC initiatives.
- Chronic underfunding, weak referral systems, the existence of unregulated private providers, and stigma create challenges to mental health, psychosocial and rehabilitative service integration.
- Global interest in integrating services into primary care systems, but a limited evidence base for doing so

- **Take Stock:** Rapid baseline assessment of select country's institutional architecture for HSS for assessing need and planning for integration of services into UHC interventions, including priority setting, costing, service delivery organization/design, and workforce strengthening
- **Strategize and Plan:** Build explicit capacity building of a relevant actor and function on high-priority institutional architecture for HSS gaps into HSSA workplan (evidence generation and data analysis likely an early need).
- **Strategize and Plan:** Enable MOH to create evidence-based strategy for stronger stewardship of health (e.g. purchasing agencies, primary care agencies) and multi-sectoral stakeholders engaged in mental health, psychosocial, and rehabilitation services (e.g. Social Welfare, Labor, Education)

**USAID/OHS – Improved TA Models for HSS**

- Journey to self-reliance means countries need to develop domestic capacity to drive ongoing health system change and improvement

- **Learn:** Produce tools to guide systematic learning about institutional architecture for HSS across countries/activities. Begin aggregating and synthesizing information coming in from "stock taking" exercises in countries. Connect with international partners to test demand for collaboration and peer-to-peer exchanges on topic of institutional architecture.

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