



# HEALTH SYSTEMS STRENGTHENING IN GERMAN DEVELOPMENT COOPERATION

*Desk Study*

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## Executive Summary

### Background and objectives

Health Systems Strengthening (HSS) is gaining importance in development cooperation for health. Most recently, the Ebola epidemic in western Africa has given impetus to the ongoing debate on the significance of functioning and responsive health systems for development. HSS is a prominent issue on the global health agenda, and was one of the health priorities of the 2015 G7 summit.

HSS is also one of three strategic directions of the German Development Cooperation (GDC) in its Sector Strategy for Health (BMZ, 2009b), the other two being sexual and reproductive health and rights (SRHR) and HIV/AIDS and infectious diseases. It is, furthermore, one of five focal areas of the German government's global health strategy. Recent developments indicate that HSS continues to play a central role in GDC's strategy towards global health: first, the Ebola epidemic once more pointed to the relevance of functioning health systems. In this context, GDC committed an additional 200 million EUR for HSS over 2015-2016. Furthermore, in September 2015 Germany together with the World Health Organization launched the *Healthy Systems - Healthy Lives Initiative* to enhance global cooperation on HSS. These developments highlight the relevance of this study aiming at providing an improved theoretical understanding of existing health policies and strategies with regard to HSS. As these dynamic changes take place, this study can help to improve current and future GDC engagement towards HSS.

In 2007 the World Health Organization (WHO) defined a health system as entailing six building blocks: (1) service delivery, (2) health workforce, (3) information, (4) medical products, vaccines and technologies, (5) financing, and (6) leadership/governance. Although this framework is adhered to by major global health actors, including the GDC, there is still a lack of consensus on what constitutes HSS and on how to generate evidence to guide future HSS programming.

As HSS is a broad topic encompassing a wide variety of definitions and approaches, this desk study aims to shed light on how the concept of HSS has evolved in the global health arena, and how it has been thus far evaluated in the international development community and the GDC. The analysis is based on a review of numerous GDC health-related policies and partner country planning documents, written in a time frame before the 200 million Euro GDC commitment for HSS and the new Healthy Systems – Healthy Lives Initiative. Thus, this study reflects how these documents explicitly and implicitly address HSS and therefore elucidates GDC's engagement in HSS from a strategic point of view, providing an overview of how the GDC intends to enact HSS.

However, a theoretical understanding of GDC efforts in HSS alone is not enough, particularly because a wide variety of definitions and approaches to HSS exist among global health actors. A practical understanding of HSS in the GDC context is necessary to assess whether GDC objectives for HSS are being met, and to find the means of improving GDC HSS pursuits. Building on this premise, this desk study approaches the important task of clarifying HSS research gaps most relevant for the GDC. The desk study also draws general considerations that should be taken into account when assessing HSS, along with recommendations for a more systemic and standardised GDC approach to HSS. "

## Methods

This desk study includes a literature review of health systems research and the development of HSS as a concept within global health. Additionally, the literature review covers evaluations and reviews of HSS in the international field, as well as health evaluations addressing HSS undertaken by the GDC since 2007. The analysis component in this desk review sought to address the strategic orientation of GDC engagement with HSS. In the first round of analysis, HSS focal areas and cross-cutting approaches were drawn from GDC health-related strategies and policy papers. Next, priority area strategies and “part A” of the joint programme proposals of eight partner countries and one region were analysed. The analysis examined the extent to which focal areas and cross-cutting approaches defined at the central level were reflected within country strategic documents and if additional approaches to HSS were addressed. This analysis enabled an understanding of how the GDC strategically pursues HSS and intends to implement it within partner countries. Findings from the analysis were then synthesised and applied to the WHO health systems framework. Finally, HSS research gaps and considerations for HSS assessment have been based on the findings of the literature review and analysis.

## Key results

### **Research question I: What is the importance of HSS and what has led to its current role in the global health arena?**

HSS emphasises the importance of addressing issues affecting the health system and not only specific diseases, sub-systems or health issues, thereby enabling a holistic approach to addressing people’s health needs. The recent spotlight on HSS has arisen from the concern over weak health systems having derailed the progress of vertical (i.e. disease-specific) health initiatives, the health workforce crisis, and the slow progress of the health-related Millennium Development Goals (MDGs) owing to health system bottlenecks.

Within the past decade, a variety of global health actors have prioritised HSS in their policies and programming. These include the WHO, the World Bank, the GAVI Alliance (GAVI), the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), the United States Agency for International Aid (USAID) and the Doris Duke Foundation. Additionally, the creation of the International Health Partnership (IHP+), which seeks to unify national health strategies and health monitoring and evaluation (M&E) structures, and the G8 Heiligendamm commitment to infectious diseases and HSS have increased the influence of HSS.

Within Germany, HSS plays an important role as one of three strategic directions in the Sector Strategy for Health and as one of the five focal areas of the German government’s global health strategy. International commitments to health made by Germany have been guided by interests in HSS as well as in vertical initiatives.

## **Research question II: How has HSS been evaluated by the international donor community and what have been the main findings?**

Although there is a clear call for the building of an evidence base for HSS, international evaluations of HSS are few in number. These evaluations have been varied in their approach and scope, ranging from strategic reviews to multi-country assessments of HSS strengths and weaknesses. The applied methods are diverse and context specific, ranging from secondary data analysis to the collection of impact-level data. However, evaluations that approach HSS as a holistic and systems-oriented concept are few in number, even though many sub-systems (or health systems building blocks) are individually well studied. It is often the case that such studies lack reference to the effects of the individual sub-systems on the overall health system.

The only evaluations that have approached HSS in a categorical sense and exclusively focused on the concept are those from GAVI (2009) and the African Health Initiative of the Doris Duke Charitable Foundation (ongoing). The GAVI evaluation approaches HSS from the donor perspective and focuses only on inputs and output level due to difficulties in being able to measure outcomes of GAVI efforts in HSS. Other evaluations encompass various health system building blocks, as defined by the WHO framework, or focus on the HSS aspects of vertical health programming.

Recommendations from international HSS evaluations and reviews include taking advantage of synergies and inter-sectoral linkages, improving understanding of what enables HSS objectives to be met, and increasing rigorous, external impact evaluations of health. Evaluations of HSS within countries, usually in the context of vertical health programming, have yielded largely positive results; e.g. showing that maternal health has improved by addressing health systems issues.

## **Research question III: How has HSS been addressed in previous GDC evaluations?**

Most programme and project evaluations focus on specific areas of GDC health cooperation that are related to the building blocks of the health system. Although occasionally they have considered interactions between building blocks, they have very rarely used broader analytical frameworks based on HSS.

HSS has featured centrally in the Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) meta-evaluation in health and the DEval evaluation of 30 years of Rwandan–German development cooperation in the health sector. A few other thematic, country and programme evaluations have addressed important issues related to HSS, such as the effects of a sector-wide approach to health and basket funding on the health system. However, thus far, there has been no comprehensive evaluation of the GDC's HSS engagement.

Overall the desk study confirms the results of the GIZ meta-evaluation and the Kreditanstalt für Wiederaufbau (KfW) thematic analysis on the side effects of targeted health interventions with regard to the need for a more standardised approach to grasp health system effects and analyse the integration of vertical programmes into the health system.

**Research question IV: What is the GDC approach to HSS as defined in its central strategic documents?**

HSS is acknowledged by the GDC overall as a precondition for universal health coverage as well as for the achievement of the health-related MDGs. By contributing to the realisation of the right to health, HSS is seen as a means of achieving sustainable and inclusive health outcomes.

The GDC approach to HSS adheres to the WHO building blocks framework. HSS is mainly defined through the support GDC provides to three focal areas supplemented by four cross-cutting approaches. The three focal areas of HSS as pursued by the GDC include: human resource development for health, solidarity-based health financing and social health protection, and institutional and organisational development of national health systems. Cross-cutting approaches used by the GDC to achieve HSS, as identified in the strategic documents, include private sector cooperation, vertical programme integration, inter-sectoral cooperation and the human rights-based approach.

For each focal area and cross-cutting approach the GDC strategic documents describe a range of specific measures at the country and global levels that potentially contribute to HSS, although they do not explicitly label these measures as HSS or clearly determine their interfaces with HSS.

**Research question V: What is the GDC approach to HSS as defined by its health programmes in partner countries?**

Although HSS was not always mentioned explicitly within the country-level documents, the strategic orientation of the GDC in its pursuit of HSS was found within the majority of the analysed priority area strategies and joint programme proposals. However, whereas HSS focal areas are largely reflected within the country strategic and planning documents, cross-cutting approaches for HSS are not as well represented, and when presented are not always connected with HSS.

Social health protection and institutional and organisational development – two of the three HSS focal areas identified within the central strategic documents – were the most frequent focal areas related to HSS found within partner countries. The remaining HSS focal area, human resource development for health, was also found in connection with HSS at the country level, though not as frequently.

The country-level analysis also revealed quality management as an HSS focal area. Additionally, private sector cooperation, which is identified as both a focal area and a cross-cutting approach at the country level, is most frequently addressed in explicit connection to HSS.

The remaining cross-sectoral approaches do not receive as much attention in the country strategic and planning documents. Vertical programme integration is only explicitly related to HSS in joint programme proposals of African partner countries. The structure of joint programme proposals suggests that integration of vertical programmes at the strategic and planning level has taken place by integrating SRHR and HIV in other focal areas such as quality management. Inter-sectoral cooperation, on the other hand, was rarely mentioned at the country level – a noteworthy

observation given the importance of inter-sectoral cooperation for the overall progress of global health, and its frequent mention as a cross-cutting approach in GDC health strategies.

Although the focal areas and cross-cutting approaches all have ties to the building blocks of the health system, the strategic documents do not yet convey a broader image of HSS from a systems perspective. This would entail paying more attention to the dynamic of interactions across the focal areas or health system blocks and with the social and political context.

**Research question VI: In the context of the GDC, where are the HSS research gaps and what general considerations should be taken for the assessment of HSS in the future?**

The review of GDC health evaluations and evaluations pertaining to HSS from other donors and international organisations revealed a number of research gaps in the field of HSS. More systems thinking would set HSS interventions in a broader perspective, thus giving more room to the assessment of cross-cutting and non-linear effects on the health system as well as beyond the health sector.

Although GDC has taken important steps towards measuring health systems performance and developing core sets of indicators, analytical frameworks and standardised methods to evaluate HSS are still lacking. Further research and evaluative work in HSS would help to identify and elaborate keystone interventions and their multiple effects on the health care system and health outcomes. It would also enable the selection of core indicators that are relevant for GDC efforts in HSS and tailored to the GDC context in and across partner countries. Thereafter, a framework might be made for HSS within the GDC, which could be used for regular cross-country planning and monitoring of HSS interventions (including interventions addressing health sub-systems and their effects on the health system), and ultimately enable a more systematic approach to HSS evaluation in the future.

## Conclusion

In order to better structure and standardise the GDC approach to HSS and methods of assessment, it is recommended for future GDC evaluations and research to adopt a more systematic approach to design and assess HSS interventions by (1) clarifying the links between health system building blocks, (2) identifying links with the broader social and political context and capitalising on potential areas of inter-sectoral cooperation, and (3) assessing the GDC pursuit of HSS in and across partner countries and the respective health system outcomes. To this end, the research started in this desk study would need to be continued on an operational level by taking into account the country-specific context.

With the importance of strong and resilient health systems having long been established and coming into focus in light of recent global events, the need for rigorous research and an evidence base for HSS is evident for global health actors, and all the more so for donors. More evidence and guidance is necessary to reflect systematically the dynamic of HSS in GDC health programmes and improve M&E frameworks. This desk study can serve as a basis for the implementation of further evaluations as well as to build a GDC conceptual framework for HSS. The *Healthy Systems - Healthy Lives Initiative* promises to become an important step towards the development of a global approach to HSS, on which GDC could base its HSS framework.

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## Acronyms and Abbreviations

BMZ	German Federal Ministry for Economic Cooperation and Development
DAC	Development Assistance Committee
DEval	German Institute for Development Evaluation
DFID	Department for International Development
EC	European Commission
GAVI	Global Alliance for Vaccines and Immunisation
GDC	German Development Cooperation
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GIZ	Deutsche Gesellschaft für Internationale Zusammenarbeit (formerly GTZ)
HSS	Health Systems Strengthening
IHP+	International Health Partnership
IOM	Institute of Medicine (US)
KfW	Kreditanstalt für Wiederaufbau
LMIC	Low and Middle-Income Countries
M&E	Monitoring and Evaluation
MDG	Millennium Development Goals
OECD	Organisation for Economic Co-operation and Development
PEPFAR	US President's Emergency Plan for Aids Relief
SRHR	Sexual and Reproductive Health and Rights
SWAp	Sector-Wide Approach
TB	Tuberculosis
USAID	United States Agency for International Development
WHO	World Health Organization

The analysis in this desk study has entailed the use of many German documents. For the sake of ease of comprehension, the following list of phrases used in the analysis is provided along with the German variations.

Focal area	<i>“zentrales Handlungsfeld”, “Komponente” or “Schwerpunkt”</i>
Joint programme proposal	<i>“gemeinsamer Programmvorschlag”</i>
Priority area strategy (in country)	<i>“Schwerpunktstrategiepapier”</i>
Priority area	<i>“Schwerpunkt der deutschen Entwicklungszusammenarbeit in einem Land”</i>

## 1 Introduction

Among sectors that play an important role in the drive for global development, health is vital and has a profound effect on other sectors and vice versa. The strong connection between health and socio-economic progress is emphasised internationally and within the German Development Cooperation (GDC), which was the third leading bilateral donor in global health in 2013.<sup>1</sup>

Recent trends and events evince the value of health investments, particularly through the strengthening of health systems: the WHO and World Bank have noted that providing universal health coverage, which is only possible through strong and responsive health systems, is crucial in bringing health and economic stability to the world's most vulnerable populations (Brearley *et al.*, 2013). Topical issues such as climate change and its expected impact on health also indicate the importance of prioritising health systems strengthening (HSS).<sup>2</sup> Most recently, the Ebola epidemic in western Africa has indicated the significance of optimally functioning and responsive health systems. HSS will continue to remain significant on the global health agenda, as it was one of the health priorities announced by the G7 presidency in 2015.

Following the writing of this report, significant developments for HSS took place, including a 200 million EUR commitment for HSS (2015-2016), and the launch of the *Healthy Systems – Healthy Lives* initiative in cooperation with the WHO. Prior to these developments, HSS was and remains one of three strategic directions of the German Federal Ministry for Economic Cooperation and Development (BMZ) in its Sector Strategy for Health (BMZ, 2009b), the other two being sexual and reproductive health and rights (SRHR) and HIV/AIDS and infectious diseases. Relative to the other strategic areas, HSS requires a more nuanced and contextualised understanding. Health systems provide a means of achieving many types of health-related goals, including those focused on singular and narrow subjects, such as HIV/AIDS or respiratory illnesses, or those affecting wider populations, such as health sector reform and finance. Just as health systems can be drivers of progress towards health-related and overarching development goals, they can also hinder their achievement. By way of example, a health system with inadequate staffing will be unable to meet a population's health demands. Similarly, an inadequate health monitoring and information system will disable the identification of key health determinants and issues within a population, thereby precluding the possibility of a health system adapting to the health needs of a population. Therefore, the strengthening of health systems in low and middle-income countries (LMICs) is imperative to meet the health populations' needs and to capacitate them to advance in other sectors, including education, agriculture and economic development.

As this study details in later chapters, HSS is a broad and complex topic that is an increasingly essential element in development cooperation for health and is widely embraced by global health actors and donors. However, due to an internationally recognised lack of standardised definition and approach to HSS, there is a risk of HSS becoming a “container concept” that embraces too much

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<sup>1</sup> Author's calculation based on data from the OECD-DAC Creditor Reporting System.

<sup>2</sup> The WHO Workplan on Climate Change and Health (2009) listed HSS as one of three areas of importance to address in order to adapt to the effects of climate change.

within the health sector without concretely and consciously establishing links with the *strengthening* of health systems. Furthermore, a lack of a well-thought out and defined approach to HSS can result in health sector interventions carried out under the guise of HSS being handled in an insular environment. In doing so, such interventions would be implemented without due acknowledgement to the complexity and inter-connectivity between various areas within health, as well as between health and other sectors. A hypothetical example of such cases can be seen with the decentralisation and the enhancement of medical referral systems. Without due consideration for staff management and sufficient health financing, these measures can inadvertently result in the overburdening of district-level health facilities and poor quality of services.

As the focus in global health shifts towards the need for strengthened health systems, such risks must be avoided if development cooperation for health is to be effective and sustainable. Given this context, this desk study aims **to highlight the importance and standing of HSS within the global health arena, and to explore how HSS has been evaluated in the international community and GDC.** Furthermore, the desk study **clarifies the strategic approach of the GDC towards HSS, providing an overview of the means through which the GDC intends to enact HSS.**

With these objectives, the GDC's strategic pursuit for HSS will become clearer. An understanding of HSS as conveyed by GDC strategies and policies is an essential step in gaining a comprehensive view of GDC engagement in HSS. The systematic approach taken in this study to analyse the strategic approach of the GDC towards HSS enables future possibilities for structured HSS monitoring and evaluation, and ultimately the improvement of HSS interventions.

However, a theoretical understanding of GDC efforts in HSS is not enough – the GDC's strategic approach towards HSS must be assessed against its implementation of HSS to obtain a practical understanding of HSS in the GDC context. This is a requisite step before the GDC can maximise its efforts in HSS and improve its investments in health. Building on this premise, the desk study also approaches the necessary task of explaining how the GDC pursuit of HSS might be assessed in the future. The analysis resulting from this study can, for instance, guide the development of a theory of change for a future evaluation, or enable the selection of key aspects of GDC efforts in HSS to focus on for assessment and improvement. As the literature review shows, other major country donors in global health, such as the US and the UK, have begun the process to better comprehend their HSS work in the effort to make the case for better investments in health and improve overall global health strategy. This desk study provides the opportunity to begin a similar self-reflective process in the GDC.

In a policy-making capacity, the BMZ can benefit from this desk study by better understanding how the GDC strategically orients its pursuit of HSS. The literature review and analysis embarked here further enables the BMZ to consider how to better conceptualise HSS and give guidance to the GDC implementing agencies in order to improve the design and assessment of health programmes and HSS interventions. Additionally, a BMZ position paper on HSS is currently being developed, giving testament to the importance of HSS within the GDC. The analysis offered in this desk study has the potential to further define and strengthen the strategic orientation of such position paper, as well as to inform future GDC policy and strategy in the health sector. Overall, the importance of giving due

attention to HSS is established in this desk review with the aim to improve GDC investments in health and support development cooperation across all sectors.

In order to achieve the aims mentioned above, the research questions listed below have been addressed in this desk study in a stepwise approach.

1. *What is the importance of HSS and what has led to its current role in the global health arena? (Chapter 2)*

Establishing the global significance and development of HSS, this question seeks to follow the conceptual and political development of HSS, as well as the importance of research in health systems. Ultimately, the relevance of HSS as a subject of evaluation within development cooperation in health is established.

2. *How has HSS been evaluated by the international community and what have been the main findings? (Chapter 3)*

Through investigating HSS evaluations undertaken by other global health actors and donors, a practical perspective can be gained of the status quo in health systems research and the subject matter that is covered through existing HSS evaluations.

3. *How has HSS been addressed in previous GDC evaluations? (Chapter 3)*

An overview of evaluations of HSS in the international community and health evaluations within the GDC enables the identification of thematic evaluation gaps pertaining to HSS.

4. *What is the GDC approach to HSS as defined in its health-related development policies and sector strategies at a central level? (Chapter 4)*

With analysis at the macro level, GDC health-related strategies are gleaned for elements relating to HSS. The analysis of the GDC approach to HSS takes a strictly strategic perspective, thereby assessing how HSS is defined and intended.

5. *What is the GDC approach to HSS as defined in its key strategic and planning documents for health programmes in partner countries? (Chapter 4)*

HSS in GDC health-related policies and strategies is linked to HSS approaches found within documents for country-level health programming. Analysis of HSS implementation is a further step of research for which the last research question provides recommendations.

6. *In the context of the GDC, where are the HSS research gaps and what general considerations should be taken for the assessment of HSS in the future? (Chapter 5)*

Based on the findings of the literature review and analysis presented in the desk study, research gaps and general recommendations for HSS assessment are given.

As described above, this desk study consists of a literature review spanning health systems research, evaluations and reviews pertaining to HSS, and GDC evaluations in health. Furthermore, document analysis is undertaken to create a sketch of HSS within the GDC. Among the documents are GDC health-related strategies, country priority area strategy papers and joint programme proposals. In the process of analysing documents for their HSS content, it has been up to the discretion of the research team to identify elements constituting HSS. However, this step was informed by the literature review and, in particular, the key document of the WHO (2007), “Everybody’s business: strengthening health systems to improve health outcomes: WHO’s framework for action “and guidance from the Alliance for Health Policy and Systems Research.

## **2 Health systems strengthening: Overview of the concept**

### **2.1 HSS and trends in the global health agenda**

Modern history of global health has seen a cyclical trend between vertical and horizontal agendas. Vertical programming, which includes disease control programmes and global health initiatives that pursue narrow and targeted health goals, is often juxtaposed with horizontal programming, which entails wider and systemic concepts, such as HSS and primary health care.

An appreciation of the significance and role of HSS within and beyond the health sector can be gained through an analysis of its development over time (for a detailed timeline see Figure 5 in Annex 2). The central role of primary care following the Alma Ata Conference in 1978 placed health systems at the forefront as a vehicle for service delivery. This brought about a focus on investments in health sector reform (especially by the World Bank) and the use of selective primary health care to target specific diseases. As primary health care became an accepted tenet, it became increasingly clear that the resources and practical means of implementation of primary health care were lacking. In response, African ministers of health adopted the Bamako Initiative in 1987, which also required a new system of self-financing mechanisms at the district level, provision of a basic package of integrated health services, and called for a regular supply of essential drugs (WHO, 1999). In the wake of the Bamako Initiative, increased attention was given to strengthen district health systems.

The birth of the Millennium Development Goals (MDGs) ushered in a number of disease-targeted initiatives in the early 2000s, including the Global Fund against AIDS, Tuberculosis and Malaria (GFATM) in 2002 and the US President’s Emergency Plan for Aids Relief (PEPFAR) in 2003. The overwhelming focus of these initiatives was directed towards HIV/AIDS. Despite the large amount of resources flowing into the disease-targeted MDG goals, it was found relatively early that weak health systems were the main bottleneck in the achievement of the MDGs (Travis *et al.*, 2004).

The year 2007 proved to be crucial owing to a paradigm shift in the health debate taking place in favour of HSS. With the launch of the WHO publication (2007), the health systems building blocks framework was released and aimed to improve disease control programmes and broaden the focus of global health to health systems. The founding of the International Health Partnership (IHP+) in 2007 also contributed to the placement of HSS at the centre of the global health stage. Building on the Paris Declaration on Aid Effectiveness and the Accra Agenda for Action, the IHP+ seeks to

### ***HSS and the Heiligendamm Commitment***

*In 2007, a paradigmatic year for HSS, the G8 committed to USD 60 billion for HIV/AIDS, malaria, tuberculosis and HSS. Within this larger commitment, Germany committed EUR 4 billion in the time period 2008–15, but actually fulfilled this by 2013. It is relevant that the GDC considers all official development assistance (ODA) for health when calculating its commitment to the Heiligendamm goal. This observation corroborates the established difficulty in distinguishing the flow of resources that are in support of HSS (for more details see portfolio analysis of GDC contribution to health; Munir et al., 2015). Furthermore, it raises awareness about the lack of an HSS definition. When HSS is embraced as a wide and all-encompassing topic, it easily turns into a buzzword that is devoid of substantial meaning. A clearly defined and categorical approach to HSS is requisite not only to the development of effective strategies, but also to monitoring and evaluation of HSS implementation.*

coordinate donors and countries in establishing country-led national health strategies and improve health monitoring and evaluation (M&E) through the use of a common results framework. These strategic milestones showed immediate influence among donors in the very same year: HSS became one of World Bank's Health, Nutrition and Population Strategies' five priorities; the Doris Duke Foundation launched the African Health Initiative, which aims in part to gather evidence on effective HSS interventions; and the G8 Summit in Heiligendamm resulted in the commitment of USD 60 billion to fight infectious diseases and strengthen health systems. The importance of HSS in global health investments continued, with GAVI opening a funding window for HSS in 2007 in the acknowledgement of health system bottlenecks preventing the fulfilment of their own objectives, improving the investment climate for immunisation and thereby increasing the likelihood of higher

coverage (Naimoli, 2009). It has also been argued that the most important effect of the creation of GAVI's HSS window has been to maintain the Alliance's power to set the global health agenda (Storeng, 2014), indicating the significance and weight of HSS as a global health topic. This was preceded by a similar funding window in 2005 by the Global Fund. In 2009, the US-based Global Health Initiative was founded and built on the principle of improving health outcomes through HSS. As the flagship programme for the initiative, PEPFAR developed a strategic tool using the WHO HSS building blocks framework. Finally, in 2010, the World Health Report focused on universal health coverage, for which HSS was identified as a prerequisite. As a result of the progressively increasing relevance and importance of HSS, it has remained at the front and centre of the global health agenda and is likely to continue as such in the post-MDG era.

The underlying factors that provided momentum for the shift towards HSS have been analysed by Hafner and Shiffman (2013), who used process-tracing and John Kingdon's streams model of public policy (Kingdon, 1995) to describe the intersection of problem, policy and politics streams that resulted in a greatly increased focus on HSS. In summary, the pertinent problems on the eve of the shift towards HSS were the emerging evidence of a health workforce crisis, the concern that weak health systems had derailed the achievement of the disease-specific global health initiatives, and international discontent with the adverse effect of vertical initiatives on health systems. The analysis refers particularly to the high reporting and coordination burden placed on health systems of low-

income countries by vertical initiatives, as well as the distortion of national health priorities (Hafner and Shiffman, 2013). In this context, health system-oriented strategies were sought based on the established legitimacy of primary health care. In doing so, however, there was a stark awareness of the lack of information and evidence in the impact of health systems on health outcomes. The Alliance for Health Policy and Systems Research at the WHO played an important advisory role in pushing global health actors to take a more systemic approach in their work and utilise HSS-based ideas to improve health outcomes. Finally, slow progress on some of the MDGs and the international community's move towards greater aid coordination spurred more attention for HSS.

Figure 5 (Annex 2) details the major international and German events in global health that are of significance for HSS, showing that the GDC focus in HSS has largely followed international trends.<sup>3</sup> Whereas much of the focus in the years prior to 2007, both internationally and within the GDC, was placed in vertical initiatives and programming, a shift in focus occurred thereafter. As the international community has attempted to incorporate HSS into existing programming and simultaneously create new funding opportunities, the GDC built HSS into its health sector strategy of 2009, broadened its focus to mother and child health, and secured positions on the boards of the largest vertical initiatives that have prioritised HSS. Simultaneously, the GDC has also maintained a deep commitment to engagement with HIV/AIDS, as seen with the concept of mainstreaming HIV prevention into other areas of GDC work remaining a high priority (BMZ, 2012). Over time it appears that the interests in health systems and HIV/AIDS have merged through initiatives such as the BMZ Initiative on Rights-Based Family Planning and Maternal Health. In the same vein, the strategic positioning of the GDC – signified, for example, by its position on the board of GFATM – relates to the strengthening of health systems as well as HIV/AIDS.

## 2.2 HSS: Definition of the concept

The World Health Report in 2000 defined a health system as a “collection of organizations and actors whose main intent is to promote, restore and maintain health” (WHO, 2000). Whereas this definition provides an initial foundation for understanding health systems, it must be acknowledged that health systems are highly context specific and are influenced greatly by a country's social, political and economic standing, national leadership, health workforce and a great number of other factors (Marchal *et al.*, 2009; Reich and Takemi, 2009; Sundewall *et al.*, 2010). Of course, the multiplicity of health systems results in different needs, which should be addressed when strengthening health systems. Consequently, the concept of HSS is complex and multifaceted, resulting in a wider range of definitions and a general lack of consensus on how to assess and evaluate HSS.

In “Everybody's Business,” the WHO (2007) sets out a general framework for HSS entailing six building blocks of health systems: (1) service delivery, (2) health workforce, (3) information, (4) medical products, vaccines and technologies, (5) financing, and (6) leadership/governance (see Figure 1). Although this framework and its categorical definition of HSS has been accepted by major global health actors, including PEPFAR, GAVI and the Global Fund (Barber, 2007), there is still a stark lack of consensus on an HSS definition and indicators to be used to generate evidence to guide future

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<sup>3</sup> Not shown are the recent 200 million EUR commitment for HSS and the launch of the Healthy Systems – Healthy Lives Initiative, which came after the period of analysis for this report.

HSS programming (World Health Organization Maximizing Positive Synergies Collaborative Group, 2009; Shakarishvili *et al.*, 2010a; Hafner and Shiffman, 2013). In the absence of a unified definition of HSS, there is a consequent lack of clarity in HSS programming and means of evaluation (Sundewall *et al.*, 2010). Consequently, research on health systems has generally been underfunded (Hafner and Shiffman, 2013).

Figure 1. WHO Health System Framework



Source: WHO, 2007

Whereas the WHO framework lays out the building blocks of a health system, the *strengthening* of health systems, of which the building blocks are an integral part, presents another concept to be dealt with. When it comes to defining health systems strengthening, the possibilities are as diverse as the actors engaged in it. In a review of 337 documents, Swanson *et al.* (2010) identified 39 separate categories that characterised HSS, indicating the vast and complex nature of HSS policy. In reference to the six defined building blocks of health systems, the WHO (2007) describes HSS as “improving these six health building blocks and managing their interactions in ways that achieve more equitable and sustained improvements across health services and health outcomes”.

Understanding the broad nature of HSS and the strategic difficulties of various actors in sharing an understanding of the concept, the Alliance for Health Policy and Systems Research has promoted systems thinking for HSS. For instance, rather than focusing on single elements of the HSS building blocks frameworks, a systems’ perspective pays attention to underlying causes, consequences and relationships between actors. The resulting emphasis is not to consider individual aspects of health systems in isolation, but rather to view them as interacting parts of a whole dynamic, and to place this dynamic within the context of sectors outside of health (de Savigny and Adam, 2009). It is interesting that the vast majority of research on HSS has focused on how to measure different aspects of health systems, often narrowly focused on individual health system building blocks, rather than on how to strengthen health system performance (Reich and Takemi, 2009).

The development of systems thinking for HSS was driven by the dominance of vertical health initiatives, especially those which operate outside of the health system and have been criticised for negatively affecting health systems. As such, it was necessary to understand the intersection of

vertical and system-encompassing strategies. In the case of the health workforce crisis, there was acknowledgement that a solution to the problem could only be found through vertical-horizontal synergy (Elzinga, 2005).

Global health initiatives have also followed suit, the most predominant examples being the Global Fund and GAVI adopting HSS as a core tenet of their work. In this context, Shakarishvili *et al.* (2010b) describe the following three types of HSS, which were adopted in the Global Fund's approach to HSS (GFATM, 2011):

- Disease-specific HSS: activities strengthening components or elements of health systems that contribute to health outcomes within only one disease or thematic area (i.e. training nurses in administering treatment for tuberculosis (TB) patients, providing cold chain for immunisation, etc.)
- Cross-cutting HSS: activities strengthening components or elements of health systems that contribute to health outcomes across more than one disease or thematic area (i.e. developing primary care infrastructure, building health worker capacity in integrated management of childhood illness, etc.).
- Sectoral HSS: activities strengthening components or elements of health systems that are not linked to any specific disease or thematic area, but rather encompass broader, sector-wide or multi-sector areas (i.e. strengthening policy-making capacity of ministries of health, developing social health insurance, etc.).<sup>4</sup>

As a result of the broad understanding of HSS, there is a danger of HSS becoming a “container concept” that is used to label a wide breadth of diverse interventions (Marchal *et al.*, 2009). In order to mitigate this risk, Chee *et al.* differentiate between health systems *support* and health systems *strengthening* (2013). Health system support is primarily achieved through increasing inputs and includes any activity that improves services. Strengthening of the health system, however, is accomplished through more comprehensive changes at the macro level, enabling relationships across the health system building blocks that motivate changes in behaviour, or allowing more effective use of resources to improve multiple health services. This distinction between supporting and strengthening health systems is important. “If activities fail to produce improvements in system performance because they constitute mere support and were incorrectly labelled as ‘HSS’, the value of HSS investments could quickly be discredited” (Chee *et al.*, 2013: 86).

Recognising the limitations of broad definitions of HSS, some experts have chosen instead to set out guiding principles for HSS. Chee *et al.* (2013) present the following questions as means of assessing whether an intervention can be classified as HSS:

- Does it have cross-cutting benefits beyond a single disease?
- Does it address policy and organisational constraints or strengthen relationships between the building blocks?
- Will it produce permanent systemic impact beyond the term of the project?

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<sup>4</sup> A classification system for HSS activities proposed by Shakarishvili *et al.* (2010b) is also described in Figure 11 in Annex 4.

- Is it tailored to country-specific constraints and opportunities, with clearly defined roles of country institutions?

A similar approach is taken by Swanson *et al.* (2010), who proposed 10 guiding principles for HSS: holism, context, social mobilisation, collaboration, capacity enhancement, efficiency, evidence-informed action, equity, financial protection and satisfaction. Neither Chee *et al.* (2012) nor Swanson *et al.* (2010) attempts to replace the WHO building blocks definition of HSS. Rather, their work elaborates and builds upon the WHO framework. Further HSS frameworks are described in detail in Annex 4.

Regardless of how one defines HSS, its practice in the field will always differ by implementing party. Donor interpretation and operationalisation of HSS, for instance, are constrained by programmatic priorities. Particularly in the case of bilateral donors, accountability to domestic taxpayers, domestic media and legal frameworks must always be considered in parallel to HSS activities (Sundewall *et al.*, 2010). Programmatic limitations are most obviously seen with vertical health initiatives with HSS funding streams, which support HSS efforts restricted to specific target disease-related activities.

**Research question 1: Why is HSS important and what has led to its current role in the global health arena?**

- HSS emphasises the importance of addressing issues affecting the health system and not only specific diseases or health issues, thereby enabling a holistic approach to addressing populations' health needs.
- In the cyclical trend between vertical (i.e. disease-focused) and horizontal (i.e. systems-focused) programming in global health, HSS has risen in importance over the last decade in particular. The increasing focus on HSS has been a result of the health workforce crisis, concern that weak health systems have derailed the progress of vertical health initiatives, and the adverse effect of vertical global health initiatives on health systems. Furthermore, slow progress on the health MDGs due to health system bottlenecks has also gained attention for HSS.
- Though there is wide acceptance of the WHO HSS building blocks framework, there is a lack of consensus on what exactly substitutes health systems strengthening, and there is no unified donor approach to it.
- Over the past decade, a variety of global health actors have prioritised HSS in their policies and programming, including the WHO, World Bank, USAID, Doris Duke Foundation, GAVI and GFATM. Additionally, the creation of the IHP+, which seeks to unify national health strategies and health M&E structures, as well as the G8 Heiligendamm commitment to infectious diseases and HSS, have increased the influence of HSS.
- HSS plays an important role in the GDC as one of three strategic directions in the Sector Strategy for Health (BMZ, 2009c) and has seemingly guided the role of the GDC as a global health actor in combination with vertical health issues, most predominantly HIV/AIDS.

### 3 Overview of health system strengthening evaluations and literature

A literature review of international and German evaluations pertaining to HSS has been included in this desk study. Criteria for the review of international evaluations were: publication in the year 2007 or after, and having evaluation objectives and/or programme objectives either dealing explicitly with HSS, or addressing a minimum of two health system building blocks as defined by the WHO. With regard to German evaluations, the selection criteria were broader and included all final and *ex post* evaluations of health programmes that have been conducted by KfW and GIZ since 2007 and were published at the time of the review. In addition, one GIZ meta-evaluation in health, one KfW thematic evaluation, one joint external evaluation of the health sector in Tanzania, and two country sector evaluations (India and Rwanda) were included in the review.

Further information on the methodology is detailed in Annex 1, and a full list of the evaluations in this review can be found in Annexes 6 and 7. This review highlights the means through which HSS has been assessed empirically and addressed by other donors. The following sections list the international evaluations pertaining to HSS, including those carried out by other donors, evaluations of HSS within countries and GDC evaluations.

#### 3.1 HSS evaluations and reviews at the international level

While evaluations on health systems are numerous, they often concentrate on specific health system building blocks or individual components of health systems focusing on specific capacities (Olmen *et al.*, 2010), such as medical supply chains, motivation of health workers, health insurance schemes, but not on broader system issues. A review by Adam *et al.* of 106 evaluations conducted between 2009 and 2010 shows that less than half of the evaluations had a conceptual framework allowing for an assessment of the wider range of the intervention's effects and impacts across health building blocks. Only 19 evaluations explored the intervention's effects on other building blocks and one looked at the health impact outside the health sector (Adam *et al.*, 2012). Even fewer comprehensive evaluations and reviews from the donor perspective attempt to assess HSS strategies and implementation.

This section addresses the HSS evaluations of GAVI in 2009 and the ongoing evaluation of the African Health Initiative, which are the only multi-country evaluations that address HSS specifically as the core focus and consider HSS at the operational level. Additionally, the European Commission's (EC) thematic evaluation of the health sector is also addressed, which covers multiple health system building blocks. Following this section is a description of reviews and evaluative work in HSS that other donors carried out.

#### *Evaluations pertaining to HSS:*

##### **GAVI Alliance – HSS support evaluation**

A 2009 evaluation of its support for HSS commissioned by GAVI, explored the strengths and weaknesses of GAVI's HSS policy at regional and global levels, as well as the value added of GAVI funding for HSS in comparison with other donors. The evaluation focused on input and output levels in an effort to better understand HSS activities in countries, better adapt GAVI's HSS programming

and enable better conditions for future evaluation. A total of 21 countries were included in the evaluation, 11 of which were through in-depth case studies and 10 through desk studies. Results of the evaluation highlighted a number of process-related issues for GAVI HSS funding, as well as problematic aspects of an outcome- or impact-focused HSS evaluation. Detailed country case studies indicated that finding a causal link between HSS inputs and outcomes or impacts in the health system are and will continue to be extremely problematic and rigorous attribution of national level changes to GAVI HSS programming will be impossible. Indeed, this is a challenge that is not unique to GAVI, but is rather typical for evaluation of HSS efforts. Nevertheless, it was concluded that GAVI's HSS funding increased the demand for HSS from low-income countries and the funding of innovations of that might not have been supported otherwise. Further information on this evaluation can be found in Annex 3.

### **African Health Initiative Evaluation**

The ongoing evaluation of the African Health Initiative of the Doris Duke Charitable Foundation focuses on five countries (Mozambique, Rwanda, Zambia, Ghana and Tanzania) and aims to generate cross-country evidence on HSS. The evaluation methodology is not consistent across all countries, e.g. a cluster-randomised controlled trial in Tanzania against the use of the balanced scorecard approach in Zambia. However, the evaluations in each country are based on the evaluation framework of IHP+, with the added advantages of including contextual factors and implementation strength as potential determinants of progress in the causal chain (Bryce *et al.*, 2013).<sup>5</sup> Furthermore, the consideration of equity is an integral part of the analysis. Further information on this evaluation can be found in Annex 3.

### **European Commission thematic evaluation**

A thematic evaluation of the EC's contribution to the health sector was carried out in 2012. It focused on the coherence of EC support with that of other donors, identification of key lessons and formulation of recommendations for future EC health strategy (MacKellar *et al.*, 2012). Though HSS was not an explicit theme in the evaluation scope and questions, key health system elements played a central role (i.e. quality, affordability and availability of health services, health system governance and financing modalities). The evaluation was carried out over three phases: a structuring phase, in which a comprehensive portfolio analysis took place; a desk research phase; and a synthesis phase. A multiple case study approach was used, although no field visits were made in the course of the evaluation. Rather, a combination of tools and techniques was used for primary and secondary data collection, including online surveys, analysis of country strategy papers, literature review and a meta-analysis of evaluations. Overall, the evaluation could show little evidence as to how successful EC support was in HSS. The magnitude and sustainability of impacts of EC support to HSS are limited, as health remains a low priority sector in most partner countries. The evaluation also recommended for the EC to maximise on the health system components of vertical programmes, with particular consideration for the health workforce. Additionally, it was recommended for synergies and inter-sectoral links to be taken advantage of.

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<sup>5</sup> See Annex 4 for more information on the IHP+ framework.

## ***Evaluative work related to HSS:***

### **Global Fund**

Other donors have also undertaken reviews of their work in HSS. A content analysis by Warren *et al.* (2013) of the Global Fund's investments based on the WHO building blocks framework showed that 37% of "Round 8" funding was allocated to HSS, and of that, 38% was dedicated to generic system-level interventions rather than disease-specific support with HSS elements. The majority of this funding supported the service delivery, human resources, and medicines and technology blocks. The analysis resulted in the strategic suggestion that the Global Fund should make its HSS priorities clearer.

### **World Bank**

A 2011 review of the World Bank addressed its work with health systems through the health systems analysis methodology.<sup>6</sup> Analysis of health systems performance, as addressed in this study, admittedly differs from the assessment of externally driven and funded HSS, but is nevertheless an integral part of evaluative work for HSS. Experience of health systems analyses undertaken in China, Mozambique, Uganda and Turkey show that the World Bank has not adopted a unified conceptual framework or design in its health systems analyses. The following methods and approaches were utilised for each country, as identified in the review:

- China: situation assessment, review of recent international evidence on various policy issues and used as a base to recommend rural health system reform.
- Mozambique: review of selected health status indicators and comparison with other countries in sub-Saharan Africa and disaggregated by socio-economic status, resulting in HSS recommendations.
- Uganda: reviewed child mortality through demographic health survey data and analysed for inequality, resulting in policy recommendations for health sector reform.
- Turkey: comprehensive review of national health system and analysis of components that flowed into recommendations for reform.

### **International Development Committee (UK)**

HSS has also been a subject of importance for donors in 2014, with both the UK and the US releasing strategic reports on their engagement with it. The International Development Committee of the UK issued a report on the Department for International Development's (DFID) HSS activities and UK's position in the global debate (International Development Committee, 2014). The report brings together various facts and expert opinions through a series of testimonies from leading global HSS experts and actors involved with the UK's contribution to HSS. Although DFID has an explicitly stated focus on HSS (DFID, 2013), it was found that a general lack of information and a lack of performance indicators for HSS make the possibility of an HSS evaluation very difficult. All the same, DFID estimates that it has spent 360 million GBP on health systems support in 2013–14. However, the

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<sup>6</sup> See Figure 8 in Annex 4 for the health systems analysis framework.

majority of DFID's spending is through multilateral channels, which proves problematic in terms of accountability and tracking the flow of funds. Through the evidence reviewed in this report, it was found that DFID focuses its HSS work on governance, finance, workforce and community and public health. Among the recommendations listed in the report is the assessment by country of existing funding arrangements that enable DFID's HSS objectives to be met. From this perspective, it can be understood that the HSS report of the International Development Committee provides the background and considerations for a future HSS evaluation; also one of the report's recommendations.

### **Institute of Medicine (US)**

Most recently, the US-based Institute of Medicine released a report on the value of American investment in health systems in low- and middle-income countries that sought to summarise how health system improvements can lead to better health, reduce poverty and make donor investments in health sustainable (IOM, 2014). The goal of the report was to recommend broad priorities for HSS to be integrated into a donor strategy for health. The report builds on the premises that strong health systems are the best insurance against shifting patterns of disease and phenomena such as climate change and epidemics, and that many of the recent advances in health have favoured the rich. The findings of the report indicate that the disparity in beneficiaries of health investments can be addressed through decentralised HSS. Three recommendations for an HSS strategy are emphasised in the report: first, the need to emphasise technical cooperation and country ownership, which ultimately means that the US should measure the outcome of its contribution to HSS as a donor rather than its inputs; further investment in global health research and professional training for students; and the necessity of rigorous, external impact evaluations for the US government global health projects that involve technical innovation or new models for service delivery.<sup>7</sup> Similar to the report issued in the UK, the US report reflects the importance of HSS in US development aid policy, and calls for the further development of the evidence base for HSS.

## **3.2 Evaluations of HSS within countries**

A number of studies within countries have examined the role and impact of HSS on specific diseases or particular aspects of the health system.

In Ghana, Awoonor-Williams *et al.* (2013) have described in an ongoing evaluation the effects of an HSS intervention on maternal and child health. The intervention itself includes many aspects, such as extending the range and quality of services for newborns, simplifying the collection of health management information and ensuring its use for decision making, and adding USD 0.85 per capita annually to district budgets. The impact of the intervention is assessed through baseline and endline surveys and the use of the Heckman's "difference in difference" test for core indicators of health status and survival rates in three intervention districts relative to four comparison districts. Data so far show that the HSS intervention is having the intended effects on maternal and child health.

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<sup>7</sup> USAID has developed an assessment framework for HSS, which is described in Figure 9 in Annex 4.

An HSS intervention that focused on the improvement of management and leadership was evaluated in six provinces of Kenya by Seims *et al.* (2012) for its effects on health service delivery outcomes. This evaluation compared measures of key service delivery indicators addressed by the intervention against measures in comparison areas not covered by the intervention. Health service coverage at the district level as well as the percentage of change in the number of client visits was calculated through baseline, mid-line and endline data. It was found that significant increases had taken place in both health service coverage and client visits, and that these increases sustained for at least six months post-intervention.

In a cross-country study of Burkina Faso, Cambodia, Indonesia and Morocco, HSS interventions encompassing midwife deployment were examined by Wim Van Lerbeghe *et al.* (2014) for their effect on uptake of health services at childbirth. It was found that service delivery networks (i.e. proximity vs level of resources of health facility) are crucial, as it motivates increased uptake of services. Furthermore, an effective network gives impetus for increased deployment of midwives to meet demand and pressure to lift financial barriers. The authors also found that the deployment of midwives was a result of managerial choices to operationalise universal access to care. The systems' approach for analysis taken in this study exemplifies the possibility to examine the effects of HSS on particular aspects of health.

A different approach of analysing HSS was taken in Rwanda by Maurice Bucagu *et al.* (2012), who undertook a systematic review of literature, national policy documents and three demographic and health surveys to examine health sector reforms in 2000–12 as well as the progress made in service delivery for women's health services. Health sector reforms and their adjoining policies were analysed within the HSS building blocks framework, showing vast support for HSS throughout the time period. The determinants for the improvement of service delivery were also analysed, and even though they were not linked to health sector reforms within the study, they open the possibility to pursue an impact evaluation in the future.

In an evaluation of Norwegian health sector support to Botswana, Singleton *et al.* (2012) assessed the outcomes and impacts of the Norwegian health sector assistance for health services users and for the health system at large. Among other questions, the evaluation sought to answer to what extent the assistance positively contributed to the changes in the Botswana health system and health status of the population. The evaluation relied primarily on secondary data (epidemiological data from demographic surveys, national health expenditures and development assistance, national policy documents, etc.) and was supplemented by interviews with Norwegian and Botswanan stakeholders. The findings of the evaluation were assessed against Development Assistance Committee (DAC) criteria and organised according to nine categories, six of which related directly to the WHO health system building blocks. Norway's assistance was found to have positively contributed to the development of the Botswana health system, principally through infrastructure development and central systems such as the pharmaceutical supply system. These developments led to a functioning primary care health system which enabled wide accessibility to health services.

**Research question II: How has HSS been evaluated by the international donor community (and what have been the main findings)?**

- Evaluations that approach HSS as a holistic and systems-oriented concept are few in number, though there is a clear call for the building of an HSS evidence base. Furthermore, donor organisations that have undertaken comprehensive HSS evaluations or reviews are even fewer, and the methodologies that they have applied to countries differ within individual studies, resulting in a lack of standardised approaches to HSS assessment even within organisations.
- Evaluations of HSS have been varied in their approach and scope. While some donors, such as the US and UK have undertaken strategic reviews of their HSS policies, GAVI – the only global health actor to have completed an evaluation of its HSS engagement – explored the strengths, weaknesses and added value at global and regional levels. Further evaluation methods include the context-intensive health systems analysis approach of the World Bank and the comprehensive multiple case study approach of the European Commission. The multi-site African Health Initiative Evaluation, which runs until 2017, utilises a variety of evaluation methods adapted to the HSS interventions in countries, including the balanced scorecard approach, which enables the collection of impact-level data and requires use over a longer time period.
- Reviews of HSS have been produced by the US and UK in 2014 including recommendations for future HSS strategies and evaluations. These reviews have been motivated largely by the Ebola outbreak in West Africa and underscore the fact that HSS is an increasingly relevant topic in international debate.
- Recommendations from international HSS evaluations and reviews include taking advantage of synergies and inter-sectoral linkages (MacKellar *et al.*, 2012), improving an understanding of what enables HSS objectives to be met (International Development Committee, 2014), and increasing rigorous, external impact evaluations of health (IOM, 2014).
- Evaluations of HSS interventions within countries included in this study have mostly been done in the context of vertical programmes with narrow health focus (Seims *et al.*, 2012; Awoonor-Williams *et al.*, 2013; Van Lerberghe *et al.*, 2014). Of importance across all such evaluations has been the selection of indicators that address both the health system and the targeted health issue.

### 3.3 German evaluations in the health sector

As a part of the literature review in this desk study, a number of broad GDC evaluations were consulted, including: a GIZ meta-evaluation in health; a KfW thematic analysis on the side effects of targeted health interventions; a joint evaluation; and two country sector evaluations. Additionally, 46 final and *ex post* evaluations of GDC health programmes were also reviewed for their HSS content and approach.

#### GIZ meta-evaluation in health

The 2013 GIZ meta-evaluation in health assessed and assigned numerical scores to 37 evaluations and programme progress reviews commissioned by GIZ in the period 2009–12. Of these, 11 were

primarily focused on HSS. Overall, projects focused on HSS scored higher than those on SRHR and HIV (GIZ, 2013b). These projects were often grounded in the HSS building blocks of the WHO framework, and interactions between blocks were often addressed. Simultaneously, it was found that projects varied widely in their intervention logic and implementation, making it very difficult to describe a typical health project or notice trends (GIZ, 2013a).

Regarding HIV and SRHR, the meta-evaluation did find effective integration between the two areas, as well as positive impact within the respective projects. To build on these positive results, it was recommended that integration should be assessed and promoted between HSS, HIV and SRHR – the three focal areas of the German Health Sector Strategy. An integrated approach between HIV, SRHR and HSS could potentially be a unique feature of the GDC in the global health community.

### **KfW thematic analysis on the side effects of targeted health interventions**

The 2012 KfW thematic analysis explored how health interventions' side effects may affect the wider health systems of partner countries, focusing on the case of HIV prevention projects and social marketing (Haenssger and Nohr, 2012). The analysis included a desk review of 71 HIV/AIDS projects financed by the German financial cooperation. The analysis concluded that in accordance with the GDC policy of linking HIV/AIDS and SRHR, over the last decade, social marketing projects have increasingly been linked to other interventions and now address a wider range of health topics in addition to HIV/AIDS. However, the analysis of the project documents highlighted the lack of a uniform and accepted approach to capture health system effects. Gaps remained regarding M&E, as health system effects were neither embedded in the target system nor monitored consistently (Haenssger and Nohr, 2012: 11). Hence, the authors proposed a methodology for examining impacts of vertical programmes on health systems using secondary data consisting of the identification of health system interfaces of the vertical intervention in question and selection of health system outcome or impact indicators emanating from the intervention. Accompanying this methodology is a list of generic indicators categorised by health system interface (Haenssger and Nohr, 2012). Such a methodology could be very useful for further formative research and evaluative work on the HSS impacts of vertical programmes.

### **Joint health sector evaluation in Tanzania**

In 2007, a consortium of donors including Germany (BMZ), Denmark and Canada carried out a joint external evaluation of the health sector in Tanzania. The evaluation objective was to provide evidence on the relevance and effectiveness of joint external support to the Tanzanian health sector between 1999 and 2006. Hence the evaluation focused on the extent of progress in nine strategic priority health areas of the Tanzanian health sector strategic plans (most of which have to do with the health system), achievements in improving access, service quality and health outcomes, donor harmonisation and the use of different aid modalities.

The evaluation was conducted in 2006, thus before the publication of the WHO general framework for HSS. While the evaluation did cover priority areas of the health sector strategic plans closely related to the health system, it operated without a theory of change and did not include an assessment of interactions between these priority areas. The methodology consisted of triangulation of mostly qualitative methods, including interviews, self-assessments and in-depth district case

studies. Quantitative methods such as analysis of resource flows to the health sector and a review of national health outcomes data also supplemented the evaluation.

A major positive finding was the contribution of harmonised donor support through a sector-wide approach (SWAp) to the health sector reform. Particularly the use of basket funding as an aid modality was found to be a critical factor in supporting health governance and strengthening health services at the decentralised level. Although global health initiatives and HIV/AIDS-focused programmes outside the SWAp also contributed to implement national health strategies, the evaluation mentioned their – at times – negative distorting effects, such as the diversion of human resources away from other priority activities.

An assessment of factors limiting equity and access to the health system found geographic isolation, poor transportation infrastructure and lack of effective solidarity-based financing mechanisms to be the most significant (Ministry of Foreign Affairs of Denmark *et al.*, 2007).

### **Health sector evaluation in India**

In a 2004 evaluation of GDC support for the health sector in India – jointly led by the evaluation teams of KfW and the former GTZ – a project that had been running for a decade was examined to assess the main areas of GDC contribution, the strengths and weaknesses of its engagement, and recommendations for future cooperation. Key problems identified included poor coordination between GDC projects as well as between technical and financial cooperation, GDC projects that ran parallel to those of the state which raised questions of sustainability, and the perception of the GDC's role in relation to other major donors in India's health sector. The recommendations proposed by the evaluation took a systems-oriented approach, though not explicitly mentioned as such. Many recommendations focused on quality improvement as a means of improving the quality of GDC support. Policy guidance and governance strengthening from the national to the district level was also recommended as a means of ensuring the sustainability of the GDC contribution. Further suggestions focused on strengthening coordination with the private sector and enhancing inter-sectoral collaboration within the other focal areas of GDC cooperation with India (Griffith *et al.*, 2004).

### **Health sector evaluation in Rwanda**

Schwedersky *et al.* (2014) of the German Institute for Development Evaluation (DEval) conducted a summative evaluation of 30 years of development cooperation between Germany and Rwanda in the health sector. In addition to analysing the cooperation on the basis of a variety of factors, including DAC and BMZ criteria, the evaluation sought to assess aid modalities, instruments and the phasing out of the GDC in the health sector. The evaluation adopted a theory-based contribution analysis using document analysis, an online survey, statistical analysis of district health systems data and a comparative case study of four district health systems. The evaluation framework was based on that of the IHP+. Results of the evaluation are analysed according to the three components comprising the joint health programme between the GDC and Rwanda, of which two are directly related to HSS (health financing and human resource development). The evaluation also details how the GDC's approach to HSS has influenced its development cooperation with Rwanda. In short, the GDC facilitated the Rwandan government with technical assistance for the development of the

community-based health insurance and supported the sector-wide approach (SWAp), both of which contributed to HSS in Rwanda. GDC efforts in HSS were also manifested in the integration of HIV and TB services. The evaluation found out that GDC support has had a high leverage effect through the mix of joint financing modalities (sector budget support and basket funding) and project-directed aid. However, the Rwanda evaluation also highlighted that improved health outcomes depended to a significant part on vertical programmes, mainly funded by the US, and global health initiatives. More harmonisation and coherence among development partners, particularly with regard to the joint financing modalities, would have improved the effectiveness of the GDC approach to HSS.<sup>8</sup> GDC's multi-level approach was found to be highly effective with regard to the improvement of overall coverage and access to targeted health care services. However, focus within the GDC-Rwanda partnership on marginalised groups was found to be lacking, resulting in only moderate reductions of health disparities.

### **Review of GDC project and programme evaluations**

As a part of the present desk study, 46 health project and programme evaluations, carried out by implementing organisations KfW and GIZ since 2007, were reviewed for their approach to HSS (see Annex 1 for the methodology and Annex 6 for a full list of evaluations reviewed).

The review reveals that most projects involved measures that relate to more than one building block of the health system. Explicit reference to the WHO health system definition in the design of the projects was rarely found, which may be because most of the evaluated projects were planned before 2007 and that many had a thematic focus on SRHR or HIV/AIDS. One noticeable exception is the GIZ programme in Indonesia (GIZ, 2011a). The evaluations analysed the projects against their results chain, the respective indicators and the DAC evaluation criteria. Although the evaluations were not based on analytical frameworks for evaluating HSS (see section 2.2 and Annex 4), some did consider interactions between the health building blocks (KfW, 2008; KfW, 2009a; KfW, 2009b; GIZ, 2012c) and broader issues such as inter-sectoral cooperation (GIZ, 2011; GIZ, 2012a, GIZ, 2012b). Furthermore, projects with a more vertical approach have generally not been evaluated for their level of integration or related back to health systems within the evaluations. One noticeable exception is the KfW evaluation on the polio immunisation programme in India, which assessed the positive, negative and unintended side effects of a disease-specific intervention on the health system (KfW, 2011). Overall the review confirms the results of the GIZ meta-evaluation and the KfW thematic analysis with regard to the need for a more standardised approach to grasp health system effects and analyse the integration of vertical programmes into the health system.

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<sup>8</sup> The KfW evaluation on sector budget support to Rwanda (KfW, 2014a) builds upon the DEval evaluation and comes to similar conclusions with regard to the effectiveness and impact of the intervention. "The changes measured ... were strongly influenced by many contributions of other bilateral and multilateral donors that did not flow into the sector budget support" (KfW, 2014a: 2). Two other recently conducted KfW evaluations on joint financing modalities in Malawi and Tanzania assess health system effects and analyse the trade-offs between the long-term effects on the establishment of functioning decentralised structures and the short-term effects on service provision, the latter being largely due to vertical programmes outside the sector-wide approach (KfW, 2014b, 2014c).

### **Research question III : How has HSS been addressed in previous GDC evaluations?**

- Both the 2013 GIZ meta-evaluation in the health sector and the 2012 KfW thematic analysis on the side effects of targeted health interventions revealed the need for further evaluation of the integration of HIV/AIDS, SRHR, and HSS and a more standardised approach to grasp health system effects. Furthermore, it was found in the GIZ meta-evaluation that projects analysed in the HSS cluster were often grounded in multiple HSS building blocks, and that interactions between the blocks were addressed. Overall the review of the final and *ex post* evaluation conducted since 2007 confirms these findings in part: whereas health system building blocks were found to be addressed within project evaluations, their interactions with one another were infrequently discussed. Country evaluations in Rwanda (Schwedersky *et al.*, 2014) and India (Griffith *et al.*, 2004), as well as a joint external evaluation in Tanzania (Ministry of Foreign Affairs of Denmark *et al.*, 2007) considered important aspects of HSS and presented conclusions that are relevant for the shaping of future HSS strategy in the GDC. In particular, the Rwanda evaluation highlighted the contribution of GDC to strengthen the health system by a largely horizontal approach and a mix of aid modalities and instruments. It also showed the need for further support of vertical programme integration in the context of a sector-wide approach.
- Up to now there has been no comprehensive evaluation of the GDC's HSS engagement. In-country and programme/project evaluations, specific building blocks and occasionally interactions between building blocks have been assessed. Consideration of HSS as an analytical framework for M&E was found to be infrequent. An important exception is the Rwanda evaluation (Schwedersky *et al.*, 2014), which based its evaluation framework on that of the IHP+.

## **4 Strategic perception of health systems strengthening within the GDC**

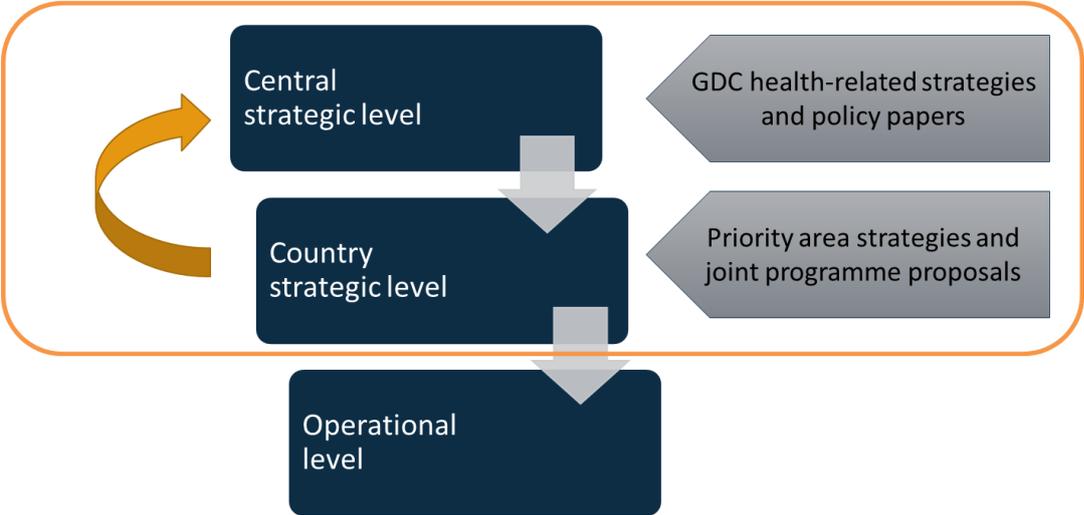
### **4.1 Analysis methodology**

In order to obtain a view of the GDC approach to HSS on a strategic level, an analysis has been undertaken of the core BMZ policies, strategies and position papers relevant for the GDC in health, as well as the inter-ministerial global health concept of the German government (for a complete list of documents see Annex 9). Document selection entailed the incorporation of all sector strategies and policies published by the BMZ under the category of health. Additionally, the BMZ draft position paper on HSS was included in the analysis.

A review of these documents, referred to hereafter as *GDC strategic documents*, revealed that the GDC strategically pursues HSS through three focal areas and four cross-cutting approaches. These focal areas and cross-cutting approaches were then used to guide the analysis of strategic documents at partner country level, hereafter referred to as *country strategic and planning documents*. These documents included the most recent joint programme proposals agreed upon by implementing agencies (*gemeinsame Programmvorschlage, Teil A*) and priority area strategies in health (*Schwerpunktstrategiepapiere*). The analysis considered the extent to which focal areas and cross-cutting approaches defined at the central level were reflected within country strategic documents. It also considered whether priority area strategies and joint programme proposals explicitly mentioned other focal areas or approaches in relation to HSS in partner countries.

As Figure 2 details, after the focal areas and cross-cutting approaches of GDC engagement with HSS were extracted from the GDC strategic documents, they were used to analyse country strategic and planning documents. This enabled an understanding of how the GDC pursuit for HSS translates into country-level planning.

Figure 2. Analytical approach



Source: Author

Eight partner countries and one region were chosen on the basis of the following criteria: their partnership with the GDC entailed health as one of their three priority areas of overall development cooperation, and health would continue to be a priority area for the foreseeable future. These partner countries and region include: Cambodia, Kenya, Malawi, Nepal, Pakistan, South Africa, Tanzania, Vietnam and the Central Asian Region.

Finally, it is worth noting that the analysis at the partner country level has only considered priority area strategies and the first part of the joint programme proposals (part A) that outline GDC cooperation in the health sector, which orients operational planning. These documents are the result of a negotiation process between partner countries and GDC, thus reflecting how GDC intends to support national health strategies. Therefore, the focal areas reflected in the documents at times differ from one country or region to another. Furthermore, in a number of countries GDC is involved alongside other donors in a SWAp to support the health sector. Hence, in some cases, the specific focus of GDC also reflects a division of labour between development partners.

The aim of the analysis was to distillate the focal areas relevant to HSS across countries and to relate those to the GDC policies and strategies at the central strategic level as well as to the WHO HSS framework. It did not intend to comprehensively assess the scope of HSS interventions in each country or/and to touch upon programme implementation.

Hence, the analysis did not consider part B of the proposals, which includes the specific technical and/or financial cooperation modules. As part B deals with the contribution of each implementing agency, it entails more information on specific measures related to HSS (e.g. sector budget support or development of various health financing models) as well as on the respective logical frameworks

and indicators. However, the major interventions outlined in part B of the programme proposal are also reflected in part A. Further evaluative work on HSS at country level would require an analysis of part B and field studies.

## **4.2 HSS as a priority within the GDC**

As stated in the German Development Policy in the Health Sector (BMZ, 2009c), HSS is one of three priority areas in health, and the inter-ministerial global health concept lists HSS as one of five strategic measures for global health (Bundesministerium für Gesundheit, 2013). From a strategic perspective, the GDC's pursuit of HSS has far-reaching implications that extend beyond the health sector and influence the achievements of its overall development goals.

On a normative level, HSS is seen as contributing to the realisation of the right to health, taking into particular consideration poor and marginalised groups. The BMZ position on HSS adopts the WHO-supported criteria for human rights and health: accessibility, availability, acceptability and quality of health care. By contributing to the realisation of the right to health, HSS is seen as a means of achieving sustainable and inclusive health outcomes. Removing structural deficits in health systems, contributing to the provision of effective, efficient and equitable health financing, strengthening participatory approaches, capacity development and empowerment all play a key role in the BMZ development priority in HSS (BMZ, 2009c).

Strategically speaking, HSS is acknowledged by the GDC overall as a precondition for universal health coverage (Bundesministerium für Gesundheit, 2013). It will not be possible to achieve universal health coverage without a functioning, effective and efficient health system. Throughout the past decade, HSS has also been understood as a prerequisite for the achievement of the health-related MDGs (BMZ, 2011). Building on these health-related aims, HSS through social health protection is perceived as a means to actively pursue poverty reduction, social justice and cohesion. Social health protection as pursued by the GDC is inspired by the German model and is based on the principle of solidarity (BMZ, 2009a).

## **4.3 Strategic approach to HSS within the GDC**

The approach taken to HSS by the GDC adheres to the WHO building blocks framework and supplements it with focal areas and cross-cutting approaches.

The BMZ sector strategy on health defines health system development as a key priority in the health sector, which includes as specific aims "increased provision of health professionals; adequate training and professional development for health workers; development of sustainable, solidarity-based funding systems (social health protection); improving the organisation, structure and management of health systems; and rehabilitation and expansion of infrastructure" (BMZ, 2009d: 13).

An analysis of all GDC strategic documents reveals three focal areas in relation to HSS: human resource development for health, solidarity-based health financing and social health protection, and institutional and organisational development. Though each of these focal areas relate predominantly to single building blocks within the WHO framework, they are actually quite nuanced and have direct and indirect ties with other building blocks as well.

1. The severe shortage of health workers is a major weakness of health systems in many developing countries and is exacerbated by a lack of adequate management, and provides the context for **human resource development for health** as a key feature of the GDC approach to HSS. The provision of a skilled workforce as well as the motivation and retention of health workers are imperative for enabling effective service delivery. Furthermore, it is believed that increasing management and organisational capacity of health workers improves governance from the national to the district and ward levels.
2. The next focal area in the GDC approach to HSS is **solidarity-based health financing and social health protection**, which is in response to weaknesses seen in many health systems: unaffordability of health services for the poor, inadequate financing of health services, and inefficient allocation of resources. These weaknesses result in inaccessibility and poor quality of health services, thereby inhibiting the realisation of the right to health. GDC engagement with partner countries enables health finance reform through a variety of models, and also focuses on donor harmonisation.
3. Tying the previous two focal areas together and enhancing their effectiveness and sustainability is the last focal area: **institutional and organisational development of national health systems**. In order for HSS to result in meaningful and sustainable impacts, structural changes at the policy and service delivery level are required. The background and setting of each health system also necessitates an approach that allows for tailoring interventions to the specific characteristics and needs of national health systems. Furthermore, giving context due consideration optimises the mobilisation of the community, ensuring that the beneficiaries of the health system are also incorporated in planning and monitoring activities. The GDC approach to HSS in this focal area encompasses a wide range of interventions, including health sector reform, decentralisation, SWAps, as well as cooperation with international initiatives for enhanced donor aid effectiveness. Investments in infrastructure at the primary and secondary level of health care are also considered as one measure to improve the access to qualitative health services.

In addition to the three focal areas, analysis of GDC strategic documents reveals four cross-cutting approaches that are explicitly mentioned in the context of HSS. These approaches influence the GDC understanding of a health system, and thereby play an important role in the strengthening thereof.

1. A health system is understood to be comprised of both public and private sector actors, consequently raising the importance of **private sector cooperation** in HSS. The GDC's efforts in this regard are underscored by the acknowledgement that progress in HSS pursued through the public sector is limited without the engagement of the private sector, both through for-profit and non-profit/faith-based channels. In light of the limited reach of government-supported health facilities and services in some countries, cooperation with the private sector can increase provision of health care for difficult-to-access populations. That being said, the strategic documents also bear the caveat that it is necessary to improve the stewardship of the government with regard to effective cooperation between the public and private sector, regulate and monitor quality, and decrease inefficiency within the private sector's health activities. Cooperation with the private sector includes the promotion of

public-private partnerships with the German health care industry, in order to develop medical technology and health infrastructure in partner countries.

2. With the past investment of a great amount of resources in vertical initiatives and programming, particularly in the area of HIV/AIDS, the GDC now prioritises **vertical programme integration into health systems**. This approach has developed with the realisation that the objectives of vertical programmes are not likely to be fulfilled without improvements and overall support of the health system. Integration of vertical programmes is thus intended to increase the efficiency and effectiveness of health systems that can cater to a variety of needs, including those addressed by vertical programmes, and allows them to deliver high-quality prevention, treatment and support services. Furthermore, integration is recognised as essential to avoid fragmentation and duplication of services.
3. **Inter-sectoral cooperation** is another cross-cutting approach that takes into consideration a context broader than the health sector alone. The increase of life expectancy in the last century is not due to health improvements alone. Nutrition, access to safe water, sanitation, education and healthy environments/climate greatly influence the sector of health, and vice versa. Cooperation among sectors is needed to improve effectiveness and the impact of HSS through health prevention and promotion measures in other sectors, for instance. As non-communicable and chronic diseases as well as climate change-related health issues gain prominence in the global health agenda, inter-sectoral cooperation is advised for making sustainable improvements.
4. The **human rights-based approach**, which is applicable across all GDC policies, shares to a large extent the same goals as HSS. This cross-cutting approach aims to improve availability, accessibility, acceptability and quality of health services for all, with a focus on the inclusion of vulnerable and disadvantaged groups.

Further detailed information on the focal areas and cross-cutting approaches for HSS can be found in Annex 11.

**Research question IV: What is the GDC approach to HSS as defined in its central strategic documents?**

- HSS is a priority of GDC in the health sector. HSS is mainly defined in GDC's central strategic documents through three focal areas supplemented by four cross-cutting approaches.
- The focal areas for HSS include: human resource development for health, solidarity-based health financing and social health protection, and institutional/organisational development of national health systems. Each of these focal areas relates predominantly to single building blocks within the WHO framework, as well as having ties with other building blocks.
- The cross-cutting approaches contributing to HSS, as identified in the strategic documents, include private sector cooperation, vertical programme integration, inter-sectoral cooperation and the human rights-based approach.
- For each focal area and cross-cutting approach the GDC strategic documents describe a range of specific measures at the country and international levels that potentially contribute to HSS, although they do not explicitly label these measures as HSS or clearly determine their interfaces with HSS.

#### **4.4 Strategic orientation of HSS within partner countries**

During the analysis of HSS within partner countries, the focal areas and cross-cutting approaches identified in the previous level of analysis of the GDC strategic documents were searched for in the country strategic and planning documents of eight partner countries and one region.

Although not all analysed country partnerships in health took HSS into specific consideration, the majority touched on various aspects of health systems and their respective strengthening, with the exception of South Africa. In South Africa, the focus of the partnerships is explicitly HIV/AIDS.

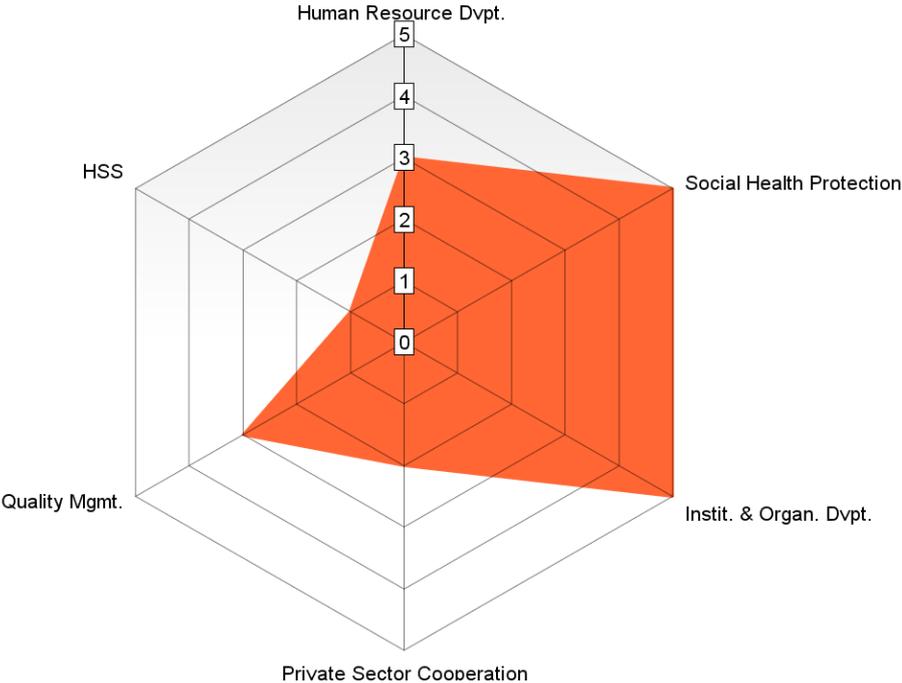
In the first step of analysis, it was found that the priority area strategies within these partner countries largely reflected the findings from the analysis of the GDC strategic documents. Next, joint programme proposals were analysed for HSS focal areas and cross-cutting approaches. Results of the analysis showed that these documents were largely in line with the central strategic documents, but differed in the extent to which certain focal areas and cross-cutting approaches for HSS were reflected within countries. As previously discussed, these differences are mostly owing to country-specific contexts and to the negotiation process leading up to the priority area strategies and joint programme proposals.

Despite these differences across the country strategic documents, a number of focal areas and cross-cutting approaches are defined as contributing to HSS.

##### ***Focal areas of HSS as reflected in priority area strategies and joint programme proposals***

Figure 3 shows which focal areas are explicitly related to HSS in joint programme proposals. Social health protection and institutional and organisational development are the most frequently mentioned focal areas, followed by human resource development. Private sector cooperation is defined as a focal area in two joint programme proposals, and is mentioned as a cross-cutting approach or explicitly associated with HSS in almost every country involved in the analysis. In one joint programme proposal (Nepal) HSS has been defined as a focal area. Quality management, while not included as a focal area in the GDC strategic documents, has emerged as a focal area related to HSS in three joint programme proposals at country level. The role of each of these focal areas within the country strategic documents is described further below.

Figure 3. GDC pursuit of HSS as defined within country strategic documents



Source: Author

Note: The numbers on the axis relate to the number of partner countries for which the programme proposals incorporate the respective focal area or cross-cutting approach as a core area. “HSS” here refers to an explicit mention of the concept as a focal area.

**Social health protection and institutional and organisational development**

As seen in Figure 3, these two focal areas were the most frequently mentioned in the analysed joint programme proposals. At a country level, planned activities under social health protection are very much in line with what is described in GDC strategic documents. When social health protection and solidarity-based health financing is seen as a focal area within partner country programme proposals, it frequently involves support for the development of health financing strategies and national health insurance systems, as well as support for various health financing mechanisms within countries, including micro-insurance and voucher programmes.

The case of institutional and organisational development is similar, in that programme proposal activities are in line with those put forth in GDC strategic documents, with emphasis resting on support to the development and implementation of national health sector strategies, decentralisation, participation in SWAPs and basket funds, and capacity development of health sector management. Expansion and rehabilitation of infrastructure is mentioned in a few documents (Tanzania, Nepal and Vietnam) as contribution to improve the performance of the health system.

**Human resource development**

Human resource development is a focal area in three joint programme proposals (Cambodia, Malawi and Pakistan) and is explicitly set in relation to HSS in two others (Tanzania and Vietnam). At country level, planned measures primarily involve strengthening the management of human resources and

supporting pre-service and in-service training of medical and para-medical staff as well as cooperation with training and academic institutions.

### **HSS as a focal area**

Although nearly all partner countries in this analysis entailed a focal area in their programme proposals that related to the focal and cross-cutting areas of HSS found in the GDC health strategies (South Africa being the exception), only Nepal incorporated HSS explicitly as a focal area.<sup>9</sup> The specific components of the HSS focal area include quality management, support of the decentralisation process, improvement of physical infrastructure, improvement of the medical procurement system and support for private sector integration. These components represent a number of health system building blocks and reflect many of the focal areas and cross-cutting approaches identified in the GDC health strategies.

### **Quality management**

Quality management was a recurring theme and focal area within three out of nine joint programme proposals, as seen in Figure 3 (Malawi, Pakistan and the Central Asian Region). Although it was mentioned within GDC health strategies, less emphasis was given to it compared to the other identified focal areas and cross-cutting approaches. This focal area is related to service delivery most directly, where improvement of the quality of care is the chief objective. In this context, there is support to development and implementation of national guidelines for quality management, as well as quality standards.

### **Private sector cooperation**

Though private sector cooperation is seen in Figure 3 to be a focal area in only two partner countries (Tanzania and Malawi), it is mentioned in detail in the documents of almost every other partner country included in this analysis. It is also most frequently directly associated with HSS, in the expectation that the involvement of the private sector will increase the coverage and quality of health services. Cooperation with the private sector involves the development of regulatory and quality assurance mechanisms for private health service providers and/or support to public-private partnerships. In the sub-Saharan context, cooperation with the private sector involves both for-profit health providers as well as faith-based and civil society organisations.

### ***Cross-cutting approaches to HSS as reflected in priority area strategies and joint programme proposals***

The analysis of the extent, to which cross-cutting approaches identified as contributing to HSS in central strategic documents are explicitly related to HSS in country strategic documents, gives a heterogeneous picture. Private sector cooperation is frequently mentioned and even defined as a focal area in two partner countries. The human rights-based approach is mentioned as a cross-

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<sup>9</sup> A change to Nepal's original joint programme proposal found after the analysis would later remove HSS as a core field of activity.

cutting approach in five partner countries' strategic documents, but only explicitly related to HSS in one priority area strategy (Kenya).

### **Vertical programme integration and inter-sectoral cooperation**

Vertical programme integration is explicitly related to HSS in the strategic documents of two partner countries (Tanzania and Kenya) in sub-Saharan Africa and briefly mentioned but not related to HSS in the multi-sectoral HIV programme for South Africa. It is not mentioned in the strategic documents of Asian partner countries.

With regard to African countries, the structure of joint programme proposals suggests that an integration of vertical programmes at strategic and planning level has taken place. For example the priority area strategy for Tanzania explicitly mentions that GDC contributes to the integration of HIV and SRHR by bringing them together into one component of the joint programme. SRHR is not conceived as a stand-alone focal area in Tanzania and Malawi but is integrated in other focal areas such as quality management of health services or cooperation with the private sector and civil society organisations.

Inter-sectoral cooperation is neither mentioned as a cross-cutting approach nor explicitly related to HSS in any of the analysed country strategic documents. It is, however, mentioned in the context of other focal areas of joint programme proposals, most frequently in connection to SRHR and HIV/AIDS, in one country (Cambodia) in the context of support to social health protection. Given the importance of inter-sectoral cooperation for the overall progress of global health and its frequent mention as a cross-cutting approach in GDC health strategies, the lack of attention paid to it in country planning and strategic documents is noteworthy. Inter-sectoral cooperation should naturally be of particular importance in those partner countries in which GDC is involved in other sectors relevant to health, such as water or education. More analysis at implementation and country level would be needed to verify the hypothesis that inter-sectoral cooperation is still weak; and explore how it can be better incorporated in country strategies and programme proposals.

**Research question V: What is the GDC approach to HSS as defined by its health programmes in partner countries?**

- The approach of the GDC to HSS as defined in its strategic documents is in part substantiated by the country-level analysis.
- Though HSS was not always mentioned explicitly within the documents, the strategic orientation of the GDC in its pursuit of HSS was found within the programme planning of the majority of analysed country joint programme proposals.
- Social health protection and institutional and organisational development are the most frequent focal areas related to HSS found within partner countries, followed by human resource development for health and quality management.
- Private sector cooperation is defined at country level both as a focal area and as a cross-cutting approach. It is also very frequently addressed in explicit connection with HSS.
- Quality management emerged as a focal area related to HSS within the joint programme proposals of partner countries although it was not identified as such in the GDC health-related strategies.
- Vertical programme integration is only explicitly related to HSS in joint programme proposals of African partner countries. The structure of joint programme proposals suggests that an

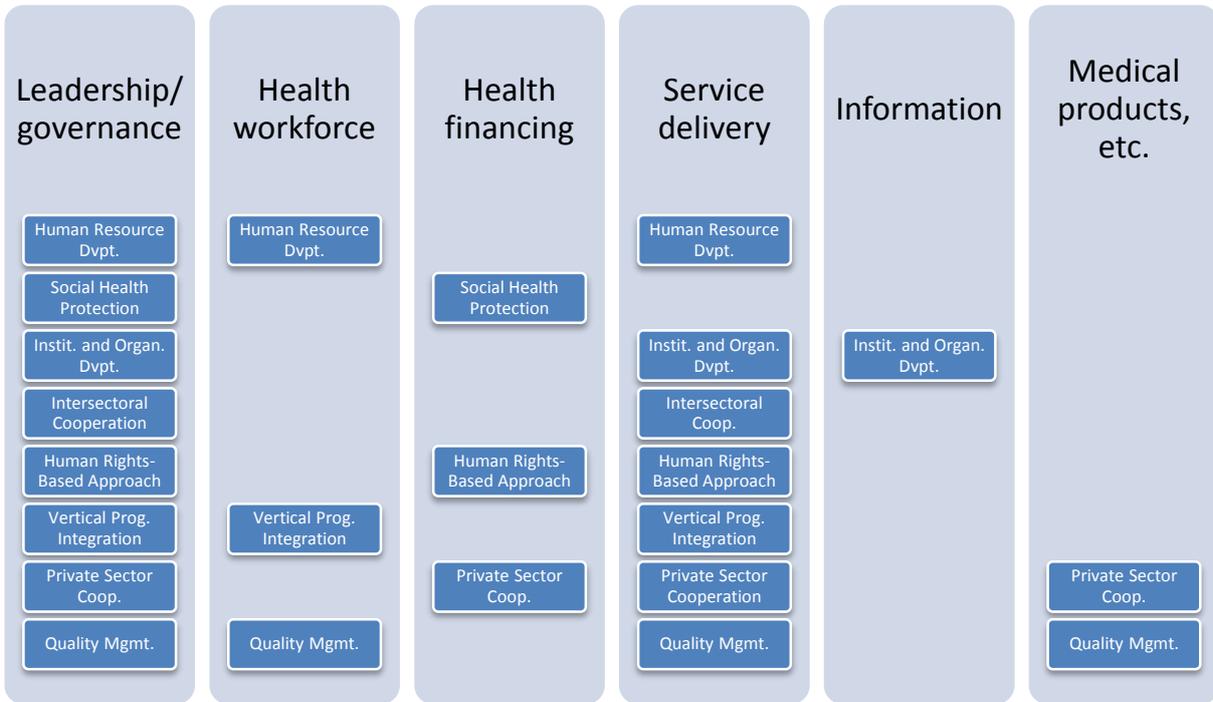
integration of vertical programmes at strategic and planning level has taken place by integrating SRHR and HIV in other focal areas, such as quality management.

➤ Given the importance of inter-sectoral cooperation for the overall progress of global health, and its frequent mention as a cross-cutting approach in GDC health strategies, the lack of attention paid to it in country strategic documents is noteworthy.

#### 4.5 WHO HSS framework applied to GDC approach

Using the results from both levels of analysis (GDC strategic level and partner country level), Figure 4 organises the GDC focal areas and cross-cutting approaches for HSS into the health system building blocks of the WHO framework. Because these results are based on strategic and planning documentation, this exercise evinces hypotheses that might be tested during an evaluation of HSS at the implementation level.

Figure 4. GDC pursuit of HSS categorised by health system building blocks



Source: Author

Note: The relevance of each focal area or cross-cutting approach for HSS, as defined in the analyses of GDC health strategies and partner countries, is categorised according to health system building blocks.

The building blocks leadership/governance, health workforce, health financing and service delivery are seemingly the most important, with the remaining building blocks not benefiting as greatly from the GDC approach to HSS. Furthermore, this building blocks categorisation suggests that the private sector cooperation and quality management are related to the most building blocks and thereby deal most comprehensively with the health system.

## 4.6 Concluding analysis

As evident from the analysis of both the GDC strategic documents and the country strategic and planning documents, HSS is mainly defined through the support GDC provides to specific focal areas supplemented by cross-cutting approaches. Although these focal areas and cross-cutting approaches all have ties to the health system building blocks, the strategic documents do not yet convey a broader image of HSS from a systems perspective. This would entail paying more attention to the dynamic of interactions across the focal areas or health system blocks and with the environmental context.

The focal areas and cross-cutting approaches found in the GDC strategic documents have been largely substantiated by the country-level analysis. Although not all of the analysed country partnerships in health took HSS into specific consideration, the majority touched on various building blocks of health systems and their respective strengthening. However, clear interfaces to HSS are normally not defined. The specific focus of GDC support to HSS differs according to the country-specific context. The findings of the country-level analysis suggest that HSS is potentially adapted to the context and situation of each respective partner country. Confirming this would entail a comprehensive analysis of programme documents (including part B of the joint programme proposals), examining the relationship and negotiation process between the GDC and its partner countries, studying the coordination with other bilateral and multilateral donors, and analysing the environment and health system of the respective countries.

Of the focal areas and cross-cutting approaches analysed in the context of HSS, social health protection and institutional and organisational development of national health systems were the most frequently observed within partner country strategic and planning documents. Human resource development and quality management were the next focal areas mentioned in terms of frequency. Additionally, quality management was a focal area in several country strategic documents and related explicitly with HSS, yet was not addressed within the GDC central strategic documents.

It is interesting that for all the focal areas and cross-cutting approaches analysed, private sector cooperation was most often mentioned explicitly in the context of HSS. This correlates well with the GDC position on a health system comprising both public and private actors (BMZ, 2009b). Though specific interventions for private sector cooperation were not always detailed, usual interventions listed included strengthening of regulatory frameworks for the engagement of private health care providers and support to public-private partnerships.

Vertical programme integration was only mentioned and related to HSS in the sub-Saharan context, where integration of HIV and SRHR in other focal areas, such as quality management, was a constitutive element of a few joint health programmes.

Inter-sectoral cooperation plays a very marginal role at the country strategic level. Inter-sectoral cooperation is clearly identified by the GDC central strategic documents as an essential component of HSS, and the lack of priority given to it by the country strategic and planning documents shows a potential window of missed opportunity.

## 5 Further health systems strengthening research and evaluative work

The present desk study has substantiated the premise that the demand for further research and the creation of an evidence base in HSS is great. Both in the international community as well as the GDC, there are few evaluations that approach HSS as a holistic concept. Although HSS is a priority of the GDC in the health sector, a focused evaluation of GDC engagement in HSS has not yet been conducted. Systematic considerations of HSS were also found to be infrequent in country and programme evaluations.

Research on HSS in the context of the GDC could potentially go in many directions. Both a large-scale evaluation of GDC efforts in HSS and more focused evaluations on specific aspects of HSS would be relevant. In both cases, an evaluation of GDC engagement should seek to further define and structure this engagement in the hopes of producing guidance for an HSS strategy, and contribute to a conceptual framework for HSS that would aim to improve HSS implementation and M&E. Doing so would not only give structure to the HSS work of the GDC and optimise opportunities to integrate HSS within individual health programmes and projects (and perhaps outside the health sector), but it would also contribute to the international discourse on HSS evaluation and research.

The analysis at the country strategic level undertaken in this study confirms the need for the GDC to specify its understanding of the linkages between building blocks and their respective pathways towards HSS. Though it is likely that the majority of health interventions will remain focused on single/two building blocks, it would be appropriate to systematically incorporate systems' thinking into these interventions. Doing so will require a clear understanding of the systemic impacts, both positive and negative, of particular health interventions.

The following sections detail HSS research gaps as identified in the literature review, and considerations necessary for future work on HSS, particularly in the GDC context.

### 5.1 Research gaps

Based on the findings of the literature review, as well as an abundance of academic literature on the need for HSS research, a number of important evaluation gaps have been identified.

#### The need for systems thinking

Of importance for the design and evaluation of HSS interventions is the explicit application of systems thinking, and respective designs that account for the intervention's effects across multiple building blocks (Adam and de Savigny, 2012; Willis *et al.*, 2012). In a review of 106 evaluations of HSS interventions conducted by Taghreed Adam *et al.* (2012), only 43% addressed broad research questions to allow for a comprehensive assessment of the intervention's effects across multiple building blocks. Of these, none incorporated evaluation designs that took into account the characteristics of complex adaptive systems such as non-linearity of effects or interactions between building blocks. The importance of taking a systems approach in HSS evaluations is exemplified by a recent study by Mutale *et al.* (2013) of the systems thinking approach in Zambia, which assessed the baseline status of HSS organised by the WHO building blocks. Results showed that weaknesses relating to individual building blocks had cross-cutting effects on the others.

Both the review of GDC evaluations as well as the analysis of joint programme proposals also showed the need to set HSS measures and those addressing single building blocks in a broader systemic perspective, thus giving more room to the assessment of cross-cutting and non-linear effects on the health system.

### **The need to standardise methods for HSS assessment**

In the context of health systems research, there is consensus on the need to standardise methods and measures for HSS assessment.

The literature review undertaken in this desk study supports this view, as many of the reviewed evaluations clearly expressed the problematic aspects of HSS evaluation. Examples of this include the GAVI evaluation being hindered from observing outcome and impact, and the European Commission thematic review being unable to present evidence in terms of how far health systems were themselves strengthened. Adding to this dilemma, health cooperation efforts from the UK were found to lack performance indicators for HSS, although it has been possible to estimate funding for and follow the direction of DFID's contribution to HSS in partner countries. In parallel, the review of HSS strategy in the US indicates a need to measure the outcome of its contribution to HSS, and calls for increased rigorous, external impact evaluations of US-supported health projects. These evaluations and reviews point in unison to the importance of the continued development of health systems research, and particularly the need for evaluation tools and methods suited for HSS.

The review of GDC evaluations confirms the need for a more standardised approach to grasp the health system effects of both vertical and cross-cutting health-related interventions.

### **The need for a stronger knowledge base on effective HSS interventions**

Furthermore, there is need for a stronger knowledge base on effective interventions for HSS (Barber, 2007). The need to identify keystone interventions that have the greatest system-level impacts for the cost-effective use of funds has also been strongly emphasised (Warren *et al.*, 2013). The current multi-country evaluation of African Health Initiative, which began in 2009 and runs until 2017, intends to produce evidence in this direction.

With regard to GDC, focal areas as constitutive elements of the HSS approach have already been defined. Assessing the multiple effects of support to these focal areas on the health system in and across partner countries would help to identify and elaborate keystone interventions, thus developing further the GDC approach to HSS. Such research would imply going beyond the assessment of policies and strategies, touch upon implementation and reflect the country-specific contexts. As the analysis in the next chapter will reveal, the focal areas of human resources for health and social health protection within the GDC approach to HSS are prime subjects for evaluation that would potentially contribute to elaborate keystone HSS interventions in the GDC context.

### **Establishing evidence on vertical programme integration**

Thus far, research on the impact of vertical disease initiatives on HSS and vertical-horizontal synergy have been lacking (Berman and Bitran, 2011) or, at best, inconclusive (Mounier-Jack *et al.*, 2014).

More importantly, experimental methods that would enable evidence on integration and complex health systems are lacking (Béhague and Storeng, 2008).

The literature review also showed advantages for both vertical and horizontal health programming with respect to the context of a given situation or programme. Evidence suggests that the direction of the effects of vertical programmes on health systems is not clear. In a review of country-level evidence, Biesma *et al.* (2009) found both positive and negative effects. Atun *et al.* (2008) establish the understanding frequently expressed among experts on the nuanced effects of vertical programming on health systems, and the need to understand the context in which they function.

A number of country evaluations in this literature review approached the topic from the opposite angle, where they looked at the impact of HSS interventions on *specific groups* (mostly mothers and children) or *specific building blocks of the health system* (service delivery or health workforce) and found mostly positive results. With a few exceptions (KfW, 2011; Haenssger and Nohr, 2012) of the German evaluations included in this literature review, the project or programme evaluations neither looked at integration of vertical programming, nor did evaluations of vertical programming give particular consideration to their impact on health systems.

Given the variety of ways to integrate vertical programming into health system-oriented programming, it is acknowledged that such approaches are almost always unique to the actor, making it difficult to standardise assessment and evaluation (Barber, 2007). In particular, measuring the impact of HSS through specific vertical interventions is a time and resource-intensive process that often requires supplementary data collection and analysis in order to understand alternative influences on measured outcomes and to rule out confounding factors. As this literature review has also shown, the highly diverse means of vertical programme integration indicate the need for donors to identify means of measuring the impact and success of integration regarding their own programming. This is reflected by the GIZ health meta-evaluation in 2013, which recommended the development of an integrated approach between its activities in HSS, HIV/AIDS and SRHR. Furthermore, the methodology proposed in the KfW thematic analysis on the side effects of targeted health interventions (Haenssger and Nohr, 2012) could be developed and used for evaluations of the integration and effects of vertical programmes on the health system.

### **Coverage of HSS within GDC evaluations**

Although HSS is a priority of the GDC health strategy, it is found relatively infrequently as a topic of evaluation in the scope of GDC work in health. As the literature review indicated, a number of project and programme evaluations have addressed specific focal areas and building blocks of the health system. HSS has featured centrally in the two most recent larger-scaled evaluations, however, including the GIZ meta-evaluation in health and the DEval evaluation of 30-years of Rwandan–German development cooperation in the health sector. The meta-evaluation recommended exploration for the integration of HSS with the other two focal areas of the GDC health strategy, HIV/AIDS and SRHR. In the Rwanda evaluation, it was highlighted that although coverage and access to health care services had improved through the GDC contribution, improved health outcomes resulted in a large part from vertical programmes mainly funded by other donors and outside the sector-wide approach. This also indicated the need for a more in-depth assessment of the complex

relationships between vertical and horizontal approaches to support the health system. Despite these evaluations, a comprehensive evaluation of the GDC pursuit of HSS across partner countries is lacking.

## 5.2 General considerations for HSS research for the GDC

Given that approaches to studying health systems and their strengthening remain varied and highly specific to context, formative research has been recommended as a potential way to systematically pursue HSS research and evaluation. Formative research would enable the identification of categories or building blocks most relevant to an actor's engagement with HSS, and would adapt the WHO HSS building blocks framework according to the context and activities of the actor (Mounier-Jack *et al.*, 2014). A similar process was followed by GAVI in its evaluation of HSS support: a five-country tracking study prior to the evaluation highlighted key areas for investigation in the evaluation, as well as potential difficulties that would be faced. The present desk study also undertakes a step in the direction of formative research, as the strategic orientation of the GDC in its engagement with HSS has been laid out. Formative research within the GDC pursuit of HSS could potentially be continued by taking this desk study's analysis further. This would imply analysing part B of joint programme proposals and assessing the implementation of interventions in support of HSS within a range of selected partner countries. Potential questions might include:

- How does the country-specific context and cooperation with other stakeholders influence GDC's engagement with HSS?
- What are the keystone interventions of GDC support to HSS across countries?
- What are the multiple effects of HSS interventions on the building blocks of the health system and on health outcomes?
- How do health interventions focused on single building blocks relate to HSS, and what impact do they have on other building blocks?
- Which interventions have the greatest system-level effects?
- To what extent does HSS support promote equity?
- How can the GDC best measure its contribution to HSS?

Whether steps are taken to improve current M&E practice in health or it is decided to support an evaluation of GDC efforts in HSS, it is necessary to adopt systems thinking to adequately address the complex nature of health systems (Marchal *et al.*, 2009; Adam and de Savigny, 2012; Swanson *et al.*, 2012). In particular, Adam *et al.* (2012) argue for conducting comprehensive assessments of system-wide effects, both within and outside the health sector.

While there have been a number of efforts to measure and assess health systems *performance*, the means to evaluate health systems *strengthening* remain few (Annex 4 provides frameworks dealing with both). Analytical frameworks used in HSS evaluation from a donor perspective limit the pool even further. However, depending on how a donor-supported HSS intervention is focused and designed, it is possible to utilise health system performance indicators and means of assessment in an HSS evaluation design. This has been done in the GAVI evaluation (HLSP, 2009), the African Health Initiative evaluation (Bryce *et al.*, 2013), and the country evaluations covered in this desk study. As seen in the GAVI and African Health Initiative evaluations, key sets of core indicators at the

intersection of the health system and the respective health focus of the actor (i.e. SRHR and HIV/AIDS in the case of the GDC) can be agreed upon through a consultative process, and assessed respectively across country cases.

A step in this direction has already been undertaken with the indicator compendium published by GIZ in cooperation with KfW (GIZ, 2012d). This resource systematically lays out the differentiating factors of various health indicators and gives comprehensive guidance on data collection for each. Furthermore, it largely reflects the indicators used in the central HSS M&E documents published by the WHO, thereby aligning GDC efforts for HSS with other global health actors.

Future research and evaluative work in health systems that would particularly benefit the GDC could potentially utilise the indicator compendium to analyse HSS interventions within countries. This would enable the analysis of HSS interventions according to country context and categorise them within the WHO building blocks framework. Thereafter, it would be possible to select core indicators addressing each building block that are relevant for the GDC. Additionally, a range of non-core indicators for each building block might also be applied according to context and framework conditions of the partner country. This exercise would enable a step towards the standardisation of HSS within the GDC and enable the creation of a conceptual framework to guide HSS planning, through which to regularly monitor HSS interventions within countries and effectively evaluate GDC efforts in HSS.

An example of such a process at a more focused level can be seen through the analysis of human resource development for health, which has been identified in this desk study as a focal area within both the GDC strategic documents and within the planning documents of several partner countries. Specifically, it was found to deal primarily with the building blocks of leadership/governance, health workforce and health services. In order to build on this information, HSS interventions that focus on human resource development could be investigated in partner countries with this focal area (Malawi, Cambodia, Pakistan and Tanzania). Such research would necessitate the consideration of country context and system-wide effects and impacts, both within and outside the health sector. This would potentially build off of the existing indicator compendium in the GDC and lead to the identification of core indicators for the focal area of human resource development for health that are tailored to the GDC context. Such a process would thereby contribute to improved M&E for HSS, as well as improve the evaluability of HSS in the future.

HSS research and evaluative work in the context of the GDC could potentially go in a multitude of directions. However, it is clear that future analysis of GDC engagement with HSS should seek to further define and structure this engagement in the hopes of producing guidance for an HSS strategy, develop a theory of change for evaluating HSS, or contribute to guidelines and core indicators for an M&E system for HSS. Doing so would not only give structure to the GDC's HSS work and optimise opportunities to integrate HSS within individual health programmes and projects (and perhaps outside the health sector), but it would also contribute to the international discourse on HSS evaluation and research.

**Research question VI: In the context of the GDC, where are the HSS research gaps and what general considerations should be taken for the assessment of HSS in the future?**

- This desk study has revealed the need for a standardised approach to assess the health system effects of GDC interventions in the health sector. Although GDC has taken important steps towards measuring health systems performance and developing core sets of indicators, analytical frameworks and methods to evaluate HSS are still lacking.
- HSS evaluation and research gaps identified in the literature review include: the need for systems thinking and standardised methods to assess HSS, the need for a stronger knowledge base on keystone HSS interventions, the establishment of evidence on vertical programme integration and more comprehensive coverage of HSS within GDC evaluations.
- General considerations for HSS evaluative work and research in the context of the GDC include: continuing the formative research that this desk study has begun, increased systems thinking and identification of core indicators for HSS tailored to the GDC context.
- Increased systems thinking would set HSS interventions in a broader perspective, thus giving more room to the assessment of cross-cutting and non-linear effects on the health system.
- These efforts would contribute to the construction of a conceptual framework for HSS within the GDC, which could be used for planning of health programmes and interventions within countries, as well as regular cross-country monitoring of HSS interventions.

## 6 Conclusions

HSS has increased in importance over the past decade and will remain high on the health agenda, as well as within the overarching development agenda. Accordingly, it was one of the priority topics for health in the 2015 G7 Summit. Given the high priority allocated to HSS within the GDC and the central role of HSS in achieving goals in health and other sectors, which is acknowledged by the global health community, it is evident that the GDC needs to further develop and refine its engagement.

Within international practice HSS is neither standardised nor approached in a categorical or systematic way within the GDC. These circumstances increase the risk of HSS being used as an all-encompassing topic for a variety of activities in the health sector, regardless of whether they strengthen health systems or not. Doing so can deem the concept of HSS ineffective, and decrease the value of HSS as a subject on the global health agenda.

GDC has made important steps in defining its approach to HSS. These include the identification of focal areas for HSS and of a core set of indicators to measure HSS interventions. However, the review of evaluations and strategic documents reveals the need for a more systematic approach to design and assess HSS. This would entail going beyond the description of structural elements of the health system to identify interactions between these and with the broader social and political context. It would enable GDC to better evaluate its contribution to HSS and to improve its HSS practices. In order to avoid the risk of letting HSS become a “container concept”, it is necessary for the GDC to structure its approach to HSS and ultimately enable HSS objectives to be met. More evidence and guidance is necessary to systematically reflect the dynamic of HSS in GDC health programmes and improve M&E frameworks. To this end, a comprehensive overview of what GDC-supported HSS looks like at the implementation level is necessary.

The analysis undertaken in this desk review identifies several focal areas and cross-cutting approaches relevant to the GDC pursuit of HSS. Among them, social health protection, institutional development, human resource development and quality management are largely cited within country planning documents. However, vertical programme integration and inter-sectoral cooperation, which were important elements of HSS identified in central strategic documents of the GDC, were not found in connection to HSS within country planning documents. Given the importance of these two factors for HSS, the lack of planning for their inclusion in HSS efforts in country strategic documents should be borne in mind when undertaking HSS operational research. In particular, inter-sectoral cooperation plays a decisive role for health development, as there is increasing evidence of the beneficiary effects of health investments on other sectors. Defining potential areas of inter-sectoral cooperation and identifying new ones will also be possible through the suggested research and evaluation of HSS at an operational level within countries.

Among focal areas and cross-cutting approaches for HSS, cooperation with the private sector was most frequently found to relate explicitly to HSS within country strategic documents. Furthermore, the application of this cross-cutting approach applies widely across the health system building blocks from the WHO framework. This also applies to the cross-cutting approach of quality management. Both of these approaches will be essential for future HSS assessment and have the potential to contribute to a GDC framework for HSS.

Of immeasurable importance for the GDC in further developing its HSS work is a means of methodologically sound assessment of its engagement with HSS. Although this is a difficult task for HSS relative to the other priority areas of the GDC health strategy, it is all the more necessary to ensure that HSS objectives are being met, and to verify that GDC health programming is indeed *strengthening* health systems. To this end, the research which has begun in this desk study would need to be continued on an operational level by taking into account country-specific contexts. This research should aim to elaborate interactions between building blocks and the impact of the focal areas and cross-cutting approaches for HSS resulting from this study. In the attempt to build a GDC conceptual framework for HSS, indicator selection will also be a necessary step – one which has already begun through the publication of the GDC Indicator Compendium. Building on these efforts in the specific context of HSS will allow the building of a systematic approach to HSS, which would benefit both the GDC investment in health and the M&E of HSS in the GDC context.

The pursuit of HSS is neither straightforward nor universally applicable. However, it is an essential element for sustainable development and is increasingly recognised as such as the international community responds to epidemics, natural disasters, and other global events. The opportunity for the GDC to reflect on how it can take stock of its HSS efforts with the aim to improve its investments in health and contribute to development across all sectors is not only timely, but necessary as well.

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## 8 Annexes

### Annex 1: Methodology for literature review

The literature review in this desk study sought to answer the first three research questions:

- Why is HSS important and what has led to its current role in the global health arena?
- How has HSS been evaluated by the international donor community?
- How has HSS been addressed in previous GDC evaluations?

The search for literature pertaining to the first two questions was done in June 2014. Eleven databases were used in the search, including conventional evidence databases of 3ie, Campbell Library, Cochrane, Organisation for Economic Co-operation and Development (OECD), Department for International Development's (DFID's) Research for Development Database, and Evidence for Policy and Practice Information and Co-ordinating Centre. The following health-specific databases were also used in the search: BioMed Central, McMaster University's Health Systems Evidence Portal, and the National Center for Biotechnology Information PubMed. Search terms included "health systems" and "health systems strengthening". A total of 2 346 hits were found. Search results were narrowed down by selecting for articles, evaluations, studies, and reviews that were published in or after 2007 and:

- Dealt primarily with the topic of health systems strengthening, OR
- Dealt with at least two health system building blocks, OR
- Took a systems-oriented analytic perspective.

The following exclusion criteria were also applied:

- Literature having dealt with predominantly upper or upper-middle-income countries
- Literature that focused heavily on vertical or target-specific health interventions (i.e. HIV/AIDS, polio, child health, etc.)

A total of 68 articles met the criteria and were included in this desk study. Citation tracking within these selected articles increased the total number of articles reviewed for this desk study to 90, of which 11 were HSS evaluations and reviews.

The year 2007 was chosen to be a part of the criteria because it was the year of the publication of the WHO health systems building blocks framework, which was a seminal framework and internationally used tool for HSS thereafter. It is acknowledged that an evaluation of an HSS programme published in 2007 may not reflect influence of the building blocks framework. However, the earliest evaluation found meeting the search criteria for this literature review dates to 2009, which suggests that interest in the evaluation of HSS (as defined by the WHO) seems to have grown after the period around 2007.

In searching for evaluative work on HSS within the GDC (third research question), a different approach was taken. In a first step, 46 final and *ex post* health project and programme evaluations

published between 2007 and 2012<sup>10</sup> were analysed for content on or related to HSS (defined as addressing at least two of the health system building blocks) or the explicit incorporation of systems thinking. The year 2007 was chosen as the cut off to stay consistent with the review of international evaluations in HSS. In the majority of the 46 evaluations, only the short evaluation reports were available, meaning that additional content in the longer evaluation reports has not been included for consideration in this desk study. These evaluations were taken from the KfW website and the complete inventory of health project and programme evaluations from GIZ made available to the researchers.

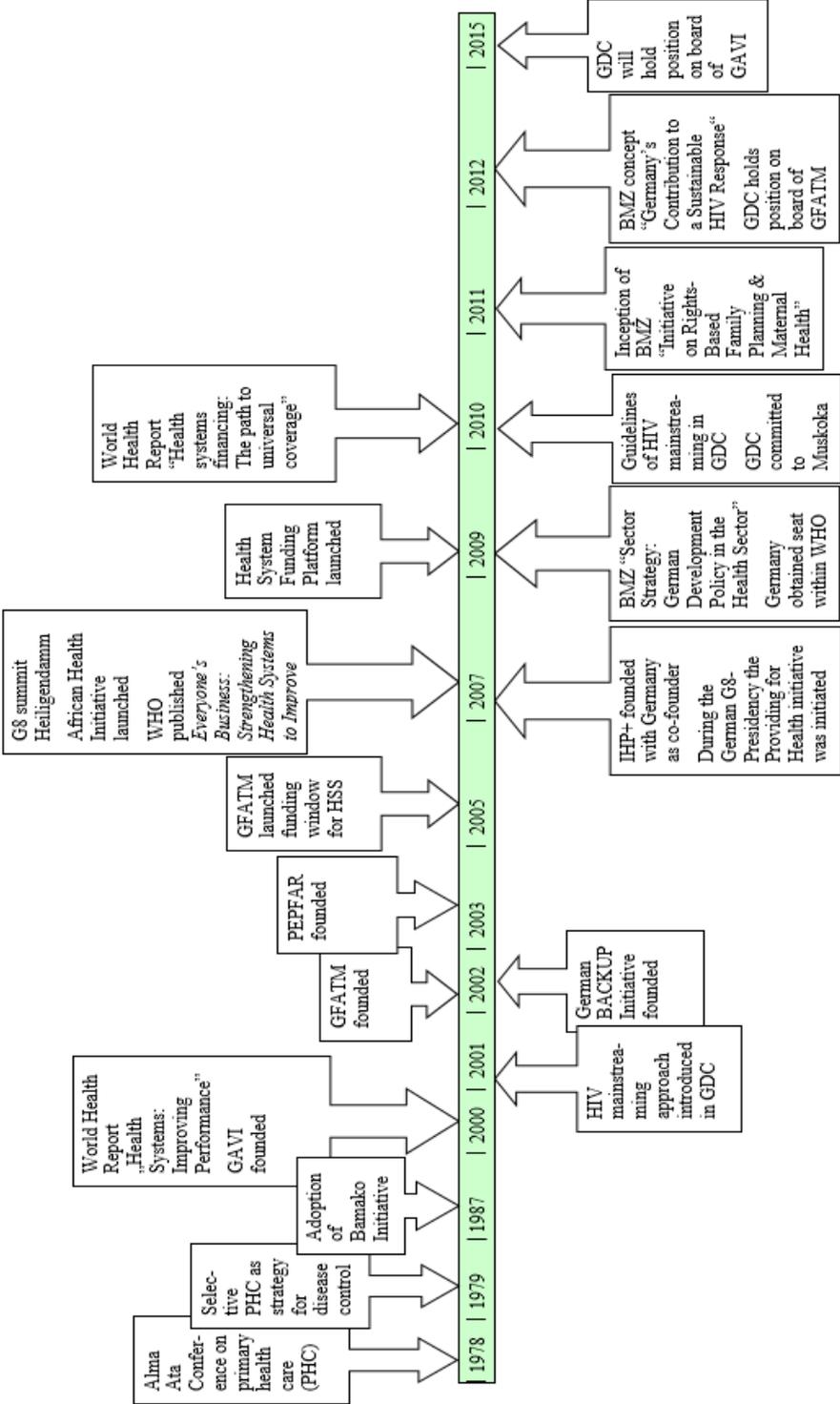
In addition, one GIZ meta-evaluation in health, one KfW thematic evaluation, one joint external evaluation of the health sector in Tanzania, and two country sector evaluations (India and Rwanda) were included in the review.

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<sup>10</sup> At the time of analysis, only evaluations up until 2012 were available.

**Annex 2: Timeline of international and GDC events related to HSS**

Figure 5. Timeline of international and GDC events related to HSS



Source: Author

Note: International events are on the top of the timeline, and GDC events at the bottom. New developments made at the end of 2015, such as the 200 million EUR GDC commitment for HSS and the Healthy Systems – Healthy Lives Initiative, are not shown.

### **Annex 3: Detailed information on GAVI and African Health Initiative HSS evaluations**

#### **GAVI**

When GAVI began its HSS funding window in 2005, it was reacting in part to the realisation that certain health system bottlenecks were preventing the fulfilment of their own programmatic goals. Although GAVI's HSS programming had not been running for more than three to four years at the time of the evaluation, the evaluation was commissioned in order to inform future funding decisions and improve implementation.

The 2009 GAVI evaluation was preceded by a HSS tracking study, which aimed to provide real-time evidence regarding the technical, managerial and policy processes for implementation of GAVI grants for HSS. Furthermore, it was intended to provide recommendations and considerations for the evaluation that was to follow.

The evaluation questions were strategic in focus, exploring the strengths and weaknesses of GAVI's HSS policy at regional and global levels, as well as the value added of GAVI funding for HSS in comparison with other donors.

Due to HSS programming being relatively new to GAVI at the time of the evaluation, outcomes and impacts were not assessed. Rather, the evaluation framework focused on inputs and outputs in an effort to better understand HSS activities in countries, better adapt GAVI's HSS programming and enable better conditions for evaluation in the future.

A total of 21 countries across Asia, Africa and Latin America were included in this evaluation. Of these, 11 were explored through in-depth case studies, and 10 through desk studies. The indicators used in this evaluation varied by country, but always included diphtheria-tetanus-pertussis (DTP3) coverage, coverage of immunisation services, and under-five mortality – which are the indicators required for all GAVI HSS programmes. These country studies were accompanied by qualitative interviews and document analysis. Country selection was done through purposive sampling for longer-term presence of HSS programming.

Results of the evaluation highlighted a number of process-related issues for GAVI HSS funding, as well as problematic aspects of an outcome or impact-focused HSS evaluation. Detailed country case studies indicated that finding a causal link between HSS inputs and outcomes or impacts in the health system are and will continue to be extremely problematic, and rigorous attribution of national level changes to GAVI HSS programming will be impossible. This is due, in part, to the following reasons: GAVI is one of a number of actors active in HSS in all countries considered; funds from GAVI may only support some components necessary to achieve change in a specific outcome; and GAVI HSS funding does not support a standardised intervention that can be compared across countries. In this context, it was suggested that a common HSS assessment be used across all countries, and there was an urge for donor harmonisation and country alignment. Nevertheless, it was concluded that GAVI's HSS funding increased the demand for HSS from low-income countries and the funding of innovations of that might not have been supported otherwise.

## African Health Initiative

Supporting partnerships that design, implement and evaluate large-scale models of care, the African Health Initiative aims to put advances in HSS into effect. The aim of the African Health Initiative at its founding in 2007 by the Doris Duke Charitable Foundation was to shift focus from vertical disease initiatives to HSS and integrated primary health care. The evaluation focuses on five countries (Mozambique, Rwanda, Zambia, Ghana, and Tanzania) and aims to generate cross-country evidence in HSS that is widely applicable.

The African Health Initiative Collaborative decided to evaluate the initiative as a whole post hoc, meaning that a standardised methodology could not be applied to all countries in the evaluation. However, the evaluation framework is based on that of the IHP+, with the added advantages of including contextual factors and implementation strength as potential determinants of progress in the causal chain (Bryce *et al.*, 2013).<sup>11</sup>

This multi-site evaluation utilises a number of evaluation methodologies, with each country's methodology adapted to its respective health partnership supported by the African Health Initiative. For instance, the partnership in Tanzania implemented a cluster-randomised control trial. Consequently, household surveys in project and "comparison" areas are analysed and supplemented by contextual information, such as the documentation of the intervention implementation and donor coordination (Bryce *et al.*, 2013). It is expected that the African Health Initiative will collect the endline data across all sites by 2017.

Metrics for the African Health Initiative evaluation were selected in a highly consultative process and organised according to the conceptual model. Indicators were drawn from various health systems frameworks as well as from frameworks targeted for specific health purposes (i.e. MDG target indicators, Countdown to 2015 for Maternal, Newborn and Child Survival). These indicators were then matched to the partnership activities in the five countries. Equity is also being considered in this evaluation by disaggregating core metrics by wealth quintiles.

In Zambia, the evaluation is utilising the balanced scorecard approach. Acknowledging the complexities of health systems and system-wide barriers to health, the balanced scorecard approach has been revamped as a response to the overwhelming majority of evaluation designs that are too narrow and lack a systems perspective. Balanced scorecards assess multiple domains within health systems, thus enabling a focus on the overall vision of the health system with its interrelated aspects while also considering the processes that are important in achieving overall goals (Mutale *et al.*, 2013).<sup>12</sup> The balanced scorecard approach has also been suggested by the WHO for HSS evaluation (WHO, 2010), has been utilised to monitor health care delivery in Afghanistan (Peters *et al.*, 2007) and a number of other countries on a district level (Bouland *et al.*, 2011; Edward *et al.*, 2011; El-Jardali *et al.*, 2011; Jeffs *et al.*, 2011). Thus far in the evaluation, results show a significant difference between control and intervention sites in the training, adult clinical observation and health information domains (Mutale *et al.*, 2014).

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<sup>11</sup> See Annex 4 for more information on the IHP+ framework.

<sup>12</sup> For further information on the application of the balanced scorecard approach in evaluation of HSS, see Mutale *et al.* (2014).

## **Annex 4: Analytical frameworks for HSS**

HSS is rooted in a deep and extensive history within the development of global health. Methods of HSS analysis have also varied over time. This annex seeks primarily to address research and methodologies that arose after 2007, the year of a paradigm shift when the WHO concept of health system building blocks was published. Future evaluation efforts in HSS can draw upon this document as background to guide the establishment of a results framework.

### **WHO framework**

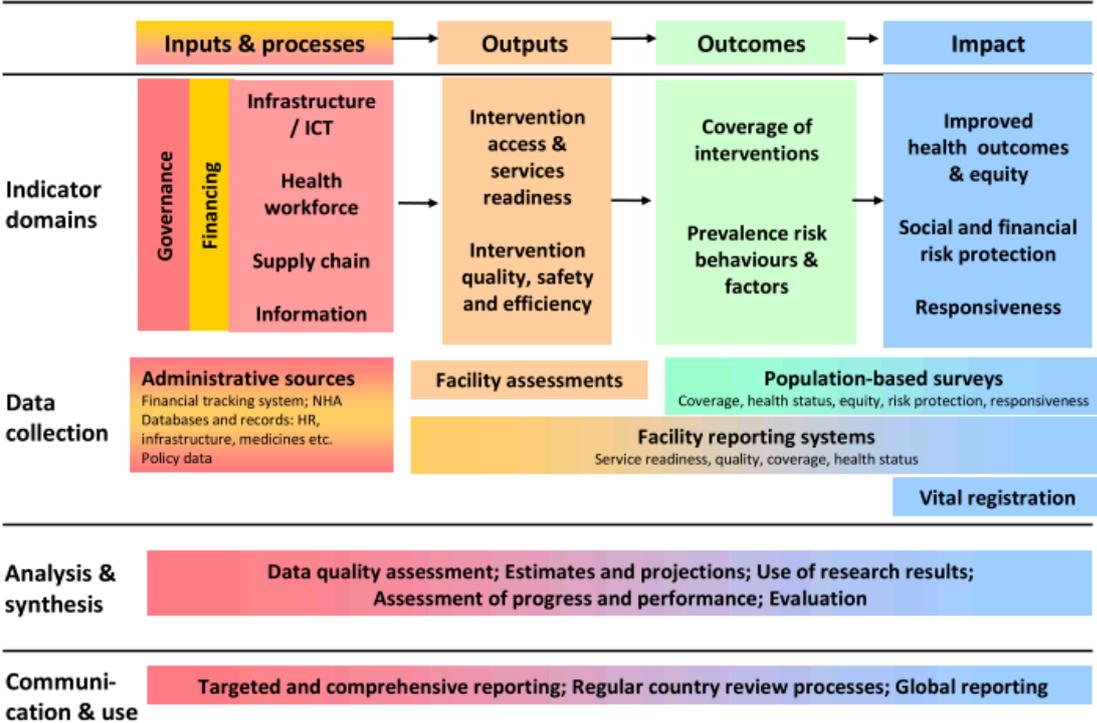
As the most frequently used framework for operational and research purposes for HSS, the WHO building blocks system presents the obvious advantage of providing a common and simple basis for researchers and policy makers alike (see Figure 1). However, it should be noted that the WHO building blocks were not intended as a framework for evaluation, but rather as an operational framework. Therefore, while it addresses the supply side of health systems, it remains largely silent on the demand side (Huff-Rousselle, 2013). Furthermore, interactions between building blocks and their weighting are essential in order to assess HSS, but are largely ignored within the traditional building blocks framework (Mounier-Jack *et al.*, 2014).

### **WHO/IHP+ framework**

The WHO has also produced another operational framework for M&E of HSS (see Figure 6) that has also been suggested for use in evaluation (Boerma *et al.*, 2009). The framework builds on the principles of the Paris Declaration on aid harmonisation and the common evaluation framework of the IHP+. It is primarily country focused and entails four major indicator domains: inputs and processes, outputs, outcomes and impact. An advantage of this framework is that it allows for several indicators to be consistently tracked across the entire results chain. However, it relies heavily on the assumption that countries have the necessary data sources, which are also reliable. The authors also note that because randomisation is not possible in HSS evaluation, stepwise approaches are often used to link trends in health outcomes (Boerma *et al.*, 2009). The model presented can map such an approach, and can be complemented by time series and dose response analyses.

While this framework can be used in country evaluations as well as by donors across multiple countries, its power to effectively do so will rely greatly on the health monitoring and information systems within countries. To this end, the country health systems surveillance platform (CHeSS) has been promoted as a means to improve the availability, quality and use of data needed to inform country health sector reviews. In doing so, it provides a platform for national and global reporting, enabling a common approach to country support and reporting requirements among partners at country and global levels (Boerma *et al.*, 2009). The actual use of this platform among IHP+ partner countries, however, has been limited.

Figure 6. Monitoring and evaluation of health systems reform / strengthening

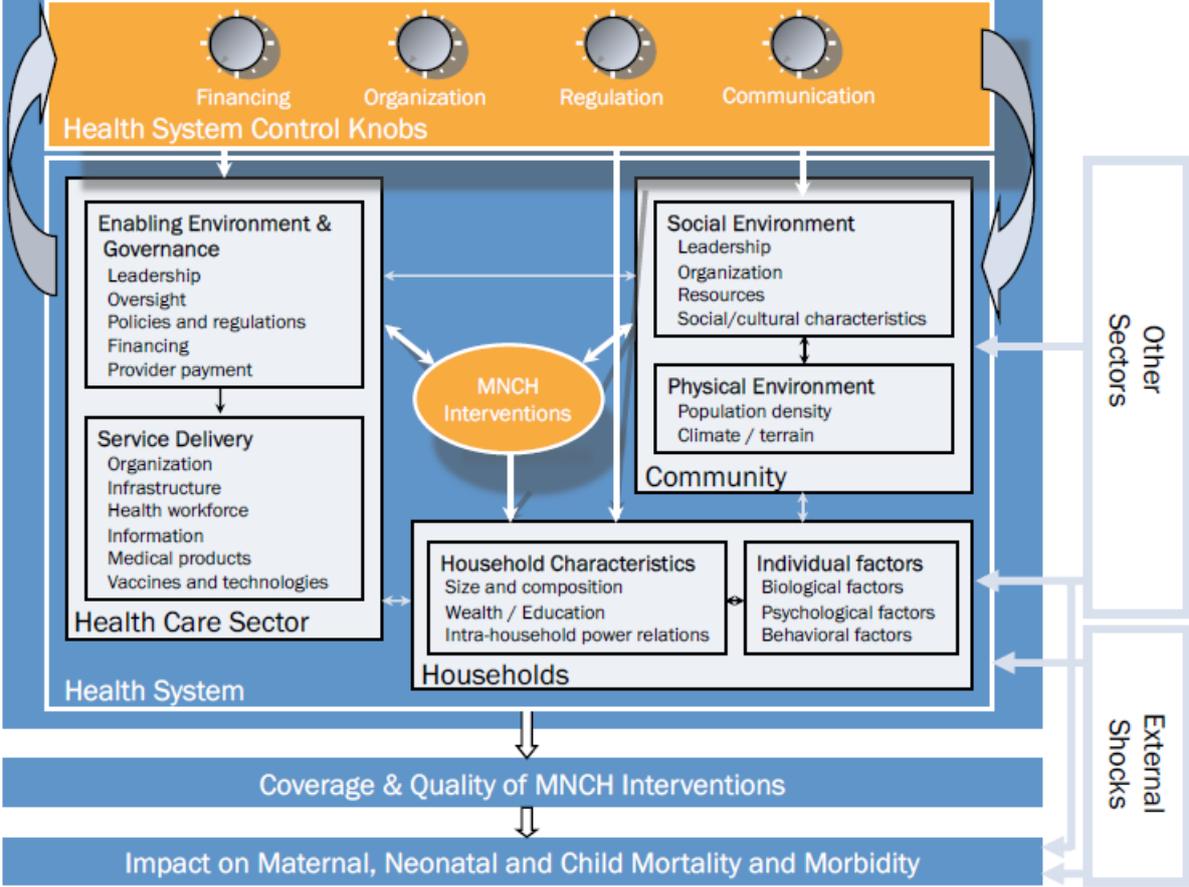


Source: Boerma *et al.* (2009)

**Control knobs in HSS / World Bank**

Along with the WHO building blocks and M&E framework in the HSS analysis debate is the concept of “control knobs” of health systems (see Figure 7). These knobs include: financing, payment, organisation, regulation and behaviour or persuasion (Roberts *et al.*, 2003). This model is more dynamic than that of the WHO building blocks, as it takes demand into consideration as well as supply through the important distinction between financing and payment (Huff-Rousselle, 2013). While this model takes a different perspective than that of the WHO, the two are not mutually exclusive and can be considered together in an evaluation design.

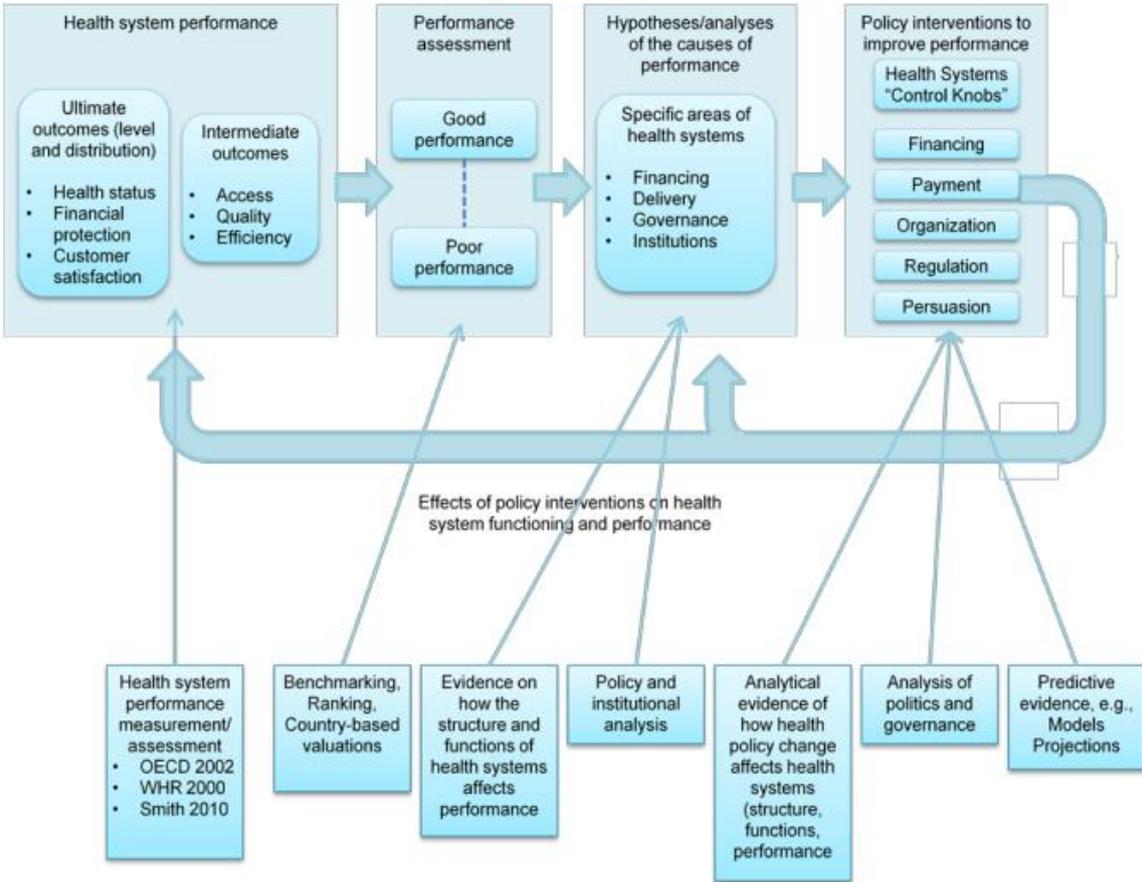
Figure 7. Control knobs framework as applied to maternal, neonatal and child health (MNCH) interventions



Source: Ergo et al. (2011)

The concept of control knobs of health systems was presented to the World Bank in 2003 and has since then been incorporated into the analytical work of the World Bank in health systems. A 2011 discussion paper reviews World Bank analyses in health systems from 2000–09, and recommends the adoption of “health systems analysis” as a distinct methodology to be incorporated in the design of policies and programmes for HSS, as well as for evaluating HSS interventions (Berman and Bitran, 2011). While health systems analysis is not backed by impact evaluation, World Bank experiences with this method have shown relatively great flexibility to accommodate for complexity and lead to better HSS interventions in Mexico, Turkey and Ethiopia. Although the approach of health systems analysis has varied by country, the following schematic in Figure 8 provides an overview of the logical structure that can be tailored to country needs.

Figure 8. The logic of health system analysis



Source: Berman and Bitran (2011)

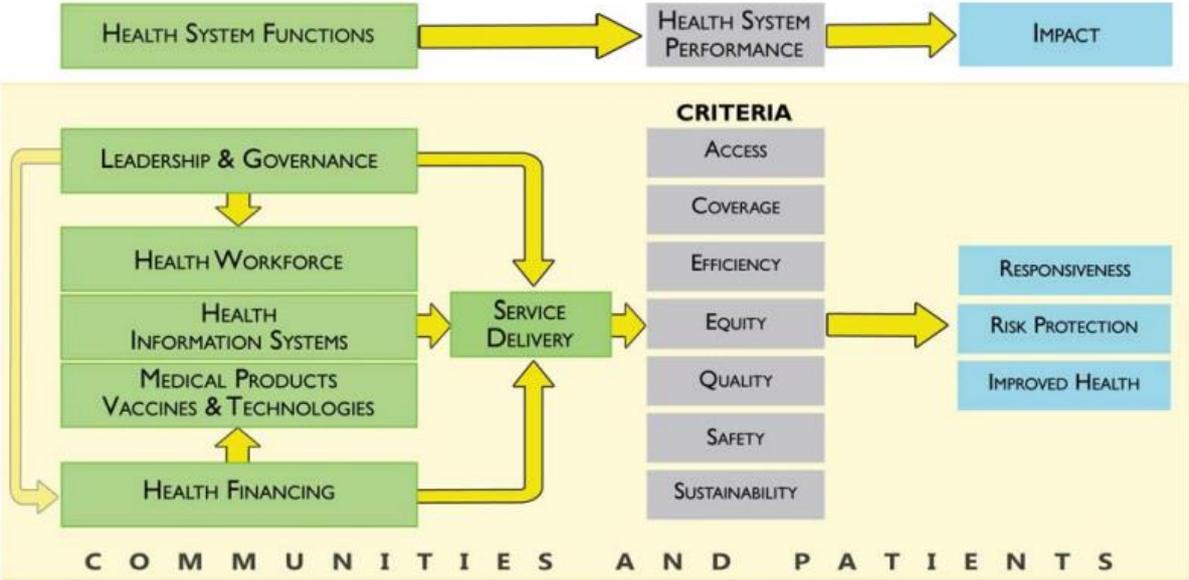
The top section of the framework presents the logic of health systems analysis and the bottom provides examples of methods and tools for each step of the logic. This method of analysing health systems is useful in conducting descriptive health system studies that build into situational or contextual assessments, and later lead to policy recommendations and health sector reform. It is also suggested that health systems analyses be conducted regularly, which would create an enabling environment for evaluation.

**United States Agency for International Development**

The United States has produced a number of publications on performance measurement and monitoring of HSS. Though the US government doesn't have a specific way of measuring progress in its HSS activities, it does identify several approaches to HSS and provides detailed information on means of achieving HSS within its aid activities (The US government, 2012). USAID also utilises and provides extensive guidance on the health systems analysis approach, which is based on the WHO building blocks model and explores the interrelated aspects of health systems (see Figure 9). Of note is the list of criteria in the health systems analysis methodology: access, coverage, efficiency, equity, quality, safety and sustainability. A comprehensive set of indicators are suggested for each of the

building blocks as well as detailed contextual information about each building block, the type of data that might be found, and potential sources of information (Health Systems 20/20, 2012).

Figure 9. Building block interactions (USAID)

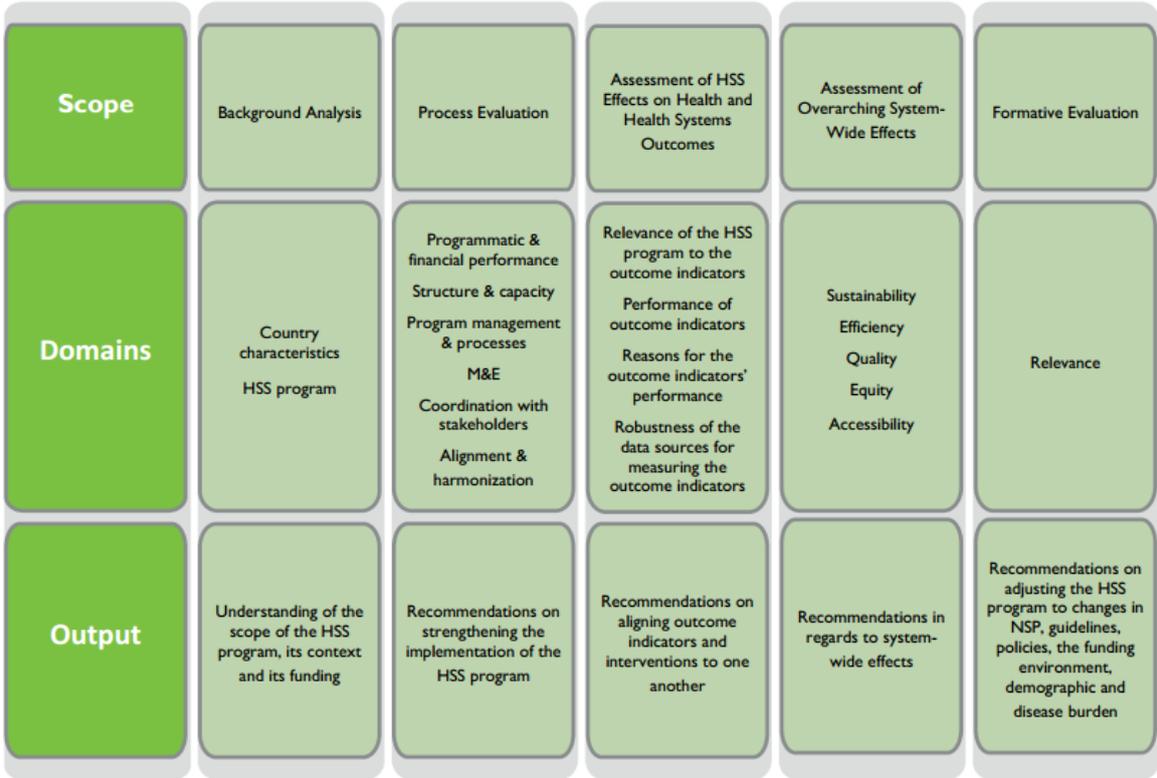


Source: Atun *et al.*, (2010)

**USAID / Global Fund**

A set of frameworks for HSS programme evaluation was also contributed by USAID to the Global Fund in 2012 for the purposes of assessing in-country HSS programmes. Figure 10 shows the various types of evaluation that can be done in this context, as well as their respective domains and expected outputs. The evaluation approach to assess HSS effects on health and health systems outcomes is covered most comprehensively and is supplemented with a template for HSS programme evaluation covering impact and outcome indicators. Though this framework is intended for the analysis of HSS programmes at a country level, it can be used to inform analysis of HSS implemented by donors at an international level as well, particularly in cases where individual country case studies are integrated in the evaluation design. Also of interest are the accompanying guiding questions which assess the system-wide effects of HSS programmes. These questions are organised within six service delivery areas, which reflect the six WHO building blocks.

Figure 10. Framework for HSS programme evaluation

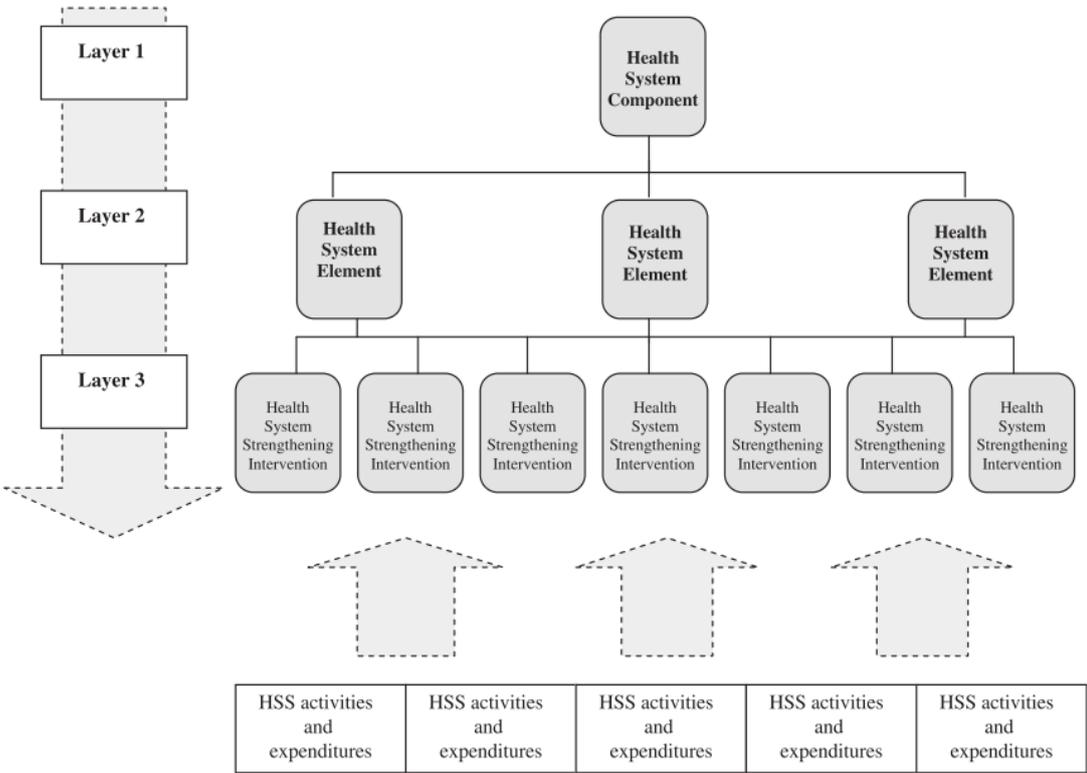


Source: Katz *et al.*, (2012)

**Donor investment analysis**

Shakarishvili, Lansang, *et al.* (2010) propose a HSS framework for investment analysis for donors. In this framework four health system components are proposed, which come directly from the WHO building blocks: health services (including supplies and workforce), health stewardship/governance, health financing systems, and health information systems (M&E). Within this model, each of these components can be broken down into health system elements, which are processes or inputs necessary for producing corresponding components. These elements are further broken down into corresponding HSS interventions, which can be defined programmatically (see Figure 11).

Figure 11. Structure of the proposed health system strengthening classification



Source: Shakarishvili, Lansang, et al. (2010)

**Diagonal approach**

The various types of HSS activities defined by Shakarishvili et al. (2010b) are also in line with the diagonal approach to HSS proposed by Ooms et al. (2008), where HSS and vertical health strategies (which are disease specific) are merged together. This has essentially enabled the definition of HSS to be stretched in order to also consider HSS activities of vertical initiatives (similar to disease-specific HSS as described by Shakarishvili et al.).

**Vertical programmes and HSS**

Similar in concept to a diagonal approach is that of the integration of vertical programming into health systems programming. The idea of affecting systemic change through vertical programmes is common among many actors in global health, including the GDC. Looking particularly at the case of Germany, Haenssger and Nohr (2012) proposed a methodology for examining impacts of vertical programmes on health systems using secondary data consisting of the identification of health system interfaces of the vertical intervention in question and selection of health system outcome or impact indicators emanating from the intervention. A control variable is established through the review of alternative determinants of the selected outcome. Necessary contextual and statistical analysis (i.e. through demographic health surveys) would then lead to results. Accompanying this methodology is a list of generic indicators categorised by health system interface. Such a methodology could be potentially useful for a low-resource analysis done without field visits.

## **Annex 5: References for indicators on HSS or health system performance**

- Alva *et al.* (USAID) (2009): Measuring the impact of health systems strengthening, pp. 19–20.
- Global Fund (2009): Monitoring and evaluation toolkit. HIV, tuberculosis, malaria and health and community systems strengthening.
- International Health Partnership+ (2014): Global reference list of core indicators for results monitoring. Outcome statement of the working group on indicators and reporting requirements.
- USAID, Health Systems 2020 (2012): The Health System Assessment Approach: A How-To Manual. Version 2.0.
- WHO (2010): Monitoring the building blocks of health systems: A handbook of indicators and their measurement strategies.
- WHO, World Bank, USAID (2009): Handbook on monitoring and evaluation of human resources for health with special applications for low- and middle-income countries.

## Annex 6: International HSS evaluations reviewed

Evaluation/review title	Countries in focus	Evaluation focus	Evaluation design and key methods
GAVI Health Systems Strengthening Support Evaluation	A total of 21 countries across Asia, Africa and Latin America	Impacts and outputs of HSS (outcomes and impacts were not assessed this time, as the HSS programming was still relatively new to GAVI)	In-depth case studies and desk studies Indicators for the different countries always included: DTP3 coverage, coverage of immunisation services, and under-five mortality Country studies were accompanied by qualitative interviews and document analysis
Africa Health Initiative	Mozambique, Rwanda, Zambia, Ghana and Tanzania	Cross-country evidence in HSS that is widely applicable	No standardised methodology for all countries. Framework was based on the IHP+ framework and metrics for the African Health Initiative Evaluation were selected in a highly consultative process and organised according to the conceptual model Evaluation methodology is comprised of endline and baseline data Household surveys in project and “comparison” areas supplemented by contextual information Balanced scorecard approach in Zambia
Content analysis of Global Fund investments	No country-specific focus	Quantification and categorisation of Global Fund’s HSS investments	Operationalisation on the WHO health system framework of the six building blocks Application of this framework provides a comprehensive quantification of system-level interventions
Review of the World Bank’s work with health systems	China, Mozambique, Uganda and Turkey	World Bank’s health systems performance (as an integral part of evaluative work for HSS)	Design: Based on the health systems analysis methodology with differing methods for each country China: situation assessment (review of recent international evidence) Mozambique: review of selected health status indicators and comparison with other sub-Saharan African countries Uganda: review of child mortality in Uganda and neighbouring countries Turkey: comprehensive review of national health system
Report on DFID’s HSS activities by UK’s International Development Committee	No specific country-focus	DFID’s HSS activities (focus areas of its HSS works etc.)	Consideration of various testimonies from leading global HSS experts and actors involved with the UK’s contribution to HSS
Report on the value of American investment in health systems in LMIC by the US-based IOM	LMIC recipient countries	Learning how health system improvement leads to better health, reduces poverty, and makes donor investments in health sustainable	The IOM convened a committee of experts to respond to a request from the USAID Bureau for Global Health. This was not an evaluation per se, but rather a review of expert opinions

## Annex 7: List of evaluations of HSS within countries

Evaluation author and year	Countries in focus	Evaluation focus	Evaluation design and key methods
Awoonor-Williams <i>et al.</i> , 2013	Ghana	Effects of HSS intervention on maternal and child health	Household surveys used to measure for selected core health indicators in three intervention districts and four comparison districts
Seims <i>et al.</i> , 2012	Kenya	Effects of HSS intervention on health service delivery outcomes	Comparison of key service delivery indicators in six provinces, including those with and without the intervention in question
Wim Van Lerbeghe <i>et al.</i> , 2014	Burkina Faso, Cambodia, Indonesia, Morocco	Effects of midwifery-focused HSS intervention on uptake of health services at childbirth	Maternal health relevant HSS interventions were identified in each country and validated through literature review and interviews. Interventions were assessed for their service coverage effectiveness, efforts to enhance coverage of services, and governance
Bucagu <i>et al.</i> , 2012	Rwanda	Health sector reform influence on service delivery	Systematic literature review of academic literature, national policy documents and three district health systems surveys. Policies were analysed within HSS building blocks framework
Singleton <i>et al.</i> , 2012	Botswana	Norwegian health sector assistance	Evaluation examined to what extent Norwegian assistance positively contributed to changes in Botswana's health system. Secondary data was mainly relied on and was supplemented with interviews with Norwegian and Botswanan stakeholders

## Annex 8: List of German evaluations reviewed

Evaluation/review title	Countries in focus	Evaluation focus	Evaluation design and key methods
GIZ Review Gesundheit: Metaevaluierung	N/A	Assessment of the methodical quality of 37 evaluations drafted in the period 2009–12 (11 of these were primarily focused on HSS), in order to identify potential for improvement	Cross-cutting and meta-analysis of evaluation reports; efficiency analysis
KfW thematic analysis: the side effects of targeted health interventions	N/A	Explores how health interventions' side effects may affect the wider health systems of partner countries, focusing on the case of HIV prevention projects and social marketing. Assessment of 71 HIV/AIDS projects financed by the German financial cooperation	Desk study of GDC policies, project appraisal and M&E documents; analysis of interfaces between vertical intervention and health system
KfW and GIZ Evaluation of GDC support for the health sector in India	India	Main areas of GDC contribution, strengths and weaknesses of its engagement	Health system was analysed for bottlenecks and strengths, financial and technical German cooperation were evaluated for effectiveness
Joint external evaluation: the health sector in Tanzania, 1999–2006	Tanzania	Relevance of health sector policies and external support; donor harmonisation and the use of different aid modalities	Methodology consisted of triangulation of mostly qualitative methods including interviews, self-assessments, and in-depth district case studies  Quantitative methods (such as analysis of resource flows to the health sector etc.) supplemented the evaluation
Thirty Years of Rwandan–German Development Cooperation in the Health Sector (DEval)	Rwanda	Aid modalities, instruments and the phasing out of the GDC in the health sector	Analysis on the basis of a variety of factors, including DAC and BMZ criteria.  Using document analysis, online surveys, statistical data analysis of district health systems data and a variety of qualitative methods, the evaluation adopted a theory-based contribution analysis

## Final and *ex post* programme and project evaluations reviewed

	Name of project/programme	Year of publication	Implementing agency
1	Förderung des Gesundheitssystems, Togo	2011	GIZ
2	Verbesserung der Gesundheitsversorgung in den Provinzen Cao Bang und Son La, Vietnam	2011	GIZ
3	Final evaluation: Programme Health/Policy Analysis and Formulation in the Health Sector, Indonesia	2011	GIZ
4	Benin: Basic health services	2009	KfW
5	Côte d'Ivoire: Basic Health Programme	2008	KfW
6	Guinea: Health Care Forécariah	2008	KfW
7	Indonesia: Improving Health in Nusa Tenggara Timur	2010	KfW
8	Cameroon: Sector Programme for Health, Phase I	2012	KfW
9	Madagascar: Basic Health Mahajanga Region	2009	KfW
10	Malawi: Improvement of Health Services in Chitipa District	2009	KfW
11	Mauritania: Health and Population in Hodh el Gharbi	2009	KfW
12	Nepal: Basic Health Programme, Phases I and II	2009	KfW

	Name of project/programme	Year of publication	Implementing agency
13	Tanzania: Health Sector Reform / Promotion of Reproductive Health Including the Prevention of HIV/AIDS	2008	KfW
14	Tanzania: District Health Care in Mtwara Region I	2009	KfW
15	Tanzania: Joint Social Services Programme – Health, Phase II	2009	KfW
16	Uganda: District Health Project	2008	KfW
17	Vietnam: Health Programme Hospitals	2012	KfW
18	HIV / AIDS Fokus E-Learning / Blended Learning	2011	GIZ
19	Multidisziplinäres HIV/AIDS-Program in Chittagong, Rajshahi, Khulna und Sylhet / Bangladesch	2012	GIZ
20	Ausbildung von Orthopädietechnikern in Marrakesch, Marokko	2011	GIZ
21	Unterstützung der Dezentralisierung des Gesundheitssystems im Bereich reproduktiver Gesundheit, Marokko	2011	GIZ
22	ETHIOPIA: Family Planning and HIV Prevention I and II	2012	KfW
23	Burkina Faso: PROMACO II and III	2010	KfW
24	Cambodia: Reproductive Health Care	2009	KfW
25	Cameroon: Social Marketing for HIV/AIDS Prevention	2008	KfW
26	CARICOM: HIV/AIDS Prevention in the Caribbean	2012	KfW
27	Chad: Family Planning and HIV Prevention IV	2012	KfW
28	Chad: Family Planning / HIV Prevention I to III	2008	KfW
29	Côte d'Ivoire: Family Planning and HIV Prevention	2008	KfW
30	Family Planning – Social Marketing of Contraceptives – Pakistan	2008	KfW
31	India: Polio Immunisation Programme, Phases I to VII	2011	KfW
32	Kenya: Family Planning and Combating Sexually Transmitted Infections/AIDS	2012	KfW
33	Lesotho: Family planning and HIV prevention	2008	KfW
34	Nigeria: Leprosy and TB Control Programme	2011	KfW
35	Pakistan: Family Planning	2009	KfW
36	Uganda: AIDS prevention II	2009	KfW
37	Uzbekistan: Promotion of Reproductive Health I and II	2009	KfW
38	Uzbekistan: Programme to Combat Tuberculosis, Phase II	2012	KfW
39	Uzbekistan: Tuberculosis Control Programme I and III	2009	KfW
40	Vietnam: Sector Programme – Health and Family Planning, Phases II-IV	2012	KfW
41	Zambia: HIV/AIDS Prevention I (Social Marketing) and HIV/AIDS Prevention II (VCT)	2012	KfW
42	Promotion of Drug Control Laos	2011	GIZ
43	Regionalkrankenhaus Diourbel Senegal	2012	GIZ
44	Joint Regional HIV/AIDS project along the Abidjan-Lagos Transport Corridor, Afrika N.A.	2012	GIZ
45	Stärkung des orthopädiotechnischen Versorgungssystems in Zentralamerika, überregional	2012	GIZ
46	Namibia: Family Planning / HIV Prevention I and II	2008	KfW

## Annex 9: List of GDC strategies analysed

	Title	Year
01	BMZ Positionspapier: Stärkung von Gesundheitssystemen in der deutschen Entwicklungszusammenarbeit (draft)	2013 (draft)
02	BMZ Sector Strategy: German Development Policy in the Health Sector	2009
03	Shaping Global Health – Taking Joint Action – Embracing Responsibility. The Federal government's Strategy Paper	2013
04	Minds for Change – Chancen schaffen. Enhancing Opportunities – Zukunft entwickeln (BMZ)	2011
05	Sexual and Reproductive Health and Rights, and Population Dynamics. A BMZ Policy Paper	2008
06	Germany's Contribution to a Sustainable HIV Response. A BMZ Position Paper	2012
07	The BMZ's new Africa policy – from a continent of crises to one of opportunities	2014
08	BMZ Special 165: Health and Human Rights	2009
09	BMZ Sector Strategy on Social Protection	2009

## Annex 10: List of partner country documents analysed

	Author	Year	Country	Title
01	BMZ	2009	Tanzania	Schwerpunktstrategiepapier. Beitrag der deutschen Entwicklungszusammenarbeit zur Verbesserung der Gesundheit in Tansania. Unterstützung des Gesundheitssektors inkl. HIV/AIDS Prävention
02	GIZ & KfW	2013	Tanzania	Deutsche Entwicklungszusammenarbeit mit Tansania. Gemeinsamer Programmvorschlag (PV) zum EZ-Programm „Unterstützung des Gesundheitssektors“. Teil A
03	BMZ	2010	Kenya	Kenianisch-deutsche Entwicklungszusammenarbeit. Schwerpunktstrategiepapier. Entwicklung des Gesundheitssektors
04	GIZ & KfW	2014	Kenya	Deutsche Entwicklungszusammenarbeit mit Kenia. Gemeinsamer Programmvorschlag (PV) zum EZ-Programm „Unterstützung des Gesundheitssektors“. Teil A
05	BMZ	2012	Malawi	Schwerpunktstrategiepapier. Gesundheit in Malawi
06	GIZ & KfW	2012	Malawi	Deutsche Entwicklungszusammenarbeit mit Malawi. Gemeinsamer Programmvorschlag (PV) zum EZ-Programm „Unterstützung des Gesundheitssektors“. Teil A
07	GTZ, DED, CIM, InWEnt & KfW	2010	South Africa	Deutsche Entwicklungszusammenarbeit mit Südafrika. Gemeinsamer Programmvorschlag (PV) zum EZ-Programm „Multisektorale HIV-Bekämpfung in Südafrika“. Teil A
08	BMZ	2012	South Africa	Strategiepapier für den Schwerpunkt „HIV-Prävention in Südafrika“
09	BMZ	2009	Nepal	Priority Area Strategy Health. Nepal
10	GIZ & KfW	2011	Nepal	Deutsche Entwicklungszusammenarbeit mit Nepal. Gemeinsamer Programmvorschlag (PV) zum EZ-Programm „Förderung des Gesundheitssektors“. Teil A
11	BMZ	2006	Vietnam	Strategy for Vietnamese-German Development Cooperation in the Priority Area "Health". Bonn
12	GTZ, DED, InWEnt & KfW	-	Vietnam	Programmvorschlag, Teil A, Dezentrale Gesundheitsversorgung, in Vietnam
13	BMZ	2005	Cambodia	Strategy for the Priority Area of Health
14	GTZ, CIM, DED, InWEnt & KfW	2009	Cambodia	Programmvorschlag, Teil A, soziale Absicherung im Krankheitsfall, Kambodscha
15	BMZ	2013	Pakistan	GDC with Pakistan. Health Sector Strategy Paper

## Annex 11: GDC focal areas and cross-cutting approaches to HSS

Table 1. Focal areas in GDC approach to HSS

Focal areas	Relevance to HSS	Specific measures in GDC Strategies (not exhaustive)
<b>Human resource development for health</b>	<ul style="list-style-type: none"> <li>- Relates most with health workforce building block</li> <li>- Skilled workforce is necessary for effective service delivery</li> <li>- Building management and organisational capacities necessary to improve governance</li> </ul>	<ul style="list-style-type: none"> <li>- Provision of training and professional development</li> <li>- Policy dialogue at national and international level on migration policies and recruitment of health workers, including the promotion of the WHO Code of Practice on International Recruitment of Health Personnel</li> <li>- Support to and cooperation with the Global Health Workforce Alliance</li> <li>- Support establishment of legal frameworks and acceptable working conditions for health professionals</li> </ul>
<b>Solidarity-based health financing and social health protection</b>	<ul style="list-style-type: none"> <li>- Relates most with health financing building block</li> <li>- Improving health financing through donor and partner harmonisation improves leadership and governance</li> <li>- Social health protection and improved health financing increases the quality and accessibility of health services, as well as increases provision of medical commodities</li> </ul>	<ul style="list-style-type: none"> <li>- Support for health financing system reform in partner countries</li> <li>- Development of various health financing models, including taxation based systems, social health insurance schemes, conditional cash transfers, demand subsidisation, etc.</li> <li>- Support to and cooperation with the Providing for Health Initiative (P4H)</li> </ul>
<b>Institutional and organisational development of national health systems</b>	<ul style="list-style-type: none"> <li>- Relates most with leadership/governance building block, in addition to infrastructure investments</li> <li>- Improving capacities in governance and management can lead to better regulation of the health workforce and improved health financing systems</li> </ul>	<ul style="list-style-type: none"> <li>- Support decentralisation of health systems</li> <li>- Support development and implementation of health sector reforms</li> <li>- Promote participation of target group and community in planning and M&amp;E of health services</li> <li>- Support harmonisation and aid effectiveness in the health sector</li> <li>- Support to SWAPs</li> <li>- Support to and participation in the IHP+ at global and country levels</li> <li>- Support expansion and rehabilitation of infrastructure at the primary and secondary level</li> </ul>

Source: Author

Table 2. Cross-cutting approaches in GDC approach to HSS

Cross-cutting approach	Relevance to HSS	Specific GDC measures (not exhaustive)
<b>Private sector cooperation</b>	<ul style="list-style-type: none"> <li>- Addresses all building blocks, with strong emphasis on service delivery, governance and medical products</li> <li>- Aim to better enable the provision of health care for difficult-to-access populations</li> </ul>	<ul style="list-style-type: none"> <li>- Support development of public-private partnerships (with private actors both in Germany and in partner countries), especially for the subsidisation of health services and medical products</li> <li>- Develop and strengthen private production, supply and distribution channels to provide medical products and drugs</li> <li>- Support to and participation in the Harnessing Non-State Actors for Better Health for the Poor (HANSHEP) Initiative</li> <li>- Support to the German Health Care Partnership to promote partnerships between German industry and partners in developing countries with a focus on health infrastructure and medical technology</li> </ul>
<b>Vertical programme integration</b>	<ul style="list-style-type: none"> <li>- Cross cuts all building blocks, with a strong focus on governance, service delivery and health workforce</li> <li>- Pursued with the acknowledgement that vertical programmes are not likely to be fulfilled without improvements and overall support of health systems</li> </ul>	<ul style="list-style-type: none"> <li>- At service delivery level: promote integration of sexual and reproductive health and HIV prevention; promote linkages between internal medicine and HIV services</li> <li>- At national level: support development of comprehensive strategies that integrate HIV activities with those of TB or SRHR; support coordination of bilateral and multilateral donor contributions for vertical programmes into national systems</li> <li>- At international and country levels: work through the Global Fund and other global health initiatives that incorporate HSS in their work; provision of technical assistance for Global Fund applicants and recipients to optimise funds</li> </ul>
<b>Inter-sectoral cooperation</b>	<ul style="list-style-type: none"> <li>- Targets the broader context in which HSS takes place, and potentially addresses all building blocks</li> <li>- Needed to improve effectiveness and impact of HSS through health prevention and promotion measures in other sectors</li> </ul>	<ul style="list-style-type: none"> <li>- Focus on prevention and health promotion</li> <li>- National and international levels: support the development of “health in all policies” (i.e. integration of health aspects into trade or migration policies); promote policy coherence and development of laws and regulations to address risk factors for non-communicable diseases (e.g. malnutrition, tobacco consumption)</li> </ul>

<p><b>Human rights-based approach</b></p>	<ul style="list-style-type: none"> <li>- Cross cuts all building blocks</li> <li>- Aims to improve availability, accessibility, acceptability and quality of health services for all</li> </ul>	<ul style="list-style-type: none"> <li>- Support development and implementation of inclusive health strategies that take into account the needs of marginalised and vulnerable groups</li> <li>- Advocacy, information, education and communication to overcome stigma and discriminatory practices</li> <li>- Development of mechanisms to strengthen patient rights, complaint and redress mechanisms</li> <li>- Support to participatory planning and decision-taking processes at all levels, including dialogue between government and civil society on health sector reform</li> </ul>
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Source: Author