SCOPING ASSESSMENT REPORT

UK PARTNERSHIPS FOR HEALTH SYSTEMS ZAMBIA

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INTRODUCTION

A scoping visit to Zambia in preparation for implementing the UK Partnerships for Health Systems (UKPHS) programme was carried out in Zambia from 3rd – 7th February 2020, by staff from THET and LSTM.

PURPOSE AND OBJECTIVES OF THE SCOPING ASSESSMENT

During the inception phase of the UKPHS programme THET and LSTM are undertaking detailed scoping assessments in each of the 10 countries, including Zambia, to get a better understanding of the current status of the Zambia health system, and to identify key health issues, challenges and priorities, including how health related gender and social inclusion issues are being addressed in the country.

The overall purpose of the scoping visit is to facilitate robust stakeholder-led analyses of national health priorities, to determine how Health Partnerships could contribute to addressing these and to use the findings to inform the design of country specific grant calls for HP projects. This will also ensure that HP projects are aligned with, and address, national priorities, are developed in the context of national needs and capacities and contribute to national health system strengthening and the achievement of UHC in Zambia.

The specific objectives of the scoping assessment are to:

- Introduce the UKPHS programme to key in-country stakeholders.
- Identify, validate and/or get consensus on national health system strengthening (HSS) issues, gaps and priorities, while considering gender equity and social inclusion, across the 6 HS building blocks with key stakeholders.
- Explore the feasibility of the Health Partnership model (using selected criteria) to address the identified HSS priorities.
- Identify interventions that could be implemented through hps and address these HSS priorities, as well as support the country's progress towards UHC.
- Review the UKPHS programme outcome statement and outcome indicators to ensure these are aligned with the identified priorities.
- Identify and understand the work of key actors supporting Health Systems Strengthening in the country to ensure hps build complementarity and synergies with these programmes and initiatives.
- Agree the way forward and national level mechanisms for ongoing programme oversight and monitoring.

ACTIVITIES UNDERTAKEN

1. Desk review of policies and country reports and other relevant documentation (See list of references in Annex 7) and production of slide deck.
2. Briefing of MoH Permanent Secretary (PS), Admin along with the Director, Quality Improvement.
3. Briefing of DFID Health Advisor.
4. Facilitation of high-level stakeholder workshop with MoH programme managers, development partners, UN agencies, THET implementing partners and health professional bodies.
5. Conduct of in-depth and key informant interviews with a range of national and sub-national stakeholders including the Vice Chancellor of Levy Mwanawasa Medical University, the former MoH PS for Training, UTH Hospital Coordinator, and representatives from UNDP and USAID to validate health system issues, challenges and priorities and elicit views and perceptions of how HPs could be optimised to address these health priorities.
6. Facilitation of stakeholder consultation workshop with MOH and provincial Health Directors, hospital superintendents, existing THET partners, and civil society members to present and validate findings identified

through the desk review, individual interviews and group discussions and to collaboratively construct a country specific TOC to map how HPs could address the identified health priorities and support progress towards achieving UHC.

7. Participation in MOH Partners Forum meeting, attended by Ambassadors, High Commissioners and UN agencies, chaired by Minister of Health.
8. Debriefing of DFID staff.

A list of peole met is in Annex 3.

DESK REVIEW AND FINDINGS

Prior to the scoping visit the team undertook a desk review of available secondary data to produce an overview of the country context and the health system, and to identify and document key health systems issues, gaps and priorities. These secondary documents included policies and strategies such as the 2017-2021 National Health Strategic Plan and 2018-2024 National Human Resource for Health Strategic Plan; survey data from the 2018 Demographic Health Survey and UN population statistics; government reports; analysis of equity gaps and other relevant gender equality and social inclusion analysis and reports, as well as reports from the World Bank, WHO, UNICEF, UNFPA and US CDC. A number of relevant peer reviewed articles were also reviewed.

ACHIEVEMENTS

Over the years, the Zambia health sector has had significant achievements due to the government's leadership and efforts, as well as bilateral donors' assistance. Maternal mortality ratio has declined to 213/100,000 and child mortality has declined to 64/1000s, contraceptive prevalence has gone up to 48%, with a gradual decrease of total fertility to 4.7. HIV prevalence declined to 11.6%. To date the government has built 275 additional health posts and 36 district hospitals. In 2016 there were 42,000 health care providers posts filled. DHIS2 has been upgraded and Smart Care electronic records have been introduced in six hospitals. Further decentralization, with devolution of authority to district level, is being planned. The government is also planning for the introduction of a Social Health Insurance scheme.

Access to and coverage of HIV, TB and Malaria services over the years has increased. Facility childbirths has gone up to 84% with 80% childbirths attended by a skilled provider. Immunization coverage of diphtheria, pertussis (whooping cough), and tetanus (DPT3) is now 91%.

CURRENT CHALLENGES

However, Zambia has a 3% annual population growth rate, and a young population, with rapid urbanization. With an increasing population and rapid urbanization, questions remain whether Zambia will manage to provide food, shelter, water, sanitation, education, health care, jobs, etc. to meet the needs of its growing population

Zambia also has a double burden of disease. Although through concerted efforts Zambia has managed to address the burden of diseases such as HIV, TB and Malaria, more needs to be done. Non-communicable diseases are increasing, stunting and malnutrition still remain a public health concern and there are increasing trends of obesity. Maternal, newborn and child health is an unfinished agenda. Teenage pregnancy, and maternal deaths among this age group, are high. Shortage of human resources and stock out of essential medicine are also critical concerns.

The government plans to further increase the training, recruitment and deployment of specialists, medical doctors, nurses and midwives, as well as other allied medical staff in the coming years, however the distribution and/or utilisation of the current stock of health workers is also a challenge. Sixty percent (60%) of all doctors are deployed in Lusaka, with about 80% of all doctors based in the four biggest cities/townships. To implement the new HRH Strategy, over 90% of

the budget would be required for salaries alone. Although the payment of health worker salaries has improved, some still do not receive their monthly salaries on time.

FINANCING

In the proposed 2020 national budget there is an increased allocation for the health sector, to Kwacha 9.4 billion (522m USD approximately) from Kwacha 8.1 billion (approximately 451m USD) in 2019.[1] However, 43% of the total national budget is allocated to servicing debt. External financing represents a significant proportion of the revenue sources for the 2020 budget.

For the implementation of the 2017-2021 Zambia National Health Strategic Plan, the government will need US$14.3 billion. Therefore, each year the health sector will need between US$2.5 billion to 3 billion to achieve the planned goals and targets. Availability of funding, timely disbursement of funds and its utilization still remains a big concern. According to the World Bank Assessment, Current Health Expenditure (CHE) during 2014-2016, was on average US$ 1.05 billion only, with 38% government, 43% donor, 12% out-of-pocket and 9% private/insurance expenditure contributions. Furthermore, of the Kwacha 12 billion that was budgeted for health in 2017, only a little over Kwacha 8 billion was disbursed from Treasury, and out of that less than Kwacha 4 billion was utilized.[2]

Although access to health services and the quality of care has improved over the years, the Health Access and Quality (HAQ) index is only 29%.[3] Currently, cooperating partners and donors invest in and support health in different provinces. For example, DFID focus mainly on the Central and Western provinces, which are lagging behind in accessibility to health care services, compared to other provinces.

MATERNAL AND NEWBORN HEALTH

Compared to other countries in the region, maternal and newborn mortality in Zambia is high. the Government of the Republic of Zambia through the President[4] and the Ministry of Health (MoH) ,has declared maternal and prenatal mortality as a 'public health emergency' and the government has embarked on plans to improve maternal and newborn health and survival. For this reason, further documentation was reviewed and analysed to fully understand the current maternal and newborn health status in Zambia.

Cooperating partners such as SIDA, DFID and USAID continue to provide support for sexual and reproductive health, including for the improvement of maternal and newborn health and survival. UNFPA, UNICEF and UNDP are working together to implement various programmes such as family planning, training on basic and comprehensive Emergency Obstetric and Newborn Care (EmONC).

DFID provided funding for the National Public Health Institute to conduct a maternal death review.[5] The review found that 674 maternal deaths were reported in 2018, with more than 21% of all maternal deaths occurring in PHC facilities or in the community. The major causes of maternal deaths were haemorrhage (38.7%), indirect causes, such as malaria, HIV, cancer, and cardiac disease (28.3%), hypertensive disorder (13.1%), pregnancy related infection (6.8%), abortive outcomes (5.3%), and unknown or undocumented causes (5.3%). A cause of death due to obstructed labour was

[1] 1 USD = 17.9392 ZMW as at April 01 2020.

[2] World Bank (2019) Health Financing in Zambia.

[3] GBD 2016 Healthcare Access and Quality Collaborators. Measuring performance on the Healthcare Access and Quality Index for 195 countries and territories and selected subnational locations: a systematic analysis from the Global Burden of Disease Study 2016. THE LANCET. 23 May 2018.

[4] https://www.lusakatimes.com/2019/05/09/president-lungu-declares-maternal-and-prenatal-deaths-a-public-health-emergency-in-zambia/.

[5] Gianett B, Musakanya KE, Ngomah Moraes A, Chizuni C, Groeneveld C, Kapina M, Hamoonga R, Mazaba ML, Mukonka V. Maternal mortality trends and correlates in Zambia. Health Press Zambia Bull. 2019; 3(4&5); pp 12-16 http://znphi.co.zm/thehealthpress/wp-content/uploads/2019/07/MATERNAL-MORTALITY-TRENDS-AND-CORRELATES-IN-ZAMBIA-2018.pdf.

minimal (.4%). All provinces (101 districts out of 117 districts) reported maternal deaths, with Lusaka province having the highest number of deaths.

Poor case management and limited or lack of skilled human resources were identified as the main causes of maternal deaths, for example in the Copperbelt Province only 59% of deliveries were attended by a skilled birth attendant. Over three quarters of the deaths were reported from hospitals, 37.5% from district, 25.3% from central and 15.3% from general hospitals. 10.7% deaths were reported from health centres, 1.8% health posts and 8.8% at the community. Lack of midwives or the presence of only one midwife in lower level facilities is forcing nurses and/or clinical officers, who may not have had adequate training, to conduct deliveries and/or cause delays in appropriate referrals. According to one provincial head, maternal and newborn deaths have shifted from the community and are now occurring at the facility.

According to recent findings and through consultation with neonatal/child specialist during the scoping assessment, newborn deaths have increased in Zambia, with the major causes of deaths being asphyxia, sepsis, hypothermia and complications/management of low-birth weight babies. One stakeholder reported that an assessment carried out in a number of hospitals found neonatal deaths were the second highest cause of infant mortality, after death due to Severe Acute Malnutrition (SAM).

GENDER AND EQUITY ANALYSIS

There is severe paucity of information on the gender aspects of health services and reform and in relation to substantive forms of vulnerability (e.g. particular categories of women, specific age groups, etc.).

A study carried[6] out by the Swedish Institute for Health Economics, and the Department of Economics in the University of Zambia found that there are inequities between rural and urban areas. In particular these differences exist because of distances to the nearest health facility. Having to travel long distances to a health facility make it very costly for rural dwellers to seek medical care, especially during the farming season. The study found thatreducing barriers and immproving equality of access to health care is a great challenge for the Zambian Government.

Another study[7] found that a higher proportion of poorer quintiles reported being ill/injured, having been continously ill for 3 months, or were facing limitations in their normal activities. Illness/injuries was the highest health care need, compared to continuous illness and functional limitations. There were also marked differences in facility utilization. Clinics accounted for 56% of all public health facility visits, hospitals accounted for 42%, while health centre utilization accounted for just 2%. The same study found that despite having lower health needs, the rich make more visits to public health facilities, especially public hospitals. The results also showed an inverse care law, meaning that the poor, who are confronted with higher 'needs', use fewer health care services.

Focus group discussions and indepth interviews in another study in 2014[8] found that the main reasons for low utilization of facility based care by pregnant women were due to a combination of factors, including the low percieved quality of maternal health care services in these facilities; the negative opinions of health care providers who referred them; and physical and economic barriers such as long distances, high transport and indirect costs, including cost of clothes and other supplies for the baby.

[6] C A Hjortsberg and CN Mwokisa (2002) Cost of access to Health services. Swedish Institute for Health Economics, Lund, Sweden and Department of Economics, University of Zambia, Lusaka, Zambia; Health Policy and Planning 17(1)71-77 2002.

[7] Phiri, J., Ataguba, J.E. Inequalities in public health care delivery in Zambia. *Int J Equity Health* **13,** 24 (2014). https://doi.org/10.1186/1475-9276-13-24 https://equityhealthj.biomedcentral.com/articles/10.1186/1475-9276-13-24.

[8] Sialubanje, C, Massar, K, Hamer, DH, and Ruiter, R (2014) Understanding the psychosocial and environmental factors and barriers affecting utilization of maternal healthcare services in Kalomo, Zambia: a qualitative study. Health Educ Res. 2014 Jun;29(3):521-32. doi: 10.1093/her/cyu011. Epub 2014 Mar 23. https://www.ncbi.nlm.nih.gov/pubmed/24663431.

The study in 2011[9] found that despite special protection under regional and international law, incarcerated women's health needs, including prenatal care, prevention of mother-to-child transmission of HIV, and nutritional support during pregnancy and breastfeeding were not being adequately met in Zambian prisons. Women are underserved by general health care programmes, including those offering tuberculosis and HIV testing. Women are reportedly physically and sexually abused by police and prison officers, that could amount to torture under international law.

Although health care services are free, because of the shortage of supplies and drugs however, users often have to pay for services, including specific diagnostic tests. The lack of hard evidence calls for further research and analysis of how women cope with health care costs, and what trade-offs they make in order to pay for health care, considering their lack of access to money and limited decision-making powers.

The WHO estimates that about 15% of Zambia's population is living with a disability, mostly in rural areas. The situation is worse for women and girls with disabilities as they are more likely to suffer sexual abuse and other forms of physical and mental violence. The Persons with Disabilities Act No 6 of 2012 provides a platform for action and specifies what is expected of MoH in terms of services however work on disability is starting from a very low base.

HEALTH SYSTEMS CONSIDERATIONS AND PRIORITIES

OUTPUTS OF MEETING WITH HIGH LEVEL OFFICIALS

In the initial meeting facilitated by the scoping assessment team with high level officials, MoH department heads discussed the current health systems issues, gaps and challenges and recommended that the following factors should be considered in the design of HP projects:

- Maternal and newborn mortality remains high and has been declared a '*national emergency';*
- The quality of care provided at PHC facilities is a key contributor to poor outcomes for women and babies;
- The number and distribution of midwives at PHC facilities where deliveries are performed and maternity services are offered is insufficient, with many deliveries performed by nurses and clinical officers, without the appropriate knowledge and skills;
- Women with obstetric complications are not always referred in a timely fashion;
- Women, particularly poorer women, are not adequately accessing health care, partly due to distance, but also due to their confidence in the quality of services provided at PHC facilities;
- Central and Western provinces need more investment and capacity strengthening.

The stakeholders further identified the following priorities under the six health system building blocks for consideration for possible HP support:

HUMAN RESOURCES FOR HEALTH

- Training of anaesthetic clinical officers and nurses;
- Building human resource capacity for neonatal care;
- Further improving skills and competencies of nurse/midwives;
- Improving the capacity of faculty from the health training institutions.

[9] Katherine W Todrys and Joseph J Amon (2011) Health and human rights of women imprisoned in Zambia BMC International Health and Human Rights 2011, 11:8 http://www.biomedcentral.com/1472-698X/11/8. https://bmcinthealthhumrights.biomedcentral.com/articles/10.1186/1472-698X-11-8.

SERVICE DELIVERY

- Building networks for provincial and districts Quality Improvement;
- Further strengthening linkages between community AND facilities;
- Helping in policy development for staff deployment, distribution and retention;
- Training on leadership and management;
- Improving capacity of blood transfusion services.

INFORMATION SYSTEMS

- Improving data analysis and use of data by managers.

MEDICINES AND TECHNOLOGIES

- Improving capacity of equipment repair and maintenance staff for appropriate and timely maintenance.

OUTPUTS OF THE STAKEHOLDER CONSULTATION WORKSHOP

The scoping team then facilitated a two-day stakeholder consultation workshop facilitated, in which stakeholders recommended the HP programme in Zambia should have the following overall focus: "**Quality service delivery for maternal and newborn health, through strengthening health systems at the PHC levels**." There was consensus that HP projects and interventions should focus their support at the PHC level, specifically in 3 districts in Western province and 3 districts in Central province. These districts were identified as follows:

- Western Province: Senanga, Lukulu and Sikongo (Lewanika General Hospital to be used for mentoring, technical support and also referrals).
- Central Province: Luano, Mukushi and Ngabwe districts, and Kabwe (Central Hospital to be used for mentoring, technical support and also referrals).

Further discussion and brainstorming led to stakeholders recommending that the following specific focus areas would be a good fit with the HP model. These priority interventions for HPs were further elaborated and refined with the incorporation of feedback shared by the MoH Permanent Secretary (Technical Services) and the Health Minister after the scoping assessment.

The proposed priority HP interventions linked to the health system building blocks are as follows:

HUMAN RESOURCES FOR HEALTH

- Reviewing/developing appropriate curricula and training materials for the multi-disciplinary team e.g. nurse and clinical officers involved in deliveries at PHC.[10]

[10] This should include conducting safe normal deliveries and newborn care, early identification of complications and need for referral and taking appropriate preventive measures before referral. The curriculum should also include adolescent sensitive/friendly services.

- Providing competency-based capacity development and mentorship of the multi-disciplinary health worker team involved in deliveries at the PHC Health Facility level.[11] This could include building a critical mass of Trainers of Trainers who could be mentored to cascade training master trainers for training, The HP should build a critical mass of master trainers over time. The UK team should oversee the initial step-down training conducted by these trainers to assure quality. The HP should build mentorship capacity of the linked District Hospital as identified above.

HEALTH INFORMATION SYSTEMS – IMPROVED GATHERING AND USE OF EVIDENCE

- Strengthening the collection and use of data and evidence (and keeping of accurate medical records) by PHC facilities and districts to inform practice and decision-making. This may also include undertaking or strengthening the use of research for decision-making and the embedding of digital platforms where this compliments MoH plans and is supported by relevant teams.

SERVICE DELIVERY QUALITY IMPROVEMENT

- Strengthen the use of Quality improvement at the PHC Health Facility level. HPs should collaborate with the MoH national directorate for QI/QA.

LEADERSHIP AND GOVERNANCE

- Strengthen the leadership and governance (planning/ oversight/accountability framework etc) at PHC facilities and at associated district and provincial levels as appropriate.

HEALTH PROMOTION AND EDUCATION

- Strengthen the capacity of community health care providers to stimulate community demand for services and improve timely health seeking behaviour associated with antenatal care (ANC), postnatal care (PNC), childbirth and newborn care, including family planning and nutrition.
- Ensure the availability of a basic set of supplies/equipment for facility that lack these e.g. suction machine, Ambu Bag, heater, oxygen, etc (approximately £500 per health facility).

EXPECTED OUTCOME

The expected outcome from these interventions would be improved maternal and newborn health and survival.

INDICATORS

Stakeholders suggested the following indicators for monitoring the above interventions:

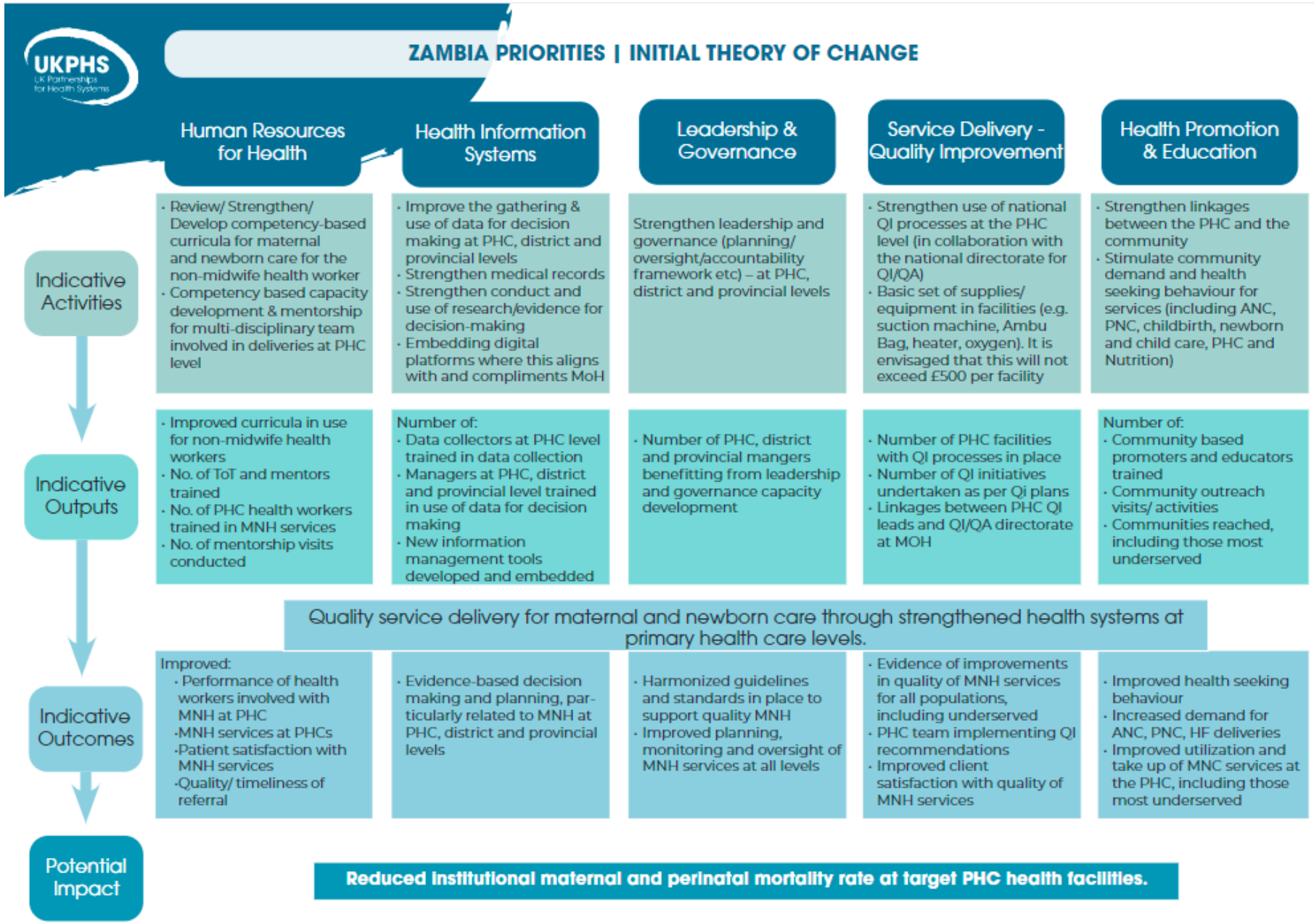
- Number of PHC health care providers trained;
- Number and quality of referrals;
- Number of mentorship visits conducted;
- Harmonized guidelines and standards in place to support quality maternal and newborn services;
- Number of Health Promotion focal persons and CBOs trained;
- Improved early ANC uptake;
- Improved data collection, analysis and use.

[11]HPs can include the costs of a basic set of supplies/ equipment in facilities that don't have them (e.g. suction machine, Ambu Bag, heater, oxygen). It is envisaged that this will not exceed £500 per facility.

STAKEHOLDER DEBRIEFING

The scoping assessment team debriefed DFID on the outcomes of the assessment and outlined the stakeholders' key recommendations. DFID appreciated the HP focus on maternal and newborn health and the proposed interventions, as well as the geographical areas selected for HP interventions. They requested that the scoping assessment team should have further discussions with UNFPA about its programme to minimize duplications. DFID also requested that HP also consider child health issues if possible. As the team was unable to debrief the Permanent Secretary, Administration during the visit, due to her other commitments and priorities, it was agreed THET Lusaka official will debrief the PS at later stage.

The Initial Theory of Change for the programme is presented below.


UKPHS
UK Partnerships for Health Systems
ZAMBIA PRIORITIES | INITIAL THEORY OF CHANGE
Human Resources for Health
Health Information Systems
Leadership & Governance
Service Delivery - Quality Improvement
Health Promotion & Education
Indicative Activities
· Review/ Strengthen/ Develop competency-based curricula for maternal and newborn care for the non-midwife health worker
· Competency based capacity development & mentorship for multi-disciplinary team involved in deliveries at PHC level
· Improve the gathering & use of data for decision making at PHC, district and provincial levels
· Strengthen medical records
· Strengthen conduct and use of research/evidence for decision-making
· Embedding digital platforms where this aligns with and compliments MoH
Strengthen leadership and governance (planning/ oversight/accountability framework etc) – at PHC, district and provincial levels
· Strengthen use of national QI processes at the PHC level (in collaboration with the national directorate for QI/QA)
· Basic set of supplies/ equipment in facilities (e.g. suction machine, Ambu Bag, heater, oxygen). It is envisaged that this will not exceed £500 per facility
· Strengthen linkages between the PHC and the community
· Stimulate community demand and health seeking behaviour for services (including ANC, PNC, childbirth, newborn and child care, PHC and Nutrition)
Indicative Outputs
· Improved curricula in use for non-midwife health workers
· No. of ToT and mentors trained
· No. of PHC health workers trained in MNH services
· No. of mentorship visits conducted
Number of:
· Data collectors at PHC level trained in data collection
· Managers at PHC, district and provincial level trained in use of data for decision making
· New information management tools developed and embedded
· Number of PHC, district and provincial mangers benefitting from leadership and governance capacity development
· Number of PHC facilities with QI processes in place
· Number of QI initiatives undertaken as per Qi plans
· Linkages between PHC QI leads and QI/QA directorate at MOH
Number of:
· Community based promoters and educators trained
· Community outreach visits/ activities
· Communities reached, including those most underserved
Quality service delivery for maternal and newborn care through strengthened health systems at primary health care levels.
Indicative Outcomes
Improved:
· Performance of health workers involved with MNH at PHC
·MNH services at PHCs
·Patient satisfaction with MNH services
·Quality/ timeliness of referral
· Evidence-based decision making and planning, particularly related to MNH at PHC, district and provincial levels
· Harmonized guidelines and standards in place to support quality MNH
· Improved planning, monitoring and oversight of MNH services at all levels
· Evidence of improvements in quality of MNH services for all populations, including underserved
· PHC team implementing QI recommendations
· Improved client satisfaction with quality of MNH services
· Improved health seeking behaviour
· Increased demand for ANC, PNC, HF deliveries
· Improved utilization and take up of MNC services at the PHC, including those most underserved
Potential Impact
Reduced institutional maternal and perinatal mortality rate at target PHC health facilities.

LIST OF ANNEXES

DESIGN AND CONDUCT OF SCOPING ASSESSMENTS FOR THE UK PARTNERSHIPS FOR HEALTH SYSTEMS (UKPHS) PROGRAMME: TERMS OF REFERENCE

BACKGROUND

UK Partnerships for Health Systems (UKPHS) is a DFID-funded grants programme that funds Health Partnerships (HPs) to improve health system performance and to enable progress towards Universal Health Coverage (UHC) in low- and lower-middle income countries (LMICs), especially for poor and vulnerable populations. The UKPHS will support the development of stronger health systems by promoting HPs that are aligned to national health priorities and strategies, focusing on quality, and gender equality and social inclusion (GESI). UKPHS will fund large strategic HPs in ten countries that explicitly focus on supporting LMIC health system priorities, complemented by smaller HP grants that test innovative approaches to specific health system challenges.

PURPOSE OF THE SCOPING ASSESSMENTS

From December 2019 to May 2020, THET and LSTM plan to undertake detailed scoping assessments in each of the 10 countries. The assessments will explore health systems issues, challenges and priorities, and identify and validate health systems priorities that HPs could potentially address and/or contribute to health system strengthening (HSS) or strengthen particular building blocks within the system, whilst ensuring a GESI perspective. These scoping assessments will consider the HP footprint in each country, as well as the potential supply of new and/or adapted HPs, ensuring the best fit between the priorities identified and the likely supply.

During the scoping visit, stakeholders will begin the process of constructing a Theory of Change (ToC) that maps out how HPs can address the identified health system priorities in that country context, contribute to HSS and UHC, and how the poorest and most vulnerable (from a GESI lens) can be supported in particular. All HPs will need to clearly demonstrate their contribution to this ToC. The assessment process will also contribute to stakeholder relationship building and promotion of the programme, and assessment findings will inform grant call design, overall UKPHS programme MEL processes, promote HP alignment with, and support of, national priorities and capacities, and ensure a good fit with the supply of UK expertise.

APPROACH AND METHODOLOGY

1. Desk review

The team will undertake a rapid desk review comprising mainly the review of country specific documents such as: health sector policies, strategies and plans including UHC, Quality Improvement, human resources for health, maternal, newborn, child and adolescent health; available HMIS data; and other relevant key government, donor and/or development partner reports/analyses, in order to construct an overview of health systems issues and priorities, and a stakeholder map for each country.

2. Design of assessment frameworks and tools

The team will draw on a number of frameworks to develop a flexible approach and tools for the scoping assessment that can be adapted to each country context. In addition to the key framework, which will be the WHO Health System Framework and the 6 Building Blocks/core functions[12], the team will draw on a number of other assessment tools and

[12] World Health Organization (2007) Everybody's Business: Strengthening health systems to improve health outcomes—WHO's Framework for Action. Geneva: WHO, 2007, p.3.

guides, such as the USAID Health Systems Assessment Approach[13]; the Roberts, Hsiao, Berman, and Reich (2003) 'control knobs framework'[14]; the DAC OECD Principles for Evaluation of Development Assistance[15]; the WHO five performance criteria for assessing a health system[16], and the WHO Human Rights and Gender Equality in Health Sector Strategies: How to Assess Policy Coherence,[17] and the Building Block Benchmarks for Gender[18] to design the methodology, approach and assessment tools to identify health systems issues and priorities, and to assess the relevance of the HP model to address these.

3. Stakeholder engagement

Multidisciplinary and multi-stakeholder involvement to discuss potential HP projects is critical, as is engagement of key stakeholders affected by the implementation of these projects. MOH cooperation, collaboration and participation in the scoping process will be essential for generating high quality findings and outcomes that are acceptable to the government of each country. Country commitment will also be critical to increase the likelihood of HP interventions being implemented, achieving the expected results, and these results being sustained beyond the lifetime of the project.

Prior to the scoping visit, THET Country Directors (CDs) will meet with high level MOH officials, DFID Health Advisors and other development partner representatives to provide information and create awareness and build support for the UKPHS programme, outline the purpose of the scoping visit and level of cooperation expected from the MOH. These discussions will also provide opportunities for the initial exploration and validation of the country's health systems issues, challenges, and priorities, including GESI issues, and how the UKPHS programme can contribute to these, as well as support the government to achieve UHC and the SDGs.

In-depth interviews (IDIs) and key informant interviews (KIIs), meetings and workshops will be facilitated with a range of national and sub-national level stakeholders, identified in advance of the scoping visit through a stakeholder mapping exercise. These will include policymakers, representatives from the MoH and other strategic sectors and line ministries, in-country DFID teams, professional bodies and associations, including nursing, training institutions, NGOs, civil society, women's, disability and faith-based organisations, development/funding partners, UN agencies, and private sector organisations.

The objectives of such stakeholder engagement are to:

- Share information on the UKPHS and the HP model
- Share findings and priorities identified through the desk review
- Seek stakeholders' inputs and views to validate findings and agree priorities

[13] Health Finance & Governance Project. September 2017. Health Systems Assessment Approach A How-To Manual. Version 3.0. Bethesda, MD: Health Finance & Governance Project, Abt Associates Inc.

[14] Roberts MJ, Hsiao WC, Berman P, Reich MR. 2003. Getting Health Reform Right. New York: Oxford University Press.* This conceptualized a health system as "a set of relationships where the structural components (means) and their interactions are associated and connected to the goals the system desires to achieve (ends)".The framework identifies five major "control knobs" of a health system which policymakers can use to achieve health system goals: financing, macro-organization, payment, regulation and education/persuasion.

[15] DAC Principles for Evaluation of Development Assistance, DEVELOPMENT ASSISTANCE COMMITTEE, OECD, PARIS, 1991 https://www.oecd.org/dac/evaluation/2755284.pdf.

[16] WHO (2007) Everybody's Business: Strengthening Health Systems to Improve Health Outcomes. Geneva, Switzerland: WHO.

[17] WHO (2011) Human Rights and Gender Equality in Health Sector Strategies: How to Assess Policy Coherence https://www.who.int/gender-equity-rights/knowledge/human_rights_tool/en/.

[18] Research in Gender and Ethics (2019) Adopting a gender lens in health systems policy: A Guide for Policy Makers. https://www.ringsgenderresearch.org/wp-content/uploads/2020/01/Adopting-a-gender-lens-in-health-systems-policy.pdf

- Collaboratively assess the potential of the HP model to address the identified priorities
- Get consensus on the interventions that could be implemented through HPs

Debriefing sessions will be facilitated to provide an overview of the outputs and outcomes of the scoping visits and present priorities identified and validated. These sessions will provide opportunities for the team to build consensus on the draft country specific ToC, which will outline potential HP activities, outputs, outcome and impact. As part of this debriefing, teams will agree the way forward and the functioning of a national oversight mechanism. Beyond the scoping visits, the teams will continue to refine and finalise these country specific ToCs.

SUMMARY COUNTRY REPORTS

Scoping visit reports, which provide an overview of the process and outcomes from each of the countries, will be produced. A summary of the agreed priorities that could potentially be addressed by HP projects and interventions and a draft Theory of Change will also be developed, which will be made available to guide grant applicants in the development of their applications and proposals. These outputs will be further refined and validated through the pre-commencement workshops and other planned stakeholder consultation fora in each country.

SPECIFIC ACTIVITIES

1. Conduct a rapid desk review of policies and country reports and other relevant documentation (national health sector plan and policies, strategies and plans for UHC, Quality Improvement, HRH, and relevant HMIS and surveillance data)
2. Map existing Health Partnerships and key stakeholders
3. Produce a draft situation analysis, including health system issues, challenges and priorities, including, progress on GESI, and identify priorities that could be potentially addressed through HPs
4. Develop standard frameworks and tools to be used across all countries to engage stakeholders in the identification and validation of health system issues, challenges and priorities, and in assessing the feasibility of the HP model to address identified HSS priorities
5. Conduct in-depth and key informant interviews and group discussions and workshops with a range of national and sub-national stakeholders to identify and validate health system issues, challenges and priorities, and elicit views and perceptions on the extent to which the HP model could address these
6. Facilitate a debriefing session with a representative group of stakeholders/gatekeepers to present and validate findings of the scoping assessment and agree the cope and functioning of national oversight mechanisms and way forward.

EXPECTED DELIVERABLES:

1. Desk review and situation analysis including map of stakeholders and health challenges and priorities
2. Country scoping assessment report, including an overview of the process, key findings, and a summary of agreed priorities to be addressed by HP projects
3. Draft country level TOC focusing on HP interventions, outputs and outcomes and broad indicators for each of the identified short-, medium- or long-term outcomes, including Gender Equality and Social Inclusion (GESI) indicators.

COMPOSITION OF SCOPING TEAM

Each scoping team will comprise up to two international specialists/leaders in HPs, HSS, and/or Gender, and a representative from the THET country offices.

TIMEFRAME AND DURATION OF SCOPING ASSESSMENT

The scoping assessments are expected to be undertaken between January and May 2020 and each country visit is expected to take up to 5 days. Country Reports and ToC will be completed for all countries by June 2020.

ANNEX 2 - FREQUENTLY ASKED QUESTIONS

WHAT IS THET?

THET is a global health charity operating in 7 countries across the world – the UK, Uganda, Tanzania, Zambia, Somaliland, Ethiopia and Myanmar. THET's primary aim is to address the statistic that one in seven people globally will never visit a qualified health worker. We do this primarily through health workforce development. We train support and educate health workers across Africa and Asia, working in partnership with organisations and volunteers from across the UK, Africa and Asia. We are the only UK charity with this focus. All of the work which THET does works within the Health Partnership model framework.

WHAT IS THE HEALTH PARTNERSHIP MODEL?

A Health Partnership is a partnership formed between a UK health institution, either a hospital, a trust, a professional association, or a health education facility like a university and their counterpart overseas. The aim of these partnerships is to deliver health worker training and peer to peer support, through utilising the skills and experience of each organisation. Partners co-develop programmes that address organisational and national priorities. The partnerships themselves are generally long term and sustainable, while the projects which they deliver are discrete and tailored to specific identified needs. The aim of all projects is sustainable impact and mutual benefit.

HOW DOES THET WORK WITHIN THE HEALTH PARTNERSHIP MODEL?

THET takes a 3-pronged approach to partnership work – we carry out policy, advocacy and research, we implement programmes directly, and we manage grants for donors. Our policy work involves advocating, mainly with the UK government, for support for Health Partnership work. In our country programmes work we work through our six country offices partnering with others (Mohs, hospitals, universities, professional associations and other organisations) both overseas and UK-based to deliver programmes that respond to local needs. Finally, THET acts as a fund manager for a number of donors. Historically we were grants manager for the Health Partnership Scheme – a 7 year, £32 million programmes funded by the Department for International Development. This programme supported 210 projects in over 30 countries and trained over 93,000 health workers. Currently, we are managing the Johnson & Johnson Africa Grants Programme, which focuses on surgery and anaesthesia and community health, and the Commonwealth Partnerships for Antimicrobial Stewardship Programme, funded through the Department of Health's Fleming Fund. This supports partnerships with the aim of improving the detection and monitoring of resistant infections at the hospital level, taking measures to reduce infection and ensuring antibiotics' effective use.

WHAT IS THE UKPHS?

The UK Partnerships for Health (UKPHS) programme was announced by the UK Department for International Development as the successor to the HPS in 2018. After some delays, management of the programme was awarded to THET with technical input from the Liverpool School of Tropical Medicine, and the programme officially began on 2nd December 2019. The programme has a total budget of £28.5m and will run for 43 months until July 2023.

The programme aims to help LMICs build stronger, and more resilient health system, making progress towards universal health coverage through improved health service performance, particularly targeting poor and vulnerable populations. Some of the key aims are to:

- Support the development of stronger health systems through better governance, information, and management of health institutions
- Provide the health workforce with opportunities to improve skills and knowledge
- Build on the institutional capacity to decrease any reliance on external support.

WHAT KIND OF PROJECTS WILL BE FUNDED UNDER THE UKPHS?

There are two main strands under the UKPHS. The first focuses on 10 strategic countries which were identified by DFID – Bangladesh, Burma, Ethiopia, Ghana, Nepal, Sierra Leone, Somalia/Somaliland, Tanzania, Uganda and Zambia. Grants under this stream must address pre-identified health priorities, as identified by stakeholders within the country. The second strand will fund smaller projects and will have neither a pre-defined country nor a health theme.

All projects under this funding programme must be delivered by Health Partnerships and must address issues with the health workforce through activities such as training**,** leadership development, or protocol and curricula development. Unfortunately, this funding cannot be used for infrastructure work, including equipment procurement or refurbishment.

HOW MUCH FUNDING IS AVAILABLE FOR WORK IN UGANDA THROUGH THE UKPHS?

The programme has a total budget of £24m available for grants. There will be 6-8 large grants of up to £400k each being implemented in each of the strategic countries. There will be around £2m available for each strategic country, including Uganda, with the number of grants being decided on based on the number and quality of applications.

WHAT ARE THE MAIN OBJECTIVES AND PLANNED OUTCOMES OF THE GRANTS PROGRAMME?

The entirety of the programme aims to contribute to SDG 3 – ensuring healthier lives and promotion of well-being for all at all ages, with a focus on Universal Health Coverage. A key outcome will be improved health worker and health service performance including for the poor and most vulnerable populations. This will be measured through monitoring the number of facilities supported by UKPHS projects demonstrating positive outcomes in health service performance, with a focus on health worker performance. Projects funded under this programme should take an approach which enhances gender equality and social inclusion, focusing on targeting poor and vulnerable groups.

HOW WILL NATIONAL OWNERSHIP AND BUY-IN BE ENSURED?

It's crucial to the success of this programme and the sustainability of its outcomes that national stakeholders play a leading role in determining priorities. The key health priorities addressed by projects being implemented in strategic countries will be determined through a scoping visit undertaken specifically to engage with national stakeholders. Over the course of the scoping visit, national stakeholders will be asked to participate in workshops, focus groups and key informant interviews, aiming to draw out key priorities for those working in the health sector.

The priorities raised during these meetings will then be agreed upon and used to develop a country-specific Theory of Change, which will form the basis for all of the project interventions. Relevant stakeholders will then be invited to join a National Oversight Mechanism (NOM), which will play a key role throughout the programme in ensuring that projects remain aligned with national priorities and feed into the relevant national plans. The NOM will be asked to review and assess applications during the selection phase of the programme and then play an ongoing role in providing oversight on projects as they progress and attending annual national review events.

In addition to the NOM, THET's Country Director and associated country office staff will support funded Health Partnerships for the duration of the programme. They will be continuously engaging with national networks, the Ministry of Health and other relevant partners.

ANNEX 3 - STAKEHOLDERS ENGAGED THROUGH SCOPING VISIT

Organisation	Designation
MOH HQ	Ass.Dir.Pharmaceutical Services
MOH-HQ	Chief Health Promotion Officer
Public Health England	Senior Public Health Advisor
Public Health England	Project Support Officer
DFID	Health Advisor
CIDRZ	Operations Manager
MOH-HQ	Snr Performance Improvement Officer
MOH-HQ	Director QA/QI
MOH-HQ	Qi Officer
MOH-HQ	Chief Nursing Officer
MOH-HQ	Clinical Health Officer
MOH-HQ	As-Dpmt
MOH-HQ	AD- Emergency Health
Embassy of Sweden	Program Manager -Health
MOH-HQ	Ass.Director (A&L)
MOH-HQ	Director Policy & Planning
MOH-HQ	Ass Director Dcd
MOH-HQ	Chief Anasthetic Officer
MOH-HQ	Principal Accountant
DAPP	Partnership Manager
MOH	Provincial Health Director
ZUNO	Manager Industrial and Labour Relations
ZAMDHAEP	Prog Officer
LUCON	Principal Lecturer
HPCZ	Pro
UNZA	Lecturer
MOH-HQ	PA Finance
MOH	PA Accountant
MOH	Obs/Gynae Coordinator
HPCZ	Manager Literacy
HPCZ	Finance Manager
DTS	Sao
EMBASSY OF SWEEDEN	Program Manager -Health
MOH-HQ	Director -Monitoring & Evaluation

MOH-HQ	Ag.Chief M&E Officer
MOH-HQ	Ass.Director Hrm
WHO	Health System Advisor
THET	Consultant
MOH-HQ	Ass Director Dcd
DAPP	Partnership Manager
LUSAKA PHO	Obs/Gynae Coordinator
CHIPATA LEVEL 1 HOSPITAL	AG Medical Officer In-Charge
ZNBTS	Finance Manager
DAPP	Manager Literacy
ZAMDHAP	Program Officer
BRIGHTON LUSALKA LINK	Project Manager
MOH-HQ	Chief NCD Officer
THET	Director of Programmes
MOH-HQ	Ass Dir Hi
MOH	SHPO
DTS	SAO

Days	Programme of activities
Monday 03.02.20	
Day 1 -am	**Meeting with Minister and DGs:** (with the PS', and with DFID)
Day 1 -pm	**High-level Workshop with small to medium group (10-15 participants):** Up to 3 hours hosted by the Ministry of Health **Participants:** high level individuals including key MoH officials (directors of departments), representative for development partners, DFID, USAID, WHO, FPA, UNICEF, etc. **Purpose**: to introduce the UKPHS programme and explore and test the Health Partnership model to address HSS priorities **Proposed approach/methods:** • Presentations for information sharing and validation and guidance for group work • Case studies and success stories/experiences/lessons learned shared by existing and/or previous DFID funded Health Partnership, • Identification (in plenary if group is too small to break into small groups) of gaps and priorities against the building blocks • Testing/assessing ((in plenary if group is too small to break into small groups) feasibility, including relevance, coherence/fit, efficiency, and sustainability of HP projects and/or interventions to address these • Discuss mechanisms for ongoing programme oversight and monitoring e.g NoM
Tuesday 04.02.20	
Day 2	**Full stakeholder workshop (day 1):** all day event (9am-4pm) with wider representation of stakeholders (including those at the high-level meeting or their representatives **Participants:** All identified stakeholders **Purpose**: to introduce the UKPHS programme and explore the Health Partnership model to address HSS priorities **Proposed Approach/Methods**: <u>Information sharing and validation</u> Presentations on 1) UKPHS programme and HP model; 2) findings from desk review including identified HSS priorities, including case studies and success stories/experiences/lessons learned shared by existing and/or previous DFID funded Health Partnership, 3) HSS and HPs; 4) Presentation of LF impact and outcome statement and key indicators <u>Information gathering through group work</u> Identification of gaps and priorities against the 6 building blocks Identification of HSS priorities to be addressed by HPs Map identified priorities against building blocks
Wednesday 05.03.20	

Day 3 -am	**Full stakeholder workshop (day 2):** As above **Participants:** As above **Purpose:** sub-groups meet to test feasibility of HPs to address HSS priorities **Proposed Approach/Methods**: **Testing and assessing feasibility and coherence/fit** Testing/assessing (in small groups, with one building block per group) the feasibility and coherence/fit of HP projects and/or interventions to address the identified HSS priorities. Stakeholders will use a prepared set of criteria including: relevance, efficiency, effectiveness and sustainability to address these fit and feasibility of HP projects and/or interventions to address these (Note: team may need to develop a matrix to enable groups capture this information or could be done on post-its/flip charts)
Day 3 -pm	**As above.** **Purpose:** sub-groups validate and agree on most feasible HP for addressing HSS priorities **Proposed Approach/Methods**: **Validation and consensus building: half day session** Review of the work of the sub-groups plenary and get agreement (Note: may need to prepare a score card) on most feasible HP projects and or interventions Revisit impact and outcome statement to test if selected HPs can achieve the expected results and assess feasibility of HP impact on health system, health service and health worker performance (LF outcome indicators)
Thursday 06.02.20	
Day 4 -am	Key informant interviews with identified individuals (as required based on discussions in previous days)
Day 4 -pm	Team meeting to prepare materials for debriefing sessions
Friday 07.02.20	
Day 5	**Debriefing session** **Participants:** Key high level stakeholders (involved in day 1 meeting) **Purpose:** appreciation of stakeholder involvement and government commitment; overview of objectives of scoping visit, outputs and outcomes achieved, way forward/next steps; **Proposed Approach/Methods**: Presentation of scoping visit objectives and results presentation and validation of findings and recommendations, Agreement on next steps and way forward

ANNEX 5 - TOPIC GUIDE FOR COURTESY CALLS, IN-DEPTH AND KEY INFORMANT INTERVIEWS, AND SMALL GROUP MEETINGS

POTENTIAL RESPONDENTS

Ministry of Health policy makers and leaders; department heads and programme managers, including gender focal persons; official from other relevant ministries (education, gender finance/ treasury, national planning and development, labour, civil/public service commission or management agencies); representatives from regional and/or local government; professional councils and associations; health training and academic/research institutions; development partners and donors/funders; representatives from UN agencies, international and local NGOs, faith based organisations, civil society groups/organizations, private sector; and institutions (governmental or non-governmental) working on gender equity and social inclusion, including any disability organisations.

MATERIALS

KII guide, notepad, pens, Programme Overview, UKPHS FAQs, Rings Guide on adopting a gender lens in health systems policy, figure of WHO HS Framework; and country-specific desk review findings/priorities.

INTRODUCTIONS

1. All participants introduce themselves
2. Establish post title and roles and responsibilities of respondent(s), if unknown
    - For government officials and NGOs, ask them to describe their area of focus and/or programme(s) they are responsible
    - For DPs and UN agencies ask them to describe their area of focus and/or programme(s) they are supporting and/or implementing
3. Scoping Team provide an overview of the scoping visit, its purpose, objectives and expected outcomes
4. Scoping Team outline stakeholder engagement strategies/plans that will be adopted and seeks respondent's feedback and inputs
5. If a workshop has been agreed, Scoping Team share the workshop programme, and discuss and seek respondent's inputs on the approach, objectives and expected outputs

OVERVIEW OF UKPHS & HP MODEL

1. Scoping Team provide an overview of the UKPHS programme, including FAQs, and examples of any previous HPs in the country, including achievements, challenges and lessons learned
2. Scoping Team provide any informational materials e.g. Programme Overview, UKPHS FAQs, Share the Rings Guide on adopting a gender lens in health systems policy. [19]

DISCUSSION AND VALIDATION OF HEALTH SYSTEMS PRIORITIES

1. Scoping Team provide a brief overview of the health system priorities, including for GESI, identified through the desk review, and through previous stakeholder consultations, if appropriate
2. Scoping Team seek inputs and validation on the identified priorities (share list of country-specific desk review findings/priorities) from respondents and probe for any additional priorities.

[19] https://www.ringsgenderresearch.org/wp-content/uploads/2020/01/Adopting-a-gender-lens-in-health-systems-policy.pdf

3. Scoping team explain that the UKPHS programme will seek to strengthen health systems and HPs will aim to support across the 6 building blocks or individual blocks as appropriate to the context and priorities identified. Check respondent's understanding of the WHO Health System Framework (share graphic in Annex if required) and map identified priorities against the building blocks as well as GESI

APPROPRIATENESS AND FEASIBILITY OF HP MODEL TO ADDRESS IDENTIFIED PRIORITIES

1. Scoping Team Summarise the identified HSS priorities, check respondent's understanding of the HP model and invite respondent's views on how the HP model and HP projects or interventions could address the identified HSS priorities. *Probe for how HP projects could improve health service performance in terms of equity, efficiency, access, quality, and sustainability, and ultimately help the country to achieve UHC?*
2. Probe for 3-5 key priority areas that could be addressed by HPs projects, including indicative activities, outputs and outcome, and overall impact

ADDRESSING GESI PRIORITIES THROUGH HPS

1. Discuss the identified GESI issues across the 6 building blocks, drawing on the Building Block Benchmarks for Gender[20] where appropriate (see Rings "Guide on adopting a gender lens in health systems policy").
2. Explore with the respondent how the identified HP projects/interventions could contribute to improving health sector performance in terms of equity (with a focus on gender equity, disability etc) and could help reach unreached and marginalised populations.

NATIONAL OVERSIGHT MECHANISM

1. Provide an overview of the proposed national oversight mechanism and discuss functions and composition

ADDITIONAL INFORMATION:

1. Any other key stakeholders the respondent would recommend the team should consult
2. Any other key documents the respondent would recommend the team should review that were not available for review during the desk review

CLOSURE

- Ask if the respondent would like to add further comments
- Bring the meeting to a close by summarising the main points
- Check respondent's availability and agree a date for a debriefing session, if required
- Thank the participant for his/her time and active participation

[20] Research in Gender and Ethics (2019) Adopting a gender lens in health systems policy: A Guide for Policy Makers. https://www.ringsgenderresearch.org/wp-content/uploads/2020/01/Adopting-a-gender-lens-in-health-systems-policy.pdf

ANNEX 6 - GROUP WORK ACTIVITIES

GROUP WORK ACTIVITY 1: HSS PRIORITIES IDENTIFIED, VALIDATED AND RANKED

- Identified HSS priority areas and activities are distributed amongst the Groups, with each group allocated a different HS building block/core function
- Each group will discuss the identified priorities and validate them, adding any that were omitted
- Each group will rank each priority area and activity, with 1 being the highest ranked priority
- Group work outputs, findings and conclusions can be captured and synthesized using Worksheet 1 below.

WORKSHEET 1

Building Block	HS Priority Area	Ranking	Priority Activity	Ranking
Governance	1. 2. 3.			
Health Financing				
Service Delivery				
Human Resources for Health (HRH)				
Medical Products, Vaccines, and Technologies				
Health Information System				

GROUP WORK ACTIVITY 2: POTENTIAL HP INTERVENTIONS AND PROJECTS TO ADDRESS IDENTIFIED PRIORITIES

- Groups will discuss and identify potential HP projects and interventions that could address the identified and ranked priority
- Groups will discuss how HPs could contribute to HSS within and across the 6 building blocks/core functions by addressing these priorities?
- Group work outputs, findings and conclusions can be captured and synthesized using Worksheet 2 below.

WORKSHEET 2

HS Priority Area/activity	Potential HP project/interventions
1. 2. 3.	

GROUP WORK ACTIVITY 3: ASSESSING HPS CONTRIBUTION TO THE HEALTH SYSTEM PERFORMANCE

- Groups will discuss how potential HP interventions/projects will contribute to improving health system performance
- Groups will answer the questions related to the following criteria to assess contribution:
    - Coherence
    - Relevance
    - Effectiveness
    - Efficiency
    - Access
    - Quality
    - Equity, gender equality and social inclusion
    - Impact
    - Sustainability
- Group work outputs and findings can be synthesized using Worksheet 3.

WORKSHEET 3

HP interventions	Coherence	Relevance	Effectiveness	Efficiency	Access	Quality	Equity	Sustainability	Impact
1									
2									
3									
4									
5									

GROUP WORK ACTIVITY 4: SYNTHESIS OF GROUP WORK AND LINKAGES BETWEEN HP INTERVENTIONS AND OUTCOME/IMPACT

- Groups will discuss and describe the most feasible HP interventions to address the key priorities and the expected outcome(s) and impact
- Group work outputs and findings can be synthesized using Worksheet 4.

WORKSHEET 4

Priority area	Description of HP Interventions	Expected output, outcome and impact

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