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Maternal and Child Survival Program

Responding to Health System Needs

Findings and Implications from Rapid Health Systems Assessments of Reproductive, Maternal, Newborn, and Child Health Services

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The Rapid Health Systems Assessment

The Rapid Health Systems Assessment (RHSA) is a qualitative exercise developed by the Maternal and Child Survival Program (MCSP) to: (1) quickly diagnose operations and management challenges at the subnational level that may affect reproductive, maternal, newborn, and child health (RMNCH) services and program activities; (2) prioritize key areas for strengthening; and (3) identify assets and opportunities in the health system. The aim of the RHSA is to gather information that MCSP country teams and health system managers can use to generate solutions to enhance the effectiveness and sustainability of planned and ongoing RMNCH activities, as well as to achieve the longer-term goal of strengthening the overall health system. To date, MCSP has conducted the RHSA with national, subnational, and facility-level stakeholder respondents in four countries: Guinea, Mozambique, Nigeria, and Rwanda. The results of this process have informed tailored local project activities and subnational decision-making in all four countries. In addition, the RHSAs found broader health system challenges and opportunities at the peripheral levels of the health systems across the four countries. These trends indicate a need for subnational managers—including those responsible for the delivery of care at health facilities—to have strong general management abilities, authority and ownership to make decisions proactively, and strategic coordination skills to achieve results. The cross-country findings are further detailed below.

Subnational managers need management capacity to fulfill their role.

Subnational health managers are the implementing arm of the health system, responsible for planning, managing, monitoring, and supervising health activities in facilities. Despite the importance of these core competencies, many subnational health managers, although they have medical and clinical training, do not have training or experience in leadership or management practices. In Guinea, RHSA respondents noted that there had not been specific management training or tools distributed at the district level for more than 20 years and that central-level training does not often cascade down to the regions and districts.

Across all four countries, supervision is a management challenge and a key concern. In Mozambique, the RHSA found that the management culture emphasizes protocol rather than judgment or discussion. As a result, supervision is a way of correcting mistakes based on protocols rather than an interactive activity for troubleshooting challenges and identifying possible solutions and preventive measures. The content and value of supervision may vary, as may the frequency of supervision visits. In Nigeria, management of personnel is fragmented, with responsibility spread across government entities, and some providers report never having had a supervisory visit by the agency charged with oversight for their facility. Health personnel, including

supervisors themselves, do not understand supervisors' roles and functions, so little supervision actually takes place. In many countries, supervision and monitoring mechanisms exist theoretically, but their implementation is neither standardized nor respected in the absence of accountability measures for supervisors. For managers in Guinea and Mozambique, for example, a lack of effective planning and resources results in a lack of supervision activities, but no mechanisms are in place to identify and rectify these challenges.

In addition to supervision, other essential elements of management include planning, resource allocation, and coordination. As is detailed below, subnational health managers often lack the authority, ownership, and involvement they need to effectively take on these functions and proactively address local challenges.

Authority and ownership empower subnational managers to be proactive.

There is a general trend toward decentralized health systems in developing countries, with key responsibilities devolving from national to subnational decision-makers. However, the RHSA found that despite national decentralization policies, subnational stakeholders often do not have the authority and support they need to make decisions locally or to effect meaningful change without higher-level support. As a result, they continue to rely on higher levels to provide solutions to local challenges and priorities. Tensions arise between the national and subnational levels around the limits of authority. In Nigeria, for example, respondents noted that the federal, state, and local levels all govern health, and states are often protective of their autonomy and skeptical of supporting national programs. Given the relative weakness of the federal government in compelling state and local action, the success of health sector initiatives relies on the state's willing and active participation, which in turn depends on the state's ability to maintain authority over key responsibilities.

Two key functions that frequently remain centrally controlled are human resources and financing, and RHSA respondents cited both as key challenges. Respondents consistently indicated that facilities have neither the quality nor the quantity of staff they need. Job descriptions, hiring, staff distribution, and training decisions are made at the central level, with very little consideration of needs at the peripheral level. In Guinea, Mozambique, and Nigeria, clinical staff shortages affect primary health care and the quality and accessibility of RMNCH services. In Mozambique, the RHSA showed that in one province there are almost 160 health facilities, but only 16 of them have one or more fully trained medical doctors. Health centers with only one or two elementary or mid-level nurses often serve high volumes of patients—sometimes more than 100 patients per day. In addition, key management positions at the regional and district levels in Guinea are unfilled, pending appointment from the central government. An additional complication in many of these contexts is that the different ministries that manage public service hiring, compensation, and training, must coordinate with each other and with the Ministry of Health.

Although subnational health management teams are responsible for developing decentralized action plans and corresponding budgets, their funding continues to come from the central level. Across the four RHSA countries, respondents indicated that funding disbursements are often delayed, and in some cases the funding does not correspond to the submitted budget due to unilateral budget revisions at the central level that are not communicated to the affected parties. In Guinea, respondents noted that funds often arrive with significant delays, do not arrive at all, or arrive only in part, impeding the implementation of activities. To plan, implement, and monitor activities effectively, subnational managers need a transparent process for budgeting and financial projections so that they know about any changes in funding ahead of time and can mobilize additional resources proactively. These human resource and financing decisions often are made at higher levels of the system, without data from or information on needs at lower levels.

Information systems that decision-makers rely on to monitor budgets and financial expenditures, human resource distribution, and service delivery often are weak in terms of the quality of data, the capacity to analyze and use data, and feedback loops. In Guinea, Mozambique, and Nigeria, few, if any, personnel at the facility or lowest administrative level have training in data management and verification. As such, there are often questions about the quality of the data submitted from the facility level upward to the higher levels of

health system management. Because managers do not understand how to use data to improve performance, some respondents in Nigeria, for example, view reporting as an administrative requirement rather than as a tool that can actually empower facility and other subnational managers to make informed decisions. This lack of awareness and the resulting lack of motivation contribute to the poor quality of health information system data.

Improving the quality of data is challenging without feedback loops. As reports and indicator data are relayed up through the levels of the health system, systems and accountability measures are not in place to ensure that concerns or aggregated data are fed back down to the different levels of the system. In Guinea, certain members of the district and regional health teams analyze data before transmitting them to the central level. However, this does not happen consistently. In addition, even at this subnational management level, staff often do not have sufficient training to analyze data or identify aberrations; thus, their ability to make use of this information is very limited. In contrast, respondents in Rwanda characterized their health information system as very robust, with trained data personnel within health centers and high performance on timeliness, data quality, and data completeness. With strong information systems, countries are able to reliably use and promote the use of data for decision-making.

Strategic coordination of activities and stakeholders increases efficiency.

In addition to effective operations and activities within facilities, coordination between facilities and across health sector stakeholders is essential to a strong health system. In analyzing service delivery capacity within health systems, the RHSA found important challenges in referral systems. In Guinea, Mozambique, and Nigeria, referral systems are weak and have no mechanisms in place to track (1) when referrals are made, (2) whether referrals are successfully realized, or (3) what follow-up is necessary after referral. In Mozambique, the lack of referral monitoring means that providers do not know the proportion of women referred for hospital delivery during antenatal care visits who actually deliver at a hospital; the average delay in emergency referral and arrival at a hospital; the proportion of women who deliver while en route to a health facility; and so on. Similarly, the system does not track counter-referrals systematically, and patients are accountable for any follow-up. Primary health care providers in Nigeria provided examples of ad hoc efforts to ensure the success of referrals, including devising makeshift referral forms and accompanying patients directly to referral facilities. However, health system stakeholders in Nigeria nevertheless see the systemic issues as negatively affecting access to high-quality RMNCH services and other essential care.

Informants in Rwanda described the referral system as strong overall, but they noted opportunities to improve particular aspects of the system such as emergency drills, alert systems, and counter-referrals back to the community level. Counter-referrals back to the community level to ensure the proper follow-up and continuous care of patients are a consistent challenge. Providers in Nigeria noted that hospitals very rarely provide any feedback, instructions, or records to the referring provider. They observed and reported some informal examples of successful feedback loops, often driven by primary health care workers who followed up directly with patients in the community. Some health facility staff in Guinea even noted that due to a lack of counter-referrals, they are less motivated to initiate upward referrals.

Just as health systems need to improve coordination of referrals to manage patient care efficiently, so too must they improve coordination of technical assistance partner input to make the best use of external resources. In some instances, partners bypass administrative authorities and provide commodities or technical assistance directly to facilities or communities. As a result, it is the partners' priorities rather than local demand for specific support that drive activities. In Mozambique, health facilities in close proximity of each other experience large resource disparities, depending on whether or not they are part of a donor-funded HIV program. In Guinea, many donors and partner organizations bypass the local administrative authorities and provide commodities and material support to particular health facilities, limiting the subnational management team's capacity to allocate resources strategically based on need. Subnational teams struggle to harness these disparate activities into meaningful contributions to the health system and often are unable to coordinate partner interventions to optimize their success and impact.

As part of the partner coordination challenge, subnational managers have difficulty in engaging with and mobilizing the communities in which they work. In some cases, this difficulty may result in low demand for health services and a lack of awareness of the services available. This was a particular problem in Guinea after the Ebola epidemic, when there was strong reticence among the population served by health facilities. In many cases, there is a broader systemic issue in which community oversight committees are established on paper, but in practice, members are not trained on their roles and responsibilities or do not receive the necessary support from the health system to effectively co-manage and govern health activities. In Guinea and Mozambique, community health committees are not fully aware of their roles and responsibilities, and many are therefore either not functional or not able to participate fully in health system decision-making processes. In Nigeria, however, the Ward Development Committees play a key role in the communication between the population and the health system; these committees disseminate health messages, publicize immunization campaigns, advocate for local government funding for health activities, and relay priority health concerns from the community to health system managers.

Conclusion: Providing effective support to subnational managers

Understanding the health system challenges that subnational managers face is key to supporting them effectively. In addition to having a national strategy and priorities, subnational health teams need support to successfully identify, analyze, and prioritize the health system challenges that have prevented them from achieving their objectives, and to develop proactive and holistic approaches to address these issues themselves. Using the results of the RHSA, MCSP country programs have been able to design and implement supportive approaches in line with their local health system context, challenges, assets, and priorities. In Guinea, where MCSP is supporting 20 districts in strengthening subnational management, district managers conducted root cause analyses to generate local solutions to priority issues in collaboration with a broad range of stakeholders, including the often-underused community health committees. With regular mentoring, these district teams troubleshoot implementation challenges. They have received training in stakeholder coordination and resource mobilization to build their capacity to plan and execute strategies to achieve their objectives and improve health outcomes. In Nigeria, the RHSA findings informed the expansion of MCSP work to address health system priorities such as financing for commodities, health worker motivation, and accountability mechanisms at the health facility level. Similarly, based on the RHSA results, the team in Mozambique further refined approaches to support referral monitoring and improved planning processes. In Rwanda, the RHSA findings demonstrated the importance of understanding how to scale up successful interventions, which led to MCSP support for costing the scale-up of successful Helping Babies Breathe and postpartum family planning interventions.

MCSP program countries have used the RHSA findings to inform planning and activity implementation approaches, and local governments have used them to set priorities. As one example, Ministry of Health officials in Guinea validated the RHSA results and have since cited the assessment in determining support needs at the regional and district levels. In addition, they have co-launched with MCSP revised, locally driven planning processes and stakeholder coordination capacity-building.

Across Guinea, Mozambique, Nigeria, and Rwanda, RHSA findings demonstrate the importance of building subnational management capacity that goes beyond specific interventions and programs to improve the coverage and quality of a full array of health services.

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