



Linking Private Primary  
Health Care Networks to  
Sustainable Domestic Financing:

# A Practical Guide for Network Managers



This guide was designed and developed by **Results for Development (R4D)**, a leading non-profit global development partner that collaborates with change agents— government officials, civil society leaders and social innovators — around the world to create strong systems that support healthy, educated people. At R4D, we help our partners move from knowing their goals to knowing how to reach them. We combine global expertise in health, education and nutrition with analytic rigor, practical support for decision-making and implementation and access to peer problem-solving networks. Together with our partners, we build self-sustaining systems that serve everyone and deliver lasting results. Then we share what we learn so others can achieve results for development, too. To learn more, please visit us at: [www.r4d.org](http://www.r4d.org)

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## What is SIFPO2?

The mission of USAID's Support for International Family Planning Organizations 2: Strengthening Networks is to increase the use of family planning (FP) services globally by strengthening the capacity and sustainability of social franchise networks of private providers.

SIFPO2 work largely focuses on two specific pillars:

- 1 **IMPROVING** quality assurance measurements, systems and processes, and
- 2 **TACKLING** sustainability challenges by analyzing the health financing landscape to develop innovative strategies.

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## Preface

In 1995, Population Services International (PSI) started its first social franchise, Greenstar — a private primary health care network in Pakistan that expands access to high quality voluntary family planning products and services. Greenstar organized fragmented private providers, introduced minimum clinical standards to address variable quality of care, and increased access to high-impact health services that were inadequately supported by the health market.

The franchise is just one model for organizing private providers into networks that deliver vital, yet often underprovided, health care services. Such networks can also effectively engage with governments to promote universal health coverage (UHC) within mixed (public and private) health systems. Despite their successes, private networks' reliance on out-of-pocket payments and (declining) donor support hinders the equity and sustainability of their business models. To ensure long-term financial sustainability and support UHC, private networks are seeking to engage more in national priorities and systems and diversify sources of funding.

Results for Development (R4D) and PSI, with support from USAID's Support for International Family Planning Organizations 2 (SIFPO2) program, developed a strategic planning process—outlined in this Guide—that managers of private primary health care networks can use to connect to domestic and/or third-party financing, delivery and oversight systems. The process systematically considers the network's strengths, needs, and place with the health financing system and market. It then helps define options to access new sources of financing to deliver high-quality health services to key populations and new modes of engagement with providers, development partners and government authorities.

To date the Guide has been adapted and implemented in four countries with four PSI-affiliated provider networks<sup>1</sup>, which support over 1,350 private health care providers. These network managers gained:

- I. An improved understanding of their organization and their country's health financing system, and the potential implications for sustainability and equity;
- II. Options to access domestic and/or other third-party financing sources to diversify and improve the equity of future funding for clients;
- III. Strategies and action plans to begin engagement with key stakeholders and implementation of priority options; and
- IV. Increased awareness among key government stakeholders of the value these platforms bring to deliver key primary health care (PHC) services via private sector providers.

We hope that this Guide will help managers of other primary health care provider networks evaluate the sustainability of their funding models and develop options to pursue strategic health financing opportunities that enhance the equity and reach of their services.



<sup>1</sup> This framework has been implemented at PSI-affiliated Clinical Social Franchises in these countries. A clinical social franchise is a network of private providers that are formally contracted to provide a defined set of health services under a brand managed and overseen by an aggregator organization which also supports providers with training, quality assurance, commodities and equipment, and demand generation.

# Acronyms

<b>CSF</b>	Clinical Social Franchise
<b>DALY</b>	Disability-Adjusted Life Year
<b>HFA</b>	Health Financing Analysis
<b>HFOA</b>	Health Financing Options Analysis
<b>HMA</b>	Health Market Analysis
<b>HMO</b>	Health Maintenance Organization
<b>FP</b>	Family Planning
<b>LMICs</b>	Low- and Middle-income Countries
<b>ONA</b>	Organization Needs Assessment
<b>PACE</b>	Programme for Accessible Health Communication and Education
<b>PEA</b>	Political Economy Analysis
<b>PHC</b>	Primary Health Care
<b>PSI</b>	Population Services International
<b>PSI/TZ</b>	Population Services International Tanzania
<b>PSK</b>	Population Services Khmer
<b>NGO</b>	Non-governmental Organization
<b>NMO</b>	Network Management Organization
<b>R4D</b>	Results for Development
<b>SFH</b>	Society for Family Health
<b>SRH</b>	Sexual and Reproductive Health
<b>SQHN</b>	Sun Quality Health Network
<b>SIFPO2</b>	Support for International Family Planning Organizations
<b>SWOT</b>	Strengths, Weaknesses, Opportunities, and Threats
<b>UHC</b>	Universal Health Coverage
<b>USAID</b>	United States Agency for International Development



# Glossary

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**Aggregator:**

A networking organization that contracts, supports and manages a group of private providers to deliver services as contractually agreed. Common global examples include health maintenance organizations (HMOs), network management organizations (NMOs) and clinical social franchisors (CSFs).

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**Domestic and/or other third-party sources of financing:**

Domestic and/or other third-party sources of financing comprise funds to support and pay for health care service delivery derived from sources other than out-of-pocket spending by users or health provider budgets. These sources may include public sector mechanisms for prepaid-pooled health financing coverage (such as social health insurance funds for UHC); health care budgets of national or subnational governments; or payments by private health insurers, employers, or philanthropies. Domestic public sources of such third-party financing are preferable for sustainably and equitably paying for services. But funds from public or private donors may also finance discrete activities to develop capacities and infrastructure, establish proof of concept, and augment or complement domestic initiatives in support of high quality, sustainable, and equitable service delivery. Examples of such initiatives by public, multilateral, or private donors may include community-based insurance and voucher programs, performance-based financing interventions, provider mapping and accreditation projects, etc.

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**Intermediary:**

Defined by Results for Development as an organization that forms networks between small-scale private providers to interact with governments, patients and vendors, while performing essential health systems functions that are challenging for individual private providers to do on their own. These include proactive coordination and continuity in health care across providers for the population, broad adherence to protocols/guidelines and requirements for continuous quality improvement, access to systems and financing to develop long-term management capacity among providers, and systematic integration of providers into more substantial payment mechanisms, such as for UHC. For example, aggregators – such as HMOs and social franchises – and provider associations can serve as intermediaries to carry out specific functions.

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**Mixed Health Systems:**

Mixed health systems feature government health services that operate side by side with private organizations providing similar or complementary products and services. In such mixed systems, the private sector encompasses a vast diversity of providers and other actors, functioning in parallel to those owned or operated by government entities, and thus includes everything from NGO health clinics, local pharmacy shops and traditional healers to high-end for-profit hospitals, and a plethora of other providers.

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**Network:**

A group of private providers supported and/or managed by an aggregator to deliver services as contractually agreed. For example, a network of general practitioners providing malaria-related services.

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**Platform:**

Platform is an umbrella term used by Population Services International to refer to its country programs (whether an affiliate program, independent locally registered network member, or implementing partner). The platform includes all country program activities including social marketing, clinical social franchising, delivery of donor projects and others.

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# Introduction: A Practical Guide for Networks to Connect to Sustainable Domestic Financing Opportunities

**The health systems** of most low- and middle-income countries (LMICs) are mixed, meaning that public health services operate side by side with private markets. The private sector may serve as the first point of care, especially for many sexual and reproductive health needs. Without interventions such as clinical social franchising, clients will pay out-of-pocket for variable service quality and limited access – excluding primarily lower-income quintile and vulnerable populations and placing an increased financial burden on users seeking care. The government, however, may lack the motivation, capacity, or mechanisms to support and regulate private providers and purchase services. Still, effective public-private engagement and partnerships are necessary to achieve universal health care coverage (UHC)<sup>1</sup> and advance national health initiatives.

Aggregators, such as social franchisors and health management organizations, organize private, independent health care businesses into quality-assured networks that provide accessible, high-quality health services. They can help to address the challenges of public-private disjunction, but face several barriers, including building enough capacity and financial support to deliver services at scale and promote public health goals. Countries making progress towards UHC may have dedicated financing available to support these efforts as harnessing the private sector will be critical to achieve and sustain success.

For private sector aggregators interested in participating in UHC initiatives and strengthening mixed-health systems, it is necessary to develop a strong understanding of both the broader health market in which they exist and their role within it to identify potential opportunities for engagement. This guide was created to help aggregators systematically gather, organize and analyze information to develop promising options for engagement, as well as develop



a foundation of knowledge around key health-system principles and functions.

## The purpose

This guide is intended for organizations working with private health care providers, as well as for health financing experts. It provides technical guidance and practical examples for planning and conducting analyses to identify opportunities to connect aggregators and provider networks with domestic (third-party) financing and delivery systems to advance UHC efforts and other national priorities.

This guide is not *directly* designed to yield research, policy-, or advocacy-related findings. However, the information gathered through desk research and stakeholder interviews using this guide can provide rich source material for such purposes.

<sup>1</sup> Pursuing Universal Health Coverage refers to ensuring population access to adequate, uninterrupted and high quality health care services without risk of financial hardship or impoverishment for users.



## How this guide is organized

The guide is structured in two parts:

### Part 1: The Core Analytic Framework

The guide consists of four separate analyses: Organization Needs Assessment, Health Market Analysis, Health Financing Analysis and Health Financing Options Analysis.

Each analysis section in this guide includes:

- **An overview** of the purpose and rationale
- **An outline** of key documents, sources and stakeholders needed to support desk research and in-depth interviews
- **A summary** of common challenges, solutions and lessons learned
- **Examples** from country experiences

While the guide provides a robust framework for conducting the analyses, and equips users with templates and resources to systematically gather and synthesize information and evidence, it is meant to be adaptable and flexible to the context in which the tool is being implemented.

### Part 2: The Implementation Approach

The approach to successfully implementing the guide uses six steps:

- I. An Induction Process:** Setting the tone for executing the analyses
- II. Research and Analysis:** Conducting and synthesizing desk analyses to build foundational country-level knowledge
- III. Orientation:** Familiarizing the aggregator organization, particularly network managers, with key health financing concepts and principles
- IV. Co-production of Options:** Development and road-mapping of health financing options with the leadership and network management teams from the aggregator organization
- V. Documentation:** Principles and good practices around documentation
- VI. Follow Up:** Key next steps to consider for the execution team and the aggregator

This section will thoroughly explain each step, suggest useful resources and provide tips for users to effectively execute the analyses.

## Description of the four analyses

### SECTION 1: ORGANIZATION NEEDS ASSESSMENT (ONA)

Identifies the specific needs and gaps of the aggregator. It describes the current financial sustainability of the aggregator and its networks as well as examines their current cost structure, funding dynamics and vulnerabilities. The analysis is informed by the aggregator's immediate strategic plans and any supporting policies and practices.

### SECTION 2: HEALTH MARKET ANALYSIS (HMA)

Examines the national health market and explores the aggregator's current and future position in it. The HMA examines the supply and demand of health services in the public, commercial and social sectors, and evaluates the enabling environment for the delivery of services with regard to the formal and informal norms and supporting functions of the health market.

### SECTION 3: HEALTH FINANCING ANALYSIS (HFA)

Explores the three core functions of health financing (revenue generation, pooling and purchasing mechanisms) — outlining different sources of funds, and detailing different pooling structures and purchasing mechanisms in public and private sectors.

### SECTION 4: HEALTH FINANCING OPTIONS ANALYSIS (HFOA)

Health financing options are co-produced with key leadership personnel and network managers from the aggregator organization. These options are based on findings from the ONA, HFA and HMA analyses to ensure each is actionable in the context of the health market.

## What does success look like?

The guide helps network managers navigate the steps necessary for gathering, structuring, analyzing and reporting information needed to make strategic plans that improve sustainability and equity. Successful application of this guide will:

- 1 **ADVANCE** the understanding of health financing mechanisms and their impact on the quality, equity and utilization of services supported by the aggregator organization;
- 2 **EMPOWER** aggregators to think and speak about health financing critically in light of the health financing landscape and their role in the health market, and define their value proposition for successful engagement; and
- 3 **ENABLE** the development of strategies and action plans for aggregators to effectively sensitize and engage with key government officials, payers and development partners as well as devise implementation approaches.

# PART 1: The Core Analytic Framework



2. Blood pressure more than 130/90?
3. Skin or eyes appear yellowish?
4. Lump in breast present?
5. Signs of inflammation?
6. Swollen or throbbing vertebrae?
7. Heavy or frequent menses?
8. Difficulty breathing?
9. Frequent headaches?
10. Signs of pregnancy?
11. Taking the drugs Rifampin or...
12. Unusual vaginal discharge occur...
13. Tumor present?

## Section 1: Organization Needs Assessment

### OBJECTIVES:

- Identify gaps between the current financial and organizational situation, and the desired financial and organizational situation of the aggregator and its network(s)
- Define the end goal from the perspective of the client, the providers and the aggregator and its network(s)

### WHO IS INVOLVED:

- Guide execution team: Consists of a 3-4 network managers and external experts (if needed) to systematically gather information and conduct the analyses
- Other important personnel to involve, as necessary: Organization leadership team, network management team and executives, network providers

### TOOLS:

Interview questionnaire (see Annex A); Example ONA template (end of section)

### Overview

The Organization Needs Assessment (ONA) describes the organizational arrangements of the aggregator and its network(s), its position and reputation in the country and its current financial sustainability. The needs assessment is further enriched by knowledge of the organization's immediate and future strategic and financial plans, as well as any supporting policies and practices. The needs assessment concludes by articulating the key challenges facing the aggregator and its network(s).

### Key Stakeholders

The following is an illustrative list of important persons to engage with to inform the needs assessment:

- Country representative/executive director
- Network(s) management team(s)
- Providers and clients
- Regional and national technical advisors
- Program/activity managers

### Potential Resources and Documents

The following documents will be helpful in supporting the needs assessment:

- Current donor program descriptions
- Current donor applications
- Current programs and partnerships
- Strategy and finance documents
- Policy and framework documents
- Recent evaluations of the aggregator/network(s)

*Please refer to Annex A to review the example stakeholder interview questionnaire.*



## Common Challenges, Solutions and Lessons Learned

**COUNTRY EXPERIENCES:** For each platform, the execution team facilitated sessions with key managers to define the challenge and success from their perspectives.

In **Nigeria**, one of these sessions revealed a robust strategy and vision for the franchise, which envisioned it being the "bedrock of the platform through which every other project needs to be channeled." Understanding the potential and future direction of the franchise was critical to ensuring the link to domestic financing was relevant to the platform.

**Challenge:** Defining the challenge and success from the platforms' perspective.

**Solution:** Understand and identify the challenges and define success with the organization/network team.

**Lessons Learned:** The language used to describe the challenge is critical for understanding the platforms' needs, and co-production of the challenge enhances its relevance. Defining success will deepen the understanding of the work for conducting these analyses and help with tailoring it to the platforms' needs.

**COUNTRY EXPERIENCES:** In **Uganda**, the execution team facilitated a session with platform managers to set expectations around the work to communicate that accessing domestic financing is not a quick win or a magic bullet. That is, the results of the core analyses were not going to move the franchise 100% away from donor financing within the next few years.

**Challenge:** Lack of clarity or consensus around expectations for financial sustainability.

**Solution:** Solicit expectations around financial sustainability and then manage those expectations in person, and document.

**Lessons Learned:** Transitions to domestic financing does not happen overnight. Setting expectations around an incremental plan will support more realistic thinking.

**COUNTRY EXPERIENCES:** For each country engagement, the execution team had limited success in tracking down information that highlighted cost-effectiveness and efficiencies for the platform. This is typical for many organizations; however, it is critical to communicate the need for this type of information, especially as platforms decide to pursue any of the options. In **Nigeria**, the team met with the chief financial officer and sought spending and budget information broken down by projects to develop rough estimates.

**Challenge:** Health financing information, such as cost-effectiveness, cost per disability-adjusted life year (DALY), and spending per provider, is difficult to find.

**Solution:** The execution team may be able to do some rough calculations to help support the discussion.

**Lessons Learned:** Highlighting the lack of information around cost-effectiveness communicates the importance of this information and can catalyze change.

**COUNTRY EXPERIENCES:** In **Cambodia**, the initial analysis of the ONA was revised in light of the interviews and other analyses conducted— these highlighted additional strengths that the platform could leverage to successfully move an option forward.

**Challenge:** Understanding of the ONA information evolves as other analyses are taking place.

**Solution:** Continually revisit and revise the ONA as more relevant and useful information surfaces while other analyses are ongoing.

**Lessons Learned:** Draft the ONA based on initial research, but plan to revise and finalize later.

## Structure for organizing needs assessment information

This template serves as an illustrative example of the type of information and level of detail desired, as well as how to frame and organize the information. Note that these guiding questions can be altered to accommodate a broader and/or different focus.

### Organization Needs Assessment

Country:

Region:

State:

Current Organizational and Financial Situation			
Current Situation	Question	Response	Source(s)
	How is the aggregator organization and its network structured? Describe the organizational arrangement of the franchise, including the roles and responsibilities of key personnel.		
	Describe the key networks/programs (e.g., objectives, providers types, services and support provided, partnerships, and outcomes to date).		
	What are the strengths and weaknesses? For each network/program area, describe the strengths and weaknesses in detail.		
	How does the organization compare to other similar organizations in the area, if any? Globally?		
Financial Situation	Question	Response	Source(s)
	What are the current funding/revenue streams for the organization and its networks/programs? What are the conditions around the financing?		
	What is the current financial strategy for the organization? For the networks/programs?		
	What are the major areas of spending for the organization and the networks/programs?		

### Future Organizational and Financial Situation

Organizational Strategy	Question	Response	Source(s)
	Describe the key areas of growth for the aggregator organization. What does success look like?		
	What are the strategic goals for organization and its networks/programs? In the next 5 years? Next 10-15 years?		
Financial Strategy	Question	Response	Source(s)
	How will the organization and its network/programs be financed going forward? Describe potential revenue sources (i.e., donor, public, private) and financing needs.		
	How will the aggregator need to position itself to access those finances to support its strategy?		

### Define the Challenge(s)

Based on the review of the organization and financial situation and future strategies, identify key challenges and describe the key concerns

Potential Challenge	Question	Response	Source(s)
	Describe the key areas of growth for the aggregator organization. What does success look like?		
	What are the strategic goals for organization and its networks/programs? In the next 5 years? Next 10-15 years?		
Financial Strategy	Question	Response	Source(s)
	How will the organization and its network/programs be financed going forward? Describe potential revenue sources (i.e., donor, public, private) and financing needs.		
	How will the aggregator need to position itself to access those finances to support its strategy?		



## Section 2: Health Market Analysis

### OBJECTIVE:

- Understand the health market, and the aggregator's and its network(s)' position within it

### WHO IS INVOLVED:

- Guide execution team: Consists of a 3-4 network managers and external experts (if needed) to systematically gather information and conduct the analyses
- Other important personnel to involve, as necessary: Organization leadership team, network management team and executives, non-state actors (e.g., ministry of health officials, research institutions, NGOs, etc.)

### TOOLS:

Interview questionnaire (see Annex B); Example HMA template (end of section)

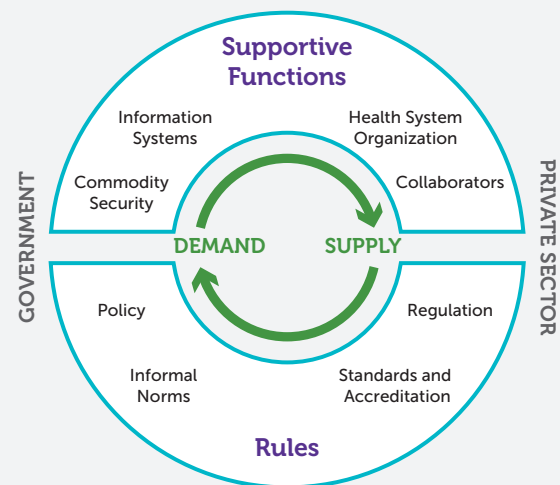
### Overview

The health markets analysis (HMA) is critical for understanding the dynamics of the health market and how the current and future position of the aggregator and its network(s) fit within it — all of which is vital for identifying health financing options.

The HMA examines the dynamics of the public, commercial and social sectors in health, using an adaptation of the Making Markets Work for the Poor (M4P) analysis (See Figure 1). As visualized by the "doughnut," the core functions of supply and demand for the client are examined alongside the overarching supportive functions (organization, coordination, information and skills and capacity) and rules (policy and regulation, standards and accreditation and informal rules and norms).

The M4P analysis identifies areas for system change that can improve the *overall* sustainability of the aggregator/network(s).<sup>2</sup>

**FIGURE 1: Adapted M4P framework for the health market analysis**



Source: The Springfield Centre (2014). The Operational Guide for the Making Markets Work for the Poor (M4P) Approach, 2nd edition funded by SDC & DFID. <http://www.springfieldcentre.com/wp-content/uploads/2014/09/2014-09-M4P-Operational-Guide-with-watermark1.pdf>.

**THE HMA FRAMEWORK** is also closely aligned with WHO's six building blocks\* for strengthening health systems, which, in fact, are also incorporated within the M4P "doughnut." This analysis, however, goes one step further by examining the dynamics between the building blocks and within the broader health system.

\*Building blocks include: governance, information, financing, service delivery, human resources, medicines and technologies

Source: World Health Organization (2007). Everybody's Business: strengthening health systems to improve health outcomes. (WHO's Framework for Action), WHO, Geneva.

<sup>2</sup> Sustainability is the capability of market systems to respond to changes and provide a means by which poor women and men can continue to derive social and economic benefits, beyond the period of intervention. Ibid.

**THE FOUNDATION OF THE HMA** is built by diligently researching the current health market and documenting the functions and rules that shape it. However, desk research may not capture the diversity of dynamics in the market and the actual (de facto) practice and division of roles and responsibilities. In-depth interviews with a series of stakeholders will help to validate desk research and understand these other dynamics. No two countries are the same — one might find that desk research is more than sufficient in one case, while the in-depth interviews prove to be more informative for another.

The health market analysis is divided into four sections to draw out the challenges and opportunities in each market:

#### DEMAND-SIDE

Examines the health seeking behavior of individuals and key indicators/statistics

#### SUPPLY-SIDE

Explores the supply factors that shape the market, such as the availability of services, opportunity for access, skills and capacities of providers and provider motivation

#### SUPPORTIVE FUNCTIONS

Analyzes the enabling environment for delivering services/areas of interest through the private sector by looking at the health system organization, collaborators, commodity security and information systems

#### RULES, LAWS AND REGULATIONS

Inspects the policy environment and coordination arrangements health services

## Key Stakeholders

While the HMA can be completed solely through an extensive desk review, interviews with stakeholders will be helpful for verifying and enriching findings. The following stakeholders can complement the HMA:

- Professional Associations: doctor, nurse, clinical officer, pharmacist
- Ministry of Health, district health authorities, private sector coordination units (such as public-private partnership units or technical working groups), public and private payers
- National accreditation and regulation agencies
- Donor agencies' representatives
- NGOs and implementation agencies

## Potential Resources and Documents

The following documents will be helpful in supporting the analysis:

- Assessments, reports and strategies (from ONA)
- Donor-specific country assessments and strategies
- Human resources for health assessments
- Commodities securities assessments and strategies
- Public sector assessments and strategies
- Private sector assessment and strategies
- World Bank Health Market Assessments

*Please refer to example template at the end of this section for a potential way to structure the HMA information and refer to Annex B to review the example stakeholder interview questionnaire.*

## Common Challenges, Solutions and Lessons Learned

**COUNTRY EXPERIENCES:** When the framework was first introduced and conducted in **Tanzania**, the execution team thought the HMA would be an output produced at the end of the exercise. However, the team quickly realized that HMA information was needed up front to identify stakeholders, craft appropriate interview questions and further understand the health market.

**Challenge:** HMA should provide critical background information needed for stakeholder interviews.

**Solution:** Draft the HMA based on desk review and use the stakeholder interviews to verify or develop insights.

**Lessons Learned:** Research for the HMA should be completed in advance of stakeholder interviews

**COUNTRY EXPERIENCES:** In **Tanzania**, the local team found it less than informative and time-consuming when just the health market information was presented (e.g., relevant policies, statistics, etc.).

In subsequent countries, the execution team switched gears and focused on presenting the analysis. This meant that platforms were better able to understand how they could be better positioned within the health market to advance or shift specific policies, participate in various initiatives and think more critically about how they can evolve into a health market intermediary.

**Challenge:** The platform already knows much of the HMA information.

**Solution:** Do not present the HMA for informational purposes. Instead, offer the information as a reference tool — platforms often do not have the most current evidence and documentation of the health market.

**Lessons Learned:** The HMA can be used during in-person working sessions to solicit insights for other analyses.

**COUNTRY EXPERIENCES:** In all the countries, the team discovered deep-seated fears on the part of the government about working with the private sector.

For instance, in **Tanzania**, a deep mistrust of the private sector prevented the implementation of financing mechanisms like service-level agreements that could work for the private sector. While in Cambodia, we came to understand the lack of interest in working with the private sector was due to dual practice. Addressing dual practice is a critical step in unlocking any potential future financing involving the private sector.

**Challenge:** Informal rules and norms are not well documented in the literature.

**Solution:** Use the stakeholder interview to understand these informal rules and norms better. Again, be diligent about documenting sources — especially quotes. Differentiate between stakeholder opinions and your teams' opinions.

**Lessons Learned:** Network staff is well placed to explain the informal rules and norms — be explicit in asking.

**COUNTRY EXPERIENCES:** In **Cambodia**, the team used a recently published political economy analysis in health care that served as the foundational piece to understanding the distribution of power. With this base knowledge, the team gently probed interviewees on power dynamics and enabling environment around specific options. This information was fed back to the platform team and used to develop a stronger, feasible set of options.

**Challenge:** The HMA should contain elements of a political economy analysis (PEA).

**Solution:** If a comprehensive PEA is not possible, working to understand the power and politics during interviews is critical.

**Lessons Learned:** The more the power and politics that can be understood, the stronger the health financing options will be; quotes from stakeholders always strengthen the analysis.

**COUNTRY EXPERIENCES:** In **Tanzania** and **Uganda**, the execution developed "operating hypotheses" about what the health financing options could be and focused the HMA around these options to better understand the context and strengthen linkages to the HFA and ONA.

In **Cambodia**, where few immediate health financing options were present, the HMA was critical for providing the evidence and support for the future advocacy work needed to advance the options.

**Challenge:** Linking the HMA to other sections of the guide is difficult.

**Solution:** Use initial hypotheses about the health financing options and ONA work to focus HMA analysis.

**Lessons Learned:** HMA analysis and synthesis are challenging — collaborate to help strengthen the linkages. Workshop ideas, give time for reflection and workshop ideas.



## Structure for organizing health market information

This template uses commonly franchised sexual and reproductive health (SRH) services as an illustrative example of the type of information and level of detailed desired, as well as how to frame and organize the content.

### Health Market Analysis

Country:

Region:

State:

Demand and Supply of SRH Services: Challenges and Opportunities			
FP/SRH Market	Question	Response	Source(s)
	% Total Fertility Rate		
	% Maternal Mortality Ratio		
	% Modern Contraceptive Prevalence Rate		
	Unmet Need for FP		
	What are the different sources of health financing (donor, out-of-pocket payments, public, private/non-personal) and why?		
	How do the sources of spending on SRH services compare?		
	How do you judge the willingness to pay for SRH?		
	Do above factors differ by geography? For example, are there differences in utilization patterns in urban vs. rural area? Any specific data?		
How do you measure demand for SRH services by different categories of users: is it low or high? Summarize reasons if it's low.			
Supply of SRH services	Question	Response	Source(s)
	Who are the main providers of MCH/SRH services (public/private)?		
	What are the main services they deliver?		
	Does the public sector partner with or fund the private sector for SRH service delivery? How?		
	Are human resources for health (HRH) personnel trained to provide FP/RH services in the public and private sectors?		
	Who mainly trains public and private providers to delivery these services?		
	How regular and widespread is this training?		
	Describe the quality – and how it is measured – of training and level of HRH capacity in the public and private sectors. What are key issues?		
Are there any <i>upcoming</i> public and/or donor resources and policy/legislative agenda items to look out for?			
<p><b>Briefly summarize challenges and opportunities for the CSF network</b>                      Considering demand and supply information gathered above, list all possible challenges and opportunities</p>	Challenges		
	Opportunities		

## Supportive Functions: Challenges and Opportunities

Supportive Functions: Challenges and Opportunities			
Processes, protocols and mechanisms	Question	Response	Source(s)
	How do levels of service delivery and levels of government correspond?		
	How does financing for health care flow through the public system? Who controls most funding?		
	Which level(s) of government has/have responsibility for policymaking? For governance/ coordination of delivery? (planning, accreditation, management, quality assurance)		
	Are there mechanisms for public-private partnerships? Who funds and executes these partnerships?		
	Who provides private sector input into these processes? Individual platforms/NGOs, representative bodies?		
	Identify the main private sector (policy and delivery) actors and their roles.		
	Who are the main suppliers of SRH commodities for public and private providers?		
	Is there widespread/easy access to and availability of commodities and supportive materials/consumables? Are there stock-outs? If possible, ask respondents to quantify.		
	What other services do these suppliers offer? (credit, training, quality assurance, business planning, bulk purchases, etc.)		
	How does information about service delivery and commodities flow among actors above?		
Are these information systems and data fragmented? Of good quality? Routine?			
<p><b>Briefly summarize challenges and opportunities for the CSF network</b>  <i>Considering demand and supply information gathered above, list all possible challenges and opportunities</i></p>		Challenges	
		Opportunities	
Policy and Coordination Arrangements for SRH Services: Challenges and Opportunities			
Policy, legislation and coordination arrangements	Question	Response	Source(s)
	Identify key national and/or state policy priorities and initiatives around FP/RH.		
	Is there a minimum set of services? Is FP/RH included?		
	What is the current role of the private sector? What is its future role in the health system?		
	What is the key legislation, if any, regulating private providers? Any salient features regarding relevant private sector delivery?		
	Identify and describe accreditation standards for private providers (e.g., responsibility, enforcement, etc.)		
	Identify and describe clinical standards for private providers.		
	How and how well are these enforced?		
How would you characterize the overall relationship between the public and private sectors? Close and cooperative? Distrustful? Minimal?			
<p><b>Briefly summarize challenges and opportunities for the CSF network</b>  <i>Considering demand and supply information gathered above, list all possible challenges and opportunities</i></p>		Challenges	
		Opportunities	

## Section 3: Health Financing Analysis

### OBJECTIVE:

- Understand current health financing mechanisms and the opportunities within them

### WHO IS INVOLVED:

- Guide execution team: Consists of a 3-4 network managers and external experts (if needed) to systematically gather information and conduct the analyses
- Other important personnel to involve, as necessary: Organization leadership team, network management team and executives, non-state actors (e.g., ministry of health officials, research institutions, NGOs, etc.)

### TOOLS:

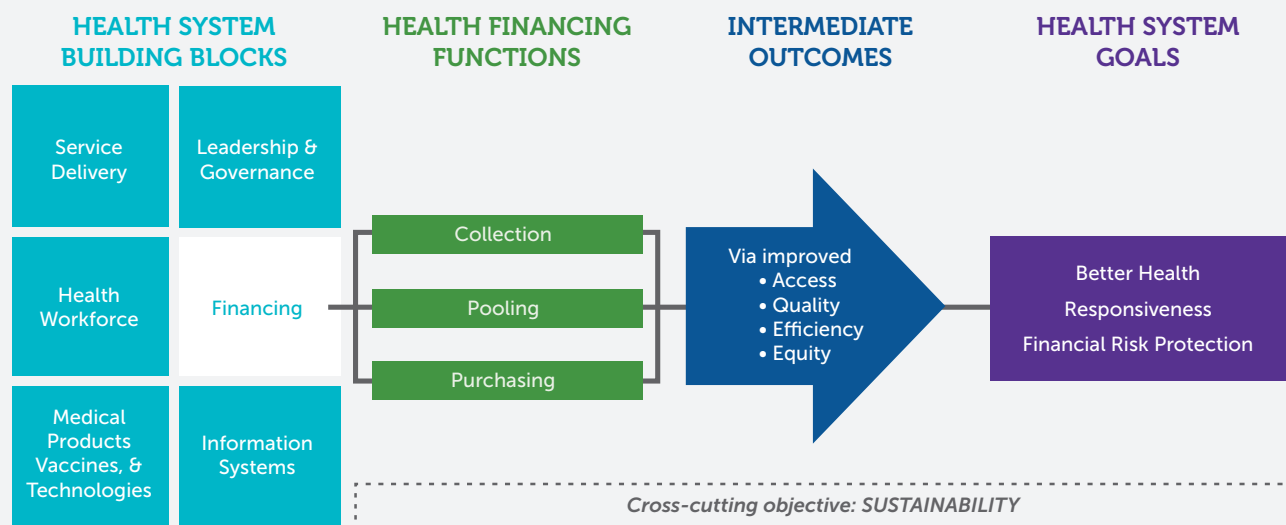
Interview questionnaire (See Annex C), Example HFA template (end of section)

### Overview

The health financing analysis examines collection, pooling and purchasing mechanisms within the health care market, including domestic public and private sources of funds, as well as external (or donor) funds. The HFA also explores policy trends and reforms that the network(s) and the aggregator can take advantage of over time. The HFA is conducted concurrently with the ONA and HMA.

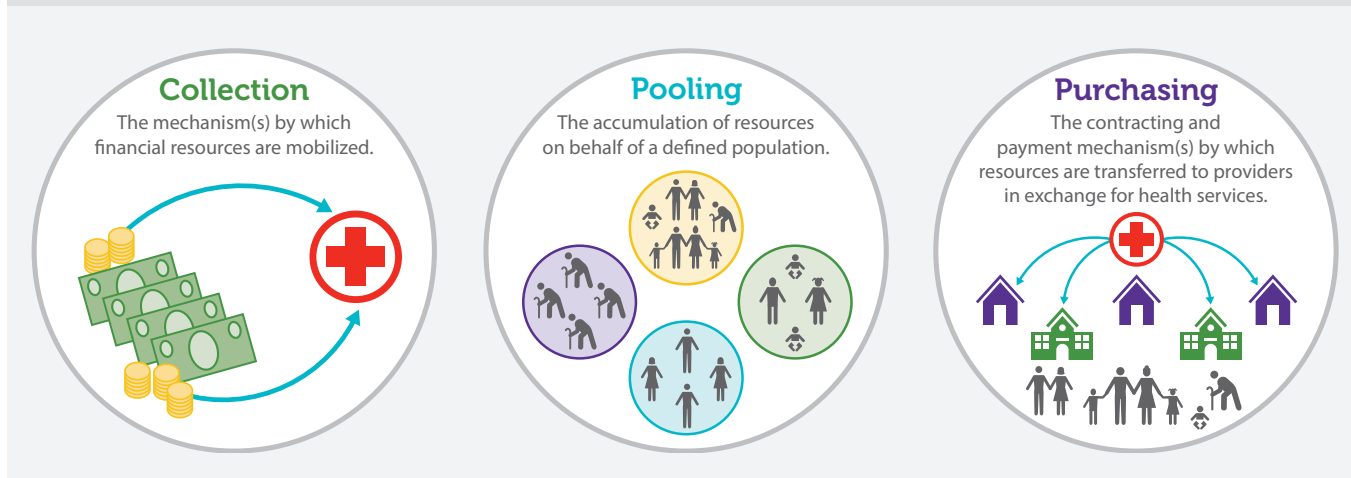
**Why does health financing matter?** As depicted in Figure 2, health financing is one of the six critical health system building blocks, in which the three health financing functions have a direct impact on the intermediate outcomes. The HFA seeks information on sources and mechanisms of health financing that helps to connect the financing and other building blocks with key intermediate outcomes important to the aggregator, so challenges and opportunities can be drawn out.

**FIGURE 2: Designing health financing systems to achieve health goals**



Note: This framework is a synthesis of prominent health systems and health financing frameworks, including those offered in Kutzin 2001, WHO 2000 and 2010, and Roberts et al. 2008, as well as R4D's own thinking and analysis.

FIGURE 3: Health Financing Functions



The Health Financing Analysis is divided into two sections of analysis:

#### MACRO HEALTH FINANCING INDICATORS –

Reviews government financial commitments to health and services/areas of interest, along with the role of donor and private financing.

**HEALTH FINANCING MECHANISMS –** For each mechanism, the analysis examines the three core functions (see Figure 3) to determine how platforms may or may not be contracted to play a certain role:

- **COLLECTION –** Describe existing and new sources of revenue for health and services/ areas of interest, looking at the level of financing contributed by each source.
- **POOLING –** Examine how risk-pooling mechanisms are arranged, managed and implemented.
- **PURCHASING ARRANGEMENTS –** Analyze existing and future purchasing arrangements in the country.

*Please refer to the example template at the end of this section for a potential way to structure the HFA information, and refer to Annex C to review the example stakeholder interview questionnaire.*

The purchasing arrangements will be critical for understanding the different opportunities that can link private sector providers to domestic sources of financing, and how countries use these arrangements to support national goals for the provision and consumption of health care.

#### Key Stakeholders

The following persons will be necessary for informing the health financing analysis:

- Ministry of Health officials involved in government-backed health insurance schemes
- National Social Security Fund officials
- Donor-supported schemes
- Private insurers
- Community-based health insurance committees
- Public health facilities
- Private health facilities

#### Potential Resources and Documents

The following documents will be helpful in supporting the health financing analysis:

- National donor coordinating documentation
- System-wide action plans
- National health accounts and sub-accounts
- National health system assessments
- World Bank database
- WHO database and country health profiles



## Common Challenges, Solutions and Lessons Learned

**COUNTRY EXPERIENCES:** In **Uganda** and **Cambodia**, the execution team found that the family planning (FP) voucher programs were ending or in transition. In Nigeria, the “Subsidy Reinvestment and Empowerment Program” conditional cash-transfer program had ended. Still, the team elected to include these in the analysis as there were several valuable lessons learned and potential for future opportunities.

**Challenge:** HFA is only a snapshot of the health financing situation.

**Solution:** Historical programs that are no longer operational can be included and labeled appropriately.

**Lessons Learned:** Extracting the lessons learned from historical programs is critical to understanding the political economy of current programs.

**COUNTRY EXPERIENCES:** In **Cambodia**, there were several different health financing mechanisms — from donor-led to government-run. Through desk research, our team built foundational knowledge to describe the schemes, but lacked understanding around the intricacies of the schemes and still required general functioning clarifications. To that end, the execution team relied heavily on key informant interviews to fill in the blanks and verify information.

**Challenge:** Details of the HFA are conflicting in the literature.

**Solution:** Draft the HFA before conducting stakeholder interviews. Use the interviews to fill gaps and verify information gathered during desk review.

**Lessons Learned:** There is an important distinction between the documentation and the realities of implementation, which the HFA must highlight to address inefficiencies.

**COUNTRY EXPERIENCES:** In **Nigeria**, 36 states have either a current or planned approach to insurance and contracting. Ultimately, the execution team selected a range of financing mechanisms that we thought would present direct and feasible opportunities for the private sector or would demonstrate new models for the platform.

**Challenge:** There are too many schemes to detail.

**Solution:** Focus on those schemes that have geographic overlap, that have the highest coverage and that work with private providers.

**Lessons Learned:** While many schemes exist, it is likely that only a few will cover the people, services and providers that are relevant to the platform.

**COUNTRY EXPERIENCES:** In **Nigeria**, the execution team was looking at eight different financing schemes that all handled primary health care differently for private and public health sectors. It was helpful to use the lens of family planning to identify what services were covered, for which population(s), delivered under which providers and how they were being paid.

In several cases, the team found that private providers were not adequately or effectively included in schemes to provide family planning. But, this helped us identify challenges that platforms would need to overcome to participate in such schemes.

**Challenge:** There is too much information on the specifics of purchasing.

**Solution:** Target key services relevant to the organization to systematically answer: for what, for and by whom, and how.

**Lessons Learned:** Purchasing details are the most important for the private providers in the social franchise networks. Unlocking barriers in purchasing has enormous potential for the providers.

**COUNTRY EXPERIENCES:** In **Cambodia**, the execution team found that the platform team had a varied understanding of health financing. Thus, the HFA was presented using the three primary health financing functions — collection, pooling, purchasing — as a framework. The HFA was supplemented with a schematic to show and reiterate the flow of funds. These sessions also served as a learning opportunity for both teams to discuss discrepancies in policies, processes and practice.

**Challenge:** HFA information can be overwhelming or inaccessible.

**Solution:** Presenting the HFA information in a uniform framework and using appropriate health financing language can be empowering for the platform.

**Lessons Learned:** Platforms have a general understanding of health financing schemes in the country but do not always have the basic knowledge to understand the full scope or the language to compare and contrast them. Bringing the information together and conducting a health financing orientation can be useful.

**COUNTRY EXPERIENCES:** In **Cambodia**, none of the health financing schemes offered up near-term opportunities for the platform. The execution team used the findings from the ONA, HFA and HMA to inform an advocacy strategy that should help position the platform to be better able to access these financing schemes in the future.

**Challenge:** None of the current schemes seem appropriate for the franchise.

**Solution:** Look at the future policy directions for health financing in the country and identify ways in which the platform can shape that direction.

**Lessons Learned:** In many cases, the platform has a critical role to play in shaping the direction of future schemes and how they work with small, private providers in their network.

## Structure for organizing health financing information

### Health Financing Schemes

Provide details for each of the health financing schemes in the country. For each scheme, you will fill in two columns: i) the first column will contain the data, ii) the second column details data sources and references. Please add more columns to capture all existing and future schemes.

	Scheme 1	References for 1	Scheme 2	References for 2
<b>General Information</b>				
Name of scheme				
Short description of scheme				
Is it system wide or project based?				
What type of scheme is it? <i>Please indicate one of the following: voucher, conditional cash transfer, medical savings accounts, community-based health insurance, micro-insurance, government backed insurance, other</i>				
What is the implementing or management organization?				
What is the start date of the scheme?				
What is the current status or end date (if applicable)?				
<b>History of the Scheme</b>				
History of the funding:				
Which donor?				
What part of the MOH was involved?				
What was the rationale for donors or government to start co-funding the scheme?				
Which management agency?				
What was the political environment for implementation of the scheme?				
<b>Collection</b>				
What are the sources of funds used to finance the scheme? <i>Such as: domestic funds, taxes (e.g., VAT, income tax, national, state or province), tariffs/ import duties, employers, corporations, foundations, foreign funds, bilateral, multilateral, foundations, individual premiums, community funds.</i>				
<b>Pooling</b>				
To what extent is there any risk pooling associated with the health financing scheme? Over time? Between rich and poor? Between the sick and healthy?				
Please describe the nature of the pooling.				
<b>Purchasing Mechanisms</b>				
<i>(Note: This section uses FP/SRH as an illustrative example of how to focus the research. This can be adapted to other contexts.)</i>				
<b>For whom:</b> What are the eligibility requirements? Does the health financing mechanism target specific populations(s)? Women of reproductive age, specific income quintiles (Q1, Q2), poor/near poor? Adolescents?				
<b>For whom:</b> What is the enrollment process for those people? What is the re-enrollment process (if applicable)?				

## Structure for organizing health financing information *(continued)*

	Scheme 1	References for 1	Scheme 2	References for 2
<b>What:</b> What is included in the benefit package? Inpatient? Outpatient? What services are explicitly NOT covered?				
<b>What:</b> Which FP services are included? Methods? Methods not covered?				
<b>What:</b> RH services? Maternal services? Neonatal services? Child services?				
<b>From whom:</b> Where are the service delivered? Public providers, private providers, a combination? How are facilities accredited to be part of the scheme? What is the empanelment process?				
<b>How to pay, at what price?</b> Does the client have to pay? If so, when and how much? Are provider incentives included? Is the scheme integrated with other health financing schemes? Please indicate which ones. Is a third party involved?				

### Impact

What is the geographic coverage? Which states or provinces are included? What is the % urban? % rural?				
How many people are covered through the scheme?				
How many people are eligible for the scheme?				
How many covered people use the scheme?				
How many new users are associated with the health financing scheme (if applicable)?				
What are the volumes and types of services, as well as any disaggregation available, by time (month/quarter/year)?				
What is the projected growth of coverage? What are the targets for coverage? In what time span?				

### Your Opinion

<b>Outcomes:</b> Was the scheme able to address any of the following goals? <ol style="list-style-type: none"> <li>Effectively target specific population</li> <li>Increase utilization of specific health goods/services</li> <li>More efficient distribution of health goods and services</li> <li>Improve the quality of the health goods/services</li> <li>Improved health of the population</li> <li>Improve financial risk protection</li> </ol>				
<b>Lessons learned:</b> What are the three main lessons learned or takeaways from this health financing scheme.				
<b>Political environment:</b> In your estimation, what was the political environment for this health financing scheme? Enabling? Neutral? Inhibiting?				
<b>Operational Environment:</b> In your estimation, what was the political environment for this health financing scheme? Enabling? Neutral? Inhibiting?				
<b>Contribution to Universal Health Coverage:</b> Did/Does this scheme make a contribution to the UHC agenda in-country? Significant? Neutral? Insignificant?				

## Section 4: Health Financing Options Analysis

### OBJECTIVE:

- To develop health financing options and assess feasibility of the proposed options

### WHO IS INVOLVED:

- Guide execution team: Consists of a 3-4 network managers and external experts (if needed) to systematically gather information and conduct the analyses
- Other important personnel to involve, as necessary: Organization leadership team, network management team and executives

### TOOLS:

Options framework and reference tables (see Annex D)

### Overview

Based on the findings from the previous sections, health financing options that are actionable in the national context are co-developed with the aggregator and its network teams alongside the execution team.

For each option, the team summarizes the health financing options analysis (HFOA) according to the framework provided in Annex D. This method standardizes the review process and facilitates comparison among all the options. Overall, the proposed opportunities offer a greater depth of understanding of how the aggregator and its network(s) can engage with domestic health financing.

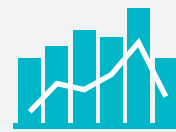
In addition to the information needed to fill out the options framework, a **feasibility analysis** is also applied to each option to examine it within the broader enabling environment using four key factors<sup>4</sup>:

*Please refer to Annex D to review the options framework and reference tables.*



#### 1 POLITICAL:

Explore the key stakeholders and institutional arrangements around particular interests<sup>5</sup>



#### 2 ECONOMIC:

Investigate fiscal space and/or economic rationale problems (e.g., franchise networks not being cost-effective enough to justify public investment)



#### 3 ORGANIZATIONAL:

Understand constraints on part of aggregator/network/provider constraints (e.g., lack of effective providers in key geographical areas)



#### 4 LEGAL/REGULATORY:

Analyze critical policies, regulations, and laws that need to change to create a better enabling environment

<sup>4</sup> Blanchet, N.J., Ishtiaq, A., Thomas, C. (Forthcoming). "Engagement of the private sector in advancing UHC: Understanding and navigating major factors for success." In Franz, C., Galambos, L., Kickbusch, I., and Sturchio, J. (Eds.) Universal Health Coverage and the New Health Economy.

<sup>5</sup> **Stakeholders** are individuals, groups, or organizations that have a political, ideological and/or economic interest in a specific policy and have the potential to influence policy direction. **Institutions** are established laws, rules, regulations, norms, or agencies that structure how relevant decision-making happens.



In presenting the options overview, the most effective approach is to develop a **theory of change** for health financing that demonstrates how different options address the challenge initially defined by the aggregator (see Figure 4). The theory of change also supports the clear articulation of *why* work in health financing is important and aligns with the goals of the aggregator.

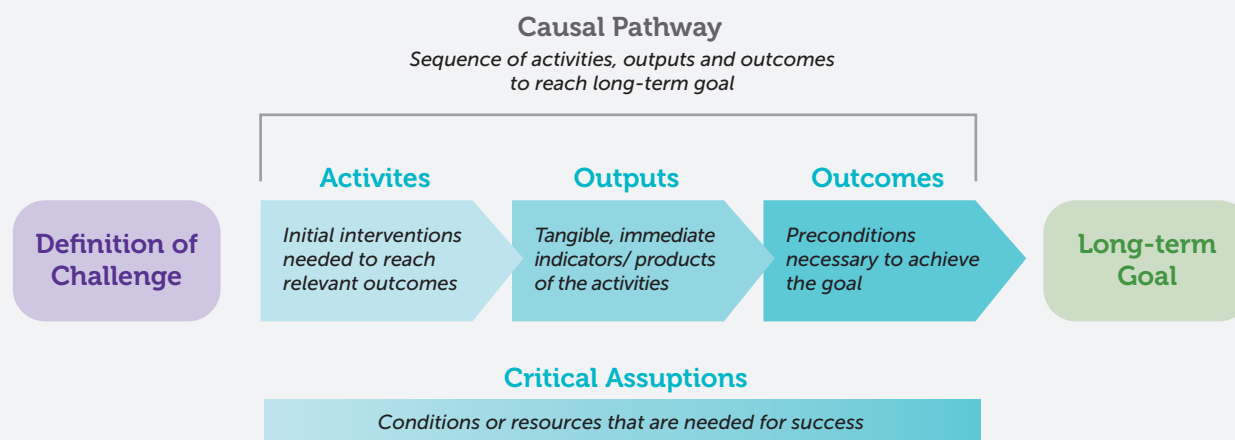
## Key Stakeholders

The specific stakeholders for each option may differ. However, if possible, it is advisable to pressure test options with relevant stakeholders to gain valuable insights into feasibility and constraints of the option which feeds into the PEA.

## Potential Resources and Documents

Resources and documents for each option differ. However, it is important to link and source the appropriate materials and evidence needed — relevant to each option — clearly so that it can support any further work. Remember to always save resources and documents in a place where the aggregator and its networks can access them.

**FIGURE 4:** Descriptive *Theory of Change* diagram



Source: Brown, A. (2016, March 18). What is this thing called 'Theory of Change'? [Web blog post]. Retrieved February 01, 2018, from <https://usaidlearninglab.org/lab-notes/what-thing-called-theory-change>

## THEORY OF CHANGE

The purpose of a theory of change is to enhance understanding of how and why a program works. It is an “approach that describes how a program brings about specific long-term outcomes through a logical sequence of intermediate outcomes.”

Source: Breuer, E., et al. Using theory of change to design and evaluate public health interventions: a systematic review. *Implement Sci* 2016;11:63.

## Common Challenges, Solutions and Lessons Learned

**COUNTRY EXPERIENCES:** In **Uganda**, one of the options analyzed was to contract with the Kampala Capital City Authority to deliver PHC and maternal and child health services through the Programme for Accessible Health Communication and Education (PACE) facilities. The next steps identified included developing a business case for stakeholders, which was used to begin discussions with different donors to help support the initiative.

**Challenge:** Many of the options require donor funding to help position the franchise for future domestic funding.

**Solution:** Still, explore the option, but highlight that donor start-up funding may be necessary.

**Lessons Learned:** Options can be used as the basis for discussions with donors or even included in proposals for funding.

**COUNTRY EXPERIENCES:** In **Nigeria**, many of the health financing options seemed like distant opportunities for the platform. Bringing the options together under a strategy helped to identify specific steps that the Society for Family Health (SFH) could take to position itself for those funds in the future. Even if a full theory of change isn't developed, it is beneficial to identify the interim steps platforms would need to pursue the option(s).

**Challenge:** : None of the options can be implemented immediately.

**Solution:** Identify the intermediate steps needed to achieve the overall vision.

**Lessons Learned:** Working through the analyses and steps laid out in this guide is helpful for informing the future strategic direction of the platform to be able to implement the options.

**COUNTRY EXPERIENCES:** In **Uganda**, the execution team hosted a road-mapping working session, where we worked in small groups to identify activities, and human and financial resource requirements for each option. The groups cycled through the different options to comment and evolve the thinking on the work plan.

**Challenge:** Next steps are difficult to define.

**Solution:** Use the group work with the platform to help define next steps.

**Lessons Learned:** Concrete next steps help the options to feel more tangible to the platform and force the execution team to be realistic in their recommended approach.

**COUNTRY EXPERIENCES:** In **Tanzania**, the execution team broke into small groups to focus on one of the financing options, where we used the strengths/weaknesses/opportunities/threats (SWOT) analysis and PEA information to refine the options. Through these discussions, the team discovered that the service-level agreement option had much more potential than we anticipated. Feeding the SWOT analysis back to the group helped to align thinking and reach consensus.

**Challenge:** The SWOT analysis feels generic.

**Solution:** Use the options group working session as an opportunity to gather feedback and improve upon the SWOT analysis.

**Lessons Learned:** Working through various iterations of the SWOT can help strengthen the overall option.

**COUNTRY EXPERIENCES:** In **Nigeria**, the execution team facilitated a session where each SFH team member was given \$100 in “fun” dollars to invest in one or more of the options. Similarly, in **Cambodia**, the execution team gave each Population Services Khmer (PSK) team member a set of stickers to conduct a passion vote—each person could choose to place all of their stickers on one options or distribute them in any manner across the options.

These activities gave the execution team quick feedback on which options had the most significant relevance and/or interest to the platform and helped them to prioritize options.

**Challenge:** Not all of the options are of equal weight or relevance to the platform.

**Solution:** Go through a prioritization process with the platform to highlight these differences. Include the weightings in the option description.

**Lessons Learned:** Having a range of options with different weighting or relevance is inevitable. Highlighting this through the overview or the role in the theory of change will help everyone to understand this.

## Part 2: The Implementation Approach



# The Implementation Approach

## OBJECTIVES:

- Detail the approach and methodologies needed to successfully execute the core analyses and effectively collaborate with key partners

## WHO IS INVOLVED:

- Guide execution team: Consists of a 3-4 network managers and external experts (if needed) to systematically gather information and conduct the analyses

## TOOLS:

Induction process checklist (see Annex E)

## Overview

The implementation approach used to undertake the suite of analyses detailed is critical to the success of the guide. The approach will support co-production, which in turn will increase the appropriateness, acceptability and ownership of the final options. The approach uses the six steps detailed below and those featured in the annexes, including: Induction Process, Research and Analysis, Orientation, Option Co-Production, Documentation and Follow-Up.

## Step 1: Induction Process

An induction meeting is critical to set the expectations and tone for the analysis. The first step is to start with a formal in-person or virtual meeting with key senior management from the aggregator – ensure key network managers are present – and the execution team that will undertake the analysis. Subsequent communications will be needed to achieve the following objectives:

1. Introduction to the guide, approach and deliverables;
2. Agreement on the scope of work;
3. Clarity on the obligations and ownership of the process; and
4. Definition of criteria for success.

## Step 2: Research and Analysis

The research and analysis are conducted through an extensive desk review of published and grey literature, as well as web resources. Additional information is gathered through stakeholder interviews.

### Desk Review

Extensive research for the organization needs assessment, health market analysis, and health financing analysis should be completed before the stakeholder interviews are carried out. This research allows the team to develop operating hypotheses of potential health financing options that can then be pressure tested with the aggregator and through stakeholder interviews; the research also yields additional key stakeholders to be interviewed. The ONA, HMA, and HFA are each useful in their own right. As such, they should be developed and delivered as stand-alone products (i.e., as a slide deck or Word document).

### Stakeholder Interviews

Stakeholder interviews are critical to verifying the desk review information and exploring potential health financing options.

Schedule ONA interviews with key organization and network team members prior to HMA and HFA interviews so that HMA and HFA interview can better

*Please refer to Annex E to review the induction process checklist*



**BEST PRACTICES FOR INTERVIEWS:**

**Thoroughly research the topic(s) for discussion before the interview.** Research facilitates more thoughtful engagement with stakeholders, as opposed to purely information-gathering sessions. Most stakeholders are frequently interviewed by consultants, so it is imperative to be able to get to the issues for discussion.

**Prepare a set of discussion topics and questions in advance, based on the desk review.** Three topics for discussion is likely sufficient for a 45 – 60-minute interview after the work program is presented and introductions are made, with time left at the end of the interview for next steps and follow-up action.

focus to address the key questions and challenges that surface from the ONA. A balance between the number of interviews for the health market and health financing analyses is recommended.

During the interviews, the tasks of data collection – questioning, note taking, listening for pertinent quotes and topics – should be explicitly assigned. Notes from the meeting should be made available to the stakeholders interviewed within a short time (one to two days). Interview notes should also be made available to the aggregator. The notes should use a standard template and include summary highlights from the discussion, as well as key quotes.

**Analysis**

The most difficult, and yet important, step is the triangulation and analysis of the desk review information and stakeholder interviews together. Dedicate time immediately after conducting the interviews and desk research to reflect on and effectively synthesize the information.

**Step 3: Orientation**

For many aggregators and network staff, the topic of health financing is new. Even if not, levels of knowledge around health financing will be heterogeneous. To ensure that everyone is using the same language and has the same understanding about health financing, conduct a preliminary health financing orientation for all relevant and interested staff at the beginning of the exercise. The orientation supports the following objectives:

1. To learn about the Health Financing Framework and language;
2. To relate the Health Financing Framework to the national context;
3. To relate the Health Financing Framework to the health impact goals; and

4. To preview challenges and opportunities from the desk review.

The orientation also allows the executive team to gauge the level of health financing awareness on the team, which can inform further work. The orientation can also be coupled with the HFA presentation so that the aggregator can simultaneously learn about the health financing mechanisms in the country, as well as describe any that might have been missed during the desk review. Depending on demand, the execution team may want to offer the health financing orientation more than once to ensure that all or most appropriate staff has had the orientation.

**Step 4: Co-production of Options**

The aggregator staff has unparalleled depth and breadth of experience with the segments of the national health market and health financing system. While conducting the analyses, it is critical to draw upon those experiences to develop tenable health financing options – start the discussions with drafts of the options. The aggregator team should work together to build their understanding of the preliminary options, provide feedback to strengthen the options, and have the opportunity to propose their own. The discussion should allow the participants to think concretely about how to implement the option, discuss potential barriers, identify key stakeholders to engage with, and determine the appropriate timeframes and resources required (both internal and external) to carry out the option. After the co-production session, the participants should analyze the options relative to each other and vote to prioritize them.

An interim report on the option co-production session should be made available to the aggregator. This report helps to document the process in-country and the evolution of ideas.



## Step 5: Documentation

Documentation for the entire exercise goes beyond the final report. This level of documentation reflects the process of the analysis and the evolution of the thinking that will occur. Please see Annex F for a checklist of the minimum documentation to be made available.

## Step 6: Follow Up

This exercise is the start of the process, not the end. The core analytic framework presented is meant to explore and identify various health financing options for the network(s) and the aggregator, as a whole. Follow up should be done after the delivery of the final report and at agreed-upon times, such as at three months, six months and one year.

### REMEMBER — BE PREPARED, ORGANIZED AND PLAN AHEAD!

- i. Draft and send detailed agendas in advance so participants can adequately prepare for the meetings;
- ii. Develop extensive facilitation plans to ensure the meetings are well run; and
- iii. Create a collaborative environment that invites critical thinking and encourages knowledge sharing.

## Common Challenges, Solutions and Lessons Learned from the Approach

**COUNTRY EXPERIENCES:** In **Nigeria**, the execution team collaborated with a manager who had been recently appointed to work across the four different projects, focusing on private providers. His interest in expanding and advancing SFH's vision to work with private providers, coupled with his experience, helped to move the strategy forward.

**Challenge:** Communications and decision-making authorities are unclear within the platform.

**Solution:** Request a point person from the platform and/or social franchise network for the process. This point person can help navigate the unique dynamics of the platform.

**Lessons Learned:** Working with a point person to build capacity helps with the continuity of the work going forward.

**COUNTRY EXPERIENCES:** In **Cambodia**, the execution team conducted a health financing orientation session which served as a critical step in effectively engaging with senior managers at PSK. Many of the managers were new to health financing and coupling the orientation with the review of the HFA was largely successful. If time permits, it is equally as beneficial to hold a separate HF orientation session. For example, in Uganda, the execution framed it as a "Lunch and Learn" event and worked with the team members to apply what they learned through a series of activities.

**Challenge:** The platform is already very knowledgeable about health financing.

**Solution:** Offer the health financing orientation as an optional session open to everyone to allow a broader range of staff to learn about it.

**Lessons Learned:** Health financing has nuances that even the most experienced staff is not always clear about. It's important to recognize the differences and come to a common understanding together.

**COUNTRY EXPERIENCES:** In **Tanzania**, the execution team only had one session at the end of two weeks to debrief, and it was not enough time to work through the information and co-produce the thinking. In subsequent countries, the team added co-production sessions for ideation, options analysis, and/or road mapping. This was done by: 1) building it into the Terms of Reference; 2) introducing these expectations into the preliminary discussions; and 3) sending out calendar invitations with clear objectives, pre-session materials and post-session materials. When the sessions are well-facilitated, participants stay engaged and support the process.

**Challenge:** The platform doesn't have time to co-produce the options.

**Solution:** Set expectations of the co-production up front.

Request support from the director in co-production; if s/he attends, this signals the importance of the meeting to the rest of the team. Prepare thoroughly and make the session interactive.

**Lessons Learned:** Any group can develop the options in isolation from the platform; however, in doing so, the learning opportunity is missed, and the options are less likely to be of high quality. Co-production of the options has been critical to the success of the work.

**COUNTRY EXPERIENCES:** The execution team effectively supported platforms in **Tanzania, Uganda** and **Nigeria** well after the core analyses were complete. However, this required the team working together with the platforms to identify and drum up support and motivation around one or more of the options. It is important to identify champions within the platform to take the work forward, frequently follow up with key platform team members and stay apprised of the current health situation to adapt to the changing environments.

**Challenge:** The platform has competing priorities and is not able to focus on the work after the exercise has concluded.

**Solution:** Co-develop a follow-up program with the platform. Identify the key people to be involved in the process.

**Lessons Learned:** Follow-up is critical. It is essential to stick to the follow-up plan and keep the momentum going.

# Annexes

The annexes provide example questionnaires, templates and frameworks as resources to structure and analyze information necessary for successful implementation of the guide.



## Annex A: Organization Needs Assessment

### 1. Current Situation

- 1.1. How are the aggregator and its network(s) structured?
  - 1.1.1. In which geographies does the aggregator and its network(s) operate?
  - 1.1.2. What types of providers are contracted?
  - 1.1.3. What is the range of services offered under each network?
  - 1.1.4. What is the relationship with government entities?
- 1.2. What are the current strengths of the aggregator and its network(s)?
- 1.3. What are the current weaknesses of the aggregator and its network(s)?
- 1.4. How does this aggregator and its network(s) compare to other aggregators and their networks in the area? Globally?

### 2. Support of Health Impact Goals

This section broadly assesses how the aggregator and its network(s) are performing against key health impact goals: quality, access, equity, utilization, cost-effectiveness and sustainability.

#### 2.1. Quality

- 2.1.1. How does each network improve quality?
  - Technical competence of the provider
  - Informed choice for the client
  - Privacy and confidentiality for the client
  - Client and provider safety
  - Continuity of care
- 2.1.2. How does the aggregator support its network(s) to achieve this goal?

#### 2.2. Access

- 2.2.1. How does each network expand access to key health services, such as FP/SRH, in urban, peri-urban and rural areas?
- 2.2.2. How does the aggregator support its network(s) against this goal?
  - Describe what programs, initiatives, and/or activities exist to expand access (e.g., community programs, provider business trainings, etc.)

#### 2.3. Equity

- 2.3.1. What is the socio-demographic profile of the clients accessing services via the network(s)?
- 2.3.2. Does each network serve its respective key target and vulnerable populations for their service delivery areas? If so, how?
- 2.3.3. How does the aggregator support its network(s) against this goal?

#### 2.4. Utilization

- 2.4.1. How does each network provide services to those who wouldn't otherwise be covered by the existing health system?
- 2.4.2. How does each network tailor outreach and service provision to the health-seeking behavior of clients (flexible/affordable fees, including first point-of-contact, etc.)?
- 2.4.3. How does each network carry out demand generation among clients?
- 2.4.4. How does the aggregator support its network(s) to achieve this goal?

### 2.5. *Cost-effectiveness*

- 2.5.1. Does each network deliver services at an equal or lower cost compared to other service delivery options (inclusive of all subsidy or system costs)? Describe current strategies.
- 2.5.2. How does the aggregator support its network(s) to achieve this goal?
- 2.5.3. Does the aggregator measure cost per (i) disability life adjusted years, (ii) couple years of protection, (iii) provider, etc., and benchmark against comparators?

### 2.6. *Sustainability*

- 2.6.1. How is each network achieving its financial, programmatic and operational goals?
- 2.6.2. How does the aggregator support its network(s) to achieve these goals?

## 3. Current Financial Sustainability

- 3.1. What are the major sources of financing for the aggregator and its network(s)?
- 3.2. What are the domestic financing sources currently in use?
- 3.3. What are conditions around the financing (tightly earmarked, burdensome reporting, etc.)?
- 3.4. What are the major areas of spending for the aggregator? The network(s)?
- 3.5. How are health, financial and organizational outcomes measured? How do these outcomes relate to spending? What are the trends?
- 3.6. What are the levels of overhead/non-delivery-related spending for the aggregator? The network(s)?

## 4. Future Strategic plans

- 4.1. What are the key areas for growth for the aggregator? The network(s)? What does success look like for the aggregator? The network(s)?
- 4.2. What are the strategic goals of the aggregator? The network(s)?
  - 4.2.1. How dependent on country context are they and what are the implications surrounding that?
- 4.3. How will the aggregator and its network(s) be financed going forward? Donor? Public? Private?
- 4.4. What is needed to position the aggregator to access those finances to support its network(s)?

## 5. Defining the Challenge

- 5.1. What are the key concerns for the aggregator at present? The network(s)?
- 5.2. What are the key concerns for the aggregator going forward? The network(s)?
- 5.3. What are the key concerns regarding financing for the aggregator? The network(s)?



## Annex B: Health Market Analysis

### 1. Core Function: Demand Side Factors

Within the core functions, the analysis looks at the health-seeking behavior of individuals for the services offered via the network(s). For example, one can particularly look at demand side factors that affect the health-seeking behaviors of clients for key FP/SRH services.

#### 1.1. *Client*

1.1.1. What is the target client or archetype in this context?

#### 1.2. *Need*

1.1.2. What is the need for services? For instance, is the need for FP/SRH specific services?

1.1.3. Who has this need (identify key populations)?

1.1.4. Where are these people located (identify geographic locations)?

1.1.5. What are the national statistics for identified disease focus areas? For instance, key indicators for FP/SRH are: total facility rate, maternal mortality, family planning, contraceptive prevalence rate, unmet need, met need?

#### 1.3. *Motivation*

1.1.6. Are women motivated to seek services offered by the network(s)? If so, which ones, from whom and from where?

1.1.7. How is the community engaged in offered services?

1.1.8. What are the main barriers to seeking these services?

#### 1.4. *Willingness*

1.1.9. Is there client willingness to pay for these services?

### 2. Core Function: Supply-Side Factors

Within the core functions, the analysis looks at the supply factors that shape the market for the services offered via the network(s). For example, one can particularly look at supply side factors that affect delivery of key FP/SRH services.

#### 2.1. *Availability*

2.1.1. In the public sector, describe the type and reach of health care providers to deliver services (can be program or disease area specific)? Private sector?

#### 2.2. *Opportunity*

2.2.1. Are all services delivered by the network(s) currently available for everyone? Describe what is and is not offered.

2.2.2. Where are these services delivered? Identify areas where access to these services is limited or unavailable.

#### 2.3. *Ability*

2.3.1. Who currently provides these services delivered by the network(s) in the public sector? Private sector?

2.3.2. What other cadre of health professionals are able to provide these services? For example, for FP/SRH-related services, are health workers able to provide services of interest (e.g., short- and long-acting reversible contraceptive methods, etc.)?

2.3.3. What are the legal barriers to service delivery? De facto or de jure?



## 2.4. *Skills and Capacity*

- 2.4.1. What is the level of training needed to deliver these services? Certification? Accreditation?
- 2.4.2. What is the rigor of service-specific training, materials, job aids, etc.?
- How often do they happen?
  - Who implements training?
  - How are they recognized?

## 2.5. *Motivation*

- 2.5.1. What are the motivations for the providers to offer these services?
- By whom and where?
  - How is this externally supported?

## 3. **Supportive Functions**

The section analyzes the enabling environment to delivery services via the private sector.

### 3.1. *Health System Organization*

- 3.1.1. Describe the organizational structure of the health system and populations covered.
- What is the structure and coverage of the public sector?
  - What is the structure and coverage of the private sector? For-profit and not-for-profit?
  - What is the structure and coverage of the informal sector?
  - What is the structure and coverage of the pharmaceutical sector?

### 3.2. *Collaborators*

- 3.2.1. Who are the other collaborators in the health care sector? What are their roles and functions?
- Other NGOs? Social franchisors? Social marketers? Other interventions?
- 3.2.2. Membership organizations?
- 3.2.3. Representative bodies?

### 3.3. *Commodity Security*

- 3.3.1. What are the levels of access to and availability of commodities and supportive materials/ consumables? For public sector? For private sector?

### 3.4. *Information Systems*

- 3.4.1. Describe the existing government information system.
- Where does it “live”?
  - How is it regulated?
- 3.4.2. How does information flow from the private sector to the public sector? Public to private?
- 3.4.3. What is the quality of the data from the public sector? Private sector?
- How is data validated?
  - How is quality assessed?
- 3.4.4. What is the culture/habit of using routine data transparently to detect and address problems in service delivery?

## 4. Rules, Laws and Regulations

This section of the analysis analyzes the policy environment and coordination arrangement for specific service delivery areas, programs, or initiatives.

### 4.1. *Policy*

- 4.1.1. What are the national policies around the services/area of interest?
- 4.1.2. What is the private sector policy around services/area of interest?

### 4.2. *Regulation*

- 4.2.1. What is the regulatory environment of the public sector? The private sector? How is it enforced?
- 4.2.2. Legislation for private sector providers?
- 4.2.3. Taxation for private sector providers?

### 4.3. *Standards and Accreditation*

- 4.3.1. What are the clinical standards for the public sector? How are they different from the private sector? How are they enforced?
- 4.3.2. Is there any accreditation? What are the terms and conditions of the accreditation? Which entities oversee accreditation?

### 4.4. *Informal Rules and Norms*

- 4.4.1. What is the dynamic between the private and public sectors? How is dual practice addressed?
- 4.4.2. Despite the formal rules and regulations, who offers services/areas of interest?

## Annex C: Health Financing Analysis

### 1. Macro Health Financing Indicators

This analysis looks at government commitment to health and services/areas of interest, along with the role of donor and private financing.

#### 1.1. Domestic Health Expenditure

- 1.1.1. What is the total domestic expenditure on health as a percentage of gross domestic product?
- 1.1.2. Of the total domestic health expenditure, what percentage is public, private and out-of-pocket?

#### 1.2. Donor Health Expenditure

- 1.2.1. What percentage of total health expenditure comes from external donors?
- 1.2.2. What percentage of spending on specific services/areas of interest comes from external donors?

#### 1.3. Sexual and Reproductive Health Expenditure

- 1.3.1. What percentage of total domestic health spending is on specific services/areas of interest (or any important subset of those services)?
- 1.3.2. What percentage of domestic spending on specific services/areas of interest is from the public sector? Private sector? Out-of-pocket?

### 2. Collection

This analysis describes existing and new sources of revenue for health and specific services/areas of interest in the country, looking at the level of financing contributed by each source.

#### 2.1 Public Sources

- 2.1.1. What mechanisms does the government use to collect revenues for health? What percentage of health financing is contributed by each source?
- 2.1.2. How sustainable are these sources in the short and long terms?

#### 2.2 Private Sources

- 2.2.1. What mechanisms does the private sector use to collect revenues for health? What percentage of financing is contributed by each source?
- 2.2.2. Are the sources of revenue for specific services/areas for interest different from the above?
- 2.2.3. How sustainable are these sources in the short and long terms?

#### 2.3 External Donor Funds

- 2.3.1. How sustainable is donor financing for health in general and for services/areas of interest in the short and long terms?

### 3. Pooling

This analysis seeks to examine how risk-pooling mechanisms in the country might be relevant to service delivery and clients of the network(s).

#### 3.1 Health Insurance Schemes

- 3.1.1. What national health insurance schemes exist or are planned? What is their role in delivering services of interest?
- 3.1.2. What social health insurance schemes exist or are planned? What is their role in delivering services of interest?
- 3.1.3. What private voluntary health insurance schemes exist? What is their role in delivering services of interest?
- 3.1.4. What community-based health insurance schemes exist? What is their role in delivering services of interest?

### 3.2 *Service and Client Profile*

- 3.2.1 What services are covered? What does the scheme cover under specific service areas of interest?
- 3.2.2 What is the compatibility of the scheme with services offered by the network(s)?
- 3.2.3 Who is entitled to benefits under the scheme? What percentage of this population does the scheme currently cover?
- 3.2.4 What percentage of the client profile does the scheme cover?

### 3.3 *Providers and Payment*

- 3.3.1 What is the role of private providers under the scheme?
- 3.3.2 What is the accreditation process for private providers (length of time, assessment metrics, etc.)?
- 3.3.3 What payment mechanisms are used by private providers under the scheme? Are there specific, targeted payments made for services of interest?
- 3.3.4 What are the reimbursement rates to private providers?
- 3.3.5 How does the scheme process claims?

## 4. **Purchasing Arrangements**

This section analyzes what purchasing arrangements are used in the country, to determine how network services may or may not be contracted by public and private providers.

### 4.1 *Public Sector*

- 4.1.1 Are there existing mechanisms by which the public sector contracts with private providers for service delivery?
- 4.1.2 If not, are there any anticipated changes in the governance of the public sector that might lead to such measures?
- 4.1.3 What is the primary contracting entity? What are the main types of contracts used (duration, payment terms, etc.)?
- 4.1.4 Does the contracting entity define terms for performance? If so, what are the general terms?
- 4.1.5 Is there competition between private providers for public sector contracts?
- 4.1.6 Are equity-enhancing purchasing mechanisms (such as public subsidies) in place to ensure access amongst the poor and vulnerable groups?

### 4.2 *Private Sector*

- 4.2.1 What mechanisms are used by the private sector to contract with independent providers for the delivery of health services? What are the main types of contracts used (duration, payment terms, etc.)?
- 4.2.2 Does the contracting entity define terms for performance? If so, what are the general terms?
- 4.2.3 Is there competition for private sector contracts?
- 4.2.4 Are there legal frameworks to encourage contracting of health services by the private sector?
  - 4.2.4.1 Are there corporate social responsibility laws?
  - 4.2.4.2 Are there formal sector employment health mandates?
  - 4.2.4.3 Are there specific references to services/areas of interest in these frameworks?

## 5 Significance to the franchise network

This section analyzes each health financing opportunity for the potential to support franchise service delivery.

### 5.1 For each health financing opportunity identified:

- 5.1.1 What is the potential to target support to the client archetype in terms of the percent of the population covered, wealth profile and rural/urban profile?
- 5.1.2 What is the compatibility with franchise's level of provider and set of services?
- 5.1.3 What is the compatibility with the aggregator beyond its network(s)?
- 5.1.4 What is the effect of the payment arrangement(s) in terms of focus on franchise services, cash flow implications and sufficiency of the reimbursement rates?

### Example assessment of health financing schemes.

Use the following framework to detail and examine relevant health financing schemes for the aggregator.

**FIGURE 5: Demand-or Supply-side Financing: the title of the financing scheme**



**WHAT DOES THIS MEAN FOR THE AGGREGATOR?** Propose and briefly describe a potential health financing option under this scheme.

## Annex D: Health Financing Option Analysis Framework

Each option should be thoroughly described and analyzed using the sections listed below. Where possible, quotes from stakeholder interviews and references from the literature may be used to bolster the argument.

1. **Title:** Give a short and memorable title to help differentiate between the different options.
2. **What:** Describe what the option entails at a high level (in one or two sentences).
3. **Why:** Provide a rationale for the option, which will likely include some of the key evidence from ONA, HMA and HFA. Link the options to the Theory of Change.
4. **Timeline:** Explain why the confluence of factors makes the option appropriate at this point and when it may happen.
5. **Where/How:** Provide a more detailed description of this option. Explain where the option would be implemented in the country and how it would be implemented at a high level. At a minimum, this section should describe the collection, pooling (if applicable) and the purchasing mechanism that may be used (for whom, from whom, for what, how to pay and at what price) for the option.
6. **Next Steps and Activities:** This section provides a detailed description of the steps that the aggregator must take to implement the option. The description should allow the aggregator to fully understand the level of effort required to implement the option.
7. **SWOT Analysis:** A high-level analysis of the strengths, weaknesses, opportunities and threats from the perspective of the aggregator. The analysis could be completed in a table format for quick understanding.
8. **Stakeholder Analysis:** At a minimum, the analysis should be undertaken from the perspective of the client, network, the aggregator and the government. The analysis could be completed in a table format for quick understanding.
9. **Options Evaluation Analysis:** This section will aim to analyze the feasibility, value for money and strategic alignment of each option. At the high level, the aggregator should be able to critically assess each option against defined dimensions and compare across options, as well as discuss the implications on the aggregator's financial and organizational strategy. (Reference tables and matrix to structure and present information).
  - a. **Feasibility:** What is the technical, financial and political feasibility of an aggregator and its network(s) to carry out a particular option?
    - i. *Technical:* Use information from the SWOT analysis to discuss the technical capacity of the franchisor to pursue an option.
    - ii. *Financial:* Use information from the ONA to discuss what the current financial capacity of the aggregator is and identify other potential sources of funds needed to support an option.
    - iii. *Political:* Describe the political constraints, economic challenges, operational barriers and legal restrictions associated with a particular option.
  - b. **Value for Money:** What are the potential monetary and non-monetary returns for the aggregator for each option? What are the potential resource needs and estimated level of investment from the aggregator's perspective?
    - i. *Monetary:* What are the potential monetary returns such as, the types of demand and/or supply-side payments the aggregator would receive?
    - ii. *Non-monetary:* What are the potential non-monetary returns, such as relationships formed and/or strengthened, experiences gained and credibility established.
    - iii. *Potential resource needs:* For each option, what are the potential resources needed? E.g., commodities, consumables, travel, community outreach, human resources, etc.
    - iv. *Investments:* Who will incur the costs for the resources needed? What types of costs will they be (i.e., major, low/other)? Use information from the preceding analyses to describe the general level of investment needed from the perspective of the aggregator (i.e., low or high).
  - c. **Alignment to strategic vision:** How aligned is each option with the strategic vision and goals (e.g., quality, health impact, additionality, equity, cost-effectiveness, sustainability) of the aggregator?



**Example Summary Table for the Options Evaluation Analysis:** Use this table to structure and present the information gathered through this analysis.

Option	Feasibility			Value for Money			Strategic Alignment	
	Technical	Financial	Political	Monetary Returns	Non-monetary Returns	Overall investment potential and returns	Organizational Strategy	National and Global Goals
A								
B								
C								
D								

**Example table for detailing potential resource needs associated with each option:** Use this table to outline and describe the resources, as well as the costs, for each option. *For example, the aggregator may need to hire a technical advisor and associated staff to implement a particular option, in which case the aggregator would bear those costs, which may be considerable.*

Types of Resources	Costs incurred by whom? <small>(domestic/donor/private/aggregator)</small>	Resource Needs <small>(determine if total resource needs investments will be high, medium, low, or N/A for each category)</small>
Building up new human resources		
Commodities, consumables & equipment		
Travel & transportation		
Capacity building, training & facilitation		
Sensitization & community outreach		
Regular & incentive payments to existing and new staff		
Strategic engagement with local & development partners		

**Example evaluation matrix to assess the implications for the aggregator's financial and organizational strategy:** The matrix should describe the relationship each option has to the likely level of investment needed by the aggregator and the scale of potential revenue return.

		Up-front Investment by Aggregator	
		High	Low
Magnitude of potential revenue	High		
	Low		

## Annex E: Induction Process Checklist

The following is a checklist for the induction process organized according to the key objectives:

### 1. Introduction to the Core Analytical Framework, Approach and Deliverables

- a. Present the analyses: Organization needs assessment; health market assessment, health financing assessment, and options analysis.
- b. Present the framework and implementation approach used to execute the analyses with emphasis on the process.
- c. Introduce the breadth and depth of the expertise on the team to be able to undertake the analysis.
- d. Solicit feedback on the specific needs and interests of the aggregator.

### 2. Agreement on the Scope of Work

- a. The scope of work should be signed off on by interested parties to confirm agreement and commitment to the overarching approach used. At a minimum, the scope of work should include:
  - i. Background on the work
  - ii. Activities to be undertaken during analysis
  - iii. Outputs and reports

### 3. Clarity on the Obligations and Ownership of the Process

- a. By the end of the induction process, it is critical that the team understands:
  - i. Who within the aggregator should be involved? What level of involvement?
  - ii. How can the team best assure aggregator ownership and involvement?
  - iii. What approach has worked best with these types of consultancies?
  - iv. How can open communications be best supported?

### 4. Definition of Criteria for Success

- a. What are the criteria for success by which the aggregator will judge the core analytic framework and implementation approach?
- b. How are these criteria prioritized? Weighted? How do they align with the criteria proposed by other partnered parties?

## Annex F: Documentation Checklist

- 1. Supporting documentation for the organization needs assessment
- 2. Supporting documentation for the health market analysis
- 3. Supporting documentation for the health financing analysis
- 4. Induction Materials
  - A. Presentation
  - B. Scope of work
  - C. Criteria for success
- 5. Stakeholder Interviews
  - A. Stakeholder interview schedule with contact information
  - B. Stakeholder interview notes
- 6. Health Financing Orientation
  - A. Presentations
  - B. Supporting materials
- 7. Options Co-Production Sessions
  - A. Co-production agenda
  - B. Co-production report
  - C. Co-production photos
- 8. Options Analysis Report and Summary Presentation
  - A. Report
    - i. Title Page
    - ii. Acknowledgements
    - iii. Table of Contents
    - iv. Executive Summary
    - v. Platform Needs Assessment
    - vi. Health Market Analysis
    - vii. Health Financing Analysis
    - viii. Options Overview and Summaries of the Options Evaluation Analysis
    - ix. Conclusion
    - x. References
    - xi. Stakeholders
  - B. Summary Presentation
    - i. Objectives and Approach including Stakeholders
    - ii. Organization Needs Assessment and Challenge
    - iii. Health Market Analysis
      - 1. Supply and Demand
      - 2. Rules
      - 3. Supportive Functions
    - iv. Health Financing Analysis
      - 1. Macro Health Financing Indicators
      - 2. Health Financing Mechanisms
        - a. Collection
        - b. Pooling
        - c. Purchasing
    - v. Options Analysis
      - 1. Overview
      - 2. SWOT Analysis
      - 3. Stakeholder Analysis
      - 4. Option Evaluation Analysis





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