Responses to questions raised during webinar *Local and Global Health System Performance Monitoring* / June 27, 2023

Questions	Answers
Has the HPHC tool been launched in other developing countries, other counties where USAID is present?	Thank you. As you can see from the comparative analyses, the tool has been used in four countries – Ethiopia, Madagascar, Philippines, and Pakistan, where USAID missions supported its use. We are expanding tool use as you can see from these countries. Bangladesh, Kenya – Data is being collected. Mozambique, Ghana, Colombia, Timor Leste - Data will be in August-September More countries are negotiating. We welcome your contribution in using the tool.
Are government procedures considered an obstacle to development in the health sector?	Thank you. This is a more general question and does not seem to be specific to HPHC tool assessment. Development health sector is a very broad field. Without government support, it is difficult to implement any development intervention on a large scale, therefore, we always promote partnership with the government or advocate for reforming existing laws and procedures for better development. Regarding HPHC tool use, we have not come across any major government procedures as obstacles. We try to fulfill government requirements before conducting the health system assessment using the HPHC tool.
Most governments in developing countries reduce allocations for health services, does this reflect the deterioration of health services in these countries?	Thank you for this question, as well. We can only talk about the HPHC tool and its findings. The HPHC tool measures overall system performance and its correlates. The hypothesis is that lower the system performance lower will health services coverage.
I am pretty unfamiliar with this topic, but the number of responses per country seem pretty low (n= 50 to 80) to be able to perform such nuanced analysis for the entire country. Is this something that the research team is	Thank you for bringing attention to sample size. Please the use guide on sample size consideration – Guide | High Performing Healthcare (HPHC) (hphctool.org). Please note that the minimum sample size is 55 and max is 110. See the rationale below. The sample size is based on two factors: a) 40 or more respondents distributed across different stakeholders and location, provide a t-distribution which approximate normal distribution; b) With

concerned about? How have you or are you planning to address that?	binomial distribution, probability of finding an object of interest is .5 provide the largest sample, used especially when the probability is unknown. With a 10% margin of error sample size would be 96 or 100 rounded. However, as the probability of finding an object of interest increases, the sample size goes down. For example, with .8 or .7 the sample size would be 81 and 61, respectively. Thus, we have high confidence in collected data. In addition, as Prof. Dasgupta pointed out, the findings are triangulated internally with four types of stakeholders (public, private, NGOS and international organizations) for validation and externally validated by comparing with global indicators like UHCSI score. The regional disaggregate requires a larger sample size which we discuss with the user organization before making a final decision.
Client trust is higher than the HPHC performance score...; any reason why this is lower?	Thank you. Please note we need and expect variations from respondents based on their health system experiences. Variations/dispersions in responses provide information on range and how much they differ from the mean. Thus, these variations allow identifying processes which are functioning very well and are working poorly. However, the mean could be low because more processes are working at a lower level and diminishing the effects of high performing processes. Clients' trust could be higher from the overall performance because mean performance is calculated from all questions scores which vary from low to high. Clients' trust taken separately is high but other processes' functionalities might be at lower level shifting overall mean performance to a lower level.
Is there a standardized tool or form to measure "trust and performance score" ? If yes, could we have this form?	Thank you. Please note that HPHC tool is a standardized tool for assessing various systems processes functionalities and aggregated to get performance percentile score. See paper for tool reliability and validity- Reliability and validity of an innovative high performing healthcare system assessment tool | BMC Health Services Research | Full Text (biomedcentral.com) See HPHC guide for tool questionnaire here - Guide | High Performing Healthcare (HPHC) (hphctool.org)
How can we get the involvement of the private sector and the community in ensuring trust in the health systems among clients?	Interesting question. There are different strategies to involve the private sector and community to increase their trust in the system. We do not promote any specific strategy and leave their selection to stakeholders' organizations. Please note the HPHC tool measures the level of private sector and community involvement and clients' trust with different questions in the tool.

	HPHC tool data collection methodology involves preparing public, private sector organizations, NGOs (representative of community), and international organizations lists with email addresses. Thus, emails are sent to the private sector and NGOs for their participation in the survey. Reminders and personal contacts are made to encourage their participation in filling out the tool questionnaire. We also use their network to get them involved in assessment and motivate them to get their voices heard by participating in the survey.
Pharmaceutical regulation functionality perception is higher than the workforce management, it is a bit counter intuitive; can you explain why?	Thanks. This question is like an earlier question about differences in clients' trust and overall performance scores. The perceived pharmaceutical regulation functionality is about processes that regulate the pharmaceutical industry. They include processes like functionality of food and drug authority, checking quality of medical products, quality of imported medical products, safe disposal of expired medical products. Thus, pharmaceutical regulatory functionality stands on its own and is different from health workforce management functionality. Both can have different score and not dependent on each other – Please see the HPHC user guide - Guide | High Performing Healthcare (HPHC) (hphctool.org) -for detailed indicator calculation for pharmaceutical regulation and health workforce management.
HPHC measures perceptions, opinions, and knowledge of respondents. (Please correct me if I misunderstood). Many of the statements in the questionnaires that respondents agree or not with can be validated by a survey (always expensive). How did you validate perceptions/knowledge with "reality" before using these results for decisions about improvement?	Excellent question, which deals with reliability and validity of the tool. Please read the following - Reliability and validity of an innovative high performing healthcare system assessment tool | BMC Health Services Research | Full Text (biomedcentral.com). To test the face and content validity of the questionnaire, we used USAID public health professionals at headquarters and later in the missions in low-and middle-income countries to review the health system processes which are appropriate, relevant, important, and critical for health system building blocks, community, private and multi-sector involvement, contributing to health system performance and outcomes such as quality, equity, responsiveness, resilience, etc. That way we assured the face and content validity of the tool questionnaire. There is internal triangulation of data from four types of stakeholders for validation. Are the scores among public, private, NGOs and International organization respondents similar or different. If the perceptions are similar or variations are smaller, they indicate that there is a consensus among perceptions validating the collected information. The data is also externally validated by comparing with global indicators such as UHC SC score as a proxy for performance or out of pocket expenditure as proxy for affordability, corruption index score as a proxy for accountability and International health regulation capacity score as a proxy for reliable care. The four-country data show high comparability among HPHC indicators and external sources indicating high validity.

What to do when there is a discrepancy between the qualitative info from the survey (perception and knowledge) and the qualitative indicator of performance (for statements that can be and are measured) more than about the reliability of the tool itself. Both info are needed.	Another interesting question. Regarding your question about how to deal with a difference between perceived and observed data (assuming I understood and reframe it correctly), we may start with looking at the data collection methodology. What is the margin of error in calculating sample size? Thus, range around estimates based on margin of error is important. Does the perceived range of score overlap with observed data, if yes, no problem because there is no major difference. Second, observe whether a single indicator differs while most of the other indicators do not then data is still reliable for decision-making and that indicator could be considered an outlier. This deviation could be considered a special case in the data. Third, if the difference between perceived and observed data is 10% or less, it should not be considered as a major difference because it could be attributed to methodological issues. **Most importantly**, a gap in perceived and observed data identifies a blind spot. If there are major differences between perceived and observed data, they are not seen as major flaws in the perceived data but a reflection of blind spots. It is a learning opportunity for respondents to understand that there are gaps in their perceptions and objective reality. This is an educational opportunity for them to reduce their perception gap because without it they will not be able to improve their performance. This is also a good opportunity for looking inwards for accountability. We avoid saying that people are lying or inflating data or lying to themselves because it makes people more sensitive and defensive. However, when people see the perception gap as a blind spot then there is an opportunity to discuss how to improve it. Having four types of organizations as respondents serve two purposes - a) triangulation information from each other; b) if there is significant difference then that is first step to show gaps for reflection before comparing with objective data. Whole exercise is about understanding your own system and taking responsibility for improving it, the basic premise of QI.
Can you provide examples of how the results of a HPHC survey have been used by the owners of the health system? What decisions did they make that they had not made before?	Thank you. Ethiopia and Madagascar Ministries of Health have made the decision to track health system performance on yearly basis using the tool. They appreciated the information on the level of functionality of processes related to six building blocks, community, private sector and multi-sectoral involvement, and processes related to outcomes such as quality, equity, resilience, responsiveness, trust in the system etc. The assessment findings were shared with various health departments to make changes based on results dissemination workshop recommendations.

Great insights, thanks from presenters. Do you have a laid down framework for measuring quality of care? Are we going to get the presentation copies?	Thank you. We have shared a recording of the presentation on Youtube. Quality is measured through assessing functionality of the quality processes. These processes are grouped under use of quality improvement methods, quality of care standards, supportive supervision, accreditation of teaching and health facilities, regulation, and quality of medical products/technology. See more details in users' guide on how quality is measured. Guide | High Performing Healthcare (HPHC) (hphctool.org) For overall HPHC framework read the paper – Reliability and validity of an innovative high performing healthcare system assessment tool | BMC Health Services Research | Full Text (biomedcentral.com)
Hi, thank you to the presenters. How do you see the referral linkage functioning between the private and public facilities among these countries. What level of system interoperability is in practice? Any reference of the successes and challenges? Thank you	Good question. Please note that the tool findings are related to critical system processes essential for better performance. Therefore, referral is captured through the process of health providers being trusted to provide care and refer to specialists if needed. Thus, there is no specific question on measuring referral between private and public facilities. Regarding system interoperability in practice, I assume you are talking about interoperability among various information systems. We do capture that. Again, the tool identifies the level of functionality of the interoperable mechanisms which gives a glimpse of interoperable success/challenge, but no further details are provided because we are taking a bird eyes view of the whole system with its critical components and do not focus on details on one aspect of the system.
Does the tool on resilience also consider the scale of the event visa vis resilience; as sometimes the scale of the event may be a factor influencing the resilience	You made an interesting observation that the scale of events can influence the level of resilience. However, the tool does not measure the scale of events because the crisis events could be different and there is no one measurement for assessing scale of different events. Therefore, it is better to assess whether relevant processes are functional which support emergence of resilience. Thus, the tool captures supply, demand and contextual processes that are important for ensuring resilience. See more detail in User's guide - Guide | High Performing Healthcare (HPHC) (hphctool.org)
Is Matrix system of assessment necessary?	I am not sure about what do you mean by "matrix system of assessment? Therefore, it is difficult to answer the question. However, if "matrix" means why a subdomain has five question items, the simple answer is to capture critical aspects of that sub-domain or construct. A single or global question/item is not able to capture variation in the construct or phenomenon of interest than a group of questions that encapsulate different aspects of the phenomenon/construct of interest.

Would it be possible to share the power point presentation with us for reading after this session? **Namaskar from Nepal .**	Namaskar from the USA. See the video on youtube. Thanks.
The HSS is only possible here in Nepal by collaborating with National health insurance program and government entity that is overseeing the public health. Isnt it ?	Thank you. This is an interesting question and probably you already know the premise of your question and the answer. As the saying goes, half of the answer lies in the question. For HSS or any development activity, all stakeholders' participation is needed because as WHO promotes, "health system is everyone's responsibility". The Government or public sector has the leadership role because they make health system policies and programs and create an enabling environment for facilitating specific changes. National health insurance covers only the financial aspect of the system. We need a more comprehensive health system picture and performance.
Thank you for this excellent presentation of the tool. Is there a contact person for further assistance with applying the tool?	For more questions and assistance on HPHC use, please contact Anwer Aqil, Senior HSS MEL Advisor, Office of Health Systems, USAID email address: aaqil@usaid.gov
The respondents coming from four types of organizations could have varying knowledge and experiences of the system. How are these differences accounted for?	This is a critical question that deals with the basics of the health system assessment. It is assumed that there are variations in perceptions of health system processes functionality based on the respondents' experiences. That is why representation is sought from different stakeholders, geographical locations, and levels of the system. Second, it is assumed that the health system is everyone's responsibility from top to bottom and horizontally across stakeholders. It is not the policy makers and managers which are important but also service providers and clients. All respondents have received system services or products and have an opinion on that which could differ. The variations are captured in the range of responses as well as in overall or average score. Average functionality of performance score represents as a whole how the system is performing. Thus, we can use both range and average to account for differences in health system performance.
Is there a need for respondents to be trained on the HPHC tool questionnaire?	The HPHC tool questionnaire consisted of simple statements of health system processes, which are then rated on a functionality scale. Functionality scale is a perception scale and there are no right or wrong perceptions. The respondents decide how they perceive the functionality of the

	health system processes. In other words, it is a self-administered questionnaire. Therefore, there is no need for getting training on use of the tool. Knowing the tool before its use, we recommend everyone to read HPHC user guide (Guide | High Performing Healthcare (HPHC) (hphctool.org). Understanding the HPHC tool, its benefits and limitations leads to fully acknowledging and recognizing the importance and implications of assessment findings. The User's guide provides information on how data is analyzed to understand not only the overall performance but its correlates, dissecting data related to health system outcomes such as equity, quality, responsiveness and resilience, health system building blocks functionality, level of clients, community, private and multi-sectoral involvement.