

Using Health Information to Sustain Support for Health Reform in Africa

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This presentation aims to cover three things. First, I share some experiences of the Health Reform Program in Zambia that I think exemplify the critical role of health information within reform programs. These experiences also suggest that reform efforts must specify the model against which they are operating.

Second, I share some examples of how development partners are helping other countries in the region to avoid similar pitfalls that were found in Zambia. Their main approach is to introduce incentives that encourages countries to 1) define a model that depicts the ways in which reform initiatives are expected to impact the health system, and 2) monitor progress toward stated aims and targets.

Last, I briefly describe Bank instruments and initiatives that can create incentives for tracking progress and for getting the health reform model right.

Many may be familiar with the Zambian Health Sector Reform Program. It is worth highlighting that the program was developed before the terms “sector investment program” and “sector-wide approach” (SIP and SWAP) were formulated. However, the Zambian program helped to propel the main tenets of sectoral investment approach, that is of a long-term, comprehensive development program jointly supported by multiple partners. The Zambian program also initiated the now fairly common mechanism of joint annual reviews.

The widely cited intention of reform in Zambia was to achieve “equity of access to cost-effective, quality health care as close to the family as possible.” However, a strategy monitoring progress toward achieving this aim was not defined. Reformers also did not make explicit the intended results expected from reform strategies or how these initiatives would result in equity of access to cost-effective care (the model).

Therefore, during the Annual Joint Reviews, existing health programs (which had indicators and recognized input-output-outcome models) continued to present their data and information. Financial indicators also were increasingly available. However, the approach used to measure overall progress of health reform was more akin to a common perception of progress among colleagues. People *felt* things were going well. The health information provided flavor, but was not used to explain the impact of policies and strategies included under the title of “reform.”

When these mutually satisfactory perceptions were tested due to changes in leadership, donor representation, and increased external scrutiny, some detractors began using existing health information (i.e., from priority/vertical programs) to publicize the “failure” of reform initiatives. For example, the model by which reform should lead to higher immunization coverage, although intuitively correct, was not found to be effective in the short term. Thus, these standard

measures served a tool for some stakeholders who were not served well by reform initiatives such as decentralization, integration of vertical programs (including loss of power), and donor coordination. The reformers were not in a position to counter criticism with data. They could not explain how the initial reform initiatives were intended to improve achieve results (i.e., service standards, resource allocation, accountability, deployment of staff, and systems) and *thus* lead to *sustainable* coverage, quality, and access because they had not specified a particular model or conceptual framework. Nor had they defined measures of success against which their work could be assessed.

Using indicators to diagnose and inform strategies, and direct and evaluate progress, implies use of a model that depicts causal relationships between variables. For example, we monitor oral rehydration salts (ORS) use rates because we accept that use of ORS decreases diarrhea deaths, and that decreasing deaths from diarrhea is a valid aim for a diarrheal disease control program.

We can define discrete models fairly readily, and we have the efficacy tests and can understand how behavior affects outcome in the case of ORS use. However, models of the impact of health reform are much more complex. We have far less understanding of how to model and assess the impact of decentralization, new financing mechanisms, staff satisfaction, improved logistics. When we do not understand the complex model, it is easy to interpret and diagnose wrongly. In the case of Zambia, one new Minister of Health—who did not see advantages of donor coordination, decentralization of authority, or staff empowerment—was able to build support for a simple message:

“specific reform strategies and policies were not yet resulting in improvements based on commonly used measures of service coverage. Thus, reform strategies and policies must be inappropriate and should be revised.” The reformers were unable to counter such a message because they had no data to back up their strategies or progress expected as a result of reform. The result was significant backpedaling on certain reform initiatives, and criticism from outsiders about the “overemphasis on process.”

However, we all are learning from experience. A quick review of documentation of new health sector reform operations that receive World Bank financing suggests an increased recognition and clarity surrounding the kinds of results that might be attributed more reasonably to common reform policies.

Traditionally HIS efforts have been couched within project components for building health systems (efforts that have produced notorious white elephants and countless reams of paper forms that were never used to inform decision making). Alternatively, HIS were established solely to respond to donor requirements. Some recent efforts have been more enlightened and have sought to foster demand for health information.

Increasingly, within reform and within sector-wide programs, there have been efforts to define an agreed list of “core indicators” against which all parties will track progress. I am not suggesting that these are the right indicators, but rather that the process of agreeing on a limited list of indicators—to be reported on annually—creates the impetus define impact models, the intentions of policy reform, and to collect, analyze, and use routine health information to monitor progress.

The mechanism of a “core list of indicators” also helps Ministries of Health, which often lack the capacity to respond to heavy demands for data, to streamline demands for reporting and consider how such indicators will be interpreted by various stakeholders (donors, MOF, health professionals, and constituents).

We also see increasing efforts to link performance to the achievement of specific targets. In some settings (e.g., Ghana, Zambia, Indonesia), there are initiatives that tie decentralized financing to certain targets. Adaptable program loans (APLs) and tranching financing can also create powerful incentives to define the right models and measure progress toward achievable targets.

The Bank recently developed a lending instrument that can reduce the effort needed to acquire subsequent financing for the same program, through setting explicit, objectively verifiable targets that will trigger new financing. APLs can foster increased emphasis on tracking progress toward targets, an improvement over the more traditional insistence on adhering to predefined lists of activities and inputs to be financed over a stated period of time. The greatest challenge to developing an APL is getting the targets right.

Adjustment lending from the Bank (i.e., balance of payments support) and more recently HIPC (i.e., debt relief) is commonly *tranching*, whereby the release of portions of funding is contingent on meeting defined targets. Poverty reduction strategy credits* (PRSCs) provide budget support for a comprehensive development program and a total expenditure program that seeks to reduce poverty. They often require that predefined targets be met related to reduction in private support to determine the rate of fund disbursement.

Debt relief programs and poverty reduction strategies are required to prioritize health interventions and improvement, and thus provide a real opportunity to focus attention on health information. Predicating national budget financing on health sector targets results in much greater support for tracking health indicators and defining the right indicators. Setting EPI or contraceptive coverage targets for HIPC money is a sure way to create internal government demand for tracking this information.

Let me conclude by making two points. First, defining indicators and investing in the development of health information systems is only a part of what must be accomplished within a reform program. We also need to know how to monitor and evaluate reforms, and we cannot do so without some common understanding of how reform strategies and policies are expected to have an impact (a model). Second, external financiers can and should help create the necessary demand for information.

* “Credits” are provided, rather than loans, to countries that have GDP per capita below a specific amount, currently \$925. These countries account for the large portion of the developing world. Credits are interest free, allow a 30- to 40-year repayment plan, and have a 10-year grace period. Given the decreasing value of money over time, only an estimated 20 percent of the value of the loans is repaid.