JUNE 2004 • HEALTH DIVISION

Health Division Document 2004:3

Issue Paper on NHA

The Case of Kenya, Zambia and Mali

Contents

Published by Sida 2004

Department for Democracy and Social Development

Authors: The Case of Kenya: Anna Glenngård; The Case of Zambia and Mali: Frida Hjalte

Printed by Edita Sverige AB, 2004

Art. no.: SIDA4131en

ISBN 91-586-8440-9

ISSN 1403-5545

This publication can be downloaded/ordered from www.sida.se/publications

Introduction

National Health Accounts (NHA) has quickly become one of the most important tools for resource tracking in the health sector in the world, especially in low- and middle income countries. It is used to produce information on the flow of resources within the health sector, answering the questions; where does the money come from, who uses it, and for what purposes. Based on this information governments can develop policies and make strategic decisions on resource allocation and health financing.

The NHA framework has been used in the OECD countries for many years on a routinely basis. However, the need for information on financial flows in the health sector is just as big in low- and middle income countries. Scarce resources make priority setting an even harder task and the need for robust information is therefore essential. NHA has made it possible to produce health financing information using a common format and made it accessible and understandable to decision makers even if they are not experts in health financing. Today a number of countries in Africa, Asia and Latin America are using NHA on a regular basis, producing health financing information and health financing indicators.

Good information is a cornerstone for health policy development, and facilitating the production of it should be a natural part of Sweden's regular support to partner countries. Through Sida's strategy to foster the development of health systems the Swedish support to NHA has so far included the production of national NHA studies in a selected number of countries, technical support to the production of the NHA Producer's Guide, support to regional networks, and specific studies on aspects of, and experiences from the use of NHA.

The case studies in this document look at how NHA has been developed in three Sub-Saharan African countries and how it has been used. The aim of the studies is to describe if and how NHA and other health expenditure data and health sector information is used for policy-purposes in the three countries. The studies investigate how far the institutionalisation process of NHA has come and what the key issues in this process are. They try to identify commonalities and key factors both for success and failure in the production and use of NHA. Although the process is different in the three countries two things stand out as vital in the process of institutionalisation; internal capacity in the country to pro-

duce and use NHA, and political will and commitment to use NHA in resource allocation decisions. The findings are not revolutionary but nevertheless of great importance for those who want to give continued support to the development of NHA. Without capacity at country level to carry out NHA work, and especially capacity at the ministries of health and finance, the institutionalisation of NHA will be weak and the chances of a regular production of health financing data are small. On the other hand, even if capacity is there, without a political will to produce national health statistics and a political commitment to use it, the incentives to produce NHA will not originate from the country itself but rather be a result of a demand from the outside.

Any support to the institutionalisation of NHA at country level must take these finding into consideration.

Pär Eriksson
Sida Health Division

Executive summary

National Health Accounts (NHA) is a tool specifically designed for policy makers and managers of the health sector. It is designed to help them in their efforts to improve health systems performance and make evidence based policymaking by providing useful information of the current use of financial resources. This study describes the use of health expenditure data for health policy purposes in Kenya. It is based on interviews with 23 people involved in the Kenyan health sector, on policy documents and other published literature. The interviews where conducted in Nairobi during February–March, 2004.

The first round of NHA in Kenya was produced in 1998 using 1994 data. The results from the 1994 NHA was not in favour of the policy makers and the report was kept in draft form and was not being recognized for a long time. Since then the institutionalization process of the Kenya NHA has come a long way. When creating the 2002 NHA capacity for doing NHA on a regular basis has been developed within the Ministry of Health (MoH). Further, the results are being recognized and used officially.

The Ministry of Health, bilateral donors and multilateral organizations are the stakeholders using NHA and other health expenditure data for policy purposes the most, according to the interviews. The Ministry of Finance (MoF), NGOs and donors giving direct support to the district level do not use health expenditure data for policy or allocation purposes. Thus, the data is currently adapted for use at the national level but there seems to be a weak link concerning NHA between the MoH and the MoF.

Two problems with NHA in general were brought up during the interviews. First, the accounts are believed to lack a distributional aspect, both among regions and among population groups. Second, there is no political dimension incorporated in the NHA, which makes it difficult to see what kind of policies drive expenditures and which does not. However, this information can be found elsewhere.

Zambia conducted their first NHA in the late 1990s. According to interviews with stakeholders in the Zambian health sector the development has been rather slow and the actual use of the NHA so far appears to be limited. Possible explaining factors are identified: the initiative to produce the NHA originated from outside, a lack of political will and commit-

ment probably explains the delayed publishing of the first report, existence of low incentives for updating the data, which in turn has made the existing NHA not credible or useful.

The second round of NHA in Zambia, i.e. for year 2002, seems to have resolved some of the identified problems. However, the way forward appears not to be straight since the schedule for conducting the NHA exercise is at present (May 2004) somewhat delayed.

Over the years there have been a few attempts to get a comprehensive description of the flow of funds within the Malian health sector. Firstly, tentative NHA were developed in the late 1980s, and secondly, a NHA feasibility study was conducted in 2002. Nevertheless, at present Mali does not possess any NHA although several donors express an interest in supporting such an exercise. A high government turnover seems to have diminished the previous rather extensive concern and knowledge of NHA within the Ministry of Health (MoH).

According to interviews with stakeholders in the Malian health sector, the actual health expenditure data is regarded poor in many aspects (e.g. availability, quality, timeliness, completeness). Some identified problems within the area of health care expenditure data and its use are: lack of analytical capacity, a high turnover of people at important positions, poor access to communications, and problems with donor coordination.

Former experience and the interest expressed by researchers within the country suggest that producing NHA is a feasible undertaking. A challenge for undertaking NHA in Mali will be to truly involve the MoH in the work with NHA.

1. The Case of Kenya

Abbreviations

AIDS	Acquired Immunodeficiency Syndrome
Amref	African Medical Research Foundation
CBS	Central Board of Statistics
CBO	Community Based Organisation
CDC	Centre for Disease Control
DANIDA	Danish International Development Agency
DARE	District AIDS and Reproductive Programme (WB)
DHAO	District Health Administration Officers
DHMB	District Health Management Board
DHMT	District Health Management Team
DFID	Department for International Development (UK)
DHP	District Health Plan
DHS	Demographic and Health Survey
DTC	Kenya Drugs and Therapeutic Committee
ESAP	Enhanced Structural Adjustment Program
ECSA	East, Central and Southern Africa
EU	European Union
GoK	Government of Kenya
GTZ	German Technical Cooperation
HIV	Human Immunodeficiency Virus
HSRS	Health Sector Reform Secretariat
IHE	The Swedish Institute for Health Economics
KANU	Kenya African National Union
KDHS	Kenya Demographic and Health Survey
KEMSA	Kenya Medical Drug Supply Agency
MDG	Millennium Development Goals
MoH	Ministry of Health
MoF	Ministry of Finance
MTEF	Medium Term Expenditure Framework

NARC	National Alliance Rainbow Coalition
NGO	Non-governmental Organization
NHA	National Health Accounts
NHIF	National Hospital Insurance Fund
NHSSP	National Health Sector Strategic Plan
NSHI	National Social Health Insurance
PER	Public Expenditure Review
PHMT	Provincial Health Management Team
PHR	Partnerships for Health Reform
PHR*plus*	Partners for Health Reform*plus*
PLWAIDS	People Living With AIDS
PMO	Provincial Medical Officer for Health
RIHS	Rural Integrated Health Services Programme (Sida)
Sida	Swedish International Development Cooperation Agency
UN	United Nations
Unicef	United Nations Children Fund
USAID	United States Agency for International Development
VCT	Voluntary Counselling and Testing Centre
WB	World Bank
WHO	World Health Organization

1.1. Introduction

1.1.1. Background

Many countries in the developing world face poor health conditions and increased burden of disease. In the East Central and Southern Africa many countries are reforming their health care systems to provide efficient health care services that better meet the needs of the population. The Kenyan National Health Sector Strategic Plan (NHSSP): 1999–2004 states that the Health Sector Vision is to "Create an enabling environment for the provision of sustainable quality health care that is acceptable, affordable and accessible to all Kenyans" (MoH, HSRS, July 1999; PHR*plus*, June 2003).

Policy makers need tools to manage their health care recourses. National Health Accounts (NHA) is a tool specifically designed for policy makers and managers of the health sector. It is designed to help them in their efforts to improve health systems performance and make evidence based policymaking by providing useful information of the current use of financial resources. As of June 2003, NHA has been implemented in 68 countries worldwide and a number of regional networks with the purpose of sharing information and knowledge has been formed. Approximately one-third of the countries conduct NHA on a regular basis, i.e. they have institutionalized their NHA (PHR*plus*, June 2003; PHR*plus*, August 2003).

The institutionalization process of the NHA is a key issue for the use of the health accounts. It is not enough to make the accounts once; they have to be up-dated regularly in order to provide decision makers with accurate information to base policy decisions upon. Evidence show that political will to produce and use NHA can be found in several countries that have succeeded in institutionalizing NHA. The most important factor in the institutionalization process is the government's actual use of the NHA. The government's perception of the NHA results can be of major importance. If the results are not in favour of the decision makers they risk being suppressed and kept in draft form rather than being recognized officially. Further, if methods and sources of data used when conducting the NHA can be questioned the results also risk not being recognized. Kenya is one example of a country where the results of the first round of NHA where not in favour of the policy makers and the report was not officially approved at first (Hjortsberg, C, 2001; De, S. et. al., 2003).

Kenya and nine other countries in the East Central and Southern Africa[1] have completed their first round of NHAs. The making of the first round of NHA involved the formation of the Eastern Central and Southern African (ECSA) NHA network in year 2000. The network was composed of country teams from the ten countries and involved representatives from governmental, non-governmental and research institutions (PHR*plus*, June 2003).

1.1.2. Objectives and method

The objective of this study is to describe the use of health expenditure data for policy purposes in Kenya. First, some background information

[1] The other nine countries were Ethiopia, Malawi, Mozambique, Rwanda, South Africa, Tanzania, Uganda, Zambia and Zimbawe.

about the country and an overview of the structure and the stakeholders of the Kenyan health sector are given. Second, a presentation of the development and the status of the Kenyan NHA are described. Third, a picture of how the NHA and other data are used for health policy purposes and problems in developing NHA and using it for policy purposes in Kenya is presented.

The study is based on policy documents and other published literature and on interviews with 23 representatives at institutions and organizations involved in the Kenyan health sector. All representatives were potential users or producers of NHA. The interviews were semi structured and partly based on open-ended questions concerning the use of NHA and potential problems and advantages connected to the use of health expenditure data for health policy purposes (Appendix A). However, depending on the respondent's place of work, not all questions were regarded relevant. In the end of each interview a questionnaire was distributed, investigating the opinions regarding availability, quality, timeliness and relevance of data and opinions about who uses health expenditure data (Appendix B). The questionnaire has previously been used by the Swedish Institute for Health Economics (IHE) at international NHA conferences. The interviews were conducted in February–March, 2004, in Nairobi.

1.2. Overview of the Kenyan health sector

Kenya is multi-ethnic country with a population of 32 million people. The population has more than tripled since the time of independence in 1963, when the population reached 9 million. About 43 percent of the population is younger than 15. The country is divided into 8 provinces, which are subdivided into a total of 70 districts. In 2001, 34.3 percent of the population lived in urban areas (World Bank, 2003; MoH, June 2003).

Box 1. Health status in Kenya

The health status and the access to health care services in Kenya differ between regions. People living in rural areas generally have lower health status and less access to health care compared to people living in urban areas. Respiratory illness, malaria and dehydration caused by diarrhoea are the major causes of child mortality in Kenaya. Immunization coverage has declined over the past 10 years and early childhood mortality has increased during the same period. In 2003, 52 percent of all Kenyan children between 12 and 23 months of age were completely immunized. The total fertility rate in Kenya is among the lowest compared to other sub-Saharan countries. The fertility rate is higher in rural than in urban areas and the use of contraceptive methods varies among provinces. The number of professional attended deliveries was 40.8 percent in 2003. The HIV/AIDS prevalence differs between regions. Provinces with prevalence levels above national average are Nyanza and Nairobi. The prevalence in urban areas is almost twice the prevalence in rural areas and women are more infected than men. Almost 44 percent of all Kenyan women report that they have been physically or sexually abused by their husbands or partners at least once, and 29.2 percent have been abused in the last year, i.e. during 2003.

Source: KDHS, 2003

Kenya experienced an average economic growth of 4.4 percent during 1982–1992 and an average economic growth of 2.1 percent during 1992–2002. The Government of Kenya (GoK) introduced adjustment programmes and structural reforms in 1986 and 1993 respectively. In 1996 growth fell back and in 1997, when the IMF suspended Kenya's Enhanced Structural Adjustment Program due to the government's failure to maintain reforms, growth fell to 1.2 percent. Severe droughts in 1999–2000 worsened the economic situation and economic growth has remained at a low level. In the December 2002 election, the 24-year-old previous KANU-regime, led by president Daniel Arap Moi, ended as the NARC opposition won the election and the coalitions leader Mwai Kibaki was elected president (KDHS, 1998; WB, 2003).

The country's recourses and people's access to health care services are unequally distributed both among regions and between rural and urban areas. In 1997, the richest 20 percent of the population earned 51.4 of all incomes while the poorest 20 percent only earned 5.6 percent. Approximately half of the population survived on less than USD 1 per day in 2000. The National Population Policy for Sustainable Development, which was formulated in 1997, has a set of goals and targets on the demographic, health and social service areas to be fulfilled by 2010. The targets include reduction of infant mortality, maternal mortality and fertility rate and increase of child immunisation and professionally attended births. In Table 1, some key economic and health development indicators for Kenya are presented. Note that the HIV/AIDS prevalence origins from testing pregnant women. In the Kenya Demographic and Health Survey (KDHS) 2003 – Preliminary report, the HIV/AIDS prevalence is estimated to 7 percent for the total population, i.e. including both men and women and all age groups. However, the report supports the negative trend in Infant mortality rate, Under-five-mortality rate and Child immunization. During 2001, the total annual expenditure on health as a percentage of GDP was 7.8 percent and private spending accounted for 77.8 percent of total health care expenditures, according to the WHO (WHO, 2003; WB, 2003; KDHS 2003).

Table 1. Development Indicators for Kenya

	1987	1990	1992	1995	1998	2000	2002
Population, total (million)	21.3	23.4	24.7	26.7	28	30.1	31.3
GNI per capita (Atlas method current US$)	370	380	330	260	350	350	360
GDP annual growth rate (%)		4.2		4.4	1.6	1.1 [IV]	1.8
Health expenditure, public (% of GDP)		2.4	2	2.2	2	2	1.8 [IV]
Poverty (% of population below national poverty line)		46				50	
Life expectancy at birth, total (years)	58	57	57	53	50	47	45.5
Illiteracy rate, adult female (% of people aged 15 and above)	45	39	36	31	28	24	21.5
Illiteracy rate, adult male (% of people aged 15 and above)	22	19	17	15	13	11	
Safe water (% of population with access)		45			42	57	

	1987	1990	1992	1995	1998	2000	2002
HIV/AIDS adult prevalence rate (% of females aged 15 and above)				11.6		13[III]	
Fertility rate (total births per woman)	6	6	5	5	5	4	4.2
Birhts attended by health staff (% of total)		50[I]		45[II]	44.3	44[III]	40.8[V]
Infant mortality (per 1,000 live births)	66	63	67	73	74	77	78
Child immunization against DPT (% of children under 12 months)	77	84	87	94	79.2	79[III]	72.7
Child immunization against measles (% of children under 12 months)	69	78	84	83	79.2	76	72.1
Under 5 mortality rate	89	97	93	111	112	120	114

Sources: World Development Indicators Database, World Bank 2003; KDHS 2003, [I] 1989, [II] 1994, [III] 1999, [IV] 2001, [V] 2003

1.2.1. Structure of the Kenyan health sector – organization and health care providers

The organization of Kenya's health care delivery system involves three levels; the Ministry of Health (MoH), the provinces and the districts.

The MoH headquarter sets policies, coordinates the activities of the non-governmental organizations (NGOs) and manages, monitors and evaluates policy formulation and implementation.

At the provincial level (a total of 8 provinces), health activities are headed and coordinated by the Provincial Medical Officer of Health (PMO). Each province has a Provincial Health Management Team (PHMT) that is led by the PMO. The team is responsible for the coordination, monitoring and evaluation of health programs in the province. The PHMT acts as an intermediary between the MoH and the districts and oversees the implementation of health policy at the district level, coordinates and controls all district health activities and monitors and maintains quality standards.

Health care activities at the district level (totally 70 districts) are lead by the District Health Management Boards (DHMB), which is monitored by the PHMT. The district level concentrates on the delivery of health care services and generates their own expenditure plans and budget requirements based on the guidelines from the headquarters through the provinces. However, there are some direct linkages between the districts and the MoH although the idea is that all requests should go through the PHMT.

The GoK is the major provider of health care services in Kenya. It runs more than 50 percent of all facilities in the country, primarily through the MoH and the Ministers of Local Governments (MOLG) in the major cities. Other important health care providers health are:

- Charitable non-governmental or non-profit organizations (NGOs) mostly located in the rural or underserved areas, which provide both curative and preventive services. The NGO sector is dominant in health clinics, maternity and nursing homes and medical centres and also operates almost 50 percent of the hospitals.
- Private for-profit practitioners, clinics and hospitals that specializes on curative services and offer preventive services to those who can afford.

This sector has developed rapidly during the last twenty years, since the MoH allowed personnel employed by the public sector to engage in private practice in the late 1980s.

– Traditional healers.

The health care system is organized in a pyramidal structure. At the bottom are dispensaries and health clinics. At the next level are the health centres and sub-district hospitals. District hospitals and provincial general hospitals come next and at the top is Kenyatta National Hospital in Nairobi. Facilities are more sophisticated in diagnostic, therapeutic, and rehabilitative services the higher up in the pyramid they are found.

Public health services during the early years were mainly focused on curative care but gradually efforts have been made to encompass a more comprehensive approach that include both curative, preventive and promotive health care services. This political aim is well articulated in the Kenya Health Policy Framework of 1994 and the National Health Sector Strategic Plan (NHSSP) 1999–2004.

The GoK launched the NHSSP 1999–2004 in 1999 to accelerate the implementation of the Health Policy Framework paper from 1994. The purpose of the NHSSP is to promote and provide efficient health care services of high quality to all Kenyans. The Health Sector Reform Secretariat (HSRS) under the MoH was established to develop the NHSSP. The NHSSP 1999–2004 includes three main areas:

– *Decentralization*. The responsibility for planning and implementation of services has been shifted from the central to the district level and the responsibility for follow-up and monitoring has been shifted from the central to the province level. All districts are to develop District Health Plans, which shall be approved by the province.
– *Health services shall be concentrated* to meet areas as reproductive health, integrated childhood illnesses, increased immunisation, environmental health, HIV/AIDS, STD, TBC and malaria.
– *Revised budget system.* Based on the District Health Plans the districts shall request their funding through the province to the MoH. The MoH then uses the requested budgets from the districts for discussing allocation of recourses with the MoF. Thus, the District Health Plans serve as linkages between the districts needs and the financial allocations (Sida, 2000; MoH, HSRS, July 1999).

1.2.2. Stakeholders in the Kenyan health sector

The different stakeholders in the Kenyan health sector are defined as those who have the ability to influence and make decisions regarding health and health care within the country.

The financial sources of health funds in Kenya, according to the 1994 Kenya NHA, are households, the Government of Kenya, private firms, parastatals and donors.

The bilateral donors contributing most to the health sector in Kenya are Danida, DFID, Sida and USAID. Norad has contributed to the health sector in Kenya as well, but their support has been channelled through NGOs. The main multilateral donors are EU, Unicef and the WB.

The health care providers identified are for-profit health facilities (private), not-for-profit health facilities (NGOs), public health facilities and traditional healers.

The public sector organizations or institutions providing services or incurring expenditures for employees are the Ministry of Health and the Health Sector Reform Secretariat (HSRS), the Ministry of Finance, the Ministry of Education, the Ministry of Home Affairs (prison department), Local Authorities and the Department of Defence. Further, parastatals and public and private insurance agencies or funds have both the interest and the ability to influence the health sector.

Local authorities include District Health Administration Officers (DHAO), District Health Management Boards (DHMB) and District Health Management Teams (DHMT).

1.3. Kenya NHA

1.3.1. Development of NHA in Kenya

The first round of NHA was conducted by the MoH in 1998, using data from 1994 and was financed by USAID and Danida in collaboration with Harvard Public School of Health. The NHA was one out of three main analyses of the health sector carried out to convert the Kenya Health Policy Framework paper from 1994 into practical action. The two other components were budget analyses financed by DFID and WB and a health situation analysis, financed by Sida and EU in collaboration with Amref (Sida, 2000; De, S., 2003).

The general opinion among policy makers regarding health care financing prior to the NHA study was that the government was the major financer. However, the NHA revealed that households accounted for more than 53 percent of health care expenditure whereas the government financed less than 20 percent. These findings where alarming, especially since more than half of the Kenyan population lived below poverty line. Due to the findings the policymakers did not officially approve the report and it was not completed until year 2000. Since then, policymakers have gradually recognized the findings and as a consequence commissioned a series of studies on the burden of health financing in the country. For example, the NHA household health expenditure survey and the utilization survey were carried out in the beginning of 2003 (De, S., 2003).

1.3.2. Data and information used in NHA

Data used in the 1994 Kenya NHA primarily originated from the 1994 Welfare Monitoring Survey of household expenditures, the MoH budget analysis and the United Nations Development Programme Kenya Development Co-operation Report (Kenya NHA 1994). Some of the expenditures that originated from secondary data, e.g. household expenditures, were believed not to be accurate. As a result data collection methods have been improved and surveys to collect more credible primary data has been carried out.

The 2002 Kenya NHA relies on both primary and secondary data. The primary data origins from two studies carried out during 2003:

- *The Households' health Expenditure and Utilization Survey*. Data was collected from 8,844 households representing both rural (6,060) and ur-

ban (2,784) areas in all 70 districts. The data was corrected to avoid under-representing of smaller districts.

- *Institutional surveys*. Data was collected from:

– Employers and firms.

- Health care providers: for-profit, not-for-profit, public health facilities and traditional healers.
- Public sector organizations and institutions providing services or incurring expenditures on employees.
- Donors.
- Insurance agencies.
- NGOs.
- Support groups for People Living With AIDS (PLWAIDS).

Secondary data has been collected from various government publications including the MoH. One example of such source is the Kenya Demographic and Health Survey 2003, produced by The Central Bureau of Statistics, the Ministry of Health, Kenya Medical Research Institute, Centre for Disease Control and Measure DHS+.

1.3.3. Actual status of the NHA

When doing the second round of NHA in Kenya two things where especially important. First, that the accounts where complete and lead by the MoH, and second, that the capacity building within the MoH should enable for the institutionalization of the NHA. In addition to these two primary objectives, a third aim was to broaden the base of collaboration by inviting more partners. The 2002 NHA was initiated by the MoH and USAID and is financed by USAID, Sida and the National Hospital Insurance Fund, thus both internal and external financing. It is produced by an NHA-team at the MoH that consists of 7 people and is lead by a Deputy Chief Economist who is both head of the team and responsible for implementing the NHA. PHR*plus* provides technical assistance in filling the tables. The Kenya 2002 NHA also have sub-accounts for TB, Malaria and HIV/AIDS. It is to be disseminated in May 2004.

The institutionalization process of the NHA is in progress in Kenya. There is institutional capacity developed within the MoH to do the accounts on a regular basis. Also, the results are being used for formulation of policies and strategies. However, there is doubt that the same methodology can be used the next time since the two most important surveys underlying the 2002 NHA, i.e. the household and the institutional surveys, were very resource demanding. Thus, there might be a problem with consistency in the data over time. There are ongoing discussions with the Central Board of Statistics (CBS) about incorporating parts of the household survey into the Income and Welfare survey, which the CBS conduct every third year. Should that be reality, there is a solid ground for household expenditure data being produced on a regular basis that is consistent over time, in the future. The aim, according to the MoH, is to produce NHA every three years.

1.4. The use of health expenditure data and NHA in Kenya

A total of 23 people were interviewed. Eight (8) were representatives from the Ministry of Health or the Ministry of Finance. The others were cooperating partners form bilateral donor organizations, multilateral organizations, NGOs and organizations providing technical assistance (TA) to the MoH (See table 2). A total of 6 respondents were members of the current NHA-team.

Table 2. Place of work for respondents.

Place of work	Frequency
Ministry of Health	8
Ministry of Finance	1
Multilateral organization	3
Donor organization	6
NGO	3
Organization providing TA	2
Total	**23**

1.4.1. Opinions regarding health expenditure data

The respondents were asked to fill in a questionnaire regarding their opinion about the availability, quality, timeliness and relevance of health expenditure data. They were asked to rate these aspects by *very poor, poor, good, very good* or *uncertain*.

The availability, quality and relevance of data were rated good by a majority of the respondents whereas the timeliness of data was rated as poor. Many of the respondents mentioned that the availability of data is improving in Kenya since the new regime took over in 2002. The MoH rated all aspects slightly better than the bilateral donors and the multilateral organizations whereas the MoF rated all aspects slightly poorer. The NGOs responded *uncertain* to all aspects most frequently.

There were two questions concerning opinions about how often policy decisions and follow-up of policy-decisions are based on health expenditure data in Kenya. The 23 respondents were asked to answer these two questions by *never, sometimes, usually* or *always*.

According to the questionnaires, policy decisions and follow up of policy decisions are *sometimes* (12 and 13 respondents respectively) or *usually* (6 respondents for both decisions and follow up) based on health expenditure data in Kenya.

The last question asked for opinions regarding to what extent different stakeholders use expenditure data. The respondents were asked to rate use of data within the MoH, health insurance agencies, providers, researchers and donor organizations by *never, sometimes, usually* and *always*. Donor organizations and the MoH were believed to use data most frequently whereas health care providers and insurance agencies were believed to use data the least. See appendix C for all answers in more detail.

1.4.2. The use of NHA in Kenya

1.4.2.1. Who use NHA and for what purposes?

Both bilateral donors and multilateral organizations use NHA for two purposes, according to the interviews. First, the NHA is used to support them in their policy dialogue with the government. Second, the accounts are used to allocate recourses to the health sector, when giving programme support. In addition to NHA, bilateral donors and multilateral organizations use the Public Expenditure Review (PER), Kenya Demographic and Health Survey (KDHS), the GoK Budget and conduct studies of their own. Besides demographic and expenditure data, both bilateral donors and multilateral organizations consider the international agenda, e.g. the Millennium Development Goals (MDGs), when making allocation decisions. Bilateral donors appear to use expenditure data both to support their policy dialogue with the government and to allocate resources to the health sector. Multilateral organizations seem to be policy-driven rather than expenditure-driven in their decision-making and focus more on the international agenda than bilateral donors. They primarily use expenditure data to support their policy dialogue with the government.

The MoH use NHA to formulate policy and strategy papers. One example of that is the proposed National Social Health Insurance (NSHI) (MoH, August, 2003). Another example is that the 2002 NHA results will be incorporated in the NHSSP 2005–2010. However, during many of the interviews it was pointed out that even though health expenditure data is used for policy purposes the policies are not followed. For example, in the NHSSP 1999–2004 it was well articulated that recourses should be shifted from hospitals to primary care. But the reverse has happened. The PER 2004 shows that allocations to the two biggest hospitals in Kenya has increased from less than 14 percent in 2000/01 to almost 20 percent of the MoH recurrent expenditures in 2002/03 (MoH, 2004). This study does not further investigate to what extent policies are followed or what reasons there might be for policies not being followed.

The MoH also used the experiences from the 1994 NHA when conducting the 2002 NHA. For example, they carried out the household and institutional surveys in 2003 to better capture private expenditures on health. They also conducted a utilization survey to investigate people's access to medical services.

There seems to be a poor awareness about the potentials of using NHA for policy purposes within the MoF, according to the interviews. The MoF primarily use the Medium Term Expenditure Framework (MTEF), which is the government's planned budget for the next three years, for allocating recourses to the MoH.

NGOs do not use NHA for policy purposes, according to the interviews. The reason is that they primarily give project support at district level and need data that better captures distributional aspects.

1.4.2.2. Positive and negative factors contributing to the use of NHA

A positive aspect of using expenditure data, from the donors' point of view, is that it indicates whether the government follows its policies or not. When comparing policy papers with expenditure data, the extent to which the government follow its own recourse allocation policies is meas-

urable. Policy documents identify the government's priorities whereas expenditure data show where money has actually been spent.

During the interviews representatives from both bilateral donor agencies, multilateral organizations and NGOs pointed out that there is an important distinction to make between allocations and expenditures. Although money is allocated to certain districts or targeted areas the money may not actually be spent. One representative explained that while the allocation to some areas increased during 2002 the expenditures actually decreased during the same period. Expenditures show that spending on promotive and preventive services and rural health services is only a part of what was budgeted. In 2002/03 actual spending for rural health services accounted only for 25 percent of the approved budget (MoH, 2004). Thus, there seems to be an inability to spend the allocated recourses in high priority areas. The reasons for this inability have not been investigated. Possible explanations are shortage of human recourses for health and a weak political commitment.

For the MoH, the NHA enables for informed decision-making. NHA provides information about the present use of recourses and is used to identify financing gaps within the health sector.

Two shortcomings of NHA in general were brought up during the interviews. First, the accounts lack a distributional aspect, both among regions and among population groups. The accounts do not relate expenditures to the burden of disease. Second, there is no political dimension incorporated in the NHA. Thus, one cannot see which kind of policies is driving expenditures and which are not. However, the general opinion among the interviewed representatives was that this information can be found elsewhere and does not necessarily have to be incorporated in the actual NHA.

A problem brought up, relating specifically to the Kenya 2002 NHA, is the use of primary data. When using primary data that has not been used by the government before, the results of the NHA risk not being recognized. Further, it will be difficult to use the same methodology the next time since the household and institutional surveys cannot be done on a regular basis, implying that the results might be difficult to compare over time. One of the interviewed representatives pointed out that there are two reasons why it is better to use secondary data when conducting NHA. First, secondary data that has already been approved or used by the government is preferable when it comes to getting the results recognized. If the government already uses the data for other purposes it is difficult to question the NHA results. Existing data should be used as much as possible in order to get maximum policy impact. Second, using data produced by a statistical or research institute, the CBS in the case of Kenya, enables for consistency both across sectors and over time.

Some of the interviewed representatives pointed out that although the ownership lies within the MoH, NHA is still looked upon as donor-driven.

2. The Case of Zambia

Abbreviations

AIDS	Acquired Immunodeficiency Syndrome
CBoH	Central Board of Health
CHAZ	Churches Health Association of Zambia
CMAZ	Churches Medical Association of Zambia
CP	Cooperating Partner
CSO	Central Statistical Office
DFID	Department for International Development (UK)
DHB	District Health Board
ECSA	Eastern, Central, and Southern Africa Region
FAMS	Financial, Administrative, and Management Information System
GRZ	Government of the Republic of Zambia
IHE	The Swedish Institute for Health Economics
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
LCMS	Living Conditions Monitoring Survey
MoFED	Ministry of Finance and Economic Development
MoH	Ministry of Health
NGO	Nongovernmental Organisation
NHA	National Health Accounts
PHR	Partnerships for Health Reform
PHR*plus*	Partners for Health Reform*plus*
Sida	Swedish International Development Cooperation Agency
SWAp	Sector Wide Approach
UNZA	University of Zambia
USAID	United States Agency for International Development
WHO	World Health Organisation
ZCCM	Zambia Consolidated Copper Mines
ZDHS	Zambia Demographic Health Survey

2.1. Introduction

2.1.1. Background

Many countries in the developing world face poor health conditions, an increased disease burden, and poor economic situations. Improving the health systems is crucial and having data on health care financing is critical in this work. In order to make appropriate allocation decisions within the health sector, reliable data of the current situation has to underpin the decisions. By analysing these data, it is possible to identify where to focus the resources in order to make best use of it. This survey has a special interest in the availability and the use of such information in Zambia. Specifically, it focuses on National Health Accounts (NHA), which is a system intended to give a full picture of the flow of funds within the health sector, i.e. the sources of funds, how the funds are channelled, and how the funds are finally being utilised.[2] NHA provides information about total expenditure on health, both public and private including households. It is important to note that NHA is only a financial dimension of the health system and that it has to be combined with other non-financial form of data such as health care output and health care outcome in order to get a comprehensive picture of the health sector performance.

2.1.2. National Health Accounts – A Challenge

As of June 2003, NHA have been implemented in 68 countries over the world (PHRplus, 2003). Many middle- and low-income countries have conducted a first round of NHA and NHA networks have been established in Africa, Asia and Latin America. NHA has been conducted by 10 countries in the East, Central, and Southern Africa (ECSA) region: Ethiopia, Kenya, Malawi, Mozambique; Rwanda, South Africa, Tanzania, Uganda, Zambia, and Zimbabwe. These countries have formed the ECSA NHA network with the purpose of sharing experiences and learning lessons across the countries at regular meetings. Even though many countries have already completed their first round of NHA there exists a lack of knowledge about the purpose and the usefulness of NHA.
The critical point for many countries is now the institutionalisation of the NHA. If to get value for money of producing the NHA, they should be up-dated regularly and the policy makers need to recognize the point of using the results in decision-making.

A recent study, conducted by Partners for Health Reform*plus* (PHR*plus*), focused on the experiences of the use of NHA in 21 middle- and low-income countries (De, S. et al, 2003). The result revealed that 19 of the countries had used their NHA in policy decisions, though with varied extension. Especially the government's perception of the NHA findings was mentioned as an important factor affecting the extent to which NHA was used. Three different ways of government's perception were defined. First, that the findings were supportive to the government general policy, second that the data was in opposition to the government direction but still regarded as favourable, third that the findings were counter the government policy and thus regarded negative. The study by PHR indicates that NHA results that run counter to government general

[2] The NHA standard set of tables includes the following: Financing sources (FS), Financing Agents (HF), Providers (HP) and Functions (HC).

policy tend to be suppressed and kept in draft form. However, it is worth noting that even if the report is kept in draft format the results may have some effect on policies.

Various factors affecting the government's perception were identified and grouped in two categories; the first category include factors that the NHA team of the country can influence and the second category include factors that are out of the team's control. Degree of stakeholder involvement, country ownership, a high-quality dissemination strategy, timeliness and reliability of the NHA report are all controllable factors while a stable government, presence of policy advocates, and government turnover are factors not possible for the NHA team to influence.

Zambia developed their first NHA between 1995–98. A team at the University of Zambia (UNZA) conducted the exercise and it is argued that NHA has not really been incorporated into the governmental or decision-making work (De, S. et al, 2003). The lack of stakeholder involvement and a poor dissemination strategy is said to be primary obstacles hindering ministries and other policy makers from start using the tool.

2.1.3. Objectives and Method

In brief this survey will explore if and how health sector information, and National Health Accounts in particular, is used in policy-making and decision-making in Zambia. More specifically the paper will *first* give a picture of what kind of information is underpinning the decisions in the Zambian health sector. *Second*, the actual status of the NHA in the country will be presented. *Third,* the study will try to find out if, and how NHA findings in Zambia have actually been used for health policy purposes. The final step is to describe the current problems with the NHA development and try to identify the factors hindering the use of NHA.

The study is based on approximately twenty interviews conducted with different stakeholders in the Zambian health sector in November 2003. Respondents were selected according to either their involvement in the NHA production or because of their managing position, thus making them potential users of NHA. The interviews with the respondents were semi structured and partly based on open-ended questions.[3] The open-ended questions concerned the use and problems with NHA and the use of other kinds of data. Further, in the end of each interview the respondents were asked to complete a questionnaire exploring the opinions regarding the use of health expenditure data.[4] This questionnaire has previously been used by IHE, the Swedish Institute for Health Economics, at international conferences.

2.2. Overview of the Zambian health sector

There has been an average increase in the total health expenditures in nominal terms while in real terms it corresponds to an overall decline in total health expenditures. In year 2000 the total expenditure on health in Zambia was 5.6 percent of GDP. The allocation of the national budget to the health sector has been declining during the period. The government expenditure on health was 11.2 percent of the total government

[3] Open-ended questions attached in Appendix A.

[4] Questionnaire attached in Appendix B.

expenditure. Total per capita expenditure on health was 18 USD (World Health Organisation, 2003). A main part of the Zambian health sector is financed by external sources, such as donor organisations and NGOs. During the 1980s Zambia experienced an economic recession, which lead to a decrease in the health care quality (Nordström, Cederlöf, 1998). At the same time the prevalence of HIV, malaria and other diseases increased and the health status of the Zambian people worsened. In the early 1990s political initiatives were taken in order to reform the health sector.

Table 1. Development Indicators for Zambia

	1990	1995	2000	2002
GDP growth (annual %)		-2 [I]	4	3
Health expenditure, public (% of GDP)	3	3	3	
Poverty (% of population below national poverty line)		73 [I]		73
Life expectancy at birth, total (years)	49	45	38	37
Infant mortality (per 1,000 live births)	108	112	112	95*
Fertility rate (total births per woman)	6	6	5	5
Illiteracy rate, adult total (% of people ages 15 and above)		24 [I]	22	20
Safe water (% of population with access)	52		64	51*

* Source: ZDHS, 2001–2002, [I] 1998
Source: World Development Indicators Database, WB 2003

Box 1. Health Status in Zambia

In Zambia, as in many other developing countries, the national health status is poor. Many health problems arise from lack of clean water and shortage of food. The standard of living declined for most people during the 1990s (NHSP, 2001–2005 draft). The main diseases and the leading causes of death are malaria, HIV, and tuberculosis. The HIV-prevalence is around 20 percent while it is higher in urban than rural areas and women are more likely to be HIV-positive than men (ZDHS, 2001–2002). In 2002 the life expectancy at birth in Zambia was almost ten years lower than the average rate for the countries in Sub-Saharan Africa (World Bank, 2003). Even though there has been a slow decline in the fertility rate during the last decade the Zambian fertility rate is one of the highest in Sub-Saharan Africa. Furthermore, the fertility rate is higher in urban areas than in rural and educated woman show lower fertility than uneducated.

2.2.1. Structure of the Health Sector

In 1992 the government presented a reform program with the aim of improving the equity, access, cost-effectiveness, and service quality within the health sector. A main objective of the reform was to decentralise both financial and other responsibility issues to the district level. The central Ministry of Health (MoH) was tightened and the Central Board of Health (CBoH) together with District Health Boards (DHB) and Hospital Management Boards (HMB) were created. The MoH became responsible for the policy-making and the strategic and overall planning while the CBoH was to supervise and monitor the work at district and hospital level (Bergman, 1997). Another feature of the reform program was the creation of the "basket funding" implying that donors could put parts of

their funds into one basket whereby the country should use the resources according to their priorities.

The MoH is composed of three directorates; Human Resources and Administration, Planning, and Development and has no direct health service delivery responsibility. The CBoH bears the overall responsibility for the health service delivery system. The delivery system is organised in four different levels; the CBoH, Provincial Health Offices, District Health Management Teams, and Health centres. CBoH is operating through four different directorates; the Technical Support Services, the Clinical Care and Diagnostic Services, the Public Health and Research and the Health Services Planning (Bossert, et al, 2000).

Zambia is divided into 9 provinces, each with one provincial health office working as liaison between the CBoH and the 72 District Health Boards and the 20 Hospital Boards (15 second level and 5 third level hospital boards). Most beds and doctors are found in the province of Copperbelt and in Lusaka.

A report produced by PHR (Bossert, et al, 2000) on the outcome and performance of the Zambian health decentralisation reforms indicate that the Health Districts have reasonable possibilities to decide upon expenditures, choice of payment, user fees, etc while the decisions upon salaries and allowances are restricted. However, there are still some districts where the decentralisation reform has had a limited effect and where the CBoH has to intervene and make decisions. Nevertheless, on the whole the decentralisation reforms do not seem to have weakened the health system in Zambia. Despite an economic decline and an increase in HIV/AIDS prevalence the utilisation of health services, if not including immunisation coverage, has been stable and family planning activities have increased. Although there has not been any major improvement there is an indication of efficiency improvements since the levels of activity is preserved in spite of a decline in funding.

Many problems within the health sector can be derived from a poor infrastructure, a lack of high-educated staff on district level, and a shortage of doctors. A large part of the skilled staff has moved to other countries where salaries are higher (Nordström, Cederlöf, 1998). Today, Zambia has a population of around ten million but the country has only 600 doctors. The problem of human resources is severe and despite recent increases in wages for doctors these wages are still relatively low (500–800 USD/month before tax) (Jansson, 2002).

2.2.2. Stakeholders in the Health Sector

The different main stakeholders in the Zambian health sector are defined as those who have possibilities to influence and make decisions concerning the health and health care in the country. Since these actors make decisions today, irrespective of the kind of data actually used, they are also the potential users of NHA. According to the NHA for 1995–1998 the main Financing Sources (FS) include the Ministry of Finance and Economic Development (MoFED), donors (multilateral and bilateral), the Zambia Consolidated Copper Mines (ZCCM), households, and NGO's. The most important Financing Agents (FA) are the Ministry of Health (MoH), the Central Board of Health (CBoH), and the District Health Boards (DHBs). These financing sources and financing agents are

still the main ones except the ZCCM. The ZCCM was privatised in the beginning of 2000 and the government now operates the hospitals and clinics formerly owned by ZCCM.

2.3. Data and Information used in decision making in the Zambian health sector

2.3.1. Data and Information Used

There exists a lot of data that could be used in the planning and decision-making processes in Zambia. Within the public health sector there are two major information systems, which are used for reporting and planning activities. It is the Health Management Information System (HMIS) and one of its subsystem; the Financial, Administration, and Management Information System (FAMS).

HMIS is a routine monitoring system that serves as the key information system for the Zambian health sector. Clinics, hospitals and private surgeries are supposed to report within the HMIS and send quarterly reports to the District Health Board. HMIS includes information about health status, service utilisation, human resources, drugs and supplies and assets. The districts are then to report quarterly to the province offices, which in turn send reports to the CBoH. The HMIS provide a wide range of information even though the quality of data varies. Sometimes the data is not regarded as reliable since the reporting is done in last minute. A reason for this last-minute-reporting seems to be that the health staffs is not informed about the rationale and importance of the reporting. One example is that some districts forget to report disease outbreaks in their area.

The decentralisation of the funding mechanism in the beginning of the 1990s raised the issue of a transparent health system. The FAMS was then implemented as to create a transparent accounting and financial framework demonstrating the flow of funds from the centre to the districts. Every health centre and hospital prepares monthly revenue and expenditure schedules which are sent to the district office. It is then the districts' responsibility to aggregate all the data and report quarterly to the CBoH. The FAMS is used for evaluating the districts' financial performance and providing information for the preparation of the action plans.

The National Population Census, which is produced every ten year by the Central Statistical Office (CSO) (the latest in 2000), is another source of information used in planning and decision-making. The Living Conditions Monitoring Surveys (LCMS), conducted by the African National Statistical Offices (NSOs) is one more. They present living conditions such as poverty level, income level and some health indicators, e.g. nutrition status, accessibility to health facilities, accessibility to clean water, education level, etc. The latest includes data for 1998 and the next one will cover year 2004.

Furthermore there are Demographic Health Surveys (DHS), which are additional sources of information. They basically look at different aspects of major health issues such as malaria, its prevalence, its gender aspects etc. The DHS have been carried out by the CSO in partnership with the CBoH. The latest covers year 2001–02. Health Facility Surveys, identifying what health facilities exist, what they are offering and what is

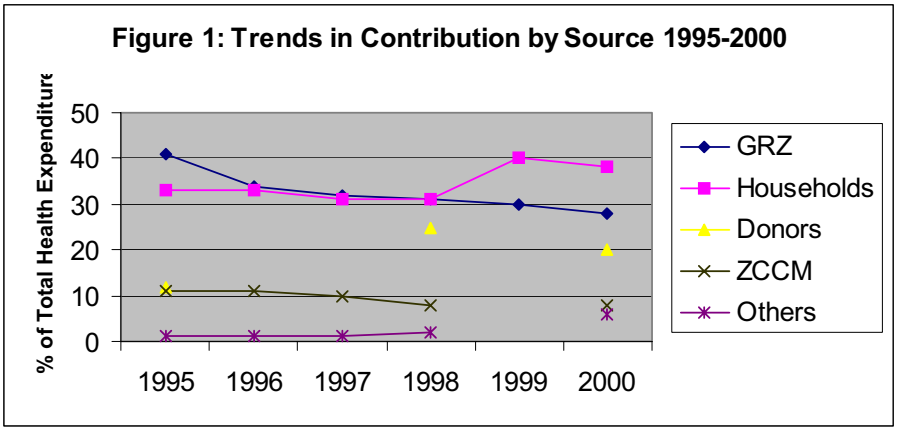
lacking are also utilised in decision-making, although they are not conducted on a regular basis (latest one is from 1998). Other types of information is to be found in different economic studies, produced by researchers at e.g. institutes, international organisations, and universities, targeting specific aspects such as employment, poverty, etc.

2.3.2. Development of the National Health Accounts (NHA)

In 1997, at the MoH/CBoH/Cooperating Partners Annual Consultative meeting, partners agreed that there was a need to better capture the amount of resources available and utilised in the Zambian health sector. Consequently, in July 1998, a NHA core team was formed with the mission to develop the first NHA in Zambia. The core team was composed of around ten representatives from the MoH, CBoH and the University of Zambia (UNZA). In November 2003 most of them still remained members while some had left and been replaced by new members.

The first round of NHA covered data from 1995 to 1998. The initial work was given external financial support from the World Health Organisation (WHO) and the Swedish International Development Cooperation Agency (Sida). Both primary and secondary data collection methods were used. Data from the public sector was found in the government financial books, CBoH financial reports and at public health care facilities. Data on donor expenditures was gathered through financing agents and providers. Data from private facilities was limited to a survey conducted in Lusaka and the Copperbelt. A survey of the traditional healers was also carried out since traditional healers cover a large part of the health care in Zambia. The LCMS from 1996 was utilised in order to capture the household expenditures. Collecting data from the private sector turned out to be a challenge for the NHA team. Many respondents in the private sector were unwillingly to provide the data as they feared the information being used for other purposes, such as by the government for tax-collection (Zambia National Health Accounts 1995–1998 report, 2003). The report for the NHA for 1995–98 was published and disseminated to the public in July 2003. Further there has been a second data collection for the years 1999–2000 for which the results, together with the results from the first round, were published in a policy brief in July 2003.

Figure 1 describes the trend in contribution by source in the years 1995 to 2000. It is obvious that the government contribution has gradually declined while the household contribution and the donor financing have increased. In year 2000 the share of GRZ health expenditures to total health expenditures was 28 percent, the donor contribution reached a level of 20 percent, and the corresponding figure for the households was 38 percent.



Source: Zambia NHA 1995–2000 Policy Brief, 2003
and Zambia NHA 1995–1998 Report, 2003

2.3.3. Actual Status of the NHA

The institutionalisation of NHA in Zambia was supposed to be finalised in 2003 but the process has been delayed. According to people responsible for the NHA at the MoH the delay has two main explanations; the problem of possessing the data and the freeze of the WHO budget. The data and the questionnaires used for data collection have been kept at the UNZA and have been difficult for the ministry to access. Therefore the team started from scratch when planning the NHA for 2002. In addition to the ordinary NHA the health accounts for 2002 should also include a sub analysis for HIV/AIDS. An overall work plan for the NHA and sub analysis was made in end of June 2003. The initial NHA reports for 1995–98 were circulated and disseminated in July 2003 together with a detailed schedule and data plan for the NHA and HIV/AIDS sub analysis for 2002. The data collection, mainly carried out by students from UNZA, was started in the end of October and should be finalised in mid November. Various questionnaires were used as primary sources for the data collection. A Facility Survey, a Health Insurance Survey, a HIV/AIDS Patient Expenditure Survey, a Traditional Healers Survey, an Employer Survey, a Donor Survey and a NGO Survey were conducted. For secondary sources government records, insurer records, household records, medical registers and cooperating partner reports were used. In the end of November the analysis of the data was supposed to be initiated and in December the report writing was to be set off. The schedule specifies that the report should be finalised and disseminated at a meeting in the end of January 2004. However, according to interviews the activities seem to have been delayed and the date for the dissemination meeting probably is postponed.

2.4. Results from the interviews

On the basis of the identified stakeholders, the sample of respondents for this study reached a number of 19. Almost half (9) were staffs in managing positions at the Ministry of Health, at the Central Board of Health, and at District Health Boards. The remaining ten were co-operating partners, i.e. bilateral donor organisations, multilateral organisations, Nongovernmental Organisations (NGOs) and the Department of Economics at the University of Zambia. A rather large part of the respond-

ents were members of the NHA core team. Table 2 presents the place of work for the 19 respondents.

Table 2. Place of work for respondents

Place of work	Frequency
CBoH	5
MoH	4
Donor organisation	5
Multilateral organisation	2
NGO	1
University	1
MoF	1
Total	**19**

2.4.1. Opinions About Health Expenditure Data Derived from the Questionnaires

The first four questions of the questionnaire regarding the opinion of health expenditure data examined how the respondents rated the availability, the quality, the timeliness, and the relevance of the health expenditure data in Zambia. The respondents were asked to rate these aspects by *very poor, poor, good, very good,* or *uncertain.* Overall, there was a rather equal distribution between the positive (i.e. *good* and *very good*) and the negative (i.e. *poor* and *very poor*) answers. For the questions regarding the availability and the quality of the data the number of positive and negative answers were more or less equal, with a light overweight to positive. When considering the timeliness of the data the result differed somewhat more. The negative opinions were 11 against 7 positive. Considering the relevance of data it was the other way around; the positive answers were overrepresented, 13 against 3. In conclusion, the results indicate that most of the respondents find the data relevant although the timeliness of the data is regarded poor by a part of the sample.

The sample was divided into two broad groups; the *MoH/CBoH-group* and the *Others,* the latter mainly represented by donor organisations.[5] This distinction was done in order to see if the *MoH/CBoH* group's point of view, which could be seen as the opinion of the party with the overall responsibility for the Zambian health sector, differed from the cooperating partners' point of view. It is rather difficult to draw any clear conclusions from the answers. The diagrams in Appendix C describe no significant difference for the questions about the availability and the quality. However, for the question considering the timeliness the *Others* seem to agree more about the poorness vis-à-vis the existing data. Further, for the question about the relevance there is a slight indication of the *MoH/CBoH* being more positive towards the data.

In the two questions about how often health expenditure data underpins policy decisions and how often such data is used to follow up policy decisions the answer alternatives were *never, sometimes, usually, always*, and *uncertain.* The most frequent answer was *sometimes.* There seems to be a clear difference between the opinions of the *MoH/CBoH* group and the

[5] Answers presented in diagrams in Appendix C.

Others group. The negative answers, i.e. *never* and *sometimes*, are more frequent among the respondents in the *Others* group. The answers for the question about how often health expenditure data are used to follow up policy decisions show a similar tendency. More respondents in the *Others* group than at the MoH and the CBoH were convinced that health expenditure data was not extensively used in policy making and in following up policy decisions. In conclusion, donor organisations and others in that group seem to be less convinced, than the MoH and the CBoH, that health expenditure data is actually used in policy decisions or to follow up policy decisions.

2.4.2. Opinions About Health Expenditure Data Derived from the Open-ended Questions

The open-ended questions in the interviews revealed the problems and obstacles connected with health expenditure data and the use and development of NHA. Many of the problems and obstacles mentioned were similar irrespective of group of respondents.

When planning and making decisions, other types of health information seem to be more commonly used than health expenditure data and NHA. It is claimed that a systematic attempt to put the information together is missing, i.e. an information system that incorporates all the different types of data, health expenditure data as well as other types of information. Respondents from a donor organisation argued that the only solution to the problem is to go out to the districts and try to explain that this information is valuable even for *their* planning and *their* decisions. The same respondent stated that sometimes the districts seem to base their planning too heavily on the guidelines from the CBoH with the result of ignoring problems not mentioned in the guidelines, although they could be crucial for that specific district.

The fact that NHA is a *new system* that will take time to fully implement is mentioned as a primary reason for the Zambian NHA not being utilised. It is argued that at present there exists no framework for how to use data, i.e. there is no tradition of using health expenditure data extensively. There are no clear guidelines concerning how to use the data, when to use it and by whom it should be used. In other words, the *analytical capacity* or the competence to use data is missing for the time being.

Nevertheless, most of the respondents expressed an interest in, and the importance of having NHA produced regularly. In addition, some of the donors meant that there is a danger with introducing too many new structural programmes and systems since many programmes are introduced without being really implemented, thus being a waste of money. One respondent expressed a fear with continuously introducing new programmes and projects when the old ones don't work, instead of really focus the resources and the attention on one, in order to fully implement it.

One problem with using and conducting NHA in Zambia has been the difficulty of obtaining data from the private sector. More specifically, the dilemma does not seem to be the actual acquirement of the data from the private sector but rather the format of the data. It was argued that within the public sector the reporting system is similar while the data format for the private sector differs and is not seen as user friendly by the

MoH. One respondent mentioned that it is often possible to get aggregate figures from the private sector but not disaggregated ones, which is needed for a comprehensive analysis. Some of the PHR findings indicate that when the NHA exercises fail to capture the private sectors expenditures the credibility of the whole report could be questioned. Thus, the *credibility of the NHA report* is another factor influencing the actual use of the NHA findings.

A problem mentioned by many of the respondents is the fact that the *initiative to produce NHA originated from outside,* i.e. from donor organisations and researchers. The first round of NHA was conducted outside the MoH at the University of Zambia and thus, the project has been regarded as too academic. Since the database and the reports have been kept outside the MoH the NHA has not been a likely tool for the MoH to use. The NHA core team is supposed to meet once every week but apparently this has not really worked as planned. Primary reasons given are that these meetings have not been prioritised among other meetings and undertakings. In short, the bridge between the MoH and the consultants has been weak. Even though the connection is getting more and more close it is stated that the work of building that bridge is slow.

Many of the respondents mention the *poor timeliness* of the report as one critical problem and important obstacle preventing the use of NHA. The 1995–1998 NHA report was heavily delayed since it was not published until 2003. The report for 1995–1998 was kept in draft form until July 2003 when it was published and recognized officially. Hence, when the report was disseminated in July the figures were no longer of actuality. Some circumstances within the health sector had changed. For instance, the ZCCM was privatised during the period so that the government now operates many of the hospitals formerly owned by the ZCCM.

Even though a NHA report is kept in draft form it may have effect on policies (De, S. et al, 2003). Many of the respondents in this study argue that the initial NHA findings have influenced and functioned as an eye-opener for the decision makers in the health sector. Almost all the representatives interviewed refer to the finding of households being such a large financing source. This appears to be the key result from the 1995–98 NHA. Thus, even though the report was kept in draft format the findings resulted in an interest in analysing social health insurance in Zambia and a request for developing a social health insurance scheme.

One respondent in this case study meant that the initial NHA result was not well received since it revealed that the households are among the largest contributors in the health sector, i.e. about the same size as the government. This uncomfortable result could be an explanation to the delay of the publishing of the first Zambia NHA report. *Lack of political will and commitment* to use NHA is mentioned several times as fundamental obstacles hindering the use of NHA.

Financial problems and lack of resources, i.e. equipment, staff and technical assistance, are further claimed to be obstacles in the NHA development. The freeze of the WHO support to the institutionalisation of the NHA is pointed out as a particular obstacle. In year 2003, the WHO promised to support the institutionalisation of NHA in the MoH by providing material (e.g. computers) and training of the staff in order to establish a desk for NHA data collection at the MoH. The database has to be moved

from the UNZA to the MoH and the staff has to be trained so that the MoH can manage the system themselves. However, the WHO expects funds for institutionalisation to be available in the first quarter of 2004 and a preparatory work together with the MoH and CBoH has been initiated. Around USD 20,000–25,000 is predicted to be allocated for equipment.

Some respondents mentioned a problem with *high turnover* of managing staff in the health sector. High turnover implies that new persons have to be educated and initiated into the meaning and work of NHA. Even though some of the interviewed persons were rather new in the health sector management and recently introduced to the concept of NHA, many of the respondents had been involved in the NHA since the set off in 1997.

3. The Case of Mali

Abbreviations

AIDS	Acquired Immunodeficiency Syndrome
CDMT	*Cadre de Dépenses à Moyen-Terme* Medium Term Expenditure Framework (MTEF)
CNS	*Comptes Nationaux de la Santé* National Health Accounts (NHA)
CP	Cooperating Partner
CPS	*Cellule de la Planification et de Statistique* Planning and statistical unit
CSAR	*Centre de Santé d´Arrondissement Revitalisés*
CSC	*Centre de Santé de Cercle*
CSCOM	*Centre de Santé Communautaire*
CSLP	*Cadre Stratégique de Lutte contre la Pauvreté* Poverty Reduction Strategy Paper (PRSP)
DNS	*Direction Nationale de la Santé*
DPM	*Direction de la Pharmacie et du Médicament*
ECSA	Eastern, Central, and Southern Africa Region
EDSM	*Enquête Demographique et de Santé au Mali* Demographic and Health Survey (DHS)
FCFA	*Franc Communauté Financière Africaine*
GPSP	*Groupe Pivot de Santé et Population*
HIPC	Highly Indebted Poor Countries
HIV	Human Immunodeficiency Virus
IHE	The Swedish Institute for Health Economics
INRSP	*Institut National de Recherche en Santé Publique*
MDG	Millennium Development Goals
MoH	Ministry of Health
NGO	Nongovernmental Organisation
NHA	National Health Accounts
PDDSS	*Plan Décennal de Développement*
PHR	Partnerships for Health Reform

PHRplus	Partners for Health Reformplus
PMA	*Paquet Minimum d´Activités*
PPM	*Pharmacie Populaire du Mali*
PRODESS	*Programme de Développement Sanitaire et Social*
Sida	Swedish International Development Cooperation Agency
SIS	*Système d´Information Sanitaire*
SNIS	*Système National de l´Inforamtion Sanitaire* National health information system
SWAp	Sector Wide Approach
UMPP	*L´Usine Malienne de Produits Pharmaceutiques*
USAID	United States Agency for International Development
WHO	World Health Organisation

3.1. Background

Many countries in the developing world face poor health conditions, an increased disease burden and poor economic situations. Improving the health systems is crucial and having data on health care financing is critical in this work. In order to make appropriate allocation decisions within the health sector, reliable data on the current situation has to underpin the decisions. By analysing these data, it is possible to identify where to allocate the resources in order to make best use of it. This survey has a special interest in the availability and the use of such information in Mali. In this context National Health Accounts (NHA) is of specific interest. NHA is a system intended to give a full picture of the flow of funds within the health sector, i.e. the sources of funds, how the funds are channelled, and how the funds are finally being utilised.[6] NHA provides information about total expenditure on health, both public and private including households. It is important to note that NHA is only a financial dimension of the health system and that it has to be combined with other non-financial form of data such as health care output and health care outcome in order to get a comprehensive picture of the health sector performance.

3.2. National Health Accounts – A Challenge

As of June 2003, NHA have been implemented in 68 countries over the world (PHRplus, 2003). Many middle- and low-income countries have conducted a first round of NHA and NHA networks have been established in Africa, Asia and Latin America. Even though many countries have already completed their first round of NHA there exists a lack of knowledge about what NHA actually is and how to actually use it. The critical point for many countries is now the institutionalisation of the NHA. If to get value for money of producing the NHA the accounts are to be up-dated regularly and the policy makers need to recognize the point of using the results in decision-making.

Currently, there are around ten countries in the WHO African Region that have completed a first round of NHA. Most of these are

[6] The NHA standard set of tables includes the following: Financing Sources (FS), Financing Agents (HF), Providers (HP) and Functions (HC).

Anglophone countries situated in the Eastern, Central and Southern Africa Region (ECSA). These countries have formed the ECSA NHA Network.[7] The countries are in different stages of the institutionalisation of the NHA and almost all have acquired technical and financial support from international institutions and organisations in order to undertake the exercises. To date, most of the support of NHA has benefited the Anglophone countries in Africa.

NHA was formally launched in Central and West Africa at a meeting in Dakar, Senegal in January 2003. At that time, the Francophone West and Central African Regional NHA Network was established to facilitate the exchange of information and experiences between the countries. The network includes around 25 countries and due to the large number, the network was split in two groups in order to facilitate training and workshop activities. In October 2003 a first Regional NHA technical training workshop was held in Dakar where 12 of the countries, including Mali were represented.[8] A second Francophone African regional NHA technical training workshop is scheduled for 2004 (April–May). This meeting will include participants from the countries that did not attend the first meeting but also countries trained in the first workshop, which probably will have some experiences of NHA activities. [9]

3.3. Objectives and Method

In brief this survey will explore if and how health sector information is used in policy- and decision-making in Mali. A special focus will be on the country's former experiences of NHA exercise and the actual status of the NHA process. The paper will try to demonstrate the interest, the potential and the connected problems with NHA in Mali. More specifically the paper will *first* present an overview of the Malian health sector and *second* give a picture of what kind of information is available in the Malian health sector. *Third* the history of the NHA process in the country will be presented. The *final step* is to find out the actual status of the NHA process and to identify the problems with the existing data and information and the factors that could be obstacles in a future NHA undertaking.

The study is based on eighteen interviews conducted with different stakeholders in the Malian health sector. The interviews took place in Bamako in January–February 2004. Respondents were selected according to their managing position in the health sector and/or their involvement in the Malian NHA process. The interviews with the respondents were semi structured and partly based on open-ended questions.[10] The open-ended questions concerned the use of health information and health expenditure data and its connected problems in Mali as well as the development of, and interest in, NHA. In the end of each interview the respondents were asked to complete a questionnaire exploring the opin-

[7] Initially the ECSA network included Kenya, Ethiopia, Malawi, Mozambique, Rwanda, South Africa, Tanzania, Uganda, Zambia and Zimbabwe.

[8] The other participating countries were Benin, Burkina Faso, Cameroon, Cape Verde, Chad, Congo, Madagascar, Niger, Rwanda, Senegal and Togo.

[9] The countries that not attended the first workshop include: Algeria, Burundi, Central African Republic, Comoros, Côte d'Ivoire, Equatorial Guinea, Gabon, Guinea, Guinea Bissau, Mauritania, São Tomé and Principe, and Seychelles.

[10] Open-ended questions attached in Appendix B.

ions regarding the use of health expenditure data.[11] This questionnaire has previously been used by IHE, the Swedish Institute for Health Economics, at international conferences.

3.2. Overview of the Malian health sector

According to the UNDP Human Development Index for 2003 Mali is ranked number 172 of 175 countries. More than 70% of the population is estimated to live below the poverty line of 1 USD a day. This situation is also reflected in a poor health status, one of the worst in the world.

Health care is mainly publicly provided in Mali. After the independence in 1960 private health care was forbidden. Private providers were allowed again in 1985 but their extension is still restricted and they are mostly found in Bamako. Even though it is difficult to obtain any written documentation on the financial resources used for traditional medicine it is clear that this form of health care is of great importance in Mali.

The Malian health sector is characterised by significant insufficiency problems of human resources, in terms of availability, distribution, capacity, and motivation. However, despite substantial insufficiencies, Mali has shown a slight positive tendency in the development of social sectors, including the health sector (*Rapport de la Première Année de Mise en Oeuvre du CSLP, 2003).*

Box 1. Health Status in Mali [12]

Malaria and other preventive diseases are the main causes of illness and death in Mali. A big part of the diseases origins from poor environmental conditions with lack of clean water and appropriate waste disposals. Knowledge of hygiene issues is low as well as the information about the spreading of diseases. Respiratory infections, diarrhoea, malaria and malnutrition are the most important problems among Malian children. Immunization coverage remains low, less than 30 percent of all Malian children between 12 and 23 months of age have been completely immunized. The current fertility rate in Mali rests high compared to earlier periods. The fertility rate differs depending on region of the country, i.e. urban areas having a lower rate than rural. Mali's HIV/AIDS prevalence is still rather low, 1.7%, in relation to the rest of the Sub-Saharan Africa. Like in other countries, the prevalence among women is higher and people in urban areas are worse off than in rural areas.

3.2.1. Reforms in the Health Sector

The first health sector reform in Mali (*Politique Sectorielle de Santé et de Population*) started in 1990. Since 1990, Mali has focused on primary health care and local participation according to the Bamako Initiative.[13]
The goal has been to achieve a financial participation by the citizens and to provide a minimum package of health care (*Paquet Minimum d´Activités*, PMA) for the whole population.

In 1997 the Ministry of Health (MoH) developed a health and social plan for 10 years, *Plan Décennal de Développement Socio Sanitaire* (PDDSS),

[11] Questionnaire attached in Appendix C.

[12] Based on the EDSM-III (Enquête Démographique de la Santé au Mali, 2001)

[13] The Bamako Initiative was a new health strategy based on community participation, adopted by African Ministries of Health in 1987. A central component within the initiative was to make essential drugs available to the main part of the population.

Table 1. Development Indicators for Mali

	1987	1990	1992	1995	1997	2000	2002
Population, total (million)	7.8	8.5	8.9	9.6	10.1	10.8	11.3
GNI per capita (Atlas method current US$)	230	270	320	250	260	250	240
GDP annual growth rate (%)					6 II	4	10
Health expenditure, public (% of GDP)		1.6		1	1.9	2.2	
Life expectancy at birth, total (years)	46.5	45	44	44	44	42	41
Illiteracy rate, adult female (% of people aged 15 and above)	91	89.5	88.5	87	86	84	82.7
Illiteracy rate, adult male (% of people aged 15 and above)	74	72	70.5	68	66.5	64	
Safe water (% of population with access)		55				65	
Fertility rate (total births per woman)	7.1	6.8	6.8	6.7	6.6	6.3	6.1
Births attended by health staff (% of total)	32			46 I	24		
Infant mortality (per 1,000 live births)	158	152	150	147	145	142	141 IV
Child immunization against DPT (% of children under 12 months)	12	42	34	49	53	52 III	
Child immunization against measles (% of children under 12 months)	27	43	40	54	57	49	37 IV
Under 5 mortality rate		254		243		233	231 IV

Sources: World Development Indicators Database, World Bank 2003, I1994, II1998, III1999, IV2001

which covers the years 1998–2007.[14] It is divided into two five-year plans where the first, covering 1998–2002 (extended to 2003), is described in the PRODESS (*Programme de Développement Sanitaire et Social*). The objectives are defined in five parts: ameliorate the availability and the quality of the health care services, fight the social exclusion, develop alternative forms for health care financing, improve the skills of the human resources, and strengthen the institutional capacity (ETC Crystal, 2002). The completion of the second 5-year health sector plan of the PDDSS is delayed and expected to reach an end in April 2004.

In May 2002, the CSLP, *Cadre Stratégique de Lutte contre la Pauvreté* (Poverty Reduction Strategy Paper, PRSP), was launched in Mali. This report is the reference document for all the Malian strategies and policies. It has been elaborated for a medium term of five years, 2002–2006. A Health and Population Component (*Composante santé et population du CSLP*) has been elaborated within this PRSP together with a number of indicators, some demonstrated in table 2.

[14] The objectives with the plan are to decrease the prevalence and mortality of the main diseases, increase both the financial and geographical availability of health care services, fight the social exclusion of the health care services, increase the social mobilisation for health, develop alternative forms of health care financing, and develop the skills of the health care staff

Table 2. PRSP Health Indicators

	2001	2002 (target)	2002	2006 (target)
% of population with access to health care services within 5 km	41	45	44	50
% of population with access to health care services within 15 km	66	70	68	80
Number of operational community health centres (CSCOM)	533	560	605	620
Number of referral health centres (CSRF) organising referrals per year	21	23	26	30
Prevalence of HIV/AIDS	1.7			1.0
Share of health budget in total State budget	8.9	9.7	5.3	10.4

Source: Rapport de la Première Année de Mise en Oeuvre du CSLP, 2003

The PRSP and the PRODESS do not make an obvious connection between the resources, the result indicators (accessibility, coverage, utilisation) and the impact indicators (mortality, morbidity). Therefore, a medium term expenditure framework for the health sector (CDMT) 2003–2007, based on the PRODESS 1998–2003 and the Health component of the PRSP, has been elaborated. The CDMT aims at ameliorating the planning and monitoring of pro-poor health policies and more clearly show the connection between the public health care expenditures and the performances within the health sector. The CDMT shows that, above all, it is the poorest part of the population that is hardest affected by the deprived health care situation in Mali. Important factors hindering the access to health care services are the low amount and distribution of health care facilities and the insufficient number of health staff. Seven different programmes presented with objectives, corresponding strategies and activities, indicators and costs are included in the CDMT.

The budget framework is a flexible instrument, depending on the macroeconomic situation and the projections of the available resources for the sector. The budgets for the different programmes indicate a required increase of resources from both the government and from the cooperating partners. If to cover all the planned activities the resources have to increase from FCFA 47.8 billions in 2002 to 65.4 billions in 2003, and to finally reach FCFA 133.2 billions in 2007.[15] These projected figures are based on different hypothesis concerning the macroeconomic situation, (e.g. inflation rate and GDP growth), the composition of the state budget, and other sources of financing. The CDMT is used especially as a planning tool for activities in the health sector. It is presented with a description of the conditions for success and the identified risks. Above all, the success of the framework depends on the quality of the resource allocation. The potential problems of mobilising required resources, either by the lack of the government to go along with the programme orientations or by the cooperating partners reducing their support, are considered as primary risks. Reaching consensus about the CDMT among all stakeholders in the health sector is regarded crucial if to reach the CDMT objectives.

[15] 1 EUR = 655.96 CFA Francs, March 2004

Research of the use of drugs has showed that the Malian people have an extensive consumption and that much of their expenditures on health actually consist of drugs. During the 1980s all pharmaceutical imports, sales and distribution were the responsibility of a parastatal, the *Pharmacie Populaire du Mali* (PPM) that had a monopoly on the import of drugs. The PPM was seen as inefficient; drugs were expensive and unavailable for the main part of the population and illegal imports created a black market. Since a central component of the Bamako Initiative is the availability of essential drugs, a reform of the pharmaceutical sector was initiated in the beginning of the 1990s. Even though the pharmaceutical sector still encounters problems, Mali is regarded as a country with a successful pharmaceutical reform (Sida, 2002).

3.2.2. Structure of the Health Sector

The Malian public health care system has a pyramidal structure. The bottom of the health care system consists of the *Centres de Santé Communautaires* (CSCOM) and the *Centres de Santé d´Arrondissement Revitalisés* (CSAR). These are health clinics providing a minimum package of health care (PMA). The Bamako Initiative, i.e. local participation and local financing, has inspired their organisation. They are financed through user fees, through drugs sales, and to some extent by taxes collected from the local community. Many of the CSCOM are subsidised by different donors in kind (e.g. fuel, per diems, drugs). Most health staff is employed and paid locally. The MoH contributes with 75% of investment costs for buildings and larger equipment.

The district level with district health care centres called *Centres de Santé de Cercle* (CSC) is the next level in the pyramid. Patients in need of other forms of care than can be provided at the CSCOM and CSAR are referred to this level. In addition, the CSCs have a monitoring and evaluating function towards the lower levels in the system. The CSCs are primarily financed by public means from the state and donors, although patients pay some kind of user fee.

Next level in the health pyramid is the hospital level. Officially there are three categories of hospitals: secondary hospitals, regional hospitals and national hospitals. However, when considering budgeting and administration issues there are only two categories: the regional-secondary hospitals and the national hospitals. The region hospitals have the responsibility for the health care in the whole region, including planning, budgeting, evaluation etc. The three national hospitals in Mali provide specialised third level health care.

At the central level the MoH have a policy making and coordinating role in the system. The Ministry is responsible for the overall policies and decisions while the operating decisions, e.g. concerning fees and recruitment are taken at the lower levels in the pyramid. Previously the MoH also included Social Development but in 2000 it was split into two different ministries.

3.2.3. Stakeholders in the Health Sector

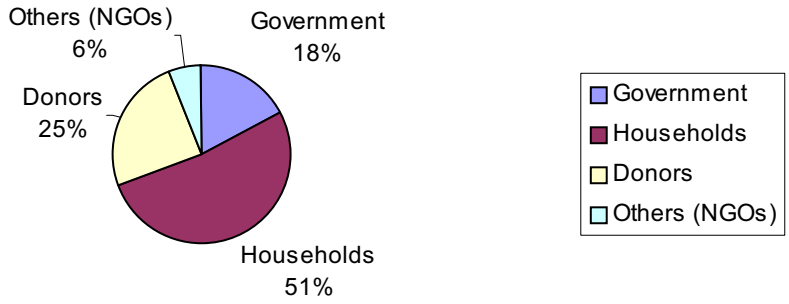
The different main stakeholders in the Malian health sector are defined as those who have the ability to influence and make decisions concerning the health and health care in the country. Since these actors make deci-

sions today, irrespective of the kind of data actually used, they are also the potential users of NHA. They should be the ones interested in finding accurate data in order to make appropriate decisions.

All actors within the pyramidal structured health system (i.e. the MoH, the different levels of providers and their monitoring staff) are important stakeholders in the Malian health sector. Bilateral donors and multilateral organisations have important roles as financing sources in the sector. Large multilateral organisations giving support are the WB, the EU, the UNICEF, and the WHO. Large bilateral donors are: the USA, the Netherlands, France, Canada, Belgium, and Switzerland. There are a lot of NGOs working in the Malian health sector. Since 1992 there exists an umbrella organisation, called *Groupe Pivot de Santé et Population* (GPSP), working with competence building within the organisation and to strengthen the cooperation between the NGOs and the MoH. GPS is mostly composed of national NGOs but have international partners as well.

The government and the donors are far from being the largest sources of finance in the Malian health sector. Apparently, the households account for a significant part of the health care expenditures. The contribution by source in 1997 is described in figure 1.

Figure 1: Contribution by source in 1997



Source: World Bank, 1998

At present, there is no comprehensive picture of the expenditures in the health sector but it is evident that the households still are large contributors and their expenditures on drugs are substantial. The household expenditures can be classed in two broad categories; expenditures made within the ordinary health care system and expenditures made outside the system, i.e. auto medication (purchase of drugs without having a clinic consultation). Malian households also seek advice from traditional healers to a large extent. In 1997 the main part, almost 85%, of the household expenditures were on drugs. Only 3.1% were fees for public health care, 5.1% for care in the private or informal sector, 3.4% were illegal private fees, and 3.4% were expenditures on traditional medicine (World Bank, 1998).

3.3. Data and Information used in decision making in the Malian health sector

3.3.1. Data and Information Used

There has been three health and demographic surveys undertaken in Mali, the EDSM-I, II and III (*Enquête Démographique de la Santé au Mali*). They are conducted by the Planning and Statistics Unit, CPS (*Cellule de Planification et de Staistique*), the National Directorate of Statistics and Computer Science, DNSI (*Direction Nationale de la Statestique et de l´Informatique),* and of the MoH together with technical assistance from ORC Macro. The first EDSM was conducted in 1987; the second in 1995/96, and the last one was undertaken in 2001. These surveys give information about fertility, family planning, maternal and infant health status, mortality, HIV/AIDS prevalence and other health indicators.[16]

There exists one health information system, SIS (*Système d´Information Sanitaire*) in the Malian health sector. SIS provides routine epidemiological data (e.g. morbidity and mortality, vaccination, family planning), which are compiled at national level into six months reports. In fact two systems for financial reporting are in use in Mali. There are reports on the state budget and one more comprehensive report including the contributions of all actors (cooperating partners, NGOs etc). The latter is often incomplete as not all donors provide the required information. However, capabilities of collect and report data have improved during the last ten years but problems with accuracy and timeliness still exist. Within the private sector the situation is different. Routine reporting concerning activities and finances within this sector is non-existent.

Furthermore, Mali has produced a Public Health Expenditure Review, *Révue des Dépenses Publiques de Santé,* (2000). This review is supposed to demonstrate the financial support originating from the state and from the technical and financial cooperating partners. However, the distribution of the review has been limited.

3.3.2. Development of National Health Accounts (NHA)

An initial work with exploring the financing of the Malian health sector was undertaken already in the late 1980s. It was an effort in constructing NHA with health expenditure data from the years 1988–91. Further, in the beginning of 2000, a NHA feasibility study was carried out as a second attempt of investigating the health care financing in Mali. These first efforts have, however, not resulted in any production of NHA in Mali. The WHO is currently taking further initiatives and is pushing for such an exercise. Last year, after the NHA launching meeting, representatives from Mali attended the first technical training workshop for the countries being members of the West and Central African Regional NHA network, which was held in Dakar.

3.3.2.1 NHA 1988–1991

The first attempts to create NHA in Mali were made by researchers at the national research institute for public health (INRSP, *Institut National de Recherche en Santé Publique)*. UNICEF financially supported the exercise, which covered the years 1988–1991. This report was published in 1993.

[16] These surveys provide information on population and health that is representative at the national level and the data are comparable with data of similar surveys conducted in other developing countries.

One major problem encountered was the data collection concerning household expenditures on health. Although it was evident that the household expenditures were much larger than the public expenditures the supervisor of the project asserted that the estimations made were not of very high quality.

The team noticed that the available information and documents at the MoH were rather limited. The bookkeeping and the financial management carried out by the MoH and the collection of health information were stated to be inappropriate and irregular, often including overestimated figures. Often, the people being in charge of the health statistics did not have the skills for performing this kind of work. Thus, the team had to lower their ambitions. Further, the team found it indispensable to make surveys regarding all health care facilities, which were started in the end of 1991. Not all regions in the country could be included in the survey because of the unstable political situation in the northern parts. The team was supposed to collect all available data for the period 1988–1991 concerning the expenditures of recurrent activities and investments, the revenues, and the frequency of different services. Some information was incomplete, some documents had disappeared, and some of the respondents were unwillingly to provide the requested information. Reluctance to give information appeared to be a common problem for the private sector. When considering the private sector and its reporting and information systems, it was denoted as "total anarchy" (Coulibaly and Keita, 1993, p. 65). Total funds received from the state were known but the facilities were often unable to provide detailed information on their expenditures. Therefore, the team estimated expenditures for the periods where no actual data was available.

As a result of a high turnover of staff within the health sector it was difficult to get information about the effects of the 1988–91 NHA report on decision and policy-making. Some respondents claimed that the results did notably change "the spirit of thinking" within the MoH but it is unclear in what way.

A major finding of the Mali 1988–91 NHA was the actual structure of the financing sources for health in Mali. The identified large national sources were the government (20%), and the households (75%). The international sources (5%) included NGOs, bilateral donor organisations and international organisations. This was an interesting and striking result since the main part of the Malian population lived below the poverty line.

The report further concluded that, by that time, and with mediocre quality of health expenditure data and information on health activities, no routine construction of NHA would be possible in Mali. A main recommendation was that the health care facilities first have to establish reporting systems and start using them. All information has to be compiled and available at the central level if to easily elaborate NHAs at a low cost.

3.3.2.2 Actual Status of the NHA

In the beginning of 2000, the Malian MoH, with a highly concerned health minister, expressed a renewed interest in conducting NHA in Mali. Furthermore, cooperating partners demanded data in accordance

with international formats and standards. Hence, construction of NHA was included in the operational program (*activités opérationnelles)* within the PRODESS for the years 2000 and 2001. As a response to these desires a research institute, *l´Institut de Recherche pour le Développement* (IRD)[17], decided to finance a feasibility study of the construction of NHA in Mali.
The feasibility study aimed at clarifying potential problems with such an undertaking. This most recent attempt within the field of NHA was published in 2002. At the same time as the report was finalised and was to be presented to the MoH, there was a government shift and the concerned minister of health was replaced.

The feasibility study first presents the general framework of the NHA. It gives a picture of the structure of the Malian health sector and then gives advises about how a NHA exercise could be organised. The feasibility study refers to recommendations outlined in the NHA Producers' Guide from 2003 by the WHO, the WB and the USAID. Recommended questionnaires for health insurance agents, employers, donors, and NGOs are attached to the report. The study suggests that the NHA exercise for Mali starts with identifying and classifying the financing agents (see an illustrated project plan in appendix 1a. Appendix 1b demonstrates a table with the identified financing agents).

It also suggested the establishment of one piloting committee and one executive board. The piloting committee should consist of representatives from the main institutional actors within the NHA project, researchers, and the main producers of the data used for producing NHA.
The executive board should be composed of one expert within statistics and economics, one person responsible for the project execution, one administrative and financial assistant, and one secretary. The execution of the NHA project, composed of nine phases, was estimated to last for one year. A detailed plan concerning the different costs within the project (equipment, salaries etc) was also provided in the feasibility study.
The total costs for the NHA project was estimated to reach FCFA 192 millions.

Since the government changed and the involved staff at the MoH was replaced, the recommendations from this feasibility study have not yet been utilised and no NHA exercise has been initiated in Mali. However, after the launch meeting in Dakar in January 2003, a budget for the NHA production was incorporated in the operational plan for 2003. Nevertheless, during the year there was a constant problem with mobilisation of funds.

The economists at the INRSP have proposed themselves to undertake the NHA exercise for Mali. Since this institute was involved in the 1988–91 NHA they have some experience within the area. Before the end of June 2004, the INRSP hopes to have a plan for the production of the Malian NHA and that they can start designing questionnaires and guidelines. However, the INRSPs knowledge of the feasibility study conducted in 2002 seems to be limited. This indicates a problem with weak linkages and poor communication among researchers within the area. The WHO appears to be the largest financing source to a NHA exercise although

[17] The IRD is a French public science and technology research institute under the joint authority of the French ministries in charge of research and overseas development. The research is focused on Mediterranean and tropical regions and has the objective of contributing to the sustainable development of these countries.

their contribution is not regarded as sufficient. Therefore the WHO demands additional support from other partners and some donors (France, EU) have expressed a willingness to financially support a NHA exercise in Mali.

3.4. Results from the interviews

The number of respondents in this study reached a number of 18. The respondent's working places are presented in table 3. Almost half (8) were cooperating partners, i.e. bilateral donors and multilateral organisations, while the remaining part was staff at different departments of the MoH, at research institutes, and at NGOs.

Table 3. Place of work for respondents

Place of work	Frequency
Ministry of Health	5
Donor Organisation	6
Multilateral Organisation	2
NGO	2
Research Institute	3
Total	**18**

3.4.1. Opinions About Health Expenditure Data Derived from the Questionnaires[18]

The first four questions of the questionnaire regarding the opinion of health expenditure data examined how the respondents rated the availability, quality, timeliness, and relevance of the health expenditure data in Mali. The respondents were asked to rate these aspects by *very poor, poor, good, very good,* or *uncertain.* Considering the availability, quality and timeliness of data there was a clear overrepresentation of negative answers (i.e. *poor* and *very poor*) while for the relevance of data the positive answers (i.e. *good* and *very good*) were in majority. This gives an indication of the existing data being regarded as appropriate but that there are severe problems with the availability, quality and timeliness of data.

In the two questions about how often health expenditure data is underpinning policy decisions and how often such data is used to follow up policy decisions the answer alternatives were *never, sometimes, usually, always*, and *uncertain.* The respondents seem to agree on that policy decisions are either *usually* or *sometimes* based on health expenditure data. No respondent answered n*ever* and 3 respondents answered *always.* Four respondents answered that expenditure data are always used for following up policy decisions, whereas the majority answered *sometimes* (7) and *usually* (5). Just a few answered *never* and *always* (2 respective 4). Hence, in spite of a perceived poor quality of data, there is at least some tradition of using the information for policy decisions. However, it is used to a lesser extent for following up on decisions, perhaps because of the poor quality, perhaps because of lack of follow-up tradition.

[18] Answers presented in diagrams in App

3.4.2. Opinions About Health Expenditure Data Derived from the Open-ended Questions

The open-ended questions in the interviews aimed at revealing the problems and obstacles with the existing health information and health expenditure data. The intention was also to find out the respondents' interest in NHA and the NHA process in Mali.

Analytical capacity

According to the interviews, there is a poor tradition of analytical work in Mali. Using data for underpinning decisions and policies is not, as explained by one respondent, "incorporated in the Malian culture". The analytical capacity to recognize the link between expenditure reports and policy implementation is weak. Scarce human resources were mentioned as one of the largest obstacles in the Malian health sector. Thus, this is one of the five focus areas within the PRODESS.

Completeness of the data

Even though there exists reporting systems for both financial information and health information the available data appear not to be complete. It is difficult to get reliable data and information from the *communautés*, the private sector, and NGOs. Moreover, there exists an obvious unwillingness within the private sector to communicate information about their health activities. One respondent stated that the poor financial reporting is actually hampering the mobilisation of available resources. An example is the finding of additional resources devoted for HIV/AIDS at the MoH in the end of the year, which had not been used. The knowledge of these resources' existence was limited and consequently "nobody had asked for it".

Turnover of people at important positions

The most striking example of how staff turnover has negatively affected the development of the Malian health sector is the replacement of the health minister in 2002. The former minister of health, apparently highly appreciated as a minister, showed a big interest in developing NHA in Mali. Hence, when she was replaced the NHA plans were set aside and no progress was done.

In addition, there have been other important turnovers within the MoH. New staff has for example replaced the ones that attended the NHA meeting and the NHA training workshop last year. It is resource demanding and time consuming to inform and educate new staff.

One respondent expressed the core of the problem in the way that information and responsibilities are centralised to a few people and that delegation and teamwork is uncommon. The respondent believed that this kind of staff usually stays at the same position for long time. However, what has happened in Mali the last year is that these key persons have been transferred and the capacity of the system has been highly reduced.

Poor access to communication

Poor communication was mentioned as a problem within the health sector. Respondents stated that not all stakeholders are sharing the same in-

formation, which hinders access to data and information. Researchers claimed that among researchers there is no coordination because of communication problems, e.g. poor access to internet. As an example, some of the respondents working at research institutes were unaware of Mali having participated in the NHA policy-launching meeting and the NHA workshop last year. Further, it was claimed that there is a gap between the ones producing the data and the ones that are supposed to use it. In sum, the different stakeholders in the health sector do not easily share data and information, partly resulting from badly developed communications.

Donor coordination

Many developing countries experience problems with weak donor coordination and Mali is not an exception. This probably decreases the efficiency of the support to the health sector. The respondents, from all categories (i.e. MoH and donors), stated that it is difficult to know how much the donors actually are contributing. Donors use many different financing tools that are not always handled by local representations. Furthermore, the support is often covering many years, which renders it hard to know the actual expenditures for one year.

In 2001, USAID administered a donor mapping exercise by Lynch and Diallo (2001) as to identify programmatic gaps and to ameliorate the donor coordination. The mapping revealed that there is a lack of partner coordination stemming from both the structure of the MoH but also from the inflexible structures of the donor organisations. Since the donors often decide and communicate their available resources late it is hard for the MoH to plan their activities. An additional problem identified is the tendency of donors to focus too much on their own plans rather than start from the national action plan. The donor mapping exercise had an intention to be updated annually as to be effective but as of February 2004 it has still not been prepared.

At the time when the PRODESS was elaborated the cooperating partners started collaborate in the form of regular informal meetings. The meetings involved not really a coordination of activities but more an exchange of information. After adoption of the PRODESS these monthly meetings, chaired by the WHO, were continued. In 1999, the necessity of having a representative from the MoH in these meetings was claimed. In 2001, the cooperating partners decided to have an annually rotating leadership in order to reinforce the coordination of interventions in the sector and to facilitate the dialogue with the MoH. Still, the donor coordination seems to include exchange of information and no strict coordination of activities.

Lack of coordination between different programmes and goals

Some of the respondents uttered a problem with the coordination of the different structural programmes and the health sector strategy outlined in Mali. The PRSP, the Millennium Development Goals (MDG) and the national strategy for the health sector are all developed in a parallel but not jointly way. It was stated that the outlined goals are not coordinated, which makes it harder to reach a successful outcome fulfilling all targets.

Concerning the CDMT (Medium Term Expenditure Framework, MTEF), which partly aims at coordinating different strategies, problems are apparent. It is unclear to what extent the CDMT is actually used. It has been used for formulating the PRODESS II but otherwise its use seems rather limited. According to one donor the document is perhaps too detailed and one should critically revise its content. One donor stated that the monitoring of the CDMT requires a significant technical input. Some questioned if the link between putting in that much money and obtaining the outlined objectives is really feasible. To a large extent the initiatives to make a MTEF have come from outside which could be one reason for the low use of the framework.

4. Concluding Remarks

The institutional capacity to produce NHA on a regular basis is a prerequisite for the institutionalization process but not sufficient. It is not the production but the actual use of the NHA that is the most important and to attain this, political will and recognition of the results are necessary.

In the process of producing the 2002 Kenya NHA two things where particularly important: First, that the NHA should be complete, i.e. that it should cover the entire health sector. Second, that the NHA as much as possible should be developed within the MoH in order to increase the institutionalization process. A third aim was to broaden the collaboration base and involve more interested parties.

Since 1994 the institutionalization process in Kenya has come a long way. Capacity building for doing NHA on a regular basis is developed within the MoH. According to the MoH, NHA are to be produced every third year. Also, the NHA are used when formulating policies and strategies. However, it will be difficult to use the same methodology the next time since the two most important surveys underlying the 2002 NHA were very resource demanding and cannot be conducted on a regular basis. Further, policies do not seem to be followed. In addition, there seems to be a risk of the NHA results not being used within the government outside the MoH due to the low awareness of the NHA potentials within the MoF.

The MoH, bilateral donors and multilateral organizations all use NHA for policy purposes. The MoH use NHA to formulate policies and strategies whereas both bilateral donors and multilateral organizations use NHA primarily for supporting their policy dialogue with the government. Multilateral organizations seem to be more driven by policies and the international agenda than by expenditures compared to bilateral donors. According to the interviews, the MoF does not use NHA for allocation or other policy purposes. Neither do NGOs and donors primarily giving project support at district or community level use the NHA for policy purposes.

Although there seem to be a widespread knowledge about the existence of NHA in Zambia the conclusion is that the development of NHA has not been given priority and thus its use has so far been restricted. The reason for the limited use of NHA originates partly from the initiative of the NHA production coming from outside. The ownership of the

NHA has not been within the government and the government involvement in the production has been weak. This might be combined with, or followed by a lack of political will and commitment to produce and use NHA. With a low interest in the NHA the data will probably not get updated and one will end up in a vicious circle, i.e. a poor timeliness of the data will make the data less credible and useful.

The PHR report concerning the experiences of the use of NHA in some middle- and low-income countries found that Zambia experienced a weak dissemination strategy and a weak government ownership of the NHA. These findings are strongly supported by the result from this study. Based on the results from the PHR study the authors propose a list of strategies to encourage the use of NHA in policy making. First, the existence and importance of NHA has to be communicated to policymakers. Second, all stakeholders in the health sector have to be initiated in the NHA process through targeting issues that are of interest for the stakeholders and through a strong dissemination strategy. Third, since the perception of the NHA findings appears to be of great importance the NHA report has to be up-to-date and credible if to be used by policymakers.

Despite the existence of important problems a positive attitude towards NHA among many of the stakeholders can be discerned in the Zambian health sector. A recent effort in the NHA process reveals a move towards the right direction. A restart with data collection for 2002 commenced in 2003 with the aim of truly involving the MoH and CBoH. It appears as the initiative to conduct this round more came from inside than the former and that people at the MoH and CBoH manifests positive attitudes towards NHA. Thus, more stakeholders are involved, interested, and aware of the importance of NHA. Nevertheless the restart has met with problems, e.g. with lack of promised support of resources/equipment from donors. Some of the respondents believe that 2004 will be the NHA year of success while other respondents give a more negative and sceptical attitude towards the future of NHA in Zambia.

There is no doubt that the health information and health expenditure data in Mali is poor. Availability of data and information is restricted and its quality and completeness is questioned. Even though the data is regarded poor, many people in managing positions seem to use data in decision-making. However, there is a consensus that more appropriate and ameliorated data is needed. NHA is seen as having an important role to play to meet this objective.

Over the years there have been a few attempts to improve the system. The first, already in the late 1980s, indicates an early interest and understanding of the importance with a tool like NHA. A second attempt, in the beginning of 2000, underlines the importance of involving the MoH to be successful. After the extensive feasibility study and the change of government the project was set aside. Hence, turnover of staff at important positions could have serious effects on such a project.

Even if Mali does not possess any NHA today the former efforts would certainly facilitate a future undertaking. Many donors, both bilateral and multilateral, declare themselves prepared to support a NHA exercise in Mali. Former experience and the interest expressed by research-

ers and others within the country suggest that a NHA is a feasible undertaking. Results and conclusions drawn from the feasibility study in 2002 are important and would save a lot of time and effort when setting up NHA. On the other hand, the fact that several persons possessing experience and understanding of NHA at the ministry level have been replaced is an obstacle for NHA in Mali. A key challenge is to involve the MoH and make them appreciate the usefulness of NHA.

References

Bergman, S-E. (1997). *Co-operation and Collaboration between MoH and CBoH*. Central Board of Health, Lusaka

Bossert, T., Chita, B.M., Simonet, M., Mwansa, L., Daura, M., Mabandhala, M.A., Bowser, D., Sevilla, J., Beauvais, J., Silondwa, G., Simatele, M.A. (2000). *Decentralisation of the Health System in Zambia*. Major Applied Research 6, Technical Report 2. Partnerships for Health Reform, Abt Associates Inc., Bethesda

Cellule de Planification et de Statistique, Ministère de la Santé, Direction Nationale de la Statistique et de l´Informatique, ORC Macro. (2002). *Enquête Démographique et de Santé Mali, 2001 (EDSM-III)*, Calverton

Central Bureau of Statistics, Ministry of Health – Government of Kenya, Kenya Medical Research Institute, Centre for Disease Control and Measure DHS+ ORC Macro. (2003). *Kenya Demographic and Health Survey 2003, Preliminary Report.* Nairobi and Calverton

Central Statistical Office (Zambia), Central Board of Health, ORC Macro. (2003). *Zambia Demographic and Health Survey 2001–2002.* Lusaka and Calverton

Coulibaly, S.O., Keita, M. (July,1993). *Les Comptes Nationaux de la Santé au Mali: 1988–1991*. Ministère de la Santé, de la Solidarité, et des Personnes Agées, République du Mali, L´Initiative de Bamako Rapport Technique Numéro 18.

De, S., Dmytraczenko, T., Brinkerhoff, D., Tien, M. (2003*). Has Improved Availability of Health Expenditure Data Contributed to Evidence-Based Policymaking? Country Experiences with National Health Accounts*. Partners for Health Reform*plus*, Abt Associates Inc., Bethesda

ETC Crystal. (Novembre, 2002*). Programme de Développement Sanitaire et Social. Mission d´évaluation externe.* Annexes.

Hjortsberg, C. (2001). *National Health Accounts – Where are we today?* Health division document 2001:6, Swedish international development cooperation agency, Department for Democracy and Social Development Health Division, Stockholm

Jansson, C. (2002). "Fallstudie: Zambia". *OmVärlden, Tema: Hälsa. Appendix to OmVärlden 7* 2002.

Keoula, Y. (Juillet, 2002). *Etude de Faisabilité pour la Construction des Comptes Nationaux de la Santé au Mali.* Institut de recherche pour le développement (IRD), Bamako

Lynch, E., Diallo, I. (September, 2001). *Donor Mapping USAID – Mali*. USAID.

Ministère de la Santé/Secretariat General, Mali. (May, 2003). *Cadre de Dépenses à Moyen Terme 2003–2007*. Version 4. MS/SG, Bamako

Ministry of Health, Department of Planning, Government of Kenya, Partnerships for Health Reform. (May, 1999). *Kenya National Health Accounts 1994 – Draft Report*, Nairobi

Ministry of Health – Government of Kenya, National Council for Population and Development, Ministry of Planning and Development, Measure Evaluation. (June, 2003). *Factors that Contribute to The Utilization of Quality Reproductive Health Care: Finding From Further Analysis of the Service Production Assessment of 1999*, Nairobi

Ministry of Health – Government of Kenya – Health Sector Reform Secretariat. (July, 1999). *The National Health Sector Strategic Plan 1999–2004*, Nairobi

Ministry of Health – Government of Kenya. (August, 2003). *Sessional paper on National Social Health Insurance in Kenya – Abridged Version Draft, Theme: Quality healthcare to all Kenyans*, Nairobi

Ministry of Health – Government of Kenya – Health Sector Reform Secretariat. (November, 2003). *Phase I district health systems support programme – Situation assessment report, Second draft*, Nairobi

Ministry of Health – Government of Kenya. (2004). *Public Expenditure Review Report 2004*, Nairobi

Ministry of Health Zambia. (2000). *Draft National Health Strategic Plan 2001–2005.* MoH, Lusaka

Ministry of Health Zambia/Central Board of Health. (2003). *Zambia National Health Accounts 1995–1998, Report*. MoH/CBoH, Lusaka

Ministry of Health Zambia/Central Board of Health. (2003). *Zambia National Health Accounts 1995–2000, Policy Brief.* MoH/CBoH, Lusaka

National Council for Population and Development, Central Bureau of Statistics, Demographic and Health Surveys Macro International Inc. (April, 1999). *Kenya Demographic and Health Survey 1998*, Nairobi and Calverton

Nordström, A., Cederlöf, C., (1998). "Djärva hälsoreformer i Zambia – med inspiration från Sverige". *Läkartidningen,* Volym 95, Nr 46, pp. 5192–5196

PHRplus. (2002). "National Health Accounts: NHA Global Policy Brief", PHRplus, Abt Associates Inc., Bethesda

PHRplus. (June, 2003). "National Health Accounts: NHA Regional policy brief. Eastern, Central and Southern Africa: Using NHA to Inform the Policy Process" Abt Associates Inc., Bethesda

PHRplus. (August, 2003). "National Health Accounts: Supporting NHA in Africa, A brief for Donors", PHRplus, Abt Associates Inc., Bethesda

Swedish International Development Co-operation Agency. Sidas regeringsskrivelse (2003-12-19), "Förslag till strategi för utvecklingssamarbete med Västafrika 2004–2006", bilaga "Landanalys för Mali".

Swedish International Development Co-operation Agency. (2002)."Annex to 'Framtid Afrika' Health Support in Africa – Country Reports" Health division document 2000:6B, Swedish international development cooperation agency, Department for Democracy and Social Development Health Division, Stockholm

Table Ronde des Bailleurs de Fonds. (Novembre, 2003). *Rapport de la Première Année de mise en oeuvre du Cadre Strategique de Lutte contre la Pauvreté (CSLP)*.

World Bank. (2003). World Development Indicators database for Zambia, Mali and Kenya, WB website

World Bank. (1998). *The World Bank and the Health Sector in Mali. An OED Country Sector Review.* Report No. 18112. June 30.

World Health Organization. (2003). National Health Accounts Indicators for Zambia, 2000, WHO Website

World Health Organization. (2003). Key Health Expenditures Indicators for Kenya, WHO Website

Appendix 1. Kenya

Appendix 1 A. Open ended questions

- What is your knowledge about NHA?
- Are you involved in producing NHA or other health expenditure data?
- Do you use NHA for policy or allocation decisions?
- What other kind of health data is available and used?
- What other data is available and used?
- Do you know if there has been any policy decision based on NHA or other health expenditure data?
- Positive aspects of using health expenditure data for policy purposes?
- Negative aspect of using health expenditure data for policy purposes?
- What kind of health data is lacking in Kenya?

Appendix 1 B. Questionnaire

1. How would You rate the *availability of health expenditure data* in Your country?

☐ Very poor
☐ Poor
☐ Good
☐ Very good ☐ not sure/uncertain

2. How would You rate *the quality of health expenditure data* in Your country?

☐ Very poor
☐ Poor
☐ Good
☐ Very good ☐ not sure/uncertain

3. How would you rate *the timeliness (up-to-dateness) of the health expenditure data* in Your country?

☐ Very poor
☐ Poor
☐ Good
☐ Very good ☐ not sure/uncertain

4. How would you rate *the relevance of health expenditure data* in your country?

☐ Very poor
☐ Poor
☐ Good
☐ Very good ☐ not sure/uncertain

5. In Your opinion, *how often are policy decisions* in Your country based on health expenditure data?

☐ Never
☐ Sometimes
☐ Usually
☐ Always ☐ not sure/uncertain

6. In your opinion, how often are health expenditure data used in Your country *to follow up policy decisions?*

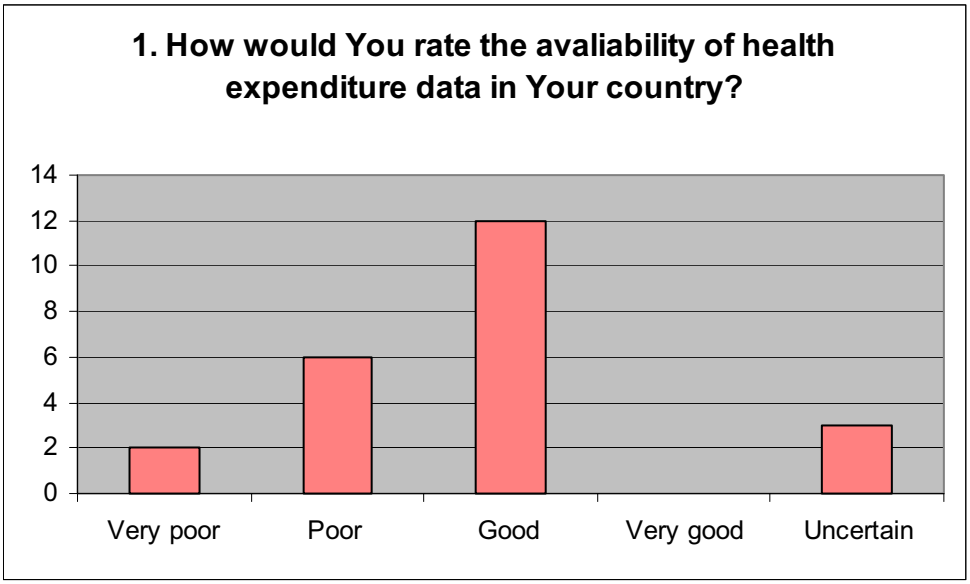
☐ Never
☐ Sometimes
☐ Usually
☐ Always ☐ not sure/uncertain

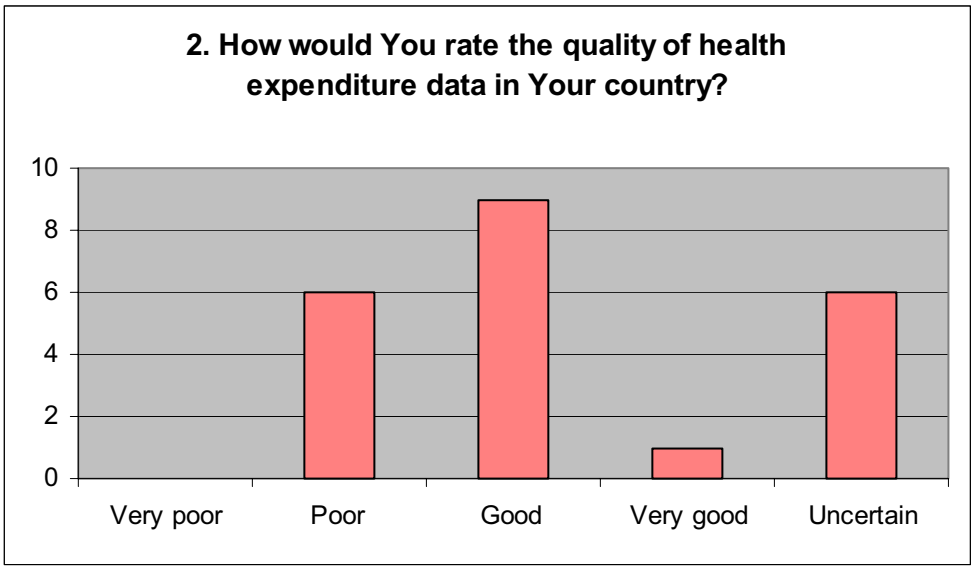
7. In Your opinion, *to what extent* do the following institutions/organisations use health expenditure data in Your country?

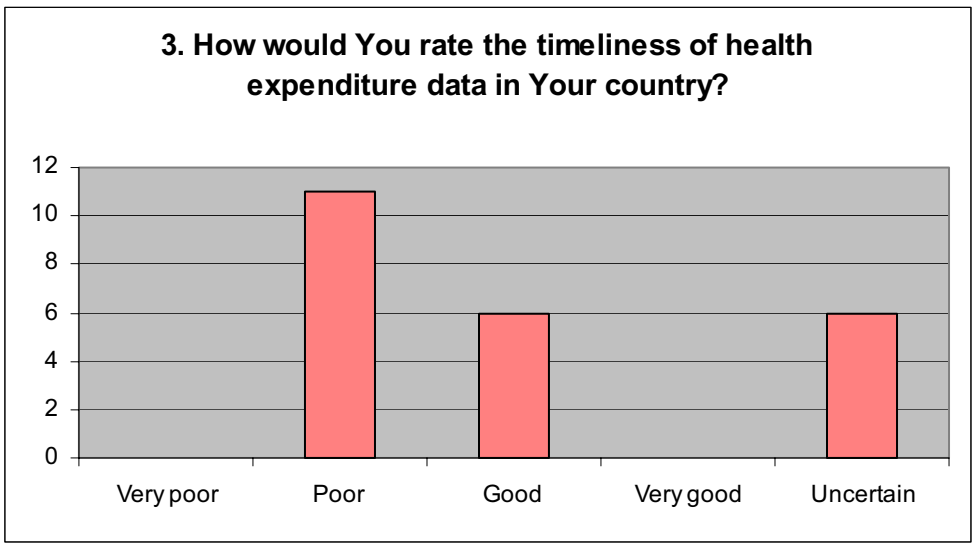
(please mark the appropriate level of use with X)

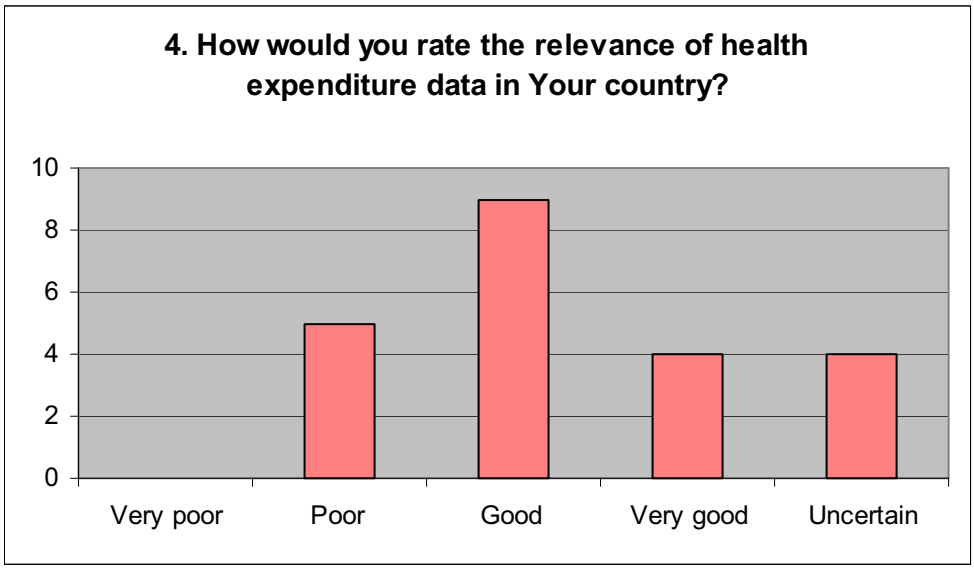
	Never	**Sometimes**	**Usually**	**Always**	**Not applicable**
Ministry of Health					
Health insurance agents/ purchasers					
Public health care providers					
Private health care providers					
Researchers at Universities					
Donors and international organisations (eg. WHO, WB)					

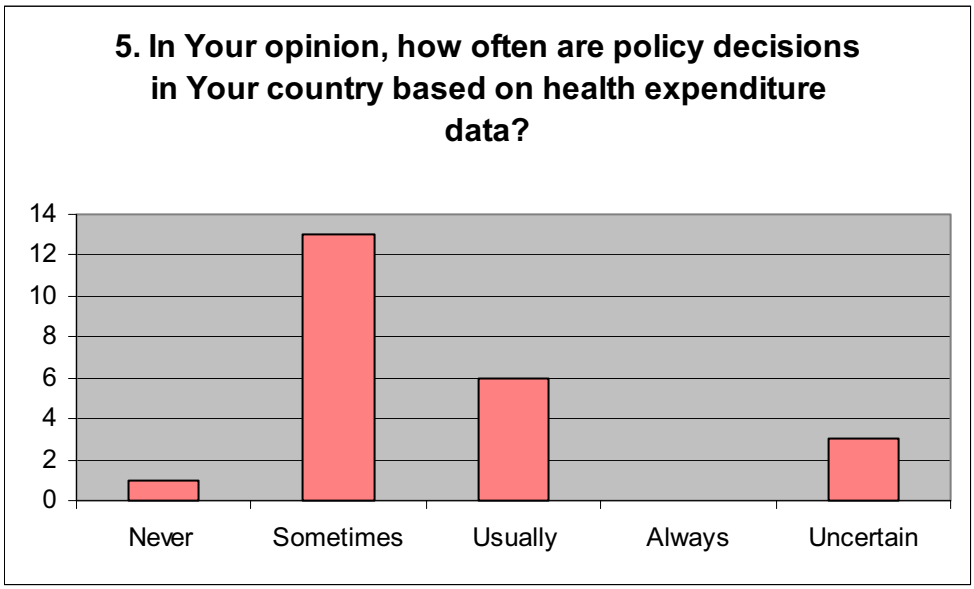
Appendix 1 C. Answers to questionnaires

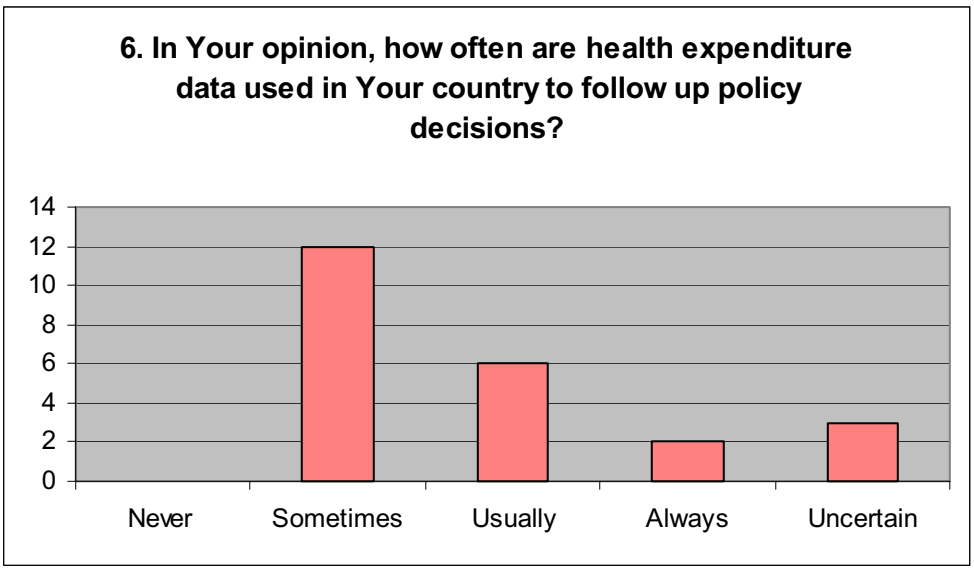


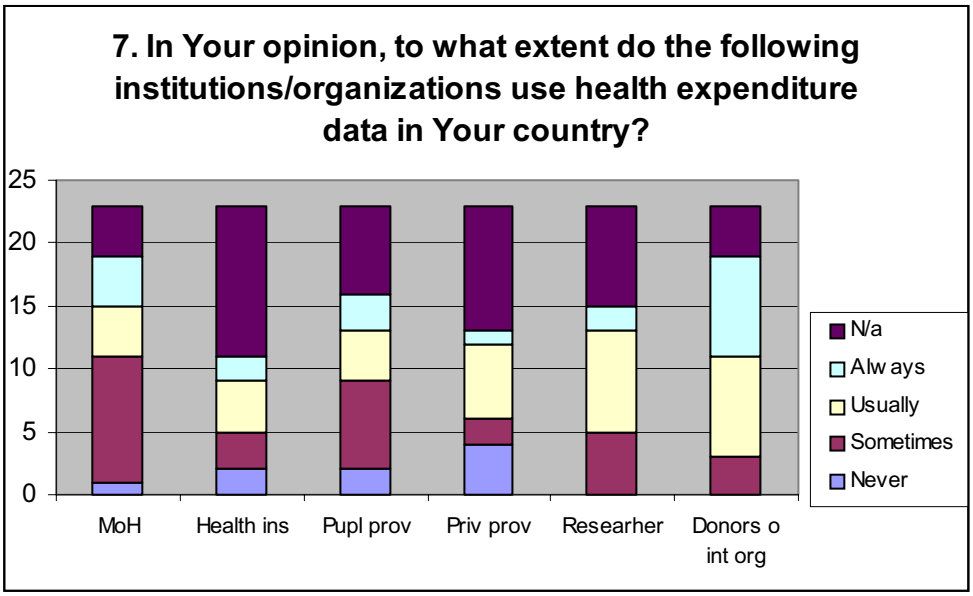





4. How would you rate the relevance of health expenditure data in Your country?
10
8
6
4
2
0
Very poor
Poor
Good
Very good
Uncertain


5. In Your opinion, how often are policy decisions in Your country based on health expenditure data?
14
12
10
8
6
4
2
0
Never
Sometimes
Usually
Always
Uncertain


6. In Your opinion, how often are health expenditure data used in Your country to follow up policy decisions?
14
12
10
8
6
4
2
0
Never
Sometimes
Usually
Always
Uncertain


7. In Your opinion, to what extent do the following institutions/organizations use health expenditure data in Your country?
25
20
15
10
5
0
MoH
Health ins
Pupl prov
Priv prov
Researher
Donors o int org
N/a
Alw ays
Usually
Sometimes
Never

Appendix 2. Zambia

Appendix 2 A. Open-ended questions

(Note that these are broad questions that were adjusted according to place of work of respondent.)

- How do you work, in terms of: preparatory and planning work, and decision-making process?
- What kind of health information and health expenditure data is available and used?
  - What are your opinions regarding this data (quality, availability, timeliness)?
- What is your knowledge about National Health Accounts?
  - Have you got any training or attended any workshops?
- Have you used NHA and to what extent do you think NHA is used in the Zambian health sector today?
- Do you know if there have been any recent policy developments stemming from the use of NHA?
- What are the current problems with NHA and what are the factors hindering the NHA from being used in decision-making?
- Is there anything you need regarding health data that is currently not available?

Appendix 2 B. Questionnaire

This questionnaire aims at exploring opinions regarding the use of health expenditure data across health care decision-makers

1. How would You rate the *availability of health expenditure data* in Your country?

☐ Very poor
☐ Poor
☐ Good
☐ Very good ☐ not sure/uncertain

2. How would You rate *the quality of health expenditure data* in Your country?

☐ Very poor
☐ Poor
☐ Good
☐ Very good ☐ not sure/uncertain

3. How would you rate *the timeliness (up-to-dateness) of the health expenditure data* in Your country?

☐ Very poor
☐ Poor
☐ Good
☐ Very good ☐ not sure/uncertain

4. How would you rate *the relevance of health expenditure data* in your country?

☐ Very poor
☐ Poor
☐ Good
☐ Very good ☐ not sure/uncertain

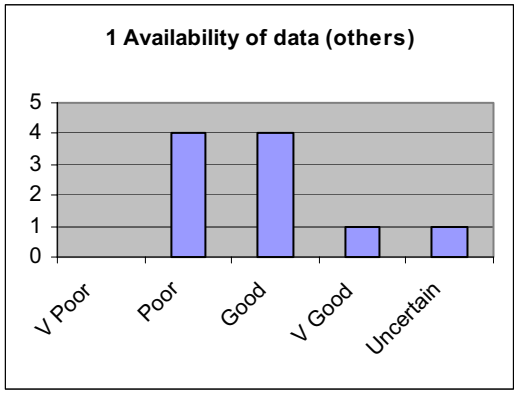
5. In Your opinion, *how often are policy decisions* in Your country based on health expenditure data?

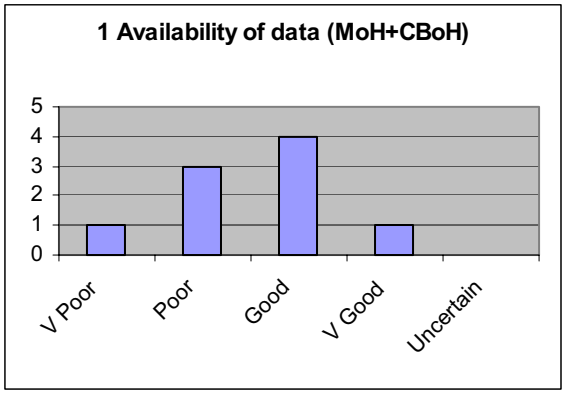
☐ Never
☐ Sometimes
☐ Usually
☐ Always ☐ not sure/uncertain

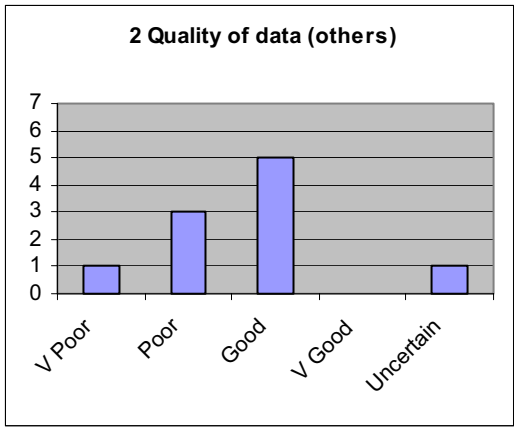
6. In your opinion, how often are health expenditure data used in Your country *to follow up policy decisions?*

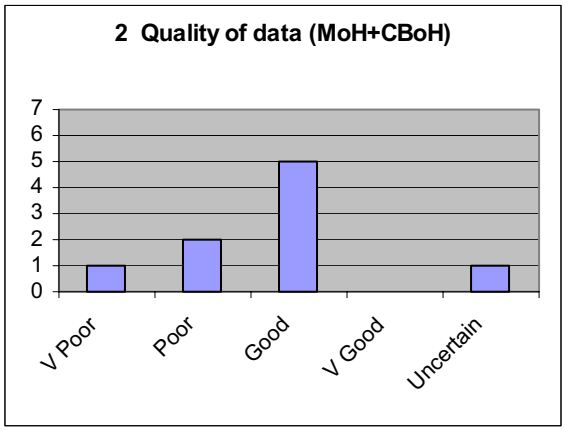
☐ Never
☐ Sometimes
☐ Usually
☐ Always ☐ not sure/uncertain

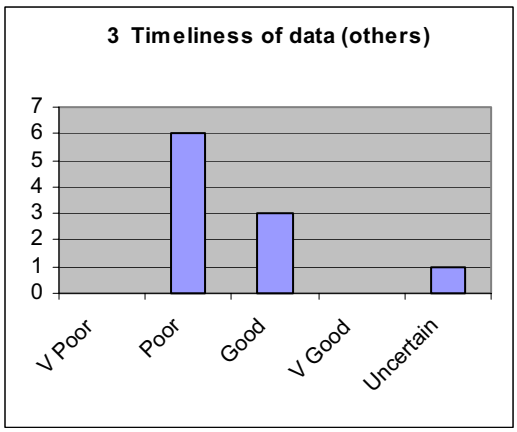
Appendix 2 C. Answers to questionnaires

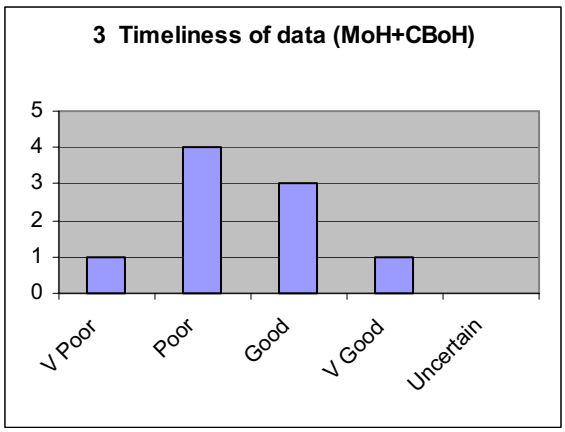


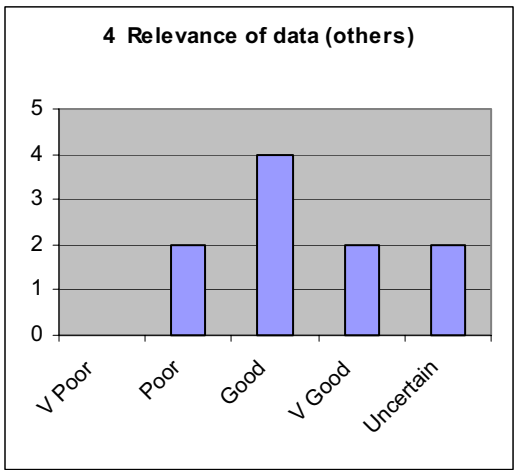


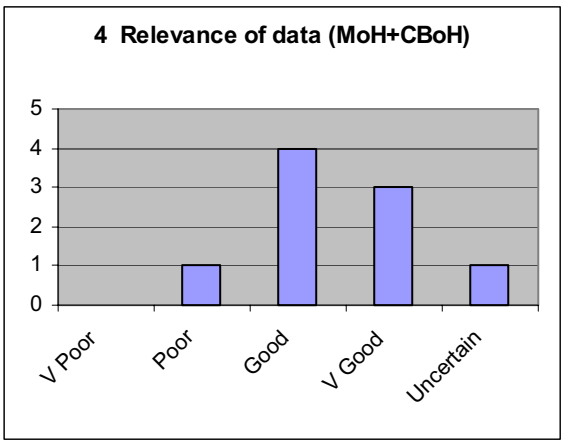


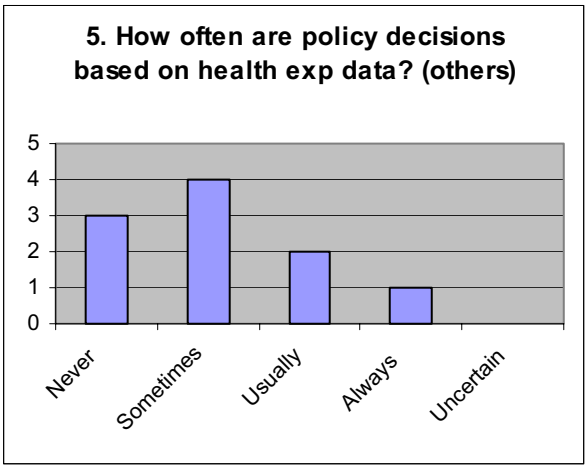


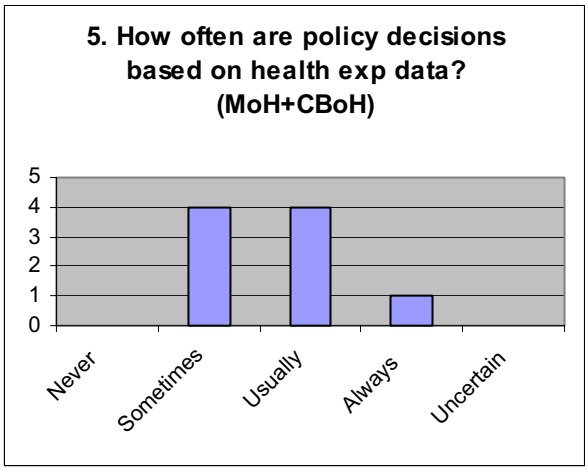


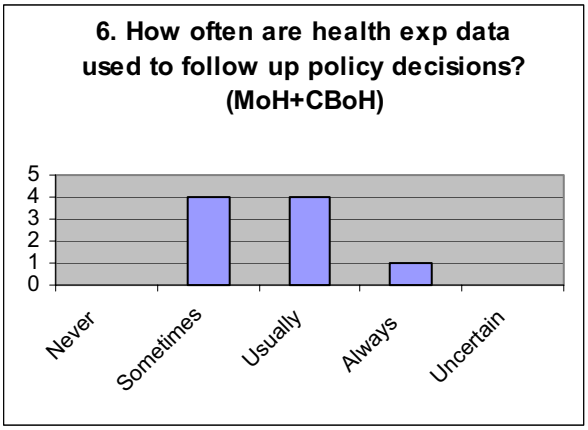


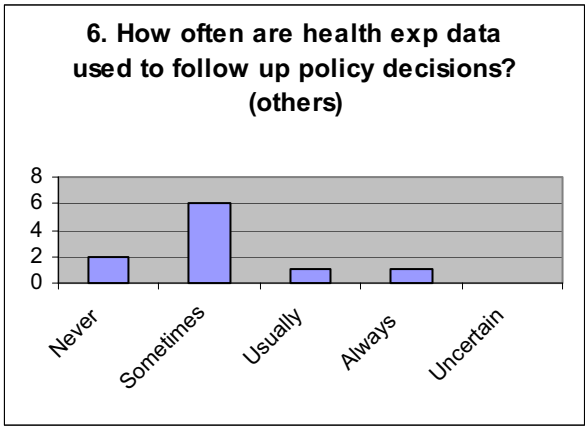





5. How often are policy decisions based on health exp data? (others)
5
4
3
2
1
0
Never
Sometimes
Usually
Always
Uncertain

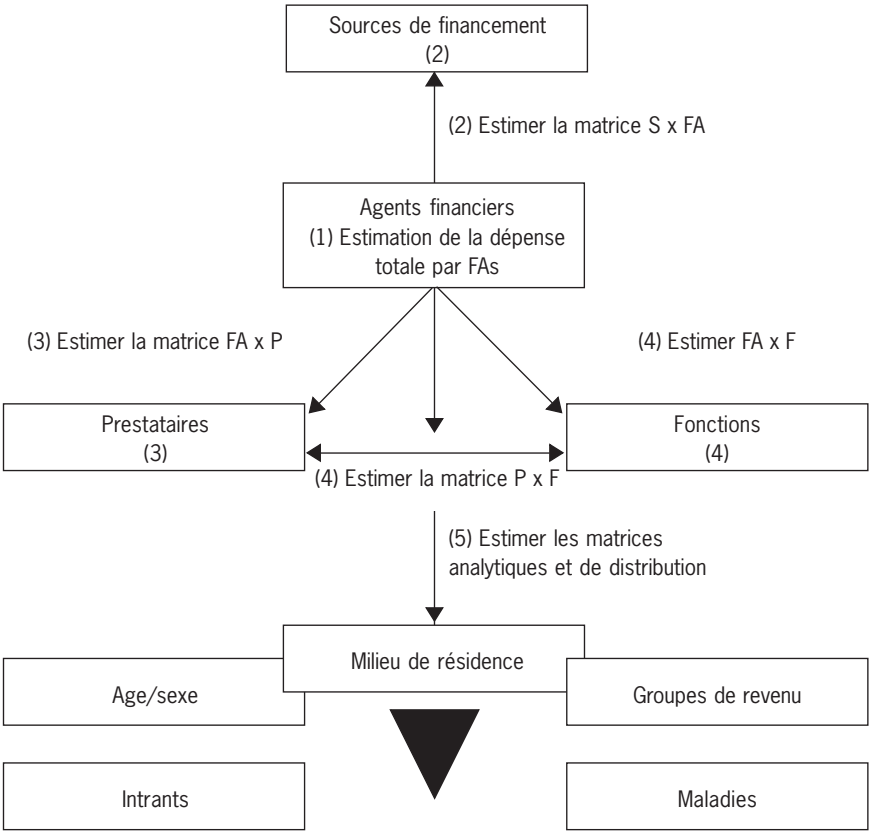

5. How often are policy decisions based on health exp data? (MoH+CBoH)
5
4
3
2
1
0
Never
Sometimes
Usually
Always
Uncertain


6. How often are health exp data used to follow up policy decisions? (MoH+CBoH)
5
4
3
2
1
0
Never
Sometimes
Usually
Always
Uncertain


6. How often are health exp data used to follow up policy decisions? (others)
8
6
4
2
0
Never
Sometimes
Usually
Always
Uncertain

Appendix 3. Mali

Appendix 3 A1. Progression recommandée pour l'estimation des matrices des CNS au Mali



Source: Keoula, 2002

Appendix 3 A2. Ebauche de classification des agents financiers

HF.1.1.1 Administration centrale	Cabinet du Ministère de la Santé, CPS, CEPRIS, CPIS, DNSP, CNI, CNTS, Dispensaire antituberculeux, CPIS, INRSP, Institut Marchoux ?, CNOS, Hôpitaux de Kati, Point G, GT, Programmes verticaux (Sida, Paludisme, Tuberculose, lèpre), DRSP*, Hôpitaux régionaux*
HF.1.1.2 Administration régionale	
HF.1.1.3 Administration locale	CSAR, CSA, CSCom, dispensaires et maternités des communes de Bamako
HF.1.1.4 Administrations de sécurité sociale	INPS
HF.2.1 Assurance sociale privée	Mutuelles de l'UTM
HF.2.2 Sociétés d'assurance privées	Collina s.a, Assurance Lafia, AGM, CNAR, SONA-VIE, Assurance Sabu-Nyuman
HF.2.3 Versements directs des ménages privées	ménages
HF.2.4 Institutions sans but lucratif au service des ménages (hors assurance sociale)	ONG, Fondations, etc…
HF.2.5 Sociétés (hors assurance maladie)	SOTELMA, SOMAHER, SONATAM et toutes les entreprises industrielles et commerciales
HF.3 Reste du monde	Système des Nations unies, Autres partenaires bilatéraux et multilatéraux.

Notes

*Il n'est pas avéré que les hauts commissariats de régions sont les institutions intermédiaires de financement des DRSP et des hôpitaux régionaux, raison pour laquelle on ne saurait classer ces entités dans les administrations régionales.

Source: Keoula, 2002

Appendix 3 B. Open-ended questions

(Note that these are broad questions that were adjusted according to place of work of respondent.)

- How do you work, in terms of: preparatory and planning work, and decision-making process?
- What kind of health information and health expenditure data is available and used?
  - What are your opinions regarding this data (quality, availability, timeliness)?
- What is your knowledge about National Health Accounts?
  - Have you got any training or attended any workshops?
- What have been the results from the NHA exercise 1988–91 and the feasibility study made in 2002?

– What is the present NHA plan for Mali and what are the potential problems with a future NHA undertaking?
– Is there anything you need regarding health data that is currently not available?

Appendix 3 C. Questionnaire

Cette questionnaire a le but d´examiner les opinions par rapport à l´usage des données de dépense de santé parmi les personnes en charge des décisions dans le secteur de la santé.

1. Comment évalueriez-vous *la disponibilité* des données de dépense de santé dans Votre pays?

☐ Très pauvre
☐ Pauvre
☐ Bonne
☐ Très bonne ☐ pas sûr/incertain

2. Comment évalueriez-vous *la qualité* des données de dépense de santé dans Votre pays ?

☐ Très pauvre
☐ Pauvre
☐ Bonne
☐ Très bonne ☐ pas sûr/incertain

3. Comment évalueriez-vous *la conformité du temps* des données de dépense de santé dans Votre pays?

☐ Très pauvre
☐ Pauvre
☐ Bonne
☐ Très bonne ☐ pas sûr/incertain

4. Comment évalueriez-vous *la pertinence* des données de dépense de santé dans Votre pays?

☐ Très pauvre
☐ Pauvre
☐ Bonne
☐ Très bonne ☐ pas sûr/incertain

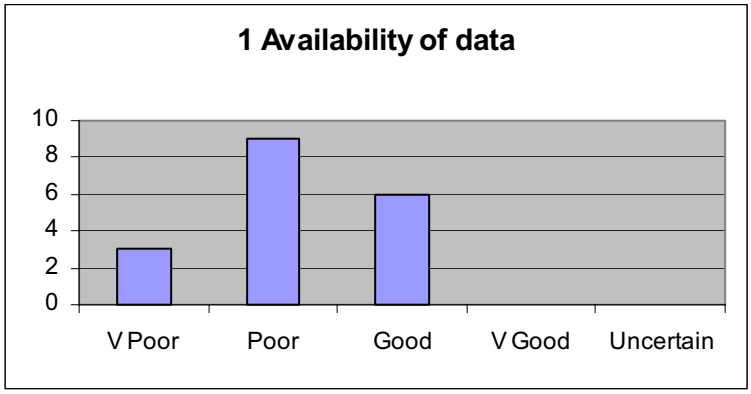
5. A Votre avis, *quand les décisions politiques* sont-elles basées sur les données de dépense de santé dans Votre pays?

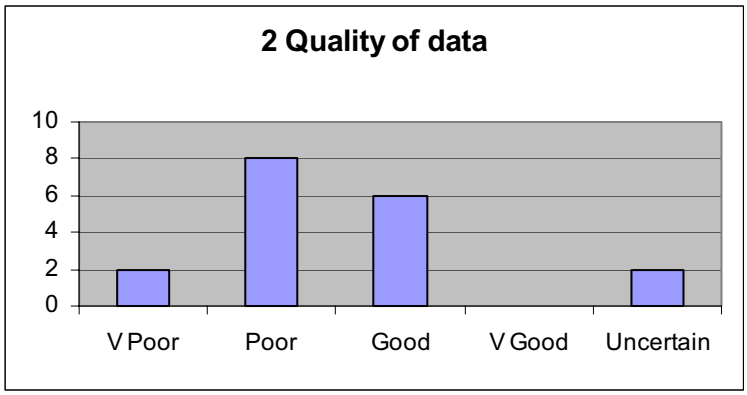
☐ Jamais
☐ Parfois
☐ D'habitude
☐ Toujours ☐ pas sûr/incertain

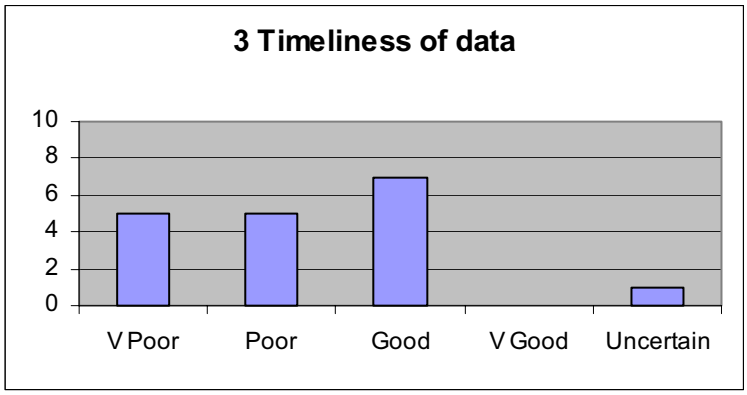
6. A votre avis, quand les données de dépense de santé sont-elles utilisées *pour donner suite aux décisions politiques* dans Votre pays?

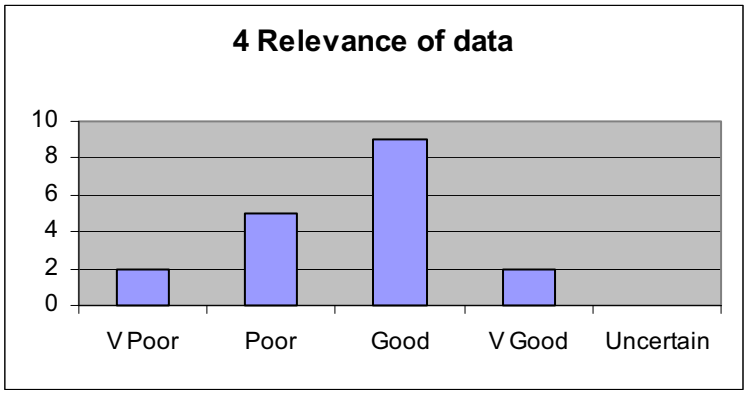
☐ Jamais
☐ Parfois
☐ D'habitude
☐ Toujours ☐ pas sûr/incertain

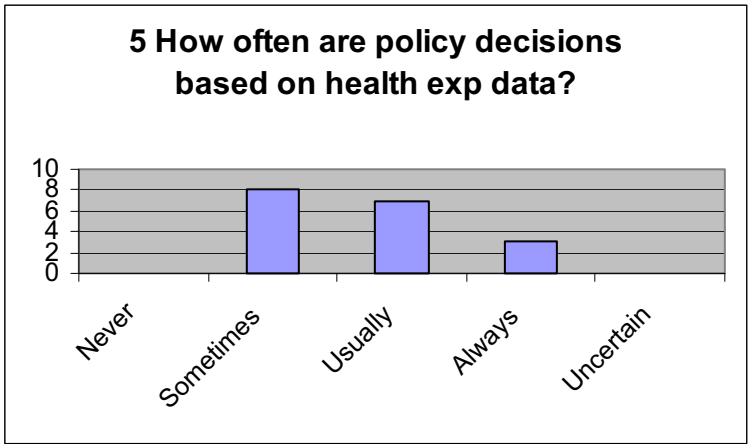
Appendix 3 D. Answers to questionnaires

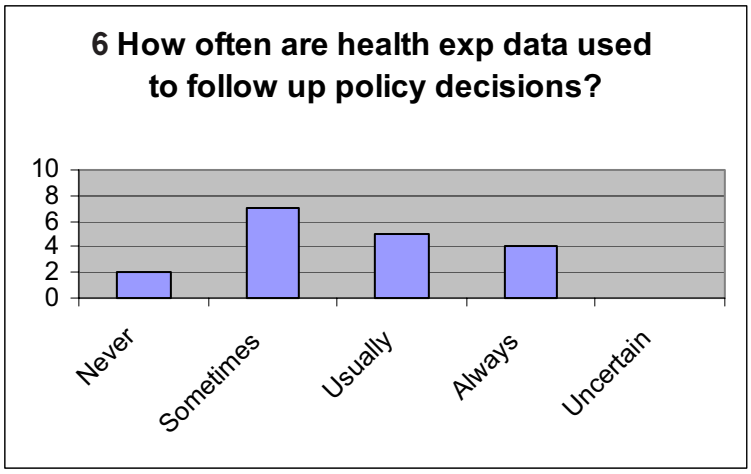







4 Relevance of data
10
8
6
4
2
0
V Poor
Poor
Good
V Good
Uncertain


5 How often are policy decisions based on health exp data?
10
8
6
4
2
0
Never
Sometimes
Usually
Always
Uncertain


6 How often are health exp data used to follow up policy decisions?
10
8
6
4
2
0
Never
Sometimes
Usually
Always
Uncertain

Sida

2004-09-07

List of Health Division Documents

Strategies/Policies

1997:1 Policy for Development Cooperation
Health Sector
– Replaced by Sida's policy for Health and Development, 2002 –

1997:2 Política para la Cooperación para el Desarrollo
Sector Salud

1997:3 Position Paper
Population, Development and Cooperation

1997:4 Positionspapper
Befolkning, utveckling och samarbete

1997:5 Marco de Referencia para la Cooperación para el Desarrollo
Población, Desarrollo y Cooperación

1997:6 Strategy for Development Cooperation
Sexual and Reproductive Health and Rights

1997:7 Estrategia para la Cooperación para el Desarrollo
Salud y Derechos Sexuales y Reproductivos

1997:8 Handbook for mainstreaming
A Gender Perspective in the Health Sector

1999 Investing for future generations.
Sweden's International Response to HIV/AIDS

2000:2 Guidelines for Action – Illicit Drugs and Swedish International Development Cooperation

2001:1 Hälsa & Utveckling,
Fattigdom & Ohälsa – ett folkhälsoperspektiv
by Göran Paulsson, Ylva Sörman Nath and Björn Ekman

2002 Health is Wealth – Sida's Policy for Health and Development

2002 Health is Wealth – A Short Version of Sida's Policy for Health and Development

2002:4 Sweden's Development Co-operation with WHO – a Strategy for the Period 2002–2005

2003 Health is Wealth – A Short Version of Sida's Policy for Health and Development. (Spanish)

2004 Health is Wealth – A Short Version of Sida's Policy for Health and Development. (Russian)

2004 Working in Partnership with UNODC/UNDCP
A Swedish Strategy Framework for 2004–2007

Issue Papers

1998:1 Maternal Health Care, by Staffan Bergström

1998:2 Supporting Midwifery, by Jerker Liljestrand

1998:3 Contraception, by Kajsa Sundström

1998:4 Abortion, by Kajsa Sundström

1998:5 Female Genital Mutilation,
by Beth Maina-Ahlberg

1998:6 Adolescent Sexuality Education, Counselling and Services, by Minou Fuglesang

1998:7 Discrimination and Sexual Abuse Against Girls and Women, by Mary Ellsberg

1998:8 Health Care of the Newborn,
by Ragnar Thunell

1998:9 Men, Sexuality and Reproductive Health,
by Beth Maina-Ahlberg, Minou Fuglesang and Annika Johansson

1998:10 Illicit Drugs and Development Cooperation,
by Niklas Herrmann
– Replaced by 2000:2 –

1999:3 Socio-economic Causes and Consequences of HIV/AIDS
by Stefan de Vylder
– Replaced by 2001:5 –

2000:1 HIV/AIDS in the World Today – a Summary of Trends and Demographic Implications
by Bertil Egerö and Mikael Hammarskjöld

2001:2 Health and Environment
by Marianne Kjellén

2001:3 Improving Access to Essential Pharmaceuticals,
by IHCAR

2001:5 A Development Disaster: HIV/AIDS as a Cause and Consequence of Poverty
by Stefan de Vylder

2001:6 National Health Accounts – Where are we today?
by Catharina Hjortsberg

2001:7 Ideas work better than money in generating reform – but how?
by Alf Morten Jerve

2002:2 Health and Human Rights
by Birgitta Rubenson

2001 Aids: The Challenge of this Century
by Bertil Egerö, Mikael Hammarskjöld and Lise Munch

2002 Health Sector Reforms: What about Hospitals?
by Pär Eriksson, Vinod Diwan and Ingvar Karlberg (NHV report 2002:2)

Continues

Health Division Documents and a complete list of earlier publications may be ordered from:

Infocenter, Sida S-105 25 Stockholm, phone: +46 (0)8 698 55 80, fax: +46 (0)8 698 56 15
www.sida.se, e-mail: sida@sida.se

Sida

List of Health Division Documents

Issue Papers cont.

2002 Sexuality – a super force. Young people, sexuality and rights in the era of HIV/AIDS by Anna Runeborg

2003:2 Human Resources for Health and Development, by Jenny Huddart

2004:3 Report on NHA; the case of Kenya, Zambia and Mali, by Anna Glenngård and Frida Hjalte

Facts and Figures

1995/96 Facts & Figures 95/96 Health Sector Cooperation

1997 Facts & Figures 1997 Health Sector

1999:2 Facts & Figures 1998 Health Sector

2000:3 Facts & Figures 1999 Health Sector

2001:4 Facts & Figures 2000 Health Sector

2002:1 Facts & Figures 2001 Health Sector

2003:1 Facts & Figures 2002 Health Sector

2004:1 Facts & Figures 2003 Health Sector

Fact Sheets

1997 Hälso och sjukvård
1997 Reformer inom hälsosektorn
1997 Rätten till sexuell och reproduktiv hälsa
1997 Befolkning och utveckling
1997 Ungdomshälsa
1997 Handikappfrågor
1999 Aidsbekämpning i Uganda
1999 Förebyggande insatser mot drogmissbruk
1999 Insatser mot familjevåld i Centralamerika
1999 Bättre mödrahälsovård i Angola
1999 Utbildningssamarbete Kenya-Linköping
2001 Sveriges stöd till Hiv/Aids-insatser – 2001
2002 Fler välutbildade barnmorskor ger tryggare förlossningar
2002 Femina skapar het debatt om sex och hiv
2002 Rent vatten ger bättre hälsa och ökad jämställdhet

Sida Evaluations

98/14 Expanded Programme on Immunization in Zimbabwe

99/10 Working with Nutrition. A comparative study of the Tanzania Food and Nutrition Centre and the National Nutrition Unit of Zimbabwe

99/11 Apoyo de Asdi al Sector Salud de Nicaragua. Prosilais 1992–1998

99/36 Support to Collaboration between Universities. An evaluation of the collaboration between MOI University, Kenya, and Linköping University, Sweden

2000 Webs Women Weave. An assessment commissioned by Sida 4 organisations networking for sexual and reproductive health and rights.

00/2 Reaching out to Children in Poverty

00/21 The Protection, Promotion and Support of Breastfeeding

01/03 Tackling Turmoil of Transition. An evaluation of lessons from the Vietnam-Sweden health cooperation 1994 to 2000

01/32 Review of PAHO's project. Towards an integrated model of care for family violence in Central America. Final report

02/13 Sida's Support to the Reproductive Health and TANSWED HIV Research Programmes in Tanzania

02/40 Evolving Strategies for Better Health and Development of Adolescent/Young people

03/19 Sida's Health Support to Angola 2000–2002

04/13 Médecins Sans Frontières – Aral Sea Area programme, Sida's Support to Turberculosis Control and Treatment

04/14 Sida's Work Related to Sexual and Reproductive health and Rights 1994–2003

Continues

Health Division Documents and a complete list of earlier publications may be ordered from:

Infocenter, Sida S-105 25 Stockholm, phone: +46 (0)8 698 55 80, fax: +46 (0)8 698 56 15
www.sida.se, e-mail: sida@sida.se

Sida

List of Health Division Documents

Country and Regional Health Profiles

1995	Angola
1995	Bangladesh
1995	El Salvador
1995	Ethiopia
1995	Guatemala
1995	Guinea Bissau
1995	Honduras
1995	India
1995	Kenya
1995	Laos
1995	Nicaragua
1995	Vietnam
1995	West Bank/Gaza
1995	Zambia
1995	Zimbabwe
2000:4	Uganda
2000:5	West Africa

Other documents

1999:1	Report on: World Youth Conferences in Portugal August 1998, by Wanjiku Kaime-Atterhög and Anna Runeborg
2000:6A	Framtid Afrika – Huvudrapport
2000:6B	Annex to Framtid Afrika – Health Support in Africa – Country Reports
1998	Gender and Tuberculosis
2001	Hälsa – en nyckel till utveckling – New edition 2003 –
2001	Jord för miljarder
2002:3	Rural Integrated Health Services – Kenya, by Gordon Tamm
2002	Health – a Key to Development
2002:5	A follow up of the components for Swedish support in Burma/Myanmar, Cambodia, China (Yunnan Province), Laos and Vietnam
2003	Hälsa – en nyckel till utveckling
2004	Ending gender-based violence: A call for global action to involve men, by Stefan de Vylder
2004:2	Sidas arbete med SRHR 1994–2003 En sammanfattning av utvärderingen "Sida Evaluation 04/14"

Continues

Health Division Documents and a complete list of earlier publications may be ordered from:

Infocenter, Sida S-105 25 Stockholm, phone: +46 (0)8 698 55 80, fax: +46 (0)8 698 56 15
www.sida.se, e-mail: sida@sida.se

Sida

List of Health Division Documents

Consultancy Reports

Conditional Grants for Health Sector Support in Uganda
December 1998

Health Systems Development in Uganda – what could Sweden do within the context of a Sector Wide approach?
December 1998

Review of Regional Organisations/Networks Working in the Area of Hiv/Aids in Eastern and Southern Africa
August 1998

SPANe – Sida partnership on adolescents network
January 1999

SPANe – Part 1: Purpose and aim of SPANe, and Part 2: Proceedings from the 2nd SPANe workshop, 19–21 october 1998 in Harare, Zimbabwe
January 1999

Swedish NGOs working with International Drug Control Issues
January 1999

Hiv/Aids in Botswana
September 1999

Resultatanalys av Sidas stöd till insatser mot narkotika 1997–1999 (Swedish)
Oktober 1999

Resultatanalys av Sidas stöd till Hälsa och Miljö inklusive Tobaksbekämpning (Swedish)
November 1999

The Maternal Health Programme in Angola
November 1999

Hiv/Aids in Bangladesh
December 1999

Hiv/Aids in Tanzania
December 1999

Continued Sida support of Hiv/Aids work within the health sector in Uganda
March 2000

Hiv/Aids in Guatemala and Honduras
March 2000

The teachers' training in sexuality education project in Malawi
March 2000

SPANe – Report from the 3rd SPANe workshop, october 11–13 1999, in Cape Town, South Africa. "Truth Time Now"
April 2000

Appraisal of ESCAP-project
May 2000

A Fact-Finding Mission on the Health Sector in Albania, Kosovo and Macedonia
June 2000

Hiv/Aids – a gender-based response
June 2000

African Youth Forum of the United Nations System
December 2000

Sida Seminar on Sector-Wide Approaches for Health
February 2001

Informal bilateral meeting on Global Health Initiatives
March 2001

Adolescent Sexuality in Africa – from Traditional Rites to Contemporary Sexuality Education
April 2001

Assessment report of RAINBO's Africa program
April 2001

Assessment report of UNICEF Anti-Female Genital Mutilation Campaign in Eritrea November 6–14, 2000
April 2001

Partner Consultation on National Health Accounts
June 2001

Review of Sida support to policy and organisational development, with particular focus on institutional collaboration in Zambia
July 2001

A Background Study on UNDCP
March 2002

Strengthening the obstetric nurse in Nicaragua
October 2001 and March 2002

Estudio independiente de pre-evaluacion y situacion para el fortalecimiento de la enfermera obstetra en Nicaragua
Octobre 2001 y Marzo 2002

Femina Health Information Project
February 2002

HIV/AIDS och utvecklingssamarbete
2003

Health Division Documents and a complete list of earlier publications may be ordered from:

Infocenter, Sida S-105 25 Stockholm, phone: +46 (0)8 698 55 80, fax: +46 (0)8 698 56 15
www.sida.se, e-mail: sida@sida.se

Halving poverty by 2015 is one of the greatest challenges of our time, requiring cooperation and sustainability. The partner countries are responsible for their own development. Sida provides resources and develops knowledge and expertise, making the world a richer place.

SWEDISH INTERNATIONAL
DEVELOPMENT COOPERATION AGENCY

SE-105 25 Stockholm Sweden
Phone: +46 (0)8 698 50 00
Fax: +46 (0)8 698 56 15
sida@sida.se, www.sida.se