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Findings from a study of regional NHA networks

Content

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Acronyms

AFRO	African Regional Office
APHEN	Asia Pacific Health Economics Network
APNHAN	Asia Pacific National Health Accounts Network
CIS	Commonwealth of Independent States
ECSA	Eastern, Central and Southern Africa
EMRO	Eastern Mediterranean Regional Office
FA	Francophone Africa
IHE	The Swedish Institute for Health Economics
IHP	Institute for Health Policy
LAC	Latin America and the Caribbean
MENA	Middle East and Northern Africa
MoH	Ministry of Health
NGO	Nongovernmental Organisation
NHA	National Health Accounts
OECD	Organisation for Economic Co-operation and Development
PAHO	Pan American Health Organization
PHR*plus*	Partners for Health Reform plus
SEARO	South East Asia Regional Office
Sida	Swedish International Development Cooperation Agency
UNDP	United Nations Development Programme
USAID	United States Agency for International Development
WB	World Bank
WHO	World Health Organization
WPRO	West Pacific Regional Office

Executive Summary

National Health Accounts (NHA) is still relatively new in many low- and middle income countries. During the last decade, however, a number of low- and middle-income countries have developed NHA, many of those with support from donor and multilateral organisations. Previously, these countries possessed only limited information on health care expenditures compiled by the government, households, donor organisations and others in their countries. Since the mid 1990s, six regional NHA networks have been established; APNHAN (Asia Pacific National Health Accounts Network) within APHEN (Asia Pacific Health Economics Network), CIS (Commonwealth of Independent States), ECSA (Eastern, Central and Southern Africa), FA (Francophone Africa), LAC (Latin America and Carribean), and MENA (Middle East and Northern Africa). The purpose of organising NHA efforts into networks has first and foremost been to, by information and knowledge sharing, make the implementation of NHA easier.

This paper reports the findings from a NHA network study, conducted during 2004–2005. The study examined the functioning of five out of six identified regional NHA networks, i.e. APNHAN, CIS, ECSA, LAC, and MENA. The overall objective was to define factors of success and/or failure for the operation of the networks. The study aimed to identify how the networks have affected the NHA processes in the member countries. It examined the experiences of both individual country representatives and representatives from donor and multilateral organisations.

In order to evaluate the networks and capture both positive effects and problems with the networks a questionnaire, which incorporated five broad contexts: relational, knowledge, recipient, source, and environmental context, was constructed. These contexts include several factors that influence the successfulness of the network. The questionnaires were sent to representatives identified as key-people in the NHA-teams in the member countries and to representatives from donor organisations and multilateral organisations, supporting network activities. Respondents from 45 member countries and 15 representatives from donor and multilateral organisations completed the questionnaire. In addition, interviews were made with individuals who have been involved in NHA activities for a long period of time in order to obtain more comprehensive information about the networks.

The respondents considered the general interest for implementing NHA in their respective countries to be relatively high. They identified

positive effects of being part of a NHA network as improvements of data collection methods, quality and timeliness of health expenditure data as well as increased use of NHA results among policy makers. The main positive effects of the networks mentioned were improved technical capacity, exchange of experiences and results from NHA and development of links between countries. The respondents also expressed an interest of having more frequent organised meetings/workshops.

The most common problems within networks, given by the respondents, were differences in technical capacity, interest for NHA and organisation of work among members, while physical distance, culture, language and political differences between members seem to constitute less of a problem.

The results from the study show that about half of the respondents benefit much or very much from being part of a network while only one out of four benefit little or very little. For those respondents who believed that they benefit the primary explanations were that the activities brought an increased need for technical capacity to implement NHA, that information sharing is valuable and that the network facilitated the access to data, regional development, methodological development and know-how.

When asked what affected the extent to which NHA networks were successful, the respondents noted a number of issues and factors. Upon analysis of their responses, it became apparent that the degree of successfulness depended partly on the driving forces within the networks and partly on the interest for NHA among network members before starting implementation. The concepts of experience and knowledge are strongly related and success in NHA networks could thus be measured as successfulness in knowledge sharing.

1. Introduction

Today, about 80 countries around the world have developed and implemented National Health Accounts (NHA)[1] and among those approximately half has institutionalised[2] NHA. In many of the OECD countries NHA have been developed on a routinely basis for many years and great efforts have been made to make these accounts coherent. Collaboration between countries and responsible agencies has been encouraged and the OECD office in Paris has taken an active role in improving techniques of collection and reporting of data. Efforts have been made to reach greater level of consistency and comparability in NHA studies.

NHA is still relatively new in many low- and middle-income countries. During the last decade, however, a number of low- and middle-income countries have developed NHA, very much thanks to the support given by donors and multilateral organisations. Previously, these low- and middle-income countries possessed only limited information on health care expenditures made by government, households, donors, and others in their countries. Since the mid 1990s, six regional NHA networks[3] have been established; APNHAN (Asia Pacific National Health Accounts Network) within APHEN (Asia Pacific Health Economics Network), CIS (Commonwealth of Independent States), ECSA (Eastern, Central and Southern Africa), FA (Francophone Africa), LAC (Latin America and Caribbean), and MENA (Middle East and Northern Africa). Under the Partners for Health Reform (PHR) and PHRplus projects, financed by the United States Agency for International Development (USAID), several of these regional networks of countries were established in collaboration with the World Bank (WB), World Health Organization (WHO – Geneva, EMRO and AFRO), Swedish International Development and Cooperation Agency (Sida), and Pan American Health Organization (PAHO). More than 70 countries are represented in these NHA networks. The intention behind the development of networks is to build capacity for the development and institutionalisation of NHA through collaboration and sharing of methodological and

[1] NHA is an internationally recognised tool providing information about a country's total expenditure on health. Expenditures are organised in a set of tables that in a comprehensive manner gives a 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. Its principal goal is contributing to evidence-based policymaking.

[2] Conducting NHA on a regular and sustainable basis.

[3] A NHA network is a set of countries collaborating in implementing NHA in their respective countries. A more precise definition of a network is given in chapter 2.

practical experiences and to encourage the use of NHA in the region. Another purpose is to harmonise the NHA methodology in the networks as to make the results comparable between the countries.

The concepts of experience and knowledge are strongly related and success in NHA networks could thus be measured as successfulness in knowledge sharing. The development and sustainability of the networks may be different depending on who initiated the creation [1]. Donor organisations and multilateral organisations sponsoring the network activities are USAID, Sida, PAHO, WB and WHO.

1.1 Objective

The objective of the study, presented in this report, is to give a description of the functioning of five regional NHA networks, i.e. APNHAN, CIS, ECSA, LAC and MENA. The overall objective is to define factors of success and/or failure for the operation of the networks and to identify how the networks have affected the NHA processes in the member countries. Further it defines factors constituting a problem in the member countries and in the networks. This report aims to inform multilaterals, donors and countries on how to best make use of and benefit from NHA networks. It is hoped that lessons learned from this study can help countries and involved partners as they move forward with efforts to collaborate in networks.

1.2 Methods and data

Five out of six identified regional NHA networks, i.e. APNHAN, CIS, ECSA, LAC, and MENA, were included in the study. FA was excluded due to the fact that it has existed only for a short period of time and most countries in the network have not yet started any NHA activities. Around 70 countries were identified to be members in the five networks.

During December 2004, two sets of questionnaires were distributed by email. One questionnaire was sent to representatives identified as key-people in each country's NHA activities (Appendix A). The respondents in the LAC countries were sent a cover letter in Spanish and were given the option to fill in the questionnaire either in Spanish or in English. Similarly, the respondents in the CIS region were sent a cover letter in Russian and the option to fill in the questionnaire either in Russian or in English. The other questionnaire was distributed to representatives from donor organisations and multilateral organisations, supporting network activities (Appendix B). Reminders were sent out during January–March 2005.

Among the identified members, 49 countries replied (54 respondents), out of which 45 countries considered themselves as members in one of the networks and four did not. In total, the empirical data for member countries used in this study is composed of 50 respondents from 45 countries.

In this study, 27 persons belonging to the donor/multilateral group were identified. Out of these, seven persons thought that they were not able to answer the questionnaire because of insufficient knowledge and lack of experience in the different networks. One of the respondents preferred to answer the questionnaire for the member countries instead and four persons did not reply at all. Completed questionnaires were obtained from 15 persons representing donor and multilateral organisations.

1.3 Shortcomings

This study does not present a definitive number of member countries in respective network. Despite several reminders, answers from all member countries have not been received and consequently not all member countries are represented in the survey. Also, for the vast majority of the countries, only one representative from each country participated in the survey.

2. The concept of networking

2.1 The concept of networks

The conceptual framework used in this paper focuses on networks. All networks have in common that they refer to a set of nodes (e.g. individuals or organisations), which are tied together in a structure by links or relationships. Networks concern the relationships between these nodes. The concept of network is all about relations or as formulated by Knoke and Kuklinski "*Relations are the building blocks of network analysis*" [2]. Mitchell [3] cited by Knoke and Kuklinski (1982) suggests that a network generally is defined as *"a specific type of relation linking a defined set of persons, objects, or events"*. This set of persons, objects or events are called actors or nodes and have some common characteristics that make them part of the network. Relations between actors are central in a network and the relations have both *form* and *content* [2]. Network structures vary in form depending on to what extent the actors are connected to each other. Content refers to what type of relation considered; e.g. transaction relations, communication relations, boundary penetration relations, instrumental relations, sentiment relations, authority/power relations, kinship and descent relations.

2.2 NHA networks and factors of success

In NHA networks the member countries constitute the nodes within the respective network. The nodes are tied together in a structure by links or relationships. The relationships in these networks are based on experiences of NHA. The concepts of experience and knowledge are strongly related and success in NHA networks could thus be measured as successfulness in knowledge sharing.

A report from the United Nations Development Programme (UNDP) discuss capacity development in the new era of networks [4]. It states that networks can be empowering instruments of capacity development as they can share information locally, regionally as well as internationally. Networks then involve information flows in many directions – within and between countries of both north and south. These kinds of networks can be denoted demand-driven networks. However, some networks can be described as supply-driven, i.e. when there is only an information flow from north to south. This may be the case when the network is donor driven, too controlled and hierarchically organised.

Cummings [5] describes different factors that can affect a successful knowledge sharing. Knowledge management is identified as how organi-

sations create, retain and share knowledge. Knowledge sharing refers to the means by which an organisation obtains access to its own and other organisations knowledge. Successful knowledge sharing involves learning processes rather than communication processes as the "local doers of development" are of high importance if to successfully implement the ideas. The definition of success in knowledge sharing is how successfully the knowledge is channelled between sources and recipients.

Internalisation of knowledge refers to the degree to which a recipient obtains ownership of, commitment to, and satisfaction of the transferred knowledge. Factors that play the major role in a knowledge-sharing process are those that support the recipient's ability to internalise knowledge.

Cummings [5] identifies five contexts that can affect the successful knowledge-sharing implementations:

- Relational context: factors that create different types of distances between the source and the recipient, i.e. organisational distance, physical distance, institutional distance, knowledge distance, relationship distance.
- Knowledge context: Knowledge explicitness refers to the extent to which knowledge is verbalised, written, drawn or else articulated. Knowledge embeddedness refers to how knowledge is embedded, e.g. in people, in tools, in products and in technology.
- Recipient context: The recipient's motivation and capability.
- Source context: A source's learning culture.
- Environmental context: Broad economic, political, cultural and institutional environmental variables.

Cummings suggests three types of analyses to evaluate knowledge-sharing activities; 1) Analysis of the form and the location of the knowledge; 2) Analysis of the types of agreements, rules of engagement and managerial practices adopted by the parties as they can affect the flows of knowledge and resources; and 3) Analysis of the specific knowledge-sharing activities used.

The approach for this analysis of the NHA networks is based on the definitions described above:

- Describe to what extent the relational, knowledge, recipient, source and environmental context contributes to a successful knowledge-sharing (recipient ability to internalise knowledge).
- Describe differences and possible explanations for these differences between members (knowledge, recipient, source) and between the different networks (relational, knowledge, environmental).

3. Overview of the regional NHA networks

Since 1997, six regional NHA networks have been established with the aim of implementing NHA in member countries. The first two networks established (in 1997) were the Latin America and the Caribbean (LAC) and the Eastern, Central, and Southern Africa (ECSA) networks. The Asia Pacific NHA Network (APNHAN) and the Middle East and North Africa network (MENA) followed, in 1998 and 1999, respectively. During 2003, the Francophone Africa (FA) and the Commonwealth of Independent States (CIS) networks were initiated. These two networks differ from the other four, particularly regarding in how they came into existence.

Table 1. Regional NHA networks

Network	Year of launching	Member countries a	Support b
APNHAN	1998	Australia, Bangladesh, Cambodia, China, Hong Kong SAR, India, Indonesia, Japan, Korea, Kyrgyzstan, Malaysia, Maldives, Mongolia, Myanmar, Nepal, Papua New Guinea, Philippines, Samoa, Singapore, Sri Lanka, Taiwan, Thailand [6]	WHO c
CIS	2003	Armenia, Azerbaijan, Georgia, Moldova, Mongolia, Kazakhstan, Kyrgyzstan, Russia, Ukraine, Uzbekistan, Tajikistan, Belarus, Turkmenistan [7]	USAID, WB, WHO, Sida
ECSA	1997	Botswana, Ethiopia, Gambia, Kenya, Malawi, Mauritius, Moçambique, Namibia, Nigeria, Seychelles, Sierra Leone, South Africa, Swaziland, Tanzania, Uganda, Zambia, Zimbabwe [8]	USAID, Sida, WHO
FA	2003	Benin, Burkina Faso, Cameroon, Cape Verde, Chad, Congo, Madagascar, Mali, Niger, Rwanda, Senegal, Togo, Algeria, Burundi, Central African Republic, Comoros, Côte d'Ivoire, Equatorial Guinea, Gabon, Guinea, Guinea Bissau, Mauritania, São Tomé and Principe, Seychelles [9]	USAID, Sida, WHOc
LAC	1997	Bolivia, Dominican Republic, El Salvador, Guatemala, Guyana, Haiti, Honduras, Jamaica, Mexico, Nicaragua, Paraguay, Peru [10]	USAID, PAHO, WB
MENA	1999	Djibouti, Jordan, Lebanon, Tunisia, Egypt, Morocco, Yemen [10]	USAID, WHO

[a] The information about member countries is based on available documents and on information collected through the questionnaires.

[b] The donor and multilateral organisation listed have contributed to the set up and development of network activities on a regular basis. In addition to those listed several other donor organisations have supported the implementation of NHA in individual countries.

[c] Very limited financial support.

The APNHAN [6] is a sub-network of the Asia-Pacific Health Economics Network (APHEN). The activities of the network are coordinated by the Institute for Health Policy (IHP), Sri Lanka (the successor in 2005 to the Health Policy Programme of Institute of Policy Studies). The APNHAN network is currently constructing a webpage that should be launched in July 2005. APNHAN is perhaps the most successful network in terms of starting and supporting NHA activities on their own. The network was not initiated by donor or multilateral organisations. Network meetings are organised when funding is available. A total of three conferences (Cebu, May 2001; Bangkok, June 2002; Colombo, March 2005) and two smaller meetings that have been parts of other conferences (Manila, February 2003; Hong Kong, December 2003) have been organised by APNHAN since the network was initiated. SEARO/WHO and WPRO/WHO provide small meeting support in terms of bursaries for some of the participants and WHO/Geneva provides a minor amount to paper preparations. The network was awarded a $200,000 competitive research grant by the Rockefeller Foundation to support its networking activities during 2001–2003. APNHAN has also been awarded a EU INCO-DEV grant for € 865,000 for Equitap[4], during 2001–2004. None

[4] Equitap is a collaborative study of equity in Asia-Pacific health systems, including twelve Asian partner institutions working together with the Erasmus University in the Netherlands and the London School of Economics in the UK.

of the other NHA networks has been this successful in receiving research grants. The APNHAN meetings are organised according to the OECD approach of NHA meetings, which means that all the members first give a brief presentation of their NHA status and then some of the countries give longer more detailed presentations. Further, focus is laid on important technical issues or problems. Some of the OECD countries are also presenting their NHA management.

The CIS network is the most recently established network. The first NHA and HIV/AIDS sub analysis workshop in the region took place in December 2003 in Almaty, Kazakhstan. Since then, several of the member countries have started NHA activities and additional technical support for the implementation of NHA is given. The network has since its initiation been supported by USAID (via PHR*plus*), Sida (via IHE), WHO and the WB.

The ECSA [7] network was established in 1997, by WHO and institutions such as Harvard School of Public Health and PHR, who introduced NHA in the ECSA region[5]. In November 2000 the Commonwealth Regional Health Community Secretariat (CRHCS) established a Health Care Financing Programme. Later a strategic plan has been formulated within this programme that includes institutionalisation of NHA as one of the major activities. CRHCS received more of a leading role of the ECSA NHA network in 2001 and has since then taken part in coordinating three regional training workshops. The first ECSA NHA regional workshop was held in Zambia in 2001. The second took place in Zimbabwe in November 2002 and the third was held in Mozambique in December 2003.

The FA network was recently established. The launch conference was held in January 2003 as to introduce West and Central African representatives from Ministries of Health, Ministries of Finance and National Bureaus of Statistics and others to the basic ideas and methodology of NHA. The first training workshop with representatives from twelve countries was organised in Senegal later the same year. In 2004 no workshops or meetings were held within the network due to lack of funding.

The LAC, launched in 1997, was the first NHA network. A privately owned institution, the Mexican Health Foundation (FUNSALUD), was selected as a regional resources centre for the network since Mexico had prior experience of NHA. Financial and technical support has mostly come from PAHO and USAID (via PHR and Harvard University). Regional workshops have been organised regularly. Two were held in 1997 (in Mexico and in Ecuador), one took place in Dominican Republic in 1998, and others followed. The latest one was held in Nicaragua in 2003.

The MENA network was launched in 1999. In 2003, one NHA workshop was held in Cairo. Further, in April 2005, the USAID/Yemen in collaboration with the Gulf Cooperation Council (GCC), the WHO, and the EC, organised a technical training workshop on NHA for the Gulf States. The participants represented ministries of finance, planning and health, and central statistics organisations of Saudi Arabia, Bahrain, Oman, Qatar, Iraq and Yemen.

[5] The first countries to undertake NHA activities, supported by the University of Cape Town, USAID/RESDO and PHRplus were Kenya, Uganda, Tanzania, Malawi, Zambia, Mozambique, Zimbabwe, South Africa, Ethiopia and Rwanda.

4. Evaluation of the networks

In order to evaluate the networks and capture both positive effects and problems with the knowledge sharing process a questionnaire was distributed to members of the networks and to representatives from organisations supporting the network activities. The questionnaire was constructed as to incorporate the five broad contexts described in Chapter 2: relational, knowledge, recipient, source, and environmental context. These contexts include several factors that influence the successfulness of the network.

4.1 Members

The questionnaire (see Appendix A) was distributed to people identified as representatives for the member countries' NHA activities. The initial part of the questionnaire related to background information about the respondent and the NHA status of the country. The other questions related to background information about the network and an evaluation of the problems and the positive effects connected with the network. A total of 49 countries replied (54 persons). Of these, four did not consider themselves as members (see table 2). Thus, the results are based on answers from 50 respondents representing 45 countries.

Table 2. Total number of respondents and countries represented

Network	Number of respondents	Countries represented	Countries missing
APNHAN	18	Australia, Bangladesh, China, Hong Kong SAR, China, India, Indonesia, Japan, Maldives, Mongolia, Myanmar, Nepal, Papua New Guinea, Republic of Korea, Samoa, Sri Lanka, Taiwan, Thailand	Cambodia, Malaysia, Philippines, Singapore
CIS	10	Armenia, Azerbaijan, Georgia, Kazakhstan, Kyrgyzstan, Moldova, Russia, Tajikistan	Ukraine, Uzbekistan, Belarus, Turkmenistan
ECSA	11	Kenya, Malawi, Mozambique, Seychelles, South Africa, Swaziland, Tanzania, Uganda, Zambia, Zimbabwe	Botswana, Ethiopia, Gambia, Mauritius, Namibia, Sierra Leone
LAC	7	Ecuador, El Salvador, Guyana, Mexico, Nicaragua, Peru	Bolivia, Dominican Republic, Guatemala, Haiti, Jamaica, Paraguay
MENA	4	Djibouti, Jordan, Lebanon, Tunisia	Egypt, Morocco, Yemen
Not member	4	Honduras, Iran, Nigeria, Rwanda	
Total	**54**	**49 countries**	

Nearly all of the 50 respondents had been involved in network activities during a period of more than one year. Most of them had been involved between one and three years. More than half of the respondents worked in the Ministry of Health. The remaining part worked in other ministries, national bureaus of statistics, donor organisations, multilateral organisations, universities, research institutes and nongovernmental organisations.

The NHA status of the member countries included in the study is presented in Table 3. The majority of the countries have produced at least one round of NHA. One third of the countries have completed more than one round but have not yet institutionalised the NHA process in the sense that NHA is developed on a regular basis. All networks, except CIS, include countries that have completed only one round of NHA. All networks, except MENA, have members who are in the upstart phase of NHA. According to the questionnaires, countries producing NHA on a regular basis are only found in the LAC and APNHAN networks.

Table 3. NHA status among the countries represented in the study

	No NHA	Upstart phase	Completed 1 round	Completed > 1 round but not on a regular basis	NHA institutionalised	Total number of countries
APNHAN	0	5	1	5	6	17
CIS	2	4	0	2	0	8
ECSA	0	2	3	5	0	10
LAC	0	1	2	0	3	6
MENA	0	0	1	3	0	4
Total	2	12	7	15	9	45

The respondents in the study considered the general interest for implementing NHA in their countries to be relatively high. More than half of the respondents, 59 percent, regarded the interest as high or very high, while only 14 percent considered it to be low or very low.

In Table 4 below different factors perceived as problems connected with implementing NHA in the countries are presented for each network. As shown in the table, the most common factor constituting a problem was lack of financial resources and equipment. The members of the LAC and CIS networks also perceived low technical capacity as a problem. In the MENA network, low interest for NHA was perceived as a problem.

Table 4. Factors constituting a problem in the country according to the members

(mean value, 1=No problem, 5=Major problem)

	APNHAN	CIS	ECSA	LAC	MENA	Average (S.D)*
Difficulties in information sharing	2.4	2.3	2.8	2	3.3	2.5 (1.34)
Low interest in NHA	2.5	2.9	2.8	3	4	2.8 (1.24)
Low technical capacity to produce NHA	2.3	3.6	2.9	3.4	2.5	2.8 (1.37)
Lack of financial resources and equipment	3	3.8	3.3	3.7	4.3	3.4 (1.39)

* Standard Deviation (S.D) is only presented for the average of all respondents since the number of respondents from each network is not large enough for such a measure to be informative.

The members were asked if they were aware of the purpose of the formation of the network. A majority of the respondents answered that they were aware of the purpose of the network formation while approximately one third did not know or was unsure about the purpose. Common purposes given for all five networks were to exchange information, compare and share experiences and results, develop technical capacity and facilitate the production and implementation of NHA in the member countries, as well as to develop relations between the member countries. In addition, the respondents from CIS and LAC believed one main purpose, of the organisation of countries in NHA networks, was to harmonise the systems and promote NHA standards among the member countries.

Regarding initial problems within the networks, one third of the respondents believed that there were such problems within their network. About half of the respondents were unsure whether there were any initial problems and a few answered that there were no initial problems. The most important initial problems mentioned were constraints in financial and human resources and a lack of interest/low commitment among the members. The respondents from the CIS and LAC networks also noted that different methodological approaches in implementing NHA in the different countries was an important initial problem. The issue of the network being driven by stakeholders, who are not members of the

networks, i.e. organisations supporting the network activities (donor and multilateral organisations), rather than by the actual members, was brought up as a problem for the ECSA network.

When asked if countries have specific roles and responsibilities and if there are any member countries or individuals that have a leading role in the network or not, most of the respondents were unsure. Among the respondents that answered yes, one country that has a specific role and more responsibility than the other members in two of the networks could be identified. For ECSA, the Commonwealth Regional Health Community Secretariat (CRHCS) in Arusha, Tanzania has a coordinating role. Similarly, the Institute of Policy Studies (IPS) in Sri Lanka has a coordinating role for the APNHAN network.

The majority of the respondents claimed that formal meetings/ workshops between the members are currently organised less than once a year but answered that a more appropriate regularity would be once or twice a year. Other contacts (e.g. e-mail, telephone, fax and mail) between the members in the networks appear to be relatively infrequent. Two out of ten say that they have contact with other members at least every month while approximately six out of ten have contact only once a year or less. Most respondents believed that contacts with the other members are *not* frequent enough.

As shown in Table 5 below, being a member in one of the networks has meant that data collection methods, and quality and timeliness of health expenditure data have improved. For most of the members it has also meant that the technical and the analytical capacity have improved. Timeliness of health expenditure data seems to have improved for the members (except MENA) as well as the use of NHA results among policy makers.

Table 5. The level of effect the network has had on different aspects of the NHA development in the member countries according to the members

(mean value, 1=No improvement, 5=Major improvement)

	APNHAN	CIS	ECSA	LAC	MENA	Average (S.D)*
Data collection methods	3.1	2.6	3.5	3.3	3.3	3.1 (1.13)
Quality of health expenditure data	3.1	2.7	3.4	3.3	2.8	3.1 (1.22)
Timliness of health expenditure data	2.7	2.4	2.7	3.3	2.8	2.8 (1.01)
Technical capacity	2.3	2.3	2.9	2.8	3.3	2.6 (1.23)
Analytical capacity	2.8	2.9	3.1	2.8	2.8	2.9 (1.23)
Dissemination of NHA results in time	3.1	2.4	3.1	3.2	2.0	2.9 (1.21)
Use of the NHA results among policy makers	3.1	1.9	3.0	2.7	1.9	2.7 (1.26)

* Standard Deviation (S.D) is only presented for the average of all respondents since the number of respondents from each network is not large enough for such a measure to be informative.

According to half of the respondents the extent to which the membership in the network has affected the political support for NHA in the country is low. A few respondents say that it has affected the political support much or very much while the remaining third answered that the network has had a moderate affect on the political support. It was improved to

some extent in ECSA, LAC and APNHAN, according to the interviews. For ECSA and APNHAN the reason for this was that representatives from the Ministry of Health had participated in NHA workshops and meetings. In the LAC region this was attained by the actual comparison of results between countries in the region, i.e. the achievement of a successful NHA process in one country put pressure on neighbouring countries.

As shown in Table 6 below, physical distance, and cultural, language and political differences between members do not constitute a problem for the networks compared to differences in technical capacity, interest for NHA and organisation of work among members.

Table 6. Factors constituting a problem in the networks according to the members

(mean value, 1=No problem, 5=Major problem)

	APNHAN	CIS	ECSA	LAC	MENA	Average (S.D)*
Physical distance between members	2.9	3.1	2.7	2.4	3.0	2.8 (1.30)
Cultural differences among the members	2.4	2.5	2.0	3.0	2.5	2.4 (1.22)
Language difference among the members	2.4	2.1	2.3	3.4	2.5	2.5 (1.16)
Differences in the organisation and work of the NHA-teams among the members	3.0	3.4	2.5	3.6	4.5	3.2 (1.01)
Differences in the political stability between the members	2.5	2.6	2.2	3.7	3.0	2.7 (1.09)
Lack of financial resources and/or equipment	4.1	3.8	3.7	4.4	4.0	4.0 (0.96)
Differences in the interest in NHA among the members	3.1	2.5	3.4	4.0	3.7	3.3 (1.15)
Low interest in NHA among the members	3.0	2.4	2.9	3.6	3.0	3.0 (1.20)
Differences in the technical capacity among the members	3.6	3.6	3.4	3.7	4.0	3.6 (0.98)
Low technical capacity among the members	3.4	3.6	3.2	3.6	3.0	3.4 (1.08)

* Standard Deviation (S.D) is only presented for the average of all respondents since the number of respondents from each network is not large enough for such a measure to be informative.

Regarding to what extent the members benefited from being members in the network, the opinions of the respondents were divided. About half of the respondents claimed that they benefited much or very much from being part of a network while one out of four benefited little or very little. Among those who stated that they do not benefit from being members, a lack of communication and low commitment among the members were regarded as the most important causes of dissatisfaction. For those respondents who believed that they do benefit from being a member the primary explanations were that the activities brought an increased need for technical capacity to implement NHA, that it is valuable with information sharing and that the network facilitated the access to data,

regional development, methodological development and know-how. The main positive effects of the networks mentioned were improved technical capacity, exchange of experiences and results from NHA and development of links between countries.

The main problems mentioned were that the contact between members is not frequent enough, that the capacity of human resources in the member countries is under-mined due to personnel turn-over, and that there is a lack of financial resources. In addition, the problem that different member countries are found in different stages of the NHA process was brought up. One respondent from MENA mentioned that the network is not self-sustainable – without support from WHO the activities would not continue. Lack of political commitment was also mentioned for MENA. One respondent from ECSA brought up that there is a problem connected with the fact that NHA focal points have shared agendas and cannot devote enough time to the development of NHA and NHA network activities.

Possible solutions to the main problems, according to the questionnaires, involve organising more workshops and in-country trainings. This would solve both the issue with not enough frequent contact among members and the issue of low technical capacity of the country NHA teams. In addition, more financial and technical support was suggested in order to improve the in-country NHA activities. Other comments was that the network activities need to move away from training workshops towards meetings where ideas and research proposals could be discussed (ECSA) and that members also should be encouraged to learn from countries outside the network, e.g. OECD countries (APNHAN).

4.2 Donor and multilateral organisations

A different questionnaire than the one sent to the members (see Appendix B) was sent out to representatives from donor and multilateral organisations. Completed questionnaires were obtained from 15 persons. The initial question of the questionnaire asked the respondent to rate all the six networks in terms of successfulness and if relevant give comments on the different networks. Since not all of the respondents were familiar with all of the networks all respondents did not rate every network. For the rest of the questionnaire, including questions evaluating the functioning of the networks, the respondents were asked to answer for the network that she/he was most familiar with. As shown in Table 7 below, the most successful networks were, according to the respondents, APNHAN followed by LAC and ECSA. All three networks were created during 1997–1998. The two most recently created, FA and CIS, were considered less successful. They have on the other hand not been operating for long and cannot yet be really evaluated. It should be noted, that the results presented below should be interpreted carefully since they are based on information of only a few respondents.

Table 7. Successfulness of the different networks according to the donors/ multilaterals

(1=not successful, 5=very successful)

Network	Respondents	Mean value	Median value
APNHAN	11	3.8	4
LAC	10	3.4	4
ECSA	11	3.3	4
MENA	10	3.0	3
FA	6	2.3	2
CIS	6	2.2	2

The majority of the respondents had been involved in network activities for more than three years. According to the respondents it was primarily donor and multilateral organisations that initiated the creation of the networks even though a few answered that the initiative came from the member countries themselves or in cooperation with donor and multilateral organisations. Most respondents agreed to that there were initial problems within the networks.

The respondents' opinions were divided regarding whether there is any member country or individual that has more responsibility or a leading role in the networks.

The most common answers to how often formal meetings or workshops between the members are held were less than once a year or once or twice a year. The majority of the respondents also thought that once to twice a year were an appropriate frequency of organising network meetings.

The respondents were also asked to rate how the networks have affected different aspects of the NHA development in the member countries. As shown in Table 8 below, the respondents were rather positive to the effects of organising countries into networks. According to the respondents, the NHA development has been affected positively in terms of data collection, quality and timeliness of data, technical and analytical capacity as well as the use of NHA among policy makers.

Table 8. The level of effect the network has had on different aspects of the NHA development in the member countries according to the donors/ multilaterals

(mean value, 1=No improvement, 5=Major improvement)

Aspect	Value (S.D)
Data collection methods	3.3 (1.15)
Quality of health expenditure data	3.7 (0.98)
Timeliness of health expenditure data	2.8 (0.58)
Technical capacity	3.4 (1.12)
Analytical capacity	3.4 (1.36)
Dissemination of NHA results in time	2.5 (0.67)
Use of the NHA results among policy makers	2.9 (1.24)

The respondents were also asked to what extent they perceived different factors as constituting a problem within the networks. As shown in Table 9, similar issues were raised by the donors/multilaterals as the individual network members. Physical distance, political stability, cultural and

language differences were viewed as minor problems compared to lack of financial resources and/or equipment, low technical capacity and lack of or differences in interest for NHA.

Table 9. Perception of factors constituting a problem in the networks according to the donors/multilaterals

(mean value, 1=No problem, 5=Major problem)

Factors	Value (S.D)
Physical distance between members	2.2 (1.07)
Cultural differences among the members	1.6 (0.96)
Language difference among the members	1.8 (1.17)
Differences in the organisation and work of the NHA-teams among the members	2.5 (1.13)
Differences in the political stability between the members	2.4 (1.45)
Lack of financial resources and/or equipment	4.2 (0.73)
Differences in the interest in NHA among the members	3.4 (1.33)
Low interest in NHA among the members	2.6 (0.86)
Differences in the technical capacity among the members	2.8 (0.98)
Low technical capacity among the members	3.2 (0.99)

The respondents representing donor and multilateral organisations were also asked to give additional comments on the networks. Several of the respondents mentioned that APNHAN has been very successful in requiring minimal donor support. APNHAN was set up as a voluntary initiative and is thus different in structure and operation in comparison with the other networks. The members expressed that they wanted to avoid a traditional north to south donor-driven network. This setup has made it difficult for APNHAN to engage both multilateral and bilateral donor organisations.[6] The network has attempted to run its activities mostly with research grant schemes. This was stated to be a significant problem in APNHAN since this network was set up as a voluntary initiative and thus it has been difficult to engage donors. However, this has not stopped information flows and some familiarity being established between the countries.

Many of the respondents stated that LAC is the network that has the most number of countries where NHA has been institutionalised. Some respondents declare that there is now an active exchange of technical assistance between the countries, which was a missing feature in the initial phase. Others are critical and say that the network is internationally managed and is not fully aimed at capacity strengthening of the members so as to substitute the international organisations in the leadership. A scarcity of skilled personnel was mentioned as both an initial problem as well as a current problem.

General comments on ECSA were that the network is still largely dependent on international donor funds even though many countries contribute with government funds and have undertaken NHA without external funding. The network has promoted NHA and created recognition for its importance and some of the respondents view the participation of countries as rather strong and active. Others express that the network has been too donor-driven and not seen as a country-owned

[6] One respondent refers to Fakuda-Parr et al. (2002)[4] when discussing problems and success of the NHA network. The respondent claimed that the major reason for lack of progress in national capacity is the old approach to network and donor aid.

process. As a consequence the first NHA results were not known and accepted in many of the countries and there has not been so much policy uptake of the findings. Another problem mentioned is that there has been a lack of consistency in terms of in-country technical support from various donors. Other problems mentioned were that more has to be done to assist countries that have already undergone initial NHA exercises on "how" to use the findings for policy purposes and that there has to be a constant increase in the number of trained technical experts. A lack of culture of use of information and data utilisation was also brought up as a problem. Positive effects of the ECSA network are the sharing of findings, methodological problems, and lessons learnt with respect to financial issues and outcomes of the health sector. The exchange of local NHA experts to assist neighbouring countries in their first NHA attempts was also referred to as a positive outcome. Others meant that ECSA has got NHA going in Africa and that it has contributed to encourage policymakers to use NHA as well as create contacts for health reform sector issues.

The general opinion about both the Francophone Africa network (FA) was that this is a new network (established in 2003) and thus not yet relevant to evaluate.

The general opinion about CIS was that the network is relatively young (established in 2003) and thus difficult to evaluate. Donors and multilaterals manage the network and much of the support for in-country NHA activities is dependent on donor funding. However, the in-country commitments and interest shown in the region is seen as encouraging. The main problems identified in the network are the limited capacity, the lack of resources and the limited political will to implement NHA within the countries. The main positive effects of CIS is the potential benefit of sharing progress experiences and problems between the countries and that the countries can begin to provide technical assistance to each other instead of being dependent on a few technical persons.

A general comment from respondents is that most countries within the MENA network undertake NHA with much donor support, both technical and financial. However, some respondents said that, as there is technical assistance within several countries, there exists an amount of exchange of technical assistance between the countries as well. A problem mentioned is the fact that the member representatives change frequently as well as the sponsorship of the network meetings. There is a lack of follow up of countries' achievement and management by sponsors.

5. Conclusions

Since the mid 1990s, NHA has been implemented in a number of middle- and low-income countries and six regional NHA networks has been formed with the purpose of facilitating the implementation of NHA in the member countries. The study captured the experiences of those who are involved in the networks and attempted to map the organisation and working forms within the networks. Furthermore, it aimed at presenting factors constituting a problem in the member countries and within the networks, as well as success factors for the functioning of the networks. It captured the experiences from both members of the networks and from donor and multilateral organisations supporting network activities. Data was collected through questionnaires and interviews.

According to the respondents, the member countries benefit from being part of NHA networks. The respondents mentioned sharing of experiences, creation of new informal contacts, transferring of knowledge, comparison of results, capacity building and improved donor coordination as important benefits. Several positive effects were identified. The data collection methods have improved together with the quality and the timeliness of data produced. Other positive effects of being part of a network were an enhancement of the technical and analytical capacities. Based on this study it seems as capacity development has occurred, thanks to the NHA networks, although it is not possible to say to what extent. Another positive outcome of NHA network activities according to the respondents is that the use of NHA among policy makers has increased. Generally, the representatives from the donor and multilateral organisations believed that there had been more of an improvement in the above mentioned factors compared to the members.

As expected, constraints in financial and human resources as well as interest for NHA were mentioned as common initial problems within the networks. These are all issues that the donor- and multilateral organisations have been well aware of when supporting networks. Some of the criticism from respondents was that some networks are perceived as donor driven. It is difficult however for the donors and multilaterals to avoid being too much of driving forces within networks and at the same time promote the implementation of NHA.

The most commonly mentioned problem for the functioning of the networks was financial constraints and constraints in technical capacity. Differences in commitment and interest among the members were also

mentioned by many of the respondents as well as the fact that the organisation of work differ between the NHA teams in the different countries. Furthermore a majority of the respondents thought that the contacts (both formal and informal) between the members was not frequent enough. Although both the members and the representatives from donor and multilateral organisations agreed on what the most difficult problems were, generally the members perceived the problems as more severe than the donors and multilaterals.

Interestingly, this study indicates that physical distance and differences in culture, language and political stability does not constitute problems for the functioning of the networks. This is encouraging for future development work and establishment of networks for other purposes. Members seem to focus on the purpose of the network and leave other differences aside.

In two of the networks there are institutions with a leading position in the network, i.e. the Commonwealth Regional Health Community Secretariat in Tanzania for ECSA and the Institute of Policy Studies in Sri Lanka for the APNHAN network. Since these two networks differ in many other aspects it is, however, not possible to draw any general conclusions regarding the importance of having such a coordinating institution for the successfulness of the network.

Regarding what factors that contribute to the successfulness of the networks one single factor stood out, i.e. length of existence of the network. The longer the network had existed the higher it was rated in terms of success by the representatives from the donor and multilateral organisations. Besides length of existence, primarily two things were believed to be of importance for the degree of successfulness: strong driving forces within the networks and strong interest among the members. Those networks rated as more successful were networks where countries themselves had strong commitments and interests for NHA.

Since financial constraint was mentioned as the most important problem and length of existence as an important factor of success a suggestion for the future is to secure sustainability in funding and organising of network activities. For the already existing networks a suggestion is to have more frequent organised meetings. This could solve both the issue of not having enough frequent contacts between the members and the issue of low technical capacity in some member countries. A suggestion before starting new networks or inviting new members to already existing networks is to promote interest in NHA and networking activities to ensure commitment among the members.

References

1. Hjortsberg, C., Health Division Document 2001:6. Issue Paper on National Health Accounts – Where are we today? 2001, Sida: Stockholm.
2. Knoke, D. and J.H. Kuklinski, Network Analysis. Quantitative Applications in the Social Sciences, ed. J.L. Sulivan and R.G. Niemi. 1982, Beverly Hills: Sage Publications.
3. Mitchell, J.C., The concept and use of social networks, in Social Networks in Urban Situations, J.C. Mitchell, Editor. 1969, University of Manchester: Manchester. p. 1–50.
4. Fukuda-Parr, S., C. Lopes, and K. Malik, eds. Capacity for devlopment: new solutions to old problems., ed. UNDP. 2002, Earthscan Publications Ltd: New York.
5. Cummings, J., Knowledge Sharing: A Review of the Literature. 2003, The World Bank Operations Evaluation Department: Washington, D.C.
6. Fernando, T. and R. Rannan-Eliya, Status of National Health Accounts in Asia-Pacific Region: Findings from the APNHAN Survey 2005, first draft March 11. 2005, Health Policy Programme for Asia-Pacific NHA Network.
7. PHRplus, http://www.phrplus.org/nha7.html. 2005-06-15.
8. Bura, M. Institutionalization of National Health Accounts in ECSA: Progress Report. in 3rd International NHA Symposium. 2003. San Francisco, California 13–14 June 2003.
9. PHRplus, http://www.phrplus.org/nha9.html. 2005-06-15.
10. PHRplus, http://www.phrplus.org/nha2.html. 2005-06-15.

Appendix A

Questionnaire for evaluation of NHA-networks – Members

A. Background information about the respondent

A_1. Your network is:

1. APNHAN (Asia Pacific NHA Network)
2. CIS (Commonwealth of Independent States)
3. ECSA (Eastern, Central and Southern Africa)
4. FA (Francophone Africa)
5. LAC (Latin America and the Caribbean)
6. MENA (Middle East and Northern Africa)

A_2. How long have You, as an individual, been involved in the network activities?

1. < 1 year
2. 1–3 years
3. > 3 years

A_3. Where do You work?

A_4. Which is Your country?

B. NHA status in the country

B_1. How would You describe the status of NHA in Your country?

1. No NHA activities
2. Upstart phase
3. Completed 1 round of NHA
4. Completed more than 1 round but not on a regular basis
5. Producing NHA on a regular basis

B_2. Who produces the NHA in Your country (multiple choice possible)?

1. Ministry of Health
2. Ministry of Finance
3. National Bureau of Statistics
4. University
5. Consultant
6. Other, please specify

B_3. Does/did Your country receive TA (Technical Assistance) in producing NHA?

1. Yes
2. No 3. Not sure

B_3_1. If yes, please specify from whom

B_4. How are the NHA activities financed in Your country (multiple choices possible)?

1. Internal sources
2. External sources (i.e. donors and multilateral organisations)
   Please specify which donor or multilateral organisation

B_5. How would You consider the *general interest* for NHA in Your country?

1	2	3	4	5
Very low				Very high

If Your country has not produced NHA please proceed to section C.

B_6. Which year were the *latest NHA results disseminated* in Your country?

Year

B_7. From which year is the *data of the latest NHA* in Your country?

Year

B_8. In Your opinion, to what extent has the development of NHA affected the *use of health expenditure data* for policy purposes in Your country?

1	2	3	4	5
Very little				Very much

B_9. In Your opinion, to what extent are NHA used today for *making* policy decisions in Your country?

1	2	3	4	5
Very little				Very much

B_10. In Your opinion, to what extent are NHA used today to *follow up* policy decisions in Your country?

1	2	3	4	5
Very little				Very much

C. Background information about the NHA Network

C_1. Do You know the purpose of the network formation?

1. Yes
2. No 3. Not sure

C_1_1. If yes, please explain briefly

C_2. Was there a formal launching meeting/workshop?

1. Yes
2. No 3. Not sure

C_2_1. If yes, did Your country participate?

1. Yes
2. No 3. Not sure

C_3. When did Your country become a member of the network?

Year

C_4. Have more countries joined since the formation of the network?

1. Yes
2. No 3. Not sure

C_5. Who initiated the creation of the network (multiple choices possible)?

1. Member country/countries
2. Donor Organisation/s
3. Multilateral Organisation/s
4. Other (please specify)
5. Not sure

C_6. Who took the initiative for Your country to become a member (multiple choices possible)?

1. Governmental officials
2. Donor Organisation/s
3. Multilateral Organisation/s
4. Other (please specify)
5. Not sure

C_7. In Your opinion were there any *initial problems* within the network?

1. Yes
2. No 3. Not sure

C_7_1. If yes, please list the three most important problems
Problem # 1:
Problem # 2:
Problem # 3:

D. Network organisation today

I. Work and relations between the members

D_I_1. Do the member countries have specific roles and responsibilities within the network?

1. Yes
2. No
3. Not sure

D_I_1_1. If yes, what is the role and responsibility of Your country?

D_I_2. Is there any member country that has more responsibility or a leading role in the network?

1. Yes
2. No
3. Not sure

D_I_2_1. If yes, please explain briefly

D_I_3. Is there any individual that has more responsibility or a leading role in the network?

1. Yes
2. No
3. Not sure

D_I_3_1. If yes, please explain briefly

D_I_4. How often are formal meetings/workshops between all members organised?

1. < Once/year
2. 1–2 times/year
3. > 2 times/year

D_I_5. Who is organising these meetings/workshops (multiple choices possible)?

1. Member country/countries
2. Donor Organisation/s
3. Multilateral Organisation/s
4. Other (please specify)
5. Not sure

D_I_6. Who is financing the network activities (multiple choices possible)?

1. Member country/countries
2. Donor Organisation/s
3. Multilateral Organisation/s
4. Other (please specify)
5. Not sure

D_I_7. How often does Your country participate in these meetings/workshops?

1. Never
2. Sometimes
3. Usually
4. Always
5. Not sure

D_I_8. In Your opinion, how often would be appropriate to have these meetings/workshops?

1. < Once/year
2. 1–2 times/year
3. > 2 times/year

D_I_9. How often do You have other contact (e.g. e-mail, telephone, fax, mail) with any other members of the network?

1. Every week
2. Every month
3. Every 6 months
4. Once/year or less

D_I_10. In what kind of situations do You (Your country) have contact with the other members (member countries)?

1. Other members contact You when they encounter problems.
2. You contact other members when You encounter problems.
3. Other members contact You to share their positive experiences.
4. You contact other members to share Your positive experiences.
5. Other situations, please specify

D_I_11. How would You consider the contact with the other members?

1. Not frequent enough
2. Frequent enough
3. Too frequent

II. Work within the country

D_II_1. Is the information from the network meetings/workshops shared with local staff that has not attended the network activities?

1. Yes
2. No 3. Not sure

D_II_1_1. If yes, when is the information shared (multiple choices possible)?

1. As soon as new information is obtained
2. Upon request from other local staff
3. Other, please specify

D_II_1_2. If yes, how is the information shared (multiple choices possible)?

1. At NHA meetings/briefings
2. At other organised meetings/briefings
3. E-mail, ordinary mail or telephone
4. Spontaneous "face-to-face" contacts
5. Other, please specify

D_II_2. In Your opinion, do the following factors constitute a problem in Your country, (mark appropriate level for each of the suggested factors, 1=no problem and 5=major problem)?

	No problem				Major problem
D_II_2_1. Difficulties in information sharing.	1	2	3	4	5
D_II_2_2. Low interest in NHA.	1	2	3	4	5
D_II_2_3. Low technical capacity to produce NHA	1	2	3	4	5
D_II_2_4. Lack of financial resources and equipment	1	2	3	4	5

E. Evaluation

E_1. In Your opinion, which are the three main positive effects of the network?

Positive effect # 1:

Positive effect # 2:

Positive effect # 3:

E_2. In Your opinion, which are the three main problems within the network?

Problem # 1:
Problem # 2:
Problem # 3:

E_2_1. How would You suggest that these problems could be solved?

Solution # 1
Solution # 2
Solution # 3

E_3. In Your opinion, to what extent has the membership in the network affected the political support for the NHA team in Your country?

1	2	3	4	5
Very little				Very much

E_3_1. If the membership has affected the political support for the NHA team, please explain briefly in what way:

E_4. In Your opinion, how has the network affected the development of NHA in the member countries regarding the following aspects (mark appropriate level for each of the suggested factors, 1=no improvement and 5=major improvement)?

	No improvement				Major improvement
E_4_1. Data collection methods	1	2	3	4	5
E_4_2. Quality of health expenditure data	1	2	3	4	5
E_4_3. Timeliness of health expenditure data	1	2	3	4	5
E_4_4. Technical capacity (physical resources)	1	2	3	4	5
E_4_5. Analytical capacity (human resources)	1	2	3	4	5
E_4_6. Dissemination of NHA results in time	1	2	3	4	5
E_4_7. Use of NHA results among policy makers	1	2	3	4	5

E_5. In Your opinion, has the network positively affected the development of NHA in the *other member countries*?

1. Yes
2. No
3. Not sure

E_6. In Your opinion, do the following factors constitute a problem in Your network (mark appropriate level for each of the suggested factors, 1=no problem and 5=major problem)?

	No problem				Major problem
E_6_1. Physical distance between members.	1	2	3	4	5
E_6_2. Cultural differences among the members	1	2	3	4	5
E_6_3. Language differences among the members	1	2	3	4	5
E_6_4. Differences in the organisation and work of the NHA-teams among the members	1	2	3	4	5
E_6_5. Differences in the political stability between the members	1	2	3	4	5
E_6_6. Lack of financial resources and/or equipment	1	2	3	4	5
E_6_7. Differences in the interest in NHA among the members	1	2	3	4	5
E_6_8. Low interest in NHA among the members	1	2	3	4	5
E_6_9. Differences in the technical capacity among the members	1	2	3	4	5
E_6_10. Low technical capacity among the members	1	2	3	4	5
E_6_11. Other, please specify	1	2	3	4	5

E_7. In Your opinion, to what extent does Your country benefit from being a member in the NHA network?

1	2	3	4	5
Very little				Very much

E_7_1. Please, explain briefly

E_8. Any additional comments?

Appendix B

Questionnaire for evaluation of NHA-networks – Donors/multilaterals

1. In Your opinion, how would You rate the following NHA-networks in terms of success (1=not successful and 5=very successful)? Please comment key factors determining level of achievement.

	Not successful				Very successful
APNHAN (Asia Pacific NHA Network) Comment	1	2	3	4	5
CIS (Commonwealth of Independent States) Comment	1	2	3	4	5
ECSA (Eastern, Central and Southern Africa) Comment	1	2	3	4	5
FA (Francophone Africa) Comment	1	2	3	4	5
LAC (Latin America and the Caribbean) Comment	1	2	3	4	5
MENA (Middle East and Northern Africa) Comment	1	2	3	4	5

2. Witch network are You most familiar with/have the most knowledge about?

1. APNHAN
2. CIS
3. ECSA
4. FA
5. LAC
6. MENA

For the following questions, please answer the questions for the network that You are most familiar with/have the most knowledge about.

3. How long have You, *as an individual*, been involved in the network activities?

1. < 1 year
2. 1–3 years
3. > 3 years

4. Which year was the network formed?

Year

5. Was there a formal launching meeting/workshop?

1. Yes
2. No
3. Not sure

5_1. If yes, how many countries participated?

Number of countries

6. Have more countries joined since the formation of the network?

1. Yes
2. No
3. Not sure

6_1. If yes, how many members are there today?

Number of member countries

7. Who initiated the creation of the network (multiple choices possible)?

1. Member country/countries
2. Donor Organisation/s
3. Multilateral Organisation/s
4. Other (please specify)
5. Not sure

8. In Your opinion, were there any initial problems within the network?

1. Yes
2. No
3. Not sure

8_1. If yes, please list the three most important problems

Problem # 1:

Problem # 2:

Problem # 3:

9. Is there any *member country* that has more responsibility or has a leading role in the network?

1. Yes
2. No
3. Not sure

9_1. If yes, please explain briefly

10. Is there any *individual* that has more responsibility or a leading role in the network?

1. Yes
2. No
3. Not sure

10_1. If yes, please explain briefly

11. How often are formal meetings/workshops between all members organised?

1. < Once/year
2. 1–2 times/year
3. > 2 times/year

12. Who is *organising* these meetings/workshops (multiple choices possible)?

1. Member country/countries
2. Donor Organisation/s
3. Multilateral Organisation/s
4. Other, please specify
5. Not sure

13 Who is *financing* the network activities (multiple choices possible)?

1. Member country/countries
2. Donor Organisation/s
3. Multilateral Organisation/s
4. Other, please specify
5. Not sure

14. In Your opinion, how often would be appropriate to have these meetings/workshops?

1. < Once/year
2. 1–2 times/year
3. > 2 times/year

15. In Your opinion, which are the three main positive effects of the network?

Positive effect # 1:
Positive effect # 2:
Positive effect # 3:

16. In Your opinion, which are the three main problems within the network?

Problem # 1:
Problem # 2:
Problem # 3:

17. In Your opinion, how has the network *in general* affected the development of NHA in the member countries regarding the following aspects (1=no improvement and 5=major improvement)?

	No improvement				Major improvement
17_1. Data collection methods	1	2	3	4	5
17_2. Quality of health expenditure data	1	2	3	4	5
17_3. Timeliness of health expenditure data	1	2	3	4	5
17_4. Technical capacity (physical resources)	1	2	3	4	5
17_5. Analytical capacity (human resources)	1	2	3	4	5
17_6. Dissemination of NHA results in time	1	2	3	4	5
17_7. Use of NHA results among policy makers	1	2	3	4	5

18. In Your opinion, do the following factors constitute a problem in Your network (1=no problem and 5=major problem)?

	No problem				Major problem
18_1. Physical distance between members.	1	2	3	4	5
18_2. Cultural differences among the members	1	2	3	4	5
18_3. Language differences among the members	1	2	3	4	5
18_4. Differences in the organisation and work of the NHA-teams among the members	1	2	3	4	5
18_5. Differences in the political stability between the members	1	2	3	4	5
18_6. Lack of financial resources and/or equipment	1	2	3	4	5
18_7. Differences in the interest in NHA among the members	1	2	3	4	5
18_8. Low interest in NHA among the members	1	2	3	4	5
18_9. Differences in the technical capacity among the members	1	2	3	4	5
18_10. Low technical capacity among the members	1	2	3	4	5
18_11. Other, please specify	1	2	3	4	5

19. Any additional comments?

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Strategies/Policies

1997:1 Policy for Development Cooperation
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– 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)

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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	Issue paper on NHA; the case of Kenya, Zambia and Mali, by Anna Glenngård and Frida Hjalte
2005:2	Issue Paper on NHA; Findings from a study of regional NHA networks, by Anna H Glenngård and Frida Hjalte

Facts and Figures

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

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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

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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

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Country and Regional Health Profiles

1995 Angola
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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

2004:2 Sidas arbete med SRHR 1994–2003
En sammanfattning av utvärderingen
"Sida Evaluation 04/14"

2004 Human Resources for Health – Overcoming the Crisis. Joint Learning Initiative

2005 Poniendo fin a la violenca de género:
Un llamado a la acción global para involucrar a los hombres

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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
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Hiv/Aids in Tanzania
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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

Human Resources and Sustainable Capacity Building for Health and Development
March 2003

Overview of Sida's Work Against Trafficking in Human Beings
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