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## **Monitoring outputs/outcomes -**

**not only a vital issue for Sector Wide Approaches in  
the health sector but also for the functioning of  
health systems**

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## **Introduction**

The Russian saying “*Dowjerei, no prowjerei*” (~ *Trust, but check*), which allegedly inspired even Lenin, has become a vital element for a successful Sector Wide Approach (SWAp). A functional monitoring and evaluation (M&E) system should demonstrate outputs/outcomes and eventually the impact of health related public (and donor agency) spending. In the context of programme based approaches M&E has the objective to monitor the process of the interaction of the different partners and to assess progress towards harmonization.

One of the purposes of performance reporting is to provide a basis for accountability and traceability. This is important for most development partners, who have to justify the use of their taxpayers’ money and need proof that resources have been used as planned...and that they have had impact.

However, perhaps from a development point of view more important, a sound and functional monitoring system is vital for the managers at different levels of a health system to help them in their decision making and setting priorities and allocating scarce resources. It provides also a basis for the Ministry of Health to engage better with Ministries of Finance. Last but not least a functional monitoring system provides also transparency, which allows communities to track the implementation progress and to develop ownership by making services more accountable to their populations.

This paper will use the logical chain that inputs lead to output and outputs to outcomes and outcomes will have an influence on the overall goal. For example the “input” educators, promotional & information material etc. will lead to the output quality information campaigns and these will lead to the “outcome” behaviour change of target group and this outcome will contribute to the goal “reduction of new HIV/AIDS infections”. For all inputs, outputs and outcomes, and also for the goal it is necessary to define one or several indicators. In all cases these indicators need to be “SMART” (specific, measurable, achievable/affordable, realistic and timely). Although this seems to be a straightforward process there are multiple pitfalls and possibilities to get indicators wrong. This is due to the fact that it is not always possible to establish direct causal linkages between outputs and outcomes and also goals. Not only vaccination campaigns, but for example also female education has a strong influence on infant morbidity. Help and ideas for indicators can be found on the World Bank website<sup>1</sup>, which provides a wide choice of health indicators. Once indicators are defined, there are two broad groups of data sources. One group related to the population as a whole (Census, vital statistics, household surveys) and those related to health services (disease records, health service records, health administration records). This information has to be collected, aggregated, analyzed at all levels of the “information pyramid”. Information collected is often aimed at specialists and therefore it is partly difficult to understand by persons outside the health system – although these will often be decision makers.

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<sup>1</sup> <http://web.worldbank.org/wbsite/external/topics/exthealthnutritionandpopulation/>

## **Issues**

In the context of a rapidly changing environment, the monitoring needs for Poverty Reduction Strategies, Scaling up Aid for Health, International Commitments such as the Millennium Development Goals (MDGs) and the changing aid modalities, particularly General Budget Support need to be reconciled with the needs and requirements of a health (or other sector) managers and the - human? - right of communities to be adequately informed so that they can participate in decision making processes. All stakeholders need information on a wide range of health related areas, ranging from mortality and morbidity, to health services (access, quality, coverage, cost), equity, broad health determinants (nutrition, socio-economic status, environment etc.).

However the priorities for the various involved parties are quite different. Development and donor agencies are primarily interested in financial and outcome information, while in simple terms health systems managers are more interested in the daily implementation and communities in health status that is output indicators.

## **Data Sources**

The sources for health information are multiple: Vital registration, censuses, household surveys like DHS, health service and administrative information systems, routine clinic-based data, disease surveillance systems, but also national health accounts and modeling. Just as multiple as the sources are the problems related to monitoring health systems, in general and SWApS in particular.

The problems related to M&E in countries with limited resources can be divided into methodological and structural problems.

A functional vital registration system is absent in many partner countries. Censuses are at best carried out on once a decade with estimations of population growth in between. Surveys, like DHS generate quite reliable data for the national (and development community) level, but cannot be disaggregated to a regional, district or local level and are therefore not very useful for the management of the health system. Routine health service records and health administrative records are of a notorious poor quality for a number of structural reasons outlined further down. As raw data collected through the mechanisms mentioned above, is rarely directly useable, efforts are necessary to ensure that data is translated into information...and information into knowledge and finally into decisions. This requires quite complex and demanding capacities in aggregating and analyzing data, expertise. This expertise is not always readily or sufficiently available. It is worthwhile to mention that a majority of MDGs related indicators are being generated through household surveys, which certainly generates valid outcome even impact data, but has little potential to assess the processes and possible bottlenecks to achieve set targets. In addition, they are high level indicators not broken down by socioeconomic status. Therefore, one could have strong movement on MDG4 (reducing infant mortality) but at the higher quintile level...leaving out the poorest. Also the M&E of SWApS relies heavily on specific sample based studies, research and broad reviews, and rarely on data collected through routine health service and administrative systems. A summary table of data sources and their possible use is in the annex.

**Methodological problems with M&E**

Problems of M&E have their roots often in poorly defined outputs and outcomes at each level. If this is the case meaningful measurement becomes for obvious reasons difficult, or even impossible. However, national health plans and strategies, and sometimes linked with PRS are now widely available and have generally acceptable standards. These plans are anyhow a critical principle for development partners to engage into a SWAp.

**Structural problems**

The larger problem area with monitoring & evaluation are structural problems. As mentioned in the last paragraph there is – not surprisingly – a low capacity and motivation to use data at the local level. Health staff is not trained to manage but rather to treat patients. Staff shortages are in the health information departments as widespread, perhaps even more important than in other areas of the health system. Recognition of the importance of health information tends to be low and thus leads to a lack of ownership by health providers, who are often not involved in designing of monitoring procedure and indicators. Why should local staff supply data when it makes very little difference to their day-to-day work? Why should Central Ministries/Entities demand data as in many cases their performance will not be judged by Ministries of Finances? In most countries there is no link between evidence based info and planning/budgeting and even budgeted releasing funds is in many countries not a straightforward process, as there are internal “transaction” costs. Although this is changing and there is now a strong shift towards performance based financing in the SWAp context, capacity for analysis is concentrated at central level, and even there often limited, depending highly on committed and capable individuals. “*Honi soit qui mal y pense*”, but this is at least partly explained by the fact that countries feel the need to meet the demands of the development partner community. The feedback provided to lower levels is limited. This is closely linked to the extent of decentralization – e.g. how much power and control does the local level have over its financial and human resources. Data from routine HMIS are often mistrusted, because the information they generate are frequently incomplete and rarely on time. In many “SWAp”-countries information systems do not yet reflect the move from project to sector/system performance monitoring. For example, a recent OECD Survey on Harmonisation and Alignment (DAC, 2004) stated for Tanzania, that “performance monitoring in the health sector faces problems of reliability and timeliness of health information.” Uganda is often cited as a country where it was possible to link health system performance monitoring to SWAps and national policy definition, and there is proof that policy adjustments have taken place. However, the Ugandan success story has received some dirty marks since the scandal around the GFATM-support erupted. Among other wrongdoings, the making up of local NGOs and activity reports resulted in a multi-million US\$ loss of funds and to a temporary suspension of the GFATM grant. This highlights that sound M&E is also strongly linked to good governance.

### ***Community owned knowledge***

A widely neglected area of M&E-systems is their potential to involve the community level, not only for data collection but with a view to promote ownership and increase accountability of services, by strengthening the capacity of communities and society in general to monitor utilization of public resources. Particularly in the field of sector programmes it is important to know what actually arrives at the grass-root or suburban level. SDC has a comparative advantage in this area, as it supports in numerous settings not only a partner in programme based approaches, but continues to support grass-root activities, which provide an opportunity of first-hand feedback.

### ***Cost of M&E and sources of funding***

Little is also known about the cost of a functional M&E System. A recent review in Mexico concluded that less than 1% of the total public health expenditure was allocated to health information systems. Contributions of development partners are not known, in detail not even at the agency level. Thailand has engaged in an innovative way to support the strengthening of the funding basis of the national health information system: A 2% excise duty has been introduced on tobacco and alcohol sales (Bayarsaikhan, Muiser, 2007).

### ***M&E and "Politics"***

It is difficult to assess to what extent political pressure influences evidence being generated through M&E systems. It is a well known phenomenon at the global level (Murray et al, 2005) where the ability of WHO to compile independent global reporting is increasingly questioned because of "political" fixing of indicators. Murray et al. (a key person in introducing the widely accepted "burden of disease" approach) recommends even a new global health monitoring organization to provide independent gold standard health information.

### ***M&E and Harmonization***

SWApS and the widely (also by Switzerland) subscribed Paris Declaration on Aid Effectiveness<sup>2</sup> should promote harmonization of monitoring systems, but the focus of development partners on outcome targets tends to be an obstacle for a general health information system, because scarce resources are being absorbed.

The OECD-DAC-study mentioned above refers to 234 donor led/initiated review/monitoring missions to Tanzania in 2003. Presumably a reduction compared to the past, but little fantasy is necessary to imagine the workload this has put on the Tanzanian partners. Joint review missions are still an exception. In Tanzania only 5% of all missions were undertaken jointly in 2003. In Uganda, another "mature" SWAp country, only 17% of donor missions were coordinated in 2005 (DAC, 2007). However, there is some evidence that the situation is improving, and awareness amongst development partners is rising. Global Health Partnerships, like GAVI and the GFATM have started to laudably recognizing the need to strengthen systems in order address the problems, they have been

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<sup>2</sup> [http://www.oecd.org/document/18/0,2340,en\\_2649\\_3236398\\_35401554\\_1\\_1\\_1\\_1,00.html](http://www.oecd.org/document/18/0,2340,en_2649_3236398_35401554_1_1_1_1,00.html)

set up for. It is only very recently that they have to some degree acknowledged the problem and started to channel resources through SWAp mechanisms (for example in Mozambique). However, in the case of the GFATM, they are still mostly using the entry points of TB, Malaria and HIV/AIDS for strengthening systems – given the vertical nature of the approach this can (and actually does ) lead to a lot of problems.

### ***Light at the end of the tunnel?***

### ***The Health Metrics Network***

The Health Metrics Network (HMN, 2006) is – one more - global partnership, which has the added value that it facilitates better health information at country, regional and global levels. Even comparatively well performing countries like Tanzania perform poorly on data collection scores, which assess the functioning of key data sources according to specific benchmarks.

*HMN has a single strategic goal - to increase the availability and use of timely and accurate health information by catalyzing the joint funding and development of core country health information systems. In pursuit of this goal, HMN lays out a vision and identifies strategies for HIS development and strengthening, support countries in implementing such strategies, and generates new knowledge and global public goods through research, technical innovation, and sharing lessons learned.*

*Specifically, HMN will pursue three interrelated objectives:*

- *Create a harmonized framework for country HIS development (the HMN Framework) which describes standards for health information systems*
- *Strengthen country HIS by providing technical and catalytic financial support to apply the HMN Framework*
- *Ensure access and use of information by local, regional and global constituencies*

*<http://www.who.int/healthmetrics>*

The HMN has developed tools to identify shortcomings of health information systems and has started a global programme to strengthen health information systems. A basic recommendation is that “triangulation” used in qualitative research is important. The take home message here is that there is no one single data approach which generates information, which can be used at all levels.

***Workshop  
Discussion  
results***

- Although the importance of M&E is widely recognized by development partners and national partners, M&E is often underestimated in terms of the resource and capacity requirements for producing reliable and valid data
- One expects too much and none needs to adopt a realistic attitude of what can be achieved
- A performing M&E system needs country leadership and understanding and good governance.
- Development partners need to find the right mix of monitoring tools, routine data and surveys
- Development partners should know exactly on how much they need to know for their “accountability”-requirements and allocate specific budget lines for this purpose
- Harmonization amongst development partners remains an issue particularly in the M&E area and continuous efforts (for example more joint reviews) will be necessary to achieve the ambitious goals
- The process of harmonization needs to be monitored as well and appropriate indicators need to be developed where not already available
- A performing M&E system does not come for free. Although a daunting task, investing in strengthening health information systems is an important avenue to make SWAps a success and to contribute to the development of sustainable health systems
- Feeding back of information and supporting the development of knowledge of populations/communities does often not receive sufficient attention
- SDC has a comparative advantage through its grass-root experience and working with communities. A future role might be the strengthening of communities/Civil Society in M&E with a view to support community owned knowledge

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## Annex

Sources of data for indicators

	Health Status	Health System		Determinants
		Inputs and outputs	Outcomes	
Census	X			X
Vital statistics	X		X	X
Surveys	X	X	X	X
Health service records	X		X	
Health administrative records		X		

Health Metrics Framework, 2006