GUIDELINES FOR MONITORING AND EVALUATION OF HEALTH SECTOR REFORMS IN THE AFRICAN REGION

World Health Organization

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List of Acronyms

DHT	District Health Team
FY	Financial Year
HMIS	Health Management Information Systems
HSR	Health Sector Reforms
IMR	Infant Mortality Rate
MDG	Millennium Development Goals
MMR	Maternal Mortality Rate
NEPAD	New Partnership for African Development
OPD	Out-Patient Department
PHC	Primary Health Care
SES	Socioeconomic Status
WHO	World Health Organization
WSC	Declaration of the World Summit on Children

Acknowledgement

Foreword by the Regional Director

Over the last two decades, most African countries have implemented various health sector reforms to address gaps in access, equity, quality, effectiveness, efficiency and sustainability of health systems. Concurrently, several other global initiatives [(Millennium Development Goals (MDG); Declaration of the World Summit on Children (WSC); Health for All in the 21st century; Agenda 2020; and the New Partnership for African Development (NEPAD)] that promised an increased leverage for improvements in population health were adopted.

Monitoring and evaluation of health sector reforms are critical for identifying whether they have met or are likely to meet their primary aims. They provide the means for feed-back to countries and development partners so that changes can be made if strategies do not appear to be working or simply need fine-tuning.

An assessment of how the African region has fared is imperative, in terms of charting future progress. The WHO/AFRO regional Committee in its resolution AFR/RC49/R1 has identified the absence of a one-stop, comprehensive monitoring and evaluation framework for health sector reforms in the region and recommended the development of these guidelines. In response WHO has developed these guidelines are drawn from a wide range of literature, reflecting the previous efforts of various stakeholders.

WHO/AFRO will continue to provide technical support to countries to establish effective monitoring and evaluation systems. I trust that these guidelines will contribute to that process.

Dr. Luis Gomez SAMBO

WHO Regional Director for Africa

Glossary of selected terms[1]

Equity – relates to avoidable and unjust differences in relation to: (i) a given health situation e.g. infant mortality rate and (ii) coverage, access and use of health services

Effectiveness and technical quality – from a provider perspective this implies that users receive effective, safe and timely assistance; from a client perspective, quality refers to care received under appropriate physical and ethical conditions

Efficiency – positive relationship between the results achieved and the resources used;

i. Allocative efficiency – resources allocated generate maximum possible gain in terms of health per unit cost and

ii. Technical efficiency – when a unit of product is obtained at minimum cost, or when more units of products are obtained with a given cost

Sustainability refers to the social and financial capacity of the institution to address short and medium- term challenges

[1] Definitions of these selected terms are adapted from 'Health Sector Reform Initiatives (1998) Methodology for monitoring and evaluation of Health Sector Reform in Latin America and the Caribbean

Overview

Health sector reforms (HSR) can be described as sustained, purposeful and fundamental changes intended to improve the performance of the sector in terms of efficiency, equity and effectiveness[2].

Implementation of HSR in the region has not always been in response to identified gaps within the sector. Some reforms have been imposed as part of broader economic reform policy. The main reforms in the past two decades have included decentralization of health services management and operation to sub-national levels; health financing initiatives such as user fees in the public sector, community co-management and co-financing mechanisms centred on essential drugs (Bamako initiative); organization of health services including autonomy of management to hospitals and promotion of public/private partnerships. More recently, some countries have considered the introduction of social health insurance.

Reforms that have not been implemented as part of a comprehensive policy framework such as introduction of user fees have tended not to be sustainable in some countries, often in conflict with the very effect they are intended to improve. The more fundamental reforms such as decentralization of health services to sub-national levels are still in operation in many countries, promising to achieve better health sector performance. The constraints overall are substantial and include inadequate inputs particularly related to the lack of human resource skills and numbers, limited information to guide the reform process and limited financing. Although there have been various efforts to assess the impact of implementing HSR in the region, there is no standard guideline to assist countries in the region to monitor and evaluate implementation performance on a regular basis.

The purpose of this document is to therefore provide planners and policymakers in the African region with guidance on monitoring and evaluating the process and progress of health sector reforms within and across countries on a regular basis.

The guideline provides a background to health sector reform implementation, proposes a conceptual framework for the analysis, as well as a framework for identifying key questions and indicators for monitoring and evaluating of the reforms.

[2] Berman A, Bossert TJ (2000) A decade of Health Sector Reform in Developing Countries: What have we learned? A paper prepared for the Data for Decision Making symposium: "Appraising a Decade of Health Sector Reform in Developing Countries" Washington D.C. March 15 2000

1: INTRODUCTION

The main[3] health sector reforms over the last two decades in the African Region have centered on i) broadening financing options for the health sector e.g. introduction of user fees in the public sector, community financing mechanisms ii) organization and management of health services e.g. granting autonomy to national and regional referral hospitals, promotion of public/private partnerships. Social insurance has been implemented in fewer countries e.g. in Kenya and Nigeria.

In implementing HSR, countries face considerable constraints and include inadequate inputs particularly related to the lack of human resource skills and numbers, limited information to guide the reform process and limited financing. Despite these constraints, countries are committed to the implementation of reforms that improve population health and performance of the health system. Timely monitoring and evaluation of these reforms provides evidence for (re-)directing reform implementation.

The WHO AFRO Regional Committee resolution AFR/RC49/R1 provides for the development of a one-stop, comprehensive monitoring and evaluation framework for health sector reforms in the region.

The **objectives** of these guidelines are:

1) To provide a common conceptual framework for the analysis of health sector reforms in the region

2) To provide a generic framework for identifying key indicators for monitoring and evaluating health sector reforms in the region

Purpose

These guidelines are principally intended for national professional officers, policymakers and planners in Ministries of Health at both national and sub-national level in the African region. Other evaluators and researchers in collaborating NGO and academic institutions may find them of use in monitoring and evaluation of health sector reforms.

Organization of the guide

The rest of the document is organized in 5 different sections:

- Section 2 presents key concepts, definitions and country experiences. Country experiences are selected based on regional representativeness and

[3] Gilson L, Mills A (1995) Health Sector Reforms in sub-Saharan Africa: lessons of the last ten years Health Policy 32 (1995) 215 - 243

how illustrative they are for the point being made, and are therefore not intended to be a comprehensive documentation of the experience in the region.

- Section 3 presents a conceptual framework for analyzing health sector reforms.
- Section 4 provides a framework for identifying indicators for monitoring and evaluating health sector reforms. It also provides a worked example using decentralization of health services management to sub-national levels
- Section 5 identifies key capacities that need to be built to better monitor and evaluate HSR in the region
- The bibliography is also a resource list for health sector reform monitoring and evaluation in the African region and other cardinal documents on the subject for those who desire a deeper understanding

How to use the guidelines

Section 2 is intended to provide some background to the task at hand. The bibliography is a reference list for other documents that provide a deeper understanding of the subject.

Use of the analysis framework needs to be adjusted to the timing of the reform. The whole framework will be applicable reforms that have been implemented for at least 5 years. For reforms that are only recently implemented e.g. 1-2 years, it may suffice to examine progress up to the implementation stage as it may be too early to detect outcomes such as equity and impact of the reform on health status indicators.

The framework as well as the worked example in section 4 is intended to assist the user in identifying indicators for monitoring and evaluating any health sector reform.

This guide assumes that the user will have some prior knowledge of health policy analysis and planning. Key capacities that are useful in the application of these guidelines are outlined in section 5.

2: CONCEPTS, DEFINITIONS AND COUNTRY EXPERIENCES

2.1 Scope of health sector reform[4]

A health sector reform can be described as a "… sustained purposeful and fundamental change to improve the efficiency, equity and effectiveness of the health sector". **Sustained** in this case refers to an ongoing process. A **purposeful** change takes account of the wider policy/political environment and adjusts the implementation process to available inputs.

A "**fundamental**" change is one that addresses significant, strategic dimensions of health systems. A change would be considered fundamental if it involved more than one of mechanisms through which a reform is expected to exert a change. These mechanisms or 'control knobs' include financing, payment, organization, regulation and consumer behavior. An example of a fundamental health sector reform in this case is the institution of an expanded system of national health insurance as this would be seen to exert an effect through literally all the 'control knobs'. Health sector reforms that are fundamental are also referred to as big 'R' reforms.

Health sector reforms that involve only one of the mechanisms or 'control knobs' are referred to as small 'r' reforms. They usually have a limited scope to cause a widespread effect within the health systems. An example of such a reform is the granting of autonomy to a national referral hospital as this only involves a change in organization of health services. Nevertheless, such efforts can have important benefits, but in isolation do not have the same scope or difficulty as the big 'R' changes. While a big 'R' reform may involve the implementation of many small 'r' activities, it is the broad systematic package that makes a big 'R' implementation more than the sum of the small components.

[4] The description of health sector reforms is taken from Berman A, Bossert TJ (2000) A decade of Health Sector Reform in Developing Countries: What have we learned? A paper prepared for the Data for Decision Making symposium: "Appraising a Decade of Health Sector Reform in Developing Countries" Washington D.C. March 15 2000

2.2 The rationale for health sector reforms

Health sector reforms take place for a number of reasons. Some health sector reforms are imposed external to the health sector and in this case take place in response to the effects of the external change. An example of an external change is the wider macroeconomic policy and implementation of structural adjustment programs to address financial crises in most of Sub-Saharan Africa that generally created reduced funding for social services. A common response to inadequate funding was small 'r' reforms that included the introduction of user fees, Bamako Initiative for community co-management and co-financing of essential.

Other changes originate directly from an identified need within the health sector e.g. decentralization of health services to sub-national levels in Uganda, Lesotho and Zambia was intended to improve geographical access to health care services.

*2.3 Goals **and** principles **of health sector reform***

The underlying goal for the development and implementation of a health reform is to effect a positive change in the health status of the population. Health reforms might contribute to improvement of health status through the redistribution of resources and services in order to achieve **equity** in access to **quality** health services and products, particularly for the poor and the disadvantaged. Because reforms take place against a background of increased poverty, high morbidity and deteriorating health services, it is anticipated that the improvement in the health systems' performance will include both **technical quality** and **efficiency** in the use of resources. Another important area of concern is that **sustainability** is instituted and maintained throughout the reform process.

2.4 Country experiences with health sector reforms

In the region, only Zambia and South Africa are noted to have undertaken a big 'R' reform – that included both more than mechanism – organization and financing. Most countries have tended to adopt the small 'r' reforms involving only one control knob such as financing – introduction of user fees, community health insurance; organization

– decentralization of health services to sub-national levels, autonomy to hospitals, public/private participation, institutional restructuring[5].

Table 1 gives some examples of the main health sector reforms that have taken place in the African Region.

[5] Berman A, Bossert TJ (2000) A decade of Health Sector Reform in Developing Countries: What have we learned? A paper prepared for the Data for Decision Making symposium: "Appraising a Decade of Health Sector Reform in Developing Countries" Washington D.C. March 15 2000

Table 1: Examples of Health Sector Reforms in the African Region

Country	Health Sector Reform	Intended effects	Mechanism (Control Knobs) through which reform exerts effect
Burkina Faso, Lesotho, Tanzania, Uganda, Zambia	Decentralization of health services to sub-national levels	Better physical access to improved health services Efficiency in resource use	Organization of health services
Burkina Faso, Kenya, Uganda, Zimbabwe	Granting national and regional hospitals greater autonomy	Efficiency in resource use through improved accountability	Organization of health services
Zambia	Institutional restructuring of government health care, creation of Central Board of Health	Efficiency in resource use through improved accountability	Organization of health services Financing of health services
Uganda, Ghana, Tanzania	Public-Private Participation	▪ Increased access to health care services through alternative providers	Organization of health services
Benin, Burundi, Cameroun, Burkina Faso, Ghana, Kenya, Lesotho, Mauritania, Mozambique, Senegal, Sierra Leone, Swaziland, Togo, Uganda, Zambia, Zimbabwe	User fees as a health financing option	▪ Generate extra resources ▪ Promote efficient use of these resources, ▪ Expenditure increment at health facility level	Financing of health services
Algeria, Benin, The Gambia, Guinea-Conakry, Mali [6]	Community co-management and co-financing of essential drugs (Bamako Initiative)	▪ Increased community participation ▪ Generation of extra	Financing of health services

Mis en forme : Portugais (Brésil)

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[6] Others include: Angola, Botswana, Burkina Faso, Burundi, Cameroun, Cape-Verde, Central African Republic, Chad, Comoros, Congo –DRC, Cote d'Ivoire, Equatorial Guinea, Eritrea, Ethiopia, Gabon, Kenya, Lesotho, Liberia, Madagascar,

		resources	
Burkina Faso, Ethiopia, Guinea-Conakry, Rwanda	Community health insurance	▪ Protecting the poor against medical expenses ▪ Improving access for the poor to health care	Financing of health services

Mis en forme : Portugais (Brésil)

2.4.1 Organization of services

The most commonly implemented organizational reform in the region is decentralization. Two areas of inefficiencies that may be associated with this reform are i) the increase in administrative costs by removal of economies of scales for some services that might have been better centrally provided and ii) increase in service bottle-necks in service delivery by the creation of additional tiers[7]. However, where adequate preparation has been made it has laid the ground for successful and a stable health sector reform process as in Ghana[8].

Implementation of organizational reforms has been constrained by centrally dictated budget ceilings which leave little room for maneuvering to implement local priorities and lack of information to inform the process. The importance of strong leadership is illustrated in the example of Zambia, where this is seen to have contributed considerably to whatever success has been realized for implementation of the health sector reforms[9].

The increased role of the private sector is perceived as an opportunity to improve health services through improved efficiency and quality. However, the definition of private sector in developing countries includes untrained providers working in sub-standard settings. This may be associated with poorer quality of services[10].

Malawi, Madagascar, Mauritania, Mozambique, Namibia, Niger, Nigeria, Rwanda, Sao-Tome and Principe, Senegal, Swaziland, Tanzania, Togo, Uganda, Zambia, Zimbabwe

[7] Gilson L, Mills A (1995) Health Sector Reforms in sub-Saharan Africa: lessons of the last ten years Health Policy 32 (1995) 215 - 243

[8] Kolehmainen-Aitken RL (2004) Decentralization's impact on the health workforce: Perspectives of managers, workers and national leaders Human Resources for Health 2004, **2**:5 http://www.human-resources-health.com/content/2/1/5

[9] Zambia Ministry of Health, WHO, UNICEF, WORLD BANK (1996) Independent Review of Zambian Health Reforms vol. II Technical Reports

[10] Kumaranayake L (1997) The role of regulation: influencing private sector activity within health sector reform Journal of International Development: vol. 9, No. 4, 641 - 649

2.4.2 Financing

There have been mixed results related to the introduction of alternative financing mechanisms. But for most, introduction of user fees proved to be inequitable[11] (O'Neill & Nath, 2005). Where user fees were also used to rationalize referral as in Kenya, this resulted in some efficiency gains in spite of overall reduction in utilization (Gilson and Mills, 1995). The maximum of funds recovered from user fees was 5% of total government health expenditure. Recovery of cost for the Bamako initiative in some countries was up to more than 40% in some places, providing the opportunity to invest in improvements of perceived quality. However technical inefficiency with respect to poly-pharmacy was noted as one of the negative outcomes[12] . This was probably influenced by provider behavior to recover maximum cost.

In some of these community-based risk sharing schemes, one of the benefits were the removal of barriers at the time of use, particularly benefiting poor families with seasonal income[12].

[11] O'Neill PD, Nath (2005) UR Make it happen: how decision-makers can use policy and research to strengthen health systems Global Forum for Health Research, 2005, ISBN 2-940286-24-8

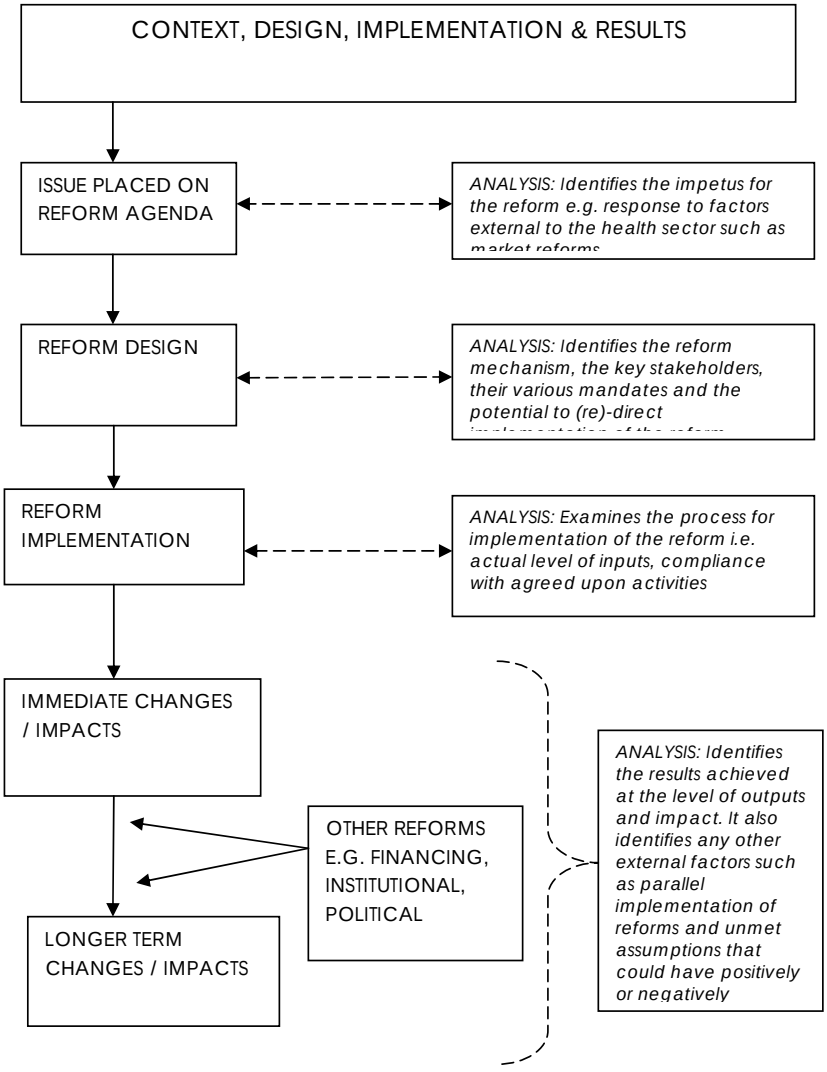
[12] Gilson L, Mills A (1995) Health Sector Reforms in sub-Saharan Africa: lessons of the last ten years Health Policy 32 (1995) 215 - 243

3: CONCEPTUAL FRAMEWORK FOR HEALTH SECTOR REFORM ANALYSIS

3.1 Framework for health sector reform analysis

The major elements for analysis of a health sector reform include a description of the context, design, process and intended results. Figure 1 lays out a conceptual framework for this analysis.

Figure 1: Health Sector Reform Analysis Framework



Source: Adapted from Gilson et al (2000)

3.1.1 Context for health sector reform

Health sector reform does not take place in a vacuum and therefore analysis of the **context** should provide clear and detailed descriptions of the key factors driving the reform. The context of the reform will be closely related to why it was placed on the agenda. The context will therefore be related to whether it is in response to an external factor such as broader macro-economic reforms or purposefully created to address an issue within the health sector such as the need to scale up access to new technologies/medicines.

3.1.2 Health Sector Reform Design

The **design** of a health sector reform takes into consideration what mechanisms or 'control knobs' will be manipulated to effect the desired change; which key stakeholders will be involved at the various stages; and their various interests, mandates and the potential to (re)-direct implementation of the reform. It also considers whether the reform is appropriate to address the identified health issues. Analysis of this level will therefore need a careful review of each of these areas and how they were executed.

3.1.3 Health Sector Reform Implementation

Analysis of the **implementation** stage reviews the actual level of inputs and compliance with agreed upon activities. Inputs to be reviewed will include finances, human resource time and skills, and other logistics. The activities to be reviewed relate to the organization of inputs in relation to implementation of the reform e.g. in decentralizing health services to the district level, it will be important to know what finances are available for capacity building for the new level created (see also figure 1). Inputs will not always be quantitative and could relate to a process that requires a qualitative assessment e.g. in the case of decentralization of health services one might want to assess the actual level of authority that has been transferred to sub-national levels compared to what was intended.

3.1.4 Health Sector Reform Results

A review of the **results** achieved is carried out at the level of outputs, outcomes and impact. The review should also identify external factors such as parallel implementation of reforms and unmet assumptions that could have positively or negatively influenced reform implementation. Reviewing the results will also enable one to determine if the health sector objectives have been met.

4: INDICATORS FOR MONITORING AND EVALUATING HEALTH SECTOR REFORMS

4.1 Monitoring and Evaluation of health sector reform

Monitoring is a continuous process intended to ensure that an activity occurs as planned. Therefore monitoring a health sector reform is about as assessment of the level of inputs (financial, human and logistics), the dynamics, processes and the outputs of implementing the reform.

Evaluation assesses the extent to which an activity has achieved the outcome and impact objectives. Therefore evaluating a health sector reform is about assessing the extent to which the reforms have helped to improve levels of equity, effectiveness, quality, sustainability.

4.1.1 Monitoring components

a) Dynamics – monitoring the dynamics of a health sector reform is related to analyzing the context and design and how they relate to inputs, processes and outputs. It therefore maps the different stakeholders, the roles they played and the mandates that they had, including the potential to (re-)direct progress of the reform.

b) Input indicators assess whether the prerequisite resources are being supplied to effect the change e.g. in granting autonomy to hospitals one might like to see if budgets meet the creation of the new management level

c) Process indicators determine if the 'control knob' is moving in the right direction in terms of timing of inputs, participation of the appropriate stakeholders.

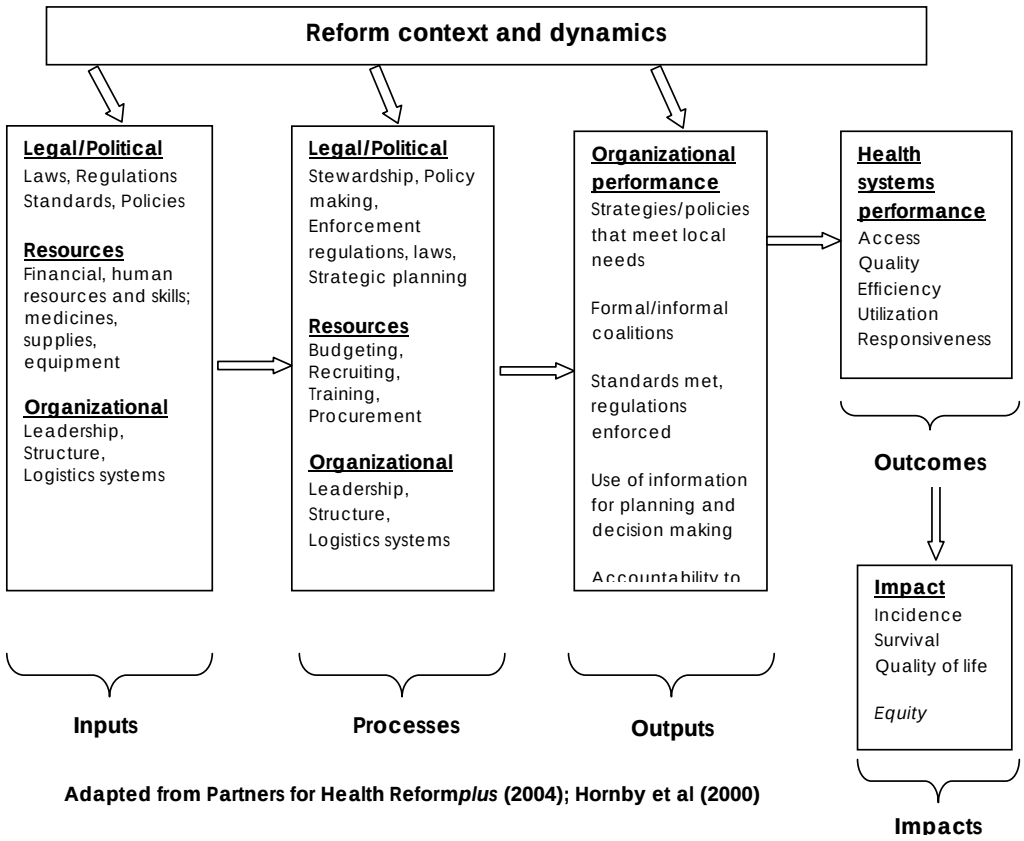
d) Output indicators determine whether a process was accomplished.

4.1.2 Evaluation components

Indicators for evaluating a health sector reform will include both outcome and impact indicators:

The evaluation of a health sector reform establishes trends in equity, efficiency and quality of health service delivery or population health that can be attributed to the changes by reform implementation.

Linkages between context, dynamics, objectives and indicators of health sector reforms



Adapted from Partners for Health Reform*plus* (2004); Hornby et al (2000)

4.4 Source of data and frequency of assessment

Data for both monitoring and evaluating a health sector reform may be obtained from a routine source such as the health information systems. Data may also be obtained from regular national household, demographic or census surveys. Some aspects of monitoring and evaluation may require special studies. In principle, special studies should be organized only after one has fully explored the utility of available information.

The frequency of monitoring and evaluating reform will to a large extent depend on the availability of data. Usually for monitoring, if the routine data sources can produce information at least on a quarterly basis, this should be sufficient to inform the assessment process. Evaluation is suited for measurement of the long term effect of a reform so information from biennial household surveys and demographic household surveys which take place almost every five years should meet the information needs. Special studies are accordingly arranged if the content of the survey is insufficient to meet evaluation needs.

4.5 Data Quality

In many countries, existing data are often incomplete or even inaccurate. Even when adequate and relevant data exist, these merit intense scrutiny. Attention must be paid to factors that might affect the validity and reliability of data for each of the selected indicators. See also box 1 on page 22.

4.6 Evaluative questions and indicators for health sector reform

Countries already have in place monitoring and evaluation tools for performance of the health sector that in many cases include indicators that are relevant to assessment of health sector reforms. This table serves as an illustration for the selection of evaluative questions and indicators in monitoring and evaluating health reforms. Countries can therefore adapt their own to this framework or identify new evaluative questions and indicators depending on the context. Examples are taken from "Decentralization of health services to district / sub-national levels" but the framework should assist in the identification of the key indicators for monitoring and evaluating any of the other reforms. Establishing the rationale for the evaluative questions and indicators will guide in their selection and definition.

4.6.1 Qualitative information

Table 2a: Evaluative questions for the dynamics of a reform

Aspect assessed	Evaluative question	Rationale	Data source
Context	What is the genesis of the reform?	▪ Identifies the impetus and therefore the wider political and policy environment	Key informant interviews Policy documents
	What is the political and wider policy environment?	▪ To identify the wider reform environment that may influence implementation of the reform e.g. sources of conflict, bureaucracy ▪ Explains the extent to which any improvements or decline in performance can be attributed to implementation of the reform ▪ Forms basis for key assumptions for reform progress	Key informant interviews Policy documents
Design	Who are the main actors and what are their mandates?	▪ Managerial feasibility of the reforms	Key informant interviews Policy documents

	What is the design of the reform?	▪ Determines its viability, relevance of the mechanism in addressing the identified problem ▪ Enables the mapping of potential conflicts, capacity gaps	Key informant interviews Policy documents

Table 2b: Evaluative questions for the process of a reform

Aspect assessed	Evaluative question	Rationale	Data source
Stakeholder participation mechanisms	▪ What are the stakeholder coordination mechanisms at district level? ▪ Do community/public participation mechanisms exist? ▪ How functional are the stakeholder participation/coordination mechanisms at sub-national level?	▪ Provides facilitation for stakeholders to review and re-direct progress as required, as well as achieving consensus and conflict resolution among the different stakeholders ▪ Public participation is anticipated to have a positive effect on equity, quality and efficiency of service delivery outputs ▪ Social participation facilitates acceptance of a reform, enabling its sustainability at this level	Key informant interviews Review reports
Timing	How timely are inputs and stakeholder participation?	▪ This determines the progress of implementation	Health information systems Key informant interviews Review reports

Table 2c: Evaluative questions for the outputs of a health sector reform

Aspect assessed	Evaluative question	Rationale	Data source
Timing Stakeholder participation	▪ Are inputs being delivered in a timely manner in relation of to the timed progress of the reform? ▪ Are all key stakeholders meeting their obligations and commitments?	▪ Determines the achievement of key milestones in reform implementation	Activity reports

4.6.2 Quantitative information

In general good indicators should have the following qualities.

Box 1: Qualities of a good indicator

Valid: measures what it is intended to measure (sensitivity) and does not measure what it is not supposed to measure (specificity)

Reliable – produces consistent results in repeated measurement of the same condition or event

Affordable – presents reasonable costs for data collection including making use of available data

Source: PHRplus 2004; WHO 2001; WHO 1994

Table 2c: Indicators for inputs of a reform

Indicator variable	Indicator	Rationale	Data source
Human resource numbers and skills	▪ Number of positions filled in accordance with staffing norms for the decentralized level ▪ Proportion trained to meet new management and service requirements	▪ The decentralization process will usually create new positions and highlight staffing gaps at the district level ▪ The decentralization process also creates need for management training ▪ Number and skills of health workers will influence the capacity for effective supervision	▪ Human resource inventory ▪ Training reports
Finances	▪ Proportion of districts budgets with health budgets for given FY ▪ Proportion of districts with budgets that are fully funded	▪ Demonstrates capacity of districts to decide on costed priorities – a key function in decentralized health services	▪ Income and expenditure records ▪ Budgets and work-plans
Medicines, supplies, and equipment;	▪ Presence of improved systems to prevent stock outs and to cater	▪ Demonstrates district capacity to address and/or improve logistic	Medicine and supply stock cards;

operations and maintenance	for equipment operations and maintenance	gaps	Equipment inventories; Review reports
Infrastructure & equipment	▪ Proportion of infrastructure & equipment budget that is funded	▪ Demonstrates capacity to finance large capital items	

Table 2d: Indicators for the outcomes and impact of a reform

Aspect assessed	Indicator	Rationale	Data source
Equity	▪ **Access** - Proportion of districts with targeted proportion of the population within a specified radius to functional basic health services ▪ **Coverage** Proportion of identified vulnerable groups that are accessing selected services in basic package ▪ **Distribution of resources** – financial, human resources by geographical area/per capita ▪ **Resource utilization** – OPD per capita/SES, expenditure per capita/SES ▪ **Impact on health status indicators** – reduction in IMR/U5MR/MR by SES or geographical region	To establish the effect of the reform on the geographical or socioeconomic disparities in: i) Access ii) coverage iii) ability to pay full cost of using services iv) distribution of resources v) resource utilization disparities for access to care amongst vulnerable groups vi) health status indicators e.g. infant mortality rate, maternal mortality ratio	▪ Health facility inventories ▪ Routine HMIS ▪ Household surveys ▪ Demographic health surveys ▪ Special studies
Quality	**Technical quality** - % of facilities with quality control mechanisms; availability of essential medicines and commodities; **Perceived quality** – degree of user satisfaction with the health services	To assess effect of quality on other variables such as equity and efficiency	▪ Supervision reports ▪ Survey reports ▪ Special studies
Efficiency	**Resource allocation** – trends for service delivery	▪ Assesses whether more efficient	Income and expenditure

	outputs per given output	resource allocation mechanisms have been introduced e.g. evidence for resource allocation to higher burden health conditions e.g. PHC	records at national and sub-national levels
Sustainability	▪ Availability of the required resources to meet medium term targets for e.g. scaling up access	▪ Will determine the viability of the reform in the short and medium term	

5: BUILDING CAPACITY FOR MONITORING AND EVALUATION OF HEALTH SECTOR REFORM

This guideline for monitoring and evaluation assumes the following capacities will be available to the teams undertaking the task:

1) Human resource skills

   - Health informatics – technical, organizational, and managerial skills related to sound processes of data gathering, analysis, storage, dissemination (appropriate package and communication) and use.
   - Research methods
   - Applied epidemiology
   - Management and leadership
   - Economic evaluation
   - Policy and planning

The training to be conducted to improve the capacity for monitoring and evaluation of health sector reform will depend on the human resource training needs assessment for these skills. Capacity building for improving the monitoring and evaluation of health sector reform is not limited to training alone and should include other aspects such as:

2) Strengthening health management information system to support the availability and quality of routine data
3) Ensuring a sustainable supply of the logistics needed to support continuous monitoring and evaluation of health sector reforms
4) Support for linkages with academic and research institutions in both the private and public sector as well as independent professionals with specialized skills in the subject

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