© UNICEF/UN0668188/Prasad Ngakhusi

© UNICEF/UN0641754/Orina

EXECUTIVE SUMMARY

COUNTRY CASE STUDIES ON ALIGNMENT

© UNICEF/UN0146018/Schermbrucker

© UNICEF/UN0668603/Dejongh

© UNICEF/UN0581200/Sujan

HEALTH DATA COLLABORATIVE

unicef for every child

Acknowledgements

Lead author: Serena Chong (consultant)

This Executive Summary was supported by UNICEF for the Health Data Collaborative. It is based on five case studies in Bangladesh and Nepal (led by Serena Chong, consultant) and in Cameroon, Kenya, and Zambia (led by Nadege Ade, consultant). We would like to thank all the stakeholders in these five countries who participated in interviews and provided documents to support the analyses. Other authors include Jennifer Requejo (UNICEF), Craig Burgess (WHO), and Mwenya Kasonde (WHO). We would like to thank the United States of America Centers for Disease Control for funding support.

Background

Since the early 21st century, international development stakeholders have committed to improve the quality and effectiveness of aid and its impact on countries' development, as reflected in the Paris Declaration in 2005 and further strengthened with the Accra Agenda for Action in 2008. The Accra Agenda for Action took stock of progress since the Paris Declaration and proposed the following main areas for improvement: Ownership; Inclusive partnerships; Delivering results; and Capacity development.

For the health sector, the International Health Partnership (IHP+) was launched in 2007,[1] with the aim of better coordinating donor aid, widening the focus of aid to include health systems, and an increased focus on support to national health plans and systems.
The 2030 Agenda for Sustainable Development incorporates 17 Sustainable Development Goals (SDGs) to guide global action for peace and prosperity. SDG 3, Good Health and Well-Being, aims to "ensure healthy lives and promote well-being for all at all ages". Sub-target 3.8 focuses on the achievement of universal health coverage (UHC). This requires strengthening health systems, of which health information systems (HIS) are a key component. Robust HIS are critical to monitoring health service delivery, improving health-care coverage in an equitable and inclusive manner, and supporting countries' progress towards SDG 3.

With the broadening of the global health agenda to include health systems, IHP+ also broadened its scope to include health systems strengthening as necessary for achieving UHC.[2] The Health Data Collaborative (HDC) was established in 2016 as a UHC2030 initiative to strengthen national and subnational systems for integrated monitoring of health programmes and their performance.

The HDC aims to contribute to the goal of data-driven performance and accountability through supporting the collection, analysis and use of timely and accurate data. Its strategies for doing this are to enhance country statistical capacity and stewardship, and strengthen the alignment of partners' technical and financial commitments for nationally owned HIS and a common monitoring and evaluation (M&E) plan. A stronger HIS means more timely, accurate and comparable data that can be more reliably

1 See website for UHC2030: <www.uhc2030.org/about-us/history/>.
2 Ibid.

used to design and monitor effective health interventions and policies, thus contributing to the goal of data-driven performance and accountability.
The HDC's Theory of Change aims to align partners' technical and financial investments with country-driven plans in order to improve efficiency and alignment of investments in health data systems, as well as to strengthen country capacity to plan, implement, monitor and review progress and processes for data collection, availability, analysis and use.

In line with the HDC's alignment agenda, five country case studies were conducted in 2021–2022 to assess the status of the HIS in the selected countries, the investments that national governments and partners are making to strengthen HIS, and the status of alignment of these investments to national priorities for strengthening HIS. The five countries selected for this work were Cameroon, Kenya and Zambia in sub-Saharan Africa, and Bangladesh and Nepal in South Asia.

METHODS

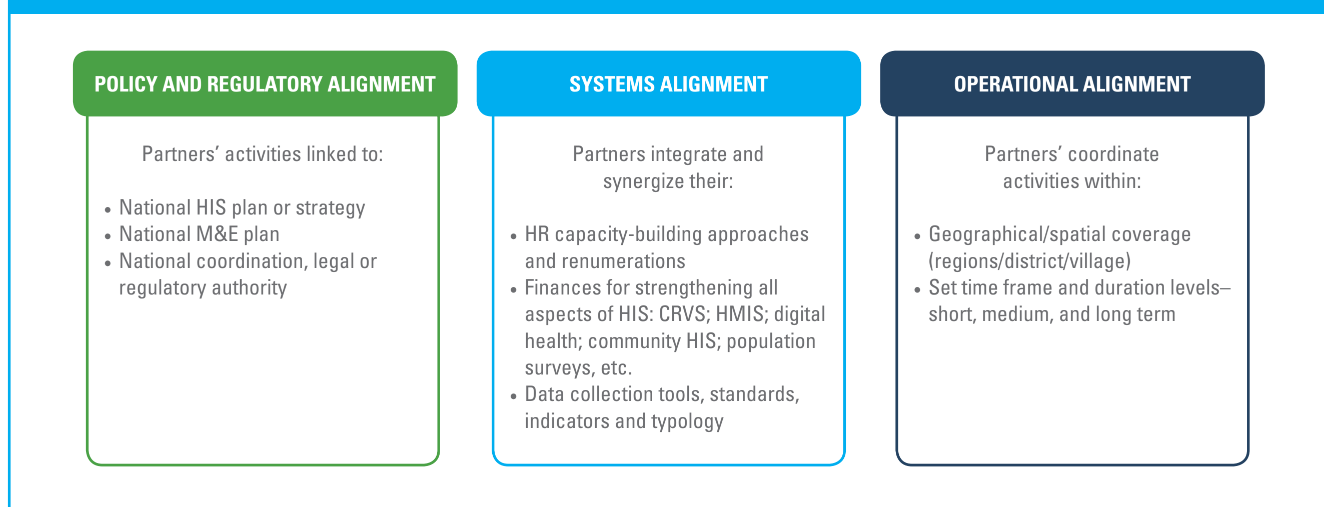
The methodology adopted for the five country case studies involved:

- Desk review of relevant literature, including country planning documents provided by national stakeholders (government stakeholders, multilateral agencies, and non-governmental organizations [NGOs]) and literature found through database searches.
- Development of a conceptual framework on alignment to structure the analysis.
- Development of stakeholder interview guides for international and national stakeholders, and a separate one for academic and private sector stakeholders, based on their roles in the HIS ecosystem.
- Stakeholder mapping, consultations and key informant interviews.
- Data analysis and synthesis.

Reflecting the principles of ownership, alignment and inclusive partnerships in the Paris Declaration and the Accra Agenda for Action, a conceptual framework of alignment (see Figure 1) was developed for the case studies that situated alignment by partners within a context of nationally owned HIS plans, strategies and priorities. Alignment occurs when partners' investments and activities are linked to national HIS policies and priorities; integrated with national HIS systems and procedures; and coordinated with the government and other partners so as to encourage efficiency.

For these case studies, alignment was framed as occurring across three domains: policy and regulatory alignment; systems alignment (technical and financial alignment); and operational alignment. Partners' financial and technical investments in national HIS were analysed according to this framework.

Figure 1: Conceptual framework of alignment



Stakeholder interview guides were developed jointly by the case study authors. These interview guides were used to administer remote interviews for each country case study, with minor modifications depending on context or stakeholder group.

For most of the country case studies, major health sector stakeholders or development partners working at national level were invited to participate in an interview or, when interviews could not be conducted, to provide responses to a short email questionnaire. These participants were purposively sampled – either through their participation in existing country coordination mechanisms, or through introduction by an existing country partner. Stakeholder responses were analysed to generate a qualitative assessment of the status of alignment for that specific domain. Where stakeholder responses were scarce or not available, available documents were reviewed and analysed to provide information relating to that component of alignment.

Limitations

An overall limitation of the case studies was that only a small number of development partners were interviewed for each country. In one country (Bangladesh), the case study was conducted as a desk review only, due to time constraints and difficulties in obtaining interviews. It should be noted that interviews for the case studies were conducted at a time in 2021–2022 when countries were dealing with coronavirus disease 2019 (COVID-19) surges. The small number of interviews conducted may affect the accuracy and reliability of the findings.

For all of the country case studies, most of the interviews were conducted with multilateral development partners (i.e., World Health Organization [WHO] and United Nations Children's Fund [UNICEF]) and national line agencies; there was limited engagement with bilateral development partners, NGOs, civil society organizations (CSOs) and research/academic institutions. No interviews were conducted with the private sector. An element of self-selection bias also exists as interview or questionnaire respondents were usually partners who were already active and engaged in existing country coordination mechanisms.

These limitations notwithstanding, the findings of the country case studies are intended to be useful as a starting point for further work on stakeholder alignment with country priorities on HIS.

MAIN FINDINGS

With reference to the conceptual framework, a synthesis of findings across the five countries are presented below by alignment domain. Based on these findings, some enabling and constraining factors for alignment have been identified and an illustrative framework of indicators for measuring progress on alignment is proposed.

Policy and regulatory alignment includes whether there is a national plan or strategy on HIS (defined broadly as systems used for health sector data collection, analysis, dissemination and use, inclusive of routine HIS [RHIS] and population surveys) that details a common vision and plans for progress, and how aligned partners are to this plan. It includes assessing whether there are government-led coordination mechanisms, and whether partners are represented or participate in these coordination mechanisms. It also includes assessing whether partners' M&E efforts are aligned to a national-level HIS M&E framework, and if indicators and reporting are harmonized across partners, donors and national reporting agencies.

Broadly speaking, the existence of official strategies and policies developed and endorsed by the national government, as well as government-led stakeholder coordination mechanisms, is a good indication that there is political will and commitment to drive better alignment and harmonization in the sector.

All five countries have relevant strategies and policies for the health sector, with certain countries (Kenya, Nepal) having overarching strategies/policies specifically for the HIS. Bangladesh, Cameroon and Zambia did not have national policies specifically on the HIS, although HIS is referenced in other related health sector plans (e.g., the Cameroon National Strategic Plan for Digital Health, the Bangladesh HIS and eHealth Operational Plan, the Zambia e-Health Strategy).

Similarly, the existence of formal, government-led coordination mechanisms encourages dialogue and consultations between partners and governments, theoretically allowing for a more inclusive priority-setting and planning process. Kenya, Nepal and Zambia all have national coordination/consultative mechanisms and frameworks. Cameroon does not appear to have specific coordination mechanisms for the HIS, and Bangladesh has broader health sector coordination mechanisms not specific to the HIS.

A consistent finding across all countries studied was a lack of or low representation of two important stakeholder groups – civil society and the private sector – in health sector coordination mechanisms. In most of these countries, private health facilities (encompassing facilities run by for-profit providers and those that are not-for-profit, such as those run by faith-based organizations or other NGOs) account for a significant share of national health service delivery. For example, the private sector accounts for approximately 70 per cent of health services in Bangladesh;[3] over 50 per cent in Kenya;[4] and in Nepal, two thirds of hospital beds in the country are private.[5] A large proportion of the countries' populations are therefore being served by facilities or organizations which may not be systematically reporting data into the national HIS. This has implications for the capture of health service coverage and utilization data, thus affecting the ability to allocate resources equitably and efficiently for all populations. Without adequate or complete reporting into the national HIS by non-public facilities, it is difficult to ensure that the needs and health status of local communities are being tracked and monitored, and used for disease control and response, service delivery planning and policy development purposes.

For some countries, particularly those undergoing decentralization processes, the level at which coordination occurs matters. CSOs working at community level are often more likely to participate in or be represented in subnational coordination mechanisms; conversely, major funding partners – such as bilateral donors and Gavi, the Vaccine Alliance (GAVI) or the Global Fund to Fight AIDS, Tuberculosis, and Malaria (the Global Fund) – are more likely to be active in national-level coordination mechanisms. Participation in these mechanisms should be assessed regularly to ensure there is adequate representation from all stakeholder groups.

Across the five countries, there were mixed perceptions on whether partners were aligned to the national HIS M&E framework or indicators. Nepal and Zambia were notable for having national M&E Technical Working Groups (TWGs), which support partner and country alignment on M&E indicators.

3 Government of the People's Republic of Bangladesh, Ministry of Health and Family Welfare, *Health Bulletin 2019*, Government of Bangladesh, Dhaka, 2020.

4 Mohamoud, Gulnaz, and Robert Mash, 'The Quality of Primary Care Performance in Private Sector Facilities in Nairobi, Kenya: A cross-sectional descriptive survey', *BMC Primary Care*, vol. 23, no. 1, p. 120, 18 May 2022. 3

5 Mahat, Agya, David Citrin and Hima Bista, ' NGOs, Partnerships, and Public-Private Discontent in Nepal's Health Care Sector, *Medicine Anthropology Theory*, vol. 5, no. 2, 15 May 2018.

Systems alignment refers to the harmonization of partners' technical and financial resources – that is, how partners' technical and financial resources are used in support of identified national priorities. Harmonization of technical resources might include, for example, providing technical expertise or guidance in development of policies and guidelines, and capacity-building for government personnel and field staff. Harmonization of financial resources speaks to how partners' financial resources are aligned or harmonized towards the achievement of common goals. Systems alignment also includes alignment of programme systems, such as ensuring that capacity-building approaches and remuneration of health personnel working on data systems are harmonized.

Across the five countries studied, a common finding was that the existence of parallel data systems to the HIS seemed to add to the reporting burden for health-care workers and constrained systems alignment. These parallel systems occur most commonly for the specialized or disease-focused programmes (e.g., HIV/AIDS, tuberculosis, malaria), where donors may request reporting on specific indicators not otherwise captured through the RHIS. This is an area where donors, countries and other partners could work on strengthening alignment – for instance, by supporting the development of interoperability guidelines or interfaces to link these parallel data systems to the RHIS.

Another common finding was that financial alignment as defined by these case studies appears weak across most of the case study countries. Specifically, it seems that the health sector funding environments in some of these countries are still largely project based, thus constraining harmonization of financial investments. All of the five countries studied have adopted sector-wide approaches (SWAp) for the health sector – a modality for having external aid financing support a set of national policies and strategies, with institutional and financial management frameworks in place, led by the national government. However, the implementation of SWAps has differed across countries, and it was found that some health sector funding in several of the case study countries still falls outside the SWAp. This 'off-budget' funding is therefore not subject to SWAp institutional and financial management frameworks, and further analysis would be needed to understand how much of this funding is aligned with national HIS priorities.

On a related note, a fundamental cause of misalignment is that external development partners have their own

constituencies to answer to, and political cycles. Bilateral partners are accountable to their own constituencies (i.e., taxpayers and voters) and their own national budget cycles for disbursement of aid; donor organizations such as the Global Fund and GAVI have their own governance architecture. External aid from these sources is often aligned with recipient government priorities only to the extent that the funding may support recipient government priorities, but may not be aligned from a budget and planning cycle standpoint.

Finally, it is unclear to what extent partner priority-setting, planning and budgeting processes in all of the countries are consultative, inclusive of all populations, and reflect local and subnational needs and development priorities. Deeper engagement of civil society in these processes would increase the likelihood that local needs are being reflected in strategic and technical plans.

Operational alignment includes how partners communicate with each other and also with local, provincial and central-level health authorities. This may include in terms of formal and informal coordination mechanisms, as well as how information and data are shared and used between partners. Partners also align operationally by coordinating their activities – for example, NGOs working in the same community may coordinate to ensure that the services provided are harmonized, cases are referred between providers according to need, and that there is no overlap in time and space.

There is insufficient evidence from the five case studies on this aspect of alignment. While there are ongoing efforts in a few countries (Kenya, Nepal) to harmonize data collection indicators and tools amongst partners, more research is needed on this aspect of alignment, particularly to assess how communications at community level occur, and how data and feedback flow through the HIS.

Aside from the harmonization of indicators, there was little evidence of partner alignment of M&E activities across the countries studied. With the exception of Nepal and Kenya, knowledge management mechanisms for sharing information and documents on health sector programmes appear to be weak or non-existent. This not only contributes to greater opacity across the health sector financing landscape, but also constrains coordination between partners and decreases the efficiency of partner investments.

Table 1 presents a summary of the alignment findings across the three domains by country.

Enabling factors for alignment

The existence across the five countries of relevant strategies and policies, as well as government-led coordination mechanisms, provides a framework for engagement and dialogue, promoting consultative priority-setting and planning processes.

Partners working together to support the government on harmonizing data collection tools and indicators feeding into the HIS help to streamline the reporting burden for health-care workers and support countries' reporting on SDG 3.

Constraining factors for alignment

Factors constraining alignment include:

Lack of or low representation of civil society, private sector and academia in coordination mechanisms – improving the representation of civil society and engagement with the private sector should be a priority for health sector stakeholders working on health data and HIS. Countries could also leverage the technical expertise of local and regional academic/technical institutions to strengthen capacity in a sustainable manner.

The existence of parallel data reporting systems – for example, vertical systems for disease-specific programmes to respond to particular reporting requirements by donors.

Project-based funding approaches or uneven implementation of health sector institutional and financial management frameworks such as SWAp.

Partners allocating funding according to their own institutional priorities and driven by their own constituencies (voters or boards), instead of recipient country priorities.

Partners' planning and M&E mechanisms often still separate from each other, resulting in a high reporting burden for countries and less effective management and monitoring.

Data on planning, funding and implementation of various health sector programmes not always easily accessible, constraining coordination in terms of planning, implementation and follow-up.

Table 1. Alignment findings across three domains, by country

	Cameroon	Kenya	Zambia	Nepal	Bangladesh
Policy and regulatory alignment					
Existence of a national strategic plan and alignment of partners around it	🟡	🟢	🟡	🟢	🟢
Existence of government-led coordination mechanisms and level of participation/representation by partners	🟡	🟢	🟢	🟢	🟡
Alignment of partners to the national HIS M&E framework	🟢	🟢	🟢	🟢	Unknown
Systems alignment					
Harmonization of technical resources (including data collection tools, processes and standards)	🟡	🟡	🟡	🟡	Unknown
Harmonization of financial resources	🔴	🔴	🔴	🟢	🟡
Operational alignment					
Communications and information flow	Unknown	Unknown	Unknown	🟡	Unknown
Coordination of activities between partners geographically/spatially	🟡	🟡	🔴	🟡	Unknown
Coordination of activities across time	🟡	🟡	Unknown	🟡	Unknown

🟢 Yes / Strong evidence of alignment 🟡 Partial / Mixed evidence of alignment 🔴 No / Weak evidence of alignment

© UNICEF/UN0663879/Schermbrucker

Measuring alignment of partners' technical and financial investments

Once work is underway with partners on strengthening alignment of technical and financial investments in country HIS, the HDC could support the adoption and use of indicators to assess and measure progress on alignment over time. Table 2 presents some sample indicators for measuring alignment over time. These indicators, along with baselines and targets, should be discussed with countries and tailored to their specific contexts.

The above proposed indicators could be standardized across countries for comparison purposes or be specific to each country's context. These indicators could be adapted in collaboration with country stakeholders, including ministries of health, provincial health agencies, other development partners and CSOs. Baseline levels for each indicator should be assessed at the start, and indicator targets and timelines for achieving intermediate and advanced levels of alignment should be set based on baselines, the work required and country resources. Countries with advanced levels of alignment might be able to achieve targets of 90–100 per cent for the above indicators, for example.

The recommendations proposed in the next section are some ways that the indicators might be achieved, with the support of HDC stakeholders.

Table 2. Examples of indicators that could be used to measure progress on alignment

Policy and regulatory alignment – indicators
Percentage of development partners who consistently attend HIS inter-agency meetings/coordinating meetings.
Number of CSOs and private sector organizations that are present in HIS coordinating meetings.
Proportion of national budgeted health sector or HIS activities that include CSOs as an implementing partner.
Systems alignment – indicators
Percentage of partners' health sector programme budgets that support the implementation of HIS activities according to national priorities.
Proportion of partners disclosing their HIS activities (including associated budgets) planned or being undertaken at national or subnational level, within relevant governance structures.
Proportion of national development partners that participate in HIS policy development and technical guidelines development.
Percentage of total national HIS funding (as allocated in national budgets) that are included in the health sector SWAp.
Number of indicators used for donor reporting that are reported through the RHIS or existing data sources.
Policy and regulatory alignment – indicators
Proportion of national development partners that conduct joint technical and financial implementation of HIS activities with at least one other partner, at either national or subnational level.
Percentage of HIS activities planned/budgeted in the national HIS work plan that are jointly implemented (i.e., at least two partners are involved).
Proportion of national development partners that conduct joint monitoring activities (with government line agency or at least one other external partner).

RECOMMENDATIONS FOR HDC PARTNERS

Some recommendations for strengthening stakeholder alignment are proposed in Table 3, by constituency group. These recommendations are not exhaustive and reflect only the main findings of the five country case studies.

To conclude, the findings of the five case studies make it clear that there remain key gaps around the alignment of partners' technical and financial resources for strengthening HIS. Incidentally, these gaps are largely reflected in the areas for improvement proposed by the Accra Agenda for Action (2008). In particular, better coordination between stakeholders, inclusiveness and representation of all stakeholder constituencies, and stronger financial alignment alongside capacity-building for better governance are areas requiring further work. With the support of the HDC and its partners, countries should take the lead – by defining their national priorities, plans and budgets – in acting and leading implementation and coordinating partners to achieve those priorities.

Table 3. Recommendations for strengthening stakeholder alignment, by constituency group

Constituency group	Recommendations
HDC countries (governments and line agencies)	• At national level, designate a lead ministry/directorate to coordinate partners. Existing coordination mechanisms can be built on, with country governments codifying/formalizing coordination and governance structures if needed. • Develop and update national HIS strategies/policies. • Develop and implement one M&E framework for the health sector for partners to align to. • Lead health sector priority-setting and planning processes, ensuring that these processes are consultative and have broad representation across constituencies. • Develop and implement policies/guidance on the integration of private health facility data into national RHIS. • Prioritize deeper engagement with CSOs and private sector organizations, particularly those involved in health services delivery. • Engage with national academic/technical institutions as thought partners and technical resources – e.g., on capacity-building or database management. • Coordinate donors and implementing partners on knowledge management – e.g., build a repository of programme documents with the aim of being more transparent and using aid effectively. • Spearhead efforts to harmonize financial resources by conducting an analysis of how national and external funds are being allocated towards strengthening the HIS.
Multilateral and intergovernmental organizations	• Ensure representation/participation in HIS coordination mechanisms. • Provide support to implementing partners, such as local NGOs, to participate in coordination mechanisms. • Work on strengthening the RHIS and streamlining reporting between national agencies and external partners, especially for reporting on the SDG 3 Global Action Plan. • Provide support to countries on the integration of parallel data systems into the RHIS, or on strengthening the RHIS so that all reporting requirements are met through the RHIS. • Support and implement joint M&E activities with other health sector partners. • Support the development of standards and guidance for data governance.
Donors (bilaterals, foundations and regional funding entities)	• Support consultations and engagement across stakeholder constituencies that feed into national health sector priority-setting and planning processes. • Provide flexibility with funding cycles in order to align with national budget/planning cycles. • Lead efforts towards greater aid transparency by publishing/disclosing planned HIS activities and associated budget amounts. • Work on strengthening the RHIS and streamlining reporting between national agencies and donors. • Provide support to countries on the integration/interoperability of parallel data systems with the RHIS.
Global health initiatives	• Provide flexibility with funding cycles in order to align with national budget/planning cycles. • Lead efforts towards greater aid transparency by publishing/disclosing planned HIS activities and associated budget amounts.
Academic and technical networks	• Support further engagement between academic/technical networks and national governments. • Support the development of interoperability protocols for national HIS. • Provide support for the development of standards and guidance for data governance.
CSOs	• Prioritize representation/participation in coordination mechanisms at both national and subnational levels.
Private sector	• Provide support to and/or invest in the integration/interoperability of private health facility data systems with national RHIS. • Participate in coordination mechanisms, as appropriate.

HEALTH DATA COLLABORATIVE

unicef

for every child