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Health Sector Reform Policies In Africa: Who Informs Problem Identification And Agenda Setting?

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Health Sector Reform Policies and Questions

The purpose of this article is to raise issues of important concern to African ministries of health, particularly those engaged in health sector reforms. We do so by pointing out areas that need well-structured research initiatives, and by raising some of the relevant research questions. This article raises more questions than answers and it is meant to stimulate discussion over research protocols on questions like: Who owns the reform programmes? Who influences programme formulation? Why are some of the reform programmes being implemented too slowly? What is the role of country-level research institutions? The article also emphasizes the important role of local policy research as a means of improving and adapting what appears to be a "universalistic systemic agenda" for reform to a local dimension of relevance. Universal or global reform concepts are certainly useful, but so are priority domestic systemic agendas for a reform policy programme. The concern here is where global policy influences suffocate or ignore the (national level) domestic concerns for reform policy agenda setting.

Most African countries are at various stages of health sector reform programmes. Reform means change, presumably to improve an existing condition. One would want to be sure that the reason for change and the methods used to effect the envisaged change are well informed by research and analysed data. In order to ensure that this happens, the reform proposal needs to be based on researched evidence that informs and justifies the need for change and outlines the likely consequences of the planned reform. Thus, health sector reforms ought to be linked to policy research.

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The health sector reform initiatives in Africa are, by and large, policy-engendered programmes meant to improve health sector performance by improving the health conditions of the population. As policies, the reforms are studied in order to understand their origins; the procedures through which they were conceived, developed and adopted; and the effect that they will have after they are implemented.

Health policy studies focusing on the health sector reform agenda should include, *inter alia:*

- What is the nature of the policy problem, who defines the problem, and how is it placed on the agenda? Are the potential policy proposal beneficiaries and implementers adequately involved in this process?
- How will the reform proposals be organized for efficient and effective performance? What are the mandates for the reform implementation actors at the national, sub national and community levels?
- What have been the inputs in terms of demands, contribution of ideas and other resources by various interested or affected parties? Are the sub national communities regarded as passive or active participants in reform policy making, all the way to implementation?
- Who will benefit and who will not, as a result of implementing the policy reform? What safety nets are systematically created to take care of unexpected health sector reform impacts, such as: a social or geographical inequitable distribution of services, cartel organization, social exclusion, price hikes, etc?

Policy studies may view the health sector reform either as a dependent or as an independent variable. As a dependent variable, the health sector reform policy in a country is seen as a product or a consequence of processes that take place within and among various stakeholders and interested parties. When this is the case, researchers will focus their attention on the powerful actors responsible for identifying, defining, and interpreting the reform concept, and for turning it into a policy problem or agenda. A policy agenda simply means a set of factors that have caused or attracted "public" concern, creating a justification for calling upon the government to develop such an agenda into a public policy programme worth committing resources to its implementation. A more pertinent question for a policy researcher using the

dependent variable perspective is to enquire into how the policy is influenced or affected by various constituencies or power centres of interested parties. It is also about whether agenda setting and policy implementation will act in favour or against one or more social, economic, political, and cultural groups.

From the dependent variable perspective, and taking into account that most health sector reform initiatives are implemented as a response to International Monetary Fund or World Bank sponsored structural adjustment programmes, one wonders whether local centres or constituencies of interests have had a chance to influence agenda setting and the formulation of health sector reforms. If it turns out that the health sector reform policies belong to the international financial institutions and country-level national elites, such policies will hardly make a significant positive impact, and it will be difficult to sustain them. The question is how to turn the top-down approach to health sector reform policy formulation into a bottom-up approach in which various sections of the local population will make significant contributions to the policy processes of problem identification, definition and agenda setting.

Where the health sector reform policy is viewed as an independent variable, the research focus is shifted from who influences the policy making process to the negative and positive impacts of the policy on the service structure, behaviour of service providers and consumers, management attributes of efficiency and effectiveness, and, how the reform policy programmes have found relevance and acceptability in the local environment in which they are implemented. Therefore, the major question from the independent variable point of view is the extent to which health sector reform concepts (universal or domestic) have managed to address and solve community, district, and national health sector problems. From a researcher's perspective, one gets interested in whether there are researched policy recommendations to enable the health sector reform programme components to make a more significant and positive impact on health service delivery.

Whose Agenda are the African Health Sector Reforms: Local or External?

There are two types of agenda. First there is a systemic agenda that encompasses concepts and intentions perceived by a wide range of interested parties and populations within and across national boundaries. Such perceptions must be important enough to merit the attention and actions of governments. Systemic agendas include structural adjustment programmes

and the campaign for "Health for All by the Year 2000." Systemic agendas also incorporate declarations that have been adopted or endorsed by various African governments for implementation before the year 2000, such as:

- Reduction of infant and under-five child mortality rates by 30 to 50% in 1990 - 2000
- Reduction of maternal mortality rate by half in 1990 - 2000
- Reduction of severe and moderate malnutrition among under-five children by half in 1990–2000. Other issues of social and economic concerns contained in the United Nations Development Programme reports and the World Development Report of 1990.

Systemic agendas, such as those taking a universal perspective, and advocated by leading international organizations -- the World Health Organization, the World Bank, UNDP, UNICEF -- have very important policy concepts that need to be studied further to determine how they can be adopted by governments and adapted to the needs of local communities. The question is what role is given to local research institutions, if at all, and how a local research capacity can be developed to appreciate, appraise and integrate the universalistic systemic concepts and to get local development policy concepts. If this is done, the universal systemic reform concepts can be transformed to suit country and community level needs regarding health sector policy reform. It is hoped that one day it will be possible for sub national and national researchers and communities to inform the global health sector reform policy sponsors. Currently the practice is a top-down approach in which the global/universal systemic centres inform the African national and sub national institutions.

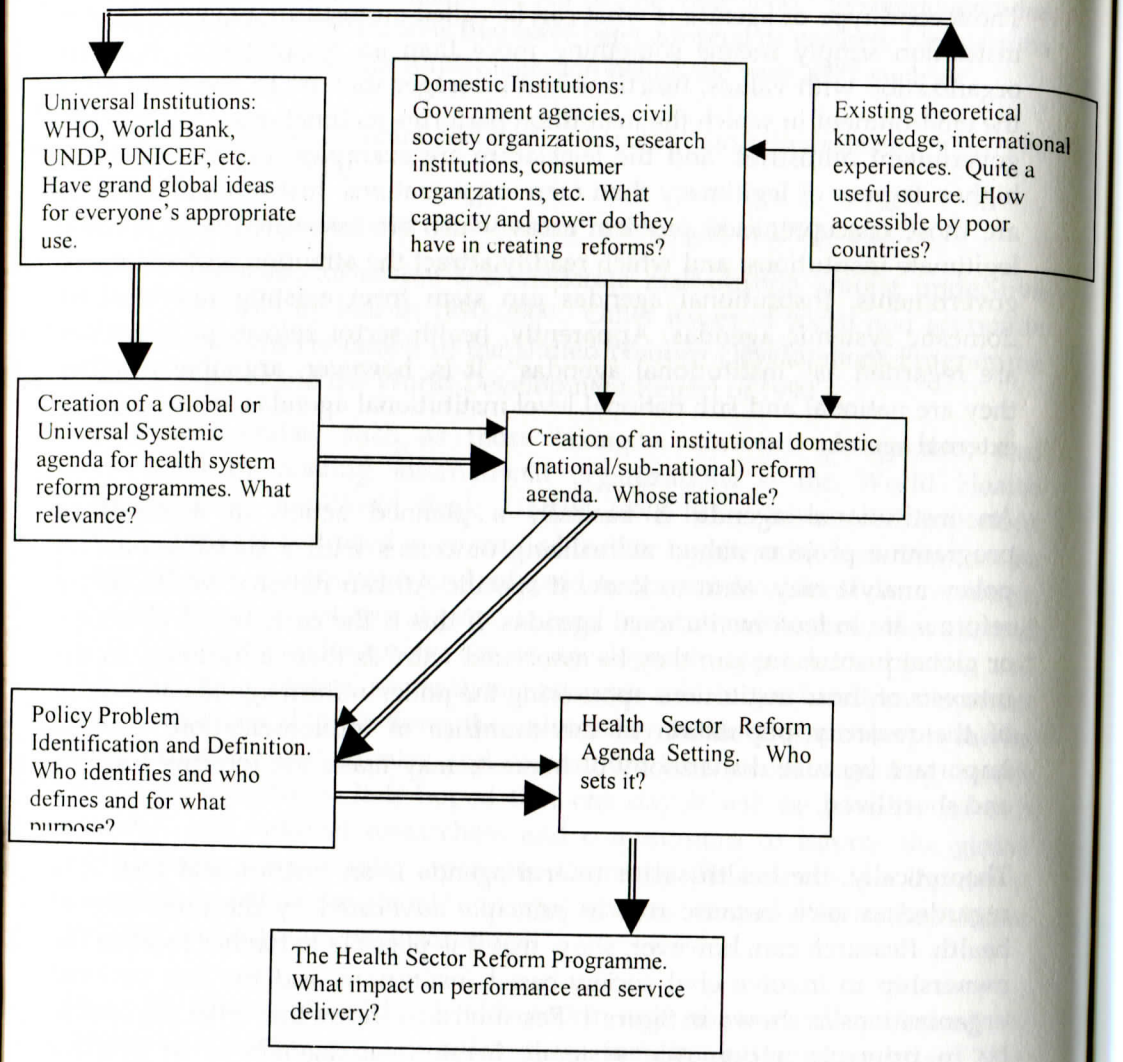
In most African countries health sector reforms are still perceived as universal systemic agendas rather than domestic systemic agendas. This anomaly can be corrected by intensive involvement processes aimed at developing a state of understanding, commitment, relevance, ownership and sustainability of the reform agendas (Redclift 1992). Systemic agendas are, and need to be, discussion points, as they are abstract and general. They should not be taken as if they are universal goods for consumption by African communities at large. Nor should they be prescribed like medicine to national and sub national communities as if to treat health sector performance "sicknesses".

The second type of agenda is what can be called an institutional agenda. An institution simply means something more than an organization. It is an organization with values, functions and messages that are in harmony with the environment in which the institution performs its functions. Universities, government ministries, and the legislature are examples. Institutions have higher degrees of legitimacy than mere organizations. Institutional agendas are those conceptualised problem areas which are associated with specific legitimate institutions, and which readily attract the attention and actions of governments. Institutional agendas can stem from existing universal or domestic systemic agendas. Apparently, health sector reform programmes are regarded as "institutional agendas". It is, however, arguable whether they are national and sub national level institutional agendas, or an entirely external agenda.

An institutional agenda is basically a planned action in a series of programme projects aimed at realizing outcomes with a social impact. A policy analyst may want to know if specific African national health sector reforms are indeed institutional agendas. If this is the case, which domestic or global institutions can they be associated with? Is there a harmony in the interests of those institutions sponsoring the policy reform agenda and those of the majority population in the countries of implementation? This is important because disharmony of interests may make the reforms fruitless and short-lived.

Theoretically, the health sector reform agenda is an institutional one. It is regarded as such because it is in principle advocated by the ministries of health. Research can, however, show that it is possible to further localize the ownership to involve civil society-based institutions and the sub national organizations as shown in figure 1. Research also shows that what appears to be in principle a domestic systemic institutional agenda is in practice regarded as a global systemic institutional policy agenda received by local communities with a lot of apathy and suspicion. The two scenarios are presented in Figure 1.

What seems to have happened is that most of Africa's health sector reform programmes have been formulated as part of conditionalities, and imposed by the international financial institutions. Such powerful institutions send out specific country "experts" as consultants, usually on "missions" to countries where reforms are to be introduced and implemented.



Note:

⟹ Predominant influences in the making of Health Sector Reform Programmes in Africa.

→ The ideal path for Agenda Setting for a sustainable programme. This is yet to be developed to bring about institutional legitimacy in the reforms.

Figure 1: *Transforming a Universal Systemic Agenda into a Local Systemic and Institutional Agenda*

They briefly and hurriedly study the situation and write up "mission" reports upon which recommendations for reform are based. The consultants base their arguments on their international experience and the existing universal theoretical knowledge. These are then exposed to national-level policy makers - especially top administrative technocrats - for consideration and incorporation into a health policy reform programme.

The externally and theoretically propelled policy-reform concepts and agenda easily gain the attention of African governments because the former contain financing and technical assistance packages, accompanied by donor promises to see them through to implementation. Moreover, some of the reforms are implemented by using "policy-based loans" in which the recipients agree to implement the programme in accordance with specific conditionalities as reasoned by lending institutions (Bavon 1998). This approach leaves little time or room for proper planning and involvement of local institutions, such as civil society organizations and research institutions, which ideally ought to influence the setting of the health sector reform agenda. Therefore, donor influences play a critical role in the creation and sponsoring of most African health sector reform policy agendas and programmes.

Issues of concern here include how to create collaborative and cooperative endeavours among national and international research institutions to better inform problem identification and definition, and eventually the agenda setting; and how ministries of health can work more closely with local research institutions to identify the relevance of the universal systemic agendas with a view to taking their most appropriate components for improving the performance of the health sector. Another area of concern is how relationships among international centres of excellence and national research institutions can be built. Finally, it is important to figure out how the policy makers and concerned communities can participate in creating well informed and relevant reform concepts and agendas, which derive support from national and sub national institutions and communities. The practice in most African countries is that global/universal institutions such as WHO, UNICEF and the World Bank impose the logic of existing global knowledge. This logic is offloaded to less knowledgeable and unprepared national policy makers, who, without much analysis, adopt the global sponsored policy recommendations, often in a bid to respond to novel universal ideals and loaning conditionalities.

For sustainable development to occur, existing universal science and experiences should inform and augment nationally based centres of excellence, which should in turn inform national and sub national level problem identification, definition and agenda setting for health sector policy reform. More appropriately, various domestic interests and research centres should critically inform the creation of domestic systemic agendas, which should in turn transform such information into national and sub national institutional agendas for reform. This may result in sustainable development (Pretty 1995). Various levels of participation, especially at the level of self-governance, partnership and execution, can help to realize this missing dimension (see Figure 2).

Involving Various Communities From Policy Agenda Setting to Reform Programme Execution

It is almost taken as a universal truth that popular involvement at the various stages of the health sector policy reform will enhance implementation and sustainability. Agenda 21 of the 1992 UN Conference on Environment and Development in Rio de Janeiro puts emphasis on consultation, citizen empowerment and delegation of authority because it is believed that:

> ... if people are not brought into focus through sustainable development, becoming both architects and engineers of the concept, then it will never be achieved (Redclift 1992).

The concept of popular involvement has various meanings for different individuals. In our case it means decentralization of power and responsibility delegation, even in executing programmes. It can be passive when the intended beneficiaries are onlookers expecting to be given the "fruits" of the policy programmes or to persevere in the face of negative impacts of a programme.

There are various levels of involvement as summarized in figure 2. At a minimum, involvement means informing those who are likely to be affected by the policy programme. At its best, involvement assumes a situation in which people are self-mobilizing, taking initiatives to identify priority problems inhibiting their well being and creating and executing policy programmes. They enter into contracts amongst themselves and with external agencies to address their priority problems. The ultimate goal of involvement needs to be a departure from a situation in which local people and researchers are passive observers or recipients of information about the current reform policy programmes to a state of affairs in which they become active participants in the production of reform policy programmes.

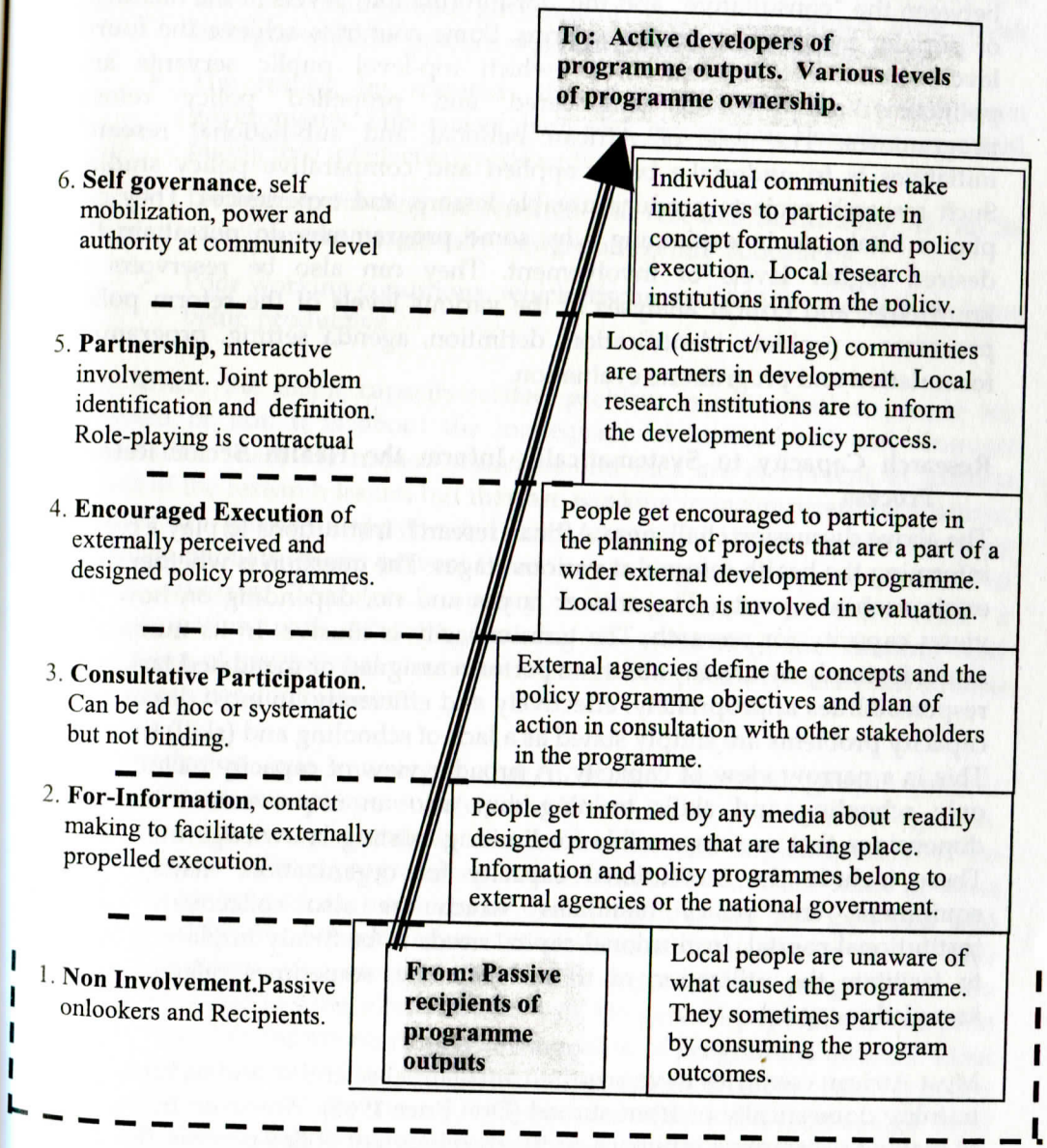


Figure 2: *A Hierarchy of Levels of Involvement in the Reform Policy Process*

Most African health sector reform policy programmes lie somewhere between the "consultative" and the "for-information" levels in the hierarchy of popular involvement in the reforms. Some countries achieve the fourth level (encouraged execution), in which top-level public servants and politicians adopt donor engineered and propelled policy reform programmes. The role of African national and sub-national research initiatives is to undertake basic, applied and comparative policy studies. Such research projects produce useable lessons and experiences. They can play a vital role in explaining why some programmes do not attain the desired higher levels of involvement. They can also be reservoirs of knowledge and critical analyses at the various levels of the reform policy processes - problem identification, definition, agenda setting, programme formulation and programme evaluation.

Research Capacity to Systematically Inform the Health Sector Reform Process

The above discussion challenges African research institutions to play a role in informing the health reforms at various stages. The question is whether there exists such a capacity. The answer is yes and no, depending on how one views capacity for research. The term capacity is illusive. In its minimalist sense, it simply means the ability to perform assigned or mandated tasks and responsibilities appropriately, effectively and efficiently. In most discussions capacity problems are simply stated as a lack of schooling and (skill) training. This is a narrow view of capacity. A broader view of capacity includes not only schooling and skills training, but also an improvement in other dimensions that are responsible for limiting existing knowledge utilization. These include the institutional capacity for organization, management, equipment, and policy mandates, which are also collectively called institutional capital. Institutional capital needs to be firmly in place in order to facilitate the utilization of trained capacity, sometimes referred to as knowledge capital.

Most African countries have acquired substantial scientific and technological training domestically or from abroad (Don Price 1965). However, in the area of making substantive influence on the development policy process, there are problems that militate against such training. These problems include:

- The isolation of scientists from each other, from development practitioners, and from policy-makers.

- The centralization and concentration of African research capacity in a few universities and government institutions, which have weak linkages with the practice of development policy formulation.
- The feeling by scientists that they are ignored by their own governments. This makes them seek recognition elsewhere to avoid falling into intellectual mediocrity.
- Inadequate funding for research and research institutions, as can be seen from the perennially meagre budgetary allocations.
- Poor working conditions, which discourage African researchers from being productive.

In Africa, the major capacity-related problem is not whether people are trained or not; it is about the inadequacy of institutional and financial capacities. There are trained scientists, and they are competent to address most of the research issues, but they are working in incompetent institutions, which are grossly under funded, and whose mandates, regulations, and management structures prevent them from taking advantage of the skills of local scholars. Therefore, capacity building needs to shift from a preoccupation with schooling/training to enhancing the funding and provision of institutional amenities to create competent research institutions for researcher deployment.

In conclusion, one can argue that it is the universal/global systemic development concept sponsors (e.g. the World Bank) who form the agendas, which in turn predominantly inform the creation and implementation of the health sector reform programmes in most African countries. Most of what appears to be African institutional policy agendas are not informed and influenced by the domestic centres of excellence or community forces. This partly explains why most of the health sector reform programmes are centralized and lacking identification with the general population, except at the level of "for-information" and consumption of programme outputs. Most ordinary people in Africa are presented with health sector reform policy programmes based on external and national elite interpretations of local realities, rather than being influenced by indigenous perceptions at the sub national and community levels. This trend needs to be reversed. Research capacity enhancement in local institutions and stimulation of popular participation are key to such a reversal.

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State, Governance and Civil Society in Tanzania

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Introduction: Civil Society in Tanzania

In the quest for good governance the relationship between the state and civil society is very important. Since governance is concerned with the legitimacy of the public realm, civil society is relevant because it is the covenant that gives rise to the state. While civil society is composed of all citizens, with their rights and obligations, they are more effective when they are organised in civil society organisations.

This article traces the uneasy relationship between the state and civil society organisations in Tanzania during the single-party era. It then examines the reform decade of the 1990s by focusing on the relationship between the new wave of civil society organisations and their relations with the state. Particular attention is paid to the implications of state-society relations for good governance.

Defining Civil Society, State and Governance

Since it is non-military, the Tanzanian state draws its legitimacy from civil society, which is the covenant that gave rise to this State. It is a fact that is often forgotten, yet it is a reality that without the support of the majority of its citizens, the legitimacy of the state would be greatly undermined. Civil Society has been defined as "an arena where manifold social movements and civil organisations from all classes attempt to constitute themselves in an ensemble of arrangements so that they can express themselves and advance their interests" (Bratton 1989, 417). From this definition we can draw the important point that while citizens in their entirety, with their rights and obligations, make up civil society, they are only truly active and effective when they are members of social movements and civil organisations that

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