Technical approach paper

Sector wide approaches at critical times: the case of Bangladesh

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Sector wide approaches (SWAps) have helped countries like Bangladesh, Zambia, Ghana and Uganda shape government health policy, strengthen its implementation and make health financing more predictable and flexible. However, after initial successes, some of the mature SWAps are losing momentum. Some of the difficulties lie in coping with changes in the complex international aid architecture, where SWAp principles and instruments come under pressure from global initiatives, large scale project aid and vertical interventions.

Nowhere are the tensions and fatigue more apparent than in the largest and oldest health SWAp, the Bangladesh Health, Nutrition and Population Sector Programme. What happened in Bangladesh, and what are the lessons for other SWAp countries? This paper, based on issues highlighted by recent Annual Programme Reviews, attempts to explain what has limited the ability of the Bangladesh SWAp to deal with new realities and to focus on the health needs of the poor.

Many of the issues identified are not exclusive to Bangladesh; they do not lie in the SWAp model, but rather in its application. Through the case of Bangladesh, the paper emphasises the importance of keeping a constant watch on key SWAp principles, such as: government leadership, a realistic government health plan, commitment to adopt common review, reporting and monitoring systems, and continued efforts to provide external financing in ways that increase absorptive capacity. When fatigue sets in and problems emerge, SWAp partners need to look critically at themselves and ensure that their focus remains on the core SWAp principles and values.

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1. Introduction

Sector wide approaches (SWAps) were born in the early 1990s with the aim to rationalise and simplify what was considered at the time an overly complex aid architecture, where many projects, vertical interventions and donor-driven initiatives were fragmenting national health systems and undermining the role of governments. Since then SWAps have achieved much, and particularly in the early years. They helped countries like Bangladesh, Zambia, Ghana and Uganda shape government health policy, strengthen its implementation and make health financing more predictable and flexible.

But after those initial successes, some of the more mature health SWAps soon began to lose momentum. In some cases it was because former "champions" of the SWAp had moved on and left a certain leadership vacuum, but more often it was because of pressure from the external health policy and financing environment. This includes new global health initiatives or large disease-specific interventions do not fit in easily with Codes of Conduct and other similar SWAp arrangements. For example, there are reports of fatigue, and of difficulties in coping with change in the increasingly complex international aid architecture among some of the older SWAps in Africa.[1]

Nowhere are the tensions and "fatigue" more apparent than in the largest and oldest health SWAp, the Bangladesh Health, Nutrition and Population Sector Programme (HNPSP). The continued existence of stand-alone projects and the new global health initiatives, combined with weak leadership and loss of momentum have delivered a serious blow to the implementation of the Bangladesh HNPSP.

However, the SWAp remains the best, if not the only option for the sector programme to get back on its feet. By looking at the Bangladesh example, this paper emphasises the importance of keeping a constant watch on key SWAp principles such as the need for government leadership, the importance of a realistic government health plan, the commitment to adopt common review, reporting and monitoring systems, and the continued effort to provide external financing in ways that increase absorptive capacity.

2. The origins of the Bangladesh SWAp

In Bangladesh the SWAp is known as the Health, Nutrition and Population Sector Programme (HNPSP). To be precise, the HNPSP is the composite five-year programme and financing framework around which SWAp arrangements work. The HNPSP was formulated to ensure that government action and resources made a cost-effective contribution to the priority health needs of the poor, particularly women and children. The first Health and Population Sector Programme started on 1 July 1998 (the Nutrition component was added in 2003), and the current HNPSP is expected to be completed by 2010.

The country's great efforts in developing a sector wide development programme were guided by the recognition that the existing system was not well suited to deliver integrated health services. The structure of the Ministry of Health and Family Welfare (MOHFW) had developed through many years of project-based funding, and through the influence of the cadre system in the civil service. For example, with much urging from donors the government had created a separate establishment, with a separate cadre of civil servants, for delivering family planning services. This Family Planning Directorate had also started to provide maternal and child health services, thus creating duplication as well as rivalry between the health and family planning cadres. The system was highly inefficient.[2]

Ten years from its launch, the Bangladesh SWAp (or HNPSP) has achieved much. It has shaped and strengthened government health policy and supported its implementation, technically and financially. It has also rationalised and simplified external health financing, making it more flexible, aligned and predictable than in the past. This has been accomplished mainly through the establishment of a large "pooled fund", financed both by government and development partners. It has also greatly improved

[1] V. Walford (2007) A review of health sector wide approaches in Africa. HLSP Institute. http://www.hlspinstitute.org/files/project/164292/AfricaSwaps07.pdf

[2] DFID Health Resource Centre (HRC), (2001) Development of administrative and financial management capacity for sector-wide approaches (SWAPs): the experience of the Bangladesh health sector. http://www.sti.ch/fileadmin/user_upload/Pdfs/swap/swap135.pdf

working relationships between the government and its development partners. Similar results have been reported from sector programmes in other countries, such as Ghana[3], Mozambique[4] and Uganda.[5]

On a less positive side, there remain some questions about the effectiveness of the Bangladesh SWAp in bringing about the much needed organisational and governance reforms in the MOHFW. This has been a primary objective of the sector programme from its early stages, which successive governments have been unable (or unwilling) to achieve. Other substantial issues and concerns have been identified in the course of two consecutive Annual Programme Reviews (APR) of the HNPSP, in 2006 and 2007. APRs are the established joint review mechanisms of the Bangladesh SWAp, and are undertaken with the assistance of external consultants who review progress against objectives and milestones. Many of the problems identified in 2006 and 2007 boiled down to lack of implementation capacity, but others appeared to affect the very foundations of the HNPSP.

On the government side, the APRs found lack of leadership and programme ownership, weak financial management practices, inadequate planning instruments, limited expenditure of pool fund resources. Significantly, there was little evidence that the HNPSP was filling in capacity gaps or resulting in more and better services for the poor.

As for development partners, the APRs noted how their erratic behaviour was negatively affecting the SWAp. Some formerly "pro SWAp" partners seemed to be revisiting a possible return to project aid because of the government's poor performance. Other partners, traditionally less committed to the SWAp (but nevertheless participating in SWAp meetings, and ostensibly supporting harmonisation and alignment principles) in practice continued to do things in their own way. So they were setting up (often incompatible) financing, planning, monitoring and reporting systems, which weakened government capacity to lead the health sector and increased transactions costs.[6]

The situation of the Bangladesh SWAp is not unique – as mentioned earlier, SWAp "fatigue" is affecting other countries. So what happened in Bangladesh, and what are the lessons for other SWAp countries? Specifically, what has limited the ability of the Bangladesh SWAp to cope with emerging realities and to focus on health services and health outcomes for the poor?

This paper is structured around some key SWAp principles: consensus around the government health plan (Section 3), government leadership (Section 4), effective policy dialogue (Section 5), common review, reporting and monitoring systems (Section 6) and the provision of external financing in ways that increase absorptive capacity (Section 7). It begins by looking at a fundamental component of any sector wide approach: the existence of a health sector plan that enables the targeting of resources to priority needs and interventions.

3. A health strategy, with consensus around it

At the basis of a SWAp there should be a health plan, strategy or programme, defined and led by government, which development partners agree to support. In Bangladesh, the formulation of a national health policy was a major political challenge. Discussion around major issues (e.g.: What proportion of services would government provide? What would be the role of government – provider or purchaser/regulator?) and conflicts of interest with and within powerful groups (such as the physicians, and family planning workers) kept delaying and blocking the process. In the absence of a formalised health policy, five-year development plans (mostly guided and supported by the international development partners) formed the basis of the policy direction.[7] This is why the SWAp in Bangladesh is known as the five-year Health, Nutrition and Population Sector Programme (HNPSP).

[3] E. Addai (2005) How far or how fast? Experience from the Ghana health SWAp. http://www.spa-psa.org/resources/2005/GhanaHealthSWAp.pdf
[4] J. Martinez (2006) Implementing a sector wide approach in health: the case of Mozambique. HLSP Institute. http://www.hlspinstitute.org/projects/?mode=type&id=100615
[5] C. Örtendahl (2007) The Uganda health SWAp: new approaches for a more balanced aid architecture? HLSP Institute. http://www.hlspinstitute.org/projects/?mode=type&id=178485
[6] In 2005, the Centre for Policy Dialogue in Dhaka reported more than 250 donor missions each year, with the government dealing separately with 74 development partners and with literally thousands of bilateral Memoranda of Understanding.
[7] DFID HRC, 2001.

There are reasons to believe that the planning instruments that jointly make up the HNPSP are not robust enough to enable either priority setting or targeting of resources. For example:

Too many planning documents …
The HNPSP is made up of several planning documents: the Strategic Investment Plan (SIP), the Project Appraisal Document (PAD) and the Revised Programme Implementation Plan (RPIP).[8] On the basis on these documents the MOHFW prepares annual Operational Plans. The problem is that SIP, PAD and RPIP often include different objectives and priorities, to the point that they cannot be considered to complement each other. This leads to confusion at the time of defining operational priorities and reviewing progress.

Too many objectives …
The PAD alone consists of six sector performance objectives, seven long term strategies, nine policy responses and five objectives to accelerate progress towards the Millennium Development Goals. When all these higher level objectives and strategies are disaggregated, they result in such a long list of operational objectives and interventions that programme priorities are blurred. A similar problem affects the SIP, which discusses a mixture of interesting policy options and reforms without clearly stating which ones enjoy government commitment, and which ones are simply proposals for discussion. Consequently, the HNPSP tends to be regarded as "everything and anything" that a health sector should be doing, and planning documents become too broad and unspecific.

… an impression of poor performance
The broad, ambitious scope of the HNPSP has negatively affected programme implementation and monitoring, as well as the relationship between the government and its development partners. Problems arise from the difficulty to visualise (and agree on) the priority interventions of the HNPSP, and from the fact that, given such a broad framework, the MOHFW (as implementing agency) can be easily found to be underperforming. The impression that the HNPSP is performing poorly in many areas (though not always true) has had a detrimental effect on MOHFW staff morale. Things would be easier if the HNPSP had fewer operational priorities that can be used for monitoring purposes.

Ownership issues
Generally, the perception is that the drafting of the HNPSP between 2003 and 2005 was rushed through, became dominated by consultants and coincided with an all time low in the relationships between government and development partners.[9] Even though HNPSP documents (PAD, SIP and RPIP) were *agreed* and signed by the government, the commitments in those documents were neither fully understood nor endorsed as firm policy commitments. As a result, many senior officers (including the 35 Line Directors charged with HNPSP implementation) are not familiar with the basic programme documents and do not see the HNPSP as their core responsibility. These issues were summarised in the 2006 and 2007 Annual Programme Reviews:

> *"It was remarkably difficult for the APR team to get a notion of what are the key strategies that the current GOB intends to prioritise right now among the many potential policy initiatives that are contained in the policy documents, particularly in relation to components 2 and 3 dealing with the emerging challenges and with reforms." (2006 APR)*[10]

> *"An overly ambitious programme with too many objectives linked to a poor definition and prioritisation of strategies and initiatives to be pursued by the programme. Nowhere is this more apparent than in the area of policy reforms, where senior officers remain either unengaged or even antagonistic to seriously undertaking key policy initiatives included in the SIP and RPIP …" (2007 APR)*[11]

[8] The SIP is a government policy document, while the PAD is the document prepared by the World Bank to finance the HNPSP.
[9] Towards the end of the previous sector programme, a serious falling out between the Bangladesh government and its health development partners caused substantial disruption in HNPSP funding. The trigger was the last minute refusal of the government to implement a key policy decision to merge the Health and Family Planning directorates. This situation negatively affected the workings of government and donors during the design of the present HNPSP.
[10] J. Martinez (April 2006) "Programme implementation and monitoring arrangements within the HNPSP" in: Annual Programme Review 2006 of the Bangladesh HNPSP, p. 10.
The APRs and other relevant documents are available at http://www.hnpinfobangladesh.com/
[11] Tawfiq-e-Elahi Chowduri (April 2007) "Health sector management and institutional issues" in: Annual programme review 2007 of the Bangladesh HNPSP. Main consolidated report, p. 31.

In conclusion, the planning documents that jointly make up the HNPSP and the basis for the SWAp are not sufficiently operational, do not guide the investments of either government or development partners, and result in a programme where development partners can continue to fund their own interests and priorities since anything and everything can be claimed to be part of the HNPSP. The 2007 APR team recommended that a limited, smaller number of critical areas in the plan should be highlighted to provide higher focus and increased concentration of efforts and resources in the remaining years of the HNPSP. This would seem a wise recommendation.

4. Government leadership

Another issue linked to the weak planning framework is the lack of leadership among the senior level cadres of the MOHFW responsible for HNPSP implementation. In fact, this is just the visible tip of a larger iceberg – poor governance and entrenched corruption within the government of Bangladesh.[12] These issues have been often brought to the attention of SWAp partners, as in the 2007 APR:

> *"Nothing is more evident … than the lack of committed leadership to carry HNPSP forward. The Independent Review Team has confirmed many issues of great concern that were already hinted or mentioned in earlier reviews. These include … the lack of common purpose & teamwork among Line Directors (LD)[13], leading to loss of institutional memory, poor accountability and a mismatch of competencies. This has been further exacerbated by the high turnover of staff at all levels, but primarily among Line Directors – 28 LDs out of 35 LDs have been transferred since the last APR ..."*[14]

Lack of leadership means, for instance, that: it is unclear who is in control of the programme or who should make decisions; that important issues remain unresolved for long periods of time; staff turnover among senior managers is high, so programme implementation is discontinued and delayed; responsibilities for HNPSP implementation are in principle assigned to line directors, but no one is made accountable for performance due to weak internal management practices and control measures; and HNPSP coordination meetings are poorly prepared and follow up is often absent.

5. Policy dialogue in the SWAp partnership

The concerns related to weak planning and leadership described earlier are not unusual. Virtually all health sectors face similar issues at one point or another, and that is why all SWAps need structures and processes for effective dialogue and problem solving among partners. What are the mechanisms for dialogue in the Bangladesh SWAp, and how effective have they been in ensuring mutual engagement, accountability and the positive working environment that characterises a partnership?

The mechanisms for dialogue

The 2006 APR noted that mechanisms for dialogue had been in place in previous phases of the health sector programme, but were then abandoned.[15] Without effective, well defined mechanisms the SWAp failed to deal with emerging issues at the critical time of the HNPSP launch, and this resulted in many problems piling up and being left unattended. It also meant that annual reviews contained several unresolved issues linked to poor follow up of recommendations from previous annual reviews.

Absence of effective mechanisms for dialogue did not preclude development partners and government from talking or meeting – on the contrary, bilateral, one-to-one meetings between MOHFW officers and development partners increased. The SWAp, however, lost the chance to discuss sector issues jointly and regressed to the pre-SWAp practice of holding a large number of one-to-one issue-specific meetings. This has eroded the sectoral dimension of the HNPSP and negatively affected

[12] In 2006 and 2007 Transparency International rated Bangladesh among the top five most corrupt countries in the world. In March 2007 the Bangladesh Caretaker Government arrested the previous Health Minister on several corruption-related charges.
[13] Under the HNPSP, 35 Line Directors are responsible for the 38 Operational Plans prepared every year.
[14] Independent Review Team of the 2007 Annual Programme review of the Bangladesh HNPSP. Main Consolidated Report, 16 April 2007, page 31.
[15] The HNPSP documents included a single mechanism for dialogue called the "HNP Forum" which comprised too large a number of stakeholders to enable meaningful discussion. No other mechanisms for regular engagement or coordination at more senior level had been defined.

communications, not to mention the resulting exponential increase in transaction costs (see Box 1). During all this time development partners met regularly in their Consortium meetings, but the effectiveness of such meetings was compromised by lack of collective engagement with the main SWAp interlocutor, the MOHFW.

Box 1: Two perceptions of "aid effectiveness" and transaction costs in Bangladesh

Government of Bangladesh perspective	Development Partners perspective
• 250 donor missions each year • Economic Relations Division (ERD) deals with 74 different development partners • Donor behaviour reflects "disbursement" imperative" rather than an "aid effectiveness imperative" • Lack of communication between Local Consultative Group (LCD)[16] and its 21 sub-groups • Lack of coordination	• Deficiencies in Public Financial Management system • Low aid absorptive capacity due to weak governance • Lack of capacity to identify the country's need for aid • Difficult to reach an agreement on how to align support based on the Poverty Reduction Strategy Paper

Source: Centre for Policy Dialogue, Bangladesh, 2005.

Quality of dialogue – calling a spade a spade

It is encouraging to note that the Government of Bangladesh and its development partners quickly reacted to the issues raised in the 2006 APR and set up two mechanisms for dialogue. One of them, the Health, Nutrition and Population (HNP) Forum, has met only once each year and not quarterly as planned – surprisingly, considered the number of areas where SWAp partners ought to exchange information. The second one, known as the HNPSP Coordination Committee, enables engagement among a small number of development partners (usually two representatives) and senior MOHFW officers. The Coordination Committee has met more regularly, which has contributed to unlocking the programme implementation paralysis reported in the 2006 APR.

What now needs to improve, according to the 2007 APR report, is the *quality* of the engagement, which should move from "formal and diplomatic" to "informal and business-like". For instance, in 2007 it was reported that many day-to-day issues of great significance (delays in procurement, lack of progress on key reforms or on follow up for previous decisions) were either superficially discussed or even "brushed under the carpet" in coordination meetings.

There is, however, a second reason why effective coordination meetings in the SWAp are needed: because certain "policy reforms" contained in the HNPSP documents exist only on paper and are not visibly endorsed by senior ministry officers. This is well illustrated by a contentious issue in the HNPSP agenda: the setting up of a Management Services Agency (MSA) within the MOHFW to enable the contracting of private health providers. The delay of more than two years in establishing the MSA is the sign of a much deeper (and contested) policy issue – whether private providers should be funded from the government to deliver public services.[17] Development partners have raised many questions about the MSA delay (some interpreting it as antagonism to the idea of private sector engagement), but the more fundamental policy debate about the role of private service providers has been sidelined. Instead of docking this issue and fighting over the contracting of the MSA, should not the Bangladesh government and its partners hold a deeper debate about it? Is this not what a true partnership like a SWAp should do? But how can it be done when there are no effective mechanisms for policy dialogue?

An opportunity has been missed here, that of arguing a policy issue as partners in a SWAp should do, openly, with technical backing, and perhaps looking at alternative options. In conclusion, SWAps (and programmes more generally) need effective structures and arrangements for mutual dialogue. This can also help to overcome the tendency to avoid problems rather than confront them.

[16] The LCG consists of the Bangladesh-based representatives of bilateral and multilateral donors of the Bangladesh Development Forum and the ERD Secretary, representing the Government.

[17] The Bangladesh government does not have an explicit policy against the involvement of the private sector in delivering public services in areas where the latter offers a comparative advantage, but internal resistance from parts of the MOHFW tends to reinforce that impression among external observers.

6. Focus on results: effective sector monitoring

Poor dialogue, weak leadership and inadequate planning all limit considerably the effectiveness and potential of sector and programme monitoring. This section describes how two important monitoring instruments, the Annual Programme Reviews and the Results Framework, are affected.

Annual Programme Reviews
It is to the credit of HNPSP stakeholders that annual programme reviews (APR) have been held every year (i.e. twice since the HNPSP was launched in 2005).[18] Unfortunately, the momentum that these exercises generate is quickly lost, partly because government implementation is weak, but also because the lack of systematic follow up means that capacity problems become deeply rooted in the system. We would argue that if government and development partners, through their established arrangements (coordination committee) reviewed commitments on a more regular basis and were open and frank about lack of progress, this would place additional pressure *on both parties* to do something about it. Instead, APRs deliver predictable, very similar results and issues every year. Many of them remain unattended either because there is no follow up, or because they are too complex to be resolved.

Raising many issues during every APR is not necessarily good for programme implementation or for staff morale. In fact, the opposite could be argued, as APRs conducted in this manner give the impression that little is moving, that the HNPSP is failing, and that the issues are so complex that they will never be resolved. For APRs to become the management tool that they are meant to be, they should enable *a selective review of a limited number of issues and of previous commitments in greater depth*. In other words, APRs should be shorter, simpler, sharper and deliver fewer, but feasible, recommendations.[19]

Bangladesh should thoroughly review the focus, scope and use of annual reviews, emphasising their learning dimension, reducing the numbers of external consultants and the scope of their terms of reference, and sharpening the focus of the annual exercise. This may mean sacrificing scope for focus, but when implementation capacity is low, the last thing an APR should deliver is long list of recommendations – this will make matters worse. In any case, APRs should not be the equivalent to annual evaluations, where anything can be put under the lens of the reviewers.

The Results Framework
Like any other sector programme, the HNPSP has a series of indicators, milestones and targets that jointly make up the so called Results Framework. Unfortunately, in the first two years of the programme the stakeholders have not been able to make much use of the monitoring framework, which the 2006 APR described as “overly ambitious, complex and, for the most part, un-measurable”.[20] In fact, two separate monitoring frameworks are included in the Project Appraisal Document: one, known as the *Results Framework* and comprising 62 indicators, and another, known as the *Logical Framework for HNPSP*, with 90 indicators. Three issues stand out as highly unusual in the context of a SWAp:

- The existence of two separate monitoring frameworks – the Results Framework “to be used by the International Development Association (IDA)” and the logical framework, to be used “by a majority of the development partners in the HNP Sector for monitoring and evaluating their support to HNPSP”.[21] It is not clear why the IDA should require a separate framework. In any case, the Results Framework is the one which prevailed and is in use.

- Both frameworks are defined to serve the monitoring needs of the IDA and the rest of development partners – but SWAp-related monitoring frameworks are usually expected to serve mainly the needs of the implementing agency (MOHFW), and to unify and strengthen reporting and monitoring arrangements.

[18] There have been three APRs since 2005; the last two have focused on the present HNPSP, while the first, in 2005, looked at the lessons from the previous sector programme. In terms of programme issues and weaknesses the three APRs have delivered similar findings.
[19] The fact that APRs deliver many recommendations partly results from the use of many consultants and the broad scope of the review, but it is also a weakness of development partners who see APRs as a means to push as many recommendations as possible to serve their individual priorities and “hobby horses”.
[20] S. Schmidt (April 2006) “Monitoring and evaluation and management information systems of HNPSP”. Independent review of the HNPSP at the 2006 APR.
[21] World Bank (2005) Bangladesh Health Nutrition and Population Sector Program. Project Appraisal Document. Report n. 31144-BD. Annexes 3A and 3B.

- The extraordinarily large number of indicators in both frameworks, many of which are for annual reporting. This involves levels of effort and volumes of resources (for collection and analysis) that exceed what a developing country can afford, and seriously compromises the feasible use of the frameworks as monitoring tools.

These issues are highly significant and help to explain the limited use of the HNPSP monitoring frameworks to date. There are also other problems. For example, implementation of the Results Framework is seriously compromised by the fact that the Health Information System cannot routinely provide information on many of the indicators included in the Framework. In addition, in 2007 baseline information was not available for 42 out of the 62 indicators and for 35 of the there was either no progress, or no information at all.[22] At the same time, both the MOHFW and development partners lack qualified staff to put the results of a monitoring framework in context. If indicators are not interpreted, their value is limited.

There are clearly some fundamental flaws in the sector monitoring process. This is the issue that SWAp development partners could address in a more constructive and developmental manner, targeting their capacity building efforts to build a monitoring culture both within the HNPSP and the MOHFW more generally.[23]

7. Health financing

In Bangladesh the health SWAp has made highly significant contributions to the process of rationalising the aid architecture.[24] For example:

- A pool fund was created to better support the MOHFW budgeting and accounting processes. Under the current HNPSP the pool fund totals an estimated $750 million over five years.[25] This represents about half of total funds committed to HNPSP by development partners, or 18.7% of the total HNPSP budget of $4 billion. The government share of the HNPSP budget represents about 66% of the total.

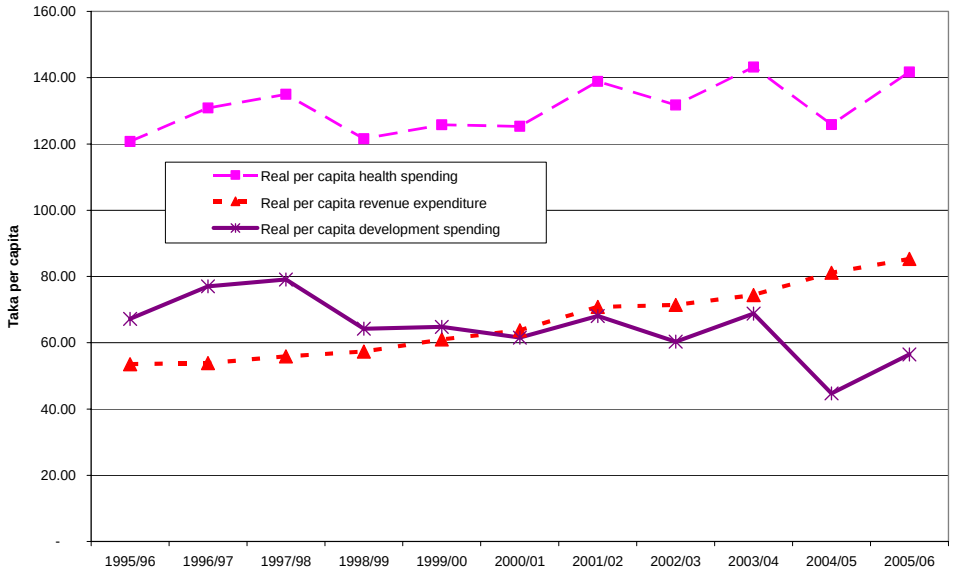
- Development partners provide an estimated $659 million through what is known as “parallel funds”, that is, bilateral, direct support to national programmes and specific initiatives. It is worth noting that parallel support relates to project type interventions which use off budget financing arrangements channelled through separate accounts, even if these funds are “on plan” (i.e. reflected in the HNPSP accounts).

- Budget preparation, forecasting and reporting on expenditure within the MOHFW have improved in recent years, but not to a sufficient extent, and financial management practices remain extremely weak. However, instruments such as Public Expenditure Reviews, National Health Accounts, Medium Term Budget Frameworks and Benefit Incidence studies have allowed greater transparency on how resources are allocated and spent, and on who actually benefits from public subsidies.

Has health financing increased?
The impact of the SWAp has been less noticeable in terms of increasing overall expenditure on health. Thus, while SWAps are not necessarily about getting more resources – the aim is to use all available resources more effectively – the assumption is that better performance should be rewarded with additional resources. This was the approach in earlier versions of the HNPSP (i.e. before 2003), where development partners were putting money in as government spent money out. Such trend seems to have suffered in recent years, with substantial fluctuations in health spending, and a slight upward trend (see Figure 1). Such fluctuations seem to suggest lack of commitment for health, and a need for an agreed, government wide Medium Term Expenditure Framework (MTEF).

[22] APR 2007.
[23] For a more detailed discussion on this topic, see the Bangladesh country note included in the CD-ROM “Performance monitoring frameworks in the health sector” (HLSP Institute, 2007).
[24] In preparing this section the author is indebted to Tim Ensor and Joe Martin for their reports in the 2007 APR.
[25] Figures and percentages included in this section have been rounded up, in part because the budget is calculated and accounted for in Taka, and the US$ equivalent changes with currency fluctuations.

Figure 1: Evolution of real per capita funding



Source: Ensor 2007

Has health sector budgeting improved under HNPSP?

HNPSP expenditure is financed from two budgets: the Development Budget and the Revenue Budget. The Development Budget was originally intended to finance investments, and the Revenue Budget to finance recurrent costs. However this distinction has been lost over time, with the Revenue Budget financing mainly (but not only) recurrent expenditure from the government's domestic resources and the Development Budget financing both recurrent and investment expenditure from both government resources and development partner contributions. To date, the contribution of development partners to the government budget has been managed only through the Development Budget, despite making a significant contribution to recurrent costs.

This dual budgeting system, common in several South Asian countries, would not be an issue except for the fact that it results in two completely separate and parallel structures and processes for budgeting and expenditure tracking within government. This results in the practical impossibility to deliver integrated and complementary budgets at central level and in the sectors. Dual budgeting is also responsible for the difficulty among senior and mid-level managers in the MOHFW (Line Directors and their Programme Managers) in integrating resources from both budgets within the national programmes they manage.

In conclusion, the HNPSP has not yet achieved the intended improvements in health sector budgeting that would enable improved and more complementary use of resources to strengthen programme implementation.

Expenditure tracking

More than a decade after the health SWAp was launched *"obtaining consistent estimates of HNPSP spending is surprisingly difficult ... What is clear from the figures* (see Table 1) *is that the development partner spending (2005/06 and first quarter of 2006/07) is much lower than planned".*[26] However, figures on actual spending in the financial management reports (prepared by the government's Financial Management and Accounting) are substantially different from those reported in individual reports from line directors.[27] This makes it extremely difficult to assess spending within each operational plan, which in turns prevents the assessment of performance by individual line directorates. Similar problems are encountered when assessing expenditure by central, district and block level health units. Therefore, it remains remarkably difficult to link inputs to outputs and to assess performance on individual units within the MOHFW.

[26] T. Ensor (March 2007) Technical Report: Health Economics & Financing, in: Health, Nutrition and Population Sector Programme, Annual Programme Review 2007. Technical Annex, p. 166.
[27] While these mismatches have never been linked to corrupt practices, they do portray weaknesses in financial management that could lead to corruption.

Table 1: Spending on HNPSP against RPIP plan (Taka million)

	2003-05	2005-06	2006-07	2006/07 Qtr 1 [1]	2007-08	2008-2010	Total
Revised PIP Budget (Taka million)							
Revenue	31,212	20,630	23,106	5,777	25,878	61,445	162,271
Development	17,685	31,730	30,473	7,618	32,341	50,003	162,232
a. core services	17,685	29,068	27,277	6,819	27,220	36,850	138,100
Dev - GOB	6,369	10,224	11,171	2,793	10,915	12,547	51,227
Dev - DP	11,316	18,844	16,105	4,026	16,305	24,303	86,873
b. Accelerated services	-	2,156	2,505	626	2,494	5,166	12,321
Dev - GOB		101	128	32	155	332	716
Dev - DP		2,055	2,377	594	2,339	4,834	11,605
c. New Investment	-	506	691	173	2,627	7,987	11,811
Dev - GOB		67	110	28	253	1,924	2,354
Dev - DP		439	581	145	2,374	6,063	9,457
				-			-
Dev - GOB	6,369	10,392	11,409	2,852	11,323	14,803	54,297
Dev - DP	11,316	21,338	19,063	4,766	21,018	35,200	107,935
							-
Total	**48,897**	**52,360**	**53,579**	**53,579**	**58,219**	**111,448**	**324,503**
Actual expenditure (Taka million)							
Revenue	31,513	19,042		5,815			56,370
Dev - GOB	4,948	5,405		159			10,512
RPA	-	1,354		9			1,363
DPA	5,115	4,797		153			10,065
Total Development Partners	5,115	6,151		162			11,428
Total development	10,063	11,556		321			21,940
Total	**41,576**	**30,598**	**-**	**6,135**	**-**	**-**	**78,309**
Actual/Planned							
Revenue	101%	92%		101%			
Dev - GOB	78%	52%		6%			
DP	45%	22%		3%			
Total	**85%**	**58%**		**11%**			

[1] Assumed budget for quarter is annual budget divided by four. Source: Ensor 2007

Has pool funding worked?

The HNSP's teething problems, combined with weak leadership and implementation capacity in the MOHFW, have resulted in low expenditure in the HNPSP pool fund in 2006 and 2007. This has sent signals to development partners who contribute to the common fund – perhaps to reconsider earlier commitments to pool funding in favour of larger amounts of project aid.

The pooling of funds does not guarantee increased disbursement rates, but it would be a serious mistake to undermine pool funding on the basis of two consecutive "bad years". Hesitating development partners should perhaps be reminded that pool funding is the government's choice for sector financing (as stated in SIP, PAD and RPIP documents) and that its potential for improving government health systems and for building sustainable capacity is incomparably greater than project aid.

Is parallel funding supporting HNPSP objectives?

In Bangladesh "parallel funding" is the term used for project type aid delivered and administered directly by development partners, and reflected in the HNPSP budget. The assumption is that this form of project aid, which many regard as a legitimate alternative to pool funding, is "aligned" with and strengthens the HNPSP as a whole. But does it?

Current evidence from a recent study suggests that few parallel funded initiatives comply with the prerequisites for project aid to be considered aligned with government policy. Aligned project aid should, among other criteria, clearly contribute to one or more HNPSP objectives, it should be formulated transparently and complement the efforts of the government and other development partners, and implementation and reporting should follow the SWAp norms. Unfortunately, the study did not find much evidence that any of these criteria were being met: *"a general assumption that parallel funded activities in the health sector are aligned with the greater objectives for HNPSP is not based on any regular and/or systematic approval process for activities in the sector and/or on the collection of regular activity and financial information on a regular basis to permit this assessment to take place at appropriate levels"*.[28]

[28] J. Martin and Reza MM (March 2007) Bangladesh Health, Nutrition and Population Sector Program: Review of Parallel Support 2007. Draft, p. 5.

Indeed, many development partners tend to claim that their parallel initiatives are aligned. These claims are based on rather superficial scrutiny, which is encouraged by the broad and vague nature of the HNPSP planning documents, as discussed earlier.

The fact that parallel funding is legitimate does not necessarily make it the best option for financing specific areas of HNPSP. Analysts of the Bangladesh SWAp argue that while parallel funding provides increased flexibility to development partners "*the potential risk of preserving the financing of separate projects is that the sector-wide approach might be undermined and donor-driven projects continued under the veil of the overall sector program".*[29]

Finally, parallel funds are not the only threats to a more rational financing framework within the Bangladesh SWAp. As in other countries, the re-emergence of project aid has coincided with the advent of new global health partnerships and of macro-projects such as PEPFAR. While these have injected new cash into priority initiatives, they have also increased the pressure on weak health systems capacity and on sustainable financing models in ways that are yet to be fully understood. They have also probably distorted overall health priorities, though this can be hard to demonstrate.

8. Conclusions

In spite of undeniable improvements and contributions achieved over the years, the Bangladesh SWAp was found to be in poor shape by the Annual Programme Reviews in 2006 and 2007. These reviews point to a poorly managed health sector, where absorptive capacity of external and domestic resources is seriously compromised. They point to a poorly performing MOHFW, unable to exercise leadership and plagued with organisational, governance and functional limitations. Thus HNPSP objectives are not being achieved, and the intended focus on the poorest and more vulnerable remains unclear or has been lost.

Some observers have seen these problems and limitations as proof that the Bangladesh SWAp, or SWAps more generally, are failing to deliver on their planning, alignment and harmonisation objectives, and have called for a different approach to better cope with the complexities of the present day aid architecture. However, this call is neither backed by a plausible alternative to SWAps, nor based on a rigorous assessment of the realities and root problems faced by countries that adopted the sector wide approach.

This review of the Bangladesh experience, based on evidence from two annual reviews, has shown that the problems do not lie in the SWAp model, but in its *application*. In other words, whether or not a SWAp is in place, health sectors cannot deliver more and better services on the basis of poorly conceived health plans, just as they cannot resolve emerging problems through inadequate monitoring arrangements or through weak mechanisms for dialogue.

The main lesson is that "mature" SWAps need to look critically at themselves and ensure that the focus remains on a set of *core principles and values*, such as a realistic health plan implemented through government leadership and based on effective monitoring and productive policy dialogue. The responsibility for maintaining such focus is not, however, limited to government: development partners should place equal emphasis on increasing health financing as on ensuring that this is delivered according to harmonisation and alignment principles, in ways that strengthen (rather than weaken) sector capacity.

When faced with difficulties, SWAp partners should focus on helping the Ministry of Health re-take control of the sector. To achieve this, capacity building in selected parts of the Ministry of Health should become once again the centrepiece of the sector programme.

In the specific case of Bangladesh, additional efforts should be made, and specifically:

- Focus the health sector plan on a narrower (and clearer) set of sector objectives and priorities, particularly as sector governance and planning systems remain weak. A few essential, long overdue reforms may need to be put in place, but through more fluent policy dialogue, not pressure or imposition.

[29] K. Kostermans and P. Geli (2005) The Sector-Wide Approach in Action. Draft, p. 18.

- As a partnership, the Bangladesh SWAp needs to strengthen its structures for dialogue and mutual accountability. In fact, recent evidence suggests that these have been already strengthened and that working arrangements have substantially improved.

- The scope and scale of annual reviews (APRs) should be reduced and adapted, so that they can be the management tools that they are meant to be. Instead of unearthing the same problems every year, APRs should place greater focus and efforts on fewer, more targeted problems, and on the governance arrangements required to solve them, including capacity building within the MOHFW.

- The Bangladesh health SWAp should revisit and clarify its sector financing architecture, making every effort to accommodate the needs of global health partnerships and the expectations of individual donors, but recognising as well that a realistic financing scenario cannot be based on the principle that "anything goes". Thus, there is a limit to how much additional parallel funding a sector can accommodate – more than that will have a deteriorating impact on sector performance and governance. There is also a need to ensure that the pool fund truly supports sector priorities and people with greater health needs in a more transparent manner. The problem is not one of "pool" versus "non-pool" funds but one of ensuring that all funds and all donors support the government and its programme with equal commitment.

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Responsibility

The views expressed in this paper are those of the author, and may not coincide with and do not represent the views of any of the people or organisations cited in it.