Technical Paper

A review of health sector wide approaches in Africa

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This report documents current experience and lessons from health SWAps in Ghana, Malawi, Mozambique, Tanzania, Uganda and Zambia and analyses implications for national partner and donor engagement in the health sector.

The six countries examined all have the basic building blocks of a SWAp in place. However there has not been consistent progress in donor harmonisation and in the use of government systems for financial management over time. In several countries there is concern that the SWAp has lost momentum. The concern to make progress against the Millennium Development Goals has seen significant increases in total funding for health, but a levelling off or fall in the share of funding through SWAp-related mechanisms. The channelling of additional resources through targeted programmes has complicated the task of managing health sectors and implementing sector programmes. Meanwhile the shift of funding from earmarked funds for the sector (through projects or basket funds) to general and sector budget support also has implications for sector wide management arrangements. The report looks at the lessons from the implementation of SWAps in the context of these trends, and suggests how SWAp working can be reinvigorated and improved.

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Acronyms and abbreviations

CCM	Country Coordinating Mechanism (for GF)
DP	Development Partner
GBS	General Budget Support
GF	Global Fund to Fight AIDS, TB and Malaria
H&A	Harmonisation and Alignment
MDGs	Millennium Development Goals
MOF	Ministry of Finance
MOH	Ministry of Health
MTEF	Medium Term Expenditure Framework
PAF	Performance Assessment Framework
PEPFAR	President's Emergency Plan For AIDS Relief
POW	Programme of Work
SBS	Sector Budget Support
SPA	Strategic Partnership with Africa
SWAps	Sector Wide Approaches
TA	Technical Assistance
TC	Technical Cooperation
WHO	World Health Organisation

Executive summary

This is the report of a desk based review of current experience in implementing Sector Wide Approaches (SWAps) in health in Africa. It was commissioned by DFID and carried out in January-February 2007. This work involved a desk based review of country documents and other literature; and interviews with selected DFID staff and other key informants from development agencies.

The purpose of the work is to document current experience and lessons from selected existing health SWAps in Africa, and to analyse implications for national partners' and donors' engagement in the health sector. It focuses on six countries which have health SWAps: Ghana, Malawi, Mozambique, Tanzania, Uganda and Zambia. These countries were selected because of the length of their experience with SWAps and because of long term involvement of DFID in the sector.

The six countries all have the basic building blocks of a SWAp in place. They have (or are developing another) strategic plan for the sector. They have a multi-year budget or medium term expenditure framework (MTEF) that identifies how the strategy can be funded and financing trends (apart from Mozambique). They have processes for common management including arrangements for policy dialogue and regular reviews of progress led by Government; joint annual reviews and sharing of information. They have shared indicators for monitoring sector progress, although there is patchy availability of data for monitoring. They all have some form of basket fund or budget support arrangements in the sector so that Government has more control over sector resources. These are all characteristics of SWAps and demonstrate that they are a tool for, and consistent with, the Paris harmonisation and alignment agenda.

However there has not been consistent progress towards closer sector wide working and increasing use of government systems for financial management over time. In several countries there is concern that the SWAp has lost momentum. The growth in global initiatives and vertical programme support in health has meant that while countries have seen significant increases in total funding for health and a rising amount through baskets or budget support, there has recently been a levelling off or fall in the share of funding through these mechanisms (however, there is not data readily available to assess this for all countries). Among basket funds, several are earmarked to specific purposes and budget lines and are not fully aligned with Government systems. With the mix of instruments and approaches, there continue to be high transaction costs.

Looking at what has worked in SWAps, there have been tremendous improvements in **coordination** and information sharing. This has particular benefits in countries with many donors in the sector. There has been less progress in coordination of technical cooperation for capacity building, especially technical assistance (TA). Despite proposals to bring this under Government control with pooled funding, development partners (DPs) continue to identify, manage and fund most TA, but there are innovative arrangements to ensure Government is involved in defining needs and selection of TA. The perceived high cost and the administrative burden to Government, and DPs' interest in having 'their' TA used, deter moves to pooled TA.

The arrival of **new initiatives** will by definition not form part of sector plans and will bring a challenge to the sector programme. This can be managed, and the new resources integrated into SWAp processes: the integration of Global Fund (GF) support in Mozambique is a good example. However the substantial scale of new initiatives can also distract management and service delivery staff from the agreed priorities and sector working, and can undermine progress in other areas, in the context of human resources shortages that all the countries face.

The SWAp countries have shown increased **capacity** in areas such as planning and management. Most sector strategies address critical issues in the sector, and are increasingly linked to national development strategies. SWAps have been useful in highlighting failings in

the health system and identifying how to tackle these. The amount and allocation of resources within the sector are clearer than before, although some funding is not captured on budget. There remains room for improvement in costing of plans and clarity of funding. There are constraints in implementation, particularly limited capacity at district level and below in planning, management and service delivery, as well as poor flow of funds (particularly for non-staff costs) to these lower levels of service delivery.

It is difficult to demonstrate the **impact** of a SWAp, as opposed to the impact of the policies and plans, projects and programmes within it, and of the adequacy of funding for fulfilling the plans. The experience has been mixed with all countries showing some improvements but stagnation in some key indicators. This does not mean that SWAps do not work. Rather it reflects the nature of SWAps: working to develop the sector's systems in a sustainable way as well as supporting current service delivery. SWAps typically include a range of complex and politically difficult reforms that may not all proceed smoothly, and may face delays in implementation. The incentives facing staff involved in implementation may not encourage implementation of planned reforms. Changes in key individuals (particularly the minister of health) can have a radical impact on the commitment to implement agreed plans. And the system may still be under-funded, have shortages of health personnel, or lack the institutional capacity to deliver the planned improvements in performance of health services.

Lessons identified from this brief review include:

- The need to take into account the **political nature of reforms and policy implementation**, and the likelihood of opposition to reforms as a result.

- The need to anticipate and deal with **changes in personnel** in government and in DPs, since understanding, relationships and trust between partners are so key to SWAp working.

- The **change in skills and competencies** needed for SWAp working – the need for skills in public finance management and public sector reform as well as traditional health topics. Furthermore, SWAp working requires DPs to have more political sensitivity, negotiation and facilitation skills and collaborative spirit than an era of project design and management.

- Dealing with **transition in aid instruments** has been challenging for ministries of health; if donors move to budget support this needs to be planned among DPs to avoid too sharp a change, and prepared for in terms of budget negotiations. It also requires appropriate skills and stronger links between Health and Finance Ministries so they work more effectively together.

- All the SWAps have realised the need for wider **participation** in sector processes and have started to address this. There is however a tension between inclusiveness and ending up with vast numbers involved in meetings, which makes substantive dialogue difficult.

- Performance monitoring and indicators remain challenging – there is agreement on the indicators but often delays in producing the data to measure progress, while targets can be over optimistic. Intermediate output indicators, such as services delivered and public finance systems strengthened, are important in health since health outcomes are measured infrequently and are affected by many factors outside the health sector's control.

- The **time** taken in setting up health SWAps is substantial – for example Malawi's took 5 years and Uganda's 3 years. This reflects both time for developing a policy framework acceptable to all partners and for setting up management and accountability frameworks for basket funds or budget support. Then it takes several years to get SWAp processes working well. These stages place significant demands on Government administrative capacity, which need to be planned for and may need strengthening. Once the SWAp is

running, there is scope for streamlining and improving the processes, and all the SWAps have updated their processes with time.

Based on the previous sections and interviews, four types of follow up action are suggested:

- **Changes in expectation and behaviour of DPs.** To make the most of SWAps requires commitment from the partners to stay within the sector strategy and progress towards alignment. DP staff need a clear message from their central management that it is important to provide their support in ways that reinforce sector working and follow agreed codes of conduct. DFID and other like minded DPs could bring pressure to bear on the headquarters level of more recalcitrant DPs to do this. DPs also need to recognise the political nature of reforms and be prepared for difficulties in implementation. Finally, the skills and competencies for working in a SWAp are different and this could be reflected in selection, training and appraisal of DP staff who work at country level.

- **Country level actions** to address the need for strong sector working relationships and for focus on achieving sector results. This could include a mechanism for briefing/training new entrants to the sector on the sector programme process and content; more time spent building relationships among the partners; ensuring robust structures in the sector; and streamlining processes to both widen participation and create opportunities for strategic level dialogue among partners. DP compliance with codes of conduct and in key areas such as funding predictability could be assessed in annual sector reviews, as part of mutual accountability.

- Opportunities for **cross country exchange** among Government staff engaged in mature SWAps could be useful, to share experience on issues such as how to: streamline SWAp processes; incorporate civil society, Global Fund and others into sector programmes; or deal with increasing decentralisation. This could be coordinated by WHO or the Strategic Partnership for Africa (SPA).

- Possible **analytic work** to learn from experience on specific issues.

Four possible areas for further analysis are suggested:

a) How to get broader stakeholder involvement in health SWAps. This would look at what measures are already in place and what incentives and barriers there are to greater involvement of national stakeholders in sector processes. The stakeholders include ministries of finance and planning, civil society, and parliamentary and local government structures.

b) Understanding the politics of sector working and reforms. This would look at the underlying political and structural issues and incentives affecting sector working and implementation of sector strategies, and identify how best to work with these.

c) How to improve coordination and effectiveness of technical cooperation. In response to the finding that there is limited progress towards coordinated programmes of TC, it may be useful to analyse in more detail why this is the case, how to enhance and monitor capacity building, and learn lessons emerging from existing TA coordination and management arrangements.

d) Monitoring impact of Joint Assistance Strategies and DP commitment to sector working. This could be a prospective study that follows the impact of changing DP representation on sector processes as the Joint Assistance Strategies are implemented. At the same time it could monitor the way that DPs and global programmes are interacting with the sector and whether they are becoming more harmonised and aligned in practice. A more ambitious study could try to demonstrate the results from SWAps and sector processes.

A review of health sector wide approaches in Africa

1. Introduction

This is the report of a desk based review of current experience in implementing Sector Wide Approaches (SWAps) in health in Africa. It was commissioned by DFID and carried out in January-February 2007. This work involved a desk based review of country documents and other literature; and interviews with selected DFID staff and other key informants from development agencies. One purpose of this review is to identify whether further work would be useful.

The purpose of the work is to document current experience and lessons from selected existing health SWAps in Africa, and to analyse implications for national partners' and donors' engagement in the health sector. It focuses on six countries which have health SWAps: Ghana, Malawi, Mozambique, Tanzania, Uganda and Zambia. These countries were selected because of the length of their experience with SWAps and because of long term involvement of DFID in the sector.

The SWAp concept has been around in the health sector for some 10 years, since the publication of "A Guide to Sector-wide Approaches for Health Development" by Andrew Cassels in 1997. At that stage they were seen as a tool for improving aid effectiveness in contrast with projects: "The key assumption underlying … a SWAp is that governments will be in a better position to achieve sectoral goals – defined in terms of improving people's health – if development assistance is used to support nationally defined policies and strategies, rather than specific projects. SWAps therefore have a dual purpose. First to ensure policies, budgets and institutional arrangements are likely to lead to improvements in sectoral performance … Second to create the conditions which allow a different form of interaction between Government and donors." (Cassels, 1997, p 12).

Thus SWAps were an early move towards the objectives of increasing national ownership, harmonisation and alignment of aid, focused at the sector level. Since their introduction, this philosophy has become more widely adopted and extended through the Rome and Paris Declarations. The Paris Declaration promotes programme based approaches, which include SWAps – and has a target for 66% of aid flows to be delivered in the context of these by 2010. Thus the use of SWAps remains relevant and central to the aid effectiveness agenda which has been endorsed by all major bilateral aid providers.

Yet there are also concerns whether SWAps are contributing to better health. Some countries have shown little progress in terms of key indicators such as maternal and child mortality reduction, while progress on health sector reforms and programmes has often been slower than planned. The concern of funding agencies to make progress against the Millennium Development Goals (MDGs) has led to establishment of targeted funds and programmes for specific health issues, such as the Global Fund to Fight AIDS, TB and Malaria (GF), GAVI Alliance and PEPFAR[1]. These have brought additional resources but also complicated the task of managing health sectors and implementing sector programmes. Meanwhile the shift of some funding from earmarked funds for the sector (through projects or basket funds) to general and sector budget support has changed the way health sectors are funded. This paper was commissioned to look at the lessons from the implementation of SWAps in the context of these trends and to suggest how SWAp working can be reinvigorated and improved.

This report sets out findings from the work and identifies possible areas for follow up.

[1] PEPFAR is the President's Emergency Plan For AIDS Relief funded by the US Government and active in 4 of the 6 countries in this study (not Malawi or Ghana).

2. Status of the SWAps in the six countries

The countries included in this review include the 'mature' SWAps in health. Ghana and Zambia were the first to introduce this way of working in the mid 1990s, while Tanzania followed in 1999, Uganda in 2000 and Mozambique in 2001. Malawi is still in the early stages of implementation as it started in 2004, following a preparation phase of some 5 years.

The core ingredients of a SWAp are generally considered as:

- Government leadership in a sustained partnership;
- All significant funding agencies support a shared sector wide policy and strategy;
- A medium term expenditure framework (MTEF) or budget which supports the policy;
- Shared processes and approaches for implementing the sector strategy and work programme, including shared progress reviews and shared indicators of sector progress;
- Commitment to move to greater reliance on Government financial management and accountability systems.

Annex 1 summarises the current status against these ingredients, in terms of the processes in place, with the exception of the first which is hard to describe in process terms. It shows that each of the countries has the basic SWAp ingredients in place, with the exception of Mozambique which does not yet have a medium term funding plan for the sector strategy.

2.1 Shared sector wide policy and strategy

All the countries have a sector policy and medium term strategic plan or programme of work (POW) (Ghana is developing a third POW currently). This is an achievement in itself, although there remains a question of the quality of the strategies and work programmes, and how these can cope with emergence of new funding initiatives and other changes mid cycle. One quality issue is how realistic the strategies are – several have been criticised for having insufficient prioritisation and unrealistic targets. This is often in terms of having a minimum or essential health care package that would cost more than the likely funding levels available (e.g. Uganda, where funding of the first sector programme covered only a third of the planned sector programme expenditure), but has also been raised as an issue in Mozambique. Uganda tried to address this by defining a minimum package and a preferred package if more funds are available for its sector programme.

It is hard for countries to get the balance right, in terms of:

- being realistic about likely funding when donors are often unclear what they will provide in the coming 5 years, and both donors and government have a poor record of meeting their pledges;
- pressure from donors to provide “ambitious plans for scaling up”;
- domestic pressures e.g. to improve urban hospital services;
- pressure from international commitments and advocates as well as domestic interest groups to include particular services (such as antiretroviral treatment);
- the experience that new funding initiatives may come along with significant (typically earmarked) resources, for example, for malaria or AIDS;
- experience that it can help to raise funds if the plan demonstrates funding gaps.

Following the High Level Forum on the Health MDGs there is work underway on developing a common framework for assessing health sector plans. This could be useful for gaining consensus, but will not necessarily address the difficulty of realism in funding identified here. These difficulties are often compounded by the practical difficulty of costing plans.

2.2 A MTEF or budget that supports the policy

A critical role of the MTEF or budget is to show that the allocation of resources will support the strategies in the policy and sector programme. One of the aims in SWAps has been to get better coverage of resources for the sector included in the budget so that the picture on allocation is clearer. There has been progress in this direction in all countries with more reporting by donors of resources for the sector even if they are provided in a project format or in kind. For example in Tanzania, USAID has been reporting its support in detail to government which has helped to increase the completeness of the budget figures.

However all countries still find that there are resources which are not included in the budget. The application of budget ceilings to sector spending encourages donors to keep their resources off budget too. This may not increase the total allocation however - one reason given by the MOF for the stagnation in the budget allocation for health in Uganda was that there are so many off budget resources coming into the sector[2]. In Malawi, there is not yet a system working to draw together the information on resources provided, even when the information is made available.

2.3 Shared processes

A core process in the SWAps is an annual sector review. It is perhaps surprising to find that Zambia had the first such review in recent years in 2006 – apparently it was not seen as a priority given the other challenges facing the sector and limited capacity to take on this task as well. Annual reviews had been part of the process in the 1990s.

The intention of the sector reviews is both to provide a structured opportunity for performance to be reviewed and specific issues to be addressed, and for accountability for the resources used. There are usually in depth studies on particular issues as well as field visits that look at the reality on the ground. Whilst these have been useful as a forum for performance review and accountability to various stakeholders, a common issue is the large numbers involved in the annual review. For example, Tanzania had over 200 people in the 2005 review; this was reduced to 120 in 2006 but this is still too many for focussed dialogue on how to address important issues.

In addition there is often a problem that data on performance against agreed indicators, and on finances, is not available in time, as noted in Annex 1. This partly reflects the difficulty of measuring health outcomes (mortality rates are usually measured only every five years) but also reflects weaknesses in monitoring and reporting systems and in the choice of indicators.

There is a complex structure of working arrangements in each SWAp between development partners/donors and Government, sometimes involving others too. There is typically a regular sector meeting between the MOH and donors, at least quarterly and sometimes monthly, to review progress against the annual plans. There are technical working groups, which may involve a range of other players and focus on particular diseases or functions. Some of these meet weekly (e.g. the Zambia M&E group meeting), others less often. The development partners typically also meet as a group to coordinate and discuss sector issues and develop a shard position on key issues. These meetings are often monthly and may, as in Malawi, include a representative of the MOH.

[2] Government of Uganda funding (including budget support) rose from some $220m in 2004/5 to $230m in 2005/6 (a cut in real terms) while donor funds almost doubled, from $255 m in 04/5 to $507m in 05/6, much of this from vertical support (source: C. Ortendahl).

There is some concern that the SWAp processes have become too cumbersome and inward looking. Modifications have been introduced to streamline and improve processes and it seems sensible to continue to review the processes. Examples include:

- in Malawi, the number of technical working groups was reduced; their composition revised to include other relevant stakeholders such as NGOs, the private sector and district level; and their terms of reference (TOR) clarified;
- in Tanzania, the last annual review recommended changing the timing of the review so it fits better with the budget process;
- in Zambia, individual agencies have agreed to act as focal point among the DPs on specific topics, so fewer people need to attend each meeting; Uganda has also been looking at taking forward this 'division of labour' approach;
- in Uganda, the number of sector review meetings was reduced from two to one per year;
- in Zambia and Tanzania, the lead donor role has been shared across three agencies – the past, present and next lead, in order to assure continuity.

2.4 Increasing use of Government systems for financial management and accountability

All the SWAps have some form of pooled funding arrangement, as indicated in Annex 1. Arguably one of the attractions of the SWAp for MOHs, and part of the deal for involving partners in policy dialogue, is that Government has more control over resources provided for the sector. The arrangements vary – some are 'basket funds' in several baskets earmarked to specific uses at district/province level and central level (Zambia, Mozambique, Tanzania); some are in a single pooled fund that is accessible directly to MOH (e.g. Ghana's Health Fund).

Whilst basket funds are under Government control, they are not fully consistent with Government systems. For example they typically flow directly to MOH rather than via the MOF, they are separately audited, and appear as a separate line in the accounts. There are usually rules agreed for their use, commonly for non-salary costs, or for certain budget lines such as drugs and supplies. There are moves to make them more closely aligned to government systems and more flexible – for example, the merging of baskets in Zambia and Mozambique.

Uganda has a form of sector budget support with funds going directly to districts as part of their conditional grant for health as well as other earmarked funds to health through the budget for drugs etc. In addition, an increasing amount of resources is provided as General Budget Support (GBS), some of which reaches the health sector within the national budget for health. This has been happening in Ghana, where two major funders of the Health Fund, EC and WB, have shifted to GBS, leaving a much reduced Health Fund. In Tanzania and Zambia, whilst DFID has moved to GBS, others seem keen to remain with basket funding.

As a consequence of these developments, and rising funding for health, the amount of funding under Government control and management has increased in the SWAp countries. It has been difficult to find consistent figures and trends, because of incomplete reporting and lack of data for some countries. This is an important finding in itself that could partners may want to address at country level. Figures for Mozambique (Table 1) indicate that the amount of health funding that is managed by Government has been increasing strongly, while the *share* managed by Government rose until 2005 when there was a surge in project funding from PEPFAR, GF and others.

Table 1: Health expenditure in Mozambique by Government and Development Partners (in US$ millions)[3]

	2001	**2002**	**2003**	**2004**	**2005**
Government budget	70	82	96	105	112
Common Funds (CF)	17	20	37	63	113
Vertical & Project funding	75	75	75	85	130
Total Public Expenditure	165	178	209	252	356
% of Gov managed funding (budget + CF)	53%	57%	64%	67%	63%

This illustrates the substantial impact that the global and vertical initiatives in health have had recently – and is a common picture reported from other countries, especially those supported by PEPFAR and foundations. This partly relates to the high prices of some commodities provided by these funders – particularly antiretroviral drugs; new medicines for malaria, and pentavalent vaccine, as well as their management costs and scaling up of services. It raises concerns for sustainability.

In Ghana, Table 2 shows a rising trend in the share of financing through the Health Fund to 2004. This was in a context of rising total donor funding for health, (up from $42.6m in 2000 to $192.5m in 2003, from OECD data). The shift to GBS by major donors and increased amounts allocated by Government and from other domestic sources, means a rising share and amount is managed within national systems. With the move of one bilateral donor back to earmarked funding, and rising spend from GF and other earmarked funders, the Health Fund has declined in importance from 2006. Also notable is the rapid increase in health funding levels – up four fold in 5 years.

Table 2: Share of health budget funding through different channels – Ghana[4]

	2001	**2002**	**2003**	**2004**	**2005 est**	**2006 budget**
Government health budget (inc credits, HIPC)	51%	61%	62%	59%	59%	48%
Health Fund	13%	18%	15%	21%	NA	13%
Earmarked Funds from DPs	22%	8%	10%	6%	NA	13%
Other (fees, insurance)	14%	14%	14%	13%	14%	26%
Per capita expenditure on health (US $)	*6.3*	*8.1*	*10.5*	*13.5*	*23.9*	*25.2*

Figures for Zambia are incomplete but also show how funding has shifted towards the Government health budget from basket funds since 2005 when GBS started. It also shows the substantial contribution of project type support in 2005 and 2006; these figures are mainly for PEPFAR and GF (it would be useful to see comparable figures for earlier years).

[3] Source: J. Martinez, Implementing a sector wide approach in health: the case of Mozambique, HLSP Institute, 2006 (based on data for 2001-2004 and estimates for 2005).
[4] Sources: MOH Review of health sector 2005 programme of work, 2006; figures for 2005 draw on Dreschler & Zimmerman, New Actors in Health Financing, OECD Policy Brief 33, 2007.

Table 3: Public expenditure on health in Zambia (in US $ millions)[5]

	2001	2002	2003	2004	2005 *	2006 budget
Government budget	64.4	67.2	88.1	78.6	118.0	159.0
Basket funds	11.4	30.2	54.0	59.3	36.0	36.0
Vertical funds and projects	n/a	n/a	n/a	n/a	183.0	204.0
Total					337.0	399.0

Table 4 shows a similar picture in Uganda of rising funding levels and an increasing share of funding through Government budgets. This is based on MOF data; MOH figures for project and global initiatives spending suggest a sharp rise in funding from these sources in 2004/5, reversing this trend, with funds through the budget falling to 46% of the total. The table also demonstrates that while funding levels have been rising, per capita funding remains well below what is needed for a basic public health service (note this excludes private spending).

Table 4: Public expenditure on health in Uganda 2000/01 – 2004/5 (in Uganda Shillings billions)[6]

	2000/1	2001/2	2002/3	2003/4	2004/5
Government budget	124.2	169.8	196.0	207.8	219.6
Donor projects and global initiatives	114.8	144.1	142.0	175.3	146.7*
Total public spending	239.0	313.9	337.9	383.1	336.3
Percentage through budget	52%	54%	58%	54%	65%
Per capita public expenditure (US $)	*5.9*	*7.5*	*7.3*	*7.7*	*8.0*

* MOH figure is 254.8 bn Shs based on their survey of 13 donors.

Thus the various country data, while incomplete, gives a picture of rising levels and share of funding through Government managed channels, until 2005 when the share has fallen due to substantial additional funding of programmes particularly from GF and PEPFAR. It would be useful for this sort of data to be available as a routine part of annual reviews and monitored as part of mutual accountability in harmonisation and alignment.

This section has shown that the components of SWAps are in place, although not always moving strongly towards more use of national systems nor qualitatively what was hoped for. The next section looks at whether experience suggests the SWAps are achieving the expected results.

3. Results from health SWAps

In order to consider what has worked, what hasn't and why, there needs to be a realistic expectation of what SWAps can be expected and intended to achieve. SWAps are a way of working in the sector, they are not everything that happens in the sector including all policies, funding and services delivered. Typically, SWAps are expected to contribute in the following areas.

- Strengthened **coordination** in the sector, so that partners' efforts are better coordinated, duplication of efforts avoided and inconsistent approaches by individual donors inhibited.

[5] Sources: National Health Accounts, IMF study, DFID Zambia office; note data is incomplete.
[6] Source: Annual Health Sector Performance Report 2004/5, October 2005.

- A mechanism for **harmonisation and alignment** – both between development partners and with government systems, including more harmonised technical cooperation.
- A mechanism to enhance **national ownership and domestic accountability**.
- Reduction in **transaction costs**.
- Better quality of **policy, planning, resource allocation and implementation**.
- As a result of these, better **results** in terms of access to health services and improved health outcomes.

This section reviews experience in each of these areas.

3.1 Strengthened coordination of efforts in the sector

The SWAps have in general provided a mechanism for coordination of efforts of development partners (DPs). Most of the significant DPs join in the sector coordination mechanisms such as joining in sector reviews; attending development partner meetings; reporting on consultants they have engaged; sharing information on their projects and programmes. This has been an improvement over the situation pre-SWAp in most countries, where there was limited donor coordination and each donor had multiple projects. This role of bringing all efforts in the sector together allows identification of areas for improvement and what is being missed, seen as by one adviser as “a powerful tool”. It is particularly valued in countries such as Mozambique and Zambia where there are many different DPs active in health.

There are some exceptions however, and variation in performance. For example, it was reported that in Tanzania, the African Development Bank (AfDB) developed a health sector loan without coordinating with partners and ensuring its support was consistent with other sector developments. In some countries including Tanzania, USAID has been active in coordination, including reporting on the funding it is providing, while elsewhere there has been less openness about its support.

The reasons for this variability may reflect a lack of clear message from agencies centrally to their field staff to prioritise coordination. There can also be benefits to the DP and to Government of avoiding sector processes in terms of faster response, and less criticism about planned activities that are not fully consistent with the sector plans and priorities (recognising that sector programmes of work tend to be negotiated and some elements are more popular with government than others). There could be a role for DFID and other like minded partners to encourage the headquarters level of these agencies to push their staff to work with sector processes and to reinforce the importance of coordinating their activities within the sector.

The arrival of new initiatives such as the Global Fund (GF) and PEPFAR can create a stress on coordination mechanisms. By definition, they bring resources that were not envisaged in earlier planning. Typically the resources are earmarked to specific programmes or diseases and many are not flexible to support existing plans. They often have their own, substantial reporting requirements. The GF required countries to set up new mechanisms to prepare and oversee grant applications called country coordinating mechanisms (CCMs). It requires its own reporting, financial supervision and diagnostic assessment of systems. In general this was reported by DFID advisers as disruptive to the SWAp, but in Mozambique the Government was able to persuade the GF that the existing SWAp coordination structure could take on the role of the CCM, and that funds could be managed through existing pool funding mechanisms. The global initiatives have signed up to harmonisation and alignment but it is not clear how far this will go (the GF performance indicator, for example, is whether grants are aligned with national fiscal cycles) [7]. Once the initiative is no longer new, it can be planned into the SWAp.

[7] GAVI Alliance’s Health System Support funding aims to enable harmonisation and alignment as it allows countries to apply for funds to support existing sector plans, and offers to align its support with existing planning cycles.

3.2 SWAps as a mechanism for harmonisation and alignment

SWAps are seen as a mechanism for harmonisation and alignment (H&A) – they are explicitly seen as this in the Paris Declaration which promotes programme based approaches (SWAps are these at sector level). In practice, section 2 above showed that they are playing a role in terms of:

- having sector development strategies linked to an MTEF or budget;
- increasing the extent that aid flows are reported on partners' national budgets (although there remain some off budget);
- to a varying extent, use of country financial management and procurement systems;
- use of common arrangements or procedures in terms of annual reviews, shared M&E, shared reports and shared diagnostic work.

All these are components of the H&A framework and targets.

In terms of other elements of the H&A agenda, one is to coordinate support to capacity development, with a target to have 50% of **technical cooperation** (TC) flows through coordinated programmes. There has been less progress in this area in the health SWAps. Several have intended to set up a pooled approach for TC where the Government would manage a pooled fund for technical assistance (TA) according to agreed procedures. For example, in Zambia's current MOU this is stated as the intention. Procedures and procurement arrangements for the pool were established, but the pool has been not implemented. In Malawi, the plan has been for long term TA (initially provided by DFID for 2 years) to transfer to being managed by the MOH and funded from SWAp pool funds, while short term TA was to be managed by MOH from the start. At the end of 2 years, the MOH has expressed reservations about funding the long term TA from SWAp pool funds, apparently deterred by the cost. In Uganda, DPs have agreed in principle to pool funds for TA but not yet done so. In Tanzania, pooled TA has been discussed but is not a priority for now. In Ghana, the DPs have offered to support a coordinated plan for TC if Government prepares one, but this has not yet been produced.

There seem to be several reasons for this limited progress. One is the cost of TA, which Ministries of Health see as high and can find hard to justify given the funding gaps in many other areas. Secondly, there are significant administrative and transaction costs in identifying, selecting and contracting TA, especially short term inputs. The MOH may have weak capacity for these functions or may prefer DPs to take on this administrative burden. National partners in Zambia indicated that DPs can procure more quickly and face less pressure in the selection process. On the DP side, there can be advantages to bringing in consultants who will address particular interests of that partner, or give more honest feedback to the agency that is funding them. It should also be recognised that Ministries often see less need for TC than their DPs and may even see them as 'spies', and hence are unlikely to propose as much TC as DPs are prepared to fund, given their perceptions of fiduciary risks and capacity needs. This has been seen in Mozambique where the removal of TA by the Minister of Health has left gaps in capacity in the MOH.

One response has been to set up intermediate arrangements that provide TC coordination without shifting full control and administrative burden to countries. In Zambia for example, the MOH decides on consultancy needs and prepares TOR, then asks the lead DPs to identify potential consultants. This is done among the DPs, and the MOH is then involved in selecting and managing the consultant. The administrative side of contracting and payment is left to the DP concerned. This was described as a 'virtual pool', and seems consistent with the H&A target for coordination. In Malawi, the long term TA funded by DFID were interviewed by MOH

as part of the selection process, and have been reporting to the MOH and to the pool fund donors[8]. However this arrangement only applies to some 18 out of the 40 TAs in the MOH.

3.3 A mechanism to enhance national ownership and domestic accountability

The emphasis in SWAps on Government leadership and all partners supporting a national plan is intended and expected to increase national ownership. This is notoriously difficult to measure. In principle the provision of budget support and of basket funding provide Government with much more control over the funds for the sector, and hence enable them to make and implement decisions about the sector. However, as we have seen above, the trend towards increasing project – type funding, and the earmarking of basket funds to specific budget lines limits flexibility in budget deployment.

A recent study of SWAps based on case studies by the Netherlands aid evaluation section[9] concluded that "In most cases, the anticipated increase in ownership in the recipient countries did not materialise." Reasons why they felt there was not increased ownership included: heavy aid dependency; limited alignment of aid with Government policy and financial management systems; interference by donors in development of PRSPs and sector policy; and "major institutional and capacity shortcomings that hamper governments from exercising effective leadership over aid and implementing the policy agreed on with donors".

However a recent study in Tanzania concluded that the SWAp had led to a very substantial increase in Government ownership of health policies and strategies, (although questioning the wider social ownership of the sector reform programme)[10].This was based on the views of a sample of 15 players in country – a small sample but indicative that the impact on ownership varies between countries.

The close involvement of partners in sector processes, with detailed discussions on strategies and budget allocations and detailed aides memoire pushing Government to take certain actions can be seen as reducing the room for ownership. It is a difficult balance for DPs in the sector between trying to secure progress in areas they see as critical, and avoiding micro-management so that government takes responsibility, control and ownership over decisions. Their close involvement also raises the issue of how much accountability DPs have for progress in the sector.

3.4 Reduction in transaction costs

There has been some progress in reducing transaction costs, especially where the country had a large number of donors each with multiple projects and their own project preparation, review and management processes. Reducing the number of projects does reduce transaction costs. However the improvements are not as great as hoped in many cases. This relates to:

- the substantial administrative workload in managing the SWAp processes themselves, such as annual reviews, monthly, fortnightly or even weekly meetings, annual reports, missions;
- the continued provision by some of the large bilateral DPs and global funds of project – type support with their own transaction costs and mechanisms such as project management,

[8] Tessa MacArthur et al, DFID TC in the health sector in Malawi: a case study, DFID, November 2005.
[9] From Project Aid towards Sector Support: An evaluation of the sector wide approach in Dutch bilateral aid 1998-2005, Netherlands Policy and Operational Evaluation Department, November 2006.
[10] Catherine Paul, Tanzania Health SWAp: Achievements, Challenges and Lessons Learnt, December 2005. Substantial improvements were also identified in efficiency in use of funds, and successful implementation of sector reforms.

steering groups and project reporting requirements, (even if these are provided within the framework of the sector programme and/or are included in the budget).

Thus Government has two sets of transaction costs to bear – for SWAp processes and for projects.

A report looking at transaction costs in Zambia's education SWAp and Senegal's health SWAp[11] found that there was very slow progress towards harmonised donor missions and reviews in Zambia. This was not just the usual suspects – donors such as Norway and Denmark also had not joined in joint missions. The report also pointed out that DPs' requirements for strengthening management systems in order to enable basket funding to take place imposed a considerable burden on the Ministry and on others such as the Auditor General's Office. The report concludes that "despite the promotion of SWAps and budget support … there is no clear evidence that transaction costs are lowered under these … modalities. There is some evidence that costs are redistributed and concentrated with an increasing burden falling on senior staff at central ministry level". The report alleges that the DPs resist changes that would increase the transaction costs on themselves – even if this would reduce transaction costs for the government.

3.5 Better quality of policy, planning, resource allocation and implementation

There is general support for the view that SWAps have helped to bring coherence and improve quality in health policy and strategic planning. They have enabled and encouraged a focus on fundamental sector issues such as human resources, procurement and financial management strengthening. They have provided a forum to incorporate issues such as gender, reaching the poorest and reproductive health in broader policy and planning, rather than leaving these as specialist niches. For example, in Tanzania, UNFPA puts its funds into the health basket system and is an active partner in sector mechanisms and debates; this was judged as helping to raise the profile of reproductive health.

In the area of **resource allocation**, several health advisers cited the benefit of having all support for the sector 'on one page', even if it is not all on budget or is still managed with diverse projects. This enables more rational allocation of resources – for example, in Uganda, the MOH has developed a resource allocation formula for allocating to districts which takes into account, in addition to a range factors such as population, health and poverty, the extent of resources from external donors. This helps to redress the balance between donor favoured districts and others with the uneven allocation that tends to result. On the other hand, from the donor perspective, earmarking funds to poor districts can more easily be justified as poverty reducing[12].

The SWAps help to improve the transparency of resource allocation, and provide an opportunity to challenge proposed allocation decisions in a way that was not possible in the past.

The ability to agree on an allocation that reflects donor concerns does not necessarily mean it will be implemented. This reflects the political nature of the budget process and the way decisions are made in practice – as discussed in the recent DFID paper on politics of the budget[13]. This paper refers to Malawi as an example, showing that while there is an MTEF which DPs support, the budget does not necessarily reflect the MTEF and then releases do not necessarily follow the budget.

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[11] Watt, Patrick, Transaction Costs in Aid: Case Studies of SWAps in Zambia and Senegal, Human Development Report Office Occasional Paper 2005/6, 2005.
[12] The Netherlands evaluation report referred to earlier discusses this.
[13] DFID, Understanding the politics of the budget: what drives change in the budget process?, Practice Paper, Jan 2007.

Moving on to **implementation**, there has been some disappointment with the pace and extent of implementation in the SWAps. There appear to be several causes, with a varying combination in each country:

- The SWAp may include ambitious or sensitive reforms. These may be very difficult to implement in practice[14].
- Changes in the political context especially a new minister or Government that is less committed to the reforms agreed in the sector policy/programme.
- Changes in personnel in the MOH and among DPs; the new generation does not have the understanding of the earlier agreements or the strategies established.
- Optimistic expectations of outcomes. This can be due to unrealistic targets being set – for example, a study in Uganda found that although stakeholders felt that the SWAp has identified good and relevant indicators, the targets set are unrealistic[15].
- Insufficient funding available to implement plans (which may be poorly costed). In Uganda, only one third of the funding required for its basic package was available in the first sector programme. It is difficult for government and DP staff to cut back the essential packages or to set lower coverage targets in their plans to match realistic funding, given the pressure to scale up in different areas, the health needs and the uncertainty of funding available.
- The issue of budget execution noted above – funds may not be released until too late in the year (e.g. Malawi) or not at all. Many DPs also have poor predictability of funding.
- Poor data quality, infrequent measurement of health outcomes and the difficulty of attribution in health contribute to concerns that there is a lack of progress.
- It takes time to get SWAp processes established and functioning. This is still an issue for Malawi in its third year of the SWAp.
- Implementation capacity constraints, including often a poor record in getting funds, drugs and staff out for service delivery at district level and below.

This last point is critical: even assuming that funds are available and there is commitment to the strategies and reforms in the sector programme, is there the implementation capacity at local level where services are actually delivered? With project support, there were typically technical and administrative staff engaged (and well funded) to support programme or project implementation. These were not necessarily replaced when projects end. There seems to have been insufficient attention to capacity building at local level in some cases, at least in areas such as financial management and planning. As countries face staff turnover and changing systems, there need to be continuing efforts to build health planning and management capacity. For example in Ghana there has been recent discussion of the need to review district Budget Management Centres capacity – some 10 years after the original process of strengthening and assessing their capacity to manage budgets.

Decentralisation complicates this, as local government capacity building may be handled by a different ministry and different staff within the DPs. Also most countries are planning for further decentralisation, but the timing and details remain unclear, making it difficult to know how to proceed. Even at central level, there can be heavy reliance on TA for core financial management and public sector reform skills, with limited capacity building (Mozambique). This can also be seen in Malawi where it has been difficult to fill counterpart posts in areas such as financial management and procurement.

The introduction of new services and products which were not included in original plans can also affect implementation – for example, the introduction of anti retroviral therapy that is

[14] There was a classic example in the Bangladesh health SWAp, where plans to merge health and family welfare services were included in the sector programme, but successfully resisted; this derailed the SWAp.

[15] Catherine Paul, Uganda's Health SWAp: an analysis of prevailing incentive systems, draft 4 January 2006.

particularly demanding on health staff time as well as other resources. This was noted in Zambia for example, as having displaced other health services. In Uganda, it has created problems for core systems of drug procurement and management as staff have been attracted to work in these projects.

Underlying this is the ongoing problem of human resources for health which is a concern for all countries. The sector programmes include plans to address the issue – pay rises, remote posting allowances, more basic training etc - but there seem to be difficulties in implementation. In Ghana for example, a substantial pay rise for health staff has crowed out funding for non-staff costs.

3.6 Better results in terms of access to health services and improved health outcomes

It is difficult to measure the results of SWAps. How much of any changes can be attributed to the SWAp as a way or working, as opposed to the health policies that were followed, the level and timing of funding available, or the support from vertical programmes? To assess this would require an idea of what would have happened without the SWAp, which is hard to tell. This problem of attribution has bedevilled attempts to assess SWAps and has not been satisfactorily overcome. There is a substantial joint evaluation of the health sector in Tanzania ongoing currently which will attempt to assess the contribution of the partnership. It will report in September 2007.

Looking at results in the SWAp countries, performance is mixed. All have made progress on some indicators – see Annex 2. For example, Zambia made progress on several key process indicators such as drug availability, immunisation coverage and supervised deliveries; however the annual review notes there was not a decline in disease burden indicators. Uganda shows major improvements in the level of outpatient utilisation and immunisation coverage, although there are not clear trends in facility based deliveries or contraceptive use. Ghana shows some increase in skilled birth attendance and TB cure rates, with limited improvement in use of outpatient services, while maintaining good levels of drug supplies. Ghana saw no fall in infant or child mortality rates (CMR) at the last Demographic and Health Survey (DHS); Tanzania saw impressive falls in CMR and infant MR. Thus there have been some significant improvements in these countries, but without detailed understanding of the context, it is hard to attribute them to the SWAp.

There have tended to be continued improvements in service indicators in areas supported by vertical programmes and funds, such as immunisation and TB control (and in the case of Ghana, promising results in terms of lower AIDS prevalence). This could be seen as evidence that SWAps do not work as well as vertical programme support. However it seems fairer to conclude that the vertical programmes can and do have a rapid impact on services, as they often bring in supplies and pay marginal costs for service delivery; and can attract scarce staff to work on ‘their’ activities. In addition these are arguably easier areas to address – getting vaccines or bed nets out to children for example. Areas where there has been less progress are often more complex – such as reducing maternal mortality through provision of emergency obstetric care and skilled attendance. This is reliant on a functioning health system with trained professionals in place, which in turn requires a range of functional supporting systems including blood transfusion, laboratory services, medical supplies and equipment maintenance, backed by a sustained programme of basic training.

This raises the issue of what the SWAp is for and what can be expected from it. It is not in general a mechanism for quick fixes; rather it is a way to support development of an effective and integrated health system, with better allocation of resources, bringing improvements in the efficiency and effectiveness of sector management. It can incorporate vertical programmes and deliver ‘quick wins’. But there can be a trade off between systems building, especially where

this includes complex and sensitive reforms that are likely to be delayed or resisted, and getting resources out to enable service delivery[16].

This tension is not confined to SWAps – it applies in other areas too as partners want to develop long term capacity but also want to demonstrate short term results against the MDGs. It is reflected in continuing debates on which aid instruments to use, in contexts where institutional capacity is limited. For example, where procurement capacity is weak, giving funds to Governments brings major risks for health service delivery due to delays or inappropriate purchasing of essential inputs. DPs such as DFID may want to confront this tension more openly to give guidance to their staff. In practice many DPs including DFID provide a mix of funding – both basket or budget support and funds for commodities or specific programmes (e.g. through global funds, AIDS projects or social marketing).

Summary

This review suggests that SWAps have made a contribution in terms of better coordination, harmonisation and better policy, planning and resource allocation. There is not conclusive evidence that transaction costs decline.

It is hard to judge SWAps' impact on health outcomes but several countries can demonstrate marked improvements in important MDG indicators, including areas supported by vertical programmes, with less progress on some of the most challenging areas such as maternal mortality. This partly reflects incomplete coverage of SWAps – limited use of harmonised and shared processes continue to impose high transaction costs; while vertical programmes may achieve results but bring their own transaction costs and may displace other services. Limited progress in terms of outcomes also reflects long term and continued under-funding of the health system, chronic shortages of some skills, and inefficiencies in resource use. The SWAp can strengthen systems, but it cannot achieve a transformation of public services and sector performance until there is adequate funding, institutional capacity, and suitably trained, motivated and deployed human resources.

For the benefits of H&A to be realised, more of the DPs need to follow the SWAp principles more closely and resist the temptation to bypass them This would not solve all the difficulties of implementation – including the difficulty of making major reforms and the weaknesses in capacity to deliver services, but it would allow the SWAp to have more impact.

[16] An example appears in all the SWAps reviewed: the strategic plans include providing more resources for the private sector to deliver services. This reform is encouraged by DPs as a way to scale up and enhance access, with good reason, but the policy is often less popular with governments. Reports suggest little or no progress in implementation in practice, unless funds are tightly earmarked or there is a tradition of support, e.g. salaries for mission health service staff.

4. Lessons from experience for SWAp processes

This section highlights some of the issues and findings from the review. It addresses the following:

- the political nature of reforms and policy implementation
- the need to anticipate and deal with changes in personnel
- the change in skills needed for SWAp working
- dealing with transition in aid instruments
- wider participation in sector processes
- performance monitoring and indicators
- the time taken in setting up SWAps and scope for streamlining processes.

4.1 The political nature of reforms and policy implementation

Whilst development of sector policies and strategies clearly has a political dimension, politics will also influence the implementation phase. Typically sector strategies include major reforms, for example, contracting more services to non-state providers; reallocating resources to poorer areas; shifting staff to rural areas; changing the roles of doctors and nurses; and new standards for procurement. All of these cut across the interests of different groups and are likely to face resistance.

Partners should anticipate that implementation of these reforms will be difficult and political, and will not necessarily run smoothly. As one adviser put it – “Swaps are cyclical, not linear, there will be regression … they are a long term process of change” to improve sector performance. The DFID paper on the politics of budget reform argues that reform plans should not be too ambitious – “effective reforms are those that are technically sound, administratively possible and politically feasible.” It argues for “good enough” reforms, sequenced well. This seems relevant to sector reforms too.

There may be a case for more attention to understanding the interests at play in health policy and its implementation. This could also include work on the potential for civil society, central ministries, media et al in bringing pressure to bear on implementing agencies to implement agreed strategies. Such an analysis should also consider the incentives for government stakeholders to ‘play ball’ in the SWAp, especially if one of the original attractions – sector basket funding that they manage – is reduced. This could help identify where DP staff such as health advisers can contribute – for example, whether they can usefully support MOH – MOF dialogue and links.

There may also be a case for more contingency planning – to expect that plans may go off track or results may be disappointing, and for DPs to be prepared to deal with this. There have been lessons learnt on how to handle problems within SWAps and this is reflected in the arrangements for dispute resolution included in MOUs; but there may need to be more work on what position to take when this happens, and whether to be more explicit with Government on how the DPs are likely to respond. This would be consistent with the PAF or MDG contract approaches used in GBS, for example these can set out how the level of funding from DPs will change if targets (for inputs or outputs) are not met. While there are concerns that this rather mechanistic link of funding to performance leads to gaming and less predictable funding, it can also help government to be clear about the consequences of their decisions.

4.2 The need to anticipate and deal with changes in personnel

In each of the SWAps reviewed, the appointment of a new minister has had a substantial impact on implementation of the sector programme. Partners should expect that appointment of new ministers or a new Government will, at least, affect the pace of implementation, and may

cause substantial disruption to progress as the new ministers gain experience, understand the sector processes and introduce their own ideas.

Change in personnel in the MOH or in the DPs will also have an effect on implementation. The early stages of SWAp development tend to involve a core group of committed Government and DP staff who work together to get arrangements off the ground and convince other partners to join. They take part in the negotiations on policy and strategy documents that lead to compromises that both sides can accept. When these staff move on, there is a loss of institutional memory of the negotiations as well as loss of the relationships and trust that has developed over time.

At the core of sector wide working is the relationship between the partners, including the extent of trust between them. When new personnel join the partnership, the dynamics will change and relationships will need to be rebuilt. New staff will need to learn about the sector management processes and the specifics of the sector programme. This is a predictable issue that can be addressed more systematically; ideas for this are discussed further in section 5.

4.3 The change in skills needed for SWAp working

Another lesson from the review is the need to consider the skill mix of the DP group. Working in a SWAp and especially taking on the lead donor role involves considerable political sensitivity, negotiation and facilitation skills. In addition the partner group needs an understanding of public sector reform, public finance management, health financing and procurement as well as health technical issues. These skills are not typically in the profile of staff selected as health advisers or embassy development officers, and it might be useful for agencies to revise their selection criteria and look at ways to broaden staff skills. For example, in Tanzania, the DP concerned is providing training in chairing meetings and leadership to their staff member who will take over as lead donor.

With the move to Joint Assistance Strategies in most countries, there may be a reduction in the numbers of partners involved in each sector (although there seems to be little progress towards this in health so far). There may be more that the partners can do together to ensure a good mix of skills represented on the resulting DP group, whilst also sharing out the work and avoiding too large a group around the table. For example, there are discussions in Mozambique on joint planning among the Nordic plus donors to ensure an appropriate mix of skills is available. In Ghana there is discussion on how DFID's governance and social development specialists can contribute to sector work in a planned way.

There were several cases where DFID advisers criticised the UN agencies in this area, concerned that their staff are still too project and technically focussed, and lack the broader understanding of public sector reforms required. Although WHO has a role in leading the UN response on the health MDGs, it was often not seen as capable of leading a sector wide response. There is a general concern with ensuring that the DP group is of high quality, so that Government appreciates and benefits from its interaction with them, and the SWAp maintains its value for the ministry.

4.4 Dealing with transition in aid instruments

Experience suggests that the move from sector funding arrangements (such as basket funds) to GBS is difficult. It is hard for a MOH that is used to relatively predictable flows and established arrangements for using a DP funded basket to cover key areas of recurrent costs, then the basket is sharply slashed, while national budget execution is likely to be less predictable and subject to different rules.

The change to budget support requires the MOH to work with the Ministry of Finance (MOF) to secure a larger budget allocation and to ensure it is released. In highly aid dependant countries, this link is often not well developed, and in many countries the MOF lacks capacity to engage in health sector debates and understand sector priorities. In most cases they are not involved in sector annual reviews and other processes (Uganda was cited as an exception in having more capacity and involvement). MOH may lack capacity and experience in convincing MOF and others that additional resources for health will be well used. This is illustrated by experience in Zambia and Tanzania - both saw declines in non-staff recurrent budgets for district services when DFID moved from basket funding to GBS, as the DFID contribution was not initially replaced.

The Zambia experience was that DFID, as a donor that moved to GBS and that has good links with the MOF, could play a useful role in linking the MOH with the MOF and helping them to make their case. The MOH eventually secured a larger budget allocation to replace the DFID funds. DFID was also able to support the continuing dialogue needed, for example, DFID funded a local consultant to track the release of funds from the budget for health, and advise the MOH if releases were off track. The transition was a painful process however, and suggests that more could be done to prepare for the change, including a joint strategy among DPs to plan the transition, so that there are not too large shifts in funding modalities that are disruptive to services. It also indicates that the DPs can usefully facilitate the development of better links between MOH and MOF. This may need inputs from advisers such as economists, and this role needs to be built into their own work-plans.

There is also a case for maintaining a mix of aid modalities. Sector budget support (SBS) can be useful for maintaining a donor presence in sector dialogue and for influencing alignment – for example, by encouraging the move from multiple basket funds towards a single basket and eventually to more aligned sector budget support requiring stronger engagement with MOF. Thus DFID in Mozambique is proposing to continue SBS alongside GBS as complementary support[17]. Project type support and direct support for NGOs may be useful to encourage civil society, tackle issues that Government does not want to (e.g. safe abortion), and enable private sector involvement (e.g. social marketing). Project and commodity support can also be used to assure the inputs for key programmes are available while systems are being developed and capacity strengthened. Each DP does not need to have a mix of instruments – what is important is an appropriate overall mix. The MOH and DPs can identify comparative advantages of different funders, to identify which agency or instrument is best placed to provide which inputs.

4.5 Wider participation in sector processes

In the medium term it would be desirable for the DP role in policy dialogue and holding government to account to be taken over by domestic constituencies including NGOs interested in health, political representatives and central ministries such as finance. The SWAps have not been well designed to encourage this participation in sector dialogue and oversight – it was neglected in early SWAp thinking which focussed on MOHs and DPs. All the SWAps studied here have recognised the issue and started to look at ways to broaden participation, and there are some good examples, e.g. Malawi involving civil society in technical working groups; Tanzania inviting civil society to annual reviews, and Mozambique involving civil society in the sector coordination process (stimulated by meeting the criteria for being the GF CCM[18]). However all recognise this is an area for further work, both to broaden participation and identify the interest and strengthen the capacity of civil society to play an effective role.

[17] The multi donor evaluation of GBS endorsed this idea of a mix of instruments: “there is scope for a limited number of sector-focused and more general GBS instruments to be mutually reinforcing”. Stephen Lister et al, Evaluation of GBS: Synthesis report, May 2006, paragraphs S76-77.

[18] Clare Dickinson et al, The Global Fund operating in a SWAp through a common fund: issues and lessons from Mozambique, HLSP Institute, January 2007.

4.6 Performance monitoring and indicators

If the SWAp is about strengthening systems and processes as part of a long term agenda, it is important to measure results in these areas, and not just focus on health outcome measures. This is consistent with DAC findings on Managing for Development Results, which indicated that accountability frameworks should place emphasis on intermediate outputs such as numbers treated or vaccinated, and also measure progress in strengthening capacity and sustainability of results. This does not mean there should not also be some input and outcome measures, but these are less useful for management purposes.

4.7 The time taken in setting up SWAps and scope for streamlining

The SWAps in this review had a substantial lead time to set up – most recently Malawi took five years of preparation. Uganda took 3 years to develop and agree the sector plan. A key lesson is to expect and plan for a time consuming process. This review has not focussed on lessons on how to set up a SWAp as there is other work on this – e.g. from the World Bank[19].

As discussed earlier, the SWAps have introduced changes to become more inclusive. One result is very large numbers involved in meetings and sector reviews, making these less appropriate for focussed discussion on the barriers to improving sector performance. There may be a case for further work to streamline and improve processes, such as constituency arrangements to enable better involvement of domestic constituencies, and a small, core donor group that meets with Government to enable a more strategic level policy dialogue.

5. Suggestions for follow up

Based on the previous sections and interviews, four types of follow up action are suggested:

1. Changes in expectation and behaviour of DPs;
2. Country level actions;
3. Opportunities for cross country exchange;
4. Possible studies to learn from experience on specific issues.

5.1 Changes in expectations and behaviour of DPs

This review has shown that SWAps have brought benefits in terms of more coherence and much more harmonised and aligned working by some of the DPs, However there are other DPs that have made less progress towards sector wide working, in terms of increasing alignment with country systems and focussing support on existing country led strategies rather than donor led initiatives. The continuing plethora of funding mechanisms and succession of new initiatives reduces the scope to lower transaction costs and can undermine efforts to strengthen systems. In some countries, DPs still do not provide good and timely information on funding they have allocated and actually provided. If the intended benefits of aid effectiveness are to be gained, then DPs need to reemphasise their commitment to sector working and increasing harmonisation. A DP group is already working on ideas for how to achieve this[20].

One approach would be for DFID and like minded donors to lobby head offices of agencies that are not consistently supportive (examples raised were ADB, USAID, major Foundations), to take a stronger stance and give a clearer message to their staff on this issue. This could complement monitoring DP performance as part of mutual accountability at country level (see below). It may also be useful to share good examples between countries of how partners have

[19] World Bank, Education and Health in Sub-Saharan Africa: A Review of SWAps, 2001.
[20] A paper is being developed on how to reform the global health architecture and strengthen SWAps, for discussion in the 7+ (Like Minded) group in mid 2007 (source: Jorn Heldrup of DANIDA).

maximised their synergy with the sector programme or adapted their own requirements (such as project management procedures) to fit with sector working. This could also link to the DAC peer reviews.

In supporting SWAps, DPs need to recognise the sector programme may not always proceed as smoothly as planned. They involve long term systems strengthening, which in turn includes substantial reforms. The complexity of the health sector adds to the formidable challenge of core areas of public sector reform such as motivation and distribution of health workers, and the roles of public and private sectors. Alongside this, changes in leadership and staff in MOHs have a marked impact on capacity to implement change. More analysis of the political interests and how these can be addressed may be useful in development of sector programmes; also DPs need to anticipate that there are likely to be hold ups and resistance in some areas and be prepared to respond to these. Responses could include having contingency plans and/or explicit PAF (along the lines used for GBS) for the sector. Whilst there is a concern that explicit conditions for continuing or increasing funding create problems for predictability, even without these there is not a great record of predictability[21].

Experience shows (see 4.3 above) that moving to a SWAp requires different ways of working, and this requires different skills among DP staff at country level. This includes a range of technical skills (such as public finance management) but also 'people skills' like facilitation, negotiation and collaborative spirit. DPs can respond to this through training and selection of the staff who engage in sector wide work and through the signals they send in their general guidance and individual appraisals of performance. In addition, it may be helpful to coordinate among DPs at country level to ensure a good skill mix, especially if there are fewer DPs covering the sector in response to Joint Assistance Strategies.

5.2 Country level actions

In addition to having the right skills, it is clear that personalities and relationships are key to sector working. Since the turnover in DP and Government staff is predictable (that it will happen, if not exactly when) there could be more effort to address this. Measures could include:

- Ensuring robust SWAp systems such as coordination mechanisms, codes of conduct, terms of reference and composition of groups, which institutionalise governance structures;
- SWAp briefing/training sessions for new MOH, provincial and DP staff; these would need to cover processes and the content of the sector programme[22];
- Conscious efforts to build relationships and trust;
- A statement of core influencing issues and positions within the agency (e.g. set out in the DP's logframe) and perhaps an explicit sector performance assessment framework (PAF) so that partners know what will trigger a response from DPs;
- Civil society and other stakeholder involvement could contribute to continuity as well as bringing other advantages for accountability.

There may be a case for a specific effort to refocus and reinvigorate sector wide working among the players in country, perhaps as part of the annual SWAp review. This could look at the benefits of sector working and discuss how to tackle current problems and how to become more results focussed. An alternative would be to work together or commission joint work on specific problems (such as how to strengthen capacity in local government for health planning

[21] Uganda Annual Sector Report 2004/5 showed this by analysing budgets promised against actual expenditure for major DPs. The actual spend ranged from nothing to 2,600 times the budgeted figure, with an overall total 3 times the budget!

[22] There may be material available that can be used more systematically – for example, in Tanzania, the DPs produced a briefing for the new Permanent Secretary in MOH on the sector working arrangements; in Mozambique a course was designed (but never used) for provincial staff on the health SWAp.

and management) as a means to address those issues and also to build up confidence and relationships.

In addition it may be useful to consider how to balance the tension between inclusiveness and enabling effective dialogue. In the context of increasing participation by national stakeholders, and the large numbers engaged in SWAp processes such as annual reviews or MOH-donor progress meetings, the DPs need to consider how they can have opportunities for strategic level policy dialogue. Zambia might be a useful model - the Joint Assistance Strategy has defined three lead or core donors for the sector, while others are defined as active and background donors. Lead donors maintain direct and regular contact with the government and then consult and link to other partners. Active partners can attend meetings but do not need to and will not take a lead. This is intended to make it easier for senior Government officials to interact with a smaller group of donors. It should enable better quality of interaction with Government as the lead/core donors are selected for their technical and personal capabilities.

The poor quality of information on sector funding and concerns about how some DPs bypass sector processes suggests that the annual sector reviews could usefully include an assessment of DP performance in health, against Paris Declaration targets and including the transparency and predictability of their funding. SWAps need clear information on funding – both what is expected and how it is allocated and actually used, and DPs need to ensure they provide budget and financial reports for this in a timely way. This would be part of moves to improve mutual accountability.

It is not clear who should lead in making the above ideas happen – this might be a role for WHO, the joint SWAp management group or the lead donors. This could be discussed at country level. Regional and central WHO may also want to review how WHO can promote SWAps and the capacity, skills and procedures that would make it effective in doing so.

5.3 Opportunities for cross country exchange

There seems to have been few opportunities for country representatives who work within SWAps to get together and learn from each others' experience. It could be useful to study cases where countries have useful experience on issues such as how to streamline SWAp processes; how to incorporate civil society, GF and others into sector programmes; how to handle transition in aid instruments; or deal with increasing decentralisation. This idea was also raised in post-High Level Forum discussions. WHO could have a convening role and/or the Strategic Partnership with Africa (SPA) which has a Sector Support Working Group.

5.4 Possible areas for further analysis on specific issues

Four areas have emerged from the work that might merit further analysis at country level:

a) How to get broader stakeholder involvement in health SWAps
This would look at what measures are already in place and what incentives and barriers there are to greater involvement of national stakeholders in sector processes. It may also be useful to assess the capacity of organisations to take on these roles and how strengthening of capacity could be achieved. This would need to include:

- **central ministries of Finance and Planning** as key players who need to understand health sector developments and strategies in order to have a proper dialogue on sector budget issues and hold MOH and its DPs to account for budget implementation. Informants suggested that Uganda has had relatively strong dialogue between the ministries while other countries have not, it might be useful to study why.

- **Civil society** in its various forms, including non-Government health providers,

professional bodies and advocacy groups. There may be questions of how to get balanced representation in a diverse NGO and private sector.

- **Parliamentary and local government** structures should also be considered.

Such work could be tackled in several ways – a workshop involving the different types of stakeholders at country level, a study of incentives and structures at country level, or both. Alternatively this could be taken forward within the normal sector working at country level, or could possibly be integrated with the political analysis below.

b) Understanding the politics of sector working and reforms

This would look at the underlying political and structural issues affecting sector working and implementation of sector strategies. It could identify the incentives and interests of stakeholders to implement closer sector working, harmonisation and alignment. It could apply the 'politics of development' analytical framework that has evolved from the 'drivers of change' approach[23]. It could be tested in a few countries to see how it can be used to find ways of working with the existing political and incentive realities in a country.

c) How to improve coordination and effectiveness of technical cooperation (TC)

In response to the finding of limited progress towards coordinated programmes of TC, there could be merit in analysing in more detail why this is the case and how to strengthen coordination in selected countries. It could also look at ways to ensure TC is building institutional capacity and how to monitor this better. This could perhaps learn the emerging lessons from shared TA management in Malawi, the 'virtual pool' approach in Zambia, the pooling arrangement in Ethiopia, as well as DFID's support to a shared TA management unit in MOH in Nepal's health SWAp. This might fit with work of DFID's Global Development Effectiveness Division which has been working on TC issues and is considering joint donor research on coordinated capacity development.

d) Monitoring impact of Joint Assistance Strategies and DP commitment to sector working

This could be a prospective study that follows the impact of changing DP representation on sector processes as the JAS is implemented. At the same time it could monitor the way that DPs and global programmes are interacting with the sector and whether they are becoming more harmonised and aligned in practice. The findings would feed into annual reviews at national level as part of mutual accountability. It could cover a few countries and look qualitatively at the way sector processes evolve, how the quality of interaction changes if some DPs pull out from the sector and others move to GBS. This could perhaps be conducted as a study by locally based researchers over a two year period, with coordination and funding from WHO (rather individual donor agencies as they will be subjects of the studies), in order to capture the national perspective on what sector working and JAS contribute, rather than that of DPs. A more ambitious study could also include demonstrating the results from the SWAps and sector reform processes.

[23] See Politics of Development Analytical Framework, Adrian Leftwich, February 2007

Annex 1: Status of key building blocks of the SWAps

Country	Sector Programme or Strategy	MTEF/budget	Sector Reviews and agreed indicators	Use of Government financial management & accountability systems
Ghana	Just completed 2nd 5 year Programme of Work (POW). In process of developing 3rd POW and common management arrangements for 2007-2011	Costing of sector POW & development of expenditure framework due by end March 2007	Annual reviews against 31 agreed sector performance indicators. Data available for 24 of these for previous year by annual review.	Pooled funds in a Health Fund managed by MOH, with separate accounting. Reached 60% of external funds through the Fund at one stage. Health Fund role declining with shift of major funders (WB, EU, perhaps bilaterals) to GBS plus more earmarked funds.
Malawi	In third year of first six year sector programme of work 2004-2010	Unclear input from non-pool funders.	Annual sector review (second one held Sept 2006), with focus on progress against last year's milestones. Common indicator framework complete and harmonised with budget support, MDGs and HIV/AIDS monitoring.	SWAp pool funding from 3 funders (DFID, Norway, WB); others may join. Pool funds were higher than pledged in 2005/6, and total ten times the MOH budget. Long term TA to MOH to strengthen management and address fiduciary risks funded by DFID but reports to MOH and pool fund donors. Annual external financial audit.
Mozambique	Strategic Plan for the Health Sector (known as the PESS) for 2001-2005. PESS 2 in formulation.	No medium term funding plan for the sector – under discussion	Joint annual review of PESS around May against agreed PESS indicators. Joint audit annually. Data concerns –most indicators not available at time of annual review.	Separate pool funds with own accounts since 1999 for pharmaceuticals & recurrent health spend by provinces. Efforts to merge these since 2003. Significant growth and rising share of pool funds and MOH budget to 2004; in 2005 this was outstripped by growth in vertical funds.
Tanzania	Health Sector Strategic Plan (HSSP) 2003-08. This followed the Programme of Work (POW) 1999-2002 To start work in 2007 on next plan for 2008/9	Has a sector MTEF covering Government and an increasing share of' external resources	7th Joint annual review April 2006 against milestones and 33 performance indicators. Data issues – most indicators not available for the previous year; half not available for 2 years ago. Joint evaluation underway, to report September 07.	'Basket funds' in place to support district plans; rehabilitation at district level; & central MOH functions. These use government management and reporting systems, but have a separate audit. Move to GBS by DFID, others continuing to use basket, more DPs to join basket Much still off budget or through projects (over 50%)

Country	Sector Programme or Strategy	MTEF/budget	Sector Reviews and agreed indicators	Use of Government financial management & accountability systems
Uganda	Currently in year 2 of 2nd Health Sector Strategic Plan (HSSP) 2005/6-2009/10 First HSSP was 2000/1-2004/5	MTEF gives clear sector ceilings. Substantial funding continues to be off budget. MOF has reduced health budget ceiling.	Annual sector reviews against sector indicators and targets	Donor earmarked funds are channelled via MOF within Gov systems – as conditional grants for health for districts, or to MOH. Medicines credit line uses Gov budget systems and earmarks funds for drugs – districts draw down drugs. Partnership Fund is a pooled fund to facilitate SWAp processes.
Zambia	Zambia National Health Strategic Plan Jan 2006 – Dec 2011 (NHSP) Previous NHSP 2001-05. Earlier NHSP 1995-1999.	Rolling MTEF – currently 2007-2009 shows rising amount & % to health	First Joint Annual Review (JAR) since 2000 was for 2005 (in March 2006). Previous reviews planned but not carried out. Indicators used but not an agreed set. Work ongoing to revise sector indicators and ensure links to GBS & National Dev Plan.	'Baskets' for districts, hospitals, etc, for non-staff costs (district basket since 1996). Moving to an 'expanded basket' that includes these baskets. DFID & EU move to GBS has reduced size of baskets, & required MOH to allocate funds to replace. Virtual TA pool – MOH defines TOR, DPs suggest consultants, MOH selects.

Sources: Country documents, interviews.
Acronyms: GBS: General Budget Support; MTEF: medium term expenditure framework; MOF: Ministry of Finance; POW: Programme of Work; TA: Technical Assistance; TOR: Terms of Reference.

Annex 2: Results of sector programmes

This annex sets out a selection of the sector performance indicators for 4 countries, to illustrate the areas and extent of progress, but also that some indicators have not improved consistently.

Ghana

	2000	2001	2002	2003	2004	2005
Outpatient visits per capita	0.45	0.49	0.49	0.50	0.52	0.52
EPI coverage (DTP3/Penta)	81.6	76.3	77.9	76.0	76.0	85.0
% supervised deliveries (skilled)	50.2	50.4	32.0	55.0	53.4	54.1
Family planning acceptors	11.6	24.9	21.0	22.6	24.3	21.6
% Tracer drug availability	75.0	70.0	85.0	85.0	80.0	85.7
TB cure rates %	44.9	44.9	48.9	53.8	63.9	

Mozambique

	2000	2001	2002	2003	2004	2005
Outpatient visits per capita	0.7	0.8	0.83	0.94	0.96	1.01
EPI coverage (DTP3)	89	87	87	91	92	94
% deliveries in health facilities	40	41	43	45	47	49
New TB cases cured %	73.2	75.4	75.4			

Uganda

	1999/00	2000/1	2001/2	2002/3	2003/4	2004/5
Outpatient visits per capita (Gov & NGO)	0.40	0.43	0.60	0.72	0.79	0.90
EPI coverage (DTP3/Penta)	41	48	63	84	83	89
% deliveries in health facilities	25.2	22.6	19.0	20.3	24.4	25.0
Couple years of FP				211,000	224,000	212,000
% facilities without stock-outs of 4 tracers				33	40	35
TB treatment success %	48	50	52	60	65	68

Zambia

	2000	2001	2002	2003	2004	2005
Outpatient visits per capita	0.42	0.77	0.73	0.86	0.76	0.78
EPI coverage (fully immunised)	76	86	76	74	80	82
% supervised deliveries	39	44	49	55	61	62
Drug kits opened per 1000 patients	0.73	0.75	0.69	0.73	0.93	1.08

Sources:
Ghana: Main sector review report – Review of Ghana Health Sector Programme of Work 2005.
Mozambique: Figures 2002-2005 - Relatorio final da Quinta Avaliacao Conjunta do Sector Saude Mocambique 2005; figures for 2000-2001 - Mozambique Health SWAP Case study, HLSP.
Uganda: Annual Health Sector Performance Report, 2004/5.
Zambia: Health Sector Joint Annual Review Report, 2005