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Integrating vertical health programmes into sector wide approaches: Experiences and lessons

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CONTENTS

ACRONYMS

AOP	Annual Operating Plan (Bangladesh)
BMC	Budget and Management Centre (Ghana)
CBOH	Central Board of Health (Zambia)
CPR	Contraceptive Prevalence Rate
DHB	District Health Board
DHMT	District Health management team
DMO	District Medical Officer
DOTS	Directly Observed Therapy
DP	Development Partner
EPI	Expanded Programme of Immunisation
FPHP	Fourth Population and Health Project (Bangladesh)
GoB	Government of Bangladesh
GoG	Government of Ghana
GoT	Government of Tanzania
IDA	International Development Association
IHSD	Institute for Health Sector Development
MCH	Maternal and Child Health
MOH	Ministry of Health
MOHFW	Ministry of Health and Family Welfare (Bangladesh)
MRALG	Ministry or regional and Local Government (Tanzania)
MTR	Mid Term Review
NTLP	Tanzania National TB leprosy Programme
RH	Reproductive Health
SDC	Swiss Agency for Development and Co-operation
SIDA	Swedish International Development Agency
SWAp	Sector Wide Approach
TB	Tuberculosis
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund

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1 EXECUTIVE SUMMARY

1. The purpose of this study is to assist SDC with its decision on whether to integrate the Tanzania National TB Leprosy Programme into national delivery structures. The paper looks at experiences in three countries (Ghana, Bangladesh and Zambia), which have integrated some vertical programmes into their national systems which are also supported by a SWAp.

2. The main finding is that integration can, and has caused problems of retaining programme performance. This can be attributed to the reorganisation of technical responsibilities, rationalisation of procurement arrangement, shortages of funding, changes in priorities and changes in government and donor relationships. At the same time however a review of other aspects of the SWAps in those countries suggests that the longer term prognosis for programme performance may be positive because there are indications of improvements in planning, financial management and accountability, greater expenditure at district level and resource allocation, swifter programme mobilisation, better linkages outside MoH and wider accountability for programme performance.

3. In response to these findings, a number of recommendations on how to deal potential problems in Tanzania are given (section 5), and then priorities summarised (section 6). Recommendations are noted here according to when in the process they should be addressed.

4. Issues to consider before making the decision to integrate:

   - Reappraise the likelihood of macro-economic decline and economic shocks (e.g. natural disasters) and their possible impact on Government of Tanzania (GoT) capacity to sustain funding to any integrated programme where overall finance levels depended on GoT funds as well as donors. Also consider the possible impact of a change of government or minister, and the effect on the programme if the SWAp lost political support.
   - Assess whether there is enough cohesion with other DPs to overcome possible future programme problems without the control offered by direct funding.
   - Assess absorption capacity of national delivery systems to utilise available funds adequately without the impetus of a vertical programme.
   - Assuming that the programme would then be funded through the existing district basket, assess whether SDC could maintain commitments to this pool, and how well the pool as a whole has been functioning to date in terms of timely disbursements etc.
   - Accept a change over to integration is probably a one way event

5. Once the decision to integrate has been made:

   - Ensure that transition is gradual and that capacity exists before any technical and managerial responsibilities are passed on
   - Plan for continued capacity building after integration, including continued technical assistance
   - Work with MoH to consider options for retaining dedicated supervisory and technical capacity at the centre and regions after integration even if these still resemble a vertical programme approach. Pay particular attention to where supervisory and leadership responsibilities lie in the system. Ensure that there is adequate technical input to national planning processes at all levels and that the process is not overly administratively led
   - Ensure reporting remains robust

- Ensure that during the transition phase and capacity building TB and leprosy control continue to be presented as national priorities. Also appraise national planning and budgeting mechanisms to establish how well they communicate and support national priorities
- Consider earmarking pooled funding as an interim measure
- Carry out a careful assessment of MoH procurement capacity in order to establish its immediate ability to procure effectively and efficiently. Anticipate having to carry out some immediate capacity building work in order to ensure that any new procurement functions operate smoothly
- Try to negotiate with GoT and other DPs a procurement system which reduces transaction costs and labour intensity rather than increases them

6. Longer term strategies to consider are:

- Consider helping MoH to develop specific strategies for advocacy for TB and leprosy as priority programmes with both national government (MRALG) and local government in order to try to ensure that disease control activities remain a priority
- Encourage improvements in participation by local populations and better needs assessment at local level with flexibility in funding to respond to these
- Carefully monitor overall expenditure of the programme in order to ensure that substitution does not take place

2 INTRODUCTION

7. This paper is a desk study which looks at experiences of integrating vertical health programmes into national delivery systems where government and donors have adopted a sector wide approach (SWAp) to supporting health sector reform. It was commissioned to facilitate decision making in SDC regarding future possible integration of the Tanzania Tuberculosis and Leprosy Programme into national delivery systems and the SWAp process. Terms of reference are at Annex 2.

8. Integration of vertical programmes changes the way in which they are implemented, managed, funded and receive logistical support. The sector wide approach changes how governments and donors interact with each other at a policy, financing and implementation level. Either of these changes on their own present opportunities and threats to the quality and effectiveness of service delivery - integrating vertical programmes at a time when sector programmes are still in a state of evolution increases the risks, but potentially maximises the benefits of new forms of integrated service delivery.

9. The structure of the paper is to review briefly the rationale for integration and the direction that this is given by the sector wide approach so that the objective of integration is clearly understood. Section 4 then reviews the experiences of three countries (Ghana, Zambia and Bangladesh) in integrating vertical programmes into SWAps, first in terms of the concrete problems they encountered and then in terms of the improvements that have been seen in national delivery systems which have been brought about by the SWAp. Although these last are fewer in number and at the moment only really hold out the *possibility* of substantial service improvements they are important because they have the potential to make a significant and long term difference to how integrated district health care may be provided more efficiently and effectively than through a system of numerous vertical programmes. In other words they may be indications that fundamental health sector reform is taking place. Section 5 then draws out recommendations from these experiences which are relevant to integrating the Tanzania National Tuberculosis and Leprosy

Programme (NTLP) into the SWAp, and Section 6 prioritises them and presents some options.

10. The rationale for selecting the three countries concerned was because of their similarities and contrasts to Tanzania.

- Ghana has similar basket funding arrangement for support to districts.
- Zambia has had some particular problems with integrating its TB programme.
- Bangladesh offers an interesting but relevant Asian contrast to African experiences.

11. Annex 1 summaries the SWAps in each country.

2.1 Terminology

12. Although the term 'Sector Wide Approach' really refers to just that, an approach, it is also used to denote the national programmes which have been supported through a SWAp. For convenience it is used in this way in this paper. A definition is at Box 1.

13. The term 'integration' requires some clarification. The ultimate goal of integration and a SWAp is that all delivery systems should be national and all funding from DPs for those systems should be unearmarked budget support (i.e. they should fall into box 4), but the reality is rather different. The three countries reviewed are all evolving their SWAps and therefore the degree of integration in each place varies, and within each country is even different for different activities. For example in Ghana many programmes still receive elements of earmarked funding and are partially vertical in implementation (e.g. EPI) but may be regarded as integrated into the SWAp in so far as they are clearly factored into the annual Programme of Work. Many public health programmes have essentially moved from boxes (1) to (4) on the matrix e.g. TB, HIV/AIDS, guinea worm, buruli ulcer but many of these programmes still receive some elements of earmarked funds to support specific activities (e.g. HIV/AIDS surveillance), and therefore are partially still in box (1). Some programmes such as malaria fall into box 4 for district level activities but vertical / earmarked programme management persists at the national level[1].

Table 1 'Integrated' funding and implementation options

		DP funding arrangement	
		Earmarked	*Pooled*
Implementation arrangement	*Vertical*	1 earmarked funding, vertical delivery	2 pooled funding, vertical delivery
	Integrated	3 earmarked funding integrated delivery	4 pooled funding, integrated delivery

14. In this paper 'integration' is used to denote previously vertically implemented programmes which have been included in the SWAp in some way. The exact extent is not particularly important given that the goal of each of the integration strategies is similar – to increase government ownership and reduce donor involvement in the detail of implementation, whilst ensuring that performance

[1] Thanks to Liz Geare for assistance with this analysis and contributing the table

improves and is supported by improved management, planning financing and delivery systems.

15. The term 'development partner' (DP) refers to bilateral donors and multilateral development agencies.

2.2 Methodology

16. Examples and conclusions are based on a literature review of individual SWAp reviews such as annual monitoring reports, other more intervention specific reviews, general SWAp literature, some as yet unpublished papers by IHSD, and selected reports detailing the experiences of integrating vertical programmes generally, without reference to SWAps (see reference list, Annex 2). A questionnaire was also circulated to interested and knowledgeable parties in the three countries, and responses given in person, in writing or over the phone. The author would like to thank all those who took the trouble to answer, but would like to stress the conclusions reached in this paper are her own and should not be taken as the official position of any donor or government representatives.

3 THE RATIONALE FOR INTEGRATION

17. Sceptics of the sector wide approach say that it has the potential to undo the gains of the last 20 years or so of vertical programming. So given the risks involved why is it worth considering integrating programmes into a SWAp? There are two main reasons, firstly that the health sector reform agenda has long advocated integration as a way of achieving more comprehensive and longer lasting health gains, and secondly because SWAps are arguably more complicated to run, and less coherent when some donors maintain separate projectised funding arrangements for priority programmes. Under these circumstances SWAps may therefore be less effective, although it is not possible to prove this.

18. The health sector reform rationale advocates integration because of the disadvantages of vertical programmes which:

- *Create duplication*. Vertical programmes are usually supported by separate staffing, infrastructure, logistical and procurement systems. Even where services are integrated at district level and below there are still separate management, supervision, reporting and support structures above this to support programme delivery.
- *Are less cost effective than integrated programmes*. Duplicate implementation and management arrangements increase the cost of delivery.
- *Lead to inefficient and costly utilisation by recipients*. Clients are obliged to make numerous visits to different practitioners to receive care, thus giving healthcare a high opportunity cost, a crucial issue for the poor.
- *May lead to gaps in care*. Where a patient has to shuttle between service providers to receive care, there is a higher risk of failed referral.
- *Are inappropriate for decentralised health delivery*. Vertical programmes are of necessity top down in design and implementation, whereas decentralisation emphasises responsiveness to local circumstances with appropriate political, intersectoral and community involvement.
- *Undermine government capacity, by absolving government of the need and responsibility to improve other aspects of public sector service delivery*. Moreover the more able staff who could carry out such improvements are often

led away from government service or from key central roles, attracted by the better terms and conditions of donor funded projects.

- *May concentrate resources (including health workers' time) on a limited range of problems*, and therefore detract from the development of comprehensive health systems and from addressing less 'fashionable' health problems (e.g. years of neglect of malaria in many countries has been due to this).

19. The sector wide approach emphasises government ownership and capacity building, and common donor support (see Box 1). It therefore supports integration because:

    - *The capacity of government staff and management systems can be built* by donors investing in national programme management, financing and implementation functions rather than setting up parallel arrangements.
    - *Common management arrangements should reduce transaction costs* between government and donors. Unified monitoring, reporting and funding procedures utilise staff time more rationally than separate systems for individual projects.
    - *Government and donors aim to develop a commonality of priorities and funding targets*. Both parties can work together to agree the place of interventions in the overall programme, and ensure that adequate attention and resources from both parties are targeted at the intervention. Neither party can ignore an intervention as being the responsibility of the other – common priorities become a common responsibility.
    - *The common funding arrangement potentially offers protection and security for priority programmes*. Where only one donor, or a few, support a programme under a projectised approach it can susceptible to insecurities of funding. If the development priorities of the donor change away from that intervention, or out of that country, then the programme may suffer from gaps in funding, and at worst, will be at risk of collapse.
    - *Delivering an essential service package on which many SWAps are based, becomes more complex (because of varied management arrangements), and may be less cost effective (because of duplication of logistical support, specialised staffing etc) when substantial elements of that package e.g. TB control, EPI, are delivered through vertical structures*.

20. As a result of this, most health SWAps are trying, or at least intending, to integrate vertical programmes into government led, national delivery systems, supported by common donor funding and monitoring arrangements. However although there is a clear rationale to do this, many donors and governments are concerned about the likely impact on the programmes themselves, and fear a loss of quality and effectiveness. Despite the inefficiencies and other disadvantages of vertical programmes they do have many positive features, which ideally should be retained under an integrated approach:

    - Operational planning is straightforward;
    - Funding can be mobilised and utilised easily, reliably and quickly;
    - Key health interventions are protected and therefore their priority can be assured, even where political commitment is weak;
    - Monitoring is usually comprehensive and thorough, and results linked to identification and resolution of problems;
    - There can be a clear poverty focus by targeting areas where other health provision is sparse or inaccessible to the poor;
    - Technical quality of services is good.

21. In short, despite their disadvantages, vertical programmes have been very successful in delivering high quality effective treatment and prevention programmes, and have made a huge contribution to disease control and improving life expectancy. Therefore a donor wishing to integrate its contribution to these programmes into a SWAp which supported national delivery systems, would want to be sure that they kept the advantages of vertical programmes and that the benefits of the SWAp were additional.

Box 1 Definition of the Sector Wide Approach (SWAp)

The sector wide approach defines a method of working between Government and donors, a mechanism for co-ordinating support to public expenditure programmes. The defining characteristics are that:

- All significant funding for the sector supports a single policy and expenditure programme;
- Government provides leadership for the programme;
- Common implementation and management approaches are applied across the sector by all partners;
- Over time, the programme progresses towards relying on Government procedures to disburse and account for all funds.

4 EXPERIENCES AND LESSONS OF INTEGRATION

22. The case study countries and literature show two main findings:

- That some disease control interventions which have previously been run as vertically managed programmes have not continued to perform as well once integration had taken place. There is concern expressed in a significant number of sector review papers that the health gains of the vertical programmes are being lost and that effective remedies need to be found and implemented as a matter of priority (e.g. Zambia).
- That although programme performance is problematic there are indications that government capacity to plan and implement programmes is increasing, ownership of programme policy and management is growing, and donor co-ordination is allowing more coherent priority setting and more rational use of resources. This suggests that there is a longer term chance of sustainable systems improvements overall and that failing performance may be only temporary and resulting from transition, as indeed the evidence suggests in some countries (e.g. Ghana).

23. This section reviews the evidence and arguments for programme failings and improvements.

4.1 Programme problems

24. The literature suggests that failing the performance of newly integrated programmes may be attributed to the following:

- Reorganisation of technical responsibilities;
- Rationalisation of procurement arrangements;
- Shortages of funding;
- Changes in priorities;

- Changes in government and donor relationships.

25. In many cases there is no single cause, but a number of different factors which have come into play at the same time. Generally it has not been the change to a sector wide approach per se which has caused the problems, but a coincidence of other reforms and the SWAp being introduced. All the SWAp programmes discussed here have been introduced in support of the major reform initiatives which in the African examples have included integration as a key tenet of decentralisation. It is therefore not appropriate to attribute failing performance only to the SWAp but to look at all the contributory factors. The question then is what part the SWAp played in contributing to these problems, and to what extent it can provide means and mechanisms to address them.

4.1.1 Reorganisation of technical and planning responsibilities

26. Where programmes have been integrated into national delivery systems there has obviously been a reorganisation of responsibilities for implementation and technical supervision. The introduction of district basket funding arrangements as part of some of the SWAp has also increased the scope and responsibilities of district staff to plan and budget for delivery.

27. Experiences, particularly in the Zambian TB example (see Box 3), and also in Ghana (see Box 2) show that:

28. ***Capacity of those with new responsibilities may be lacking*** In Zambia, staff at district level underwent a rapid transition of reorganisation after which they became responsible for managing and implementing a whole range of primary healthcare activities – however the technical capacity to deal adequately with this new remit was lacking. Although capacity building activities had been planned at the time of change over they were inadequate to meet the new challenges. Moreover supervision was lacking from above. This had particularly serious consequences for areas such as drug ordering – the system moved from a 'push' to a 'pull' arrangement for calculating requirements and ordering supplies so that drugs were no longer routinely distributed by the national level, but districts had to take action to order them. Where districts lacked the capacity to manage this process, the results were drug shortages and stock outs[2].

29. ***There is a risk that new supervision arrangements may be inadequate.*** In Zambia the 9 regional provincial health offices had been replaced by 4 regional health offices. There was no longer a layer of technical staff at this level specifically responsible for TB supervision and quality control, and when key programme officer staff were deployed a lot of technical knowledge and experience was lost[3]. At national level in the Central Board of Health (CBoH) no effective solutions were developed for continuing to provide adequate technical support and capacity building to districts. In recognition that the new structure was partly to blame for poor performance, the regional health offices have since been reformed back into provincial offices and are expected to provide supportive supervision and performance audit, and have developed guidelines, checklists and audit tools. In practice these activities have been effectively suspended due to a lack of funds, both at district and provincial level. A Joint Mission review reported that '*In some instances, this has already resulted in poor compliance with (for example) TB treatment guidelines or HMIS reporting procedures. Potentially, the discontinuation of supervision can lead to a decrease in quality of services if people are left too long without technical support*'[4]. Irrespective of funding shortages, the value of

[2] BOSMAN, CJ, (b)
[3] ZAMBIA JOINT MISSION (b)
[4] ZAMBIA JOINT MISSION (b)

these guidelines has been dubious. A report of a national workshop citied in ZAMBIA JOINT MISSION (b) suggested that a lack of in-service and on the job training and supervision, coupled with a high turnover of staff, meant that too many health workers were unaware of correct practices and new policies.[5]

30. In Ghana a review reported that '*TB focal persons are sometimes weak, and unsupported by regular meetings of institutional teams or District Health Management Teams (DHMTs) to review TB issues*'.

31. ***The role of the centre in supporting them may not be adequately defined or carried out*** With integration coupled with decentralisation the role of the centre in Zambia in TB control was also diminished. Responsibility for TB was probably placed too high up in the system, at director level, without clear definition of roles and inadequate authority to play an effective part in the quality of implementation[6]. A working group had been set up in 1999 but it only held an advisory function, and the technical skills of those charged with some responsibility for TB oversight were probably inadequate for the task, so that analysis of systemic problems was weak. In contrast other newly integrated programmes such as EPI, RH and child health fared better with a larger number of dedicated advisory staff with stronger technical skills, and better programme performance was retained.

32. In Ghana the TB programme also suffered from poor intra-sectoral co-operation at MoH/HQ level which led to drug stock outs.

Box 2 Ghana: Selected programme performance indicators

Mixed programme performance is evident in some of Ghana's key interventions implying that some problems of transition have been overcome:

- DPT-3 drop out rates have fallen and coverage has increased, from 51 per cent in 1996 to 71 per cent in 1999[7]. Measles coverage and drop out rates have also improved.
- Ante-natal care has been increasing.
- The proportion of deliveries supervised by trained personnel (including traditional birth attendants) is increasing.

However:

- There has been a significant rise in the new cases of guinea worm, attributable to an initial failure of district managers to adjust to new arrangements for integrated planning and budgeting[8].
- TB control is poor, attributable to a lessening of its priority status at district and regional level, plus poor technical performance and support. Poor management capacity and inadequate intra-sectoral co-operation at MoH/HQ level had led to drug stock outs, although this problem has now largely been rectified[9]

33. ***Monitoring systems may not be adequate.***. It is perhaps not fair to judge the supervision of Zambian TB control activities without being aware of some of the problems of monitoring, which meant that neither district health staff, nor the limited number of supporting technical staff remaining at higher level, had adequate information on which to evaluate TB control activities in terms of outcome or

[5] ZAMBIA JOINT MISSION (b)
[6] Personal communication
[7] MOH GHANA (a)
[8] Personal communication
[9] Personal communication

quality. The end of the vertical programme and separate reporting and monitoring systems meant that after 1996 there was no national TB data available on key indicators such as cure rates or defaulter rates[10]. Although there was a new, quarterly 'health management and information' form, the information it contained on TB (registrations and defaulters) was not adequate to either assess the quality of diagnosis or treatment, so it could not be used for routine evaluation and surveillance of TB control, a serious omission when TB rates have risen so much in the wake of HIV.

34. ***The focus may have been elsewhere on capacity building***. Although the problems outlined above were not necessarily attributable to the existence of a sector wide approach to supporting national delivery systems, the SWAp in Zambia and also in Ghana could be said to have deflected capacity building activities away from district level and may have been overoptimistic in assuming '*a level of capacity which wasn't there*'[12] at both national and district levels. In both countries governments and donors placed a lot of emphasis on improving financial management competence, perhaps at the cost of the technical capacity to deliver the planned package of services. The Ghana "*BMC readiness assessment has … tended to focus more on financial management competency than on planning, budgeting and technical implementation capacity (e.g. to deliver a specified package of services*)"[13]. This focus on financial management above technical competence was a reaction to the need to get the basket funding arrangement working correctly which necessitated a strong focus on national level system. The consequences in Zambia were that: '*Centrally, it would be all too easy to conclude that the heavy investment in 'systems development' (often, of course, to meet external pressures for financial probity and good governance) has meant that insufficient attention was given to effecting early and much needed improvements in service delivery*.[14]

Box 3 TB control in Zambia

The recent state of TB control in Zambia paints a bleak picture of a health priority which is suffering from its integrated status. The National Tuberculosis Review[11] found that:

- TB focus has been lost and key activities of TB control such as reporting and recording, patient follow up and treatment outcome monitoring were not being performed in the majority of districts.
- Technical capacities for TB diagnosis including laboratory microscopy had dwindled both at central and district/peripheral levels.
- Funding for TB control activities including drugs and laboratory supplies was been inadequate
- Procurement of anti-TB drugs had since 1998 been on emergency basis leading to erratic supplies and shortages. No laboratory supplies have been procured since 1997.
- The health management information system in use by CBoH was inadequate to monitor and evaluate key TB control activities.

[10] BOSMAN, CJ, (b)
[11] Central Board of Health
[12] ADDAI, E. & GAERE, L
[13] ADDAI, E. & GAERE, L
[14] ZAMBIA JOINT MISSION (b)

35. ***Speed of integration was a problem*** The rate of integration was clearly a challenge in Zambia and led to major difficulties both in terms of the capacity to deliver services and in understanding at district level of how the new system was to work[15]. This also existed in Ghana to a certain extent where the transition between vertical financing and the basket arrangement led to a hiatus in service provision whilst one form of support finished and the other one started and district planning staff attempted to understand new budgetary and planning arrangements.

36. ***New planning systems needed time to settle down***. In Zambia decentralisation and integration meant great reliance on the annual district action plans formulated by the District Health Management Team. However in April 2000 the Joint Review Mission reported that the quality and content of plans was variable, and concluded that a review was necessary because the approach was overly resource driven and did not '*readily relate to the population served*'[16] – in other words that decentralisation was not ensuring that meeting local priorities were being met. One reason for this may have been that the planning process was judged to have been too driven by administrators without sufficient input from technical staff[17] who could have helped to ensure that priority health needs were being met adequately. Similarly in Ghana there has been a recommendation that '*strengthening of annual planning guidelines to enable a clear prioritisation by the BMCs of specific areas of public health and improvement of service delivery is required*'[18].

4.1.2 Rationalisation of procurement arrangements

37. The integration of vertical programmes ultimately means removing logistical control from separate programme management arrangements and placing it in national systems. Similarly the sector wide approach emphasises the use of common arrangements for purchasing under government leadership. Undertaking this transition effectively is a major challenge because:

    - If procurement goes wrong for any reason, or is simply managed less than efficiently, then programmes can suffer. Reports from Bangladesh suggests problems in procurement can be a major threat to programme performance (see Box 4).
    - It entails donors being prepared to move away from relying on their own procurement arrangements and committing to supporting government systems.
    - Donors are particularly vulnerable to criticism in this area in their domestic constituencies because inappropriate or inexpert use of funds is conspicuous.

38. Therefore the stakes for getting it right are very high. Experience shows that problems have arisen in the following areas:

39. ***Technical capacity to manage procurement effectively***. Zambia and more recently Bangladesh have faced problems in establishing adequate procurement capacity in the MoH. The Government of Zambia created a Unit in MoH in 1995 which was meant to have executive responsibility for all central level procurement, but in practice its lack of capacity has meant that many of the procurement activities have been and still are being done by technical units at the central level, such as the CBoH Support Services for the procurement of drugs[19].

[15] Personal communication
[16] ZAMBIA JOINT MISSION (b)
[17] Personal communication
[18] ADDAI, E. & GAERE, L
[19] ZAMBIA JOINT MISSION (a)

40. In Zambia key capacity problems included:

- Persistent staff shortages. Since its set up in 1995, it has been staffed by only two professional procurement officers, the Director and deputy, although 12 positions have been allocated[20] .
- An ongoing lack of clarity on the relative roles and responsibilities of each of the procurement units in MoH and CBoH .
- A lack of a coherent set of procurement procedures and guidelines. Those manuals which do exist in different places in the system omit important areas such as quality assurance and ethics[21].

Box 4 Bangladesh: The impact of procurement problems

The Mid Term Review identified serious procurement problems:

- Problems with procurement had contributed to significant shortfalls in spending in the first two years of the programme.
- Only a fraction of the procurement packages had been completed and most of the packages were still in the initial stages of the procurement process. Only 40% of the procurement packages (years 1998/1999 & 1999/2000) had been awarded.
- Major constraints in service delivery had been avoided only because emergency procurement arrangements for contraceptives and drug kits have been made through UN agencies (UNFPA and UNICEF).
- Procurement problems were directly impacting upon the delivery and up take of health and population services. EPI and TB programmes had been constrained by drug stock outs.

The review concluded that:

- '*A crisis situation is imminent'*, and that '*fast tracking arrangements urgently need to be set in place*'.
- Without immediate resolution of the problems, '*the HPSP will now face substantial falls in such key indicators as CPR, TB cure rates, etc'*.
- Unless addressed urgently, many of the health gains of the last decade could be seriously compromised[22].

41. In Bangladesh procurement activities were to be transferred from different donor agencies to the MOHFW itself through its Line Directors. Subsequently as a response to evidently poor procurement performance by these Directorates, a Procurement Monitoring Co-ordination Cell was set up in late 2000[23]. The Bangladesh Mid Term Review identified the following constraints to effective procurement:

- There had been an overestimation of the technical capacity of the Ministry of health and Family Welfare to carry out procurement on the scale necessary to support such a large scale, sector wide, programme[24].
- There had also been an overestimation of the willingness of the Ministry to implement the necessary organisational and structural changes. The MTR suggested "*there is a widespread reluctance of officers to accept responsibility*

[20] ZAMBIA JOINT MISSION (b),
[21] ZAMBIA JOINT MISSION (b),
[22] MISSION TEAM REPORT
[23] MISSION TEAM REPORT
[24] MISSION TEAM REPORT

and to verify decisions. This "culture" is responsible for gross delays in the processing of documents"[25]

- Both of these problems were compounded by the insistence by the IDA that MoHFW adopt its guidelines in order to enable IDA pooled funds to be accessed, but the MoHFW had had very little experience in applying these guidelines. Moreover these guidelines did not replace other donor procedures, but supplemented them, thereby increasing the workload for the Ministry's staff[26].
- In addition proposed timeframe in which these guidelines would be applied effectively was unrealistic.

42. The results of these delays are outlined in Box 4.

43. ***Governance issues***: Since 1998 the Zambia SWAp has had an ongoing problem with governance issues around the award of a contract for management of its medical stores. The concerns of development partners focussed on the lack of transparency before and during the process of awarding the contract, and the high fees approved to the winning company. The Joint Review Mission also identified some of the problems in the functioning of the medical stores which were having consequences for programme performance including reporting alleged inappropriate issuance of drugs, incomplete stock level and movement reports and a lack of audit[27]. It would not be unreasonable to assume firstly that programme performance is being affected by less than good quality stores management and that also as a result of these issues the confidence of the development partners in this and wider governance issues has been undermined. This is potentially a serious problem for a programme which depends on good partnership in order to maintain basket funding levels and the sector wide approach as a whole.

4.1.3 Shortages of funding

44. Although many sector wide programmes afford the opportunity for more efficient use of funds and therefore potentially allow for higher levels of expenditure, in practice this has not always been the case, and some of the programmes have had problems which have affected implementation coverage and quality.

45. ***Reduced government expenditure due to macro-economic problems*** e.g. Zambia, where the Joint Review Mission suggested that the deterioration of TB control activities was partly attributable to the lack of financial resources for routine activities in the district through the district basket funds. As a result DHMT staff were not able to carry out regular supervision of the health centres and posts nor were health centre staff able to implement DOTS adequately[28].

46. ***Reduced government expenditure perhaps resulting from substitution by donor funds***. The Bangladesh SWAp was negotiated on the assumption that public financing for the sector would increase. However a recent report stated that "*Trends in percentage allocation of total Government finance have shown a worrying fall over the 2 years of HPSP. Certainly the hoped for increase in focus by government and consequent increase in percentage of Government total expenditure has not yet happened. Donors are expressing increasing concerns*

[25] MISSION TEAM REPORT
[26] Personal communication
[27] ZAMBIA JOINT MISSION (b)
[28] ZAMBIA JOINT MISSION (b)

that, rather than the GOB contribution increasing in terms of total expenditure, substitution of GOB funding by donor funding is occurring".[29]

47. ***Low expenditure on the programme due to limited absorption capacity*** In the first two years of the Bangladesh programme disbursement from IDA and pooled funds was about 40% of the original commitment. This has been attributed to the procurement constraints described above and also to execution shortfalls on 17 of the 25 Annual Operational Plans (AOPs). A recent report stated that "*the five largest plans (Essential Services Package Reproductive Health; Essential Services Package Health Services; Hospital Services; Community Nutrition; Construction), which accounted for over 80% of the programmed Development Budget expenditure, all had execution rates below 35%*"[30]. However this needs to be seen in the context of previous disbursement performance under the previous Health and Population Project when only 12% of the consortium fund was utilised in the first four years of implementation[31]

48. ***Reduced expenditure on the programme due to unfulfilled promises by DPs*** This was the case in Ghana where the Health Fund initially performed badly in 1997-8 with only very limited releases against budget, because donor contributions were much lower than promised. Some partners were not able to mobilise funds as quickly as expected and others withheld their contributions because of concerns about procedures[32]. Overall DP contributions to date have reached only 67% of the expected total[33].

49. In Zambia during the implementation of the current Strategic Plan (1998-2000), DPs disbursements have suffered from fluctuations. In 1998, the DPs disbursed only 57% of the pledges while in 1999, there was an over-disbursement of 15% (catch up). Variations between commitments and disbursements have serious consequences for the planning, budgeting and implementation system[34]

4.1.4 Differences in priorities

50. The literature and interviews show that a key issue for ensuring that previously vertical programmes retaining their quality and effectiveness is the degree to which they keep their status as national priorities. One of the main problems in integrating these activities has been the fact they tend to have got somewhat 'lost' in amongst the other demands at district and central level. For example the Ghana Health of the Nation report stated that it "*has been difficult to ensure adequate visibility, attention and responsiveness to priority problems*"[35]

51. This maybe due to a number of factors:

52. ***Lack of technical ability to appreciate the need for continued effort***. This may be compounded by inadequate technical involvement in district planning, limited technical understanding of appropriate strategies and activities necessary exacerbated by insufficient supervision and training.

53. ***A failure of national planning and budgeting process to communicate priorities and ensure they are met.*** Many of the SWAp evaluation documents reviewed, expressed the need to improve planning and budgeting processes at all

[29] SIMPSON et al
[30] SIMPSON et al
[31] SIMPSON et al
[32] ADDAI, E. & GAERE, L p15
[33] ADDAI, E. & GAERE, L p9
[34] ZAMBIA JOINT MISSION (b) p28
[35] MOH GHANA (a) p26

levels, and also identified the need to establish mechanisms for negotiating and agreeing priorities in a resource scarce environment. Moreover there may be the perception that local priorities are different. A paper written in 1999 about the Zambia TB programme suggested that "*As the relative share of interventions of the (essential service) package is unquantified, neither in volume nor with regard to lower limits or ceilings of budget per intervention, the risk exists that tuberculosis might receive insufficient attention and funding. Even though the current rate of tuberculosis is as high as 400 per 100,000 population, this number might be perceived by the DHB and DHMT as relatively small in view of the total morbidity and mortality due to all diseases in the district*"[36]. This may have been compounded by the relatively high cost of drugs so that DHBs may have seen TB control as taking too high a share[37].

54. ***The message failing to be conveyed that a programme is still a priority even where it does not have earmarked funds*** It may be that a previous emphasis on vertical programming implied priority to staff at district and central level, whereas an integrated approach does not. Moreover vertical programmes usually offer incentives for performance, or additional allowances, which may have been lost at integration, the loss of which would have acted as a disincentive on staff.

55. ***Attention being focused elsewhere on other capacity building efforts***. Ghana focused on building financial management competency rather than implementation capacity, which again may have given signals that that the latter was less important than the former.

4.1.5 Changes in the development partner role and relationships

56. The adoption of a sector wide approach should imply a fundamentally different role for development partners and a change in the form of relationship with recipient governments. The move from project support to integrated programmes implies a focus on policy level issues by DPs whilst leaving government to concentrate on the detail of implementation. Although this is not yet fully happening in most countries (generally DPs have taken on the policy focus but not yet disengaged themselves from the details of programme implementation) the relationships between government and DPs have changed in terms of expectations. Also the mechanisms by which DPs influence strategy and performance are different. The arrangements are evolving and have been tested by and impacted on issues around newly integrated services. For example:

57. ***Governance problems with procurement in Zambia have been the cause of DPs withdrawing support or hesitating to commit assistance***. SIDA withdrew from the supply of drug kits in 1998 because of the contract award issues described above. And although the first steps towards setting up a Drug Supply Fund has been taken by government, DPs are not yet sufficiently confident of the clarity of the management arrangements to transfer money directly into this 'basket'[38]. Wider governance problems also led to a temporary withdrawal of basket funding.

58. ***The effectiveness of the partnership is highly dependent on Government's willingness to accept it***. The new role of DPs as policy influencers is dependent on the willingness of the recipient government to welcome or allow that degree of intervention across the whole of the sector rather than on project issues. Zambia experienced considerable difficulties with this following a change of Minister who

[36] BOSMAN, CJ, (b) p8
[37] BOSMAN, CJ, (b) p9
[38] ZAMBIA JOINT MISSION (b) p89

less favourable to the idea of reform and the DPs role in this, and who wanted to revert to a more projectised approach to aid management. This issue, plus a number of other factors at the time meant that relationships and implementation suffered.

4.2 Programme improvements

59. The literature and interviews suggest that there are areas of overall improvements in the sector programmes which are either currently impacting on the performance of activities which were previously integrated, or have the potential to do so. These areas are:

- Improved planning
- Greater expenditure at district level and more rational resource allocation
- Improved financial management and accountability
- Swifter programme mobilisation
- Better linkages outside MoH
- Wider accountability for programme performance

4.2.1 Improved planning

60. Both Ghana and Bangladesh report improvements in planning capacity. In Ghana, staff at all levels in the Ministry and districts have reported that their skills in planning integrated services have increased[39]. This has been supported by improvements in reporting[40] and the investment in reforming disbursement mechanisms which have given CoG greater control of resources and supported a more integrated approach to planning and budgeting. This last has been reported to be one of the major benefits of the SWAp[41], as well as an improved reporting and review process.

61. In Bangladesh MoHFW is reported to have made significant progress in developing management capacity particularly in Directorates and at Upazila (sub-district) level. This had been facilitated by important re-emphasising of the functions of various levels made possible by the end of projects and the introduction of the sector wide approach, in particular separating policy and planning functions (located in the Secretariat) from implementation responsibilities (located in the directorates and below) [42]. At secretariat level the quality of six monthly policy dialogues with DPs have also improved[43].

62. The integration of the majority of vertical programmes into an essential service package has necessitated a major rationalisation process of planning as well as implementation, which has had important consequences for increasing realism and transparency in planning and budgeting. The 25 Annual Operating Plans have now been reduced to two (one each for Health and Family Planning), which cover planned activities for the year, both capital and recurrent, and are based on realistic resource assumptions by including funds from all sources - government revenue and development funds, development partners pool funds and other development

[39] STARLING, M
[40] MOH GHANA (b)
[41] ADDAI, E. & GAERE, L
[42] SIMPSON et al
[43] Personal communication

partner support provided in parallel[44]. This has been a major achievement because, according to Simpson et al they now:

- "*Demonstrate that funds will be well used on sound plans directed to achieving agreed objectives;*
- *Draw together project and programme activities that are funded in different ways to show the total investment and activities for each operational area;*
- *Provide a solid input basis so that donors (and government) know in advance what their money will be spent on;*
- *Provide a mechanism for monitoring implementation and expenditure*"[45].

4.2.2 Greater expenditure at district level and more rational resource allocation

63. Both Ghana and Zambia can demonstrate a shift in resources to district level, and Bangladesh is increasing allocations to ESP. In Ghana "*There has been a significant reallocation of expenditure to the district level, from 26 per cent in 1997 to 41 per cent in Jan-Sept 1999*"[46]. In 1999 district spending was above target even though allocations to tertiary and regional levels were slightly higher than those targeted[47]. Gaere et al suggest that this overall shift in resources to district level "*can be taken as a marker of the success of budgetary reform*"[48] which has taken place as part of the sector wide approach.

64. Similarly in Zambia rough analysis of the GRZ & DP expenditures for the period 1998 and 1999 shows that actual allocations to the districts increased from 47% to 55%[49]). Not withstanding the limitations outlined in previously, allocations between districts have been shown to be based on a strong relationship between the 'needs based' indicators, so that the higher the IMR and incidence of extreme poverty in a district the higher the allocations it receives[50]. Therefore despite a fall in real per capita expenditure overall brought about from macro-economic problems amongst other causes, it has still been possible to improve allocative efficiency and target funds towards areas and service delivery levels of greatest need.

4.2.3 Improved financial management and accountability

65. Ghana offers a positive example of the improvements in financial management and accountability that can be brought about through a sector wide approach. Gaere et al judge it to be "*One of the most successful areas of systems development and capacity-building in the Ghana health SWAP, contributing considerably to the overall efficiency of the health system*" [51]. Specific achievements which have helped with programme planning and implementation are detailed in Box 5. The result has been that managers at Budget Management Centres have direct control over resources including pooled funding. Also donor confidence in government systems is reported to have grown which may increase the potential for additional resource mobilisation.

[44] SIMPSON et al
[45] SIMPSON et al
[46] MOH GHANA (b)
[47] ADDAI, E. & GAERE, L
[48] ADDAI, E. & GAERE, L
[49] ZAMBIA JOINT MISSION (a),
[50] ZAMBIA JOINT MISSION (a),
[51] ADDAI, E. & GAERE, L

4.2.4 Swifter programme mobilisation

66. A key area of success in the Bangladesh SWAp has been the impact that the integrated approach has had on the process by which new programmes have been approved and funded. Under the Fourth Population and Health Project, an umbrella for 65 differently funded and negotiated projects, the average time from the formulation of each individual project from concept to approval was 2.5 years, whereas the equivalent time for preparation of the HPSP as a whole was about 1.5 years[52]. Also once HPSP had been approved implementation began almost immediately afterwards and the first reimbursement from the pooled fund happened 6 months after that. Under FPHP some project disbursement took as long as four years to come through[53].

4.2.5 Better linkages outside MoH

67. Although all the SWAps under review have been slow to take on board the contribution of the non governmental sector (both for profit and not for profit), there are reports that this is gradually being addressed, suggesting a sector wide approach offers some prospect of more structured working with non governmental providers. Ghana MoH is considering how best the state sector can support and facilitate private and mission sector provision, although indicators of progress need to be developed[55].

Box 5 Ghana: Financial management and accountability improvements to support programme planning and implementation

Gaere et al report the following improvements in financial management and accountability[54]:

- Reliable and timely financial reports from the various levels of BMCs, supporting regional and national aggregation and analysis, for example expenditure by facility level and by type of expenditure.
- The national level Quarterly Financial Statements, and amalgamated Annual Statements, are detailed and high quality reports which have been accepted by partners as basis for ongoing release of funds. In addition, generally satisfactory arrangements for internal and external audit are in place, there is regular joint review of audit findings and mechanisms are in place to follow up on problems that are identified.
- The process of BMC readiness assessment to hold funds has been the overall catalyst for decentralisation of planning and budgeting (see above). The major benefits of BMCs managing their own funds have been noted elsewhere. This has been a lynchpin development in terms of the wider SWAp process.

[52] SIMPSON,D et al
[53] SIMPSON,D et al
[54] ADDAI, E. & GAERE, L
[55] MOH GHANA (b),

68. Starling also reports that inter sectoral work is improved by support to district based integrated systems, for example by enabling "*a more cohesive approach to the planning and implementation of complex malaria interventions*" [56]

4.2.6 Wider accountability for programme performance

69. One of the most important changes which has been brought about by the SWAp has been the alteration in perception regarding accountability for programme performance. For example in Ghana Gaere reports the pooled fund has led to accountability for resources becoming wider for both MoH and those DPs contributing to the common fund[57]. The improvements in policy dialogue between MoHFW and DPs in Bangladesh also suggests a changing perception of more 'common ground' and shared interest in the programme as a whole rather than individual donors concentrating on one or two programme aspects. In Zambia, when relations deteriorated with the government it was the commonality between donors which enabled them to give a collective response and act as a group in addressing problems[58].

5 RECOMMENDATIONS

70. This section is based on the above problems experienced in the programmes reviewed, and the possibilities for performance improvement. It gives recommendations on how to address potential problems and capitalise on opportunities presented by the SWAp in Tanzania to deliver a reliable integrated TB and leprosy control service. Recommendations include both those that could be adopted in the short term, which are summarised in section 6, and others which are longer term. Some recommendations are also for issues that could be included in any appraisal exercise that SDC may wish to consider prior to taking the final decision to integrate.

5.1 Capacity building

71. This is a key area given the major reorganisation that is resulting from the current decentralisation programme underway in Tanzania, which will place major demands on staff and systems capacity even before any vertical programme implementation is further integrated into their daily responsibilities. The NTLP does already have some degree of integration at district level and below which is an advantage over the situation in Zambia for example, but many issues remain similar because of the proposed further decentralisation of implementation and supervision activities from the centre to regional and district levels. Recommendations are:

72. ***Ensure as far as possible that capacity exists <u>before</u> any technical and managerial responsibilities are passed on***. Although there is something to be said for the 'learning by doing' approach it has clearly not been successful in Zambia. Specific strategies need to be developed for managing and implementing TB and leprosy control that build on existing capacity building initiatives with the District Health Management Teams and others at regional level. It is important not to lose sight of the need for capacity building in planning and implementation as well as financial management systems. This should include consideration of the incentives that existed in the vertical structure for staff to work on the TB

[56] STARLING, M
[57] ADDAI, E. & GAERE, L
[58] Personal communication

programmes (e.g. extra payments or allowances) and the performance management structure, in order to consider how these can either be continued or replaced without de-motivating staff. The wider performance management system should be considered and become a target for possible capacity building.

73. ***DP and MoH should plan for continued capacity building after integration*** Even in Tanzania where activities are already integrated at district level and below, a change in funding arrangements, reporting and drug ordering will necessitate new skills and concrete understanding of how disease control national systems will work above district level in order to avoid a hiatus in implementation as happened in Ghana. This is particularly important where systems are in transition as it implies ongoing capacity building even after the initial integration. This capacity building may be done as part of wider district based capacity building initiatives, but there is a case for ensuring that disease control is given high profile within any such initiatives.

74. ***Continued technical assistance is likely to remain necessary***. Ideally it should be placed more under the direction of MoH and preferably should be something they purchase themselves with pooled funds – this is something to aim for – but in the interim and especially during the transition phase SDC may wish to consider extending options for providing TA into integration.

75. ***Work with MoH to consider options for retaining dedicated supervisory and technical capacity at the centre and regions after integration even if these still resemble a vertical programme approach.*** The experience in Zambia shows that this is essential and its absence has directly impacted on performance

76. ***Pay particular attention to where supervisory and leadership responsibilities lie in the system***. The Zambia experience shows that central technical leadership needs to have sufficiently high position and status in order to ensure that priority is retained amongst other national priorities, and technical support at all levels below is effective. At the same time middle levels need to have retained sufficiently expert supervisory capacity to retain contact with district level activities and ensure that priority is retained. This need not be one person who only does TB but a supervisor who knows enough to help plan and then supervise TB activity (as well as other public health issues) The future role of the programme co-ordinators at district and regional level needs particular consideration.

77. ***Ensure that transition is gradual.*** The almost overnight integration in Zambia created major problems but Ghana benefited from a more gradual approach. Although in Tanzania a significant degree of integration has happened already it will still be necessary to ensure that integration above district level is carefully paced as continued supervision is essential – [interruptions will swiftly impact on lower levels. A phased approach to moving away from existing NTLP planning processes and integrating them into national systems would be appropriate with perhaps both running in parallel for a time if this is feasible.

78. ***Ensure reporting remains robust*** Reporting is clearly essential for effectively managed TB/L control activities. There is a clear need to ensure that reporting covers all aspects of TB/L control necessary to monitor performance both locally and nationally. Given the importance of TB in particular there is a case for setting up additional indicators in the existing national health management information system where this is judged to be lacking. Consideration should be given to continuing to report on drug stocks in order to ensure that districts are able to manage ordering and that the national level is able to respond adequately.

79. ***Consider helping MoH to develop specific strategies for advocacy for TB and leprosy as priority programmes with both national government (MRALG) and***

local government in order to try to ensure that disease control activities remain a priority.

5.2 Addressing procurement issues

80. Procurement issues are clearly an area where considerable attention needs to be paid in order to protect drug supply and other essential goods. Recommendations are:

81. ***Expect problems***. In addition to the case studies reviewed here many other programmes have had a history of procurement difficulties and full scale interruptions in implementation for both capacity and governance reasons. Attempts to resolve the difficulties have generally moved slowly as it is a sensitive area and one where problems can lead to suspension of funding and the whole programme being affected. However procurement generally cannot wait, so DPs need to take a strategic long term view of building capacity and dealing with immediate problems.

82. ***Carry out a careful assessment of MoH procurement capacity in order to establish its immediate ability to procure effectively and efficiently***. This should include reviewing recent performance, current procedures and management culture.

83. ***Anticipate having to carry out some immediate capacity building work in order to ensure that any new procurement functions operate smoothly***. It may also be necessary to have in place emergency plans, and to put these into action early in the course of any difficulties. Bangladesh DPs having to carry out emergency procurement found that even this took several months so an emergency solution may not necessarily be a quick one.

84. ***Take a longer term view of capacity building***. Both the Zambian and Bangladesh experience suggest that the initial strategies to handing procurement over to government have not been successful; other approaches have been necessary, including technical assistance to support a long transition phase; for example Ghana has continued technical TA, and independent procurement audits

85. ***Try to negotiate with GoT and other DPs a procurement system which reduces transaction costs and labour intensity rather than increases them***. Ideally procedures should eventually be based on government's own systems so that procurement for both external funds and internal funds is improved.

86. ***Consider professionalising the procurement function if this is not already the case*** Interviews from Bangladesh suggest that one of the problems has been not only staff turnover which means capacity building has to be repeated, but the generalist skills of those staff in an area which in most other countries is at least led by professional procurement officers. It may be that advocating professionalising their skills, whilst possibly contentious, may be a step towards improving performance. Another option may be to contract out procurement e.g. to Crown Agents either early on or as an interim strategy, although capacity would still need to exist in MoH to manage that contract.

5.3 Funding

87. In an integrated programme, the maintenance of overall funding levels to the SWAp will be essential to ensure that performance does not suffer. If SDC is considering transferring the current NTLP pooled funding arrangement to the district and central baskets then the following recommendations may be appropriate:

88. ***Reappraise the likelihood of macro-economic decline and economic shocks (e.g. natural disasters) and their possible impact on GoT capacity to continue current funding to the programme***. In the SDC Programme Document this risk is rated as medium[59]. Consider therefore also the capacity and willingness of SDC and other partners to step in if government funding does of necessity drop.

89. ***Carefully monitor overall expenditure of the programme in order to ensure that substitution does not take place***. An analysis of budgetary allocation and expenditure since the start of the five year programme of work should inform any judgement about possible future performance. This monitoring should be done on a ongoing basis and should include relative proportions to tertiary, secondary and primary care where targets have been set. Essentially the question is whether funds channelled through the pool will represent additionality which can benefit primary care including TB / Leprosy control or whether funding for these activities will effectively diminish.

90. ***Assess absorption capacity of the programme overall to utilise available funds adequately***. The results of this need to be seen in the context of previous absorptive capacity under the projectised vertical approach and whether indications are of progress since such capacity was rated as weak in the SDC programme document[60].

91. ***Ensure that SDC as a single donor has the ability to meet its commitments to the pool on time.*** Similarly the performance of the Basket Funds in meeting disbursement commitments needs to be assessed, as delays by other donors will have a serious impact on delivery of district services.

92. ***Consider earmarking pooled funding as an interim measure.*** This is not an ideal solution but in Bangladesh the annual operating plans which detail all sources of expenditure and planned activities have provided an interim solution to better management of vertical programmes which are not yet fully integrated. They ensure that funding levels remain transparent and therefore targeted as promised, and in turn help programmes to retain their priority status. It should only be an interim measure because flexible unearmarked funding is preferable assuming the government system can set and meet priorities which should be the goal of full integration.

5.4 Addressing priority issues

93. Some of the problems of the TB and Leprosy Control activities losing their priority status may be partly addressed by building planning and implementation capacity at all levels .Other recommendations for ensuring priority is retained are:

94. ***Appraise national planning and budgeting mechanisms to establish how well they communicate and support national priorities***. This is a particularly crucial issue because of the nature of decentralisation in Tanzania and the role of MRALG. The efficacy of block grants and the national minimum standards for health should be considered as well as the strength of district planning in response to these. This should include an appraisal of the efficacy of inter-ministerial working with MRALG, and capacity for joint priority setting and planning.

95. ***Ensure that during the transition phase and capacity building TB and leprosy control continue to be presented as national priorities.*** Assess to what extent they are reflected in health policies, the essential service package and training courses , both basic and in service

[59] SDC(a)
[60] SDC(a)

96. ***Ensure that there is adequate technical input to national planning processes at all levels and that the process is not overly administratively led***.

97. ***Encourage improvements in needs assessment at local level and flexibility in funding to respond to these***. This will be a long term strategy but should be a priority focus on SDC participation in ongoing policy and implementation dialogue.

98. ***Encourage strategies that facilitate participation by local populations***. This is important but is likely to take some time to be effective, and even then may not guarantee that TB and leprosy get the attention that the centre or DPs may consider that they need.

5.5 Addressing relationship issues

99. The strength of the relationship between DPs currently supporting NTLP, MoH and MRALG will be key to determining how effectively future problems can be resolved. Recommendations are:

100. ***Consider the possible impact of a change of government or minister, and the effect on the programme if the SWAp lost political support***. Would it be possible for SDC to retain the degree of influence on the programme overall and TB leprosy control in particular?

101. ***Accept a change over to integration is a one way event*** and it is then difficult to return to old funding arrangements without seeming to withdraw support to the programme as a whole. Whilst there is strong momentum towards integrated systems and GoT is encouraging funding through pooled arrangements a return to a projectised approach would be politically difficult

102. ***Assess whether there is enough cohesion with other DPs to overcome programme problems*** and whether the five year programme of work DP coordination arrangements give opportunity for effective raising of technical and implementation problems. if this is not the case then it may be appropriate to consider retaining the NTLP Management Committee, as an additional forum to discuss issues in more detail.

6 CONCLUSION – PRIORITY RECOMMENDATIONS

103. The main lesson of this paper is that programme performance is likely to suffer in the short term, but that wider SWAp developments in Tanzania may eventually redress shortcomings. The ToRs state that drop in quality in the long term is not acceptable to SDC, and it may be that even an interim phase would be too long lasting to be permissible. Assuming however that the decision is made to integrate, in the short term there are clearly a number of things that could be done to try to ensure that programme disruption is minimal. Primarily integration should be based on:

- A phased approach;
- A realistic appraisal of the environment into which the programme is being introduced e.g. national procurement systems, district planning capacity;
- Continued support throughout transition.

104. Based on the consultant's knowledge of Tanzania and the documentation provided for this assignment the priorities may be:

105. ***Build capacity at district level in the DHMTs especially of the DMO***. This could be done by either linking up with wider capacity building efforts, or if these are too long term or cannot be focussed enough, then specialised TA could be used. One

option could be to reassign some existing NTLP staff at regional and district levels to become support and capacity teams focusing on transition issues and areas where skills are known to be deficient. They would need to focus on conveying the concept of integration, explaining new structures and financing arrangements and ensuring that planning and monitoring functions are strong. This arrangement could run for as long as it took to create sufficient capacity, and could be supported by external TA as required.

106. To summarise the key points above it is recommended that:

Capacity building should happen in advance of any change over of responsibilities

It should continue after integration, including ongoing TA.

Central support should be considered as a long term option

107. ***Protect funding to the programme.*** The issue of setting and following priorities and therefore districts allocating adequate funding to TB and leprosy, is very bound up with wider local government reform and the linkages between that and MoH. Whilst it will be important for SDC as a donor to advocate for improvements etc, in the sort term the effective execution of the programme is going to depend on there being enough money at district level, and the DHMTs being prepared to spend it on TB/leprosy control activities. Therefore earmarked funding may be a wise option to consider, ideally as a short term measure but for as long as it takes to ensure that district capacity exists to utilise and manage these resources. This should include guidance on the proportions to be allocated to drugs etc. This would also mean that a phased approach was adopted by avoiding devolving both technical and planning responsibilities at the same time. Planning and budgeting for the programme should be included as part of capacity building in order to anticipate these new responsibilities once earmarking is no longer in place.

108. ***Ensure that procurement continues uninterrupted.*** It was not clear from the documentation provided how integration of procurement is envisaged. At the moment the arrangement appears independent of MoH core procurement functions, and is effective. If the MoH procurement function is weak but is expected to take up TB/leprosy drug and supplies procurement then an interim strategy will be essential to provide a safety net. This could be done either by contracting procurement to another organisation e.g. Crown Agents, whilst the central capacity is built up, or retaining current arrangements but moving minor procurement exercises to MoH as a trial run. Alternatively the whole process could be handed over but with support of external TA, or the use of existing NTLP staff temporarily assigned to the procurement unit during the transition phase. At the same time procurement should be the focus of special capacity building at district level so that any changes to 'push/pull' arrangements can be managed. Main recommendations from section 5 are:

- Any change over of responsibilities should be preceded by a careful and far sighted capacity assessment
- Capacity building should be started in advance of any changes in systems.
- The emphasis should be on decreasing workload rather than duplicating systems or procedures

Annex 1 Country Programme Summaries

Ghana

Vertical programme integration started in the early 1990's, with programmes such as TB, MCH and Leprosy control being moved, incrementally, into existing institutional arrangements for service delivery. The intention of the MoH in adopting this strategy was to address the problem of the dominant role of donor projects, as well as bring services closer to communities and make them more holistic and easier to access. Support systems such as planning, procurement and transport have also been integrated within the decentralised district health system. Health centres are now structured to provide an integrated package of preventive, clinical and maternity services

Services at district level, (like those at national, regional and tertiary levels) are supported in part by the Health Fund, to which 5 donors contribute on an annual basis. Whilst the Health Fund is disbursed separately from GoG funds, it is budgeted for and reported on in an integrated way (budgets and financial reports are based on a combination of Health Fund, GoG funds and Internally Generated Funds). The proportion of donors funds being channelled through this pooling mechanism is increasing, and in 1999 was estimated at 39% of total donor funding.

Zambia

Vertical programmes were rapidly integrated into national delivery structures in 1997 as part of a comprehensive restructuring of health service delivery and management which aimed to increase decentralisation and democratisation. The focus was on strengthening district health systems to provide a basic packages of health services, supported by decentralisation of financial and administrative powers to health boards MMP At the central level (within the Central Board of Health) a limited number of technical staff remain, the number of which vary between programmes, but all other implementation responsibilities now lie within District Health Management Teams supported by Provincial Health Offices. Procurement is centralised with districts ordering drugs and supplies from Medical Stores Ltd through the Central Board of Health

Zambia innovated the 'district basket' concept with unearmarked funds being channelled to districts (approximately 20% of donor funding in 1999). A 'basket steering committee' meets quarterly to monitor performance and approve allocations.

Bangladesh

Vertical programmes were integrated into national delivery systems at the same time as the sector wide approach was introduced, in July 1998. The main impetus was to increase government ownership of health policy and implementation and reduce the problems generated by over 120 different donor funded projects. Now there is a single sector-wide programme, and all activities are managed within it under the responsibility of GoB Line Directors. Funding is allocated according to a sectoral annual planning and budgeting process. Line Directors produce their own plans and these are coordinated with each other to produce an annual plan for the sector. Most vertical programmes are included in the costed Annual Operational Plans (AOPs) of the two ESP Line Directors (Family Planning and Health), which are shortly to be unified. Fund release is managed centrally and Statements of Expenditure are compiled in the Ministry, against which donors make reimbursement. However many parallel funded activities remain, which are within the SWAp and are jointly planned (in the AOPs) and monitored, but separately funded (although again funding is captured in the AOPs) . Decentralisation has not yet taken place beyond the Directorates, and therefore logistical functions such as procurement are highly centralised.

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Annex 2 Terms of reference

Terms of reference

(Revised 10 April 2001)

Background:

SDC is supporting since 1979 the Tanzania National Tuberculosis and Leprosy Programme (NTLP). Over all these years the amount of CHF 19'030'000 has been spent from the Swiss side for the programme. Since four years now several other donors have joined in supporting this programme, these include the Royal Netherlands Government, Ireland Aid, Netherlands TB association (KNCV), German Leprosy Relief Association (GLRA), WHO and the Government of Tanzania. The Programme is being implemented by a specifically designated unit of the preventive department within the Ministry of Health. A long -term external backstopping mandate is assigned to KNCV for supervision and monitoring.

Since 1996 the Tanzanian partners introduced a fund pooling arrangement in order to facilitate the handling of the programme. The Ministry of Health is the leading ministry for the programme.

The NTLP has continued to have all the characters of the typical vertical programmes. This characteristic seemed to have further been strengthened by the emergency of the heavy burden of disease resulting from the HIV/AIDS. However, with the introduction of the Health Sector Reform as well as a Sector Wide Approach planning process for health, the first initial steps towards integrating this programme within the national health planning and budgeting excise is under way. Since the main focus of the reform is to decentralise implementation and supervision responsibilities from the centre to the district and regional levels respectively, the need to progressively integrate NTLP activities in the public health systems at each tier is becoming more urgent than before. Considering the long duration of the Swiss support and the amount of funding made available to the programme, and not withstanding the increased number of patients due to HIV/AIDS pandemic, the overall performance track record of the NTLP has remained good and commendable.

Today the NTLP planning mechanism is structured in the following manner: Based on a vertically designed continuous data collection mechanism in place, the central Ministry responsible unit is able to collect all important national TB related information from the districts. The NTLP Programme co-ordinators at district and regional levels facilitate this process. This information is analysed and compiled at the central level for translation into a main input for the planning exercise. The next step is, based on the information collected; the centre is able to outline priority programme objectives and activities for a three-year phase often broken down in single year Plan of operations.

Regarding the flow of funds: Based on an approved annual Plan of operations which is further broken down in four quarters, the donors/partners together with the Government are able to disburse funding to a special bank account designated for the programme. Using this account the Programme Manager is first able to procure all programme requirements centrally, this includes drugs, reagents, equipment etc. The balance, which is usually meant for programme district activity implementation, is transferred to an account held by each of the Regional TB Co-ordinators (RTLCs) who reside at the regional level. The RTLCs in turn forward cash to the District TB co-ordinators (DTLC) of their region on imprest/advance basis for programme activity implementation. For purposes of receiving the following quarter allocation, the previous quarter allocation/advance has to be accounted backwards up to the central level. Donor/partners fund disbursements to the joint special account for the programme is also subject to the submission of an audited report of the previous quarter disbursement. The flow of funds is vertical and centrally managed. The District Health Management Team which is in-charge for the overall health activities implementation in the district is by passed and often not informed on what has been made available for the TB & Leprosy programme.

The study:

SDC is heavily involved in the health sector SWAP in Tanzania. The nature of its involvement has been presented last November in Maputo and should be known by the consultant.

The NTLP programme is going to its 8th phase and a planning workshop for the next three-year phase was conducted this last December. SDC's current position towards the programme is to maintain its funding level – this is justified by the prevailing burden of disease. While SDC agrees to a continued support to the programme, we would however like to assess on the possibilities of integrating this programme within the national health delivery system without jeopardising the achievements so far made or negatively impacting on the expected outputs and outcomes.

The study should therefore collect worldwide experiences of the integration of vertical programmes into national health management structures, and specifically SWAPs where information is available. The paper will explore the impact of changing both management and financing arrangements. SDC would like to have the most important insights, recommendations and results in this field, before making any further decision for its input to the NTLP programme. The study should therefore be structured in a way that facilitates decision making on our part, i.e. rendering us aware of lessons, weaknesses, risks/traps, strengths etc. in order to proceed with the integration of the NTLP programme into the SWAP process without lowering its impact on outputs. A decreasing quality and quantity of outputs on the long term is however principally not acceptable under today's circumstances.

Given that there is as yet little hard evidence of the impact of integration of vertical programmes into SWAps the study will also try to review field experiences of practitioners which have not yet been documented – through interview, questionnaires etc.

The task:

Collect and analyse international experiences in the light of the core question: Experiences made and lessons learnt in the integration of vertical programmes into sector wide approaches.

It is meant as a desk study, going through the available literature, filtering the most important lessons and experiences in order to facilitate SDC decision making in its NTLP programme. SDC expects the following outputs:

- An analytical and synthetical report of max. 25 pages (without annexes) with an executive summary
- A limited number of recommendations related to the core question
- If necessary outlining alternative scenarios for such an integration

Timing:

The study should be finalised latest July 31st 2001 and should be sent in an electronic version to SDC Berne.

Information:

An information package on the NTLP programme in Tanzania will be sent to the consultant after signature of the contract. The co-ordination office in Dar Es Salaam is available to give any further detail information.

For SDC — The consultant

G. Siegfried — A. Brown

Background papers:

- Project documents and credit proposals NTLP
- Project documents and credit proposals SWAP Tanzania