



Good Governance, Aid Modalities and Poverty Reduction: Linkages to the Millennium Development Goals and Implications for Irish Aid

Research project (RP-05-GG) of the Advisory Board for Irish Aid

The Advisory Board for Irish Aid
An Bord Comhairleach do Chúnamh Éireann



Working Paper 7

Donors and the Political Dimensions of Health Sector Reform: The Cases of Tanzania and Uganda

Kent Buse and David Booth
with Grace Murindwa, Aziza Mwisongo
and Andrew Harmer

March 2008



Acknowledgements

The views presented in this paper are those of the authors and do not necessarily reflect the views of the Advisory Board for Irish Aid or those of any of the organisations in the research consortium implementing the project.

The authors also thank Bill Morton of the North-South Institute for comments on a previous draft, and Jo Adcock for excellent editorial assistance. Responsibility for the content of published version remains with the authors.

Good Governance, Aid Modalities and Poverty Reduction Working Paper Series

Working Paper 1: *Democratisation's Third Wave and the Challenges of Democratic Deepening: Assessing International Democracy Assistance and Lessons Learned*

Lise Rakner, Alina Rocha Menocal and Verena Fritz (2007)

Working Paper 2: *Neopatrimonial Politics, Decentralisation and Local Government: Uganda and Malawi in 2006*

Diana Cammack, Fred Golooba-Mutebi, Fidelis Kanyongolo and Tam O'Neil (2007)

Working Paper 3: *Corruption, Anti-corruption Efforts and Aid: Do Donors Have the Right Approach?*

Ivar Kolstad, Verena Fritz and Tam O'Neil (2008)

Working Paper 4: *Regional Organisations and Incentives to Improve Governance: The APRM Experience, with Particular Reference to Ghana.*

Sven Grimm with E. Gyimah-Boadi (forthcoming 2008)

Working Paper 5: *Measuring Governance: What Guidance for Aid Policy?*

Julius Court and Verena Fritz with E. Gyimah-Boadi (2007)

Working Paper 6: *Building Blocks or Stumbling Blocks? The Effectiveness of New Approaches to Aid Delivery at the Sector Level*

Tim Williamson and Zainab Kizilbash Agha with Liv Bjornstad, Gerald Twijukye, Yamungu Mahwago and George Kabelwa (2008)

Working Paper 7: *Donors and the Political Dimensions of Health Sector Reform: The Cases of Tanzania and Uganda*

Kent Buse and David Booth with Grace Murindwa and Aziza Mwisongo (forthcoming 2008)

Working Paper 8: *What is New in the New Thinking about Conditionality? The Experience of General Budget Support in Ghana and Tanzania*

Zainab Kizilbash Agha and Andrew Lawson (forthcoming 2008)

www.odi.org.uk/PPPG/politics_and_governance/what_we_do/Politics_aid/Governance_Aid_Poverty.html.

Overseas Development Institute

111 Westminster Bridge Road

London SE1 7JD, UK

Tel: +44 (0)20 7922 0300

Fax: +44 (0)20 7922 0399

www.odi.org.uk

Contents

Executive summary	vi
1. Introduction.....	1
2. Literature on the political-economy of reform and health reform	2
2.1 The political-economy of policy reform	2
2.2 Experience with health sector reform – the politics	2
2.3 Politics of sexual and reproductive health reform.....	4
2.4 Prospective management of the political dimensions of health reform	6
3. A survey of approaches to understanding the politics of health reform	7
3.1 Donor approaches – results of a telephone survey	7
3.2 Politics in health sector strategy documents	9
4. Experience on the ground: Tanzania and Uganda.....	11
4.1 Health reform challenges	11
4.2 Dimensions of stakeholder politics	12
4.3 Feasibility of a proactive political-economy approach to informing policy dialogue and guiding action	15
5. Conclusions	20
References	23
Annexes.....	29
Annex 1: Tanzania field report	29
Annex 2: Uganda field report.....	41
Annex 3: Question guide for donor agencies	50
Annex 4: Question guide for technical agencies	51
Annex 5: Health Sector Strategy documents reviewed	52

List of acronyms

AfDB	African Development Bank
AHSPR	Annual Health Sector Performance Report
BFC	Basket Financing Committee
BFP	Budget Framework Paper
CAS	Country Assistance Strategies
CCHP	Comprehensive Council Health Plans
CCM	Country Coordination Mechanism
CEC EU	Joint Research Centre of the European Commission
CGP	Country Governance Profiles
CIDA	Canadian International Development Agency
CPIA	Country Policy and Institutional Assessments
CSP	Country Strategy Papers
DfID	Department for International Development (UK)
DGIS	Netherlands Ministry of Foreign Affairs
DP	Development Partners
DPG	Development Partner Group
FBO	Faith Based Organizations
GBS	General Budget Support
GFATM	Global Fund to Fight AIDS, TB and Malaria
GHI	Global Health Initiative
GoT	Government of Tanzania
GoU	Government of Uganda
GTZ	German Development Cooperation
HPAC	Health Policy Advisory Committee
HSR	Health Sector Reform
HSSP	Health Sector Strategy Paper / Health Sector Strategic Plan
IAU	Irish Aid Uganda
ICPD	International Conference on Population and Development
IDA	International Development Association
IMG	Independent Monitoring Group
JAHSR	Joint Annual Health Sector Review
JRM	Joint Review Mission
KNASP	Kenyan National AIDS Strategy Paper
MAP	Multi-country HIV/AIDS Program (World Bank)
MDG	Millennium Development Goal
MoF	Ministry of Finance
MoFPED	Ministry of Finance, Planning and Economic Development
MoH	Ministry of Health
MoHSW	Ministry of Health and Social Welfare
MTEF	Medium Term Expenditure Framework
NHA	National Health Assembly
NORAD	Norwegian Agency for Development Cooperation
NSGRP	National Strategy for Growth and Reduction of Poverty
OC	Other Charges
PAF	Poverty Action Fund
PEAP	Poverty Eradication Action Plan
PEPFAR	[US] President's emergency Plan for AIDS and Relief
PER	Public Expenditure Review
PORALG	Presidents Office, Regional Administration & Local Government
SBS	Sector Budget Review
SDC	Swiss Agency for Cooperation and Development
SIDA	Swedish International Development Cooperation Agency

SRH	Sexual and Reproductive Health
SWAp	Sector-Wide Approach
TACAIDS	Tanzania Commission on AIDS
TAS	Tanzania Assistance Strategy
TEHIP	Tanzania Essential Health Intervention Project
TUGHE	Tanzania Union of Government and Health Employees
UJAS	Uganda Joint Assistance Strategy
UNFPA	United Nations Population Fund
WHO	World Health Organization

Executive summary

Reforms intended to improve the equity and efficiency of health service delivery in developing countries have had a mixed record of success, for reasons that are at least partly understood. One of the factors distinguishing more successful from less successful reform initiatives is the degree to which stakeholder interests and other political-economy factors are taken into account during design and implementation.

This generalisation is supported by a significant literature, based mainly on Latin American and Asian experience. Some of the literature goes on to propose the adoption of a prospective and proactive management of the political dimensions of reform by a wider array of reform-oriented stakeholders, including aid donors. It therefore provides a useful point of departure for the consideration of the more generic question of what role donor agencies can and should have in the political-economy of reform at sector level in their partner countries.

This paper begins (Section 2) by summarising the evidence that proactive management of the political dimensions of reform is feasible and beneficial, making particular reference to the field of sexual and reproductive health. It then addresses two questions: 1) to what extent are donor agencies, directly or through the health sector strategies they support, already undertaking and applying political-economy analysis to processes of policy change? and 2) what adjustments need to be made to the case for proactive management of the politics of reform when the geographical context is sub-Saharan Africa, and the institutional context includes the complex set of aid relationships now typical of that region, including sector programme support and global health initiatives?

The first question is addressed briefly on the basis of telephone interviews and a selective document review (Section 3). The second was explored through short field investigations undertaken in Uganda and Tanzania in late 2006. The main overarching conclusions from the case studies are set out in the main paper (Section 4), while the factual and observational details concerning the two countries are presented in Annexes 1 and 2.

The paper finds that while important adjustments are necessary in recognition of the increasing internationalisation of the politics of African health reform, the core of the argument for a proactive approach continues to be persuasive. Our brief field work in Tanzania and Uganda confirmed the political nature of the reforms in those countries. In particular, it pointed to an inter-locking set of features involving issues of sector leadership, donor practices and poorly informed and organised progressive interests, which seem to be blocking efforts to improve efficiency, effectiveness and equity in the sector.

The research also revealed a series of constraints to addressing the political-economy obstacles and some potential opportunities. It seemed to suggest a number of attitudinal preconditions for realising these opportunities. As rules of thumb, we suggest:

- Focus on a few key reforms which have proponents in key government positions.
- Unravel the political dimensions associated with the proposed changes – including those which emanate from the constellation of aid modalities.
- Work to address the misconceptions arising out of the current approaches to partnership and government ownership.
- Further develop the coalitions to include civil society interests by building their capacity for political and technical issues.
- Take any opportunities to learn from past success and failure of policy change to inform policy engagement strategies.

The Conclusion (Section 5) introduces a Policy Engagement Framework, and includes an initial analytical toolbox for those embarking on the proposed approach and consideration of ethical issues.

1. Introduction

Over the past two decades, donors have supported a range of health sector reforms (HSR) in low- and middle-income countries (LMICs) to improve equity and efficiency in healthcare financing and delivery. More recently donors have supported reforms to assist countries to meet the health-related Millennium Development Goals (MDGs). Reforms include changes to financing, resource allocation, organisation, public financial management and planning (e.g., SWAps), accountability and stewardship among others. Achieving these second-generation reforms has not been easy and often not wholly successful. The challenge has resulted, in part, from the political dimensions of reform which have not always received the same attention as the technical dimensions. Reform is inherently political, and neglecting to address the political barriers and opportunities for reform has undermined donor ability to support countries to more cost-effectively reduce the burdens of illness they confront.

Donors and foundations are committed to rapidly ramping up health, and particularly HIV-AIDS, spending, while simultaneously considering the most judicious aid modalities through which to do so in different settings. In this context, a more overt politically-oriented approach to understanding the political feasibility of reforms would appear to be warranted.

The remainder of this paper is divided into four sections. Section 2 is a review of the evidence on the political nature of health sector reform. Using the case of sexual and reproductive health, it illustrates the role that politics plays in different stages of the policy process: agenda-setting; policy formulation and adoption; and implementation. Section 3 provides an overview (based on a telephone survey) of what donors are presently doing to understand the political dimensions of health sector reform, and then outlines the extent to which a sample of health sector strategy documents (from LMICs) deal with politics.

Section 4 presents the main findings from short field visits to Tanzania and Uganda. Interviews and documents were used to examine the political-economy of recent health sector reforms in those countries, with a view to identifying the constraints and opportunities facing donors in supporting evidence-informed policy change. Further detail on the two country experiences is provided in Annexes 1 and 2.

Section 5 concludes with an initial analytical toolbox for those embarking on a more proactive approach to African health reform. It provides a summary of an approach which may enable donors to understand better the politics of the reforms for which they advocate and to support national coalitions to engage more effectively to address the politics involved. This section ends with a short comment on some of the ethical issues involved.

2. Literature on the political-economy of reform and health reform

2.1 The political-economy of policy reform

Peter John (1998) defines policy as the 'interplay between institutions, interests and ideas'. This captures three of the main theories why policies change or remain the same, since it emphasises the contributions of institutions (i.e., the rules of the game), actors and networks and their underlying interests, and ideas, including the role of argument, discourse and advocacy, in the policy process as well as that of research and evidence.

Policy change is a complex outcome of the interaction among institutions, interests and ideas as well as luck, uncertainty and unanticipated events (Kingdon, 1984; Hajer and Wagenaar, 2003). Recognising that the policy-making process itself plays a role in determining the success or failure of policy implementation, some developed countries have attempted to 'modernise' policy-making. The United Kingdom, for example, has issued detailed guidance to ministries on core principles and methods (UK Cabinet Office, 1999). Yet, even in high-income, well-governed countries, modernising policy processes is uneven (Alvarez-Rosete, 2005). In low-income and weakly-governed contexts, where 'a single set of institutional rules of the political game are seldom present', policy change is more political and more likely subject to capture by elite interests (Leftwich, 2006).

The first generation of reforms in developing countries, concerned largely with economic stabilisation and structural adjustment (e.g., tariff reductions, exchange-rate devaluation), were often referred to as 'stroke-of-the-pen' reforms because they were largely single-event policy adjustments and self-executing. In contrast to macro-economic policy changes, Nelson (1999) has argued that 'Social sector reforms are a different ball game, with far more actors, less leverage, different fields of play, a much longer playing period (with unpredictable time-outs) and uncertain scoring'. She draws attention to the strong administrative and professional apparatus that resist reform in these sectors (Nelson, 2000).

Literature on the political-economy of social sector reform suggests that the prospects for pro-poor reform are not encouraging (Batley, 2004). Rational choice theory explains these outcomes by drawing attention to the asymmetries of power and incentives facing winners, losers and politicians – specifically that the potential losers are aware of their losses and quick to respond (e.g., health-provider unions), while potential winners (e.g., primary beneficiaries of interventions) are less likely aware of their benefits (which may not accrue immediately) and are less well organised.

Some political economists have focused on the role of formal and informal institutions in explaining reform failure – for example the distribution of power between the executive and legislature, or the number of political parties, central control over political parties, or common ways of doing things (e.g., clientelism) (North, 1991; van de Walle, 2001). Institutional factors affect the extent to which winners and losers have access to decision-making forums as well as the value of their political assets (Swank, 2002). Interests defending the status quo tend to be more powerful than reformers as they are usually the winners of prior policy contests and have rigged the rules of the game in their favour (Oliver, 2006) – the so-called 'mobilisation of bias' (Schattschnieder, 1960).

2.2 Experience with health sector reform – the politics

The relatively limited literature on health sector reform in developing countries presents a mixed picture concerning the prospects for pro-poor, evidence-informed policy change. Health sector reform has been described as changes that are fundamental (as opposed to incremental) and

sustained (as opposed to one-off) (Cassels, 1995). These reforms tend to be concerned with improving the performance of the civil service, decentralising authority, broadening financing sources, better prioritising and targeting of public expenditure, contracting-out service delivery and introducing managed competition (World Bank, 1987; World Bank 1993).

Donors have supported governments to adopt and implement such macro-level health reforms with technical and financial assistance over the past two decades – particularly the World Bank and USAID (through Abt Associates and Partnership for Health Reform) as well as DFID and others. Donors and technical agencies have also backed less far-reaching reforms such as the introduction or scaling up of specific evidence-based or evidence-informed technical interventions (such as Prevention of Mother-to-Child Transmission of HIV/AIDS or Hepatitis B vaccination). A number of retrospective analyses of both systems-level and intervention-oriented reforms have appeared in the literature. These are reviewed in Gilson and Raphaely (forthcoming).

Analysts place different degrees of emphasis on the role which contextual factors, institutional features, policy process, and actors/interests play in explaining policy outcomes. Based on an analysis of health reforms in seven countries, Collins et al. (1999) elaborate on a number of interacting contextual features impacting on policy content. Shiffman (2002) also demonstrates how context affects policy content in a comparison of reproductive policies in Serbia and Croatia following the break up of Yugoslavia. Green (2000) examines both contextual factors and the shifting power of interest groups in keeping needed health reforms off the agenda in Thailand. De la Jara and Bossert (1995) explore the role of antecedents, interest groups and consensus-building over the longer term in Chile, and conclude that the processes are inherently complex and not captured by simple hypotheses. Weyland's analysis of health reform in Brazil (1995) underscores the role of institutions. As members of the reformist social movement gained posts in different public agencies to support reforms, they 'soon absorbed these agencies' organisational interests and were drawn into the rampant bureaucratic politics that ravages the Brazilian state'. Reforms were further undermined by opposition from clientelistic networks.

Literature on health sector reform confirms that the politics of reform are as important to success and failure as are the financial, administrative and technical features. Reichenbach (2002), for example, provides a detailed account of cancer policy formulation in Ghana which illustrates that politics 'can trump' scientific (epidemiological and economic) evidence. Chung and Kim (2005) draw attention to the failure of the South Korean government to adequately manage interest groups in relation to drug pricing policy. A review of health sector reform in ten countries, organised by the World Health Organization (WHO), found that in all countries implementation had stalled at a sub-optimal state, often for political reasons (Blas, 2004). Following Lipsky (1980). Walker and Gilson (2003) studied how nurses, as street-level bureaucrats in an urban primary healthcare clinic in South Africa, experienced and responded to the implementation of the 1996 national policy of free care, and conclude that 'policy success' may have been 'limited by the manner in which nurses exercise their discretion in implementation'. Internal tobacco industry documents reveal the tactics adopted by companies to undermine tobacco control policies (Saloojee and Dagli, 2000; Trochem et al., 2003). The literature reinforces the inherently political nature of health sector reform.

There is evidence on how broad health sector reform has been achieved in some countries, specifically in Latin America and Asia, 'despite the odds' (Grindle, 2002). These analyses do not deny the role of interests and institutions in the success, limited success, or failure of reform. However, they point to the importance of the policy process, the considerable agency and choices facing reform leaders and change teams (technical officers brought together from various agencies with a mandate to generate political strategies for a reform), and the use of different strategies and tactics (e.g., careful timing, creation of networks, use of information to mobilise public opinion, etc.) in explaining outcomes.

For example, Nelson's account (2000) of the ambitious Colombian reforms of the early 1990s reveals the role contextual variables played in facilitating change, but also the use of shrewd

tactics in overcoming institutional and bureaucratic resistance. Gonzalez-Rosetti and Bossert (2000) analyse the relative success in Chile and Colombia compared with Mexican reforms. They highlight the strategies of the reform teams – which reveals some of the conditions for their success. But they also underline the existence of strong state-society networks buttressing the power of both pro- and anti-reform groups. These networks have many of the features of advocacy coalitions – i.e., groups distinguished by a shared set of norms, beliefs and policy goals which can include politicians, civil servants, members of interest groups, journalists and academics (Sabatier and Jenkins-Smith, 1993).

Nelson's overview of social sector reforms in Latin America (2000) points to the different types and appropriateness of tactics that can be deployed during different stages of the policy process: in agenda setting; obtaining executive approval; getting legislative and public acceptance; and launching and sustaining reform in response to the changing and distinct political challenges at each stage of the policy process. A further analysis of health reform in six Latin American countries leads Nelson (2004) to conclude that piece-meal and incremental reform is more likely to be successful than big-bang approaches. Such findings suggest that moving pro-poor health reforms forward may be well served by working with advocacy coalitions to support government officials to manage discrete policy reforms.

2.3 Politics of sexual and reproductive health reform

This sub-section develops the argument by considering evidence in the more specific field of sexual and reproductive health (SRH). It illustrates how political factors determine which SRH issues are included in national policy agendas, what evidence and policy alternatives are considered (or fail to be considered), the policy that is ultimately adopted, and whether or not interventions are implemented as intended. A more detailed review has been provided in Buse et al. (2006).

Agenda-setting

The policy agenda is what decision-makers are paying serious attention to at any one time. There is strenuous competition to get issues onto the agenda. Windows of opportunity may present themselves when a problem becomes widely recognised, a feasible solution is made known to decision-makers and when, and only when, the politics of the situation are 'right'. The right moment, from the decision-makers' point of view, may present itself when they are needed to be seen to be taking action, and the political costs of doing so are likely to be low and the benefits potentially high.

While we might hope that health agendas are primarily set on the basis of evidence of needs or entitlement, experience demonstrates that these alone are not sufficient – for example in relation to addressing maternal mortality (Shiffman, 2007). This is particularly the case if the issue:

- is culturally taboo. For example adolescent SRH services in Cameroon (Tantchou and Wilson, 2000) and the promotion of condom use in Indonesia (Bennett, 1999).
- negatively affects some interest groups. For example, obstetricians have curbed the role of midwifery and therefore access to skilled birth attendants in rural areas in Latin America (Nelson, 2004).
- is perceived to be too administratively challenging. For example, complexity was used as a pretext to keep the integration of sexual and reproductive healthcare services off agendas in some countries (Oliff et al., 2003).
- has benefits that primarily accrue to those with little political influence (e.g., the poor, women and girls).

Policy formulation and adoption

Evidence of the technical feasibility of affordable, cost-effective interventions addressing a significant health condition may not be sufficient to ensure evidence-informed policies are formulated and adopted. Indeed, in some cases the opposite obtains. That is, policies are adopted in the absence of sufficient evidence, in contradiction with the existing evidence – or even when the data suggest that the proposed intervention may not work – because political factors dominate. For example, systematic reviews of interventions which focus solely on the promotion of abstinence as a tool for reducing unintended pregnancy, sexually transmitted infections (STIs) and HIV-risk among young people have shown that when abstainers become sexually active they may be less likely to use condoms (Bruckner and Bearmans, 2005), or to have adequate access to accurate information on HIV/AIDS or contraception (Human Rights Watch, 2004). Nonetheless, abstinence-only programmes are now widely adopted as a result of influence and funding in international development cooperation – often in consideration of domestic political constituencies as opposed to evidence on the efficacy of the intervention (Santelli et al., 2006). Conversely, sexuality education has been stigmatised as promoting early initiation of sexual behaviour, despite evidence to the contrary (Kirby, 2004). Emergency contraception, like sexuality education, has fallen victim to interest-group manipulation of the evidence, and in consequence access to emergency contraception remains subject to legal and policy barriers in some countries (Grimes, 2004).

Policy implementation

The adoption of a policy does not guarantee its implementation. Early political pressure to implement a ‘model’ essential health-service package for SRH based on the 1993 *World Development Report* recommendations left many countries struggling over which components could be sacrificed due to cost, and other service-delivery barriers to implementation. As a result, in some settings the package for maternal health included antenatal care and family planning, but not delivery care or STI treatment – despite policy commitments to do so (Wyss, 2004).

Reviews of policies for antenatal screening for syphilis across sub-Saharan Africa have found that, whilst the majority of countries have adopted a policy for universal screening of pregnant women, rates of congenital syphilis remain unacceptably high, as the policy has not been effectively implemented (Gloyd et al., 2001). A lack of champions or supportive coalitions results in this feasible, cost-effective intervention languishing unimplemented in the settings where need is greatest (Hawkes et al., 2004). Similarly, magnesium sulphate, which is effective and recommended for the prevention and treatment eclamptic seizures, and could prevent as many as 50,000 maternal deaths annually, remains underused. This may be explained by the fact that this inexpensive treatment ‘has no industrial advocate to facilitate licensing, production and distribution’ and because providers are reluctant to change their practices (Roberts et al., 2002).

Likewise, policies to reduce maternal mortality and morbidity by liberalising abortion laws are not sufficient in themselves. Zambian law allows abortion on both health and socio-economic grounds. However, abortion is difficult to access because it requires three doctors to certify that the woman meets the legal requirements. Evidence suggests that women seeking abortion are turned away by health workers because the hospital does not have three physicians, some physicians are reluctant to sign the forms for religious reasons and crowded hospitals make it difficult to get an appointment. By implication, abortion is seen as a privilege of the elite that ‘can be conferred or withdrawn by healthcare workers’ (Ngwena, 2004). In other situations, political support is tacit rather than explicit – for example in countries where abortion is illegal, but may be unofficially endorsed (Ahmad, 2002). This underscores the reality that service delivery is a function of a number of factors, including the interests and ideas of those tasked with implementing policy.

The SRH-related MDGs are not on track to be met by 2015 (UN, 2005). However, there have been positive international and national developments over the past two decades – particularly as a result of the political strategies adopted by the women’s and rights-based movements (Sen et al., 1994). There are a number of case studies of successful SRH policy reforms and, although the

analyses of the factors which account for success are wide-ranging and lack specificity, they all point towards the importance of advocacy coalitions (often international in scope) and astute political management. Schneider and Fassin (2002), examining the role of key actors in the legal battle to ensure access to antiretrovirals (ARVs) for HIV-infected pregnant women in South Africa, highlight the role of advocacy coalitions in catalysing and sustaining the [ultimately successful] court case. Shiffman and colleagues' (2004) work on safe motherhood emphasises the unusually cooperative relationship that developed between international donors and national health officials, resulting in effective transfer of maternal health policy and institutionalisation of the cause within the domestic political system in Honduras. In Indonesia 'the persistent and proactive cultivation of national-level policy-makers' was identified as critical to success (Shiffman et al., 2003).

2.4 Prospective management of the political dimensions of health reform

The authors of some retrospective studies of health sector reforms which failed to deliver pro-poor, evidence-informed policy change have recommend more proactive policy analysis and management. Gilson et al. (2003), for example, reveal the limited influence of technical analysts over the implementation of health-financing reform in South Africa and Zambia. They argue that the analysts gave insufficient attention to generating political support for their preferred policy options and did little to anticipate and manage the needs of implementers. Upon applying Kingdon's (1984) model of agenda-setting to adult ill-health in poor countries, Reich (1995a) calls for political mapping. In a similar vein, having reviewed the politics of pharmaceutical policy in three developing countries, Reich (1995b) concludes that for reform to succeed, policy-makers need to analyse the relevant political factors so as to be able to manage them. Kajula and colleagues' (2004) retrospective analysis of the multiple reversals of user-fee policy in Uganda concludes that future policy development requires strategies to manage the politics of reform. Analysts looking at other health-policy reforms, mainly in Asia and Latin America, have called for more strategic approaches, including political analysis (Thomas and Grindle, 1994; Leighton, 1996; Collins et. al., 2002).

Despite calls for pro-actively managing the political dimensions of health sector reform, and retrospective analysis of some attempts at doing so, there are few accounts of systematic attention to political-economy factors and real-time documentation with immediate lesson-learning and feedback to engender reform. Glassman et al. (1999) provide one partial account which met with limited success in the Dominican Republic. Thorough knowledge of the sources of power and the strategies that reformers and counter-reformers adopt is required to inform reform initiatives. Part of the challenge of understanding the politics of bringing about reform is the difficulty of obtaining detailed information on the strategies adopted – yet only from analysis of these strategies is it possible to distil lessons on how the barriers to policy reform can be addressed (Campos and Syquia, 2006).

3. A survey of approaches to understanding the politics of health reform

3.1 Donor approaches – results of a telephone survey

We undertook a survey of agency staff as a first step towards exploring how different donor and technical agencies approach the challenge of understanding the health sector reforms in developing countries which they support. We wrote to contacts in 17 agencies to inform them of the purpose of the survey and to request that they identify an appropriate headquarters-level respondent(s) in their organisation. We then wrote to potential respondents to invite them to participate in a telephone interview and provided a written question guide.

We administered two different semi-structured interview guides to a total of 14 staff from 10 donor and technical agencies (see Annexes 3 and 4 for the guides). Two respondents were unable to participate in telephone interviews but provided written responses to our questions via email. While the intention was to get an overview of the approach adopted across the agency, respondents made it clear that there was considerable variation within the agencies and that different staff would have different perceptions as to how the issue was approached – particularly given differences in country settings. Three informants were based in country-level offices. The findings were as follows.

Analytical tools for understanding the political dimensions of reform

All donor and technical agency (TA) staff interviewed confirmed that their organisation attempts to understand the politics of sector-level reform in the countries in which they have health programmes. Indeed, the GTZ respondent commented that his agency attempted to understand politics ‘to the highest extent possible’. Yet, answers were heavily qualified. Both the AfDB and the World Bank noted that their organisations have a non-political mandate, and thus tend to perform ‘institutional’ rather than ‘political’ analyses. Other informants expressed a clear commitment to political analyses but understood ‘politics’ using soft governance terms such as equity (DGIS), or transparency and corruption (World Bank), or as technical and policy-oriented guidance (GTZ, WHO). No informant understood ‘politics’ in terms of the dynamics expressed in the interview guidance (i.e., understanding the players, positions, power and perceptions concerning specific reforms and who was likely to get what, when and why). Several made a point of saying so (CEC EU, SDC).

None of the donor organisations reported the use of any specific analytical tool through which to understand the politics of sector-level reform. Each donor does employ tools for assessing broad social, economic and political trends at country level. The political content of the documents that these mechanisms produce is low: 40% of the questions that the World Bank’s Country Policy and Institutional Assessments (CPIA) ask are governance-related, and Country Strategy Papers provide only an overview of governance issues. The Bank’s Country Assistance Strategies (CAS) provide ‘notional allocation’ of funds that *may* incorporate political considerations.

Technical Agencies support processes of change in partner countries, and these always have political, technical, social and economic dimensions. Indeed, the GTZ respondent noted: ‘There is no reform process without a political dimension’. As with donors, TA support depends on the particular design and focus of the specific programme at country level. WHO representatives face significant capacity and time constraints and thus rarely have time to conduct political-economy analyses. The WHO doesn’t have the ‘upstream’ presence in most countries to influence politics of health sector reform, although, as the WHO respondent noted, WHO influence depends on the particular country and the particular WHO representative.

With whom do donors work to understand the political dimensions of reform?

Most informants indicated that their assessment of a country's political context was based on dialogue with a broad range of actors that included government officials, other donors and key stakeholder groups. At least one informant acknowledged that the category 'other key stakeholder groups' was the least consulted, and that this was a weakness (CEC EU). All informants stated that their organisation was engaged in dialogue with these groups, and consequently their understanding of the politics of sector-level reform was ongoing. However, formal analyses were also undertaken whenever a donor conducted country evaluations or drafted sector strategies.

Is political feasibility of a reform programme a determinant of sector funding?

In allocating funds among different sectors within a particular country, donors reported that they rarely considered political feasibility of the proposed reforms in those sectors, although there was some interest in strengthening donors' understanding in this area (CEC EU, SDC). At least one donor emphasised that arrangements for allocating funds to the health sector are different from arrangements in other sectors (CIDA). Allocation of funds was generally based on various non-political considerations, such as whether the donor agency has the necessary expertise, capacity and experience to support a particular sector, and how many other donors are present in it.

Does political feasibility influence the choice of donor aid modality?

In deciding their choice of aid modality, donors do not appear to treat political risk as a major consideration, although most donors indicated that awareness of a country's political context was very important. Fiduciary, implementation and institutional risk were the principal areas of risk considered most important by donors. These risks are assessed through the various assessments, reviews and strategy papers cited above.

Donors indicated that their decision on which aid modality to adopt is done on a country-by-country and sector-by-sector basis. For example, DGIS provides project support to Ethiopia, sector budget support (SBS) and general budget support (GBS) to Nicaragua, and basket funding to Tanzania. As with the allocation of funds among different sectors, donors rely heavily on local and sector-level knowledge and expertise, and their decisions are made in consultation with government officials.

Policy dialogue

Bilateral donors reported that relations with Ministries of Health (MoH) vary considerably. As a bilateral organisation acting on behalf of the German government, GTZ only engaged in dialogue with governments. Other donors' engagement ranged from ongoing 'strategic partnerships' with MoH (AfDB, WB, CEC EU), to consultation with MOH and other donors and partners (SDC), to very little contact with MOH (DGIS). In SWAp contexts, some donors felt that it was important to engage in multilateral rather than bilateral dialogue. A DFID respondent, for example, explained that the department attempts to keep bilateral dialogue to a minimum in order to help governments cut back on transaction costs. Some donors, and one of the TAs, commented that dialogue was restricted because they had a limited number of (largely administrative) staff working in country offices who did not have the time and capacity to engage other donors and government officials in policy dialogue.

Annual or biannual group meetings were commonly cited by donors as the principal interface between them and other partners, including MoH. More frequent meetings were also cited, such as the monthly meetings of the Health Policy Advisory Committee (HPAC) in Uganda – a forum established mainly to advise government and development partners on the implementation of the National Health Policy (NHP) and the Health Sector Strategic Plan (HSSP), and which comprises representatives from that country's MoH and other departments, development partners and private not-for-profit providers (Hutton, 2004).

An informant from Irish Aid, based in Uganda, emphasised how important it was to understand the ‘mindset’ of the Ugandan MoH. Irish Aid has a protocol for engaging with Ugandan government, depending on the perceived political sensitivity of the issue. As a European donor, the informant (a Ugandan) added that it was important to have ‘black and white faces here’ to understand the politics.

Donor perspectives on the feasibility of prospective health policy analysis

Donor responses to the question of whether it was feasible for them to conduct prospective political-economy analysis of sector-level reform were mixed. One respondent indicated that health sector political-economy analysis was ‘business as usual’ for his organisation, whilst other donors were less specific, noting that their organisations do conduct indirect political analyses, with the caveats about ‘politics’ indicated in Box 1. Another respondent added: ‘we all do political-economy analyses – it’s just words, just semantics; it’s just a terminology’.

A number of informants identified obstacles to conducting prospective political analyses. Typically, donors distinguished between conducting political-economy analyses ‘in theory’ and then translating that theory into ‘practice’ (WB, CEC EU). Problems cited included: providing appropriate indicators of ‘political’ reform at sector level; measuring ‘politics’; recognition that different countries have different political and economic contexts; rapidly changing country contexts, such that any political-economy analysis would become redundant quite quickly; and ‘moral hazard’ (i.e., *should* donors be conducting such analyses?). One informant commented: ‘we try to minimise the politics from the reality’ (CIDA). Despite these obstacles, some donors indicated that a political-economy analysis of aid modalities would be interesting and add value by providing more structure to donors’ ongoing political analyses (CEC EU, DGIS).

Box 1: Survey findings summarised

All donors attempt to understand the politics of sector-level reform, but their explanations of how they do this are heavily qualified. The most important qualification focuses on the definition of ‘politics’, with the majority of donors defining the word in terms of governance issues such as corruption and transparency.

Although some donors indicated that political analysis of recipient countries is ‘business as usual’ and conducted by them ‘all the time’, no donor said that they have a specific analytical tool for performing such analyses.

Donors decide which sector to support on the basis of their history and their expertise of that sector in a particular country. Donors decide which aid modality/modalities to adopt on a country-by-country basis. Political risk is not an important factor in their choice of aid modality.

Although donors recognised that there are a number of obstacles to performing a prospective political-economy analysis of health sector reform, many donors appreciated the potential added value of such an analysis to their work.

Further analysis is needed at the country level to explore how donors understand these politics.

3.2 Politics in health sector strategy documents

Very few MoHs in sub-Saharan Africa put their HSSPs on the web; consequently, public access to HSSP documents is restricted. Nevertheless, this study reviewed twelve HSSPs which were available to the researchers (Annex 5). Each document was scanned and any references to ‘politics’ were highlighted. These documents share a number of common features.

Although each document makes some reference to the politics of health sector reform, discussion is ill-defined, and brief. For example, the Kenyan HSSP notes that priority-setting includes: 'political criteria of access to and re-distribution of power and resources within the country', but does not elaborate on what is 'political' about either access or power; indeed there is no mention of the latter anywhere in the document (NHSSP II: 11). One exception is the Zambian HSSP, which reviews in detail the political implications of restructuring the MoH under its Public Service Reform Programme, and implementing its new National Decentralisation Policy (Zambian NHSP: section 1.2.2).

Most of the documents emphasise the importance of political will. For example, the Kenyan HSSP states: 'the role of political leaders, including MPs, is critical but needs to be carefully defined and delimited to avoid conflicts of interest' (NHSSP II: 11). Although suggestions are given for mobilising political will, there is no guidance on *how* it might be achieved in practice.

Nigeria's Health Sector Reform document (Nigeria, no date) is a partial exception. It identifies the 'communication strategy for mobilising and sustaining the HSR programme' as a cross-cutting programme of work. This includes developing advocacy packs and briefing sessions for different audiences, including representatives and senate members, advocacy visits to major political parties, discussions with governors and other key stakeholders, briefing the media, etc. Yet the strategy focuses on presenting the rationale for reform as opposed to identifying who will be opposed and how to deal with such opposition.

The Nigerian HSR also devotes a few pages to the 'structure and management of the reform process'. Here it presents a number of functions of HSR management, including to 'cultivate champions and change-agents for the reform agenda [and] mobilise latent forces in favour of the reforms within and outside government'. It stops short of considering how to identify and deal with opposition – although it does consider the political dimensions of alternative institutional arrangements for the proposed reform team. Most strategies, however, simply call for 'political will', as in the conclusions of the Benin document, but there is no consideration of what this might depend on, or any consideration of the conditions under which the strategy might be expected to work.

Most of the documents emphasise the importance of mobilising communities, including civil society and the private sector. For example, the Kenyan NHSSP II notes the importance of 'community empowerment' and empowering vulnerable groups, particularly PLWHA, women and children.

Most HSSPs do not indicate an awareness of political obstacles to the implementation of health sector reform. One exception is the PDS of Niger, which refers to political constraints on implementation both in general terms and with reference to the strategies that different actors use to gain and defend material and symbolic advantages (Niger PDS: 12, 100 and 16, 101). Another exception is the Kenyan 2005/6 National AIDS Plan, which notes that an important obstacle in the performance of the preceding KNASP (2000-5) was political interference in programme activities at constituency level. However, the document gives no indication of how this obstacle might be overcome in the future.

A number of HSSPs call for more pro-active policy management. The Zambian document, for example, highlights the low review-rate of legislation, adding that: 'The challenge is for the Ministry to enhance capacities for policy analysis and formulation, as well as develop appropriate mechanisms to support policy implementation' (NHSP: section 10.1.1). A background note to the World Bank's Health, Nutrition and Population Sector Strategy affirms that countries are increasingly interested in how to manage the politics. In particular, 'Countries increasingly not only want to know what to do but also how to do it, particularly how to design and manage the transition from current to reformed systems' (World Bank, 2006: 16).

4. Experience on the ground: Tanzania and Uganda

This section discusses the political-economy of recent health sector reforms in Tanzania and Uganda with a view to identifying the constraints and opportunities facing donors in supporting evidence-informed policy change in sub-Saharan Africa (SSA). It is based on discussions held with a range of stakeholders in Dar es Salaam and Kampala in November 2006 and a cursory document review.

Uganda and Tanzania were chosen from among the recipients of Irish Aid financing in the region on the basis of the ODI team's familiarity with their somewhat different national political and aid-management contexts. While they cannot be considered representative of the SSA region as a whole, the two countries appear to provide sufficient insights into the particular political challenges confronting health sector reform in SSA countries.

The section provides a summary analysis across the two countries. The more detailed field reports on each country upon which the analysis is based are included in Annexes 1 and 2.

4.1 Health reform challenges

Both countries have adopted medium-term health strategies which form the sectoral component of a package of reforms covering all aspects of national development – including fiscal, public financial management, administrative and legal issues, and political decentralisation. These reforms are being implemented to varying degrees in the context of: 1) hybrid political systems which exhibit both legal-rational and patrimonial features; 2) insufficient resources to fully finance the health plans or to provide a set of basic services; 3) considerable dependence on external finance and support; and 4) significant service delivery by the private not-for-profit (PNFP) sector – in part publicly funded.

Uganda and Tanzania launched health Sector-Wide Approach (SWAp) programmes around the same time, but on the basis of somewhat different financing arrangements – with donors moving from projects to basket funding in Tanzania and to sector budget support (SBS) and general budget support (GBS) in Uganda. In combination with other initiatives, the SWAps are credited with delivering a range of innovations and improvements – including more systematic approaches to priority-setting and efficiency savings.

Prioritisation within constrained resources occurs in both countries on an annual and continuous basis through two mechanisms and their interaction: 1) the annual preparation of the budget within the context of a Medium Term Expenditure Framework (MTEF); and 2) negotiations about external project funding that take place more or less in the margins of the formal sector budget process – sometimes involving different stakeholders (e.g., the President's office, senior executives from Global Health Initiatives (GHIs), and national programme managers).

In both countries there is serious cause for concern regarding prioritisation within the health budget (allocative efficiency) and the composition of expenditure in the sector by modality – the latter a reflection of the growing project element in relative and absolute terms. The marked increase in project funding since 2004/5 is largely, but not exclusively, accounted for by GHIs – the Global Fund to Fight AIDS, TB and Malaria (GFATM), PEPFAR and the GAVI Alliance. Collectively, these earmarked funds have had a considerable distorting effect on government leadership and coordination, sector financial planning (a significant share is off-budget), expenditure patterns and sustainability. In Uganda, the overall health resource envelope has been squeezed in recent budgets, in part because: (a) project funding accepted by the government has to fit within the sector budget ceiling; (b) the Ministry of Finance, Planning and Economic Development (MoFPED) has taken the view that when funding moves from the public to the private (not for profit) health

sector to produce the same results, it should be offset by a corresponding reduction in public expenditure; and (c) the MoFPED is aware of the considerable unscheduled project funding available to the sector.

The abilities of the health ministries to address efficiency, prioritisation and coordination goals appears constrained in both countries by the re-emergence of project funding, with parallel management structures, and the commensurate increase in the influence of project managers who have a stake in maintaining the trend – not least for the discretionary control they gain over spending. In addition, in each of the countries health ministers' hands are also somewhat tied by organisational arrangements. In Tanzania, this relates mainly to the bifurcation of authority between the Ministry of Health and Social Welfare (MoHSW) and the regulatory authority for Local Government (PORALG), which limits the control of the MoHSW, for example over personnel at the district level. In Uganda too the decentralisation to the District Councils usurps some MoH controls. These structural impediments are exacerbated by what was perceived by informants as a deterioration in health sector leadership over the past three years in both countries.

4.2 Dimensions of stakeholder politics

We found that progress on the reform agenda appeared to be blocked by a powerful, interactive set of political-economy constraints relating to the sector leadership, the aid architecture and the organisation of interest and advocacy groups.

Sector leadership

Strong sector leadership seems to be a precondition for tackling sector inefficiencies. But leadership presumably benefits from an enabling environment – such as that which gave rise to the Uganda SWAp at the end of the 1990s – and is harder to exercise when those conditions are no longer present. For a combination of reasons, leadership in the Ugandan MoH has been weak since 2003. This constitutes a major determinant of how the ministry conducts itself in relation to the MoFPED, local government, donors and other stakeholders. Reputational decline has been exacerbated by the perceptions of corruption – not least the high-profile suspension of the GF grants in 2005. High-level executive decisions to introduce policies without sufficient consultation (e.g., abolition of user fees in 2001 and a salary increase for medical workers in 2004) have also arguably jeopardised the perception of the leadership offered by the Health Ministry.

Populist and patronage politics has affected the health sector in Tanzania too. Ill-informed pet policies and projects, including those championed by global health initiatives, are accommodated by requests for supplementary budgets mid-year which are considered outside the health budget ceiling and do not enter into the policy dialogue with donors. Within the sector, a health policy cabal with a relatively stable membership makes many decisions largely behind closed doors – consulting on an invitation basis – which delimits the possible dialogue at the annual sector review meetings. In both countries, perceptions of weak leadership have strained relations between government and donors.

Aid architecture

In both countries, the political-economy of health sector reform is heavily conditioned by the presence of a large number of development partners and the incentives they introduce directly and indirectly on account of the high proportion of external support in MTEF, significant off-budget project support, and support for a proliferating number of NGO service providers. These structural features carry implications for stakeholder politics. In particular, they lead to a fragmentation of influence and shifts in the balance of power among the Ministry of Finance (MoF), donors and programme/project managers within the MoH.

The traditional donors have a range of venues and mechanisms through which they attempt to exercise some influence over policy developments in the sector – which are detailed in the country

reports (Annexes 1 and 2). Some of them are apparently benign yet quite disruptive; the perverse incentives associated with the use of per diems are widely documented, yet replacing them poses a serious collective-action problem.

In both countries, despite official government pronouncements in favour of budget support, and relatively mature SWAps (common basket-funded in Tanzania), many donors maintain projectised aid modalities. Project aid is used by some development partners (DPs; e.g., Japan and US) as, for legislative reasons, they find it difficult to co-mingle funds. It is used by GHIs for reasons, it is claimed, of attribution and fiduciary assurance. It is even used by some donors who also provide sector budget support. A range of rationales is provided for project funding, including claims that the benefits of GBS have not materialised. Yet, the bottom line is that project support strengthens the hand of individual donors over discrete policy areas while weakening the hand of those who wish to see the development of more rational and systematic approaches to setting priorities and bringing about downward domestic accountability.

A succession of very large global (e.g., GFATM and the GAVI Alliance) and bilateral (e.g., PEPFAR, Clinton Initiative) health initiatives offer a 'tyranny of terrible incentives'. They have contributed to shifting the balance of stakeholder interests against the defenders of budget support/SWAps, significantly altering the local political-economy of health policy.

In Uganda, external support for the SWAp and sector budget support approach has been weakened by the unhappiness of the Nordic Plus donors with the course of democratisation and human rights in the country. These donors are committed in principle to providing support on the continuous and predictable basis needed for rational planning and the building of effective systems. However, for domestic political reasons they tend to have a low tolerance for government actions seen as infringing basic human or civil rights.

GBS and health systems proponents and the MoF in Uganda initially opposed Global Fund programmes operating outside the government's budget framework processes. However, they were overcome by an alliance of ideological and interest groups within and outside the country, which persuaded the President to overrule the MoF on the issue. The compromise solution, where GFATM funding was projectised and managed through a parallel system but placed within the health ceiling, has worked against the rest of the health system. This is a perverse effect, because the MoF rule requiring project funding to be counted against MTEF ceilings for sectors was supposed to give incentives to line ministries *not* to fund activities through projects without good reason.

In both countries, the GFATM Country Coordination Mechanism (CCM) system endows new private-sector stakeholders, and some other public officials, with new influence on sector policies, but without the disciplines and constraints of the SWAp system and the budget process. This has set precedents for other donors to work outside established SWAp procedures and thereby undermine those mechanisms and their products. Moreover, the CCM established/imposed a new political space for priority-setting within the three disease programmes (by stipulating the composition of the group and imposing constraints on the time for arriving at decisions) with implications for the distribution of influence over decisions.

PEPFAR and other large US programmes operate in theory outside government, but this does not stop them exercising a depressive influence on mainstream health sector funding, priorities and incentives to reform. For example, it was reported in Tanzania that the donor community largely opposed a proposal of the Clinton Initiative in relation to HIV/AIDS treatment and care and was supported in this opposition by analysts in the MoF – but that this did not prevent the initiative, which gained the support of the President.

Traditional development partners appear to be dissipating their influence through a failure to speak with a common voice on systemic issues. In Uganda, budget support is subject to a very heterogeneous system of conditionality, and follow-up on the 'undertakings' of the sectors' annual

Joint Review Mission is poor because, among other things, too many non-essential undertakings are tabled. In Tanzania, basket-funders impose soft conditionalities in their 'side agreements' with MoHSW each year which are different from the 'undertakings' agreed at the Joint Annual Review. This underscores the disparate messages emanating from donors, which ultimately leads to lack of traction on key issues. Moreover, in Tanzania, donors themselves reported problems including a lack of donor leadership on key issues (e.g., human resources) and divisions among themselves on several issues (e.g., fiscal space, user fees, choice of aid modalities). Donors disagree on technical strategies in relation to reforms (e.g., human resources) and on tactics – how hard to push for reforms.

Donor influence may be further dissipated by the numerous *ad hoc* initiatives which certain members support, thereby fragmenting the DPG-health agenda. These initiatives are often championed by external actors with support from local DPs who, in both Uganda and Tanzania, at times, feel frustrated that 'nothing is moving'.

The donor culture in Uganda has also changed over the past three years – no longer can reform minded advocates within the MoH count on key donors (speaking with one voice) to denounce actions/decisions taken which are not in the spirit of the SWAp. This unwillingness may reflect donors' interpretation of the rules of the Partnership Agreement (MOU) for the sector, but it may also reflect a sense of complicity. Even the Nordic Plus group acknowledge their culpability for the proliferation of unruly global initiatives. Finally, there is a perception that the poor quality of some technical assistance may have somewhat undermined the credibility of the donor voice and MoH in the eyes of other stakeholders.

Informants in Tanzania told conflicting stories about whether relations between donors and government were improving or worsening. Whatever the case, high-level public challenges to the government by donors are not tolerated with grace in Tanzania, as DFID learned in its interaction with the MoF over health sector user fees. This suggested the need to tread sensitively in the policy terrain.

The MoH also play a role in the landscape of aid modalities. The official government position in both countries is that GBS is the preferred modality. However, as one informant in Tanzania put it, the MoHSW prefers the basket to GBS but likes projects even more. Lack of resources in the first quarter of each fiscal year in the government treasury system creates material disincentives to shift to budget support and creates additional incentives for special project accounts. Competing levels in the system also prefer different modalities (e.g., MoHSW vs local government authorities). The opportunities for rent-seeking likely also play a role in choice of modalities; the health sector is not immune to corrupt practices, as the alleged sale by officials of vouchers intended for family-level acquisition of subsidised bednets for prevention of malaria attests. Thus, it is with some reason that the report of the Independent Monitoring Group refers to a 'collusion of interests' between donors and ministry officials in the perpetuation of projects.

The organisation of interests and advocacy

Priority-setting takes place outside the formal procedures established in the budget process and SWAp, as well as through other party-political or patrimonial processes. For example, in Uganda the issue of social insurance was placed in the ruling party election manifesto without discussion in the Health Policy Advisory Committee (HPAC) and is now, despite insufficient technical discussion, *de facto* government policy. Similarly, a number of private hospitals are receiving government subsidies, in contravention of the draft policy on Public-Private Partnership in Health and affecting resource allocation.

Professional groups do not appear to be a particularly well organised group in either country. Nonetheless, the meetings of Regional Medical Officers in Tanzania were reported to provide an avenue for influencing health policies and priorities beyond the discussions between donors and bureaucrats.

Health worker trade unions are not particularly strong in Uganda, but in a pre-election context they can be very powerful. The wages decision of 2005 has had damaging effects on health service delivery in the PNFP sector, both directly and indirectly. Multiparty elections have not so far had a compensating effect by giving greater voice to the mass of health service users and non-users.

In Tanzania, there are restrictions on the right of public health employees to engage in collective bargaining and they are banned from striking – although that has not prevented recent wildcat strikes over pay. Moreover, this group can exert its influence and exercise resistance in more subtle ways. The report of the 2006 JAHSR notes that ‘bureaucratic obstacles will need to be overcome in order to redistribute scarce health personnel in favour of under-staffed areas’ (MoHSW) – which is surely a euphemism for political opposition to such postings.

Service-providing NGOs (e.g. the religious foundations and networks) are, despite their importance in policy implementation, less influential than might have been expected. In Tanzania, both of the SWAp committee seats held by NGOs are filled by appointments made by the MoH – circumscribing their willingness to advocate positions at odds with government policy. In Uganda, one reason for the lack of influence may be that they are fragmented into three umbrella organisations (along religious lines). In both countries, NGOs are not well placed to do advocacy on policy, because they can be portrayed as self-serving, lack capacity, and often lack understanding of health-planning and macro-economics as well as insider politics of government ministries. Many service-delivery NGOs have problematic relations with donors, who are their funders and rather uncertain allies. With some exceptions, well-informed advocacy NGOs appear to be thin on the ground.

District-level authorities have, as described above, some control over resource allocation and, in effect, a veto over policy implementation, but have limited involvement in the national-level SWAp processes (which consequently lack ownership). They are not well organised or represented to make their power felt at the national level.

The **middle classes** in Dar es Salaam and Kampala are largely unaffected by the most pressing health issues, having mostly opted out of public-sector provision, and are therefore not organised to address them. Despite the active involvement of **parliamentarians** in the 2006 National Health Assembly and JRM in Uganda, parliament is not viewed as a useful ally for pro-poor reform, given the patrimonial politics in which its members engage.

The best organised interest group in the sector appears to be the international-national alliance of **AIDS interests**. The group has been highly effective in securing major increases in funding and a raft of policy initiatives – even if some of these are questionable. Technical arguments against the level of allocation to HIV/AIDS (and the project mode of aid delivery to AIDS activities) advanced by MoF, MoH, and WHO technocrats, are not expressed publicly due to the emotive nature of the discourse and the political pitfalls of being on what is perceived to be the moral low ground.

4.3 Feasibility of a proactive political-economy approach to informing policy dialogue and guiding action

The aim of the fieldwork in Tanzania and Uganda was to assess the feasibility of employing more systematic approaches to understanding the underlying political-economy factors associated with proposed reforms. In these country contexts, what were the prospects for using such understanding to engage more effectively in the reform policy process through the development, for example, of creative alliances among progressive, evidence-informed, pro-poor reformers in the ministry of health and civil society groups? Informants found it difficult to respond directly to this line of questioning but their responses to more general questions concerning the political-economy of the health sector provide some clues.

Constraints

It is not clear to what extent **lack of political intelligence** about the interests which may block or be mobilised in favour of reform is a particularly large constraint to donor support of evidence-informed, pro-poor policy-making. On the one hand, donor informants were hard pressed to identify domestic stakeholder groups and their underlying interests in relation to the policy issues they considered important. Certainly, there are informational asymmetries which depend on such factors as the relationship between the donor agency staff and their counterparts in the ministries; the proportion of national staff employed by the agency; the interest, orientation and skills of the staff in relation to politics; and the length of time expatriate staff have been in post. In Uganda, a recent stakeholder analysis of the sector revealed that no one respondent produced the same stakeholder map (suggesting that analysis is not widely shared and that some stakeholders must not be fully apprised of the true influence and interests of actors in the sector) (Paul, 2007).

In both countries government informants were of the view that donors have limited knowledge of the inner workings of government and were not sufficiently familiar with how things work to engage effectively in policy influencing. On the other hand, and despite frequent turnover of staff, Development Partner Groups (DPGs), including those in health, appeared relatively well-informed as a group/at the lead-donor level – in part as a function of informational exchange at the DPG and more importantly through personal relationships among advisors and government officials.

Approaches to **partnership** appear to operate as constraints to working on political-economy issues. First, there is a rather formal understanding among many donors of what it means to be working in partnership with government, an implication of which is that even when there is good understanding of the political-economy issues, it is not felt appropriate to act on that understanding. Second, the health partnership as presently practised in both countries is very heavy in formal meetings, leaving little time for issue-based networking and developing influencing strategies.

Approaches to **aid effectiveness** reinforce the strictures of the partnership approach. Many donors seem to interpret the Paris Declaration principle of the primacy of country ownership in a manner which is shallow and unrealistic, leaving donors to alternate between meekly accepting 'government' inadequacies and pulling out/cutting back funding, as opposed to working with like-minded groups within (and outside) government departments to change the direction of government travel.

The Paris Declaration contains a set of mutually interdependent commitments, recognising that there is a need both for governments effectively to take charge of development efforts and for donors to be supportive of this. Building country 'ownership' is seen as a process, necessarily taking a number of years. Unfortunately, the practical effect of the Declaration on donor attitudes in many countries has been to discourage any questioning of government decisions, even when these fall far short of reasonable expectations, with 'ownership' being treated less as an objective than as an established fact. This leaves them with only one other option when performance becomes really bad – that of withdrawing support.

Moreover, differences exist among donors on how to address constraints to change which are predicated upon challenging **rent-seeking** – particularly where donors are funding vertical programmes within which it is taking place. The Global Fund has taken a particularly strong and public stance in Uganda. But with donors divided on how to approach the issue, there is less political will to address it than might be expected.

More surprising is the lack of attention to identifying and supporting instances where domestic stakeholders, including parliamentary committees, take a stand on the same issues that concern donors. In the context of GBS, concerns about issues such as presidential by-passing of established budgetary procedures have sometimes arisen simultaneously in parliament and among

donors. On such occasions, the donors have tended to raise the matter with government counterparts immediately, rather than waiting to support or make common cause with parliamentarians. This (in principle correctable) feature of donor practice helps to explain the finding of the GBS joint evaluation that under the budget support regime donors have 'tended to overshadow domestic stakeholders, including Parliament' (IDD and Associates, 2006: Appendix 66).

Developing **advocacy-type coalitions** appears difficult for a number of reasons. It would appear that many donor health advisers tend to be technical health specialists, not brokers of reform alliances. If they are sometimes good networkers, it is by accident. Multilateral organisations appear particularly cautious about working with civil society organisations (CSOs). Meanwhile, donor CSO support programmes tend to run in parallel with macroeconomic and sectoral programmes, as if they were not relevant to each other.

In both Uganda and Tanzania, a culture of mutual mistrust characterises relations between civil society and government – particularly so in Tanzania. Certainly, the confrontational approaches used by some CSOs in the past have not helped. Moreover, the GoT fears that the Civil Society Foundation established as a multi-donor initiative under GBS is the donors' Trojan horse. The government views the proper role of CSOs as NGO service/welfare provision – as opposed to supporting efforts to improve policy content, process and implementation, or holding government to account. In neither country was there a forum for open and structured dialogue on key policy issues.

In practice, **civil society** has limited capacity on key reforms and limited influence. One prominent NGO with good access to government has concluded that while it is necessary to begin to develop coalitions of allies on key issues, it lacks capacity to explore the interests associated with the issue. For different reasons, either mobilising the grass roots or appealing to the middle classes appeared remote.

On the other hand, many respondents, when pressed, came back to the theme of **leadership and capacity in the government**. They remarked that the feasibility of more proactive pro-poor reform efforts was affected mainly by the quality of official leadership. Respondents argued that government-established task forces to deal with key reform issues do not attempt to explicitly consider the politics of the issue (e.g., identify losers and how they might be dealt with or systematically identify possible allies). Similarly, studies and policy option documents do not attempt to probe the political issues inherent in proposed changes. This being the case, there are few hooks on which to hang civil-society engagement.

Opportunities

The opportunities for more structured and proactive engagement on political-economy factors appear less obvious than the constraints. However, the opportunities do not seem negligible or unimportant. In Uganda and Tanzania, technical studies, Public Expenditure Review processes, value-for-money studies, national health sector reviews and so on, provide ample platforms for the discussion of efficiency and equity issues. The challenge that presents itself is to take the relationships created through policy dialogue in these forums as the basis for a more deliberate building of alliances around the political factors blocking more equitable and efficient policies.

In Uganda and Tanzania in the present period, a sound starting point would be the common ground that is to be found among MoF, health planning and other like-minded stakeholders in defence of the health system and SWAp. This would be a matter of building (or perhaps rebuilding) the trust and cohesion these stakeholders need in order to be able to stand up to the GHIs and project-minded lobbies. The central problem is that the procedural mechanisms established to provide discipline to spending (such as the Health Sector Working Group in Uganda and the Policy and Planning Department of the MoHSW in Tanzania) have been sidelined in

decision-making on projects. Giving these institutions their teeth back, and shining light on their operations, might provide a focus for an initial phase of alliance-building.

This seems a necessary first step if reform advocates are to influence priorities, improve accountability and begin to act more coherently on all the other political-economy factors. At least in the initial stages, this would not imply working outside the established channels for policy dialogue. It is rather a matter of putting these channels back on a sensible basis. Joint annual review missions, as well as the technical working groups, provide a good platform for stakeholders to jointly explore more deeply why progress has not been made (or is being reversed) including the 'small p' political obstacles. Relevant analytical work can and should inform these discussions.

New ways of working by official donors and partners might in turn provide opportunities for different types of civil society inputs. Donors could support the capacity-development of NGOs to participate in discussions on setting national priorities and ensuring their implementation. This approach – in other terms, the formation of advocacy coalitions – is arguably a more sustainable approach for NGOs than the establishment of unintegrated projects to achieve the same ends. Donors can support advocacy coalitions by providing funding for secretariat costs (e.g., salary support for members working in NGOs, convening and communications costs) and, importantly, financing the costs of implementing the activities associated with the coalitions.

Having established in these ways some of the currently missing conditions for alliance-building, the progressive group in Tanzania and Uganda would be in a position to address some of the other constraints on proactive management of the political-economy of reform. All of this would require, however, a shift in attitudes on the part of donor advisers and others.

Attitudes

Our research points to a number of preconditions for working more systematically on the political-economy of health reforms in countries like Uganda and Tanzania. These can be expressed in terms of five required changes in attitude.

First, it is clearly not possible to do everything. There is a need to focus on a few reforms which are important to health outcomes and where progress can be made, which may mean putting aside some of the advisers' 'pet' concerns and professional biases. At least at first, this may mean particularly those with natural constituencies in the MoF and MoH.

Second, there is a need for tough-mindedness about the political nature of priority-setting. This should never be viewed as merely a technical exercise concerned with cost-effectiveness. It should be explicitly acknowledged that resource reallocations affect the interests of different groups, which are endowed with very different amounts of power, raising the question of whether and how pro-reform alliances should be generating corrective or compensatory actions. If not a change of attitude, a change of language may well be required.

Third, the interconnectedness of some of the main issues needs to be recognised. The political-economies of the aid modality choices and of the policy reform issues are bound up together, and both of them have global, national and sub-national aspects. All of these need to be addressed, including the difficult matter of the incentives required to change the behaviour of donors and GHIs.

Fourth, an accurate reading of the Paris Declaration on Aid Effectiveness is essential if the type of partnership required to address the political-economy obstacles to reform is to take shape. The Paris commitments should not be understood as forbidding the questioning of prevailing policies. Country ownership of a result-based policy agenda is a process objective, not a dogma. This is particularly true if the policies at issue are only questionably country-owned (e.g. the GF approach in Uganda) and are anyway not in-keeping with the country's publicly pronounced pro-poor policy goals.

Finally, a more systematic documentation of lessons from successful and unsuccessful experience of policy reforms in sub-Saharan Africa is called for. In future years, it ought to be possible to draw on literature from within the region, as well as from Latin America and Asia, in considering the scope for pro-active management of policy reform processes. This means continuous documentation of any significant successes or failures in applying this approach.

5. Conclusions

The literature, although sparse, is unanimous in its view that health policy change is inherently political. The literature has begun to point to the different groups and interests which operate in the sector and how evidence and argument, and power, are used – most often to block progressive reform, but potentially to enable it to happen. Donors are increasingly vexed by these politics and do care to understand them better. But all too often they are too timid in their approach and too hesitant in acknowledging the often perverse incentives inherent in the aid regime which they would need to address in tandem with any efforts to intervene in the domestic political economy.

Our brief field work in Tanzania and Uganda confirmed the political nature of the reforms in those countries. In particular, it points to an inter-locking set of features involving issues of sector leadership, donor practices and poorly-informed and organised progressive interests, which seem to be blocking efforts to improve efficiency, effectiveness and equity in the sector. The research also reveals a series of constraints to addressing the political-economy obstacles and some potential opportunities. It seems to suggest a number of attitudinal preconditions for realising these opportunities.

It seems particularly important that the reform coalitions in sub-Saharan Africa consider the following lessons which would appear to emerge from our research as they attempt to engage more successfully in the politics:

- ❑ Focus on a few key reforms which have proponents in key government positions.
- ❑ Unravel the political dimensions associated with the proposed changes – including those which emanate from the constellation of aid modalities.
- ❑ Work to address the misconceptions arising out of the current approaches to partnership and government ownership.
- ❑ Further develop the coalitions to include civil society interests by building their capacity of political and technical issues.
- ❑ Take the opportunity to learn from past success and failure of policy change to inform policy engagement strategies.

We now conclude in two ways. First, we argue that a policy engagement (or influencing) framework may provide a helpful tool for unblocking the institutional log jams in health sector reform processes. The main features of the framework itself are described in Buse (forthcoming). Here we briefly indicate its nature and purpose. Second, we address some of the concerns that may remain in some readers' minds concerning the ethics of what is being proposed.

Policy Engagement Framework

As noted in Section 2, we understand policy to comprise interaction among **institutions, interests and ideas**. Policy change (or stasis) is essentially political and subject to the distribution and exercise of power by agents and structures/institutions through decision-making and non-decision-making, and through latent means to maintain the status quo (Lukes, 1974). Power is wielded through mechanisms at all levels in society which impact on the way issues reach policy-makers', the way that policies are formulated and implemented, and whether or not individuals and communities benefit from them. These political dimensions shape the content and impact of policies.

Understanding the way that power is wielded with respect to specific issues increases the probability, all other things being equal, of one's ability to influence the policy process and thereby to bring about improved societal outcomes. Hence, despite the power of interests and institutions to resist change, **reformers have 'room for manoeuvre'**, the use of which bring about changes in public policy (Grindle and Thomas, 1991).

Treating policy as a complex interaction of institutions, interests and ideas leads us to conceptualise **the relationship between research evidence and policy** as an indirect one which may take many forms (Weiss, 1979). Notwithstanding this indirect relationship, the elective affinity model holds; that is, a decision-maker is more likely to react favourably to research findings if s/he has participated in the research process in some way, if the findings are timely in the decision-making process, and coincide with the values and beliefs of the policy audience (Short, 1997).

Considerable research has been undertaken on the characteristics of networks, and the environments in which they operate, to understand what makes them effective in influencing policy (Marsh and Smith, 2000). We build on these findings and other recent thinking on the research-to-practice linkages which suggest **the benefits of 'deliberative processes'** in which technical, scientific experts, programme managers, decision-makers and others collectively weigh various types of evidence (Thompson et al., 2006; Lomas et al., 2005). It would appear that decision-makers will not only benefit from greater proximity to technical experts but also from better evidence concerning political-economy variables which can inform the tactics they employ to overcoming resistance to the use of scientific evidence in the policy process.

While recognising the role that serendipity plays in the policy process (Kingdon, 1984), we hypothesise that a **systematic understanding of the political dimensions of change** increases the chances of developing and implementing strategies to influence policy change (Roberts et al., 2004; Reich, 2002; Buse et al., 2005).

The Policy Engagement Framework (PEF) offers a systematic approach to the ongoing collection, analysis and use of political information (e.g., concerning actors, their interests, institutions, ideas, and policy processes and context) that can alter the balance of power between those in support of and those resisting change by enabling pro-reformers to intervene more effectively in the policy process. The tool is adapted from existing instruments used for different purposes (Hogwood and Gunn, 1984; Buse et al., 2005; Roberts et al., 2004; Walt and Gilson, 1994; Bossert, 2000). Detailed guidelines on how to conduct the first step of the Policy Engagement Framework (i.e., understanding the political context in which reform occurs) will shortly be published (Buse, forthcoming).

Possible ethical issues concerning donor support for an improved policy process

Concerns may arise about the ethics of external groups supporting domestic constituencies to improve the prospects for the development and implementation of evidence-informed, pro-poor policies. Such concerns apply particularly where there are grounds for thinking that the policies being promoted are not in fact evidence-based and the subject of a technical consensus – the first generation of privatisation and cost-recovery measures for health sectors being a possible example. However, we suggest that a generalised objection on ethical grounds to the type of intervention we are proposing cannot be sustained – at least not without inconsistency with the commitments and activities that the donor community already undertakes.

To begin with, the distinction between 'external' groups and internal issues is hard to sustain. The main pro-poor policy goals now transcend national boundaries (e.g., the MDGs), for the good reason that achievement of those goals requires *global* efforts. Neither the drivers nor the blockers of the corresponding reforms are restricted to the domestic policy arena. Experience suggests that pro-poor reforms will likely be blocked by a variety of national and international groups with an interest in maintaining the status quo or in altering it in ways that may further their interests at the expense of the poor.

Secondly, the aim of prospective management of reform politics is to empower national groups to achieve reforms which have global technical acceptance and support, but which are faced with entrenched interests, either at home or abroad or both. In other words, the image of external actors foisting ill-considered policy measures on unwilling countries is entirely inappropriate. In any case,

donors can minimise any risk of this sort by scrupulously supporting only those coalitions that are pursuing technically-appropriate, globally-accepted, evidence-informed interventions.

Thirdly, the ethical boot is arguably on the other foot. Without external support, both financial and technical – which we submit should include good policy analysis tools – the goals are unlikely to be met in many countries. For this reason, it is not only ethical but imperative for external groups to support the efforts of pro-poor groups to remove obvious obstacles to the attainment of the goals.

Finally, it is inconsistent to promote pro-poor policies but not to support the conditions for their success. Northern donors systematically attempt to influence the content of policy (through, for example, loan conditionalities and policy dialogue at national and sector levels). If this is ethically acceptable, it cannot be unacceptable to take a hand in the way those same policies are packaged, presented and carried through, when we know that these issues are crucial to their effectiveness.

Some donors recognise this logic in their general development work, although not in the health sector, as far as we know. The Policy Engagement Framework approach which we have outlined in this paper has affinities with the issue-based approach and Coalitions for Change programme being trialled by DFID staff on the basis of ‘drivers of change’ analysis in Nigeria (Pycroft and Butterworth, 2005).

A more specific and practical set of ethical concerns does deserve continued attention. This relates to disclosure of information. Much of the data upon which the PEF is based will be collected in an informal manner – during meetings in which the advocacy coalition members participate, in corridor discussions, and also in social settings. An advocacy coalition would have to decide whether and how its members should communicate the nature of its project to the wider policy community.

References

- Ahmad, K. (2002) 'UN Study Expresses Concern Over National Antiabortion Policies', *Lancet* 360 (9326):64.
- Alvarez-Rosete, A. (2005) 'Modernizing Healthcare Policy Making'. Paper presented at the Politics of Health Group Conference, Oxford, September. London: Kings Fund (Unpublished).
- Batley, R. (2004) 'The Politics of Service Delivery Reform', *Development and Change* 35 (1): 31-56.
- Bennett, L. (1999) 'Single Women's Experiences of Premarital Pregnancy and Induced Abortion in Lombok, Eastern Indonesia', *Reproductive Health Matters* 7 (14):106-117.
- Blas, E. (2004) 'The Proof of the Policy is in the Implementation', *International Journal of Health Planning and Management* 19:S3-23.
- Booth, D. and Nsabagasani, X. (2005) *Poverty Monitoring Systems: An Analysis of Institutional Arrangements in Uganda*. Working Paper No. 248. London: Overseas Development Institute.
- Bossert, T. (2000) *Methodological Guidelines - Enhancing the Political Feasibility of Health Reform in Latin America*. LAC/HSR 38. Harvard School of Public Health.
- Bruckner, H. and Bearman, P. S. (2005) 'After the Promise: The STD Consequences of Adolescent Virginity Pledges', *J Adolsc Health* 36: 271-8.
- Buse, K. (submitted) 'Theoretical, Practical and Ethical Challenges Inherent in Prospective Health Policy Analysis: How Addressing Them May Improve Health Outcomes', *Health Policy and Planning*.
- Buse, K. with Hawkes, S. and Jones, N. (forthcoming) *Understanding the Political Context of Policy Change – A How-To Guide*. London: Overseas Development Institute.
- Buse, K., Mays, N. and Walt, G. (2005) *Making Health Policy*. Milton Keynes: Open University Press.
- Buse, K., Martin-Hilber, A., Widyantoro, N. and Hawkes, S.J. (2006) 'Managing the Politics of Evidence-based Sexual and Reproductive Health Policy', *The Lancet* 368 (9552): 2101-2103.
- Campos, J.E. and Syquia, J.L. (2006) *Managing the Politics of Reform: Overhauling the Legal Infrastructure for Public Procurement in the Philippines*. Washington, DC: World Bank.
- Cassels, A. (1995) 'Health Sector Reform: Key Issues in Less Developed Countries', *Journal of International Development* 7 (3): 329-347.
- Chung, W.J. and Kim, H.J. (2005) 'Interest Groups' Influence Over Drug Pricing Policy Reform in South Korea', *Yonsei Medical Journal* 46 (3): 321-30.
- Collins, C., Omar, M. and Tarin, E. (2002) 'Decentralization, Health Care and Policy Process in the Punjab, Pakistan in the 1990s', *International Journal of Health Planning and Management* 17: 123-146.
- Collins, C. Green A. and Hunter, D. (1999) 'Health Sector Reform and Interpretation of Policy Context', *Health Policy* 69-83.

- de la Jara, J.J. and Bossert, T. (1995) 'Chile's Health Sector Reform: Lessons from Four Reform Periods', *Health Policy* 32 (1-3): 155-66.
- ESRF (2005) *Enhancing Aid Relationships in Tanzania: IMG Report 2005*. Dar es Sallam: Economic and Social Research Foundation.
- Gibson, B. (2003) 'Beyond "Two Communities"', in Lin, V. and Gibson, B. (eds), *Evidence-Based Health Policy: Problems and Possibilities*. Melbourne: Oxford University Press.
- Gilson, L. and Raphaely, N. (forthcoming) 'The Terrain of Health Policy Analysis in Low and Middle Income Countries: A Review of Published Literature 1994-2007', *Health Policy and Planning*.
- Gilson, L., Doherty, J., Lake, S., McIntyre, D., Mwikisa, C. and Thomas, S. (2003) 'The SAZA Study: Implementing Health Financing Reform in South Africa and Zambia', *Health Policy and Planning* 18 (1): 31-46.
- Glassman, A., Reich, M.R., Laserson, K. and Rojas, F. (1999) 'Political Analysis of Health Reform in the Dominican Republic', *Health Policy Plan* 14: 115-26.
- Gloyd, S., Chai, S. and Mercer, M.A. (2001) 'Antenatal Syphilis in Sub-Saharan Africa: Missed Opportunities for Mortality Reduction', *Health Policy and Planning* 16 (1): 29-34.
- González-Rossetti, A. and Bossert, T. (2000) 'Enhancing the Political Feasibility of Health Reform: A Comparative Analysis of Chile, Colombia and Mexico', *Latin American and Caribbean Regional Health Sector Reform Initiative*.
- Green, A. (2000) 'Reforming the Health Sector in Thailand: The Role of Policy Actors on the Policy Stage', *International Journal of Health Planning and Management*. 15 (1): 39-59.
- Grimes, D.A. (2004) 'Emergency Contraception: Politics Trumps Science at the U.S. Food and Drug Administration', *Obstet Gynecol*. 104: 220-221.
- Grindle, M.S. (2002) 'Despite the Odds: The Political Economy of Social Sector Reform in Latin America', in Abel, C. and Lewis, C.M. (eds), *Exclusion and Engagement: Social Policy in Latin America*. London: Institute for Latin American Studies.
- Grindle, M.S. and Thomas, J.W. (1991) *Public Choices and Policy Change: The Political Economy of Reform in Developing Countries*. Baltimore: Johns Hopkins Press.
- Hajer, M. and Wagenaar, H. (2003) 'Introduction', in Hajer, M. and Wagenaar (eds) *Deliberative Policy Analysis*. Cambridge: Cambridge University Press.
- Hawkes, S., Miller, S., Reichenbach, L., Nayyar, A. and Buse, K. (2004) 'Antenatal Syphilis Control Programmes: People, Programmes, Policies and Politics', *Bulletin of the World Health Organization*. 82 (6): 417-423.
- HERA (2005) *Technical Review 2005: Public Private Partnership for Equitable Provision of Quality Health Services*. Independent review on behalf of the MoH, PORALG and the Government of Tanzania.
- Hogwood, B.W. and Gunn, L.A. (1984) *Policy Analysis for the Real World*. New York: Oxford University Press.

- Human Rights Watch (2004) 'The Less they Know the Better: Abstinence-Only HIV/AIDS Programs in Uganda'. New York, NY: Human Rights Watch. Accessed on 31 January 2006 at http://www.hrw.org/doc/?t=hiv aids_pub.
- Hutton, G. (2004) 'Case Study of a "Successful" Sector-wide Approach: The Uganda Health Sector SWAp'. A lessons learned paper established in the frame of the SDC-STI SWAp Mandate. SDC.
- IDD and Associates (2006) *Evaluation of General Budget Support: Synthesis Report*. University of Birmingham, International Development Department.
- IMF (2005) *United Republic of Tanzania: Third Review under the Three-Year Arrangement under the PRGF and Requests for Waiver of Performance Criteria and Modification of Performance Criteria – Staff Report*. Country Report 05/181. Washington, DC: IMF.
- Jeppsson, A. (2002) 'SWAp Dynamics in a Decentralized Context: Experiences from Uganda', *Social Science and Medicine* 55 (11): 2053-2060.
- John, P. (1998) *Analysing Public Policy*. London: Cassell.
- Kajula, P.W., Kintu, F., Barugahare, J., and Neema, S. (2004) 'Political Analysis of Rapid Change in Uganda's Health Financing Policy and Consequences on Service Delivery for Malaria Control', *International Journal of Health Planning and Management* 19: S133-153.
- Kapperiri, L. and Martin, D.K. (2006) 'The Global Fund Secretariat's Suspension of Funding to Uganda: How Could This Have Been Avoided?', *Bulletin of the World Health Organization* 84 (7): 576-580.
- Kingdon, J. (1984) *Agendas, Alternatives and Public Policies*. Boston: Little Brown and Co.
- Kirby, D. (2004) 'Emerging answers: Research Findings on Programs to Reduce Teen Pregnancy'. Washington, DC: National Campaign to Prevent Teen Pregnancy. Accessed on 31 January 2006 (www.teenpregnancy.org/resources/data/report_summaries/emerging_answers/default.asp).
- Leftwich, A. (2006) 'Draft: Drivers of Change: Refining the Analytical Framework'. Unpublished.
- Leichter, H. (1979) *A Comparative Approach to Policy Analysis: Health Care Policy in Four Nations*. Cambridge: Cambridge University Press.
- Leighton, C. (1996) 'Strategies for Achieving Health Financing Reform in Africa', *World Development* 24 (9):1511-25.
- Lomas, J., Culyer, T., McCutcheon, C., McAuley, L. and Law, S. (2005) 'Conceptualizing Evidence for Health System Guidance: Final Report'. Ottawa: Canadian Health Research Foundation.
- Lukes, S. (1974) *Power: A Radical Approach*. London: Macmillan.
- Marsh, D. and Smith, M.J. (2000) 'Understanding Policy Networks: Towards a Dialectical Approach', *Political Studies* 48 (4): 4-21.
- MoH (2006) *Annual Health Sector Performance Report – Financial Year 2005/06*. Ministry of Health, October. Kampala: MOH.
- MOHSW (2006) *Health Sector PER update FY 06*. United Republic of Tanzania Ministry of Health and Social Welfare.

- MOHSW (2006) *7th Joint Annual Health Sector Review, 27th-29th April 2006 – Record of Proceedings*. Health Sector Reform Secretariat, DPP, Ministry of Health and Social Welfare.
- Nelson, J.M. (2004) 'The Politics of Health Sector Reform: Cross-national Comparisons', in Kaufman, R.R. and Nelson, J.M. (eds), *Crucial Needs, Weak Incentives. Social Sector Reform, Democratization, and Globalization in Latin America*. Washington, DC: Woodrow Wilson Center Press. Co-published by The Johns Hopkins University Press.
- Nelson, J.M. (2000) 'The Politics of Social Sector Reforms'. Washington DC: Overseas Development Council. At www.iadb.org/sds/doc/nelson1.pdf
- Nelson, J.M. (1999) 'Reforming Health and Education: the World Bank, the IDB and Complex Institutional Change'. Overseas Development Council Policy Essay 26. Baltimore: Johns Hopkins Press.
- Ngwena, C. (2004) 'An Appraisal of Abortion Laws in Southern Africa from a Reproductive Health Rights Perspective', *J Law Med Ethics* 32 (4): 708-18.
- Nigeria, Federal Ministry of Health (no date) *Health Sector Reform Program: Strategic Thrusts; Key Performance Objectives; and Plan of Action 2004-2007*.
- North, D.C. (1991) 'Institutions', *Journal of Economic Perspectives* 5 (1): 97-112.
- Oliff, M., Mayaud, P., Brugha, R. et al. (2003) 'Integrating Reproductive Health Services in a Reforming Health Sector: The Case of Tanzania', *Reprod Health Matters* 11 (21): 37-48.
- Oliver, T. (2006) 'The Politics of Public Health Policy', *Annual Review of Public Health* 27: 195-233.
- Paul, C. (2007) 'Mission Report: Uganda's Health SWAp: An Analysis of the Prevailing Incentive System Through the Prism of Conditionality Mechanisms and Underlying Politico-institutional Factors'. GRIP-SWAP.
- Paul, C. (2005) 'Mission Report. Tanzania's Health SWAp: Achievements, Challenges and Lessons Learnt'. GRIP-SWAP.
- PEFAR (2005) *Tanzania – Public Expenditure and Financial Accountability Review Mission for 2004/05. Aide Memoire*.
- Pycroft, C. and Butterworth, R. (2005) 'Where Capacity is not the only Problem: Moving from Generic Capacity Building to Support for Issues-based Change in Nigeria'. Capacity Development Briefs Number 12, September. Washington, DC: World Bank Institute.
- Reich, M.R. (2002) 'The Politics of Reforming Health Policies', *IUHPE – Promotion & Education* 9 (4): 138-142.
- Reich, M.R. (1995a) 'The Politics of Agenda Setting in International Health: Child Health Versus Adult Health in Developing Countries', *Journal of International Development* 7 (3): 489-502.
- Reich, M.R. (1995b) 'The Politics of Health Sector Reform in Developing Countries: Three Cases of Pharmaceutical Policy', *Health Policy* 32: 47-77.
- Reichenbach, L.J. (2002) 'The Politics of Priority Setting for Reproductive Health: Breast and Cervical Cancer in Ghana', *Reproductive Health Matters* 10 (20): 47-58.

- Roberts, M.J., Hsiao, W., Berman, P. and Reich, M.R. (2004) *Getting Health Reform Right: A Guide to Improving Performance and Equity*. New York: Oxford University Press.
- Roberts, J.M., Villar, J. and Arulkumaran, S. (2002) 'Preventing and Treating Eclamptic Seizures', *BMJ* 325 (7365): 609-619.
- Sabatier, P.A. and Jenkins-Smith, H.C. (1993) *Policy Change and Learning: An Advocacy Coalition Approach*. Boulder, CO: Westview Press.
- Santelli, J., Ott, M., Lyon, M., Rogers, J. et al. (2006) 'Abstinence and Abstinence-only Education: A Review of US Policies and Programs', *J Adolesc Health* 38: 72-81.
- Schattschneider, E.E. (1966) *The Semisovereign People*. New York: Holt, Rinehart and Winston.
- Schneider, H (2000) 'On the Fault Line: The Politics of AIDS Policy in Contemporary South Africa', *African Studies* 61: 145-67.
- Schneider, H. and Fassin, B. (2002) 'Denial and Defiance: A Socio-political Analysis of AIDS in South Africa', *AIDS* 2002 16 (suppl 4): S45-S51.
- Shiffman, J., Stanton, C. and Salazar, A.P. (2004) 'The Emergence of Political Priority for Safe Motherhood in Honduras', *Health Policy and Planning* 19 (6): 380-390.
- Shiffman, J. (2007) 'Generating Political Priority for Maternal Mortality Reduction in Five Developing Countries', *American Journal of Public Health* 97 (5): 796-803.
- Shiffman, J., Skarbalo, M. and Subotic, J. (2002) 'Reproductive Rights and the State in Serbia and Croatia', *Social Science and Medicine* 54: 625-642.
- Short, S. (1979) 'Elective Affinities: Research and Health Policy Development', in Gardner (ed.), *Health Policy in Australia*. Melbourne: Oxford University Press.
- Schmid, G. (2004) 'Economic and Programmatic Aspects of Congenital Syphilis Control', *WHO Bulletin*.
- Swank, D. (2002) *Global Capital, Political Institutions, and Policy Change in Developed Welfare States*. Cambridge University Press.
- Tantchou, J. and Wilson, E. (2000) *Post-Cairo Reproductive Health Policies and Programs: A study of five francophone African Countries*. Washington: The POLICY Project, Futures Group International.
- Thomas, J.W. and Grindle, M.S. (1994) 'Political Leadership and Policy Characteristics in Population Policy Reform', *Population and Development Review* 20 (supplement): 51-70.
- Thompson, G.N., Estabrooks, C.A. and Degner, L.G. (2006) 'Clarifying the Concepts in Knowledge Transfer: A Literature Review', *Journal of Advanced Nursing* 53: 691-701.
- Transparency International (2007) *Corruption Perception Index 2006*. http://www.transparency.org/policy_research/surveys_indices/cpi accessed 30/08/07.
- UK Cabinet Office (1999) *Professional Policy Making for the Twenty First Century*. Report by the Cabinet Office Strategic Policy Making Team. London.
- UN (2005) *The Millennium Development Goals Report*. <http://unstats.un.org/unsd/mi/pdf/MDG%20Book.pdf>

- van de Walle, N. (2001) *African Economies and the Politics of Permanent Crisis, 1979-1999*. Princeton, NJ: Princeton University Press.
- Walt, G. and Gilson, L. (1994) 'Reforming the Health Sector in Developing Countries: The Central Role of Policy Analysis', *Health Policy and Planning* 9 (4): 353-370.
- Weiss, C.H. (1979) 'The Many Meanings of Research Utilization', *Public Administration Review* 39: 426-31.
- Weyland, K. (1995) 'Social Movements and the State: The Politics of Health Reform in Brazil', *World Development* 23 (1):1699-1712.
- Williamson, T. (2003) *Targets and Results in Public Sector Management: Uganda Case Study*. ODI Working Paper No. 205. London: Overseas Development Institute.
- World Bank (2006) *Forthcoming World Bank Health, Nutrition and Population (HNP) Strategy - Note for CODE* - 30 May. Washington, DC: World Bank.
- Wyss, K. and Lorenz, N. (2002) *Primary Health Care in Sub-Saharan Urban Areas: Current Issues and SDC Experiences in N'Djamena, Duala and Dar es Salaam*. Berne: Swiss Development Corporation.

Annexes

Annex 1: Tanzania field report

Kent Buse and Aziza Mwisioongo

Summary

- Health policies are often populist and patrimonial in nature – sponsored by the highest levels of government
- Policy is made by a small cabal (core executive) of government officials
- There exists a lack of reform champions within Ministry of Health and Social Welfare on key issues (lack capacity and unwilling to take risks)
- Lack of reform champions among donors (although there have been exceptions to this – user fees was adopted by DFID unsuccessfully)
- Evidence is not available and/or ignored on some policy issues – which may in part be a function of capacity, but is also partially likely a function of politics
- Processes to dialogue on a more rational allocation exist in the budget and SWAp processes, yet these formal platforms are sidelined and emasculated by Global Health Initiatives and the persistence of project modalities – which result in considerable off-plan and off-budget allocation
- GHIs are influential in determining priorities both through access to high level officials and through financing
- Beyond the influence bestowed by resources on what is financed, it is not clear that traditional donors have great influence over setting the health policy agenda
- After broad directions of policy travel are set, working at technical level provides a vehicle to influence policy content and implementation – an option closed to agencies without technical advisors
- Informants unable/unwilling to reveal much about domestic interests
- No evidence that systematic processes being employed to reveal/assess interests, positions, commitment, influence of different groups on specific issues
- Creating creative alliances among like minded pro-reform officials in government, civil society and donors to work on policy processes will be challenging due to mistrust and lack of capacity – but presents an area of fruitful experimentation

1 Introduction

- This report discusses the political-economy of recent health sector reforms in Tanzania with a view to identifying the constraints and opportunities facing donors in supporting evidence-informed policy change.
- The report is based on discussions held with a range of stakeholders in Dar es Salaam in November 2006 and a documentary review.
- The report is complemented by a similar report on Uganda. Both of which feed into a wider analysis of 'Good Governance and Aid Modalities' supported by the Advisory Board of Irish Aid undertaken by the Overseas Development Institute, London (insert web address of an output).

2 Health reform challenges in Tanzania

The country context

- The second Poverty Reduction Strategy Paper (PRSP), named the National Strategy for Growth and Reduction of Poverty (NSGRP), known in Kiswahili as *Mkukuta*, was approved in April 2005 covering the period through 2010. Sectors are no longer addressed separately, but grouped into three thematic clusters. Health falls under the 'Improved quality of life and social well-being' cluster and, in 2006, the Ministries of Health and Social Welfare were merged (MoHSW) [although the new President indicates that there may be a return to sector by sector objectives of the NSGRP].
- The long-term strategy to implement the government's PRSP in the health sector is outlined in the *Health Sector Development Strategy 2000-2011* with a medium-term strategy, the *Second Health Sector Strategic Plan* (HSSP II), running from 2003 to 2008. These strategies form the sectoral component of a

package of reforms covering all aspects of national development. Fiscal, public financial management, administrative, legal, and political decentralisation¹, and the approach to macroeconomic management and planning, create a particular set of opportunities and constraints for health sector reform. The challenges are reinforced by the relatively recent transition from a state-led economy, the attenuated relationship between government and donors in the early 1990s' to 1995 under President Mwinyi over macro-economic issues, as well as the changing role proposed for the MoHSW, from one concerned primarily with delivering services to one focusing on steering, policy development, results orientation, and integration of unruly global initiatives.

- The political system is a hybrid of legal-rational and patrimonial elements.
- The bureaucracy is a UK-style permanent civil service – reformed but not thoroughly transformed since the late-1990s reform programmes were launched, and much affected by aid dependency (i.e., development partners fund approximately 39% of government expenditure in FY2006/07). According to the IMF, effective use of additional aid would likely require further improvements to absorptive capacity (IMF, 2005).
- In 2002, the Government of Tanzania (GoT) adopted the Tanzania Assistance Strategy (TAS) which sets out a framework for the management of external resources and for cooperation with Development Partners (DP). The TAS expresses Government preference for programme aid modalities – particularly General Budget Support (GBS). In July 2007, the TAS was replaced with a Joint Assistance Strategy Tanzania – negotiated with 40 Development Partners – which reiterates the desire for a greater proportion of aid allocated as GBS and an improved division of labour among donors. In addition to joint monitoring mechanisms, an Independent Monitoring Group (IMG) reports on progress.
- Much of the GBS (US\$ 600 million) flows through the Poverty Reduction Budget Support Facility – a single joint instrument of 14 DPs (11 bilaterals plus World Bank, African Development Bank and EU). In FY06/07, forty-two percent of aid was GBS with the remainder basket and project finance.
- Tanzania differs from the Latin American contexts where political economies of reform have been documented in greater relative weight and where there is a different composition of internal and external stakeholders. This doesn't necessarily weaken the case for using political intelligence to inform donor decision-making, but does bring in additional issues and constraints.

Progress in the health sector

Some progress on some health outputs and outcomes has been recorded since 1999, particularly on infant and child mortality, and increased use of insecticide treated bed nets have lowered the incidence of malaria. But major problems persist, for example, with low family planning acceptor rates, inadequate use of skilled birth attendants, a drop in facility based births, and no progress on high maternal mortality rates since the Tanzania Reproductive and Child Health Survey of 1999.

While there have been significant efforts in better prioritising and managing resources in the sector, key strategic challenges remain. For example, there has been a lack of progress on the contentious public private partnership (particularly the subvention rate to private providers of publicly financed services – which after a pay hike in the public sector has led to staff migrating from private to public sector facilities) and to address a widely recognised human resources crisis (there is an estimated deficit of 15,000 staff which require financing of new posts and incentivising staff to serve in remote areas).

Prioritisation and coordination with constrained resources

- Since 2000, total public expenditure on health has increased in real terms and as a percentage of GDP, yet the per capita spending of US\$ 7.21 in FY05 (budgeted at 9.92 FY06) remains far below the level required for basic health services and to fully finance the HSSP. Health spending remains very dependent on external support (i.e., in the order of 50%).
- The HSSP II sets a broad framework for resource prioritisation (e.g. on prevention, district health systems, and health services addressing MDGs) but actual prioritisation occurs on an annual and continuous basis, through two mechanisms and their interaction: (1) the annual budgetary process in the context of the rolling Medium Term Expenditure Framework (MTEF); and (2) negotiations about external

¹ The health sector was a pioneer in decentralization of planning and management – yet the local government reform launched in 2000 remains 'incomplete, still in transition or inadvertently undercut by other new policy processes' (ESRF 2005). Importantly, planning and spending by local governments (urban and rural district councils) remain under tight central government control – through guidelines issued by PORALG and the MOHFW covering utilization of block grants and grants from the Health Sector Basket Fund.

project funding that take place more or less in the margins of the formal sector budget process – sometimes involving different stakeholders (e.g., the president’s office, senior officials from Global Health Initiatives and programme managers).

- The budgetary process is informed by a process of annual Public Expenditure Review (PER) (which since FY04/05 is a Public Expenditure and Financial Accountability Review), which is an *ex post* analysis of the efficiency of public spending, the quality of budget execution, and the matching of expenditures with national and sectoral needs. The quality of the PER² and MTEF is deemed to be relatively high in the health sector (ESRF 2005) – yet it provides no data on what is significant health spending at the local government level (MoHSW 2006). In the health sector, the budgetary process consists of two linked exercises, one managed by the Ministry of Finance (MoF) which issues its budget guidelines to sectors against national priorities, and one managed by PORALG which allocates its resources among all the decentralised activities that it supervises.
- A health SWAp was launched in 1999 and, among other things, involved the establishment of a joint funding mechanism (the basket – i.e., sector budget support) among some donors and provided further reinforcement to prioritisation and coordination among donors and government.
- **Achievements of the SWAp** are reported to include:
 1. increased (central) government ownership of health policy;
 2. some convergence among donor policies³;
 3. an increase in donor support to the sector – and importantly concomitantly a doubling of the amount of non-personnel recurrent budget available to the sector at the district level (through the donor basket grant) and consequently;
 4. a boost to decentralisation;
 5. a slight increase in allocation to preventive/primary care from 33% of overall spending in FY1999/00 to 42% in 2003/04;
 6. the reduction of off-budget donor expenditure (as a % of total donor expenditure) from 85% in FY99/00 to 53% in 2004/05;
 7. an increasing number of projects (managed using donor-specific procedures) are integrated into the health sector programme and MTEF;
 8. increased use of government procedures for the management of aid as well as the PER and sector monitoring;
 9. increasing, although far from widespread or systematic, use of consultative mechanisms in sector programme planning and review (e.g., through the Joint Annual Health Sector Review - JAHSR).
- Some of these sector improvements are likely, at least partially, the result of other developments in the sector. For example the Tanzania Essential Health Interventions Project has generated local evidence to demonstrate that the allocation of health funding at the district level in accordance with the local burden of disease data and on the basis of cost-effectiveness principles can lead to significant reductions in morbidity and mortality (de Savigny et. al., 2004).
- Despite these achievements, the health sector remains plagued by a number of problems which lead to **inefficiencies**, including:
 1. The practice of incremental budgeting persists;
 2. Block grants to districts as well as basket fund grants are allocated in a rigid (although not harmonised) manner. In the case of district basket, only 5% of funds are not ‘pre-allocated’. This obviates against reallocation between central and district levels and between staff and non-staff spending which might enable greater input efficiencies to be realised. It was argued that the formula was necessary as the District Councils may not have the capacity to allocate rationally or that District Executive Directors may raid the health funds.⁴ This suggests that health reforms may be contingent on greater implementation of decentralisation reforms. Although it may equally be the case that central programme managers may not wish their programmes to suffer at the periphery;
 3. FY 2006/07 sees a real cut in allocation to ‘other charges’ (OC): these are non-salary, recurrent expenditure for factor inputs required to run health services;

² The PER is characterized by Paul (2005) as open and participatory.

³ Although it would appear that there are significant differences over the relative weight which ought to be accorded to ARVs, the issue of cost recovery (i.e., user fees) and the merits of different aid modalities (e.g., sector vs general budget support vs special initiative).

⁴ It was alleged that the independent auditors were raising an increasing number of queries on reports from the Districts – expenditure at that level is signed off by the DED (a presidential appointment over which District Medical Office has little leverage).

4. A significant proportion of scarce 'OC' is allocated to training and associated per diems;
 5. An extensive system of allowances is in place which enables the 'topping up' of certain officials' salaries which are viewed as 'an inefficient way to alleviate the problem of low pay in public service (PEFAR, 2005);
 6. A significant increase in allocation in FY2006/07 to capital expenditure (rehabilitation of health facilities) for which operating expenses are scarce;
 7. Anti-retroviral drugs (ARVs) are treated within the health sector MTEF ceiling and an increase in budgetary allocation to ARVs in MTEF appear to be at the expense of a significant reduction in some more cost-effective services such as basic immunisation;
 8. More sophisticated and expensive vaccines were 'forced upon' Tanzania by the GAVI Alliance (MOH 2005 in Paul 2005) although it was reported that pentavalent vaccines were 'resisted';
 9. Basket restrictions on expenditure require separate accounting which results in a duplication of administrative burden (PEFAR, 2005);
 10. A significant proportion of new funds entering the health system are earmarked leaving few discretionary resources to allocate to priorities or in a flexible manner;
 11. Despite official policy of decentralisation, the central level accounts for a high percentage of total public sector health expenditure (68% of FY06 budget) (MOH 2006);
 12. Poor physical coordination between establishment of private and public facilities undermines overall sectoral efficiency of spend.
- Moreover, political weight is placed on initiatives which would further undermine efficiency, including, for example, the President's intention to establish one dispensary in every village – with implications for the human resources crisis and recurrent expenditures.
 - Deterioration is even more clearly seen in the composition of the health sector budgets in the MTEF, where the 'off-budget' (i.e., funds which do not flow through the exchequer system) remain high. **Off-budget** finance accounts for approximately 30% of the sector's resource envelop in the FY05/06 MTEF – whereas the HSSP II had envisioned that this figure would have shrunk to 5.3% in FY05/06. Significant off-budget expenditure is largely the result of the fact that roughly 50% of donor funds are still 'off budget. Off-budget financing (mainly through projects) undermines the budget process, may relate more closely to donor rather than government priorities (at the cost of true ownership and sustainability),⁵ often involves costly Technical Assistance inputs, and is unlikely to enhance geographic equity.
 - Off-budget allocations are grossly under-reported in the MTEF as many project funds, particularly those of the Global Health Initiatives (GHIs), are not reported to treasury.
 - **Global Health Initiatives** (GHIs) have had a substantially distorting effect:
 1. As they tend to 'ignore' or 'challenge' official sector policy and strategy – particularly those initiatives related to 'HIV/AIDS and immunisation' (Paul, 2005);
 2. As they tend to place considerable strain on government leadership and coordination provided by the SWAp mechanisms;
 3. As a result of failing to integrate into the MTEF process or due to the great uncertainty in amount and timing of disbursement;
 4. On the balance of attention accorded to different disease programmes;
 5. On efforts to strengthen national systems as they tend to establish parallel systems for planning, budgeting, procurement and monitoring (and thereby increase transactions costs);
 6. Budgets by increasing expenditure on very costly commodities (e.g., ARVs, Coartem, etc.) which may require government co-payment, dedicated health delivery/monitoring systems, and lack of support for incremental costs of delivery;
 7. On overall sector efficiency given parallel planning, monitoring and reporting and sometimes even implementation mechanisms;
 8. On financial information transparency, programme coordination (e.g., SWAp structures), and joint review processes; and
 9. On financial and institutional sustainability.
 - Dependence on donor funds is yet more stark in the **AIDS sub-sector** where external support accounts for 90% of the yearly AIDS budget. Eighty percent of these funds come from three sources: The Global Fund \$108.5m (HIV and AIDS grants alone with a further \$83m from a TB/HIV grant); PEPFAR \$309m allocated through to end 2006; and the World Bank MAP \$70m. The Tanzania Commission on AIDS (TACAIDS), under the President's office, is legally mandated to provide strategic leadership and to coordinate and strengthen the efforts of all stakeholders involved in HIV and AIDS, but has limited

⁵ While some projects reflect government priorities – a government official argued that more often than not USAID is in 'default'.

control over external resources for HIV/AIDS because: (1) PEPFAR funding is managed completely separately from TACAIDS, (2) although TACAIDS is a sub principal recipient on one GF grant it has no real leverage on GF funds more generally (although TACAIDS controls the proposal development process); and (3) funds from the World Bank's MAP are channeled to LGAs and TACAIDS has limited allocative influence on these.

- The GoT's decision to increase the wages of government employed health workers while freezing the grants to the Private Not For Profit (PNFP) sub-sector caused some staff to leave the PNFP facilities to take up employment in what many see as the less efficient government health units. This created quite severe staff shortages in the PNFP sub-sector which renders it arguably now less effective and efficient.
- There are some challenges to health sector development budget execution – only 77% in FY05 – which also highlight efficiency issues.

Constraints to improving efficiency and effectiveness of services

- The ability of MoHSW planners to address efficiency, prioritisation and coordination goals is constrained principally by two factors:
 - The bifurcation of responsibility and financing in the health sector between the MoHSW and PORALG (and the Local Government Authorities) in relation to regional and local administrations. The MoHSW is assuming more of a stewardship role (in theory at least) and its only role in delivery of health services is restricted to tertiary hospitals and medicines procurement. The MoHSW does not exert formal control over health personnel decisions at the District level as this rests with the PORALG and LGA machinery.
 - The re-emergence of project funding, with parallel management structures, and the commensurate increase in the influence of Project Managers who have a stake in maintaining the trend of project support – not least for the discretionary control they gain over spending.

These constraints might not be overwhelming if the Ministry were energetic and proactive in undertaking its oversight functions (i.e., through procedures governing the sector-wide approach (SWAp) and widening the scope of the budget process to cover project inputs). Yet, MoHSW leadership was considered by informants to be wanting. Senior staff were thought to lack technical capacity to address strategic reform issues⁶, lack the time to deal with them (as they are frequently on mission), and unwilling to take risks – certainly key policy issues⁷, such as reigning in the GHIs and dealing with the human resource crisis, have failed to elicit champions from within government.⁸ On some issues, such as on working with the private sector, the government's own analysis reveals that the MoH is inconsistent (or unclear or weak), making it difficult to address. A key department at the centre of advice on priority-setting (the Policy and Planning Department – which has a formal role in ensuring alignment of projects, for example), is thought to lack capacity to critically analyse funding proposals in relation to incremental and recurrent costs and thus make convincing arguments for or against particular policy thrusts, projects or initiatives.

In some cases where decisions have been taken, there are complaints that they have been *ad hoc*, failing to consider the relevant evidence and their implications and have not been accompanied by strategies aiming to deal with the implications (e.g., increasing allowances for MoHSW staff).

3 Dimensions of the stakeholder politics

Progress on the above reform issues appear blocked by a rather powerful, interactive set of political-economy constraints.

The high politics of health sector policy

While the initiative to establish a SWAp is credited to a few key donors in the late 1990s, real influence over sector is thought to rest elsewhere. Tanzania's Heads of State have used the sector to propose both **populist and patrimonial initiatives** which depart from evidenced-informed policy (e.g., a dispensary in every village) as well as less popular ones after advice from special interests (e.g., national AIDS testing

⁶ The rotation of the permanent secretary was seen as too frequent to enable the official to come to terms with the complexities of the health sector.

⁷ Donors contended that there are at least eight health policy areas where MoHSW has not paid serious attention to.

⁸ A number of informants stressed the culture of decision making is one which is naturally cautious – and that one benefit of such an approach is that policies have not had to be reversed in Tanzania in contrast to health policies in neighbouring countries.

day). Pet projects, such as infrastructure ones, can be accommodated without confrontation with donors though requests for supplementary budgets in mid-year (although they require MoF and parliamentary approval) and are considered in addition to the MTEF instead of taking up fiscal space within it. Presidents have also been swayed by contacts with external champions to pursue particular policy lines or initiatives – often ones with significant implications for recurrent expenditure – for example, the controversial decision to acquiesce to the Clinton Foundation's Care and Treatment project despite near universal opposition from the local donor group and technical officials in the MoF owing to concerns about the ensuing incremental costs.

Informants spoke of a **health policy cabal** with a relatively stable composition including, in the MoHSW, the Minister, the Principal Secretary and the Chief Medical Officer, key officials in the Prime Minister's and President's offices and the MoF. It is reported to take decisions on major policy discussions largely behind closed doors – sometimes consulting with other departments and key donors as required – but not before consulting more broadly. This dynamic is very much like the 'core executive' model which is presently being used to describe policy-making in the UK administration. Informants also suggested that members of the cabal place limits on the agenda, as both the Health Minister and Permanent Secretary did in their opening statements to the 2006 joint annual review when they indicated that they did not want the group to address the controversial user fee policy. It was also suggested that members of the cabal can successfully reframe policy issues to suit their interests. Examples of external influence on the policy initiatives of the cabal could be readily identified (e.g., ideas/initiatives arising out of meetings between the minister and champions of global health initiatives), yet informants were less able and/or willing to identify domestic constituencies exercising influence to promote or protect their interests in the sector (beyond the bureaucrats).

The impression given is that senior power brokers are willing to listen and dialogue on health policy issues, but do so by invitation and behind closed doors as there is high sensitivity around implied criticism of government or public dissent.

The global and local aid architecture

- The health sector has a large number of development partners – with 23 of them involved in the Development Partner Group (DPG) Health – a high proportion of external support in its MTEF, significant off-budget project support and a significant amount of service delivery through the private (largely not for profit) sector. These structural features carry implications for stakeholder politics – such as the fragmentation of influence as well as the balance of power among the MoF, donors and programme/project managers in the MoHSW.
- **Donor influence** on the policy process accrues through a number of avenues. Finances play an obvious role – particularly project funds which are directly linked to actions – some support unfunded activities of the HSSP II and some those not specified in it. Finances also confer some influence on donors in the annual budgeting process and accompanying policy dialogue.⁹ The DPG-Health provides written comments on the MoH 'Sector Requirement' paper which feeds into the MTEF. The SWAp mechanisms (e.g., joint annual review, the SWAp Committee, the Basket Financing Committee (BFC), the Health Technical sub-Committee, Task Forces and Working Groups) provide a platform to convey donor positions on policy issues – and donor influence could be buttressed by the united position of the DPG-Health (a donor-only grouping). It was argued that the Working Groups present a particularly important route through which to influence the details of policy and its implementation – a route only open to those donors with the technical capacity on the ground to undertake the arduous graft involved. Yet, even analytic work is no guarantee of policy influence, for example the World Bank and WHO developed detailed policy options for the human resources crisis but which were never seriously discussed by decision-makers. The widespread use of per diems to attract officials to certain meetings is also used to influence positions and priorities – a strategy which is having a deleterious impact on the running of the health services.
- A succession of very large global (e.g., GFATM and the GAVI Alliance) and bilateral (e.g., PEPFAR, Clinton Initiative) health initiatives offer a 'tyranny of terrible incentives' and have contributed to shifting the balance of stakeholder interests against the defenders of budget support/SWAPs, significantly altering the local political-economy of health policy.
- The GFATM Country Coordination Mechanism (CCM) system endows new private-sector stakeholders, and some other public officials, with new influence on sector policies, but without the disciplines and constraints of the SWAp system and the budget process. This has set precedents for other donors to

⁹ DFID attempted to compensate treasury for any losses incurred if it abolished user fees in the sector, but the promised finances were not effective in bringing about this U-turn in policy.

work outside established SWAp procedures and thereby undermine those mechanisms and their products. Moreover, the CCM established/imposed a new political space for priority-setting within the three disease programmes (by stipulating composition of the group and imposing constraints on the time for arriving at decisions) with implications for the distribution of influence over decisions.

- PEPFAR and other large US programmes operate in theory outside government, but this does not stop them exercising a depressive influence on mainstream health sector funding, priorities, and incentives to reform. For example, it was reported that the donor community largely opposed a proposal of the Clinton Initiative in relation to HIV/AIDS Treatment and Care and was supported in this opposition by analyst in the MoF – but that this did not prevent the initiative which gained the support of the President.
- Traditional **DPs may be dissipating their influence** through a failure to speak with a common voice. Donors themselves reported a lack of leadership on key issues (e.g., human resources), divisions among themselves on these issues (e.g., fiscal space, user fees, choice of aid modalities, etc) and technical strategies in relation to reforms (e.g., human resources), and disagreements on how hard to push for reforms.
- While the **basket funders** may have enjoyed some preferential access to government through membership of the Basket Financing Committee, the real or perceived ‘insider’ status distinction between basket and non-basket development partners may have diminished over time – particularly since it is reported that members tend to focus on the minutia of technical issues (often among themselves – which may be a good thing) instead of the bigger picture including the strategies they should advocate/pursue. Nonetheless, the basket funders do impose soft conditionalities in their ‘side agreements’ with MoHSW each year which are different to the ‘undertakings’ agreed at the Joint Annual Review and underscore the disparate messages emanating from donors which ultimately likely lead to lack of traction on key issues.
- Donor influence may be further dissipated by the numerous *ad hoc* initiatives which certain members support and thereby fragment the DPG-Health agenda. These initiatives are often championed by external actors with support from local DPs who, at times, feel frustrated that ‘nothing is moving.’
- DFID’s switch from basket funding to GBS, which included it withdrawing its technical advisor, is thought to have not only to have diminished but terminated the Department’s influence in the sector. A lesson that was not wasted on the World Bank as it planned to leave its health specialist in post after moving to GBS.
- The SWAp milestones (undertakings) are intended as common agreements on priorities and outputs/outcomes that the GoT aims to achieve in the coming year. In practice, the milestones have not enjoyed a good track record in that government has failed to deliver on its commitments. In 2005, the majority of undertakings were not met and many informants felt that the rationales for poor performance provided by government officials were not credible. While these undertakings draw attention to donor (and other stakeholders’) concerns, their hands appear tied in relation to enabling/ensuring effective government action – on the one hand as funding decisions not formally linked to performance and on the other because donors do not appear to assess the underlying reasons for non-action.
- Despite Government preference for GBS, and a relatively mature SWAp (with concomitant basket), many donors maintain projectised aid modalities. The project aid modality is used by some DPs (e.g., Japan and US) as they find it difficult for legislative reasons to co-mingle funds, by GHIs (it is claimed for reasons of attribution and fiduciary assurances) and also by those donors who provide sector budget support (e.g., DANIDA and the World Bank).
- Basket funders, and others, argue that the **project modality** is defensible as it gives voice to those areas which may lose out in resource allocation.¹⁰ In particular,
 - Projects provide a means to support activities which not been anticipated in the annual planning process. For example, support for operational research (and action) to address implementation blockages.¹¹
 - Given the rigid budget allocation formula at the district level, it is the case that additional funds may be required for specific activities in some districts but not in others. For example, a specific percentage is allocated to the facility rehabilitation cost-centre which may be insufficient in some

¹⁰ Despite these arguments, UNFPA switched its funding to the Basket for a number of reasons, among them the ability to mainstream its agenda in policy dialogue, sector planning and importantly to get ICPD relevant outcomes embedded in the sector monitoring and evaluation frameworks.

¹¹ A project support facility would be a requirement to finance prospective policy action-research – which arguably could not be financed through SBS.

- (or many) districts and require additional funding.¹² While this is understandable, a project is not necessarily the most rational response.
- Projects are also seen by donors to be useful when there is a divergence of priorities between them and the central or district levels of government (e.g., over the nature of sexual and reproductive health policy or the priority which ought to be accorded to district hospital reforms). This divergence speaks to issues of ownership (and the fact that governments are not monolithic and nor are their priorities always in line with those of civil society or the dictates of evidence) and of course to the contestability of evidence (on some matters there is limited evidence) and values (e.g., equity in the user fee issue).
 - Projects provide the means deploy national or expatriate technical support which can be used to generate and produce evidence and argument, lobby, and engage in policy in a number of ways – arising either out of a difference of perspectives, values or lack of evidence.
 - Projects also provide the means ‘to get things done.’ USAID supported a reportedly successful bednet voucher programme which it was argued would not have been equally successful in the public sector.
- Moreover, it was argued that projects might remain relevant given that some of the theoretical benefits of GBS are not yet materialising fully in practice. For example:
 - First, the downward accountability mechanisms are weak (e.g., in the health sector PER is carried out by an expatriate consultant and not owned or embedded in the MoHSW), structurally flawed (e.g., stipulation that membership of a health facility management committee requires enrolment in the Community Health Fund in which approximately only 5% of the population in enrolled), or lacking (e.g., a mechanism for communities to hold Districts to account for fund expenditure are non-existent).
 - Second, donor relationships with sector officials suffer as donors lose interest, staff capacity and an ability to understand the issues (the Bank has learned from DFID’s mistake and is keeping a sector advisor in post when it fails to renew its commitment to basket funding). The MoHSW felt betrayed with DFID switched from the basket to GBS – despite assurances from DFID that any resultant hole in the budget would be filled from the treasury.¹³
 - Third, funding for civil society organisation involved in civic engagement on health issues is difficult to access, particularly for national NGOs. Notwithstanding the CARE/Action Aid report findings (ref) – it was argued that the data are not robust enough to make a convincing case that funding for NGOs has not decreased in the era of GBS. Moreover, the way donors fund CSOs can often effectively tie CSO hands. For example of the Foundation for Civil Society (a joint donor initiative), which funds local NGOs, has been criticised for micro-managing NGOs, and is reportedly not providing core resources or salary support rendering NGOs unable to build their own internal capacity or sustainability.
 - The funding basket is no panacea and suffers from three major problems:
 - First, it directs accountability to donors on the BFC (some of whom, it is argued, are insufficiently knowledgeable about the sector to make relevant demands) as opposed to strengthening accountability to broader society (public accounts committee of parliament, MoF, health facilities boards, media, etc).
 - Second, the draft budget is presented in April at which time many donors have not made firm commitments – making alignment difficult.
 - Third, with funds from the GHI dwarfing the basket, MoH officials understandably question why they should expend the effort on managing the basket as opposed to pursuing easier funding.
 - The **MoHSW** also plays a role in the landscape of aid modalities. While the official government position is that GBS is the preferred modality, as one informant put it, the MoHSW prefers the basket to GBS¹⁴ but likes projects even more. Lack of resources in the first quarter of each fiscal year in the government treasury system creates material disincentives to shift to budget support and creates additional incentives for special project accounts. Competing levels in the system also prefer differ modalities (e.g., MoHSW vs LGAs). The report of the Independent Monitoring Group talks of the collusion of interests between donors and ministry officials in the perpetuation of projects. The opportunities for rent seeking likely also play a role in choice of modalities; the health sector is not immune from corrupt practices as

¹² In this particular case, a District Capital Development Fund is available to provide support where shortfalls exist, but the donors might be concerned that a particular District Executive Director may not be willing to allocate resources to health.

¹³ When the MoF failed to make good on this promise in the draft MTEF, DFID applied pressure successfully.

¹⁴ It was explained that former MoF PS changed his negative perceptions of sector baskets once he was transferred to a sector where he proposed a basket.

the alleged sale by officials of vouchers intended for family level acquisition of subsidised bednets for prevention of malaria attests.

Whether or not trust between development partners and government was improving and worsening was contested by informants. Whatever the case, high level public challenges to the government are not tolerated with grace as DFID learned in its interaction with the MoF over health sector user fees.

The organisation of interests and advocacy

The organisation of donor influence over the sector has been described above, but it constitutes only one of many stakeholder groups vying for policy influence. Before turning to these, it is worth reiterating that priority-setting takes place outside the formal procedures established in the budget process and SWAp, including through party politics or patrimonial processes.

- The **Ministry of Finance** holds the purse strings, and the very large supplementary budget funds accruing to the MoHSW outside of the regular budget process likely colours its view of the appropriate budget allocation to the sector in the MTEF. It is reported that the MoF takes a very limited interest in the health sector development budget as it views these as donor funds – although failing to question the use of increasingly limited ‘OC’ on buildings instead of drugs, for example, may appear short-sited. On some key issues, the MoF does cite its preferences. For example, it would oppose any solution to the human resources crisis which would increase its pension liability. Wrangling between the MoF and MoH over which ministry would control funds from the Global Fund resulted in the country losing its first planned grant from the organisation in 2002. It appears that the MoF is insufficiently engaged in health sector discussions; for example it was not represented at the 2006 JAHSR.
- Professional associations do not appear to be well organised as an interest group in the sector. Nonetheless, the meetings of Regional Medical Officers were reported to provide an avenue to influence health policies and priorities beyond the discussions between donors and bureaucrats.
- Public health sector workers are organised into the Tanzania Union of Government and Health Employees (TUGHE). There are severe restrictions on its right to collective bargaining and it is banned from striking – although that has not prevented recent wildcat strikes over pay. Moreover, this group can exert its influence and exercise resistance in more subtle ways. The report of the 2006 JAHSR notes that ‘bureaucratic obstacles will need to be overcome in order to redistribute scarce health personnel in favour of under-staffed areas’ (MoHSW) which is surely a euphemism for political opposition to such postings.
- Service-providing NGOs are, despite their importance in policy implementation, less influential than might have been expected. Select NGOs have been invited into the SWAp processes. For example, 10 of the 250 seats at the 2006 were reserved for NGOs. In relation to the SWAp Committee, whereas the government holds 10 seats and donors hold 9, one seat is for faith-based organisation and one for civil society (as of November 2005). The latter two are appointed by MoHSW and reportedly do not advocate positions at odds with MoH for fear of losing access (Paul 2005). This concern is not without basis: the Women’s Dignity Project had been a member of the SWAp Committee and its TWG in 2005, but was asked by government officials to step down for what appears was the tabling of questions concerning barriers to access and public participation and accountability in the SWAp.
- It was argued that most NGOs lack sufficient capacity and understanding to engage effectively in the health reform issues. They also tend to be ill-informed about the insider politics of government ministries, and have problematic relations with donors, who are funders and rather uncertain allies. There is almost no understanding of the constellation of issues described above among local NGOs and in the media and little evidence of NGOs seeking to lobby on systems improvement and countering patrimonialism. Even those invited to the SWAp process recognise this limitation. They are, moreover, not well placed to do advocacy on policy, because they can be portrayed as self-serving.
- Advocacy NGOs with the courage and credibility to count on are few, and they don’t have the resources to be active in sector policy forums and overall budget advocacy (e.g., perks for Members of Parliament etc.).
- District level authorities (LGA and DED) have, as described above, some control over resource allocation and, in effect, veto over policy implementation, but have limited involvement in the national level SWAp processes (and consequently lack ownership) and are not well organised or represented to make their power felt at the national level.
- The middle classes in Dar Es Salaam are largely unaffected by the most pressing health issues (e.g., high maternal mortality rates) and are not organised on the health issues.

- The best organised interest group in the sector appears to be the international-national alliance of AIDS interests. The group has been highly effective in securing major increases in funding and a raft of policy initiatives – even if some of these are questionable.

Progress in the sector has slowed in the recent past as a result of the inter-locking political-economy features presented above. Surprisingly, it appears that no specific incentives were created to compensate the ‘losers’ from their engagement in SWAp processes and the implementation of pro-poor policies – this may simply be the case that compensating losers requires an ability to identify and engage with them.

4 Feasibility of a proactive political-economy approach to informing policy dialogue and guiding action

One aim of the research was to assess the feasibility of employing more structured and systematic approaches to understanding the underlying political-economy factors associated with proposed reforms and of using such understanding to engage more effectively in the reform policy process through the development, for example, of creative alliances between progressive, evidence-informed, pro-poor reformers in the MoHSW and civil society groups. In short, for greater use of policy analysis by stakeholders seeking to pursue evidence-informed, pro-poor policy goals. Informants found it difficult to respond to this line of questioning but their responses to more general questions concerning the political-economy of the health sector provide some clues.

Constraints

It is not clear whether or not lack of political intelligence among donor actors of the interests which may block or be mobilised in favour of reform is a particularly large constraint to donor support of evidence-informed, pro-poor policy making.¹⁵ On the one hand, informants were hard pushed to identify domestic stakeholder groups and their underlying interests in relation to the policy issues that they raised as important. Government informants were of the view that donors have limited knowledge of the inner workings of government and were not sufficiently familiar with how things work to engage effectively in policy influencing. Some informants even questioned the extent to which some donor staff could get to grips with more manageable health systems issues. On the other hand, and despite frequent turnover of staff, Development Partner Groups (DPG), including in Health, appear relatively well-informed as a group/at the lead-donor level – in part as a function of informational exchange at the DPG and more importantly through personal relationships among advisors and government officials.

- Important constraints include:
 - A rather formal understanding among many donors of working in partnership with government, which means that even when there is good understanding of the political-economy issues above, it is not felt appropriate to do anything with it;
 - An interpretation of the Paris principle of the primacy of country ownership which is shallow and unrealistic, leaving donors to alternate between meekly accepting ‘government’ inadequacies and pulling out/cutting back as opposed to working with like minded groups within government departments to change the direction of government travel. For example, the present ‘conditionality’ inherent in the JAR milestones not working – as there are no penalties for not achieving milestones. Some donors would prefer to tighten the links between performance on health outcomes (which would need more robust health management information systems than presently obtain) and donor rewards. Yet this obviating the political challenges inherent in making the money work and assuming that the MoHSW as an entity is willing and able to tackle problems and bottlenecks.
 - Differences which exist among donors on how to address constraints to change which are predicated upon challenging rent seeking – particularly where donors are funding vertical programmes within which it is taking place. The Global Fund has taken a particularly strong and public stance – but with donors divided on how to approach the issue – there is less political will to address it;
 - Lack of attention to identifying and supporting instances where domestic stakeholders, including parliamentary committees, take a stand on the same issues that concern donors;

¹⁵ The extent to which donors fully understand the interests at stake within the MoF, PORALG and MoHSW with respect to various policy reforms was contested by donors. Certainly there are informational asymmetries which depend on such factors as the relationship between the donor agency staff and their counterparts in the ministries, the proportion of national staff, the interest, orientation and skills of the staff in relation to politics, the length of expatriate staff have been in post, etc.

- The health partnership as presently practised is very heavy in formal meetings, leaving little time for issue-based networking and developing influencing strategies;
- Health Advisers tend to be technical health specialists, not brokers of reform alliances – if they are sometimes good net workers, it's by accident;
- Donor CSO support programmes tend to run on parallel tracks with the macroeconomic and sectoral programmes, as if they were not relevant to each other;
- Undue caution among some multilaterals to work in coalitions with civil society to challenge government policies and/or government official's perspectives.
- Culture of mutual mistrust between civil society and GoT. The government views the proper role of CSO as NGO service/welfare provision – as opposed to a role of supporting efforts to improve policy content, process, implementation and to hold government to account. It would appear that confrontational approach was not productive in Tanzanian context (the approach of Women's Dignity Project in relation to user fees was often mentioned). The GoT feared that the Civil Society Foundation established as a multi-donor initiative under GBS was the donor's Trojan Horse. NGOs feel that there is no forum for open and structured dialogue on key policy issues.
- In practice, civil society has limited capacity on key reforms and limited influence. One prominent NGO with good access to government has concluded that drawing evidence from demonstration projects is insufficient to influence policy; its new strategy will also involve developing coalitions with donors and ask donors to advocate on its behalf. It has identified allies on key issues, but lacks capacity to explore the interests associated with the issue;
- Leadership and capacity limitations in the government in which the prevailing culture generally (hierarchical and patriarchal – unsupportive of critical thinkers) and MoHSW in particular which is dominated by the medical establishment, and where independent views are suppressed.¹⁶
- Mobilising grass roots appears to be difficult – even on issues which affect them so directly
- Task Forces are set up to deal with key reform issues – often with the relevant stakeholders (e.g., the human resources task force includes PORALG, MoF, Civil Service Department, etc), but these groups do not attempt to explicitly consider the politics of the issue (eg., identify losers and how they might be dealt with or systematically identify possible allies)
- Similarly, Studies and policy option documents do not attempt to reveal the political issues inherent in proposed changes.

Opportunities

- Engage the MoF more closely in health resource allocation issues.
- Public Expenditure Review (PER) provides a platform for various stakeholders to analyse the composition of expenditure and express views on priorities.
- Technical studies on health accounts, PER, value-for-money may provide evidence for strategic dialogue – but need to go further than dialogue to building alliances.
- The Joint Annual Review Mission is useful for information sharing and making the unpredictable more predictable (i.e., in relation to potential cuts in budget support) and has the benefit of involving a range of stakeholders. Using the JAR to seeking to understand why undertakings not met and what could have been done differently – a form of retrospective policy analysis.
- New donor country frameworks which might provide support to different types of civil society inputs. Donors could support the development of capacity of NGOs to participate in discussions on setting national priorities and ensuring their implementation. This approach is arguably more sustainable and less undermining than the establishment of unintegrated projects to achieve the same ends.
- SWAp Technical Working Group and its task forces are considered useful for frank policy dialogue. Encourage them to begin to look at the politics of the issues on their agendas.
- It has been possible to mobilise the President on occasion to take on health systems issues – there is the risk that reactions will be knee-jerk and populist in nature – but synergies could be sought.
- Generating and making better use of evidence may play a limited, but helpful, role in bringing about better resource allocation – and this is something that donors could support

Preconditions (attitudes)

¹⁶ It was reported that two good female PSs were not able to make much headway due to the effects of such a culture. Those who display critical faculties have wings clipped or are poached by donors/civil society.

- Focus on a few important reforms – particularly those which have natural constituencies in the MoH and MoF
- Tough-mindedness about the political nature of priority-setting
- Recognition that global and local issues – in terms of both aid modalities and specific policy interests – are entwined with each other
- A proper reading of Paris Declaration on Aid Effectiveness
- Learning from recent ‘successes’ – for example governments effective response to fistula which involved the development of a creative alliance

5 Conclusions: time to think outside the box

- The literature reveals that a number of approaches have enabled social sector reforms ‘against the odds.’ These include the empowerment of change teams (constituted by officials from various departments/ministries) to lead reform processes from protected positions within the MoH, the nurturing of state-society coalitions among groups with similar aims and interests around specific reform issues, the calculated buying off of groups which stand to lose from reform, or the mobilisation of public opinion, etc.
- Those strategies that rely on empowered technocrats employing shrewd tactics to get around the opposition have some relevance but are not to be relied upon:
 - Latin American technocrats are often temporarily co-opted academics and sometimes have remarkable autonomy from societal pressures – not like African permanent civil servants.
 - Successful SWAp do often reflect the efforts of a good team of senior civil servants, but they are notoriously fragile in the face of transfers etc.
- Those that involve advocacy coalitions in which membership organisations, effective mass media and rights enshrined in laws may suggest too high a level of ambition for Tanzania under the present circumstances.
- However, with more modest objectives, there does seem to be scope for more proactive networking among donors, non-governmental health stakeholders, poverty-focused budget advocacy organisations and SWAp-minded officials, in the social sectors and Ministry of Finance.
- Getting these people to speak the same language and avoid red-herring issues which divide them (e.g. whether overall fiscal policy is too tight or not) would be a substantial step.
- None of this would be a substitute for like-minded donors finding a better overall way of working on the political constraints to success with the GBS approach; macro and sectoral activities are both needed, and they could be expected to be synergistic.

November 2007

Annex 2: Uganda field report

Kent Buse, David Booth and Grace Murindwa

1 Introduction

- This report discusses the political economy of recent health sector reforms in Uganda with a view to identifying the constraints and opportunities facing donors in supporting evidence-informed policy change.
- The report is based on discussions held with a range of stakeholders in Kampala in November 2006 and a cursory document review.
- The report is complemented by a similar report on Tanzania. Both of which feed into a wider analysis of 'Good Governance and Aid Modalities' supported by the Advisory Board of Irish Aid undertaken by the Overseas Development Institute, London (insert web address of synthesis report).

2 Health reform challenges in Uganda

The country context

- The Health Sector Strategic Plans (HSSP I and II) form a sectoral component of a package of reforms covering all aspects of national development. Fiscal, financial management, administrative and political decentralisation, and the approach to macroeconomic management and planning, create a particular set of opportunities and constraints for health sector reform.
- The political system is a hybrid of legal-rational and patrimonial elements in which the latter appear to have been gaining ground during the formal transition to multi-party politics (the first multiparty elections were held in 2006).
- The bureaucracy is a UK-style permanent civil service – reformed but not thoroughly transformed since the 1980s, and much affected by aid dependency (i.e., development partners fund approximately 50% of government budget)
- Uganda differs from the Latin American contexts where political economies of reform have been documented in greater relative weight and where there is a different composition of external stakeholders. This doesn't necessarily weaken the case for using political intelligence to inform donor decision-making on aid modalities broadly defined, but does bring in additional issues and constraints.

Prioritisation and coordination with constrained resources

- The HSSP I & II set a broad framework for resource prioritisation but actual prioritisation occurs on an annual and continuous basis, through two mechanisms and their interaction: 1) the annual preparation of Budget Framework Papers (BFP)¹⁷ and associated work-plans with the help of joint Sector Working Groups which set out priorities and plans against allocated Medium Term Expenditure Framework (MTEF) ceilings¹⁸; and 2) negotiations about external project funding that take place more or less in the margins of the formal sector budget process – sometimes involving different stakeholders (e.g., programme managers).
- A health SWAp was launched in 2000 and provided further reinforcement to prioritisation and coordination among donors and government. The halcyon days of the SWAp (2000-2003) witnessed a number of improvements in the health system as a result of reforms such as the transfer of control of resources to the district level through the conditional grant for primary health care (from 32% of the

¹⁷ This system is described briefly in Booth and Nsabagasani (2005: 3-4) and more fully in Williamson (2003). According to these sources, it has never quite realised its potential as a way of increasing efficiency and equity pressures on the Health budget because of various constraints on the redistribution of spending within the MTEF. Nonetheless, it provides both a rational and practical way of linking spending plans to objectives. The UJAS (2005:3) described the budget process as 'one of the most admired in Africa'.

¹⁸ In 2004 the GoU decided to establish strict budget limits encompassing both government and donor expenditure for the overall budget and to the various sectors to curb inflationary pressures (PEAP 2004:190-200)

health budget in FY1999/00 to 54% in FY 2003/04)¹⁹, establishment central drug finance facility, and decentralisation of service delivery. The period was also marked by an increasing number of donors providing budget support and providing funds to a pooled health sector basket.

- Both prioritisation and coordination seem to have deteriorated over the past 3 years, following the 3 previous years of progress.
- To some degree this is because the MoH budget submissions reflect a reading of the HSSP that does not emphasise equity – e.g. Perinatal and maternal conditions are the highest contributors (20.4%) to the total national disease burden resulting in very poor infant and maternal health but child survival interventions and emergency obstetric care and do not necessarily receive commensurate resource allocation. Similarly, political weight is placed on the proposed health insurance scheme, which is a complex and (in view of precedents) highly risky venture²⁰ but has strong support from civil servants who stand to benefit.
- Deterioration is even more clearly seen in the composition of the health sector budgets in the MTEF, where the project element has substantially increased in relative and absolute terms (especially via Global Health Initiatives (GHIs)), surpassing the Government of Uganda (GoU) element of the budget. From the Government's perspective, General Budget Support (GBS) is the preferred mode of funding and consequently GoU element should constitute the greatest and growing proportion of the health sector budget. While this was the case for FYs 2001, 2002 and 2003, by FY 2004/05 project financing rose to 53.7% and by 2005/06 to 68.8% of public expenditure (MoH 2006). The marked increase in donor project funding since 2004/5 is largely, but not exclusively^{21,22}, accounted for by GHIs – PEPFAR, GFATM and GAVI contributed more than 50% of the project expenditure in 2004/05 in the health sector. The figures would have been even more pronounced had the Global Fund not suspended operations in 2005 after disbursing less than 50% of its planned spend.
- GHIs have had a substantially distorting effect on:
 - the attention accorded to different disease programmes;
 - the balance between commodities (e.g. drugs) and health delivery/monitoring systems and lack of support for incremental costs of delivery;
 - efforts to strengthen national systems as a result of the establishment of parallel systems for planning, budgeting, procurement and monitoring (and thereby increased transactions costs);
 - increasing expenditure on very costly commodities (e.g., ARVs, pentavalent vaccines, Coartem, etc.) for some of which government co-payment is required;
 - financial information transparency²³, programme coordination (GFATM and GAVI not represented on SWAp structures) and review through Joint Review Mission (GHI supported activities are not always subject to this mechanism);
 - financial and institutional sustainability.
- Prioritisation within some health programmes is also questionable. For example, within the Making Pregnancy Safer programme, with support from UNFPA, investments have been made in the training of Traditional Birth Attendants at the apparent expense of investments in equipment for emergency obstetric care at level IV (county) health facilities.
- The overall health resource envelope has been squeezed in recent budgets as a result of competing claims at the national level, including the expansion of the Public Administration section of the budget and investment in meeting the electricity power crisis. However, the budget controlled by Ministry of

¹⁹ There was considerable resistance to these reforms from the MoH but the MoFPED prevailed (Jeppsson 2002; Hutton 2004)

²⁰ Presidential initiatives in other spheres do not provide encouraging precedents. The 'can do' attitude emanating from State House combines with self interest on the part of those charged with implementing the initiative to override technical advice and careful design in the light of local and international experience. The classic instance is the microfinance initiative launched by President Museveni in the late 1990s, which vanished without trace after a few years of operation; however, several other instances can be cited. The implication is that the initiative may not be as carefully designed as it should be; that it will not cater to the very poor seems highly likely, but this is only one of the risks.

²¹ Some donors reverted from budget- to project-support over lack of progress on road map to multiparty elections and failure to act on recommendations of various commissions of enquiry.

²² Some donors concerned that particular issues will lose political visibility if they do not provide them with project support – eg. sexual and reproductive health.

²³ A survey in 2005 revealed that over US\$ 130 million worth of commodities had been imported without MoH advance information and planning or reference to its annual work plan.

Health (MoH) planners has been disproportionately squeezed, because: a) project funding accepted by the government sector has to fit within the sector ceiling; b) although this is not formally the case for funding of NGOs and private bodies, the Ministry of Finance, Planning and Economic Development (MoFPED) has tended to take the view that when funding moves from the public to the private (not for profit) health sector to produce the same outputs, an increase in the Health ceiling may not be justified.

- MoFPED attitudes to the Health ceiling – including the implementation of the MoFPED-MoH agreement to provide compensating budget funds when projects come to a scheduled end and are not replaced – is affected by MoFPED perception, not disputed by MoH, that there are major inefficiencies in the health spend and that in any event a great deal of unscheduled (or should one say unplanned from the perspective of the MTEF and BFP²⁴) project funding is available to the sector (e.g., from the GHIs but also from bilaterals²⁵). Efficiency gains from converting project funding to General Budget Support (GBS) in the early 2000s are probably being reversed.
- The GoU's decided in 2004 to increase the wages of government employed health workers by 50% in 2005 while freezing the grants to the Private Not For Profit (PNFP) sub-sector. The wage increase caused some staff to leave the PNFP facilities to take up employment in what many see as the less efficient government health units. This created quite severe staff shortages in the PNFP sub-sector which renders it arguably now less effective and efficient. Undertakings (conditions) of the annual sector Joint Review Mission in 2005 and 2006 included the objective of increasing PNFP grants to enable its management to increase wages off staff in the private facilities have not been acted upon.

Constraints to improving efficiency and effectiveness of services

- Improving efficiency and effectiveness constitute major objectives of the HSSP. The ability of MoH planners to address these goals is constrained by two organisational factors²⁶:
 - Decentralisation, which makes staff at lower levels responsible to District Councils²⁷ (which also control funds for vehicle purchase, etc), with the MoH restricted to setting policies, norms and standards, and monitoring (as well as control over a diminishing budget for some centralised procurement under Programme 9).²⁸
 - The re-emergence of project funding, with parallel management structures, and the commensurate increase in the influence of Project Managers who have a stake in maintaining the trend of project support – not least for the discretionary control they gain over spending.
- These constraints might not be overwhelming if the Ministry were energetic and proactive in undertaking its oversight functions (i.e., through procedures governing the sector-wide approach (SWAp) and widening the scope of the budget process to cover project inputs).²⁹ On this aspect of leadership, too, there is perceived to have been a major deterioration over the past three years. For example, there are established processes in place for enhancing the dialogue and partnership with the PNFP sector, but these are not currently being used. Similarly, the approvals for some project funding are taking place outside the formal processes of the Health Sector Working Group (composed of representatives of MoH, MoFPED and the DPG) which is supposed to screen all project proposals to ensure compatibility with the health sector strategy and ensure value for money.

²⁴ 'Budget performance' (i.e., the actual vs planned spend) of donor projects and global initiatives was estimated at 299% in FY 2004/05 and 246% in FY 2005/06.

²⁵ Predictability was voiced as a concern with emphasis placed on the discretionary funds at the disposal of most donors for ad hoc programme allocation during the year.

²⁶ Notwithstanding the fact that the early reforms targeted the less difficult issues in the sector.

²⁷ These Councils may be less concerned with health sector efficiency than with ensuring re-election – perhaps through ensuring well stocked pharmacies – even if the drugs are not cost-effective for one reason or another.

²⁸ The Programme 9 (National Shared Services Programme) budget line was created after introduction of budget support under SWAp mainly for procurement of commodities and health supplies/logistics such as medicines, family planning supplies, medical equipment, vehicles, infrastructural development etc which were previously undertaken by projects. This was intended to be a temporary arrangement until systems were established under the SWAp arrangement to transfer responsibility to lower levels for procurement.

²⁹ After decentralisation, the Ministry retains normative, regulatory and inspection functions, which it can perform more or less actively. The earmarked Health funds received by districts are not unconditional but depend on regular reporting to the MoF and MoH. While much of this is concerned with procedural and financial matters, it is in principle results-oriented, as are the sectoral Budget Framework Papers on which budget allocations depend. To the extent that project funding for Health-sector activities is brought into the budget/MTEF process, it too is potentially subject to these disciplines.

- Decisions have been taken under trade union/political pressures that have disrupted the partnership with the large not-for-profit private sector, threatening gains in efficiency and access achieved in the previous period.
- The combined effects of all these processes has been a decline in the quality of Health BFPs from being clearly the best, to being among the worst – dramatically reflected in the Health Development Partners Group decision to not endorse the submission for the 2007/08 financial year budget round (for the 2007/8 financial year).

3 Dimensions of the stakeholder politics

We find a considerable degree of consensus in seeing progress on the above reform issues as blocked by a rather powerful, interactive set of political-economy constraints.

The high politics of sector leadership

- The health SWAp emerged at a time when there was a confluence of enabling factors including, importantly, key figures within the MoFPED, MoH and donors - including Hon. Dr. Crispus Kiyonga, then Minister of Health, and Prof. Francis Omaswa, then Director-General of Health Services, and Dr. Patrick Kadama - the Commissioner of Planning. There was also very strong and effective leadership from Dr. Hatib Njie, the then WHO Country Representative.
- Leadership of MoH has been weak since about 2003 which constitutes a major determinant of how well the ministry conducts itself in relation to the MoFPED, Local Government, donors and other stakeholders. Turn over of the senior officials in Ministry of Health and development partners has been high – and policy dialogue is not considered particularly robust and frank.
- These conditions have changed the relation of forces within the Ministry and created an unfavourable context for those wishing to defend the previous efficiency and equity gains by the SWAp against the political and financial pressures discussed below.
- The reputational damage to the sector from the GFATM scandal³⁰, and the widespread perception – including some evidence (e.g., the MOFPED vehicle misuse study)- that sector is more corrupt than others, has made matters worse.
- To some extent, the perceived leadership of the MoH may have been jeopardised by decisions taken by the President, apparently without sufficient consultation and planning, over significant policy issues (e.g., abolition of user fees in 2001 and the medical workers salary increase in 2004).
- As a result of the problem of leadership, relations between donors and government have been strained.

The global and local aid architecture

- The health sector has perhaps the highest number of development partners among all sectors (despite the division of labour initiative of the Uganda Joint Assistance Strategy (UJAS), 25 bilateral and multilateral donors are signatories to the second sector MoU signed in 2005) as well as the highest proportion of external support in its MTEF and is marked by support for a proliferating number of service providing NGOs. These structural features carry implications for stakeholder politics – such as the fragmentation of influence as well as the balance of power among the MoFPED, donors and programme/project managers in the MoH.
- A succession of very large global (e.g., GFATM and the GAVI Alliance) and bilateral (e.g., PEPFAR, Clinton Initiative) health initiatives have contributed to shifting the balance of stakeholder interests against the defenders of budget support/SWAPs, significantly altering the local political economy of health policy.
- Simultaneously, external support for the SWAp and sector budget support approach has been weakened by the unhappiness of the Nordic Plus donors with the course of democratisation and human rights. These donors are committed in principle to providing support on the continuous and predictable basis needed for rational planning and the building of effective systems. However, for domestic political reasons they tend to have a low tolerance for government actions seen as infringing basic human or civil rights.
- GBS and health systems proponents initially opposed Global Fund programmes operating outside the BFP processes, but were overcome by an unholy alliance of ideological and interest groups within and outside the country, which persuaded the President. The compromise solution, where GFATM funding

³⁰ GFATM temporarily suspended five grants worth US\$ 367-million to Uganda in August 2005 alleging that it had found serious mismanagement in the distribution of the money. An external audit revealed ‘inappropriate, unexplained and/or improperly documented expenses’ among other failings (Kapiriri and Martin 2006)

was projectised and managed through a parallel system but placed within the Health ceiling, has worked against the rest of the health system. This is a perverse effect, because the rule on projects and ceilings was supposed both to ensure macroeconomic stability and incentivise line ministries not to fund activities through projects.

- The GFATM Country Coordination Mechanism (CCM) system endows new private-sector stakeholders, and some other public officials, with new influence on sector policies, but without the disciplines and constraints of the Sector Working Group system and the budget process. This has set precedents for other donors to work outside established SWAp/BFP processes and procedures and thereby undermine those mechanisms and their products. Moreover, the CCM established/imposed a new political space for priority setting within the three disease programmes (by stipulating composition of the group and imposing constraints on the time for arriving at decisions – thereby introducing downward pressure on the quality of policy dialogue) with implications for the distribution of influence over decisions.
- PEFAR and other large US programmes operate in theory outside government, but this does not stop them exercising a depressive influence on mainstream Health Sector funding and incentives to reform³¹.
- Donors may be dissipating their influence through a failure to speak with a common voice. For example, there are concerns that budget support is subject to a very heterogeneous system of conditionality and that follow up on the ‘undertakings’ of the sector’s annual Joint Review Missions is ‘poor’ because, among other things, too many non-essential undertakings are tabled. Moreover, it is not clear that donors have implemented a system of rewards and sanctions in relation to the achievement of sector targets (Paul, 2007)
- The donor culture has also changed over the past three years – no longer can reform minded advocates within the Ministry of Health count on key donors (speaking with one voice) to denounce actions/decisions taken which are not in the spirit of the SWAp. This unwillingness is presumably because the interpretation of the Partnership (MOU) and perhaps because even the Nordic Plus group acknowledge their culpability for the proliferation of unruly global initiatives. Moreover, there is also the perception that the poor quality of some Technical Assistance may have somewhat undermined the credibility of the donor voice and MoH in the eyes of other stakeholders.
- Donors are now reconsidering their approaches to supporting the health sector. It is likely that in future cooperation frameworks proportionally more funding will flow to NGOs. This could be beneficial if some of this support is provided to NGOs which wish to constructively support the budget process, SWAp and other mechanisms for pro-poor, evidence-informed resource allocation and policy-making and build robust systems to increase formal and informal systems of downward accountability of government and service providers to the people. Yet, additional funding to the NGO sector for service delivery may further undermine MoH coordination of resources in the sector.

The organisation of interests and advocacy

- Priority-setting takes place outside the formal procedures established in the budget process and SWAp – described above – as well as through other party politics or patrimonial processes. For example, the issue of social insurance was placed in the ruling party election manifesto³² without discussion in the Health Policy Advisory Committee (HPAC³³) and is now, despite insufficient technical discussion, de facto government policy. Similarly, a number of private hospitals are receiving government subsidies in contravention of the draft policy on Public Private Partnership in Health and affecting resource allocation.
- Health worker trade unions are not particularly strong in Uganda, but in a pre-election context, they can be very powerful. The wages decision of 2005 has had damaging effects on health service delivery in the PNFP sector, both directly and indirectly. Multiparty elections have not so far had a compensating effect by giving greater voice to the mass of health service users and non-users.
- Service-providing NGOs (e.g. the religious foundations and networks) are, despite their importance in policy implementation, less influential than might have been expected. One reason may be that they are fragmented into three umbrella organisations (along religious lines). They are, however, not well placed to do advocacy on policy, because they can be portrayed as self-serving. They also, however, lack capacity (their secretariats are financed by donations), and lack understanding of health- and macro-economics and have dissipated some of their influence on the wrong causes (e.g., Sachs versus the IMF

³¹ For example, PEPFAR promotes the use of multi-tablet, branded ARVs whereas the GoU promotes the use of single-tablet, generic ARVs.

³² It was alleged that SHI made it onto the agenda as a result of a deal with politician from the opposition party to resign his parliamentary seat.

³³ The HPAC is the highest governing body of the Health SWAp – it is a multi-ministerial body, chaired by the Director General of Health Services, at which policies and budgets are negotiated.

on the Health sector ceiling issue). Given the religious health services bureaux network's lack of traction over finalisation of the Policy on Public-Private Partnership for Health, the credibility of its leadership is under scrutiny further imperilling its effectiveness.

- Advocacy NGOs (Civil Society Organisations) with the courage and credibility to count on are few, and they don't have the resources to be active in sector policy forums or district Poverty Action Fund (PAF) monitoring³⁴ and overall budget advocacy (e.g., perks for Members of Parliament etc.). NGOs also tend to be ill-informed about the insider politics of government ministries, and have problematic relations with donors, who are funders and rather uncertain allies. There is almost no understanding of the constellation of issues described above among local NGOs [or in the media]. Links with international NGOs are not always helpful, with a tendency to focus on IMF-bashing rather than systems improvement and countering patrimonialism.
- Professional associations do not appear to be well organised as an interest group in the sector.
- District level authorities (LGA and DDHS) have, as described above, some control over resource allocation and, in effect, veto over policy implementation, but have limited involvement in the national level SWAp processes (and consequently lack ownership) and are not well organised or represented to make their power felt at the national level.
- Despite the active involvement of parliamentarians in the 2006 National Health Assembly and JRM, parliament is not viewed as a useful ally for pro-poor reform given the patrimonial politics in which its members engage
- The best organised interest group in the sector appears to be the international-national alliance of AIDS interests. This alliance has been highly effective in securing major increases in funding and a raft of policy initiatives. Policies on ARV treatment and Prevention of Mother to Child Transmission, among others, were prepared and fast approved by Top Management and eventually Cabinet, while policy on Traditional Medicine and the National Policy on Public-Private Partnership for Health have remained in draft form for years awaiting Cabinet approval. Technical arguments against the level of allocation to HIV/AIDS (and the project mode of aid delivery to AIDS activities) advanced by MoFPED, MoH, and WHO technocrats, are not expressed publicly due to the emotive nature of the discourse and the political pitfalls of being on what is perceived to be the moral low ground.
- Progress in the sector has slowed in the recent past as a result of the inter-locking political-economy features presented above. Surprisingly, it appears that no 'specific incentives were created to compensate the 'losers' from the SWAp' (e.g., some departments and their managers, some districts, some NGOs etc.) (Paul, 2007). Compensating potential losers from reform requires an ability to identify and engage with them.

4 Feasibility of a proactive political-economy approach to informing policy dialogue and guiding action

One aim of the research was to assess the feasibility of employing more structured and systematic approaches to understanding the underlying political-economy factors associated with proposed reforms and using the understanding to engage more effectively in the reform policy process – particularly using donor support.

Constraints

- It is not clear whether or not lack of political intelligence among donor actors of the interests which may block or be mobilised in favour of reform is a particularly large constraint to donor support of evidence-informed, pro-poor policy making.³⁵ On the one hand, a recent stakeholder analysis of the sector

³⁴ The PAF was established in 1997, in the context of the first HIPC initiative, as a 'mechanism for strengthening the pro-poor orientation of the budget'. It consists in a 'virtual fund' established within the general budget and MTEF to ensure that the resources made available by debt reduction under the HIPC initiative are 'ring-fenced'(i.e. protected from in-year budget cuts) and truly allocated to expenditures and programmes considered critical for poverty reduction. The Uganda Debt Network has established monitoring committees at district level but their effectiveness has been constrained by a lack of resources.

³⁵ The extent to which donors fully understand the interests at stake within the MoFPED and MoH with respect to various policy reforms was contested by donors. Certainly there are informational asymmetries which depend on such factors as the relationship between individual donor agency staff and their counterparts in the ministries, the proportion of national staff, the interest, orientation and skills of the staff in relation to politics, the length of expatriate staff have been in post, etc.

revealed that no one respondent produced the same stakeholder map (suggesting that analysis is not widely shared and that some stakeholders must not be fully appraised of the true influence and interests of actors in the sector) (Paul, 2007). On the other hand, and despite frequent turnover of staff, Development Partner Groups (DPG), including in Health, appear relatively well-informed as a group/at the lead-donor level – in part as a function of informational exchange at the DPG and more importantly through personal relationships among advisors and government officials. Although there may have been some failure to make important connections between Health Advisers, Economists and Civil Society Advisers, this is probably improving.

- Important constraints include:
 - a rather formal understanding among many donors of working in partnership with government, which means that even when there is good understanding of the political economy issues above, it is not felt appropriate to do anything with it;
 - an interpretation of the Paris principle of the primacy of country ownership which is shallow and unrealistic, leaving donors to alternate between meekly accepting ‘government’ inadequacies and pulling out/cutting back as opposed to working with like minded groups within (and outside) government departments to change the direction of government travel. The Paris Declaration contains a set of mutually interdependent commitments, recognising that there is a need both for governments effectively to take charge of development efforts and for donors to be supportive of this. Building country ‘ownership’ is seen as a process, necessarily taking a number of years. Unfortunately, the practical effect of the Declaration on donor attitudes in many countries has been to discourage questioning of government decisions even when these fall far short of reasonable expectations, with ‘ownership’ being treated less as an objective than as an established fact. This leaves them with only one other option when performance becomes really bad, that of withdrawing support;
 - differences which exist among donors on how to address constraints to change which are predicated upon challenging rent seeking – particularly where donors are funding vertical programmes within which it is taking place. The Global Fund has taken a particularly strong and public stance – but with donors divided on how to approach the issue – there is less political will to address it.
 - lack of attention to identifying and supporting instances where domestic stakeholders, including parliamentary committees, take a stand on the same issues that concern donors. In the context of General Budget Support, concerns about issues such as presidential by-passing of established budgetary processes have sometimes arisen simultaneously in parliament and among donors. On such occasions, the donors have tended to raise the matter with government counterparts immediately, rather than waiting to support or make common cause with parliamentarians. This (in principle correctable) feature of donor practice helps to explain the finding of the GBS joint evaluation that under the budget support regime donors have ‘tended to overshadow domestic stakeholders, including Parliament’ (IDD and Associates, 2006: Appendix 66);
 - the health partnership as presently practised is very heavy in formal meetings, leaving little time for issue-based networking and developing influencing strategies;
 - Health Advisers tend to be technical health specialists, not brokers of reform alliances – if they are sometimes good networkers, it’s by accident;
 - donor CSO support programmes tend to run on parallel tracks with the macroeconomic and sectoral programmes, as if they were not relevant to each other.

Opportunities

- The National Health Assemblies (NHA) may present a forum to engage more stakeholders and to hold government to account. The NHA are reportedly under-attended by NGOs and churches. While the Management Boards of National Medical Stores (NMS) and National Drug Authority attend the NHA, the Management Boards of hospitals at all levels (National Referral, Regional Referral and General Hospitals) do not attend. Mass media organisations only attend the NHA to cover the proceedings but do not participate in the discussions. District officials have been willing to question implementation but require outside support.
- Public Expenditure Review (PER) provides a platform for various stakeholders to analyse the composition of expenditure and express views on priorities.
- The Poverty Eradication Action Plan (PEAP) implementation review provides a new opening with few parallels elsewhere (except maybe the Tanzanian Public Expenditure Review and Poverty Weeks). In particular, the PEAP policy matrix is the only known PRS-derived action matrix which could be used creatively by health reform advocates to influence priorities and improve accountability.

- Technical studies on National Health Accounts, PER, and value-for-money may provide evidence for strategic dialogue, but there is a need to move beyond dialogue to building alliances among sidelined technocrats, better informed civil society organisations, service providers, programme managers and concerned donors.
- Health Sector Working Group. The HSWG provided a platform to overcome differences among interest groups and established clear procedures to discipline off-plan proposals (as described in the PEAP 2004); but it has recently been sidelined. The October 2006 JRM reiterated the need to implement these processes and may provide a forum to discuss small 'p' political barriers to rational resource allocation in the sector.
- Joint Review Mission. Useful for information sharing and making the unpredictable more predictable (i.e., in relation to potential cuts in budget support) and has the benefit of involving a range of stakeholders.
- New donor country frameworks which might provide support to different types of civil society inputs to the budget and policy process.

Preconditions (attitudes)

- Focus on a few important reforms – particularly those which have natural constituencies in the MoH and MoFPED.
- Tough-mindedness about the political nature of priority-setting.
- Recognition that global and local issues – in terms of both aid modalities and specific policy interests – are entwined with each other.
- A proper reading of Paris Declaration on Aid Effectiveness which allows for questioning of policies which may not be wholly nationally owned nor in keeping with a country's commitment to publicly pronounced pro-poor policy goals.

5 Conclusions: time to think outside the box

- The literature reveals that a number of approaches have enabled social sector reforms 'against the odds.' These include the empowerment of change teams (constituted by officials from various departments/ministries) to lead reform processes from protected positions within the MoH (or executive office), the nurturing of state-society coalitions among groups with similar aims and interests around specific reform issues, the calculated buying off of groups which stand to lose from reform, or the mobilisation of public opinion, etc.
- Those strategies that rely on empowered technocrats employing shrewd tactics to get around the opposition have some relevance but are not to be relied upon:
 - Latin American technocrats are often temporarily co-opted academics and sometimes have remarkable autonomy from societal pressures – not like African permanent civil servants.
 - Successful SWAPs do often reflect the efforts of a good team of senior civil servants, but they are notoriously fragile in the face of personnel transfers etc.
- Those strategies that involve advocacy coalitions in which membership organisations, effective mass media and rights enshrined in laws may suggest too high a level of ambition for Uganda under the present circumstances.
- However, with more modest objectives, there does seem to be scope for more proactive networking between donors, non-governmental health stakeholders, poverty-focused budget advocacy organisations and SWAP-minded officials, in the social sectors and MoFPED.
- Just getting these people to speak the same language and avoid red-herring issues which divide them (e.g. whether overall fiscal policy is too tight or not) would be a substantial step.
- None of this would be a substitute for like-minded donors finding a better overall way of working on the political constraints to success with the GBS approach; macro and sectoral activities are both needed, and they could be expected to be synergistic.

References

Booth, D and Nsabagasani X (2005) *Poverty Monitoring Systems: An Analysis of Institutional Arrangements in Uganda*, London: Overseas Development Institute, Working Paper 248.

IDD and Associates (2006) *Evaluation of General Budget Support: Synthesis Report*, University of Birmingham, International Development Department.

MoH (2006) Annual Health Sector Performance Report – Financial year 2005/06. Ministry of Health, October 2006

Hutton G (2004) Case study of a 'successful' sector-wide approach: The Uganda health sector SWAp, a lessons learned paper established in the frame of the SDC-STI SWAp Mandate. SDC.

Jeppsson A (2002) SWAp dynamics in a decentralized context: experiences from Uganda. *Social Science and Medicine* 55(11): 2053-2060.

Kapperiri L & Martin DK (2006) The Global Fund Secretariat's suspension of funding to Uganda: how could this have been avoided? *Bulletin of the World Health Organization* 84(7): 576-580.

Paul C (2007) Mission Report. Uganda's Health SWAp: an analysis of the prevailing incentive system through the prism of conditionality mechanisms and underlying politico-institutional factors. GRIP-SWAP.

Williamson, Tim (2003) *Targets and Results in Public Sector Management: Uganda Case Study*, London: Overseas Development Institute, Working Paper 205.

November 2007

Annex 3: Question guide for donor agencies

1. Does donor attempt to understand the politics of sector level reform?
 - 1a. If so, does the donor use a specific analytical tool? Or is it less systematic?
 - 1b. If so, does the donor do this jointly with (1) government and or (2) other donors;

and/or (3) other key stakeholder groups (e.g., church, professional associations, service unions)? Which?
 - 1c. If so, when is such understanding sought? At what stage of the programme cycle: (1) design; (2) evaluation; and/or (3) other
 - 1d. If so, how [a report, verbally, other written] and with whom are the results shared [only internally, like-minded donors, all donors, government]?
 - 1e. If so, does the donor have any documentation that they can share on methods/results?
 - 1f. If not in the health sector, is the donor piloting any of this kind of work in other sectors?
2. How does donor decide on allocation among different sectors within country allocations?
 - 2a. Is the political feasibility of chosen sector strategies a consideration?
3. If sector budget support is provided – are institutional and political risks assessed in some specific way? How?
4. How does donor decide on type of aid modality?
5. Does donor hold bilateral policy discussions with MOH? If so, who does this?
6. In addition, does donor participate in ongoing sector aid coordination meetings for policy dialogue or does it happen in joint annual programme review meetings, or both? Who does this on behalf of the donor – i.e., HQ, foreign office diplomatic mission, resident technical specialists?
7. If not already doing so, how feasible would it be for the donor to undertake prospective political-economy analysis of sector reforms,
 - 7a. what would be the major opportunities and obstacles?

Annex 4: Question guide for technical agencies

1. What has your organisation been doing in the area of Managing the Political Dimensions of Reform from a technical point of view (i.e., to what extent do members ask for and to what extent does your organisation offer support on understanding the political dimensions of reform)? If not active in this area, why not? If so, have tools or guidance been produced? Can we see these and any outputs?
2. To what extent does the organisation at the country level attempt to understand the political dimensions of reform?
3. Is your organisation typically involved in discussions of HSR at country level, or does it leave this to the Bank and bilaterals? Does this depend to some extent on whether or not a SWAP is in place and if so, how?
4. Does your organisation use its budget at country level to buy political support from potential reform champions (e.g. through study tours, degrees, etc)?
5. What do you know about what other donors are doing to understand the political dimensions of reform?

Annex 5: Health Sector Strategy documents reviewed

Country	Document	Web link
Benin	Politique et strategies de developpement du secteur sante 2002-2006.	n/a
Ethiopia	Health Sector Development Programme II, 2002/3-2004/5	http://cnhde.ei.columbia.edu/files/4/1/2005-Aug-Tue-062057.pdf
Kenya	The 2 nd National Health Sector Strategic Plan of Kenya (NHSSP II) 2005-10.	http://www.hsrs.health.go.ke/assets/nhssp2.pdf
	Kenyan National AIDS Strategic Plan (KNASP) 2005/6-2009/10.	www.nacc.or.ke/downloads/KNASP_2005-2010_Final_Report.doc
Malawi	The Malawi Essential Health Package 2002/3 FY Plan of Action	http://www.hrresourcecenter.org/node/304
Mozambique	Strategic Plan for the Health Sector 2001-2005- (2010).	n/a
Nigeria	Health Sector Reform Program: Strategic Thrusts; Key Performance Objectives; and Plan of Action 2004-2007.	n/a
Rep of Niger	Plan de Developpement Sanitaire 2005-2009	n/a
Rwanda	HSSP 2005-9	http://www.moh.gov.rw/docs/pdf/strategic_plan.PDF
South Africa	HIV/AIDS/STD Strategic Plan for South Africa 2000-05	http://www.doh.gov.za/docs/index.html
Tanzania	Second Health Sector Strategic Plan July 2003-June 2008	http://www.muhef.or.tz/articles/ref%20145.pdf
Uganda	HSSP II 2005/6-2009/10	http://www.health.go.ug/pubs.htm
Zambia	National Health Strategic Plan 2006-2011	n/a