

# SECTOR-WIDE APPROACHES FOR HEALTH DEVELOPMENT

A Review of Experience

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WORLD HEALTH ORGANIZATION

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**ABOUT THE  
INTER-AGENCY GROUP ON  
SECTOR-WIDE APPROACHES AND  
DEVELOPMENT COOPERATION**

The Inter-Agency Group on Sector-wide Approaches and Development Cooperation (IAG) is a small informal group of experienced senior technical people from international development agencies. WHO provides its secretariat.

The group's interest is in advancing policy and practice of development assistance for health development. Toward this end, members of the group meet to review and discuss specific issues and topics in development aid, commission new analytic work, review results and disseminate information both through the communication networks of their own organisations and through WHO's publications series.

In 1999, the Inter-Agency Group commissioned five country case studies and a synthesis report to review experience with sector-wide approaches to date. Additional case studies are planned to document the evolution of sector-wide approaches in the context of other development initiatives and instruments, particularly poverty reduction strategies.

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**ACRONYMS**

CAPE	Centre for Aid and Public Expenditure (in ODI)
CBO	Community Based Organisation
CDF	Comprehensive Development Framework
CoC	Code of Conduct
CWIQ	Core Welfare Indicator Questionnaire
HIPC	Heavily Indebted Poor County
HMIS	Health Management Information System
HSDP	Health Sector Development Plan
IAG	Inter-Agency Group
IMF	International Monetary Fund
MFPED	Ministry of Finance, Planning and Economic Development (Uganda)
MoF	Ministry of Finance
MoH	Ministry of Health
MoU	Memorandum of Understanding
MRALG	Ministry of Regional Administration and Local Government (Tanzania)
MTBF	Medium-Term Budget Framework
MTEF	Medium-Term Expenditure Framework
n.a.	not available
NGO	Non-Governmental Organisation
ODA	Overseas Development Assistance
OECD	Overseas Economic Cooperation Fund
p.a.	per annum
PAF	Poverty Action Fund (Uganda)
p.c.	per capita
PRSP	Poverty Reduction Strategy Paper
SIDA	Swedish International Development Agency
SoI	Statement of Intent
SWAp	Sector-wide Approach
TA	Technical Assistance
ToR	Terms of Reference
UNDAF	United Nations Development Assistance Framework
UNDP	United Nations Development Programme
WHO	World Health Organization





## EXECUTIVE SUMMARY

This report is a synthesis of findings from case studies of five countries (Mozambique, Uganda, Tanzania, Cambodia and Vietnam) and an exploratory visit to Ethiopia, all of which are involved to some degree with a sector-wide approach to health development.

Although there are marked variations between the countries in their commitment to a SWAp and in progress in implementation, it is possible to draw some conclusions about the value of the approach as an aid co-ordination mechanism.

Progress has been made in a number of areas:

- there is improved diagnosis of barriers to service utilisation and improvement, including better understanding of corruption and incentives problems. This is underpinned by more reliance on information and analysis focussing on an annual review cycle. Although sector-wide information is weak, it is improving and there is a new demand for it
- sector programmes are becoming better integrated within the budget planning process, and the need to develop links to other public sector reform processes is recognised, if not yet realised. The development of poverty reduction strategies, a requirement for access to International Development Association and concessional IMF funding, will provide a good opportunity to connect health strategy with national poverty reduction policy and associated monitoring
- common procedures for planning, disbursement, accounting, audit and review are the key to reducing the high costs of dealing with donors, and increasing the coherence of the programme. In order to build capacity within the sector to take responsibility for sector development, programmes need to be built around governments' own core procedures. Financial procedures based on those of government are being used in Tanzania and to a certain extent in Mozambique, with good prospects for doing so in Uganda. Joint reviews of progress using common reporting and indicators are in place, though achieving the full benefit will require donors to rely on them
- the links between policy and implementation are growing. Governments now have the resources to implement sector-wide policies without negotiating multiple projects, and donors have a forum for raising sector-wide concerns. Governments are stating their intentions to support policy statements with resource shifts to primary and preventative services.

In general, there is a sense that the process of developing and implementing a sector-wide approach should gather momentum as more donors come on board with budgetary support, and governments are better able to prioritise.

However, other expected changes have not yet occurred in the countries reviewed:

- although SWAps are more successful at drawing attention to crucial policy decisions, these case studies provide no evidence to suggest that they help to resolve politically sensitive problems e.g. the difficulty of providing an essential service package for all, on very limited resources

- broad participation in SWAp design and planning has been limited, both within government and externally with civil society
- monitoring systems are underdeveloped, and much needs to be done before they will substantially improve, and donors gain confidence in them as the main source of sector performance information
- the monitoring issue, amongst other reasons, has meant that donors are still keeping close to the detail of sector programme development and implementation, expecting close liaison and consultation with government officials throughout the process.

The lack of progress in some key areas gives rise for concern:

- the management complexity of moving from projects towards a single sector programme can be overwhelming and risks an extended preparation phase in which government capacity is strained. There is some evidence that there has been a greater focus on the process than on agreeing clear policy priorities, and that long delays have produced frustration on both sides. Evidence of service delivery suffering because of the transition from project to sector-wide approach is largely anecdotal, but merits further investigation
- weak monitoring systems mean the review process lacks credibility
- several donors, including some of the largest, are not yet providing funding through government systems.

In conclusion, the review team would draw out a number of key recommendations for improved sector-wide management:

- an agreed strategic direction, consistent with resources, is essential for ensuring the coherence of the programme. This needs to set out clearly the role which government intends to play in the sector and how it relates to other service providers and sources of funding
- the development of a sector-wide approach should be seen as a process not a blueprint. In support of continued planning and review, the government needs a permanent analytical capacity, an effective consultative policy process, a system of focused annual reviews, and priorities based on the available capacity
- the annual review process must be made more rigorous. It is helpful to separate the process of assembling data and analysis, which needs the focus of a tightly managed and independent team, from the review meeting at which government and donor stakeholders take decisions based on these findings
- although formal agreements are not an effective substitute for good working relationships, mutual trust and strong government ownership, even with these in place disagreements can arise, and agreed 'rules of the game' are helpful for resolving disagreements
- donors need to exert greater discipline in their relationships with governments, standing back from the detail and focused on key messages. They also need to carry out a critical review of their technical skills and procedures in order to take the broader view now needed for effective SWAp development
- sector programmes are dependent on donors' funding for recurrent and development expenditures. Such budget dependence requires donors to be

responsible for delivering promised resources on time. Without this, government efforts to rationalise their budgetary processes and improve planning will be severely undermined. It is important to ensure that conditionality based on performance does not merely reinforce swings in funding caused by factors outside the control of the Ministry of Health.



## 1 INTRODUCTION

### 1.1 Definition and process

The sector-wide approach (SWAp) characterises a method of working between government and donors. Various definitions have been proposed, although the criteria defined have often gone far beyond the actual achievement so far in those operations defined as taking a sector-wide approach<sup>1</sup>. For the purposes of this paper, the defining characteristics of a SWAp are that:

*All significant funding for the sector supports a single sector policy and expenditure programme, under government leadership, adopting common approaches across the sector, and progressing towards relying on government procedures to disburse and account for all funds.*

However, a key message from the experience so far is that most programmes, even quite well-established ones, are in the midst of a SWAp *process*, moving over time towards broadening and deepening policy dialogue, bringing more sector funds into co-ordinated arrangements and developing common procedures based on those of government. The working definition thus focuses on the intended direction of change rather than just the level of attainment.

The steps involved in getting to a sector-wide approach, entail health strategy being:

- formulated and costed
  - matched to available finance through an iterative process
  - converted to a workplan
- and then
- formalised in agreements between the implementing agency and the sources of finance.

Some of these processes proceed in parallel, or may not be fully completed, but it is conceptually helpful to distinguish them like this. This is the model we have used in this synthesis report.

### 1.2 Research methodology

This review is a synthesis of findings from five country case studies<sup>2</sup> and an exploratory visit to Ethiopia carried out for the World Health Organization and the Inter-Agency Group on Sector-Wide Approaches and Development Co-operation. For full references of the case studies in the series, see inside front cover. The work was carried out by the Centre for Aid and Public Expenditure at the Overseas Development Institute. Each country was visited for one week during October and November 1999, when interviews were held with key government officials, donor representatives and members of NGOs. The case studies, and thus this report, are based on conclusions from these interviews, plus a review of associated literature,

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<sup>1</sup> For example, Harold and Associates (1995) define six criteria: sector-wide in scope, a coherent policy framework, local stakeholders in driving seat, all donors sign on, common implementation arrangements, and minimal long-term technical assistance.

<sup>2</sup> Mozambique, Tanzania, Uganda, Cambodia and Vietnam

both country specific and more general. A week was a very short time to become familiar with local issues in each country, and the availability of interviewees varied considerably. Two of the field visits also coincided with major review missions, which had both advantages and disadvantages for the researchers. Conclusions should therefore be taken in the spirit of the Terms of Reference: "*Given the breadth of the concerns set out below, the aim will be to make well informed judgements, rather than collect large amounts of quantitative data*" (See Annex 3).

### 1.3 Case study countries

The five case study countries are at different stages (see Annex 1):

- *Cambodia and Vietnam* have not yet decided to adopt a sector-wide approach, nor is it clear that they will choose to do so. These two case studies are mainly of interest for issues of sector planning being debated in a context quite different from Africa
- *Uganda* has gone a long way towards establishing a SWAp in health, and already has other sector programmes, as well as an overall poverty reduction strategy and medium term budget framework (MTBF), within which the SWAp will be nested. It is this broader context and the experience of grappling with decentralisation which makes the case study of most interest. The programme is expected to start in July 2000
- *Tanzania* has the most fully developed SWAp, underway since July 1999, including arrangements for joint financing sub-sectoral allocations, currently in use by five donors
- *Mozambique* is early on in the process of developing a sector-wide approach, but has many of the 'building blocks' already in place such as pooled funding and budgetary support.

In order to extend the generalisability of the results, reference is also made to other literature on health sector SWAps, and to the experiences of countries of which the authors have recent direct experience, especially Bangladesh and Ghana.

## 2 PROGRAMME DEVELOPMENT

### 2.1 Participation in health sector planning

There was little evidence of broad participation in the SWAp planning process in the case study countries (see Annex 2). Generally programmes tended to be developed:

- primarily by officials, supported by consultants and by donors
- without being subjected to a process of national dialogue and consultation
- without drawing upon the bodies of knowledge and insights from participatory poverty assessments or other efforts to consult the poor directly
- without involving key implementation partners e.g. the private sector
- without drawing on representatives of civil society e.g. the involvement of NGOs at the policy formulation stage was generally weak despite some promising indications (see Box 1). Donors in some cases played a helpful role in raising awareness of research and of insights from the work of projects and NGOs, but this could not be said to be systematic.

The reasons for weak participation vary between countries, and include:

- a belief within government that the main lines of policy reform needed were clear
- limited experience and capacity within governments to manage a participatory consultation exercise
- capacity problems in the ability of NGOs and CBOs to make an effective contribution.

#### **Box 1 NGOs and health policy debates in Cambodia**

There is the potential for NGOs in Cambodia to play an important role in formulating health policy, but in practice this is not happening.

International NGOs had played a particularly significant role in Cambodia during the 1980s, when Cambodia was cut off from most ODA and enjoyed good policy-level contacts. These were somewhat squandered from the early 1990s, as official donors entered the scene and the NGOs embraced the opportunity to engage in more conventional, locality-based projects. Nonetheless, medical NGOs retain a potentially important position in health reform debates. Some international NGOs have shown a willingness (in principle) to contribute to pooled funds and others would be happy to act as contracted agents to deliver elements of the SWAp programme.

The greatest potential channel for NGO participation is through the apex organisation Medicam, founded in 1989 as an umbrella organisation for NGOs in the health sector. In the words of the Director, *"It's a deal: we encourage NGOs to follow policy, providing we can contribute to it."* Medicam is clear about the need for a more meaningful form of co-ordination and co-operation between MoH, donors and NGOs in order to deal with a 'Frankenstein' health sector comprised of unconnected activities. It proves a potentially effective intermediary, bringing village-level NGO perspectives upon the progress of reforms into policy debate in a coherent manner. It is also surprisingly neutral, being often quite critical of unruly NGO behaviour. However, this potential for policy influence may be compromised by what the Director sees as a declining interest from both the MoH and member NGOs themselves. This reflects both the general malaise in the health sector co-ordination system, and a worrying trend for elements of the MoH and individual NGOs to negotiate piecemeal on projects, rather than through the co-ordinating mechanism of Medicam.

Recognition of the process nature of SWApS has meant that governments have stated their intention to strengthen participatory processes at a later stage of programme development, but it is questionable whether this will have the same impact as greater stakeholder involvement early on in the process. There are examples where the NGO role has been strengthened after the formal launching of the SWAp, and where (as in Uganda) increased attention is now being given to transparency and to enabling the users of the service to hold government to account for service delivery. Nevertheless, it would be fair to conclude that the dominant model remains one in which SWApS are designed and led in a fairly top-down fashion by a public sector bureaucracy, supported by the donor community.

Participation within government has also been of variable quality, and often weak.

- *links with other Ministries have been very limited, including with:*
  - departments managing sectors impacting on health e.g. those responsible for sanitation and water. Although the organisation of the health SWAp around the health ministry is helpful for manageability, an absence of lateral links can undermine the success of the programme. Also, a narrow focus presents a problem for monitoring SWAp programme impact when indicators may respond more to investments outside the service delivery sector (see section 5.4)
  - departments whose policies impact directly on health programme implementation e.g. Local Government for decentralised delivery of services, Civil Service for staffing, Finance for the treatment of revenue raised by user charges
- *within health ministries, the degree of consultation varied.* Ghana Health provides a strong example of a process which directly involved staff down to district level and below, and which is well understood by those required to implement it. Other cases have not involved all staff even in headquarters, and have faced confusion and lack of understanding by outposted staff. This lack of consultation has extended into technical issues where internal expertise is not fully utilised in programme development e.g. in integration of vertical programmes.

## **2.2 The value of political endorsement**

The experiences we have reviewed strongly suggest that political endorsement of the strategy by Cabinet and by Parliament is important for sustainability because it can help to ensure that:

- the programme represents government policy rather than being dependent on the will of a single Minister or small group of officials
- key assumptions that depend on other Ministries for action have been considered by government as a whole
- government retains ownership of the programme.

In some countries the donor group have made political endorsement a condition of its support.



### 2.3 Government and donor planning process

Evidence from the case study countries showed broadly similar planning processes in which donors tended to have a close involvement in the development of sector policies, strategies and implementation plans. The government representatives interviewed were accepting of this, given that donors would eventually be helping to finance the programme.

However, a review of the processes showed tensions between the needs of donors and those of government:

- *donors* need to present to their boards for approval a document which is comprehensive in scope, which addresses all the major issues, and which is linked to the level of resources available. There are pressures on donor staff to get to the commitment stage quickly, given the desire to show progress during a three year posting, and the pressures to commit or disburse funds
- *governments* may lack political consensus on some key issues, making it difficult to give the clear statements required by donors.

Resolving the tensions may require donors to accept that not all issues can be resolved at the outset, and to focus more on identifying short term priorities on which immediate action is feasible, together with a realistic process and timetable by which other issues will be addressed. The implication of this more process-oriented approach is that planning and policy-making are continuous, requiring strong and permanent capacity. This flexibility can counteract the over-determinism and risk of planning paralysis that tend to be a feature of some sector programmes.

Discussions in Ethiopia and Tanzania revealed a perception by government that donors are often in too much of a hurry to press government to agree policy positions consistent with their own views and priorities, allowing too little time for the necessary political process of reflection and consensus building. Pressures to include commitments on which there is insufficient domestic political consensus can lead to long implementation delays while the policy issues are resolved, as occurred with user fee retention in Bangladesh. Pressures to expand the agenda to include all the donors' favourite topics can result in over-ambitious plans which receive *de facto* prioritisation after the event, often in response to *ad hoc* pressures not reflecting what is most important for achieving better health outcomes. This implies that:

- governments are still having to manage competing donor demands
- in many cases, ownership and policy-making capacity are still not strongly developed enough to offset these pressures.

Commonly neglected health policy issues include what to do with the hospital sector once funds are diverted to primary health care; how to regulate the private sector effectively as a precondition of better resource allocation; how to meet the huge preventative and especially palliative problems presented by HIV. These omissions are not directly the result of adopting a sector-wide approach, but rather reflect the problem areas common to most health sector reform programmes.

How may these problems be overcome? What is not satisfactory is a planning process which aggregates views from a disparate group of government and donor officials. We would suggest that three key elements for success are:

- a clear vision from government of the direction which future health sector reforms should take
- strong in-house analytical capacity
- an effective policy process for obtaining necessary Cabinet, legislative, and budget approvals.

## 2.4 Donor co-ordination

Although governments are wary of donors 'ganging up', several of them recognised the value of donors co-ordinating their position, in order to keep the process focused on a limited agenda of important issues. This requires discipline by the donors, and possibly different skills, with capacity to move beyond project level concerns to focus on the important policy issues.

The donor role in co-ordination and in helping to maintain momentum is a particularly sensitive one. Donors as a group feel more comfortable where internal co-ordination of the donor group is led by an agency without a very strong personal agenda. This is a role which agencies with strong technical capacity but limited budgets may be well placed to perform, and there were favourable reports of the roles of WHO in Uganda and Cambodia. Personalities of co-ordinators count for a great deal to create trust from donors and government, and consensus.

Sensitive donor co-ordination, and all parties working in a collegiate way, become especially important where policy positions among the donors differ. A typical divergence is between the American tradition of private healthcare markets, and the Scandinavian tradition of health services funded from general taxation. Aspects of the divergent philosophies are present in disagreements between SIDA and the World Bank in Vietnam, and were also present at an early stage in development of the Tanzania reforms, where they were resolved through development of a number of pilot projects to test market-based options.

The UNDAF process has the potential to improve UN agency co-ordination, allowing each agency interacting with the SWAp to do so with a clearer mandate. In practice in most countries there was little evidence of this. This was partly because UNDAF was not sufficiently far advanced in most countries, but also because it did not answer some of the wider problems facing the UN with regard to SWAps, especially how its own technical programmes would integrate with the sector one, and how (and indeed whether) UN systems can be modified to support budgets directly even to a limited extent of pooling funds for specific purposes. Moreover, like all donor bilateral systems outside the SWAp, UNDAF has put an additional burden on governments. In Tanzania there were efforts to complement the government processes already underway, but in other countries developing the country assessments had entailed a series of separate discussions.

## 2.5 Government ownership, preconditions and conditionality

All the countries reviewed have a long history of health sector strategies and plans, of varying quality and commitment. This makes it difficult to judge where the initiative for a SWAp came from and to assess ownership. However, in interview government interlocutors made clear statements concerning what they hoped to get from the SWAp process, how the experience so far compared with their expectations, what they thought donors wanted and whether this was reasonable, and what rate of future progress should be expected. In each of the case study countries, even the most aid dependent governments have shown determination to resist donor pressure where they are unconvinced. The SWAp process can certainly not be characterised as a donor imposition on an unwilling or supine government. Compromise has of course been necessary, but the main donor influence on policy has been through support to policy analysis and dialogue, and through the experience of joint working, rather than hard conditions.

The logic of a 'process' definition of a SWAp is inconsistent with the idea of 'preconditions'. The model is rather one in which the modalities of support may change as the programme is defined and capacity built. Various conceptual frameworks have been developed for assessing when a SWAp is appropriate. The matrix approach developed by CAPE<sup>3</sup> argues that the SWAp approach is most likely to be attractive to both sides of the partnership in situations where aid dependency is high and there is a reasonably credible budget process in place to give assurances of sector funding and the basis for forging a consensus on sector policy and expenditure programmes.

Of the case study countries, only Tanzania has direct experience of imposing conditionality within functioning SWAps. In the case of Tanzania, donor release of funds through the basket is dependent on satisfactory district plans being received, and government releasing its money first (see Box 4, p. 21). In the visit to Ethiopia it was learned that the conditionality was beyond sector control. Diplomatic concern over the war with Eritrea led to donors being obliged to suspend funding to new programmes. In general at sector level:

- there is as yet no consensus within the donor community about the appropriate role of conditionality within SWAps
- most donors prefer to rely on partnership-based relationships rather than strong conditions to encourage better performance and adherence to agreements. The focus in these sector programmes has therefore been more on what government has done within the sector rather than what it has achieved. It was not possible within the scope of the study, and on the limited experience to date, to assess how successful this approach is
- although donors are working more as a group, conditionality still mainly operates at bilateral level through individual donor agreements. However, conditionality is normally drawn from government commitments specified in key sector documents (e.g. sector strategy) and smaller donors often follow the lead of the World Bank or other main donor in forming their own conditions.

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<sup>3</sup> Foster, M, and Naschold, F. 1999 *Developments of Programme-type aid*. Report for OECF Japan, London: Centre for Aid and Public Expenditure, Overseas Development Institute; October 1999.



### 3 PROGRAMME CONTENT

#### 3.1 SWAp impact on policy and content

The sector-wide approach can be said to have had an influence on sector policies and content in the countries reviewed. Although this has not necessarily resulted in an immediate greater concern for health outcomes within government, the scope for government and donors focused more on measures that will deliver these has increased:

- there is greater consensus on what the sector priorities are, which should afford greater possibility for agreement on how to address them
- donors have a stronger mandate to focus on sector priorities, and despite sometimes delivering conflicting or unfocused messages, are talking more about fewer key issues
- governments are becoming better able to see and respond to the linkages between sub-sector issues and programme components, and are gaining a stronger sense of how to phase activities
- there is evidence to suggest that governments are becoming better able to draw connections between programme components
- the perverse incentives which existed under the project approach, to focus on selected issues at the expense of the bigger picture, have diminished.

Although the signs are positive that SWApS can promote a better environment for policy dialogue and negotiation, it is not yet clear whether this will result in overcoming major policy problems or differences. Some fundamental problems remain unresolved, such as the unaffordability of state provided health services, which will be politically very difficult to address. However, if a sector-wide approach can highlight options, and make implementing new policies a possibility, then it will have fulfilled a vital function in helping to improve the quality and responsiveness of state services.

#### 3.2 Pro-poor focused strategies

Improving the poor's access to health services is a central objective in all but one of the case study countries. The increased focus on primary and preventative services, and the shift of the percentage share of resources in this direction, should improve the share of health expenditures benefiting the poorest quintiles of the population at the expense of the richer. However, evidence in support of this in the programmes under review was limited, with the exception of Ethiopia, the longest running programme, which had significantly increased allocations to the health sector as a whole. The Ghana, Uganda and Ethiopia programmes all aim to increase the share of resources allocated to primary health care at district level and below, and those countries negotiating HIPC II debt relief are intending to channel repayment savings into health. Uganda has a mildly progressive equalisation grant in the formula for allocating funds to districts, in order to favour poor districts and the medium term budget framework has frozen, in money terms, the budget of the teaching hospitals in order to leave room for increased spending on primary health facilities.

The fundamental dilemma confronting the pro poor content of strategy is that, in low income countries with limited government capacity, government is simply unable to afford even a basic essential services package for all. Table 1 shows per capita spending by government and donors substantially below the World Bank estimate of a \$9 per capita cost of a minimum package at 1990 prices<sup>4</sup>. Moreover, it is politically impossible for government to refuse to provide services beyond those defined in the minimum package, and all governments in practice spend a large share of sector resources on such expenditure. Although the World Bank estimates are extremely crude, it is nevertheless clear that current and prospective levels of funding are not consistent with universal coverage. In practice the consequence is unmet need, low effectiveness of the services that are provided, and diversion to formal and informal private sector services. This leaves the majority of the poor excluded from access to effective health services. The dilemma is complex politically as well as technically, and there are no very obvious solutions in any of the countries we studied.

**Table 1 Per capita expenditure on health by governments and donors (including NGOs)**

Source	Tanzania		Mozambique		Uganda		Ethiopia		Cambodia		Vietnam	
			1997		1999/2000		1997 / 8		1996		1997	
	\$	%	\$	%	\$	%	\$	%	\$	%	\$	%
<b>Government</b>	2.11	47%	1.97	30%	2.58	42%	1.7	55%	1.00	15%	5.27	87%
<b>Donors/NGOs</b>	2.34	53%	4.60	70%	3.63	58%	1.4	45%	5.50	85%	0.78	13%
<b>Total</b>	<b>4.45</b>		<b>6.57</b>		<b>6.21</b>		<b>3.1</b>		<b>6.50</b>		<b>6.05</b>	
<b>non-household</b>												

*Sources and notes:*

Ethiopia: Calculated from 1999 *Public Expenditure Review*.

Tanzania: From *World Bank Project Appraisal Document* on a proposed credit to the Government of Tanzania for a health sector development programme, July 1999. Year not given.

Mozambique: From Beattie, A. and Kraushaar, D. 1999, *Health Expenditure in Mozambique: An Analysis of Major Policy Issues, Volume 2*.

Uganda: Figures based on Government of Uganda *Medium Term Expenditure Framework 1998/9 – 2001/02*, January 2000.

Cambodia: Government expenditure from WHO 1999b *Cambodia country co-operation strategies* and Char Meng Chur 1999: External assistance figures WHO 1999a (WHO Country Representative, *Cambodia Analysis of the health sector in Cambodia*); and World Bank 1999 *Public expenditure review*.

Vietnam: Government spending figure from WHO 1999 *Vietnam health systems profile: HQ working draft*, quoting Deolalikar 1999. Donor figure a very approximate indicative figure, based upon assumption of total donor funding to health sector of \$60m p.a.

If there is a resolution to the problem, it will come through acceptance that affordable per capita government expenditure is too low to finance essential services, and that private expenditures, including those of the poor, represent over half of total health expenditures in many countries. The most feasible way to extend services to the bulk of the population is likely to involve the extension of innovative approaches to cost recovery and social insurance, and harnessing the contribution of the private sector, combined with the search for more effective ways to ensure that the poor are not excluded. The World Bank in Tanzania has focused attention heavily on the cost recovery and social health insurance pilots for this reason, initially showing only

<sup>4</sup> Although household expenditure in some countries may on paper make up the shortfall, initiatives to harness it to ensure rational use are very underdeveloped. There are several other fundamental problems in defining, quantifying and financing a minimum package.

limited interest in a health sector programme heavily focused on a public financing and delivery model. In Bangladesh, the Health Economics Unit analysis has succeeded in making senior management aware that coverage can only be extended with better cost recovery and rigorous prioritisation, and pilot initiatives are recognised as an important part of the future agenda.

Connections to poverty reduction are in practice often fudged. The emphasis has been placed on expanding infrastructure to underserved areas in Uganda and Ethiopia. However, existing facilities in Uganda are operating below capacity, partly because of lack of drugs, high and uncertain (often illegal) charges, and poorly motivated staff not opening facilities at predictable times. Expanding ineffective services may do little for effective access. If target populations actually use the facilities, the recurrent budgets would prove inadequate.

Information has been collected in Uganda and Tanzania on the poor's perceptions of government services, together with the experience of attempting to use them. In the Uganda case, this has been done under the auspices of the Finance Ministry (see Box 2). The health sector ministry is unfortunately wary of using these impressions, stressing the difficulty of utilising participatory approaches in a sector where there is a strong asymmetry of information between the providers and the customers, who are not well placed to judge the effectiveness of health interventions. The solution is to be careful to distinguish which types of information can usefully be collected by these means. Policy-makers should also make use of the experience of NGOs and others who enjoy good links to the poor.

Efforts have also been made in Uganda and Tanzania to track what happens to government expenditures. Uganda has attempted to address some of the constraints outlined above through a policy of greater transparency, with publication and display of user fee schedules, and efforts to involve communities in holding facility managers to account. The need for 'survival' corruption is being reduced through higher incentives for staff, though the disciplinary constraints on wrongdoing remain weak.

### **3.3 Scope of programmes**

There was a high degree of similarity between the sector plans of the case study countries. The logic of the 1993 World Development Report is reflected in most plans, with the focus on:

- improving the coverage of preventative and primary services, with an essential services package defined explicitly in many cases
- increasing resources for the health sector
- developing the capacity and motivation of staff
- decentralising or deconcentrating services in African health sector strategies, although much less so in South Asia.

### **Box 2 Linking Poverty Strategy, Participation, Accountability and Monitoring Systems to Macro and Sector Budgets in Uganda**

The Government of Uganda Poverty Eradication Action Plan came from a broadly participatory process, an approach which is maintained in poverty reduction policy making, implementation and monitoring.

Poverty policy formulation, and analytical support for it, is powerfully located within the Ministry of Finance, Planning and Economic Development (MFPED):

- the *Poverty Monitoring Unit* integrates annual household surveys, conducted by the statistics bureau, with other data sources (e.g. participatory analysis, sector surveys, line ministry data sources) in order to track progress, and ensure that policy is continually influenced by poverty data and perceptions of the poor
- the *Expenditure Management Reform Programme* will support regular service delivery surveys, to monitor service quality and access
- the *Participatory Poverty Assessment Project* is working with 10 districts on participatory approaches to planning for poverty reduction.

Findings from these initiatives are fed into the budget formulation process. Expenditure programmes important for poverty are identified within the Medium Term Budget Framework (MTBF), and then protected from cuts by including them in the Poverty Action Fund (PAF). Monitoring is also built into the process. Donors and NGOs are members of the Poverty Working Group, monitoring PAF implementation, and participating in meetings to review and roll forward the MTBF, on which the media is invited to report. Donors also carry out joint reviews of sector spending against agreed targets and indicators.

As a result of feedback to the Poverty Monitoring Unit, findings have:

- increased priority given to clean water
- raised the importance of security issues for the poor
- led to recognition that the conditional grants to districts need more flexibility to reflect local conditions
- emphasised the need for equalisation grants to reduce inter-district inequality.

There were no examples in the case studies where the programme as initially designed encompassed the entire health sector. Common omissions tended to be the full contribution of NGOs and the private sector, vertical programmes funded by donor agencies, and contraceptive provision where this was outside government control e.g. through social marketing. There are a number of reasons for these omissions:

- some programmes were not necessarily intended to cover the entire sector immediately. Tanzania emphasised the process of reaching a sector-wide approach, with the intention of widening the scope of the programme later on as key policy issues were addressed and pointed the way to further change
- the responsibilities of the health ministry do not cover all aspects of health provision, other Ministries commonly having major or sole responsibility for some care for selected groups
- addressing the whole sector requires knowledge that is often missing, e.g. on the contribution of the non governmental sector.

In the early stages of a SWAp, it is not necessarily a problem that the scope of the programme is not sector-wide as long as there is the intention to broaden it quickly to be so. Also, given that the process of developing and managing a SWAp entails the lead Ministry gaining a better understanding of its function within the sector, and building consensus on this, it is natural that the vision of the scope of the programme will change over time.



### 3.4 Transition issues

There is widespread concern that the provision of essential services is at risk when moving towards a SWAp. The following problems have been suggested by those closely involved with vertical programme delivery:

- civil servants and service delivery staff become overly focused on SWAp development at the expense of maintaining service delivery
- the transition of donor contributions away from project funded vertical programmes to budget support leaves those programmes vulnerable to poor financial management, and competing priorities
- technical experts delivering programmes do not have sufficient input into the reorganisation of services
- the reorganisation of systems leaves some management issues unresolved.

In the countries reviewed there was a lack of hard evidence beyond anecdote to suggest that these problems, where they exist, have negatively affected service delivery. Where there had been a fall in standards, this could be attributed to other health sector reform initiatives, not necessarily the SWAp. However, it is important that this issue should be investigated, and for donors and governments to keep in mind the risk of services suffering during the transition, and to monitor the quality of service delivery accordingly.



## 4 PROGRAMME FINANCING

### 4.1 SWAPs and the budget process

In Uganda, Tanzania, and Mozambique, the health sector programme is integrated within a medium term budget framework (MTBF) which matches expected government and donor resources to expenditure plans, with a three year planning horizon which is rolled forward each year as part of the budget cycle<sup>5</sup>.

The health sector is given a hard budget constraint within which to manage, which emerges from an overall budget process that allocates resources in line with national priorities. This is extremely important for ensuring that:

- enthusiasm for sector programmes does not distort the overall pattern of government expenditures
- government is able to meet its own commitments to the sector.

If the sector programme is not subject to such a process of overall prioritisation, the danger is that expenditures will be expanded with donor support to a level which is not sustainable in the medium to longer term as that donor support is phased out. This seems to have been a problem in Ethiopia, where the three sector programmes as designed required more financial resources than were forecast to be available for the whole budget, a problem deferred mainly by the inability to spend the allocated budgets in full<sup>6</sup>. This has been addressed in Uganda and Tanzania, where the budget process includes joint meetings with the donor community, to set out government spending plans and indicate government requirements for future donor commitments. The sector programme planning and review process can add value to the overall government budget planning process, provided the main meetings are timed to support the sector ministry in preparing the necessary budget submissions to the Ministry of Finance.

The budget process does not stop with approval of the budget. It is also important to ensure that funds are released at appropriate times in the annual budget cycle. Governments in low income countries are less able than rich countries to manage budget cash flow by borrowing and lending, and therefore need to place constraints on the release of funds through the year. Ideally the cash flow forecast would be based on the implementation needs of the programme. In practice, constraints have to be placed on the rate at which funds are released, most seriously in Tanzania, where each month's releases depends on the revenue collected in the previous month. In addition to these constraints on when funds are released, there can be delays in fund releases actually reaching the facilities which need them. The responsible managers are unable to place orders or commission works until they are confident of receiving the budget. This sets up a strong likelihood of perverse effects: in Ethiopia, moneys were received too late in the year for letting contracts in time to achieve the expected programmes, one reason for low out-turn. In other countries, there are incentives to commit funds before they are received, and to spend as fast as possible, both to avoid

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<sup>5</sup> In Uganda, the health ministry has maintained a parallel planning process with a five year horizon, different both from the MTEF and from the local government planning approach. There is a similar disjuncture in Ghana. This seems unhelpful and unnecessary.

<sup>6</sup> World Bank, *Ethiopia Public Expenditure Review*, 1997.

the risk of budget cuts due to underspending, and in expectation that over-commitment will be regularised after the event.

Health sector policies and priorities only become meaningful when they are linked to some forecast of the level of resources available to fund them: otherwise, they are simply wish lists. Statements of health sector priorities can also be effectively meaningless unless the choices being made, and the options which are excluded, are made explicit. In principle, the Medium Term Budget Framework requires the health ministry to set out not only the funds it needs over the coming three years, but also to explain what it intends to achieve with them. The challenge function of the Ministry of Finance, together with subsequent defence of the budget proposals in Cabinet and parliament, should in principle sharpen the focus on a coherent plan with sustainable benefits. To some extent this happens, with more discussion and analysis in Uganda, for example, of the recurrent cost implications of capital investment, and with a more orderly process to ensure that projects are not begun without the funding to complete them and an assessment of the availability of future resources to operate and staff them.

However, despite the discipline of an MTBF a number of problems remain:

- the fundamental dilemma discussed under section 3.2 remains: targets for comprehensive coverage remain unaffordable from government and donor sources. Without the political will or mandate to address this problem, the MTBF can only provide a ceiling to expenditure, rather than an effective tool for assisting prioritisation in the planning process
- even where the framework for medium term budgeting exists, it does not necessarily mean that all expenditure on health is captured. Problems remain about significant donor flows remaining off budget, even when nominally included in the sector programme, which makes overall resource envelopes for programmes difficult to calculate
- donor funds, even when accounted for in the budget, are no more guaranteed to be delivered than before. While there will be increased pressures on donors who are providing budget support to deliver funds as planned, there is as yet no mechanism by which governments can enforce this.

New thinking on the World Bank-inspired CDF is likely to influence the MTBF. Along with the PRSP it should lead to pressure for a more transparent and accountable budget process, closer to the Uganda approach (see Box 2, p. 12).

#### **4.2 Moving towards integrated funding**

Three of the case study countries have developed joint funding mechanisms, though Tanzania is the only one yet using them in health. The systems under discussion in Uganda and Mozambique are broadly similar to Tanzania. They involve channelling funds via government budget systems, place strong emphasis on approval of district plans, and include conditions for districts to be eligible to receive funds. One danger with this approach is that the poorest districts may lose access to funding because they have the least capacity to meet requirements. In Ghana, this problem was confronted by ensuring that it was only who manages the funds which was at stake, with non-qualifying districts receiving money via the region.

An important problem is the present lack of synchronisation between the release of donor funds and the budget cycle. If government and donor funds are received too late in the budget year, the window of opportunity for utilising them is too narrow for meeting targets. Donors have arguably attached too little importance to ensuring timely availability of funds within the budget year.

Barriers to the expansion of joint funding include:

- donor lack of confidence in government systems to account for funds disbursed
- donor need to see monitorable outputs for their investments, leading to earmarked funding and separate monitoring arrangements
- donor unwillingness to adapt procedures.

In order for budget support to become the predominant means of funding for sector programmes, both governments and donors will have to make significant changes to their financial management and monitoring arrangements. The implications of failure to do this may be:

- a loss of government confidence in donor support to the programme
- an unwillingness on the part of government to welcome a high level of policy input from donors who are not providing budgetary support
- the continuation of high transaction costs as governments have to manage a range of donor funding arrangements (see section 5.8).

One point worth emphasising is that the World Bank has not so far committed direct budget support. Although theoretically possible, it is difficult for the World Bank to use existing investment lending procedures, which require the World Bank to say how their funds are spent, and to avoid co-mingling with other funds, and to use World Bank procurement and other procedures. The only way around this at present is by using adjustment funds, as in Uganda education, but there are limits on how far this can be expanded. Having the Bank as an exception is a fairly major constraint on the prospects for reaching joint procedures, and it needs to be addressed by World Bank management and Board.

As more donors move towards providing budget support, but others lag behind, a number of results may occur:

- governments may pay more attention to the policy priorities of the former, and regard other donors as less significant
- the influence of donors relative to their size may change. Financial support that funded only a small number of low cost projects may prove to 'buy' donors more influence in policy formulation when channelled through government systems
- commitment to the sector or country may be weakened in agencies unwilling to commit to budget support and accept strong government ownership in determining modalities of support. This may also deter new donors<sup>7</sup>.

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<sup>7</sup> This is not necessarily a bad thing. There would be benefits from donor specialisation, with each sector dependent on fewer donors, each providing a larger share of the resources needed.



## 5 IMPLEMENTATION ISSUES

### 5.1 Developing a workplan

The health policy and overall strategy needs eventually to be converted to a workplan in which the roles, responsibilities and tasks to be undertaken are allocated and phasing specified, together with the budgets and funding sources. In Vietnam and Cambodia, the health strategy has not reached the stage of preparing a workplan for joint working with donors. This section therefore refers only to the three African case studies and the exploratory visit to Ethiopia, plus some additional references to other work familiar to the authors.

When deciding how to prioritise and sequence actions in the workplan, a key question is whether there is the capacity to implement the programme as designed. In looking at the capacity question, it is important to unpack it a little, and look at whether the potential management and technical skills available are being optimally deployed. Capacity may be there in latent form, but this potential may go unrealised because of inappropriate roles and lack of delegation (see also section 5.3).

Uganda, Mozambique and Tanzania found the process of developing the basic SWAp documents time consuming, requiring many rounds of comments from donors, not always on what the government felt were priority issues. The short term workload on staff increased as bilateral project arrangements were still in place. This is an important problem, because the planning process can be extended, usually lasting two years or more. In Zambia, the perception of an extended planning process during which services were perceived to have deteriorated contributed to serious problems and the suspension of the approach. Generally, governments agreed that the transaction costs of dealing with donors increase with a SWAp, at least until new arrangements replace old. At the same time, the increase in transaction costs should not all be seen as resulting from the adoption of a SWAP per se, but more the product of government undertaking a major and necessary planning exercise.

In order to contain and focus the planning process, it is helpful to specify the process and the timetable in advance, even if it does not prove possible to keep to the plan. In Ethiopia, development was done through a series of joint missions, which seemed to work well and which also set up an iterative inclusive process with regions and federal government (see Box 3). Ghana had a similar process.

#### **Box 3 Ethiopia SWAp development process**

- *October-November 1997*: Draft central MoH and regional plans reviewed at three workshops, feedback on revisions advised given to national counterparts and regional health bureau teams.
- Plans revised by regional health bureau.
- *February – March 1998*: Pre-appraisal: plans reviewed again. Substantial improvements in plans noted by mission, which made minor comments and recommendations for amendments and action needed prior to appraisal.
- Plans finalised.
- *May – June 1998*: Health Sector Development Plan (HSDP) appraised by donor group.
- *October 1998*: HSDP Programme Action Plan completed.

All sector programmes have been relatively strong in producing paper work plans, setting out what needs to be done, who needs to do it, and the intended time scale. The problem has been that plans have often proved overly ambitious for the capacity available. Long lists of actions to be taken can be counter-productive. Failure to prioritise the most important ones can mean that key tasks get ignored between donor missions, with a flurry of activity (too little and too late) to try to achieve some progress before the next government-donor review meeting. Keeping the focus requires effective government leadership based on good analysis. It also requires the donor community to act responsibly in helping to agree what should receive immediate priority, and what can be deferred for later action.

## 5.2 SWAps and decentralisation

A decentralised approach is widely used in Africa for delivery of health care:

- *deconcentration* has been adopted by Ghana, Mozambique and Zambia. For example, in Ghana responsibility remains with the health ministry, but authority has been delegated to district health teams, working to plans which they have produced and are held accountable for delivering
- *devolution* has been adopted by Tanzania, Uganda and Ethiopia. For example, in Uganda local government has received line responsibility for delivery of health services, with technical oversight remaining with MoH. Districts are made responsible for producing rolling plans and budgets and receive grants to deliver them. Amongst countries that have adopted this model there are differences in the extent to which responsibility has been delegated, especially for procurement and for capital projects. Some countries have made tertiary hospitals autonomous self managing bodies, required to manage within a fixed subsidy from government. Others continue to fund hospital budgets directly.

Box 4 sets out how a decentralised approach will operate in the health sector in Tanzania. District plans will be prepared locally and approved centrally, and accounting information on previous funds used will be submitted in order to release each quarter's funding. This is intended to provide a framework for both giving districts an incentive to raise their capacity, while also making available support for them to do so, and resources to put that capacity to effect in improving services. It would be naïve not to expect early district plans to be very weak, and there will be problems in financial accounting, but the basic approach seems positive. A similar approach of defining readiness criteria was used in the Ghana Health sector. The district planning approach was also used in Zambia, although the required plans were widely criticised for being over elaborate and absorbing capacity in an unrealistic paper exercise.

Implementing a sector-wide approach in a decentralised health service presents significant challenges:

- under the devolution model MoH retains accountability for technical performance without direct responsibility for delivery. The SWAp policy development, planning process and programme evaluation therefore has to involve widespread consultation and continuous iteration with local government



- all the MoHs in the devolved model case studies were in the process of major organisational changes to enable them to undertake the necessary regulation and policy making functions. This tended to happen at the same time as SWAp development, adding to the workload, and sometimes temporarily disabling capacity
- donors have often built close working relationships with district service providers through projects, but under a SWAp are required to step back to take a more strategic role at the centre. Donor opinion in interview in a number of countries suggested they may be reluctant to sever these relationships and would like to retain them, especially where earmarked funds were going towards building district capacity. Ethiopia has tried to accommodate their wishes by setting up Regional Joint Steering Committees for the Health Sector Development Programme which have limited donor representation on them. The appropriateness of this under a SWAp is questionable, because individual donors will have influence on different regions
- intermediate tiers of local government, which are typically short of funds, tend to divert funds which were intended for first level health care to other purpose. The conditional grant system in Uganda, and the accelerated districts approach in Cambodia, both represent responses to this problem by seeking more direct routes for disbursements, and by making use of greater transparency to enable those who are to receive the funds to complain if they are not received.

#### **Box 4 Decentralised health services in Tanzania**

Tanzania is in the process of decentralising health services as part of the Local Government Reform Programme. From January 2000, 35 districts will have decentralised decision-making powers. Two subsequent years will extend this to the remaining 113 districts in phases. Districts will gain responsibility for hiring and firing staff, and managers will be trained in planning and budgeting, and reorienting health services based on essential drugs, medical supplies and equipment<sup>8</sup>. It will be up to districts to set priorities and allocate funds accordingly. Subventions with itemised line budgets will be replaced by conditional block grants (for recurrent expenditure only); pooled funds from donor will be integrated with these.

Readiness Criteria will have to be met before districts will be able to receive and manage funds. These will include:

- an approved district health plan and budget
- positive assessment by the MRLAG of technical and financial management capacity according to benchmarking criteria
- satisfactory and timely reports.

Under this new system, district health plans will be agreed at council level, scrutinised at regional level against guidelines and ceilings, consolidated and then forwarded to the Ministry of Regional and Local Government (MRLAG) for approval. Performance will be measured against planned outputs and achievements in line with National Minimum Standards. The GoT-Donor 'Basket Financing Committee' will then receive district plans and approve the release of pooled funds on a quarterly basis against approved district plans and budgets, providing GoT funds have also been released.

<sup>8</sup> World Bank, *Project Appraisal Document on a proposed credit to the Government of Tanzania for a health sector development programme*, July 1999.

In the case study countries, sector-wide approaches have not acted as centralising forces per se. The tensions existing between central and local Government over control of resources and policy existed before SWApS were introduced, and the use of conditional grants to ensure appropriate allocations has not come about as the result of a SWAp. However, when all donor support has to be accessed via the SWAp rather than districts directly attracting projects, the scope for districts to implement heterodox policies will be diminished.

### 5.3 Building implementation capacity

There are concerns in all countries that capacity may be inadequate to implement the health sector plans as designed. This is recognised to be partly the result of system-wide problems:

- bureaucracies which absorb staff time unproductively
- inefficient basic systems for managing financial, human and other resources
- low pay and motivation.

These problems cannot be tackled solely within the health sector, and there is a tension between meeting the immediate needs for more staff or higher incentive payments to get the work done, and meeting longer term capacity development needs. There have been attempts in Uganda, Mozambique and Tanzania to build links to the overall civil service reform process. Reviews have not so far resulted in fundamental changes to roles, responsibilities, and staff allocation, partly because inflexibilities in government budget and personnel policies still give Ministries little incentive to offer savings.

The long term solution to the problem of low incentives depends on economic growth and increased revenue to make higher salaries affordable. Mozambique experimented with donor-funded salary supplements, but created distortions and rigidities in personnel management, and faced sustainability problems. Uganda made some progress in implementing a medium term programme to provide living salaries for all public sector workers, though salaries for health staff remain at around 40% of private sector levels. Key lessons of experience are:

- training and bonding of staff to government work does not build capacity if not supported by other measures
- a credible government commitment to long-term salary improvement can be effective in motivating staff to remain, and may create an environment in which donor support can be designed with a clear exit in view
- higher salaries need to be linked to better performance management and sanctions for misbehaviour, including strong penalties for those found to be corrupt
- increased transparency and community involvement, as used in Uganda, may help to discourage unacceptable staff performance
- non-salary incentives can be effective, especially increased delegated authority with the opportunity to achieve and be recognised for real improvements to services.

The importance of increased delegated authority as a way to build capacity is a key part of the argument for building the SWAp within government, using existing government systems. A positive feature of the African SWAps is that they have rejected the model of project implementation units outside the main government structure in favour of building capacity in core functions.

Devolution of financial authority is seen by both donors and government as a way to develop capacity. District managers can achieve more if they have access to resources and the authority to use them. It is acknowledged that there are weaknesses in the financial control environment in all country cases, but some donors take the view that improvements to financial management systems are easier to achieve in parallel with donor willingness to disburse funds conditional on such improvements. The experience of Mozambique suggests that it is important to be realistic about the pace at which such improvements can be realised. However, willingness to use government systems and work with government to improve them is seen by government as a key test of donor willingness to work in partnership, and even modest amounts of additional funding via this route can have major effects at district level, where non-salary budgets have often been tightly compressed.

#### **5.4 Information systems for sector-wide monitoring**

Health sector programmes establish explicit targets, and information systems for monitoring progress against them. A summary of indicator levels with examples and comments is outlined in Table 2 (p. 25). From a review of the indicator sets used and the data available from them, the general conclusion is that:

- data on expenditure related in a meaningful way to output remains weak, making it difficult to derive efficiency data with any confidence
- a range of indicators at all levels is essential for gathering a complete picture of sector performance, including distributional issues. This implies the need for a greater national research capacity
- the quality of administratively collected data is a serious restraint on manageable and effective programme monitoring. Most programmes are awaiting the installation of management information systems which should eventually improve the availability of statistics. However data will only be as good as the systems for ensuring staff compliance and for analysis in meaningful ways
- given problems over administratively collected data, and the importance of addressing service quality issues, the approach of using data from service delivery surveys and tracking studies to check on trends is extremely important, and needs to be continued and to be systematic
- too much of the data flow within health systems is upwards only, and too little use is made at present of the potential to motivate staff through peer comparisons and emulation. Uganda has gone furthest in increasing reporting and accountability to the users and to civil society, and many of the approaches used would be worth copying, as one powerful way to place demand pressure on the system for improvements.

Some donors, especially those who have had a strong field presence in country, are uneasy about lessening their TA which they use as sources of information and have concerns about the rigour of the annual monitoring process as a substitute. This points to the need to improve the quality and comprehensiveness of this process. It is difficult to establish from the case studies whether monitoring improves over time, although other, more advanced programmes such as Ghana are reporting progress. The evidence from Ethiopia, where good progress has been made in improving the HMIS<sup>9</sup>, suggests that the process of getting programme managers to then relate that better activity data to financial information and decision making will be a long one. There is also a tendency in new sector programmes to be very ambitious in the monitoring proposed, which is scaled down as programme development continues.

### 5.5 Managing joint working

The case study countries have wisely built the SWAp on existing government management structures and responsibilities, unlike Bangladesh and Pakistan where parallel co-ordination and planning cells staffed by consultants were established outside the main Ministry line management. Although there were variations in all the countries reviewed, the common management process for an operational SWAp was usually:

- an overall *steering committee* with representatives of a number of ministries, including local government, senior health officials and donors. There may also be attendance by politicians; this type of committee generally meets once a quarter
- an *implementation committee* which may meet more frequently, perhaps monthly, again with representatives of some ministries and local government (but at a more junior level) and donors. This level tends to be responsible for monitoring the overall programme and reporting to the steering committee
- an *operational committee* which exists where implementation is well underway, or where there is a labour intensive period of developing and agreeing financial systems; for example, donors and senior MoH officials, plus some more junior civil servants may meet once a week to address current issues and keep the process moving.

As programmes are developed, these arrangements may already be in place to oversee the process, with the addition of working groups to address programme components and key issues such as financing and monitoring. Donor involvement in programme management varies. In Tanzania, although donors are not members of the Health Sector Reform / Programme of Action Implementation Management Committee which meets monthly, some are key members of the Basket Financing Committee

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<sup>9</sup> Ethiopia Health Sector Development Programme 1997/98- 2001/02. Report of Second Joint Review Mission, 9 November to 2 December 1999. Final draft December 1999.

Table 2 Common monitoring indicators

Indicators	Purpose	Examples	Possible sources	Comment
Impact indicators and proxies	What is the long term impact of the programme on the health of the population?	<ul style="list-style-type: none"> <li>• Life expectancy</li> <li>• Infant and child mortality</li> <li>• Fertility</li> <li>• Maternal mortality</li> </ul>	Census; Demographic and Health Surveys	<ul style="list-style-type: none"> <li>• Tend to respond slowly to health sector improvement</li> <li>• May be driven by non-health factors in the short term (e.g. drought)</li> <li>• Infrequently measured. Therefore need to rely mainly on service quality and outcome indicators as proxies.</li> </ul>
Outcome	What are the immediate health effects?	<ul style="list-style-type: none"> <li>• Lower incidence of targeted diseases</li> <li>• Better health awareness</li> </ul>	Demographic and health surveys; MoH reviews	<ul style="list-style-type: none"> <li>• Responsive to successful delivery of outputs</li> <li>• Provide valuable information for programme management</li> <li>• Reliant on research capacity</li> </ul>
Output	Are more health services being provided?	<ul style="list-style-type: none"> <li>• Immunisation coverage</li> <li>• Outpatients seen per type of facility</li> <li>• Drug availability at clinics</li> <li>• Equity indicators (rural/urban, male/female, poor/non-poor)</li> </ul>	Administrative sources (e.g. MoH service statistics, HMIS); Demographic and health surveys; Non government health provider service statistics	<ul style="list-style-type: none"> <li>• Can be used as a proxy for service quality</li> <li>• Reliant on good quality health management information systems</li> </ul>
Service quality	Do service users perceive changes in quality?	<ul style="list-style-type: none"> <li>• Are facilities open at appointed times?</li> <li>• Are bribes sought? Are user fees acceptable?</li> <li>• Are patients treated fairly and with respect?</li> <li>• Distance to facilities</li> </ul>	Service Delivery Surveys; CWIQs; Patient surveys; facility records; Supervisory visits; Participatory Poverty Assessments	<ul style="list-style-type: none"> <li>• Quality improvements are a proxy for outcome indicators.</li> <li>• Valuable for identifying access barriers and service responsiveness.</li> <li>• Increasingly used for annual SWAp programme monitoring e.g. Uganda, Tanzania and Bangladesh have systematically collected data on the experience of those attempting to use services.</li> </ul>
Cost effectiveness	Do expenditures provide best value for money?	<ul style="list-style-type: none"> <li>• Unit costs per outpatient visit</li> <li>• Patient contacts per staff member</li> <li>• DALYs</li> </ul>	Hospital and District / regional Health accounts; Health economics research	<ul style="list-style-type: none"> <li>• Can be helpful in defining essential service package</li> <li>• Can permit comparison between performances of service providers</li> <li>• Requires reliable budget and activity data</li> </ul>
Activity / Process	Has the sector implementation work programme been completed on time?	<ul style="list-style-type: none"> <li>• Agreed actions taken</li> <li>• Policies implemented</li> <li>• Next year's work plan developed</li> </ul>	Budget proclamations (Gazetting); MoH reports	<ul style="list-style-type: none"> <li>• Reliant on effective staff supervision for monitoring</li> <li>• Relatively straightforward to collect for MoH level activities, more difficult lower down system</li> </ul>
Input	Have financial disbursements reached the budget levels against specific categories of spending?	<ul style="list-style-type: none"> <li>• Tertiary/primary</li> <li>• Wages/ non-salary Capital /recurrent</li> <li>• Urban /rural</li> <li>• Regional</li> </ul>	Government budget and donor statistics (MoF, district/regional Health and MoH Finance Division reports)	<ul style="list-style-type: none"> <li>• Reliant on good quality budget information - often not available</li> <li>• Can be difficult to distinguish between different types of spending below district level therefore usefulness of input indicators alone can be limited</li> </ul>

approving pooled fund disbursements to central, and shortly, local government on the basis of plans and performance reports. In Ethiopia it is intended that donors will sit on Regional Joint Steering Committees.

## 5.6 Managing the annual cycle

The approach to the annual planning cycle which appears to be gaining ground is based on two main meetings per year, timed for the appropriate part of the budget cycle: one to review physical progress after the end of the year, and a second to prepare and discuss plans and budgets for the coming year. This is the Ghana model. These large 'set piece' meetings are often supplemented by local working groups with donor involvement. In Tanzania and Uganda these fulfil a helpful function in supporting the Ministry in preparing medium term budget framework submissions which are consistent with the SWAp.

The capacity problem usually manifests itself in governments experiencing difficulty in submitting timely and complete reports for consideration by the review meetings. Time can then be wasted in assembling basic information and analysis, and too little time is left for reflection on the main issues. The most effective way to run review meetings is by separating the information gathering and analysis phase, best done by a single team with agreed TORs and appropriate skill mix, from the actual meeting. The preceding technical mission can provide both an objective review of the issues, and recommend an agenda for discussion and suggest decisions to be taken.

Where domestic policy and planning capacity is weak, the three week annual review mission may prove to be a poor substitute. Continuity of leadership and staffing between missions can be helpful in ensuring well informed advice, and separation between the analysis phase conducted by a professional team, and the review meeting composed of government and donor representatives can help in retaining objectivity and focus. Nevertheless, the dynamics of a short review mission aiming to complete a report before the team dissolves is not conducive to calm reflection and well-judged consideration of priorities and options, while the risk of ill-informed or eccentric recommendations is always present in short missions.

## 5.7 SWAp agreements

Sector-wide programmes feature agreements at various levels, and of varying degrees of enforceability:

- at an early stage in programme development, a government and its donors may sign a *Statement of Intent* (SoI) to move towards a sector-wide approach. The donors may either be all those who are planning to adhere to the sector plan as the guide for health sector support, or just those who are intending to provide pooled funds. The statement usually summarises principles of joint working and sets out next steps to programme development. Mozambique has a 'Code of Conduct' which fulfils a similar purpose
- when the sector programme is ready to come into existence with the implementation of the sector plan, then government and donors (as a group) may sign a *Memorandum of Understanding* (MoU), which more clearly details means of support and principles of partnership. This usually states management and review arrangements and sets out channels for funding
- although donors may sign a common document expressing the intention to support the programme, *bilateral financing agreements* with the government still have to be negotiated, setting out what resources will be provided, over what period, through what mechanisms, and with what conditions. These will normally be consistent with the sector

programme document and MoU, though there may be additional restrictions or conditions related to the donors' own financing.

As can be seen from Table 3, there are similarities between the SoIs and the MoUs, indicating that they are signed with a view to clarifying current country specific issues, and reflect government-donor relationships at the time. Although the negotiation of an SoI and the MoU may therefore play a significant part in programme development, and are often seen by governments as important expressions of support from partners, the rigour and true partnership of the agreements is questionable:

- the main focus of specific undertakings tends to be on the government side, with weaker statements by the donors. This implies that the agreements may be being used for committing governments to a course of action when donors see ownership as low
- neither the Statement of Intent, nor more crucially the MoU, are enforceable documents – neither party is bound to comply with the agreement, although conditions may be strongly weighted towards the government undertaking specific actions in order to trigger release of donor funds
- conflict resolution provision in the agreements is based on reference to the content of the agreement, the programme documents where they are explicit about means of support of methods of joint working, and discussion and negotiation. There are no arbitration arrangements set up, nor an indication of when resort to conflict resolution may be necessary. The agreements rely more on the principles of partnership and peer pressure to overcome disputes (see also section 2.5). Given the absence of an international arbiter in aid relations, plus the reliance of good working relationships on principles of partnership rather than compulsion, trying to introduce more formal conflict resolution is probably not practical, and could be seen as counterproductive if it called into question the trust donors had in the recipient government
- experience has been that there can be very long delays between agreement to the MoU and the signing of bilateral agreements, and still longer delays before funds are actually released. Where governments have the capacity to spend the additional resources, this inevitably causes implementation delays in the first year and the absence of expected funds can undermine government perception of donors' commitment to the SWAp. Causes of donor delay vary. Innovative arrangements for providing direct budget support have challenged donor procedures in some cases, and encountered internal opposition, a problem which has affected World Bank support in Ghana. External events may play a factor, e.g. the Ethiopia/Eritrea war. Not surprisingly, some governments have been sceptical of the value of an MoU; Ethiopia saw little value in an agreement which did not commit donors to specific funding.

Table 3 Common features of Government / Donor agreements

Features of the agreements	Mozambique		Tanzania		Uganda	
	CoC <sup>10</sup>	SoI <sup>11</sup>	MoU <sup>12</sup>	SoI <sup>13</sup>	MoU (draft) <sup>14</sup>	
Agreement on key documents identifying scope, timescale & content of SWAp	✓	✓				✓
Organisational arrangements e.g. role of committees	✓		✓			✓
Commitment to national agreements e.g. per diem rates	✓					
Description of means of donors engaging with SWAp process	✓		✓			✓
Donors' commitment to all financial support being within SWAp	✓		✓			✓
Reiteration of support & commitment to government health policy framework	✓	✓	✓			
Acknowledgement of shortcomings of pre-SWAp donor procedures & systems		✓			✓	
Statement of commitment by donors & government to joint working re reviews, appraisal, etc	✓		✓		✓	✓
Statement of perceived benefits to new working arrangements e.g. transparency, accountability, sustainability, efficiency, effectiveness, stronger partnership	✓	✓			✓	
Summary of critical activities to be addressed as priorities			✓	✓		✓
Commitment to joint use of government financial systems	✓	✓	✓			
Commitment to SWAp principles	✓	✓	✓		✓	
Signed by donors only						✓

**Key:** CoC: Code of conduct  
 SoI: Statement of intent  
 MoU: Memorandum of Understanding

Others have been more positive. Although our case study countries are at an early stage in the SWAp process, most government and also donor representatives interviewed felt that the formal agreement between government and the donor group in the MoU was mainly of use in reaching consensus: they did not expect to rely on it as a binding document in the event of needing to resolve problems, which would be done informally rather than 'legalistically' by reference to what had been agreed. This contrasts somewhat with the rather longer

<sup>10</sup> MoH, 1999, *The Kaya Kwanga Commitment: A Code of Conduct to Guide Partnership for Health Development in Mozambique* Dar Es Salaam: October 1999.

<sup>11</sup> MoH/Partners, *Statement of Intent for the Further Development of Health Sector Reform in the Context of a Sector-wide Approach* Dar Es Salaam, March 1998.

<sup>12</sup> MoH/Partners, *Memorandum of Understanding between The Partners (Government of Tanzania and donors) participating in the joint funding of the Health Sector concerning the joint funding of the Prioritised Plan of Action of the Government of Tanzania for the Health Sector for the Financial Year 1999/2000*. Dar Es Salaam, October 1999.

<sup>13</sup> Development Partners, *Statement of Intent 1999 Health Sector Policy Framework*.

<sup>14</sup> MoH, *Items to Include in MoH/partners Agreement Document*: Kampala.



experience of Ghana Health. Both donors, and some government officials, felt that it had been helpful in that case to have explicit agreements on the process for adding projects to the investment programme. The search for a compromise might have been even more difficult if donors had been unable to refer to a document making quite clear that government had agreed to certain procedures for consultation and for appraisal before new investment proposals could be added. A similar condition is in place in the Bangladesh health and population programme.

## 5.8 Transaction costs

A fundamental assumption underlying the case for sector-wide joint working is that it will reduce the transaction costs of dealing with the donors, and will thereby release government capacity for managing the sector more effectively. As previously discussed, donors place heavy demands on government during the SWAp planning process (see section 2.3). This appears to continue into the transitional phase when some donors may be providing budget support, and placing new and additional demands on the government system for information, while government is still meeting project demands. Government ends up providing more information than before for both new and old systems. Ethiopia, for example, is now reforming its financial management system, but has had to introduce interim reporting arrangements, with increased workload.

In the course of the field work for the case studies, the opinion was strongly expressed by some government representatives that donors have not been willing to accept the logic that a sector-wide approach requires them to stand back from the detail. A relationship where trust is not strong (possibly due to lack of experience of new ways of working) tends to lead cautious donors to seek to replicate procedures similar to those they used for projects, leading to a heavy central burden. In some cases, donors have sought to retain their grass roots linkages by providing support direct to districts or regions within the context of a SWAp, sometimes talking in terms of sub-sector or regional SWAps. This seems inappropriate, inconsistent with the desire to reduce transaction costs, and in danger of perpetuating uneven provision between districts, and a culture of dependency on the donor. Persuading donors to sever the umbilical cord of direct project connections to field experience does require the building of confidence that the review process will generate high quality and objective information on what is happening.

Despite these comments, the general consensus in countries studied is that the joint appraisal/review cycle has or would reduce transaction costs:

- less time spent in one to one meetings between government and donors
- fewer bilateral missions taking up government time
- meeting with donors as a group may produce better quality policy dialogue, enabling government to make better use of technical resources, and focusing less on individual donor concerns.

Governments conceive the relationship as one in which the government side concedes some responsibility to have a dialogue with the donors on overall policy and performance of the sector, in return for donors providing their support in more flexible on-budget forms. As the SWAps get more advanced and there is a wider range of funding paths ranging from donors who can provide budgetary support to those who follow traditional paths, governments are facing dilemmas as to how to manage a range of relationships, which may increase transaction costs from those in place when one group of donors is being dealt with. There are also issues of whether donors providing budget support should have greater access to budget dialogue than those continuing with project support in parallel.



## 6 CONCLUSION: PROGRESS AND PROSPECTS

The case study countries represent a spectrum. At one end, Vietnam and Cambodia are at the earliest stage of discussing improvements to sector policy and to joint working with donors. They have not developed the archipelago of donor projects and conflicting approaches which have afflicted our African cases, and have yet to be convinced of the need for a SWAp, though Cambodian officials see some of the advantages it could bring. The other three countries are aiming for a fully developed SWAp, in which government and donor funds are used jointly to support a common programme and budget. In these countries, very substantial progress has been made towards new ways of working jointly, and the foundations laid for common procedures by at least a core of donors able to provide such support.

### 6.1 What has changed

What has changed is that:

- there is evidence of improved diagnosis of problems of service delivery, and access by the poor
- there is a better understanding in some countries of corruption and incentives problems
- linkage to a credible MTEF process is being developed in some countries
- there is increased opportunity to address sector-wide problems at macro and sector level. This is not always being taken but the forum exists, as does the mandate for donors to participate. There are encouraging signs that the process is one that will develop
- a clearer link between policy and implementation is being developed. Sector priorities are becoming clearer, and governments and donors focus more on these
- a policy thrust towards primary level services is beginning to be reflected in actual and planned resource shifts
- per capita funding has increased, or is planned, from some governments employing a SWAp process
- decentralisation to district level has led to capacity development in health financial and service management
- capacity is being built within central Governments to plan and implement sector programmes
- there is more reliance on information and analysis-based annual review process. Sector-wide information, though weak, is improving
- some disbursement is taking place through government systems, with joint reporting to government and donors.

### 6.2 What has not changed

What has not changed is that:

- there is still low civil society participation in strategy and policy formulation
- there is little internal consultation within health services on proposed organisational changes
- donors do not stand back from the detail enough, partly because they do not trust the review process to provide rigorous ground truthing of the programme, and also because they have yet to adapt their working practices to meet the new demands of SWAp programmes

- the fundamental dilemma not yet resolved is that a credible package for all is not affordable without enhanced private contributions. However, it is at least on the agenda in some countries, to find ways to mobilise and regulate
- links to civil service and local government reforms and budget reform are still too weak. Donors can help but are too dominated by technical sector specialists whereas more donor expertise is needed on wider organisational development issues
- information for monitoring is stronger on actions than outputs and patchy on inputs. Useful information is becoming available on perceptions and access, but more is needed for peer comparisons
- monitoring and information systems are still underdeveloped.

### 6.3 Causes for concern

Causes for concern include the following:

- overloaded Ministries of Health have to achieve and maintain high levels of momentum and productivity, especially when transaction costs have increased as a result of SWAp negotiation. There is a danger of burn out
- SWAp programmes tend to be orientated towards immediate expansion of health provision without concomitant emphasis on increased efficiency
- as health services move from vertical to horizontal delivery, outcomes may suffer. A sector-wide approach to sector reform must be used to address these problems, not exacerbate them
- steering a path between well-informed analysis and excessive concern with detail requires effective and transparent field truthing
- not all donors are using common systems.

### 6.4 Achievements and prospects

In terms of achievements and future prospects:

- there is the prospect of review processes gathering content and momentum. It may be possible to build links to PRSP and MTEF processes
- models are in place for providing donor support through common disbursement channels, with donors using them. Ways are being found to strengthen financial management capacity through donor assistance: a very positive achievement
- there are growing opportunities for health to benefit from and use systems developed by finance ministries or for other sectors, which should promote a common approach across sectors
- transaction costs, which increase in the negotiation stage, should reduce in future
- there may be a differentiation in donor relationships, with an inner circle supporting a government programme directly and others providing more traditional forms of support.

### 6.5 Recommendations

Policy change happens through consultation, persuasion, and alliance formation over extended time. A SWAp needs to reflect this and accept that not everything can be addressed up-front. To develop dialogue and capacity among partners to address policy issues, there is need for a permanent analytical capacity to support government, an effective policy process, a focused annual review process with good concentration on the important problems and the

immediately feasible solutions, plus a process for how important but not immediately feasible solutions will be addressed in future. Key recommendations of this report are that:

- donors need to encourage wider participation throughout the SWAp development and implementation process, and explore strategies for helping governments, NGOs and CBOs build capacity for more effective consultation
- high level political endorsement is important for ensuring sustainability, and government officials and donors should seek to secure this
- donors need to adjust their expectations of the time needed for policy making and programme development in order to allow governments to build the consensus essential for successful implementation. Pressure for immediate results must be counteracted by realism to avoid disappointment and damage to programmes
- donors as a group need to focus on delivering coherent and consistent messages
- donors need to carry out a critical review of their skills in order to better support SWAp development and implementation
- Ministries of Health should be encouraged to improve connections with government-wide reform programmes, to ensure better SWAp co-ordination and coherence
- sector programmes need to become truly sectoral to include all health delivery. Ministries of Health need to tackle the challenge of working with other government departments delivering health care, and impacting on health programmes
- donors need to keep out of the detail of programme development and implementation
- in order for affordable health services to become available to all, the SWAp policy forum should be used to create stronger consensus and clarity around service priorities and funding options
- where donors funds are factored into sector expenditure plans, donors need to be aware of the importance of meeting their financial commitments
- donors as yet unable to provide budgetary support need to reform their procedures as a matter of priority
- both governments and donors need to keep sight of the quality of essential services when moving towards a SWAp, ensuring that they are not disrupted
- action plans need to recognise capacity limitations by prioritising action lists, especially where much needs to be done by an overloaded government
- the timetable and process for reviews and preparation of activities need to be clearly specified and adhered
- review processes need to be better organised, and be rigorous and independent of government and donors. Emphasis must be placed on information as a management tool, and efforts made to improve monitoring at all levels.

## **ACKNOWLEDGEMENTS**

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The views expressed in this report and the supporting case studies are purely those of the authors and should not be taken to be representative of any other party. Responsibility for any remaining errors of fact or interpretation are also those of the author.

## Annex 1 Health SWAps Progress summary

Country	Agreement on move to SWAp	Health policy agreed with donors	Statement of intent signed	Aide memoire /code of conduct signed	SWAp start	Sector strategic plan agreed	Programme Implementation plan agreed	Joint funding process agreed in principle	Joint funding in operation
Uganda	December 1998	September 1999	October 1999	Agreed to develop aid memoire, now being drafted	Start date planned July 2000	In process	Not yet	Trust fund for technical assistance being set up	Not yet
Ethiopia	1996	1993	None	GoE decided against aide memoire without financial commitments from donors	July 1997	Health Sector Development Programme Action Plan (1997/98 – 2001/02) based on 5 year regional health plans. Agreed Oct 1998.	Programme Implementation Manual December 1998	Not yet	Not yet
Mozambique	October 1998	Revised health policy not yet finalised	October 1998	Being drafted	Start date planned April 2000	To be completed April 2000	To be completed April 2000	Not yet agreed as part of SWAp	Pre SWAp budget support from some donors started '90. TA & drug pools since 1996.
Tanzania	Early 1998	1994	June 1998	Aide memoire signed 1999	April 1999	Programme of Work approved June 1999	Plan of Action approved June 1999	Agreement on Basket Fund arrangement for selected services March 1999	Basket fund disbursement started October / November 1999
Cambodia	Reconfirmation of MoH interest, early 1999	Policy review background paper not yet available. World Bank sees current policy as good basis for SWAp	Moh SWAp Policy Paper (proposed for December 1999, not yet produced)	SWAp Lead Group to be formed January 2000	Not yet	Sector Partnership Agreement planned for Q1/2 in 2000	Not yet	Common management systems to be developed, January-December 2000	Implementation of Sector Partnership Agreement planned for 1 January 2000
Vietnam	No	No: donors regard current policy as too basic for SWAp	No	No	No	No	No	No	No

## Annex 2 Participation in the SWAp process

Country	Cabinet / Parliament	Ministry of Finance	Other Ministries	Local Govt.	NGOs and other civil society	Feed in of voice of poor	Donors
Tanzania (Plan of Action)	Approve	Approved MTEF	MoH and MRLAG jointly approved district plans	District councils draft district health plans	Inform	Indirect (service delivery surveys)	Approve
Mozambique (Health Policy)	Approve	Approved MTEF and established proposed common disbursement procedures for sector programmes	Consult	District councils draft district health plans	Inform	unknown	Approve
Uganda (Health Strategic Plan)	Approve	Approved MTEF Poverty unit in MoF monitors impact of policy	Consult	District councils draft district health plans	Consult and inform	Service delivery surveys, PPA, etc Participatory planning in 10 pilot districts	Approve
Ethiopia (Health Sector Development Action Plan)	Office of Prime Minister approved	Sector programme not fully integrated in budget	Consult	Regional health bureaus prepared plans	Inform	unknown	Approve
Cambodia (Health sector policy development)	Not yet	Consulted	Several important responsibilities fall outside MoH	No	Informed, some consultation through Medicam & CoCom	No	Consult, advise
Vietnam (Health sector policy development)	Not yet	Consulted	Ministry of Planning consulted; important responsibilities fall outside MoH e.g. HIV	Central and local health policies not fully coordinated	unknown	Small NGO and academic studies	Attempt to lead resisted by government



### Annex 3 Terms of Reference

#### Background

The Partnerships for Health Sector Development Project seeks to commission a consultant to carry out and report on a series of country case studies - and subsequently to prepare a synthesis paper - on current issues in sector programmes and development assistance in the health sector.

The work will be carried out on behalf of *Inter-Agency Group on Sector-Wide Approaches and Development*, for which WHO provides the Secretariat. The purpose of the assignment is to provide insights and recommendations relevant to the policies and practices of agencies which are members of the group, as well as to the governments with whom they interact.

The scope of work which follows is based in part on discussions and issues arising at a preliminary meeting of the Inter-Agency Group (1 June 1999). It will be further refined following the completion of a preliminary desk study by the Centre for Aid and Public Expenditure (to be completed by 31 July 1999), and comments received from members of the Inter-Agency Group (IAG).

#### Countries

Case studies will be carried out in Mozambique, Tanzania, Uganda, Cambodia and Vietnam. These countries have been selected because of their engagement in the development of sector approaches as well as the nature of their cooperation with international financial institutions (CDF, ESAF). Their physical proximity within Eastern and Southern Africa and South East Asia will allow efficiencies in travel. Work in additional countries may be financed by other partners in the IAG. In preparing the synthesis paper the consultant will also draw on relevant experience from other countries. The studies in each country will take the form of policy analyses and will be based on interviews with key actors and reviews of documents. Given the breadth of the concerns set out below, the aim will be to make well informed judgements, rather than collect large amounts of quantitative data.

#### Scope of work

Reports should assume an understanding of the rationale for and basic concepts of sector-wide approaches. They will focus on issues emerging as sector programmes are implemented in practice. In each of the country studies, and in preparing the synthesis paper, the consultant will pay particular attention to the following questions:

- policy quality and policy process:** what evidence is there to suggest that the process of developing sector programmes has influenced the content of sectoral policies? Most agencies supporting SWAs see them as a way of promoting pro-poor health policies: how has this intention been expressed in practice? Is there any evidence to suggest that sector programmes have been successful in promoting a greater concern for health outcomes? To what extent do donor concerns about ownership and national concerns about consensus limit the scope for real policy negotiation?
- managing relationships between governments and development partners:** what have we learnt about the negotiation/transaction costs of SWAs? How effective are the various types of accord/compact / MOUs? What conclusions can be drawn about the need for and effectiveness of, conflict resolution systems? Is there any evidence that processes such as UNDAF have increased the effectiveness of UN agencies as participants in sector programmes?
- planning:** a great deal of emphasis has been placed on the preparation of sectoral plans of different kinds: what conclusions can be drawn about sectoral planning processes? Are sector programmes over-determined? Is there a risk that the focus on planning reduces flexibility and the need to adjust policies in the light of changing levels of performance? Do donors demand too much detail in preparing programmes work and operational plans? How much variation in planning processes is beginning to emerge between countries?

- ❑ **scope of sector programmes:** does it remain true that many SWAps constitute a discrete programme *within* the sector? To the extent that this hypothesis is correct, what elements of sectoral spending tend to be omitted? With what implications? What needs to happen to move on toward time-slice funding of national sectoral budgets? What evidence is there to suggest that sector programmes have been successful in influencing intra-sectoral resource allocation in line with stated policies?
- ❑ **links with the PFP and medium-term budget frameworks:** to what extent are sector programmes fully reflected in overall budget plans? Is new thinking on the comprehensive development framework likely to influence this process? Where is there scope for more effective macro-sectoral dialogue?
- ❑ **preconditions and conditionalities:** do we need to revisit the whole idea of preconditions for SWAps if it is a term that is increasing being applied indiscriminately? To what extent do donors still impose conditionalities within the context of sector programmes? What form do these conditionalities take? Is there any evidence for their effectiveness?
- ❑ **capacity building:** to what extent does adequate capacity in national management systems have to be in place prior to the implementation of pooled funding arrangements? Is there a risk of a hiatus in the provision of essential services when moving toward a SWAp?
- ❑ **sector performance:** have we got any further in developing manageable ways of monitoring performance? Does monitoring improve over time? Does it take into account distributional issues which are often overlooked by routine systems?
- ❑ **decentralisation:** it was predicted that designing sector programmes in decentralised systems would be difficult - what has been the experience to date? To what extent have fears about SWAps acting as a centralising force been realised in practice? What national approaches to earmarking of sector priorities have been agreed and applied by central and local governments?
- ❑ **civil society and NGOs:** most governments and development agencies emphasise the importance of broad participation in the development of sector programmes: how has this intention been reflected in practice? with what effects?

#### OUTPUTS AND TIME FRAME

The consultant will submit draft reports and make a presentation to the Inter-Agency Working Group in November. Final reports are to be completed by 31 December 1999.

#### Additional ToRs on debt relief (added later)

1. Is there a government policy on poverty reduction in place or in the process of production?
2. Are there plans for the production of a poverty reduction strategy paper (PRSP)? If the answer to 1 is yes, what is the relationship between the government policy and PRSP?
3. If the answer to 2 is yes, what is the process for producing it - who will? Government? IMF, Bank, all three? Others? Time frame?
4. Is the MoH involved in writing/advising on the health component of the PRSP? If not, why not? If so, how?
5. What do we know about negotiations (if any) and about conditionalities (if any) attached to HIPC Initiative II?

How is the poverty focus reflected in the health policy and in the health sector expenditure framework?

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