

Swedish International Development Cooperation Agency

Mapping of Sector Wide Approaches in Health

July 2003



Institute for Health Sector Development
27 Old Street
London
EC1V 9HL
Tel: +44 (0) 20 7253 2222
Fax: +44 (0) 20 7251 4404
e-mail: enquiries@ihsd.org
website: www.ihsd.org

Sector Wide Approach Mapping

TABLE OF CONTENTS

| | page |
|--------------------------------|------|
| Acknowledgements | 1 |
| Abbreviations | 2 |
| Introduction | 3 |
| Approach | 4 |
| Findings | 5 |
| Annexes: | |
| Annex 1: Country Overview | 12 |
| Annex 2: Country Questionnaire | 19 |
| Annex 3: Country reports: | |
| Ghana | 21 |
| Tanzania | 24 |
| Mozambique | 28 |
| Senegal | 31 |
| Bangladesh | 33 |
| Zambia | 36 |
| Mali | 38 |
| Uganda | 40 |
| Burkina Faso | 43 |
| Cambodia | 46 |
| Malawi | 50 |

Acknowledgements

We are very grateful to the following individuals for providing detailed case studies of the status of the SWAp / sector programme in each of the following selected countries:

| Country | Respondent | Institutional Base |
|----------------|----------------------|--|
| Ghana | Dela Dovlo | HLSP Consulting, Ghana |
| Tanzania | Sally Lake | Independent consultant, Tanzania |
| Mozambique | Carin Salerno | SDC Mozambique |
| | Guy Hutton | Swiss Tropical Institute |
| Senegal | Chris Atim | Abt Associates / PHRplus, Senegal |
| Bangladesh | Pete Thompson | HLSP Consulting, Bangladesh |
| | Enamul Karim | HLSP Consulting, Bangladesh |
| Zambia | Sam Nyaywa | Health Sector Reforms Adviser, Tanzania |
| | | Formerly with Ministry of Health, Zambia |
| Mali | Alexis R.Sibo | Independent consultant, LSE |
| | | Former Technical Advisor to the Minister of Health, Mali |
| Uganda | Rob Yates | Health Planning Department, Uganda |
| Burkina Faso | Bonaventure Savadogo | Swiss Tropical Institute |
| | Guy Hutton | Swiss Tropical Institute |
| Cambodia | Joe Martin | HLSP Consulting, Cambodia |
| Malawi | John McCullough | Liverpool Associates in Tropical Health |

Details on Malawi were also received from Robert Grose, an independent consultant who is advising DFID on investment in the SWAp in Malawi, and Catriona Waddington, Institute for Health Sector Development.

The study was conducted by the Institute for Health Sector Development on behalf of SIDA. The authors were Emma Jefferys and Veronica Walford with technical input provided by Mark Pearson.

Abbreviations

| | |
|--------|---|
| BFC | Basket Financing Committee |
| DBS | Direct Budget Support |
| DP | Development Partners |
| EHP | Essential Health Package |
| GAVI | Global Alliance for Vaccines and Immunisation |
| GFATM | Global Fund to Fight AIDS, TB and Malaria |
| JIP | Joint Implementation Plan |
| MoF | Ministry of Finance |
| MoH | Ministry of Health |
| MoHFW | Ministry of Health and Family Welfare |
| MoHP | Ministry of Health and Population |
| MoPF | Ministry of Planning and Finance |
| MoU | Memorandum of Understanding |
| MTEF | Medium Term Expenditure Framework |
| NHA | National Health Accounts |
| NHSP | National Health Strategic Plan |
| PDIS | Programme de Developpement Integre du Secteur de la Sante et de l'Action Sociale d'Investissement Sectoriel |
| PEAP | Poverty Eradication Action Plan |
| PER | Public Expenditure Review |
| PNDS | National Programme of Health Development |
| PORALG | Presidents Office, Regional Administration and Local Government |
| POW | Programme of Work |
| PRSP | Poverty Reduction Strategy Paper |
| PS | Permanent Secretary |
| SWAp | Sector Wide Approach |
| TA | Technical Assistance |

External Development Agencies

| | |
|--------|--|
| ADB | African Development Bank |
| ADB | Asian Development Bank (in relation to Bangladesh) |
| DANIDA | Royal Danish Ministry of Foreign Affairs, Denmark |
| DFID | Department for International Development, UK |
| EU | European Union |
| GTZ | Gesellschaft für Technische Zusammenarbeit, Germany |
| JICA | Japan International Cooperation Agency, Japan |
| KfW | Kreditanstalt für Wiederaufbau, Germany |
| NORAD | Norwegian Agency for Development Cooperation, Norway |
| SDC | Swiss Development Cooperation, Switzerland |
| SIDA | Swedish International Development Cooperation Agency, Sweden |
| UNAIDS | United Nations – HIV/AIDS |
| UNFPA | United Nations – Family Planning |
| UNICEF | United Nations – Children |
| USAID | US Agency for International Development, USA |
| WB | World Bank |
| WFP | World Food Programme |
| WHO | World Health Organisation |

Mapping of Sector Wide Approaches in Health

Introduction

Purpose

The purpose of this report is to give an up to date picture of the status of Sector Wide Approaches (SWAs) in the health sector, in a concise and easy to read form, for the SIDA funded SWAp meeting in USA in June.

Coverage

The mapping was intended to cover the Health SWAs that are beyond the stage of having discussions on whether to introduce a SWAp or not. The countries concerned are:

- Ghana
- Tanzania
- Mozambique
- Senegal
- Bangladesh
- Zambia
- Mali
- Uganda
- Burkina Faso
- Cambodia
- Malawi

Scope of the study

To provide descriptive data on the existing health SWAs, to include the following characteristics:

- Title of sector programme
- Whether there is a comprehensive sector policy and strategy
- Timing of current sector programme and stage of development, current issues
- How much of health sector funding is included in the annual sector budget
- MTEF and/or PRSP and if they are consistent with the sector programme and expenditure framework
- The coordination mechanism between donors and government; and role of government leadership
- Which donors are key players in the SWAp, which are not involved at all
- Mechanisms for participation of national stakeholders in policy development and in monitoring
- Extent of pooled funds or sector budget support, in \$ and as a % of all donor funding for health
- Whether pooled funds or sector budget support is increasing, and what the funds can be used for.
- Extent of shared systems for monitoring and annual reviews, as opposed to donor or project reviews
- Key reference materials

Methodology

The SWAp mapping study was undertaken over a six-week period in May and June 2003. During May, the overall approach was defined, the country questionnaire was developed and piloted, the reporting format was agreed, key informants were identified, and country case studies commissioned for most of the eleven SWAp countries identified in the Terms of Reference (see above). The remaining case studies were commissioned in early June, and all country reports received by mid-June. The reports were checked by the study coordinators, gaps identified, and measures taken to complete the country data where possible. However, in the short time frame of the study the findings could not be approved by the country Governments concerned and thus reflect the views of the authors rather than a formal shared assessment by SWAp partners.

Overview of the report

This report provides an overview of the status of the eleven SWAs, for discussion at the SIDA SWAp seminar in San Francisco on 19 June 2003. An outline of the approach is provided, followed by a report of the main findings and a brief discussion of issues. A table showing the summary data across each country is included at the end of the main report, followed by a copy of the generic questionnaire used to elicit the country information. Individual country briefing reports are included in Annex 3 to provide further details.

Approach

The findings of this study are grouped into themes, relating to the characteristics usually associated with Sector Wide Approaches. These were presented in a discussion paper drafted by Veronica Walford for the Inter-Agency Group on SWApS for Health Development (IAG), the aim of which was to explore different definitions of a SWAp and the methods and options for evaluating them¹. The paper presents the following definitions and the core elements of a SWAp.

Definition of a SWAp

A broad definition used in the IAG training seminars was:

The sector wide approach defines a method of working between government and development partners, a mechanism for co-ordinating support to public expenditure programmes, and for improving the efficiency and effectiveness with which resources are used in the sector. (IAG)

However, a definition which highlights the SWAp characteristics in more detail is provided by Mick Foster²:

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 for all funds. (Mick Foster, 2000)

Despite the fact that many documents and agencies have different definitions of SWApS³, this definition is widely regarded as reasonable, and hence it is agreed that the following are the core elements of a SWAp:

1. All significant funding agencies support a shared, sector wide policy and strategy
2. A medium term expenditure framework or budget which supports this policy
3. Government leadership in a sustained partnership
4. Shared processes and approaches for implementing and managing the sector strategy and work programme, including reviewing sectoral performance against jointly agreed milestones and targets
5. Commitment to move to greater reliance on Government financial management and accountability systems

The analysis which follows therefore identifies whether the programmes in the case studies have these core elements in place. For example, for elements no.1 and 2, we need to identify the following:

- Is there a sector wide policy and strategy in place?
- Was it developed in partnership with stakeholders?
- Does it fit with the SWAp or sector programme?
- Is it supported by the significant funding agencies?
- Does it fit with overall government policy and expenditure frameworks (PRSP and MTEF)?
- Does it include all activities and funding sources (for example, does it reflect global initiatives)?

SWAp development

SWApS are a process and it is clear that countries will not have all five core elements in place from the start. Typically there is a decision between Government and development partners to move to a SWAp, which is followed by a development stage often lasting two years or more, where there are preparatory activities such as development of the sector strategy and programme; design of shared monitoring and reporting processes or strengthening financial systems. Then the shared sector programme starts to be implemented. In some cases this preparatory stage is seen as part of the SWAp, in others it is seen as preparation for or moving towards a SWAp. This second definition is generally more widely accepted, and is the one used here.

The SWApS studied for this report are at different stages of development; some are close to the beginning of the process, still in preparation, and some have a well developed SWAp in place. The purpose of this paper is to provide an overview of the main findings, an understanding of the stage that each country is at with their Sector Programme, and highlight any similarities and differences, and key country issues.

¹ Veronica Walford, 2002, "Defining and Evaluating SWApS: A paper for the IAG" Second version, Draft, 5 December 2002

² Mick Foster, 2000, "Experience with implementing Sector Wide Approaches", ODI

³ This is discussed by Veronica Walford, and an analysis by Richard Teuten, 2002 is presented of how different criteria are viewed by different partners; the Strategic Partnership with Africa, DAC (OECD Development Coordination), ODI, EC, DFID, SIDA and the Dutch.

Findings

Stage of development

Of the eleven countries studied, five; Ghana, Tanzania, Mozambique, Senegal and Bangladesh began their SWAp in 1997. The Zambia health reforms started in 1992, based on the 1991 National Health Policy, however the first National Health Strategic Plan was 1998-2000 and the Memorandum of Understanding was only signed in 1999. Mali also developed a comprehensive sector policy in the early 1990s, and built on this to develop their SWAp.

Uganda launched their SWAp in 2000 after 2 years build-up, and Burkina Faso officially adopted theirs in 2001, although implementation did not begin until 2002. Cambodia is committed to the process, and has come a long way along the preparation process (the Health Sector Support Project to support the sector strategy and management is due to start in 2003), while Malawi is still finalising the design and drafting the Programme of Work, Memorandum of Understanding and other key documents.

Involvement of donors

The table below shows the countries where different donors and partner agencies operate, and their role in the SWAp process. It should be noted that this was an assessment by key respondents, and not based on clear criteria. In addition, some partners may have been omitted (not all donors or UN agencies were named specifically). The figures therefore give an indication rather than a comprehensive picture.

Donor commitment to SWAps (as assessed by key respondents)

| | SWAp leaders | % | Supporting SWAp | % | Not involved in SWAp | % | Total countries supported |
|---------------------------------|--------------|------|-----------------|------|----------------------|------|---------------------------|
| Bilaterals | | | | | | | |
| USAID | 2 | 22% | 4 | 44% | 3 | 33% | 9 |
| DFID | 8 | 100% | | | | | 8 |
| JICA | 2 | 25% | 4 | 50% | 2 | 25% | 8 |
| GTZ | 3 | 43% | 1 | 14% | 3 | 43% | 7 |
| Netherlands | 6 | 86% | | | 1 | 14% | 7 |
| DANIDA | 3 | 50% | 3 | 50% | | | 6 |
| Development Cooperation Ireland | 4 | 100% | | | | | 4 |
| NORAD | 3 | 75% | 1 | 25% | | | 4 |
| SIDA | 1 | 25% | 2 | 50% | 1 | 25% | 4 |
| Italy | | | 1 | 33% | 2 | 67% | 3 |
| France | | | 1 | 33% | 2 | 67% | 3 |
| SDC | 2 | 100% | | | | | 2 |
| KfW | 2 | 100% | | | | | 2 |
| Spain | | | | | 2 | 100% | 2 |
| Multilaterals / Banks | | | | | | | |
| World Bank | 7 | 70% | 2 | 20% | 1 | 10% | 10 |
| UNICEF | 4 | 50% | 4 | 50% | | | 8 |
| WHO | 4 | 57% | 3 | 43% | | | 7 |
| EU | 2 | 50% | 2 | 50% | | | 4 |
| UNFPA | 2 | 50% | 2 | 50% | | | 4 |
| Asian Development Bank | 1 | 50% | 1 | 50% | | | 2 |
| African Development Bank | | | 2 | 100% | | | 2 |
| UNAIDS | | | 1 | 50% | 1 | 50% | 2 |

The table shows only those partners who were identified as supporting two or more of the countries studied. Of the partners involved in a number of countries, DFID, the Netherlands, NORAD and the World Bank emerge as most often playing a leading role in the SWAp. Others which are assessed as supportive include DANIDA, Development Cooperation Ireland, UNICEF, WHO, EU, SIDA and UNFPA. DFID, SDC, KfW and Development Cooperation Ireland were reported as key SWAp leaders in all the countries they support. Of the bilaterals, Spain, Italy and France are most likely not to be involved in the SWAp mechanism.

The average number of agencies playing a leading role in the SWAp is 4.5 per country; although the World Bank is seen as sole lead agency in Senegal, and Tanzania have 8 key donors in the SWAp.

Comprehensive Sector Policy and Strategy

All countries studied have a Sector Policy and Strategy in place. Most countries have two documents, while Mozambique has just one.

In most countries, the Strategic Plan is developed once the Health Policy is agreed. These are usually regarded as conditions of (or part of) working towards the SWAp or sector programme, and not part of the SWAp itself. For example, in Cambodia drafting the sector strategy was seen as a key element in preparing for the SWAp. Following this, the Health Sector Support Programme (HSSP) is to support development of the Sector Programme and Programme of Work (POW).

Most countries report that the Health Policies and Strategies are comprehensive in terms of identifying the role of NGOs and the private sector, however most report weaknesses in the definition of these roles, how the public sector will work to strengthen their roles and partnership, and few resources are allocated to this.

All countries report that the SWAp is very strongly linked to the Health Policies and Strategies. In a number of cases the SWAp mechanism is *the* strategy or mechanism for delivering the stated policies (most notably Ghana and Uganda). In Senegal the SWAp (PDIS) is the strategic framework for health sector development, translating health sector goals into five year plans with set targets and performance indicators.

Wider Planning, Budgeting and Priority Setting

All countries reported having a Poverty Reduction Strategy Paper in place. However the PRSPs in Senegal and Bangladesh were only approved in January 2003 and May 2003 respectively. These two countries are also the only ones without a Medium Term Expenditure Framework in place as yet (none was reported for Zambia or Mali, but it has been assumed from the responses that they have MTEFs).

The PRSP in Tanzania is broadly in line with the SWAp POW, and in Malawi it fits extremely well, as the basis of the Health Strategy and SWAp POW, the Essential Health Package, is *the* pro-poor strategy for the health sector. There was some divergence between the PRSP and POW reported in Ghana, however this was mostly in the use of different indicators rather than the strategic direction. Similarly in Burkina Faso, as the PRSP preceeded the SWAp it has different figures, but overall they are a good match on strategy.

In Uganda the MTEF fits with the Poverty Reduction Strategy (Poverty Eradication Action Plan) and the Health Sector Strategic Plan, however the MTEF ceiling is much lower than the requirement outlined in the Plan, and so achieving the objectives of the plan is under threat. There is a similar concern in Cambodia, where the question of altering resource allocation to achieve the PRSP targets is seen as the big challenge.

Activities / funds outside the SWAp

The major concern for most countries about activities outside the SWAp were the new global initiatives, GAVI (Global Alliance for Vaccines and Immunisation) and GFATM (Global Fund to Fight AIDS, TB and Malaria), both in terms of the levels of funding to be received, and the management of those funds outside the SWAp. MAP, the Clinton Fund and the Bush Initiative were also mentioned by some countries.

In Uganda it was reported that the global initiatives have had a destabilising impact on the SWAp, particularly in the light of sectoral expenditure ceilings set by the Ministry of Finance. The inflows from the global initiatives are also substantial - likely to be over \$60m next year – three-quarters of the total projected donor spend on health (\$80m). The impact of global initiatives being introduced part way through an existing sector programme was also an issue for Ghana, Mozambique, Senegal, Bangladesh, Cambodia and Tanzania (where only Global Fund funding for Malaria have been programmed into MTEF).

Malawi and Burkina Faso report that monies from global initiatives are expected (Malawi is due to receive huge inflows), however that they have been taken into account in SWAp design (Malawi) and programmed into the PNDS (SWAp) budget planning (Burkina Faso), and so are not seen as a problem for the SWAp.

Other activities outside the SWAp were only reported in Ghana (USAID, JICA projects) and Bangladesh where all activities not under the MoH are by definition outside the SWAp (including a major nutrition project and health activities implemented by other Ministries). Implementation of parallel donor programmes are also still a huge problem in Bangladesh, and have recently been particularly destabilising for the SWAp.

It is not clear whether private sector activities are included in the SWAp in any of the countries. This was mentioned as missing in Ghana, and may also be the case for other countries under study.

Participation of stakeholders in policy formulation and monitoring

The reports of stakeholder participation are mixed. In most cases, it appears that stakeholders (NGOs) are consulted during planning phases, but are generally not involved in monitoring of the health service (except in Uganda and Tanzania where NGOs participate in the joint reviews, and in Zambia where the Monitoring and Evaluation Sub-Committee of the Donor Coordinating Committee has NGO and donor representatives).

In Ghana stakeholders are involved through technical working groups, committees and consensus building conferences, and in Tanzania NGOs are also members of the MoH Technical Sub-Committee. In Burkina Faso the General Assembly for Health brings together all stakeholders and sectors, and there is also a strong role for stakeholders in local level planning. The same is true in both Senegal and Mali, where the decentralisation programme means annual workplans are a synthesis of national, regional and district plans.

There is very limited stakeholder participation in Bangladesh; a National Stakeholder Committee is proposed but not in place, and there is still no stakeholder involvement in annual programme reviews, even though the SWAp in Bangladesh has been operating since 1997. Equally in Mozambique (also one of the first), the Central MoH leads on policy formulation with little involvement of the provinces, and even less from NGOs.

Malawi and Cambodia have yet to fully define their mechanisms for stakeholder participation, however in Cambodia proposals include a Steering Committee chaired by the Minister of Health to oversee all policy decisions, with representatives of Government, donors, NGOs and civil society, and Technical Committees.

Coordination / joint monitoring and review

Joint annual reviews (bi-annual in Bangladesh) take place in all countries where a SWAp is in the programme implementation stage (ie. not Malawi and Cambodia), except Mali and Burkina Faso, where an annual conference for main health partners and government is held instead (but not a review, as there are no joint monitoring and evaluation mechanisms).

Ghana, Tanzania and Uganda appear to have very good coordination mechanisms with bi-annual joint reviews / summits between partners and MoH, quarterly or monthly meetings of health partners, chaired by MoH, and involvement of key donors and NGOs in regular working groups and technical committees.

The other early SWAp countries, Mozambique, Senegal, Bangladesh and Zambia also appear to have good coordination with donors. These include SWAp working group meetings every two weeks in Mozambique, a PDIS officer for each donor responsible for regular coordination of the relationship between PDIS and the donor in Senegal, consultative committees, joint approval of plans and review of progress in Bangladesh, and quarterly donor coordination meetings and a Monitoring and Evaluation Sub-Committee in Zambia. However, coordination in Burkina Faso (a more recent SWAp country) was less well rated, particularly at regional and district levels.

A Memorandum of Understanding and/or Code of Conduct was not seen to be essential to the operation of the SWAp (only three countries reporting having either); in Bangladesh this was seen as potential problem as the document which currently acts to define the role, responsibility and relationship between SWAp partners is the formal credit agreement between the Government and the World Bank. Malawi and Zambia are currently drafting these documents.

Separate donor mechanisms

In most of the countries studied, individual donors still undertake separate evaluations for bilateral projects and programmes, even in those countries which have had a SWAp for over 5 years. On the whole these are reducing over time as the number of projects outside the SWAp falls, and in Tanzania and Zambia they are timed to coincide with the Joint Annual Reviews to reduce the burden. In Cambodia, yet to fully embark on the SWAp, there are still multiple reporting, monitoring, accounting and review systems for different donors.

Two-thirds of the countries with SWAps in operation have regular separate donor coordination meetings (without Government partners). For Mozambique a change in the mechanism is planned. They are to be phased into comprehensive integrated planning at central and provincial levels, and the new Code of Conduct (under review currently) will ban these parallel mechanisms.

Government leadership

In all cases, Government leadership in the health sector is judged to be increasing, and in some cases this is linked directly to the implementation of the SWAp. The indicator for this is that the Ministry of Health is generally responsible for leading the Annual and Bi-annual Reviews, chairing all SWAp Meetings, Working Group Meetings and Technical Committees, and producing POW and related SWAp documents, including Taskforce and Consultancy TORs.

In those SWAPs still to be fully introduced (Malawi and Cambodia), the donor influence on the process is reported to be strong, but with a gradual increase in leadership from the Government. This issue is not reported in any of the more developed SWAPs. In fact, in some of the more mature SWAPs (particularly Ghana and Bangladesh) the strengthened role has caused some tensions with donors, as the donors' role in policy debates and monitoring is seen to be reduced.

However, the respondents have identified a need in a number of SWAp countries for capacity of Government to be strengthened further, even in relatively mature SWAp countries, in particular Mozambique, Zambia and Mali. In these last two, change-over of staff during the implementation of the SWAp caused leadership to be reduced for a time.

Management of SWAp funds

The table below attempts to show the variety of funding mechanisms currently in operation in the SWAp countries studied. Burkina Faso (the most recent SWAp) has no pooled funding at all as yet, and although donors in Senegal jointly agree their share of the health budget, there is no common account for the funds. Cambodia also is not planning pooled funding.

SWAp partners in Uganda allocate pooled monies to the Poverty Action Fund budget line within the MoF, where the Government is largely free to allocate between social sectors. In Mozambique, partners are showing commitment to Government procedures by allocating 1 of the 3 pool funds directly to the health sector budget. By 2004, it is expected that the other two pool funds will move from SDC management to inclusion in the MoH budget.

In Tanzania, SWAp partners provide MoH support through the Central Basket. It is not strictly sector budget support, as the activities have to be approved by the Basket Financing Committee (partners and MoH), and can only be used at the Ministry of Health Central level. However it is included as such here. Pooled basket funds are allocated directly to separate accounts in the districts from the MoF Health District Basket Account.

Partners in Ghana, Zambia and Mali show some confidence in Government financial procedures as pooled funds are managed by the MoF or MoH, albeit from a separate account. However in Bangladesh, all pooled funds are managed by one donor (World Bank) in a separate account.

Modes of managing external funds

| | Programme / Project funds Managed by each donor in separate accounts ⁴ | Pooled funds Managed by one donor in a separate account ⁵ | Pooled funds Managed by MoF or MoH from a separate account ⁶ | Sector budget support Held by MoH in normal account – no earmarking ⁷ | Targeted budget support Held by MoF in normal account, under specific budget line ⁸ | General budget support Held by MoF in normal account – no earmarking |
|--------------|---|--|---|--|--|--|
| Ghana | | | Health Fund | EU | | |
| Tanzania | | | District basket | Central basket | | DFID |
| Mozambique | | 2 of 3 pool funds | | 1 of 3 pool funds | | |
| Senegal | | | | | | |
| Bangladesh | | Pooled funds | | | | |
| Zambia | | | District basket | | | |
| Mali | | | Basket account | | | EU |
| Uganda | | | | | PAF budget line | |
| Burkina Faso | | | | | | EU, WB, NL |

⁴ In Senegal, there is no common account for PDIS partners. MoF and MoH have to sign off releases, but donors manage and release their funds independently into the programme interventions once their share of the budget is agreed.

⁵ In Bangladesh the World Bank manages all pooled funds, and in Mozambique, SDC currently manage 2 of the 3 pooled funds (drugs at a national level and provincial budget support). This is due to transfer to MoH in 2004.

⁶ Basket funds allocated to districts by MoF are held in a separate account at MoF and at district level. The Health Fund in Ghana is a separate account held by the MoH with pooled funds to support the agreed POW.

⁷ In Mozambique, the general pool fund (1 of 3 pooled funds) is managed by the MoH and incorporated into the overall MoH budget.

⁸ The Poverty Action Fund in Uganda is an internal budget funded by donors and Government. Priority sectors have agreed PAF budget lines (including health), and funds are allocated according to the PRSP (PEAP) and health sector (HSSP) priorities. This is a step between un-earmarked sector budget support and un-earmarked general budget support, as priority sectors have to be targeted.

Mechanisms for releasing funds

Nearly all SWAp funds are released on the basis of progress against plans and budgets outlined in financial reports, either on a bi-annual or quarterly basis. First quarter funds are often released automatically, and later releases only made against satisfactory reports. In Uganda funds are released by the Government from the Consolidated Account, but in most other countries MoF and/or MoH and partners have to sign releases.

The main bottlenecks with releasing funds were described as:

- delays in submissions of financial reports, particularly from local levels;
- difficulties in reconciling expenditure figures between MoF and MoH;
- difficulties with different reporting periods for donors and government;
- transferring money to district health boards from district administration;
- late and erratic release / flow of funds by MoF due to liquidity problems;
- late release of funds into holding account by basket / health fund partners

Health sector expenditure

The following table shows a summary of the data provided on health sector expenditure. Due to limited data, the figures are from a variety of years, from 1999-2003, however the data are consistent within each country.

Selected health sector expenditure data (1999-2003)

| | Total budget US\$ million | Total budget US\$ per capita | External funds % total budget | Pool funds % of total budget | Pool funds % of total external |
|--------------|------------------------------|---------------------------------|----------------------------------|---------------------------------|-----------------------------------|
| Ghana | 117 | | 28% | 26% | |
| Tanzania | 215 | | 19% | 10% | 54% |
| Mozambique | 136 | | 59% | 29% | 50% |
| Bangladesh | 429 | | 37% | 19% | 50% |
| Zambia | | \$14.00 | 32% | | |
| Mali | | \$3.50 | 50% | 7% | 14% |
| Uganda | 340 | | | | |
| Burkina Faso | | \$8.50 | 35% | 0% | 0% |
| Cambodia | | \$8.30 | 30% | 0% | 0% |
| Malawi | | \$12.00 | 58% | 0% | 0% |

Burkina Faso has no pooled funding as yet, Malawi is still in the early stages, and Cambodia is unlikely to have pooled funds. No figures were available for Senegal.

However, of those countries where data was available, between 20% (Tanzania) and 60% (Mozambique) of the total health funds are contributed from external sources, and SWAp funds alone make up between 7% (Mali) and 30% (Mozambique) of total health funds. SWAp pooled funds as a proportion of external spend are limited in Mali (14%), but make up half (50%) of all external funding in Bangladesh, Mozambique, over half (54%) in Tanzania, and higher still in Ghana (a recent review indicated that the figure for 2001 was 63%).

In Uganda it is impossible to calculate the level of external funds entering the health sector, as they are pooled with government funds in the MoF Poverty Action Fund budget before being allocated to the PAF budget lines of priority sectors, including health. Figures for the joint government and donor budget support to the health sector for 2002/03 show 32% of total health spend comes through this source, and 23% from donor projects funded separately (but contributing to the SWAp).

In all countries where data on SWAp expenditure was available (including Uganda), the level of SWAp pooled or budget support funding is increasing in absolute terms over time, but also as a proportion of external funds. This is due to:

- An increase in the number of partners contributing through pooled mechanisms,
- A decrease in projects and programmes being funded outside the pooled mechanism, and
- An increase in the contributions of those already involved in pooled funding through the SWAp.

Current issues facing the sector / SWAp

A number of issues were identified as challenges not only for the SWAp but for the health sector as a whole. Some of these relate specifically to the functioning of the SWAp, however a number relate more generally to policy issues affecting the functioning of the entire system, which may impact on the successful functioning of the SWAp.

Issues related to SWAp development identified by the country respondents include:

- Performance monitoring, and a related regulatory mechanism
- Timely disbursement of funds, by Government and partners
- Governance and fiduciary risk, particularly at the local level
- Government financial management and accounting capacities
- Administrative capacity at central level to produce reports
- SWAp financing system to minimise delays and inefficiencies
- Modalities for pooled funding at the district level
- Need for political commitment to reforms from top leadership
- Capacity building at central level to plan, manage, implement, and monitor
- Move from project support to direct budget support
- Partnerships with NGOs in policy development and monitoring
- Global initiatives and parallel financing mechanisms

Other issues are more related to the content of sector policies, such as:

- Human Resources - retention, restructuring, building capacity, salary reform
- Institutional development and government strengthened to undertake new roles
- Public private partnerships and address the role of private sector
- Prevention and promotion activities (malaria, TB, AIDS, EPI)
- Improving quality, access and coverage for the poor
- Protection of the vulnerable to ensure pro-poor focus
- Ensuring sustainable and affordable drug supply
- Mass media and community participation in health activities
- Anti Retrovirals and the impact of HIV/AIDS
- Quality Assurance
- Implementation of Decentralization

The response for Burkina Faso concentrated on the next steps in moving towards a SWAp. These tasks are also faced by Cambodia and Malawi, as they are still in the process of preparing for full implementation of their SWAps:

- Definition and implementation of the PNDS
- Joint monitoring and evaluation mechanisms
- Committee for monitoring PNDS
- Financing mechanisms for PNDS
- Links and coherence between the planning of the budget, the MTEF, and the annual budget.

These issues are having a major impact on the SWAp process in some countries – with for example, suspension of the sector credit in Bangladesh linked to the decision by Government not to proceed with some structural reforms that were agreed in the sector strategy. In Ghana, the amounts of funding available in the donor pool fund have been severely constrained, as Government has been unable to keep up with the reporting requirements of the partners that provide pooled funds.

The main challenges which were identified in the majority of countries were increasing the capacity of Government to plan, manage and account for the system, improving governance and donor confidence in government systems, strengthened Government leadership and further definition of the role of stakeholders. These are seen as activities in which the Government and partners both need to participate.

Conclusion

The eleven countries are at very different stages of development of their Sector Wide Programmes. Ghana, Tanzania, Mozambique, Senegal and Bangladesh have had SWAps in operation for over five years.

Zambia, Mali and Uganda launched their SWAPs more recently, but they have been operating for a number of years now. Burkina Faso is implementing theirs now, and Cambodia and Malawi are still in preparation (Cambodia is further along the line), but are both committed to proceeding with a SWAP of some sort.

Across the countries there are different approaches in terms of the management of funds – Uganda has already moved to a form of cross-sector budget support, whereas Senegal has no form of pooled funding and Bangladesh and Mozambique have their pooled funds managed by one of the donors. This is expected to change in Mozambique, however there seems to be no commitment towards moving in Bangladesh.

However there are many similarities between the countries, and many similar challenges, largely relating to the role of government, the extent of shared funding and reliance on Government financial management, accounting and reporting systems, and the sustained level of real partnership in the sector. How far each of the countries achieves the following five core elements described at the outset is summarised below.

Five core elements

1. All significant funding agencies support a shared, sector wide policy and strategy
2. A medium term expenditure framework or budget which supports this policy
3. Government leadership in a sustained partnership
4. Shared processes and approaches for implementing and managing the sector strategy and work programme, including reviewing sectoral performance against jointly agreed milestones and targets
5. Commitment to move to greater reliance on Government financial management and accountability systems

Extent to which countries are judged to achieve the five core elements

| | Ghana | Tanzania | Mozambique | Senegal | Bangladesh | Zambia | Mali | Uganda | B.Faso | Cambodia | Malawi |
|---|-------|----------|------------|---------|------------|--------|------|--------|--------|----------|--------|
| 1 | | | | | | | | | | | |
| 2 | | | | | | | | | | | |
| 3 | | | | | | | | | | | |
| 4 | | | | | | | | | | | |
| 5 | | | | | | | | | | | |

Ghana, Tanzania and Uganda have what can be considered a full SWAP in place. There are still areas where further movement is required, for example on pooling of funds in Ghana and Tanzania, and more reliance on Government systems. Mozambique has four of the five elements fully in place, however some concerns were raised about the extent of government leadership.

Senegal, Bangladesh and Zambia have yet to implement an expenditure framework, MTEF, that matches with the sector programme, as well as show increased commitment to move towards relying on Government financial systems. Zambia also needs to ensure that the role of government is strengthened. It is unclear the extent to which Mali is currently pooling funds, and how this should alter in the future.

Burkina Faso, Cambodia and Malawi are all at earlier stages (although the SWAP in Burkina Faso has been operating for a short while now). They all need to work on ensuring government leadership is strengthened, shared processes for implementing and managing the sector programme and monitoring and evaluating performance of the sector are implemented, and that moves are made towards relying on government financial management systems. It is interesting to note that Cambodia states it will not go down this route.

Whilst some of the sector programmes reviewed have all the characteristics defined for a SWAP, in several countries there are questions over how stable the sector arrangements are and how they will be sustained in the face of other changes.

The challenges include changes in the Government (at political level); changes in the working relationships as new donor and Government staff take over from those who were involved in the early days of building up the SWAP; and the challenges of implementing difficult administrative reforms which are often built into the sector programme (e.g. Ghana, Bangladesh). The introduction of new global initiatives have also been a challenge for managing the SWAP as they intervene in carefully negotiated priorities and funding plans.

In operational terms, there are still challenges from partners insisting on maintaining parallel projects / programmes, and the inability of government systems to meet the administrative challenges of reporting on pooled monies and SWAP targets. The low levels of health expenditure in some countries is also a threat to the achievement of the goals of the sector.

ANNEX 1 Country Overview

| | Ghana | Tanzania | Mozambique | Senegal | Bangladesh | Zambia | Mali | Uganda | Burkina Faso | Cambodia | Malawi |
|---|--|---|--|--|---|---|--------------------------------------|--|--|---|--|
| Title | Ghana Medium Term Health Strategy and Ghana 5 Year Health Sector Programme of Work | Government of Tanzania Health Sector Programme | FASAUDE Support to the health sector, Mozambique | PDIS translates PNDS into 5 year development plans | Health and Population Sector Programme (HPSP) | Zambia Health Reforms | PRODESS | Health Sector Strategic Plan (HSSP) 2000/01-2004/05 | National Programme of Health Development (PNDS) 2001-2020 | SWIM - Sector Wide Management, as outlined in the Health Sector Strategic Plan, 2003-2007 | Malawi Sector Wide Approach |
| Stage of development | Second 5YPOW now underway | Work began in 1997. MoU signed 1998, joint annual reviews since 1998/99, basket fund in operation since 1999/00 | PESS (Health Sector Strategic Plan) and indicators in place and agreed jointly. 3 common funds in place which donors contribute to | Started in 1997 with 5YPOW to 2002. Second phase 2004-2008 agreed. | Health sector strategy approved in 1997 - basis for HPSP POW. June 2003, end of first five year plan for HPSP. Health Policy approved 2000. | Reform on-go for 11 years, based on 1991 National Health Policy. MoU signed in 1999. | Implementation, review and extension | Launched in Aug 2000 after 2 years set-up. Mid-term review just been completed | 2 years build-up. Officially adopted by MoH July 2001, implemented 2002. April 2003 saw first meeting of donors on financing | 2001 Working groups set up to develop draft sector strategy. 2002 Strategic plan drafted. 2003 HSSP, Health Sector Support Project due to commence. | 4th National Health Plan in 1999 signalled intention to move to SWAp based on EHP. Final options presented Nov 2002, POW being developed. Serious consultation with donors yet to begin. |
| Key donors / SWAp leaders | DFID, DANIDA, WB, Netherlands | DFID, SDC, Netherlands, DANIDA, GTZ, KfW, NORAD, Development Cooperation Ireland | NORAD, DFID, EU, SDC, Netherlands, Development Cooperation Ireland | WB | WB, DFID, most bilateral and multilateral donors incl. USAID, JICA, UN agencies | SIDA, DANIDA, Netherlands, DFID, WB, USAID, UNICEF, WHO, UNFPA, JICA, Development Cooperation Ireland | WB, WHO, UNICEF | DFID, WB, Development Cooperation Ireland | WHO, UNICEF, Netherlands, UNFPA | WB, ADB, DFID, WHO, UNICEF, GTZ | DFID, NORAD, Netherlands, EU, GTZ, KfW, Dutch |
| Other donors involved / supporting PoW (actively or passively) | UNICEF, WHO, UNFPA, UNAIDS | WB, USAID | DANIDA, Cooperation Francaise | ADB, UNICEF, Danish (Funds Nordic), EU | Outside the pool, USAID, UN agencies, JICA and ADB | | | WHO, EU, USAID, SIDA, DANIDA, UNICEF, JICA, ADB, NORAD, Italy | WB, Plan International, Save the Children UK, SIDA, GTZ, Belgium, WFP | USAID, JICA | UNICEF, WHO, UNFPA, JICA |
| Donors not involved in SWAp | USAID, JICA, GTZ, Saudi Fund, Save the Children, Action Aid | | Italy, Spain, Portugal, Germany, Sweden | USAID, JICA, Cooperation Francaise | | | | UNAIDS, UNFPA, Belgium, GTZ, Spain, Netherlands | France, China, Italy | | WB, USAID |

| | Ghana | Tanzania | Mozambique | Senegal | Bangladesh | Zambia | Mali | Uganda | Burkina Faso | Cambodia | Malawi |
|--|---|---|--|---|---|--|--|--|---|---|---|
| Sector policy & strategy in place | Yes, including attempts to include private sector and NGOs | Yes, National Health Policy and Health Sector Strategy both under review. Previous versions included NGOs and private sector. | Yes, PESS is comprehensive sector policy and strategy. Future role of NGOs is under study | Yes. PNDS (Plan National Development Sanitaire et Social du Senegal) includes private sector and NGOs. | Health and Population Sector Strategy HPSS, and Programme Implementation Plan PIP incorporated in National Health Policy. Private sector and NGO roles mentioned, but not in detail | National Health Policy in place since 1991. National Health Strategic Plan 1998-2000 followed in 2001 by NHSP 2001-2005, MOH Action Plan, CBOH Action Plan and Joint Investment Plan. NGO detailed, some private sector. | Sector Policy developed in the early 90s is the foundation for the national health system, establishes framework for action, and defines the role of key health partners incl. NGOs. Local level services decentralised and semi-privatised. | Yes, 1999. HSSP started 2000 includes NGO, but weaker on private sector | Yes, PSN - Politique Sanitaire National adopted 2000 prior to PNDS. Includes private sector and NGOs, work on-going to define roles | Yes. Comprehensive sector strategy includes private sector and NGOs - just needs to be put into operation | Yes, strategy based on EHP - robust, but ambitious (US\$17 per capita). Consultative process used to develop policy and strategic framework will also be used to develop SWAp PoW |
| SWAp link to strategy / policy | Sector programme is the strategy | HSR PoW 1999-2002 fully linked to policy, strategy & programme | Fully linked. | The PNDS is the strategic framework for health sector development. The PDIS is the translation of PNDS goals into five year plans of work with set targets and indicators | Sector programme linked to the strategy but less so to the policy. HPSP developed a logframe to link policies, expenditure plans, use of resources and activities | Sector programme linked to sector policy and strategy through annual health sector plans | Close link between sector policy, strategy and sector programmes. A few vertical programmes are still in place, but the aim is to integrate these into the SWAp | Very close fit. HSSP is mechanism for delivering SWAp | Fully linked. | Key element of SWiM was drafting sector strategy. HSSP supporting the MoH to draft a sector programme to meet policy issues, and develop POW. So directly linked to SWiM. | Sector programme based on providing EHP. Joint PoW based on delivering EHP and SWAp |
| MTEF / PRSP - link to SWAp | MTEF + PRSP. Some divergence with POW - varying sets of indicators etc. | MTEF + PRSP. MTEF covers PRSP priority sectors, but PRSP broadly in line with HSR PoW | MTEF + PRSP. Being revised to reflect HIV/AIDS epidemic better, and new funders in the health sector | No MTEF as yet. PRSP approved Jan 2003, but health component not widely known | No MTEF as yet, but health furthest advanced in MTEF planning. PRSP approved in May 2003 | PRSP been prepared, but not yet consistent with sector programme expenditure framework | Health sector objectives in PRSP match the sector programme objectives. | MTEF + PRSP/ PEAP (Poverty Eradication Action Plan). MTEF ceiling much lower than HSSP requirement, but focus slowly shifting to HSSP priorities | MTEF + PRSP. MTEF took PNDS into account, so well linked. PRSP preceded these, so different figures, but good match on strategy | MTEF + PRSP. MTEF totally linked to the health sector strategy and SWiM, but how to alter resource allocation and achieve PRSP targets is a big challenge | MTEF + PRSP. Joint PoW for 6 years to be synchronised with MTEF. EHP is the pro-poor strategy for health, and is significant part of the PRSP. |

| | Ghana | Tanzania | Mozambique | Senegal | Bangladesh | Zambia | Mali | Uganda | Burkina Faso | Cambodia | Malawi |
|---|---|--|---|---|--|---|--|---|--|--|--|
| Activities / funds outside SWAp | GAVI, GFATM distort resource envelope & MTEF framework. USAID, JICA projects not integrated into strategic framework. Private sector not included | GFATM - Malaria been programmed into MTEF. GFATM, Clinton Foundation and Bush initiative on HIV/AIDS, GFATM TB money and GAVI funds raises huge concerns re: sustainability and SWAp | MAP, GFATM, Clinton Fund all offset the picture as vertical programmes - will not join pools or common funds. Need to be 'on planning' if not 'on budget' | GAVI, GFATM not included in PDIS. Already had an impact on resource allocation in health sector both from government and donors | All activities which are not directly under the MoH are seen as outside; including major nutrition project; all activities implemented by other Ministries; and any parallel programmes by donors (which are particularly destabilising for the SWAp). Bangladesh due to receive funds through the second tranche of GFATM - also likely to affect SWAp. | Most CPS and GRZ activities and funds are in the sector programme although the WHO and UNFPA still is questionable. | | MAP (\$50m over 3 years), GAVI (\$50m over 5 years), GFATM (\$35m next FY, then \$50m over the next 2 years) have been extremely destabilising. Estimates from MoF indicate that the likely inflows from these global initiatives are over \$60m next year - over three-quarters of the expected total donor project spend. | Known funds (ie GFATM) are included in PNDP budget planning | Potential funds (ie GAVI and GFATM) are not been included in sector strategy risk of parallel processes destabilising SWiM | GFATM taken into account in SWAp design, however can't go through SWAp, as this was based on EHP delivery. So GFATM seen as complementing resources to fund POW. Malawi is to receive large amounts of funds from both GFATM and GAVI. |
| Participation of stakeholders in policy formulation and monitoring | Through technical working groups, committees and consensus building conferences | NGOs in the MoH Technical Sub-Committee and annual joint review - would like to be involved in PER. Politicians through Social Sector & Public Accounts Committees. | Very limited - Central MoH leads on policy formulation, with little involvement of provinces, and very little from NGOs | Annual PDIS workplans are synthesis of regional, district and national plans - so involve donors, local management units, NGOs. Participation in monitoring less developed. | Wide consultation during planning phase. Minimal consultation during implementation. NSC, National Stakeholder Committee proposed under HPSP, but still no stakeholder involvement in annual programme reviews. | Stakeholders invited to participate in policy formulation - not clear how. Monitoring and Evaluation Sub-Committee of the Donor Coordinating Committee has NGO and donor reps | In theory civil society and NGOs can get involved in planning at district, regional and central levels with District and Regional Health Teams and the National Technical Committee. This is often difficult, and is only slowly developing. | NGOs and politicians participate in joint reviews, and NGOs in HPAC too. Public-private partnership office also been set up | General Assembly for Health brings together all stakeholders and sectors, as did development of the National Health Policy and PNDP. Local level planning should also involve regional and district stakeholders | Still under design, but plan is for Steering Committee, chaired by Minister of Health to oversee all policy decisions and have reps from govt, donors, NGOs and civil society - who will also be on Technical Committees | Involvement of civil society, NGOs and politicians has been limited. However they were included in the design of the SWAp, and will be involved in implementation. |

| | Ghana | Tanzania | Mozambique | Senegal | Bangladesh | Zambia | Mali | Uganda | Burkina Faso | Cambodia | Malawi |
|---|--|---|---|---|--|---|--|---|---|---|---|
| Co-ordinating mechanism / mechanisms for joint monitoring and review | Joint annual review. An external team evaluates performance against plans, based on MoH data, and reviews at district, regional and national level. Bi-annual summit with partners and MoH. Monthly health partner meetings chaired by MoH. Partner involvement in working groups and committees | Joint annual review. Bi-annual SWAp meeting. Quarterly meetings of the Basket Financing Committee (chaired jointly by MoH and PORALG). BFC reviews govt and basket expenditure reports, and quarterly reports. Key donors and NGOs also attend weekly meetings of the MoH technical sub-committee for health planning, budgets, finance and reviews | SWAp Working Group meets every two weeks. Code of Conduct 2000 in place, currently being reviewed. MoU also in draft to take account of new General Funding Pool. Joint annual reviews in place since 2002. One set of joint indicators guides sector monitoring. | Annual review of PDIS - RAC (Revue Annuelle Collective) involving MoH and donors. Also PDIS officer for each donor responsible for regular coordination of the relationship between PDIS and the donor. | Bi-annual joint reviews (very donor-led). Consultative Committees and joint approval of plans and review of progress and inputs. No MoU as yet - the document which acts to define the role, responsibility and relationship between SWAp partners is the formal credit agreement between the Govt and the World Bank. However there is an agreed set of indicators to monitor HPSP between govt and partners. | Joint Annual Health Review in place. Donor coordination meetings held on a quarterly basis. Good coordination in first five years of reforms. Sub-committee dealing with Monitoring and Evaluation chaired by director of planning. | Regular partner meetings take place between CEPES - the Partners Coordinating Unit at the MoH and the other partners. A MoU and Principles of Cooperation exist. | Bi-annual joint reviews and monthly meetings of Health Policy Advisory Committee, HPAC. Formal MoU signed by government and partners setting out partnership principles. Annual joint reviews are also held, and shared monitoring is proceeding: 3 key indicators have been agreed as the PEAP (PRSP) indicators, and 15 as the HSSP indicators. | No formal Code of conduct or MoU. Annual Conference for main health partners and government in place, and although some areas have coordination mechanisms, no overall joint monitoring and evaluation mechanisms are in place yet. Coordination at regional and district levels is very weak. All reviews and evaluations are conducted by government with partners involved, and MoH also involved in most donor evaluations. | No formal coordination mechanism for SWIM yet, and no joint reviews. But it is likely that existing national and provincial coordination committees of MoH and partners which meet bi-monthly and/or quarterly to ensure joint MoH-donor working will develop into this. A steering committee for HSSP, with MoH, MoF, donors and NGOs is in place (possibly operating parallel to the SWIM process). | Draft MoU developed June 2003, and code of conduct also planned. Primary mechanism is the Joint Implementation Plan Committee (especially EHP / SWAp JIP) includes all donors, some NGOs and MOHP. New committee structures have been proposed to fit with new POW. Joint reviews are also proposed under the SWAp design, however have not yet been implemented. |
| Separate donor mechanisms in operation? | No, but some partners and MoH officials still liaise on separate projects and earmarked activities. | Yes, Bilateral and Multilateral Health Forum meets monthly (more often in run-up to joint reviews). Also separate reviews undertaken by some partners, but timed to coincide with joint annual review. | Yes, but to be phased into comprehensive integrated planning at central and provincial levels. New Code of Conduct to ban these parallel mechanisms. Separate evaluations still take place for donors with bilateral programmes. | Not known, apart from EPI ICC group | Yes, Local Consultative Group for all donors (whether fund via MoHFW or not), and HPSO, housed by WB which has agreed to monitor for most donors (except UN). Individual donors still do reviews of individual components. | The CPS in the basket have an informal platform, GRZ have Joint Coordination Committees. Separate project reviews have been reduced or streamlined to fit in with Annual Reviews. | Yes, monthly 'donor coordination' meeting. A representative from the MoH is present, but these are not viewed as planning meetings. | Yes, a health sector donor group meets regularly. Separate project reviews also continue, but are decreasing as number of projects falls. | Common Country Assessment / United Nations Development Assistance Framework CCA/UNDAF for country. Coordination meetings of health partners held every trimester, WHO as president. | To date still have a multitude of reporting, monitoring, accounting and review systems for each donor. | Yes, but includes MOHP officials - Health and Population Sub-Group. Separate donor project reviews are also undertaken. |

| | Ghana | Tanzania | Mozambique | Senegal | Bangladesh | Zambia | Mali | Uganda | Burkina Faso | Cambodia | Malawi |
|---|---|--|--|--|--|--|---|---|--|--|---|
| Government leadership | Govt produced PoW and docs which form the basis of the SWAp. Also chairs monthly health partner meetings. Some tension around reduced donor role in policy debates and monitoring | Govt chairs all meetings for coordinating sector programme, ie Annual Review (PS), Basket Financing Committee, and Technical Sub-Committee | Gradually increasing, but capacity strengthening is required. | Govt staffs the unit (CAS) that executes the PDIS workplan and coordinates donor interventions, and has the lead role in making plans and proposals. This role is set to increase. | HPSP enabled MoHFW to take a much stronger leadership role, with donors and within govt - still increasing - however problems rising with relations with donors as left out of key consultations | Govt leadership in the reforms evident from 1991, however instability within Ministry of Health resulted in a fall in from 1998-2002. Back on track. | Govt chairs mtgs, sends invites, takes mins, drafts TORs, leads calender of activities. But can still be influenced by strong donors. Change in senior staff has reduced leadership recently. | Govt chairs HPAC, leads the annual reviews and has taken on amending the operation of these bodies. Govt lead is increasing, however global funding initiatives are a threat to this. | Introduction of PNDS has strengthened the leadership of MoH. | MoH gradually taking over the leadership, but still strongly supported in this by donors | Initial thrust from donor partners. But Govt has led SWAp design process, and will develop draft POW before sharing with donors. But donor influence on the process is still strong |
| Spending in the health sector | Total \$117m (2002) - Govt, external funds and internally generated funds. No data on private spend. | Total \$215m (2001/02) - \$134m on-budget, \$81m off-budget. No private sector spend data | Total \$136m (2000) - \$56m govt, \$80m external funds | Partners 1999: Govt 53%, Donors 30%, User Fees 11%, Local Authorities 6%. Lack of data on actual figures | Total \$2,147m over 5 years of HPSP. 62% from govt, 18% from IDA & pool, rest from bilaterals | Per capita spend US\$14 in 1998 (\$8 govt, \$4.5 donors, \$1.5 community). Fallen now as currency fell. | Per capita spend approx US\$3-4. Out of pocket spend approx same. Donor funds make up 50% of public funds | Total \$340m (2002/03) - Govt & donor budget support \$108m, Donor projects \$78m, Private \$154m. | Per capita spend US\$8.5 - Govt \$5.5 and external funds \$3. Estimates of private spend US\$60 per household (for 7 people) | Total \$99.4m (2001) - per capita US\$8.3; two-thirds from govt, one-third from external | Per capita spend US\$12; US\$7 is from donors (2002) |
| Level of SWAp / pooled funding | Total on-budget external funds \$33m. \$31m through Health Fund (94%) | Approx \$22m (basket), 54% (2001/02) of donor funds | \$40m 2003 (estimates): General: \$9m, Drugs: \$23m, Provincial: \$7m | In 1999, PDIS (SWAp) expenditures were \$94m. | \$400m over five years - approx 50% of donor funds | | Pooled funds 7% of budget (0.25 US\$). | \$108m (Govt & donor budget support) | | | |
| Are SWAp funds increasing? | Yes, number of partners moving to Health Fund and contributions of those already in Health Fund. | Yes, from 7% of health spend in FY00 to a predicted 24% in FY03. Risen as % of donor spend from 28% to 60%. | Yes, estimates \$45m in 2004: General \$17m, Drugs: \$8m, Provincial: \$10m | Yes, spend within the PDIS framework doubled over first 4 years from \$67.6m in 1998 to \$137m in 2001 | Have been increasing over time. Currently between programmes | | Yes, due to increasing number of donors and increasing level of contributions | Yes. Health budget more than trebled in five years - largely due to donors. Also increased as % donor funds. | | | |
| Donors moving to sector budget support | EU already, DFID likely to do so in 2-3 yrs | Sector budget support only through basket | All donors in pool are providing sector budget support. France has recently joined in context of debt relief programme | Donors in the PDIS have agreed to move towards sector budget support in the next phase of the PDIS, starting in 2004 | No | | EU moved to sector budget support. Basket funds also regarded as sector budget support | DFID, Development Cooperation Ireland, SIDA, NORAD, WB, EU all moved | Netherlands District Support Project only. | Not in the health sector | NORAD has started to provide direct support to districts. DFID is considering direct district support and TA fund managed by MOHP |

| | Ghana | Tanzania | Mozambique | Senegal | Bangladesh | Zambia | Mali | Uganda | Burkina Faso | Cambodia | Malawi |
|--|---|--|---|---|--|---|---|--|---|---|--|
| Donors moving to general budget support | EU likely. | DFID shifted in 2003/04 - earmarked to MoH (but for the coming FY only) | Not yet | | No | DFID intending to do so, but unstable situation may affect this. | EU provides some general budget support, conditional on progress in health sector indicators | Yes, as govt is largely free to allocate PAF between social sectors | EU, WB and Netherlands all give general budget support | | Yes, but on hold due to IMF/WB restrictions - include DFID, EU, Dutch, DANIDA, NORAD |
| Management of SWAp funds | The Health Fund is a separate account with donor pooled funds which support the agreed POW. Earmarked project funds also support the POW, but can only be spent on specified activities. | General budget support is merged with the overall government budget and allocated to the broader process of inter-sectoral allocation. Basket Funds are channeled through a separate account, held at MoF level, but transferred directly to MoH or districts (2 basket funds) | State budget lines are used, and managed by MoH, with no earmarking. SDC manage the drugs pool at a national level, and the provincial budget support - until 2004, when these will transfer to MoH as well. | No common account for PDIS partners - manage and release funds independently once their share of budget is agreed | Separate fund managed by World Bank reimburses in arrears. | Basket funds are channelled to district donor accounts via Central level. Govt funds are also channelled to districts, but kept separate. Central level basket funding is not in place. | Donor funds can either be general budget support to MoF, targeted support to special MoF accounts, basket funding to MoH basket account, support to MoH projects through MoH special account, and donor project support to donor account. | Poverty Action Fund (PAF) - internal budget funded by donors and govt. Some sectors have agreed PAF budget lines to receive funds. Allocation of funds to health PAF budget lines guided by HSSP priorities. Project funds managed independently but still regarded as part of SWAp. | No SWAp funds as yet. Netherlands provide district support to finance plans. All other donors fund on project basis | There will be no pooling of funds under SWiM due to problems with public expenditure management arrangements. Health sector reform will remain funded by donors to separate bank accounts, outside of govt systems of reconciliation and audit. This also applies to HSSP initiative. | SWAp not yet reached this stage. |
| Mechanisms for releasing funds | Delay in release of funds is a major constraint - caused by Govt disbursement difficulties (sometimes due to slow reporting by MoH), and by delays in donors transferring agreed funds into the Health Fund | Q1 and Q2 basket funds released automatically, Q3 and Q4 based on satisfactory reporting. Delays caused by late plans and budgets, or reports from local level, late release of funds by partners into the Holding Account, late release of funds by MoF | Funding pool for recurrent costs released twice a year against plans and budget execution of pre-previous term. Drugs budget released twice a year. General funding pool released quarterly. Bottlenecks caused by erratic financial flows at govt level. | Ministry of Finance and Ministry of Health have to sign off releases, and then donors pay the costs directly of their programme interventions within the PDIS | Reimbursement made on basis of quarterly financial statements. Turnaround is generally good. Main bottleneck reconciliation of govt figures and MoHFW. | Basket funds released to districts on quarterly basis on basis of technical implementation progress reports and financial statements. | Funds released based on plans and reports of performance. Bottlenecks are capacity of MoH to analyse the data and produce the reports, and the demands of donors for reports for different periods from government. | Funds released by Govt from consolidated account. Cash flows well managed on the whole, but bottlenecks occur at district level when transferring money from district admin. | | Still under discussion, but it is expected that clearly costed programmes of work will be analysed on their merits and funding will flow from commercial bank accounts with joint signatures required from MoH and donor personnel to release funds. | |

| | Ghana | Tanzania | Mozambique | Senegal | Bangladesh | Zambia | Mali | Uganda | Burkina Faso | Cambodia | Malawi |
|---|---|--|--|---|---|--|--|---|--|--|--|
| Key factors affecting success of SWAp / sector programme | How can SWAp address funding of low performing programmes? Improvement in timeliness and accuracy of performance monitoring. Improvement in disbursement of funds - Common Management Arrangement (CMA) conditions need to be altered to enable this. Govt also needs to engage more with partners to ensure relationship is not damaged by change in leadership. | Pressure to demonstrate impact, especially on the poorest of the poor. Improved service quality and coverage. Governance, especially at local level. Need for improved costings within the sector. | Inadequate absorptive capacity for wide range of funds - NGOs, multilateral and bilateral programmes, pooling etc. Related to lack of capacity to manage and implement the process of health sector planning and monitoring. Lack of supervision. Need to build confidence in govt systems to switch from donor to state auditing. | Main difficulty is administrative bottlenecks and long procedures to get donor funds released on time...Last EPI campaign was postponed because money was not available on schedule to purchase supplies. Donors also require greater transparency in the PDIS. | Key issue currently is the major MOHFW efficiency reforms which were tied up in the new programme as the SWAp was introduced. Change of government has seen these reforms repudiated for political reasons. This has led to a breakdown of relations with donors. | Trust between govt and partners - especially on corruption, transparency, financial accountability, good government, political leadership and commitment. | Capacity of planning unit and financial / administrative unit at central level to compile annual plans/reports and realise the (available) resources in the districts. Lack of Human Resources (number and capacity) especially at operational level. Decentralisation beyond deconcentration. Political engagement of Government and donors to the SWAp and commun funding mechanisms | Inadequate funding. Only a third of HSSP is funded. Global funds seen as plugging the gap, however these threaten the SWAp. MoF setting sector ceilings to include project funding. Other issues include lack of human resources, insufficient drug supplies, poor infrastructure and transport, inadequate management and supervision and performance management at district level | Difficult economic situation and poverty prevents poor accessing services. Low education limits impact of preventive and promotive activities. Endemic diseases and emergency situations occupy MoH. Poor performance of health services due to weak organisation, management, functioning, lack of skills and low staff motivation, low level of service use by poor. Limited inter-sectoral collaboration and community participation. | Strong political commitment; good planning, supervision and monitoring systems; timely and adequate funds and commodities; essential drug supplies; income for staff; human resource management; outreach activities; mass media campaigns; community participation; flexible financing arrangements; performance based contracting; partnerships with NGOs; technical, management and financial support from partners | Small number of donors and extreme understaffing of MoHP (and health service as a whole) means lack of capacity to implement process. MoHP disillusioned with SWAp design process. Lack of effective health care delivery at all levels. High HIV rates in working population. Need to strengthen communication, participation and financial systems. Lack of commitment by key donors to SWAp. Influx of GFATM funds. |
| Current key policy issues | Improving equity and access. Health Insurance. Targeting the poor. HR retention. Institutional development of MoH, GHS etc. Movement of SWAp funds to direct budget support | ARVs, and HIV/AIDS plan. HR strategy. Reproductive health. Regional secretariat role. Financing the sector. Performance monitoring. Cost-sharing and protection of vulnerable | HIV/AIDS strategy. Institutional development. Public sector and salary reform. Maternal mortality rates. | Prevention. PDIS financing mechanism. Budget not programmatic approach. Health financing alternatives to user fees. Development of mutual health organisations. | MoH management reforms, unification of health and family welfare, reform of budgetary and financial disbursement mechanisms, involvement of NGOs and private sector. | Decentralisation. Financial management. Autonomous boards. Implementation of EHP. HR development. Community involvement. Strengthened private sector. Streamlining of beaurocracy. | | Accommodating GFATM monies. Increased decentralisation. ARVs for HIV. Hospital autonomy and private wings in hospitals. Public Private Partnerships. Drug supply system. | Definition and clarification on implementing PNDS - joint monitoring and evaluation, financing mechanism, links and coherence between MTEF and planning of PNDS and annual budget | Decentralisation. Developing HR capacity. Public private partnerships. Community involvement. Health information. Equitable financing systems for priority services | Decentralisation. MoHP restructuring. HR projections and strategies. Implementation of EHP for Poverty Alleviation Strategy. QA. Pooled funding at district level. HIV/AIDS and ARVs. |

ANNEX 2 Country Questionnaire

Health Sector SWAp Questionnaire

Institute for Health Sector Development

Please complete the following questionnaire to describe key characteristics and status of the SWAp in the health sector in **Country**. Please type directly into the grey boxes, and return the completed form by email.

This paper will be used by IHSD to form the basis of an overall paper for Swedish SIDA to describe the current status of the SWAps operating in the health sector in the following countries: Ghana, Uganda, Tanzania, Mozambique, Zambia, Malawi, Mali, Senegal, Burkina Faso, Cambodia and Bangladesh.

Dr Ken Grant will present the paper at a post-iHEA conference session in San Francisco on 19 June 2003. Please send your response to Emma Jefferys at IHSD (emma.jefferys@ihsd.org) by _____.

Thank you for your time.

1. Title of sector programme

2. What stage of development is the sector programme at? Please specify the key milestones.

3. Which donors are key players in the SWAp? Which lead, which participate more passively and which are not involved at all?

4. Is there a comprehensive sector policy and strategy? Does the strategy cover the private and NGO sectors' roles and how Government relates to them?

5. What are the key policy issues under discussion at the current time?

6. To what extent is the sector programme linked to the sector policy and strategy? Are there elements of the strategy which are not included in the SWAp / sector programme?

7. Is there a Medium Term Expenditure Framework or PRSP (interim PRSP) in place? Are they consistent with the sector programme and expenditure framework in terms of total expenditure and allocation within health? How far do they reflect the strategies and funding framework in the sector programme?

8. Are there other activities or funding sources that were not envisaged in the sector programme / SWAp? What effect are these having on SWAP processes and the health budget? (e.g. GFATM)

9. What is the coordination mechanism between donors and Government? How often does it meet / become active? Is there a formal Code of Conduct or Memorandum of Understanding setting out the principles underling the partnership?

10. Is there a separate coordination or planning mechanism just for donors and agencies?

11. How is government leadership exercised? Is there any evidence that Government's leadership role is increasing as the SWAp progresses?
12. What is the extent of shared systems for monitoring and annual reviews? Are there separate donor or programme / project reviews?
13. What are the mechanisms for participation of national stakeholders including politicians and NGOs, in policy formulation and in monitoring?
14. How are the funds managed for the SWAp / sector programme. Are they held in a separate account or are they merged into the government budget? Are there limits on what they can be spent on?
15. What is the mechanism for releasing funds, and what are the major problems / bottlenecks?
16. What is the current level of spending in the health sector (Government, donor and private sources, in \$)?
17. What is the level of SWAp / sector programme 'pooled' funds (in \$)? What proportion is it of all donor funding for health?
18. Are the SWAp / sector programme 'pooled' funds increasing over time? As a % of total donor support?
19. Have any donors moved towards sector budget support? If so, what is the level of sector support (in \$)?
20. Are any donors providing (or moving towards) general budget support? If so, are there any conditions relating to the allocation of resources to the social sectors?
21. What are the key issues affecting the development / success of the sector programme now? Please describe current issues and concerns
22. Please list the key reference materials
23. Any other comments

ANNEX 3: Country Reports

GHANA

Ghana Medium Term Health Strategy & Ghana 5 Year Health Sector Programme of Work

Ghana is now in its second 5 year Programme of Work. Key milestones include the following:

- Agreed health sector strategy and programme of work
- Partner fund pooling (at about 60% of partner funds pooled)
- New budget support stage for EU (also proposed for DFID)
- Common management arrangements under operation
- Joint Partner-MOH annual reviews
- Increased % of Government budget assigned for Health

Donors

- Key SWAp donors / leaders include DFID, DANIDA, World Bank and Netherlands Aid
- Donors funding earmarked activities and projects include USAID, JICA, GTZ, Saudi Fund
- NGOs also contribute funds including Save the Children, Action Aid etc
- Multi-lateral support to POW from UNICEF, WHO, UNFPA, UNAIDS.
- Programme Specific Global Initiatives: Global Fund, GAVI. etc.,.

Sector policy and strategy

Ghana has a comprehensive sector policy and strategy which covers private sector and NGO activities, particularly the mission based Christian Health Association of Ghana (CHAG). A Private Sector Unit also exists within the MOH although establishing a private sector policy and agreements (MoU) with NGO service providers have not yet occurred. However GOG is currently funding 100% of personnel emoluments and about 3% of other recurrent service delivery costs of CHAG. CHAG is also involved in all policy discussions and reviews alongside other partners. The relationship with "private for profit" providers is much less defined.

There is a Traditional Medicine Unit within the MoH dealing with self-regulation by indigenous traditional health providers. Government has good relations / links with the Ghana Registered Midwives Association (largely private membership), and provides financial support through training programmes etc. Stakeholders have been involved in the development of policy and strategy in Ghana to a certain extent. This has mostly been through the Technical Working Groups, Committees and Consensus Building Conferences, as well as specific inputs to some of the Health laws concerning the Health sector reforms.

The SWAp / sector programme 5YPOW is the document outlining all health sector policy and strategies. There is also a MTEF and PRSP in place, which form an integral part of the planning and implementation process of the SWAp. There is some divergence between the PRSP and POW (for example different indicators) which suggests a possible lack of coordination between the two documents. There are also some integration problems with the spending and targets on new initiatives, for example access policy and insurance and the MTEF. However, the PRSP targets appear to be well matched to the POW targets.

Activities which were not envisaged in the SWAp were the new global initiatives such as GAVI and GFATM. These proposals have the potential to disrupt financial plans by distorting the resource envelope and MTEF framework, especially in terms of long term sustainability of funds for continuing activities. Earmarked project funds from some partners (USAID, JICA) are often still negotiated separately and whilst attempts are made to integrate these into the strategic framework, it is very difficult to determine and project and plan for the funding levels. The significant private for profit sector is also not well investigated or included in the SWAp and health strategy and funding. This sector is likely to cover some 20-35% of all health services in Ghana.

Coordination mechanism

Ministry of Health and partners conduct joint annual reviews, bi-annual summits and monthly Health Partners meetings, chaired by MOH. Partners also input into specific technical areas, through Working Groups and Committees. A Memoranda of Understanding (MOU) is produced at each bi-annual summit to guide the agreements between the health sector partners (GoG and donors). There is also an annual joint partner / MOH external review which reports on the progress with the implementation of the programme of work.

All SWAp reviews are joint partner and MOH reviews. The reviews examine local and district level monitoring reviews, regional reviews and national agency reviews, and a joint donor / MOH external review team evaluates overall performance against plans at the apex of this review process. For non-SWAP projects (eg;

JICA) separate project specific reviews take place, however MOH data monitoring systems are the source of data for reviews for all sides.

There are no separate donor coordination mechanisms in Ghana, however, there are still a number of non-SWAp projects and earmarked activities which require interaction between individual partner representatives and MoH officials in specific technical areas, and separate coordination and planning systems.

The Government of Ghana is firmly in the lead on the SWAp, and GoG has produced all the documents that form the basis for the SWAp. There is currently some tension with partners however about the governments role in "sole" production and ownership of PoW and less donor involvement in policy debates and monitoring,

Management of funds

The POW is supported through The Health Fund, a donor pooled fund which is held in a separate account, and by earmarked project funds which are held and managed in separate accounts at donor level. The EU and DFID are proposing to move to funding the sector programme through general MoF budget support.

Although the Health Fund monies are not tied to specific projects, the funds must be spent within the agreed programme of work priorities. Some earmarked project funds are also channelled directly to specific programmes and activities (as stipulated by some partners, ie. USAID and JICA). Ghana's programme remains a mix with some partners supporting separate projects but within the wider framework of the POW.

Constraints in releasing funds are related to delayed disbursement caused by the government's budget (liquidity) difficulties and by the delay of payments into the health Fund from donors. Some of these delays are due to delays in reporting and accounting for previous disbursements by MoH and its agencies. However some delays are also due to problems arising from delayed transfer of agreed funds from donor countries.

Health sector expenditure

The total expenditure in the health in 2002 was approximately sector \$117m, including Government funds, Internally Generated Funds (IGF) and external aid. This excludes private expenditure (no data is available). IGF relate to cost recovery from MoH agencies etc. Table below shows recent trends in income and spend.

In 2002, \$33m was contributed to the Health Fund (94% of external aid to the sector). Health Fund has been increasing over time as a proportion of donor aid as the number of donors contributing to the Health Fund increases, and those already involved increase their contribution. However, some donors are moving to sector and general budget support. The EU has been doing so for some time. DFID are likely to move soon.

Projected and actual contributions to health sector financing⁹

| | 1997 | | 1998 | | 1999 | | 2000 | | 2001 | |
|----------------------------------|------------|------------|------------|------------|------------|------------|------------|------------|------------|--------|
| | Proj | Actual | Proj | Actual | Proj | Actual | Proj | Actual | Proj | Actual |
| <i>Health Sector Financing</i> | | | | | | | | | | |
| GoG | 81 | 68 | 93 | 85 | 108 | 65 | 119 | 69 | 136 | |
| IGF | 6 | 13 | 7 | 14 | 7 | 15 | 8 | 14 | 8 | |
| Ext. Aid | 40 | 78 | 40 | 56 | 40 | 49 | 40 | 31 | 40 | |
| Total | 127 | 159 | 140 | 155 | 155 | 129 | 167 | 114 | 184 | |
| <i>Health Sector Expenditure</i> | | | | | | | | | | |
| Tot. Rec | 87 | 89 | 96 | 108 | 107 | 106 | 119 | | 136 | |
| Tot. Cap | 40 | 70 | 43 | 47 | 48 | 23 | 8 | | 48 | |
| Total | 127 | 159 | 140 | 155 | 155 | 129 | 167 | | 184 | |
| Shares | | | | | | | | | | |
| MoH Rec / GoG Rec | 10 | 8.4 | 10.5 | 9.9 | 11 | 8.1 | 11.5 | | 12 | |
| MoH Cap / GoG Cap. | 6 | 1.5 | 6 | 1.2 | 6 | 0.04 | 5 | | 5 | |
| IGF / Tot Health Exp | 4.9 | 8.5 | 4.8 | 9.1 | 4.6 | 14.2 | 4.6 | | 4.5 | |
| Hlth Aid / Tot Hlth Exp | 32 | 17.4 | 29 | 14.9 | 26 | 25.6 | 24 | | 22 | |
| Health Aid / Total Aid | 9 | | 10 | 5 | 11 | 6.8 | 11 | | 11 | |
| MoH Tot. / GoG Tot. | 5.9 | 3.9 | 6.2 | 5.5 | 6.9 | | 6.9 | | 7.3 | |
| MoH Total / GDP | 1.02 | | 1.19 | | 1.25 | | | | | |
| Tot Hlth spend.%GDP | 1.8 | 2.3 | 1.9 | 2.1 | 1.9 | | 1.9 | | 1.9 | |
| Hlth Exp / Cap(excl Aid) | \$4.8 | \$4.2 | \$5.3 | \$4.9 | \$5.9 | | \$6.4 | | \$7.0 | |
| Hlth Exp / Cap.(Incl Aid) | \$6.9 | \$8.1 | \$7.4 | \$7.8 | \$8.0 | | \$8.4 | | \$9.0 | |

The total resources required for the health programme of work from 1997–2001 was estimated to be US\$770 million. These were to be mobilized from government tax revenue, private sources and external aid. Government tax revenue was projected to be the biggest source of financing the health sector program forming 64 per cent in 1997 rising to 73 per cent in 2001. Revenue from private sector sources in the form of

⁹ The Health of the Nation: Reflections on the First Five Year Health Sector Programme of Work, 1997 to 2001. MoH, April 2001

internally generated funds was projected to rise modestly by 5 per cent each year from \$6m to \$8m by 2001. 40 per cent of the total required was expected to be contributed by external development partners remaining constant at \$40m per annum. Actual revenue mobilised for the period showed that GOG commitment increased from 1997–1998 and then fell in 1999 but improved again in 2000 amounting to 320.8 Cedis.

Donor funds did not reach their target of 40 per cent and did not go beyond 20 per cent between 1997 – 1999 partly due to under-reporting of direct donor expenditure. However, they increased in 2000 to US\$31m. An unexpected source of funding was commercial credits which were used mainly for capital investment at the secondary level. More resources were mobilised from IGF than projected, practically double that projected. This gives rise to concern that the poor may be increasingly unable to afford access health care. Such concern is deepened by the observation that IGFs have risen faster than fee exemptions.

In principle, there may be some potential for growth in health sector financing from private sources, as long as the poor are not the main contributors. The largest single source of financing for health services was households with 50 per cent of total health spending being out of pocket. Households purchased health services from formal and informal providers, from pharmacies and from government facilities, both formally and informally. Health insurance and other pre-payment schemes contributed very little to health financing during the first 5YPOW. The main policy issue is the extent to which this expenditure should be captured by the government health system and the extent to which the government should see its main role as influencing the choices and quality of treatments that households purchase from non-government providers.

The expenditure patterns indicate that increasingly more funds have been moved to the district level reaching 50 per cent in 1998 and 42 per cent in 1999 as against targets of 37.5 and 39.4 percent respectively. Total spending on health as a percentage of GDP exceeded the target of 1.8 in 1997 to 2.3 and in 1998 it was 2.1 as against a target of 1.9. In 1999 and 2000 the figures were....? Total per capita expenditure on health in 1998 was \$7.8 but dipped in 1999 to \$6.83.

Current issues for SWAp

- How can SWAp arrangements address the funding of key programmes with low performance (ie TB)
- Performance monitoring - detailed monthly or quarterly monitoring is required in addition annual reviews
- Delays in disbursement of funds which is seriously affecting some programmes. Conditions set out in the Common Management Arrangements (CMA) needs include a position on unforeseen problems that may cause delay in completing financial statements, to protect the disbursement of donor funds.

Current policy issues

- Improving access and equity via the introduction of various Health Insurance schemes and better targeting of exemptions for the poor.
- Retention and restructuring of human resources against the onslaught of international labour markets causing severe brain drain, and internal distribution problems reflected by inequity of access to skills.
- Institutional Policy, decentralization and managing performance of agencies under the MoH - clarifying the roles of the MoH and agencies such as the teaching hospitals and the Ghana Health Service.
- The change in nature of donor funds to the health sector from the Health Fund to direct budget support being proposed by some partners (this seems to be well supported by the MOH).

Key reference materials

- 2002 Annual Performance Review, Ghana Health Service, March 2003
- 2002 Health Sector Review Report
- April 2000 Consolidating the Gains: Managing the Challenges, 1999 Health Sector Review, MoH
- January 2003 The Ghana Health Sector Annual Programme of Work 2003, MoH
- April 2003 Annual Report 2002, MoH
- June 2002 Review of the Five-year Programme of Work, 2001 Annual Review (First draft), MoH
- November 2001 Partnerships for Health: Bridging the Inequalities Gap, Second Health Sector Five Year Programme Of Work: 2002–2006. SWAp II, MoH

TANZANIA

Government of Tanzania Health Sector Programme

The Health Sector Programme in Tanzania is relatively mature. Work began in 1997 to develop a Sector Investment Programme. A Code of Practice and Memorandum of Understanding were signed in 1998 and 1999 following a stakeholder meeting to discuss the development of a Sector Wide Approach. The MOU is between "The Partners (Government of Tanzania and Donors) participating in the joint funding of the Health Sector" (MOU 2000), and was updated in 2000 (to relate to the MTEF period 2000/01 - 2002/03).

The Health Sector Reform Programme of Work 1999-2002, developed with a Plan of Action by a joint GoT - donor task force, included a framework for development of a SWAp and outlined the mechanisms for joint funding, through Strategy 8 which focuses on the MOH - donor relationship. Joint Annual Reviews have been held every year since 1998/99, and the Basket Fund (mechanism for pooling funds) has been in operation since 1999/2000. A side agreement with basket partners is signed following the Annual Reviews. A separate Code of Practice was drafted for basket partners in 2002 but is not yet signed: "The Code of Practice document shall deal with general issues relating to the behaviour of partners and government which are not included in the specific memorandum of understanding." (draft Code of Practice, 2002)

Donors

If the SWAp is considered to be the Joint Programme of Work, then most of the bilateral and multilateral agencies are involved, whereby support to elements within the POW is given by the agencies felt to have a comparative advantage. For example DFID and SDC lead on public financing, World Bank on private financing, DANIDA on district health services, USAID on HIV/AIDS, etc. However, if the SWAp is considered to be only the basket funding element of funds orientated towards the health sector, the list is more limited.

The basket fund become operational in 1999/2000 and funds the health sector recurrent and development budget at both central and district level. Contributors in FY03 included DFID, SDC, Royal Netherlands Embassy, DANIDA, GTZ, KfW. NORAD have also contributed in the past. For FY04 onwards, DFID have moved to general budget support, and World Bank funding is uncertain. Due to the reduced level of funding, and the fact that DFID budget support was expected to be replaced by central basket funding, such that the majority of basket funding will now be allocated to local government, GTZ has also withdrawn from the basket for FY04 as its support was targeted specifically at the central level, but KfW support continues. The Development Cooperation Ireland also supports the SWAp in Tanzania.

Sector policy and strategy

The National Health Policy (revised draft 2002), and the new Health Sector Strategy / POW / Strategic Plan (revised draft 2003) comprise the sector policy and strategy. In terms of comprehensiveness, the first HSR POW (1999-2002), referred to Public / Private Mix, covering methods for developing and promoting private sector participation, possible contracting options, legislative requirements, role of professional associations, and including private sector, NGOs, and missions in planning, monitoring and supervising health services. In terms of stakeholder involvement, NGOs sit on the MoH Technical Sub-Committees, should be involved at local level planning, and participate along with other stakeholders in the Joint Annual Reviews of the sector.

The draft HSR POW July 1999-July 2002 represents a single programme of work "which covers all national, regional and district health requirements", and is developed and funded by all participating partners. As such, it forms the sector programme. At the same time, the document makes explicit that "this document is NOT a three year plan in the traditional sense of a plan. Rather, it is a re-iteration of objectives, policies and priorities developed over several years, which are translated into a three year time frame of strategies ... and 'enveloped' in finite resource assumptions." As such, the policy, strategy and programme are fully linked.

The MTEF in operation since 1999/2000 - 2001/02 covers the PRSP priority sectors, including Health, rather than the whole government expenditure framework (60% of planned expenditure in 2002/03). The PRSP was approved in 2000. Policies for health in the PRSP, although phrased differently, and highlighting certain services in particular are broadly in line with the District Health Service strategy which aims to integrate key public health programmes into a basic health package. Similarly, personnel training and private sector promotion detailed in the PRSP reflect strategies within the HSR Strategy / Programme of Work. However, one recent observer has indicated that "it is not clear how adequately the public expenditure implications of the targets identified in the PRSP have been costed over the full-term of the PRSP to 2010 and the extent to which the MTEF programme costings are consistent with these longer-term requirements" (Bird 2002)

GFATM funding has been approved for HIV/AIDS (\$5.4m for one year) and Malaria (\$19m over three years). The malaria funding is intended to fund one element of the National Malaria Medium Term Strategic Plan, and has been programmed into the Malaria Control Programme MTEF. Initial injections of funding can probably be absorbed, but the issue of longer term subsidy and the relative balance of funding between priority diseases remain of concern.

In terms of HIV/AIDS, all funds are outside the framework of the existing strategy, including large sums of money expected from the Clinton Foundation and Bush Initiative. These, along with the resubmitted to TB / HIV GFATM proposal, and the longer sustainability concerns arising from the GAVI funding for new vaccines, are compounding concerns around financing of the sector programme.

Indeed, concern was expressed by the MoF in December 2002 regarding the possible use of parallel systems by GFATM: "We are concerned that the mechanism of aid delivery proposed by the Global Fund against AIDS, Tuberculosis and Malaria, has the potential of undermining government accountability and negate all efforts made so far to improve development partnership and aid effectiveness." (MOH Dec 2002)

Coordination mechanism

A Joint Annual Review takes place, involving a detailed technical review of areas of concern (undertaken by government officials, local and international consultants), and a main review, attended by government, donors, NGOs and other stakeholders including National Health Insurance Fund etc. A SWAp meeting is convened twice a year, once to review the outcomes of the Joint Review and once to prepare for it, involving Government (MOH, PORALG, Finance, Tanzania AIDS Commission), development partners and NGOs.

The Basket Financing Committee meets quarterly to review progress in implementing the annual plan and budget, and to approve disbursement of funding through the basket at both central and local government levels. This is done through review of financial performance from Government systems, and the quarterly technical and financial implementation reports from the local government authorities and the MOH. The BFC is chaired jointly between MOH and PORALG (local government) as both are recipients of basket funding. A specific annual report on the basket fund is also produced by the Accounts Department of the MOH.

Key donors and NGO representatives also sit on the weekly MOH Technical Sub-committee for Health Planning, Budgets, Finance, Reviews. This is chaired by the MOH Directorate of Policy and Planning and meets on a weekly basis to discuss current policy priorities or issues of concern within the sector. This committee acts as the steering committee for the Health Sector Public Expenditure Review update process, and also reviews progress with the development of the revised Health Sector Strategy etc.

The Government (MOH and/or PORALG) chair the regular fora for coordinating the sector programme, the Annual Review (Principal Secretary), the Basket Finance Committee and the Technical Sub-committee. The success of the recent Annual Review has been ascribed partly to strong government leadership. However, a Donor-specific mechanism, the Bilateral and Multilateral Health Forum, currently chaired by DFID, also meets monthly for most of the year, and more in the run-up to the review. Some partners are also still mandated to undertake separate reviews, although most try to harmonise this to some extent with the Joint Annual Review process. DANIDA / World Bank hold their reviews just after the Annual Review, so that the outputs feed into their review, and UNFPA / USAID reviews are just before or during technical review.

Management of funds

Basket funds are held in a separate account, and channelled directly to MoH and districts from the MoF. General budget support is merged with the overall government budget and allocated according to the broader process of inter-sectoral allocation. First and second quarter basket funds are generally released automatically. Satisfactory reporting at the Basket Finance Committee for the first quarter is the trigger for the third quarter release, and similarly for the fourth quarter. Some problems have been experienced with procurement, and so basket funding procurement was undertaken through an agent, funded from the DFID contribution to the basket. This has recently ceased due to the DFID switch to general budget support.

Other delays are experienced in the release of funds, including:

- late receipts of plans and budgets
- delayed release of funds by development partners into the Holding Account
- delays in the triggers for release, ie BFC gets postponed or reports are not circulated in advance
- capacity at local government leading to failure to submit implementation reports or inadequate reporting
- delays at the Treasury between the Holding Account and the Consolidated Fund and on to the LGAs

Health sector expenditure**Total public health expenditure in Tanzania, FY98 – FY03**

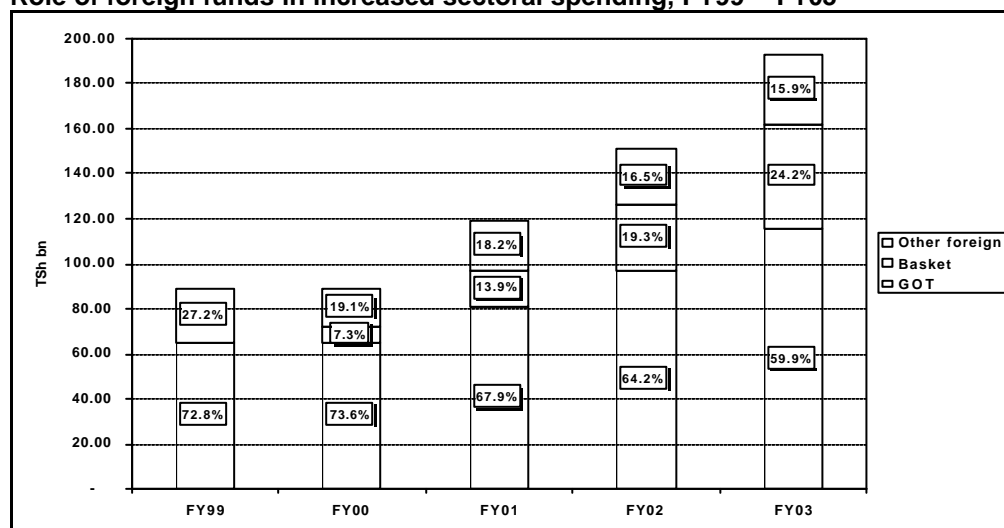
| | 1998/99 | | 1999/2000 | | 2000/2001 | | 2001/2002 | | 2002/2003 |
|-------------------------------|---------------|---------------|---------------|---------------|---------------|---------------|---------------|---------------|---------------|
| | Budget | Actual | Budget | Actual | Budget | Actual | Budget | Actual | Budget |
| Recurrent | | | | | | | | | |
| MOH | 37.25 | 37.15 | 39.20 | 32.39 | 49.39 | 44.25 | 61.60 | 58.99 | 86.94 |
| Region | 9.25 | 8.68 | 9.36 | 9.01 | 6.21 | 5.61 | 7.06 | 6.58 | 7.60 |
| Local Govt | 15.72 | 16.34 | 18.69 | 17.95 | 36.35 | 35.67 | 46.26 | 46.28 | 57.66 |
| Total rec. | 62.21 | 62.18 | 67.25 | 59.34 | 91.95 | 85.53 | 114.92 | 111.86 | 152.20 |
| Development | | | | | | | | | |
| MOH | 21.21 | 17.27 | 17.75 | 10.19 | 20.47 | 14.84 | 32.07 | 21.12 | 33.78 |
| Regions | 5.00 | 0.67 | 2.57 | 0.79 | 4.62 | 1.39 | 2.35 | 1.28 | 4.75 |
| Local Govt | 0.62 | - | 1.18 | 1.06 | 1.73 | 1.52 | 1.70 | - | 2.04 |
| Total devt | 26.83 | 17.94 | 21.50 | 12.03 | 26.81 | 17.74 | 36.12 | 22.40 | 40.57 |
| Total on budget | 89.04 | 80.11 | 88.75 | 71.38 | 118.76 | 103.27 | 151.04 | 134.26 | 192.77 |
| Off budget expenditure | | | | | | | | | |
| Cost sharing | - | 1.09 | - | 1.49 | - | 1.86 | - | 1.37 | 1.20 |
| Other foreign funds | 35.55 | 42.76 | 52.33 | 60.04 | 59.41 | 75.00 | 66.14 | 79.37 | 49.25 |
| Total off budget | 35.55 | 43.85 | 52.33 | 61.53 | 59.41 | 76.86 | 66.14 | 80.74 | 50.45 |
| Grand total | 124.58 | 123.96 | 141.08 | 132.91 | 178.18 | 180.13 | 217.18 | 215.01 | 243.23 |

Source: MOH 2003, *Health sector PER update FY03*. Final draft. Table 1

These figures are subject to various caveats - the precise volume of external funding off-budget, incomplete estimates of cost-sharing revenues, small additional expenditures by other ministries. There is also some debate on the contribution of Government to the National Health Insurance Fund. Contributions have been made by the MoF on behalf of civil servants, but these have not yet translated into expenditure by the NHIF.

The planned level of basket funds in FY03 was stated to be US\$41.7m (side agreement signed after the April 2002 Joint Health Review). Revised figures for FY04 were US\$ 23.13m, but may well be subject to revision. It is difficult to determine the total extent of donor funds, due to different figures being supplied from different sources (MoH development budget, MoF External Finance Department database, or donor reported actual). However, it has been estimated that basket funds make up between 45%-48% of donor funds to the sector.

This has been increasing up to FY03, as shown in the figure below. However, the move by DFID to general budget support (earmarked to the central MOH budget for the FY04 only), together with uncertain funding from the World Bank, and the withdrawal of GTZ, means that the basket funds for FY04 onwards have shrunk substantially as a proportion of the MOH budget. Following the 2003 Annual Review, Government established a special committee to explore the implications of moving from basket to general budget support.

Role of foreign funds in increased sectoral spending, FY99 – FY03

Source: MOH 2003, *Health sector PER update FY03*, Final draft, Figure 5

Current issues for SWAp

- Pressure to demonstrate impact, with particular attention to the poorest of the poor
- Improved service quality and coverage, again for the poorest of the poor
- Good governance and fiduciary risk, particularly at the local level
- PER FY03 findings and the government commitment to financing the health sector
- Need for improved costings within the sector

Current policy issues

- ARVs and the ambitious health sector HIV/AIDS plan, including scaling-up of PMTCT
- Possible new HR strategy
- Reproductive health and the need to improve on falling figures for delivery by qualified personnel

Issues which arose for the coming year at the April 2003 Joint Review include:

- Role and staffing of the Regional Secretariats to enable them to provide the necessary support to local government authorities
- Clarity on financing of the sector - is basket funding replacing government funding as per PER update FY03? Special committee established to look into this.
- Sectoral performance monitoring and the need to demonstrate impact
- Human resources - remuneration, both generally and incentives for hard to reach areas
- Cost-sharing and protection of the vulnerable so that policy is consistent with the pro-poor policy focus

Key reference materials

- GOT, 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 Government of Tanzania Health Sector Programme based on the Health Sector MTEF 2000/2001-2002/3
- MOF, Brief note on funding mechanism (with reference to the Global Fund against AIDS, Tuberculosis and Malaria), Ministry of Finance, Dec 2002
- MOH Draft Health Sector Reform Programme of Work July 1999 - July 2002
- MOH 2002, Tanzania Joint Health Review 11 - 13 March 2002: Main report. 22 March 2002
- MOH PER 2001, and update for FY 2002/03
- A Bird 2002, Design and implementation features of Medium-Term Expenditure Frameworks and their links to poverty reduction: Tanzania country study. Part of a multi-country study by the Overseas Development Institute, funded by DFID and the EU.

MOZAMBIQUE

FASAUDE Support to the health sector, Mozambique

The Sector Wide Approach in Mozambique is work-in-progress. There are 3 common funds which donors contribute to. At present, not all donor support is on budget and bilateral projects exist. The PESS (health sector strategic plan) and a list of indicators were defined jointly, and there is an annual joint review.

Donors

Norway, UK, EU, Netherlands, Switzerland, and Ireland are all in the SWAp with a rotating focal donor. France recently joined, but is more passive, as is DANIDA. At present, Italy, Spain, Portugal, Germany, and Sweden are not in the SWAp.

Sector policy and strategy

Mozambique has a comprehensive sector policy and strategy (PESS). The SWAp activities are entirely linked to the PESS, and there are no elements outside the SWAp. Health related policy formulation is conducted under a strong central MoH lead. Provinces are rarely involved in the setting of policy at a national level, and other stakeholders are involved even less. The future role of NGOs is under study.

Mozambique also has a Medium Term Expenditure Framework. However, there is little consistency between the MTEF and the big new players in the health sector, such as the GFATM, Clinton Fund and MAP funding,, which offset the entire MTEF. Bilateral donors insist that all new funding to the health sector should be within existing procedures and systems, however multilaterals continue with vertical programmes, and will not join pools or common funds. It is still important that all funds are 'on planning' if not 'on budget' however, and so the MTEF is currently being revised to take account of these, and to better reflect the HIV-AIDS epidemic.

Coordination mechanism

The coordination between partners and government is good in Mozambique. A SWAp Working Group meet every two weeks, the Code of Conduct 2000 is currently being revised in the light of recent developments, and a Memorandum of Understanding is in draft for the new "Fundo Commun Geral" (general funding pool).

There are also common / joint reviews once a year. These have been operating since 2002. A single set of indicators (defined jointly by MoH and donors) guides the monitoring of the sector for all partners involved. However separate evaluations still exist for some donors, and separate donor planning and coordination mechanisms also exist. The aim is these latter mechanisms will be phased into a comprehensive integrated planning at central and provincial levels. The new Code of Conduct would ban these parallel mechanisms.

Government leadership of the process is increasing over time, however the Government of Mozambique is currently struggling to upgrade and strengthen its capacities to absorb additional funding and work, and so this role is still developing.

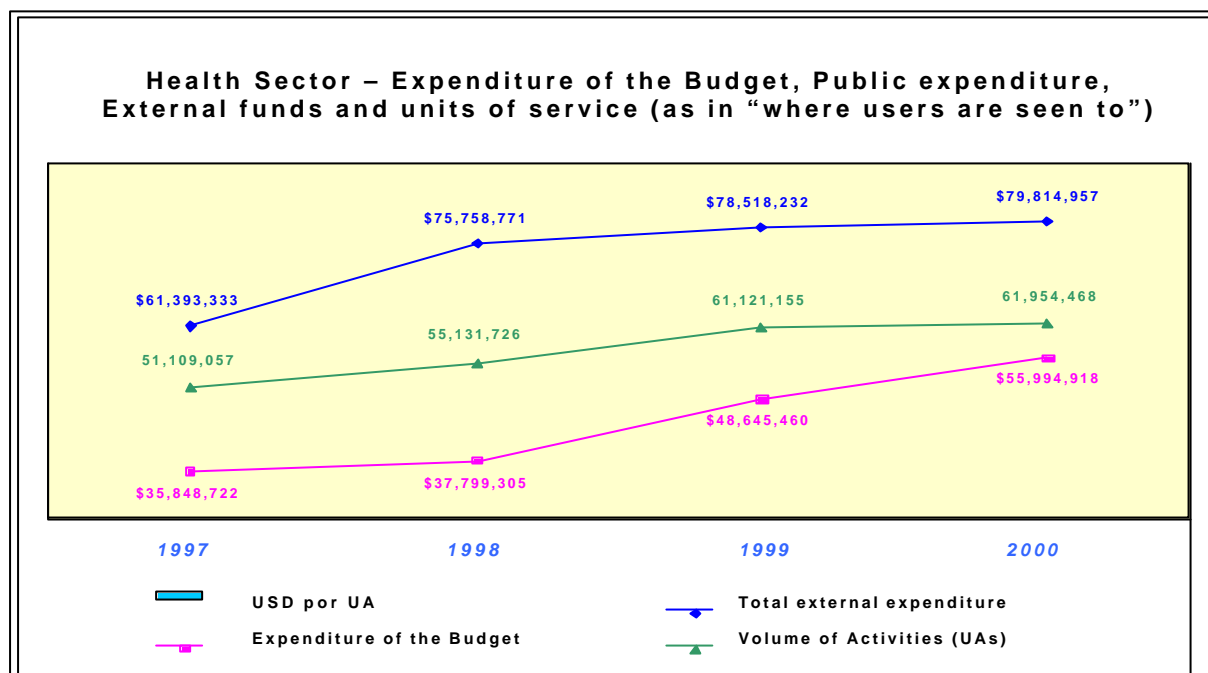
Management of funds

There are 3 pooled funds. All SWAp funds should be transferred directly into the MoH budget, with no limits or earmarking, using state budget lines, with management the responsibility of MoH (central and provincial level). This currently occurs for the the general fund, and the aim is that the drugs pool (currently managed at the national level by SDC), and the Provincial budget support (also managed by SDC at present) will completely pass to the MoH for management by 2004.

Funds are released twice a year for drugs, and for the Fundo Commun de Gastos Correntes (funding pool for recurrent costs), and on a quarterly basis for the new "Fundo Commun Geral" (general funding pool). Funds are released against plans and budget execution of pre-previous term. A major threat is the high risk of erratic financial flows (liquidity problems), at Ministry of Planning and Finance level if external and State funds are fully merged. That is why 2 of the 3 pools are managed off-budget at present. A new financial management system is expected to be put in place and functioning by 2004 when the funds will transfer.

Health sector expenditure

The figure overleaf shows the expenditure of the budget, public expenditure and external funds for the period 1997-2000. Total external expenditure for health is shown against budget (\$80m as against \$56m in 2000).



In terms of funding the SWAp through the common pools, results from a survey of all external donors, and the institution that manages the funds currently being carried out are shown below (work in progress, May 2003). These indicate predicted future funding (in Euros) to the common funds, and indicate that funds to the pool are increasing over time. They also show that this is increasing as a proportion of total external aid.

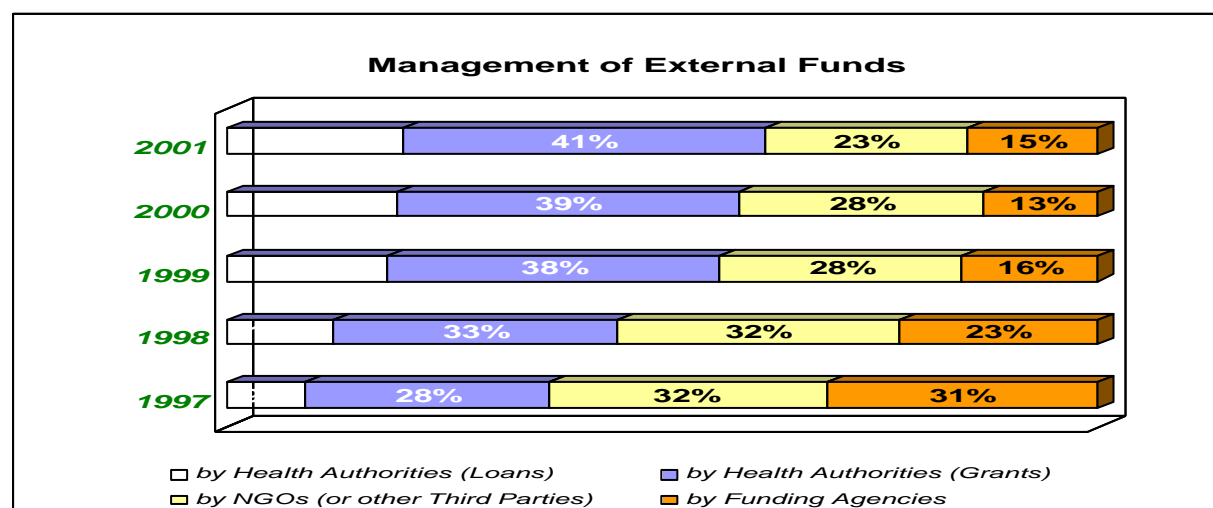
| Year | General Pool | Pharmaceutical Pool | Provincial Pool |
|------|--------------|---------------------|-----------------|
| 2003 | 8,526,075 | 20,751,349 | 6,216,061 |
| 2004 | 15,484,797 | 16,668,562 | 8,757,291 |
| 2005 | 14,720,030 | 7,299,240 | 6,485,932 |
| 2006 | 10,828,278 | 6,499,240 | 6,469,481 |

NB: Data for 2005 and 2006 is incomplete

The decrease in tied aid, and in funds which are managed by the funding agency (or NGO) are shown in the table below and the associated figure. The table shows the type of external contributions received over the same period 1997-2000, and the figure below indicates how these funds are managed, and by whom.

| | 1997 | | 1998 | | 1999 | | 2000 | |
|---------------------------------|---------------------|-----|---------------------|-----|---------------------|-----|---------------------|-----|
| Donations | \$45,715,728 | 74% | \$59,378,500 | 78% | \$59,900,832 | 76% | \$57,295,527 | 72% |
| Loans | \$5,614,606 | 9% | \$9,389,112 | 12% | \$14,669,131 | 19% | \$15,610,419 | 20% |
| Ajuda “Condicionada” (Tied Aid) | \$5,165,000 | 8% | \$171,405 | 0% | \$449,260 | 1% | \$427,712 | 1% |
| Without information | \$4,898,000 | 8% | \$6,819,754 | 9% | \$4,499,008 | 4% | \$6,481,299 | 8% |
| Total | \$61,393,333 | | \$75,758,771 | | \$78,518,232 | | \$79,814,957 | |

Management of the external funds 1997-2001



Current issues for SWAp

- Inadequate capacity to absorb so much money with the current level of capacity to manage and implement
- The process of supporting the health sector to do its own planning (NGOs, vertical programmes by multilaterals, bilateral programmes, pooling, etc)
- Weak capacities to plan and monitor
- Lack of supervision
- Build in confidence in Government capacities, such as switching from donor to State-controlled auditing.

Current policy issues

- HIV-AIDS strategy
- Institutional development
- The public sector and salary reform
- Maternal mortality

Key reference materials

- Análise do Financiamento Externo para o Sector de Saúde, 1997-2000, com Estimativas para 2001-2003.

SENEGAL

Programme de Developpement Integre du Secteur de la Santé et de l'Action Sociale d'Investissement Sectoriel (PDIS).

The PDIS represents the programmatic translation of the objectives of the Plan National de Developpement Sanitaire et Social du Senegal (PNDS) into a series of 5-year development plans. PDIS is the equivalent of the SWAp and is based on a programme approach, involving the coordination of donor interventions and funding for the health sector in accordance with prior-fixed objectives and work plans.

The PDIS programme started in 1997 for 5 years, ending in 2002. A second phase has been agreed from 2004-2008. This year (2003) is a bridging or transitional year to enable activities planned under phase one but uncompleted to be finished. Evaluation was carried out at the end of phase one, however performance was generally considered to be less than satisfactory.

Donors

The World Bank is the lead donor in terms of funds, and the most active key player. Other key players are the African Development Bank (ADB), UNICEF (for EPI) and the Danish Assistance (known as the Fonds Nordic). The European Union is nominally a participant in the PDIS but has tended to manage its funding somewhat more directly than the other three mentioned. USAID and JICA are outside the PDIS framework, preferring a project approach. It also appears that the French Aid lies outside the PDIS framework.

Sector policy and strategy

The PNDS is the general strategic plan and framework for health sector development, within which the PDIS was developed. The PNDS comprises 11 strategic orientations, of which promotion and support for the private sector, including NGOs and traditional medicine, is the eighth. As the PDIS is a direct translation of the PNDS goals into five year plans of work with set targets and performance indicators, they fit completely. There does not appear to be an MTEF in place at the moment in Senegal. A PRSP was approved in January this year, however the contents of the health component are not widely known, and impact is yet to be felt.

Funding mechanisms such as GAVI and GFATM were not included in the PDIS, and Senegal has already benefitted from both (GAVI extension of EPI to include hepatitis B and GFATM money towards malaria, TB and AIDS treatment (ARVs)). These sums are large both in relation to previous funding for the activities and also in relation to donor contributions to the PDIS. They are already affecting the pattern of health financing, although the longer term impacts of this are yet to be seen. One example quoted is that of an NGO in Senegal that USAID had decided to stop funding because they were not performing, however they are now receiving more than they previously received through a huge influx of funds from GFATM.

In terms of involving stakeholders in policy formulation, the annual PDIS work plans are usually a synthesis of the health development plans of the regions and districts and those at the national level, and involve close collaboration with donors and development partners. In addition, Senegal has a fully decentralised health services, with budgeting and management devolved to local levels and elected health committees run health facilities. The annual implementation plans of these local management units involves consultation with many local actors including NGOs. While the donors participate actively in monitoring, the involvement of other local stakeholders outside the MoH is rather less significant. There is however a person at the PDIS responsible specifically for coordinating the relations with and participation of NGOs in the health sector.

Coordination mechanism

There is an annual review of the PDIS involving the MoH and all the donors, known as the RAC (Revue annuelle collective). The purpose of the review is to examine the budget proposals of the PDIS and its past activities during the year. The PDIS does not involve a common basket mechanism as yet, but there is an officer in the PDIS per each donor involved in this programmatic collaboration, responsible for regular coordination of the relationship between PDIS and that donor. Donors and agencies involved in EPI have a separate coordination mechanism, however there is not a separate donor mechanism for the health sector.

Government leads the SWAp mainly through MoH staffing of the CAS, the unit that executes the PDIS workplan and coordinates the donor interventions. This unit prepares the budgets and calculate the share for each donor in accordance with pre-agreed criteria and areas of interest. Donors have the right to object (often resulting in delays in execution), but the MoH has the lead role in making the plans and proposals. The Government's role is going to increase with the new budget financing system being considered.

Management of funds

The donors participating in the PDIS currently do not put their funds into a common account, but rather, once their share of the budget is agreed (and they are informed by the CAS), release their funds for the programmes identified in accordance with procedures laid down before hand. Release of funds have to be signed off by the MoF (except for small expenses where the MoH can approve), and then the donors pay directly for costs associated with their programme interventions within the PDIS process.

Health expenditure

Partner shares in health financing (1999): Govt 53%, Donors 30%, User Fees 11%, Local Authorities 6%. It was not possible to obtain accurate information on health spending in Senegal due to lack of data in-country.

However, it can be shown that funds directed towards the SWAp have been increasing over time; expenditure within the PDIS (SWAp) framework for the first 4 years show funds increasing from \$67.6m in 1998 to \$137m in 2001. It is not possible to identify this as a proportion of all donor funds, but donors in the PDIS have agreed to move towards sector budget support during the next PDIS phase, beginning in 2004.

Current issues for SWAp

The main issue at present is administrative bottlenecks and long procedures involved in getting donor funds released on time for activities. The EPI is a case in point - the last campaign was postponed because money was not available on schedule to purchase the supplies. Donors also allude to a need for greater transparency in the PDIS.

Current policy issues

Prevention is a major preoccupation at the current time. A new Department for Prevention, one of two under the MoH, has been created to put greater emphasis on promotional and preventive activity. Within this, the prevention of malaria, tuberculosis, AIDS as well as promotion of the EPI vaccines, takes priority.

Another key policy issue at the moment is the need to improve the PDIS financing mechanism, widely blamed for introducing delays and inefficiencies in the funding of health sector programmes. It is now widely accepted that a budget approach would be better than the present programmatic approach.

Health financing alternatives (to user fees) are also being actively discussed and a new law has just been passed to encourage the development of mutual health organisations across the country.

Key reference materials

- Plan National de Developpement Sanitaire et Social du Senegal (1998 - 2007), Ministere de la Santé Publique et de l'Action Sociale, Mars 1997
- Plan stratégique de PDIS (5-year D-Plan)
- Annual reports of the RAC (Revue Annuelle Collective)

BANGLADESH

Health and Population Sector Programme (HPSP)

The HPSP is approaching the end of first five year plan (in June 2003). The programme is currently stalled due to change of policies on reform elements of HPSP by Government following election with change of Government mid plan. World Bank DCA (the agreement which governs the SWAp) was recently suspended and pooled funding disbursement has been suspended. However, most health outcome indicators have improved during the HPSP period. There is a general consensus that the introduction of the SWAp generated substantial one-off organisational efficiencies and strategic benefits. The key milestones:

- Health policy approved in 2000 - some linkage to the sector programme
- Health sector strategy (Health and Population Sector Strategy (HPSS) approved in 1997 - prepared with all stakeholder consultation and is the basis for the HPSP (POW)
- Resource / financing plan for the sector for five years formulated and a system of annual operational planning covering all financing sources installed and operational
- Five donors (WB, EC, DFID, Dutch and SIDA) have pooling arrangement with the GOB - others either have parallel arrangements or go through GOB financing which was agreed before the implementation
- MOHFW manages the implementation of the plan - bi-annual reviews have all DPs participating;

Donors

The key players for the SWAp are the WB and DFID with major support from most bilateral donors, including USAID and JICA. Multilateral UN agencies are supportive. However, a large number of funders continue to support from outside the pool (USAID, UN agencies, Japan and ADB). USAID, with significant investment in the Bangladesh Health Sector, remains the main non-pool funder on both theoretical (principally that they do not fully support the SWAP approach as they have concerns over outcomes) and financial (that the SWAP mechanism does not meet their requirements for disbursement or accountability) grounds.

Another reason for donors maintaining parallel funding may be that they are unsure of their role in a SWAP process. It is interesting to note that even donors who have committed all their money to the pool have continued to conduct bilateral negotiations with MOHFW.

Sector policy and strategy

Formulation of HPSP commenced with the Health and Population Sector Strategy (HPSS), followed by the Programme Implementation Plan (PIP). These are now been incorporated into The National Health Policy. Approval of the HPSS was one of the agreed milestones to have been achieved before pre-appraisal of the HPSP by donors. The HPSS received strong political and general support and was accordingly approved by the Executive Committee of the National Economic Council (ECNEC). This approval at the highest level of government legitimised the HPSS and the subsequent HPSP, even in the absence of a health policy.

The sector strategy covers the role of private and NGO sectors, but much less completely than the public sector. The Health Policy also suggests several areas that private sector, NGOs, and traditional practitioners will be "encouraged to perform complementary roles to those of government." In addition, the Development Credit Agreement states 'development and implementation of a framework for borrower-NGO cooperation'. However, the HPSP program specifies very little funding or other resources to achieve this. There was wide consultation during planning phase, but there has been little consultation during implementation.

The sector programme is closely linked to the sector strategy but to a less extent to the policy. A logical framework was developed to ensure an integrated approach, a clear policy and strategic framework and clear links between sector policies and expenditure plans. From the logical framework, the costed Programme Implementation Plan and individual detailed costed Operational Plans were developed which identified the specific activities to be carried out and planned use of resources. The approach provided integrated management and a common approach to reporting and performance monitoring arrangements.

The SWAP consists of those activities coming directly under the remit of the Ministry of Health, and funding for HPSP reflects this. Therefore, some major health related activities are not directly reflected. These include a major nutrition project and health related activities implemented by other ministries, parallel donor projects and future funds from the global initiatives (GFATM funds are due in the second phase of SWAp).

In terms of wider policy, a PRSP has just been agreed by GoB and donors, and MTEF planning is underway.

Coordination mechanism

In the Bangladesh SWAP there is no formal memorandum of understanding between the SWAP partners that defines their relationship or roles or responsibilities. The document that acts in this role is the formal credit agreement between the GOB and the World Bank. This is seen as a difficulty. However, joint reviews are undertaken on a bi-annual basis (although heavily donor-led, and without other stakeholders), and Consultative Committees meet regularly to jointly approve plans and review progress and inputs. A set of indicators has been agreed to monitor the HPSP in addition to standard government formats, and there are well-established APRs, APIRs etc. for monitoring in place.

However, individual donors have continued with independent reviews of their components, and there are also three separate coordination mechanisms in place for donors and agencies. The Local Consultative Group (LCG) has members from all development partners whether they are funding through MOHFW or not, there is a Health and Population subgroup of the LCG which meets regularly for those development partners funding the health sector, and there is also the Steering Committee of the HPSO. The WB offices the HPSO and has agreement with most partners (except the UN organisation) to monitor for the donors.

In terms of involving other stakeholders in the co-ordination mechanism, a Line Directorate, and a focal point for inter-governmental and non-governmental (including private) co-ordination is proposed under HSPPS, to include a National Co-ordination Committee for Inter-Sectoral and Multi-Sectoral Collaboration with the Secretary, MOHFW as its chair, and the concerned LD as its member secretary. Membership would include relevant Ministries, all concerned LDs, representatives from NGOs, the private sector and civil society.

The leadership role of the Government of Bangladesh is generally seen to be increasing, however this has very recently resulted in a breakdown of relations with donors as GoB have made decisions contrary to the spirit and letter of DCA without consulting donors. Specific achievements are indicated below:

- It placed the health needs of the poor firmly on the agenda.
- It changed the way the MoF and the Planning Commission conduct business with the MoHFW.
- It changed the relationships between the MoHFW and its development partners.
- It changed the nature of the relationships between the sector's development partners.
- It has allowed joint management and supervision mechanisms to be developed.
- It has given MoHFW more control over budgetary resources.
- It has allowed sector managers to take a broad view of the sector's needs and priorities.
- It has reduced the costs of expenditure approval by incorporating these into Annual Operational Plans.
- It has improved accountability.

Management of funds

HPSP funds are managed by the World Bank in a separate account, reimbursed in arrears. There is a complicated formula in place to identify the proportion to be funded by each partner, based on percentage reimbursements against different predefined categories of funding. Percentage reimbursements against categories are variable and often used as conditionality in annual discussions against compliance / outputs.

Funds are released on the basis of quarterly Statements of Expenditure produced by the Government. Turn around is generally good, and this is quoted as one of the successes of the SWAp. The main bottleneck is the reconciliation of MoF figures from the general accounting system with MOHFW expenditure data.

Health sector expenditure

The resource envelope for HPSP (over 5 years of the project):

| Funding source | US\$ million |
|-----------------------|---------------------|
| Govt recurrent | 1,035.0 |
| Govt development | 298.5 |
| IDA & Pool | 396.5 |
| Bilateral | 416.8 |
| Total | 2,146.8 |

There are three ways for partners to contribute to the health system under the SWAp: Pooled Financing System, Pool fund plus and Bilateral & Parallel Financing System. These are described below.

Pooled Funds in HPSP:

IDA, DFID, The Netherlands, SIDA & EC are five pooled funders in HPSP. Their total contribution in the pool is around US\$ 400.00 million over the 5 years (IDA=US\$ 200.00 million & other DPs US\$ 150.00 million). During the first two years the pool had a total of US\$ 341 million from IDA, DFID, SIDA and the Netherlands. In the third year, the EC also joined contributing US\$ 61 million to the pooled financing arrangements. Within the World Bank trust fund some donors agreed that their money would be included, but earmarked, ie not fully in the pool, or ring fenced for particular activities. The Netherlands are probably the purest "SWAPer", to date committing their money totally to the pool fund and resisting and arguing against parallel funding.

Pool fund plus:

Some partners committed to the pool also continue parallel funding outside the pool. While these activities are reflected to a greater or lesser extent in the AOPs, the funding is direct from the donor to the agency. An example of this approach is DFID. DFID is a pool funder, but funds TA to support HPSP directly and funds NGOs in support of HPSP through the directly managed Bangladesh Population & Health Consortium.

Bilateral & Parallel Funders in HPSP:

DFID, CIDA, GTZ, KfW, IDB, JICA, ADB, SFD, GAVI, UNICEF, WHO, UNDP, UNFPA etc. are bilateral DPs.

Current issues for SWAp

Major MOHFW efficiency reforms are tied up in the new programme as SWAp has been introduced. These repudiated by new government for political reasons leading to breakdown of relations with donors.

Current policy issues

Efficiency reforms of MOHFW, mandated as part of the introduction of the SWAp:

- Unification of separate health and family welfare divisions
- Management reforms at Ministry level
- Reforms of budgetary and financial disbursement mechanisms

Relations between partners have also been under pressure. Issues related to the involvement of the NGOs and Private Sector will be additional key policy matters for discussion between the DPs and the government.

Key reference materials

- Health and Population Sector Strategy (HPSS), 1997
- Health and Population Sector Strategy (HPSS), 1998
- Health and Population Sector Programme, Annual Programme Review, Independent Technical Report, April 1999
- Health and Population Sector Programme, Annual Programme Review, Independent Technical Report, Dec 1999
- Health and Population Sector Programme, Annual Programme Review, Independent Technical Report, April 2000
- Health and Population Sector Programme, Annual Programme Review, Independent Technical Report, Dec 2000
- Health and Population Sector Programme, Annual Programme Review, Independent Technical Report, May 2001
- Health and Population Sector Programme, Mid-Term Review, Nov 2001
- Health and Population Sector Programme, Annual Programme Review, Independent Technical Report, January 2003
- Health and Population Sector Programme, Annual Programme Review, Independent Technical Report, May 2002
- Management Capacity Appraisal, 1998

ZAMBIA

Zambia Health Reforms

The Zambia Health Reforms have been running for 11 years.

Donors

SIDA, DANIDA, Netherlands, DFID, WB, USAID, UNICEF, WHO, UNFPA, JICA, Development Cooperation Ireland

Sector policy and strategy

A National Health Policy has been in place since 1991. The first National Health Strategic Plan 1998-2000 was followed by the NHSP 2001-2005, in January 2001. The NHSP was supplemented by the MOH Action Plan 2001, CBOH Action Plan 2001 and the Joint Investment Plan and Manual 2001. These included NGO activities in detail (including Churches Medical Association of Zambia) and some private sector activities. A PRSP been prepared for Zambia, but is not yet consistent with sector programme expenditure framework.

The sector programme is linked to the sector policy and strategy through the annual health sector plans. Most CPS and GRZ activities and funds are in the sector programme. WHO and UNFPA are uncertain.

Coordination mechanism

Donor coordination meetings were held on quarterly basis in the first five years of reforms. The CPS who are in the basket also have an informal mechanism/ platform, and GRZ have Joint Coordination Committees.

Separate project reviews still exist, but have been reduced or streamlined to fit with Annual health review.

Stakeholders are usually invited to participate and input during the formulation of policy documents, which are then tabled to the ministers for comments and to provide guidance before they are finalised. New policy issues are taken by the Health minister to cabinet through cabinet papers, where politicians can input. Other ministers, under the chairmanship of the President debate the policy proposals, and either adopt the policy or refer back.

In terms of monitoring, a Monitoring and Evaluation Sub-Committee of the Donor Coordinating Committee is chaired by the Director of Planning, and includes donor and NGO representatives.

Government leadership in the reforms was rose significantly from 1991 to 1998, however political change caused key players and institutional memory to be lost. The situation has been improving again from 2002.

Management of funds

The application of SWAP principles in Zambia have been more successful at district level. Implementation at central level has been problematic from 1998 onwards. Separate accounts for district donor basket funds exist at central level for channeling money to the district health boards. Districts also have separate accounts for the same. Govt funds are also channelled to the districts separately - they are not pooled and do not mix.

The release of District Basket Funds is conditional on successful submission of Technical implementation progress reports and financial statements on a quarterly basis. The Basket Committee then releases the funds to recommended councils. Government funds are released also on quarterly basis. Problems include government meeting its commitments in funding and delivery of adequate drugs and supplies

Health sector expenditure

In 1998 the total amount of resources available the health sector was 14 USD per capita. Of this 14 USD, approximately 57% was from the government and IDA loan, 31.5% from cooperating partners and 11.5% from the community.

At that time the rate of the local currency was 1USD to 1,500 Kwacka but the local currency is now about 1USD to 4,700 Kwacha, so USD per capita is likely to have reduced drastically.

DFID was intending to move to sector budget support, but this has not materialised as yet, as improvements to financial management and accountability still need to be undertaken.

Current issues for SWAp

Trust between the government and the partners especially relating to addressing corruption, transparency and financial accountability, good government, political leadership and government honouring commitments.

The Zambian reforms which by now should have been a shining example to the rest of Sub Sahara Africa slid backwards because of a combination of most of these problems, including lack of political commitment to reforms at top leadership especially Ministers and Permanent secretaries from the years 1998 to 2001.

Current policy issues

Strengthening on going decentralisation through:

- autonomous boards applying deconcentration
- improved financial management, and financial performance
- redirection of funding from centrally managed projects to funding activities defined locally
- implementation of defined EHP
- implementation of human resources development especially competencies of staff
- increased community involvement
- strengthened role of private sector in the provision of health services
- radical streamlining of the central bureaucracies (central, CBOH and the provinces)
- change of MoH to purchaser and CBOH with district health boards to contracted providers.

Key reference materials

- Zambia National Health Policy 1991; NHSPs; Minutes of the sub committee on M&E, 2003 (e-mail)

MALI

PRODESS

The sector programme, PRODESS is currently at the stage of implementation, review and extension.

Donors

WB, WHO, UNICEF

Sector policy and strategy

There is a comprehensive sector policy which was established in the beginning of the 1990s. This lays the foundation for the national health system, establishes the framework for action, and defines the role of key health partners, including the roles of the NGO. The health system in Mali is highly decentralised, with devolution and semi-privatisation of health service delivery on local levels.

Planning starts at District level. In theory all actors at district level participate including Civil Society and Local Government Authorities, but in practice it is dominated by the Government District Health Team. The district plans are compiled at Regional level, and the plans of the Regional Health Team are added. Here again all regional actors participate including bilateral / multilateral agencies involved in the region and central MoH.

The plan is then approved by a National Technical Committee including RHTs and technicians from some Civil Society Organisations including NGOs and multi/bilateral donors. The last step is a Management Board meeting (Comité de Suivi) which is supposed to be a more political dialogue but in practice is more a rubberstamping of the decisions made by the National Technical Committee (Comité Technique). Comité Technique and Comité de Suivi meet twice a year for monitoring and or (adjustment of the) planning.

Civil Society (including NGOs) have not been well organised to date, and their capacity has been insufficient to be an effective player in the policy dialogue. However, this is improving at regional level, and increasingly NGOs can also be seen contributing to the policy dialogue at national level. Politicians influence specific issues of the sectoral programme, for example the decentralisation, hospital reform, essential drugs supply.

There is a close link between the sector policy and strategy and the sector programmes. A few vertical programmes are still running, but the policy is to integrate these into the wider SWAp. There is also a high degree of congruence between the sector programme objectives, the policy and strategy and the PRSP.

Coordination mechanism

Regular meetings take place between the CEPES (Partners Coordinating Unit at the MoH), and other development partners. A Memorandum of Understanding, and Principles of Cooperation exist. There is also a monthly 'donor coordination' meeting organised by the donors. A representative of the MoH is present, but these are not regarded as planning meetings.

Government chairs the partner meetings, sends the invitations, takes the minutes, as well as drafts the TORs for taskforces and consultancies. The calendar of activities is also determined by the MOH. However some donors try to influence the MoH to include their preferred activities into the annual plans, and it is not always possible for the MoH to resist those activities by some donors. Recent changes in senior staff has affected the ability of Government to lead the SWAp, however it is expected that this will improve again in time.

The planning and monitoring system is computerised and therefore used to create the joint SWAp plans / reports. However some donors require separate reports and separate reviews of their individual project.

Management of funds

There are all kinds of financing mechanisms:

- 1: macro-economic general budget support conditioned on progress in the health sector indicators
- 2: targetted (geography, level of care, kind of diseases) budget support on special accounts
- 3: basket funding managed by MOH; basket account
- 4: programme / project support national execution; special account
- 5: programme / project support donor execution; donor account

Funds are released on the basis of annual plans and reports. Quality (content, completeness) is crucial. However, the MOH often experiences difficulties in compiling these reports, and analysis of the information can be superficial. Major bottlenecks are the capacity of the Planning Unit and the Financial / Administrative Unit of the MOH to produce these reports, and the demands of donors regarding reporting periods, which can often be different to government standards. Harmonisation of procedures including planning and reporting documents between donors and MoH needs to be linked to strengthening capacity of MoH.

Health sector expenditure

Approximately US\$ 34 per capita. Out of pocket expenditures are estimated to be in the same order. Of the public funding, around 50% is provided by the donors. Pooled funding is only around 7% of the budget. In 2002, 53% of the budget was to be provided by the donors. In 2003 this is expected to be 54%.

Pooled donor funding is increasing slowly due to an increasing number of donors that start with limited funds to support the SWAp in this way (next to other funding mechanisms), as well as increasing contributions. It is difficult to know as a % of total donor support but it seems the tendency is an increasing %.

The EU has moved to sector budget support, with a component directed to macro-economic budget support, conditional on progress in health sector indicators. The World Bank is also considering this, but is not likely to move in this direction at the present time. The basket fund can also be viewed as sector budget support.

Current issues for SWAp

- Capacity of the planning unit and financial / administrative unit at central MoH level to compile annual plans and reports, and get the (available) resources in the districts
- Lack of Human Resources in number and quality, especially at operational level.
- Decentralisation beyond deconcentration
- Political engagement of Government and donors to the SWAp and common funding mechanisms

Key reference materials

- Fatoumata N.Traore(1999). LA reforme du systeme de sante du Mali (1986-1996)
- Health Sector Specialist, Netherlands Embassy.
- CEPES

UGANDA

Health Sector Strategic Plan 2000/01 - 2004/05, Ministry of Health, Republic of Uganda

After around 2 years in setting up the SWAP, the Health Sector Strategic Plan (HSSP) was launched in August 2000. A Mid Term Review of the plan has just been undertaken by the MoH and other SWAP stakeholders. Plans are underway to start preparation for HSSP II.

Donors

- SWAp leaders: DFID, World Bank, Development Cooperation Ireland
- Active participants: WHO, EU, USAID, SIDA, DANIDA
- Less active participants: UNICEF, JICA, ADB, NORAD, Italy
- Little involvement: UNAIDS, UNFPA, Belgium, GTZ, Spain, Netherlands

Sector policy and strategy

A National Health Policy was prepared in 1999, and the HSSP implementation began in August 2000. Uganda has had an MTEF for 6 years, and a PRSP (Poverty Eradication Action Plan, PEAP) is in place. The HSSP covers the NGO (Private Not For Profit Provider, PNFP) sector and there have been considerable advances in improving this partnership. HSSP is weaker on relations with the private for profit sector, although plans are underway to establish improved policies here. There is a very close fit between the SWAp and the HSSP, in fact the two should be almost indistinguishable as the latter is the mechanism for delivering the former. However, there are more concerns around the match of the HSSP and the MTEF.

Current MTEF ceilings (include Government budget figures and estimated projections for donor project spends) amount to \$8 per capita for health, whereas HSSP requirements have been calculated at \$28. However, allocations within the MTEF ceiling for GoU funds have become much more focused on HSSP priorities (eg % spend on District PHC services has increased from 32% to 54% in 4 years. The share for central hospitals has fallen from 22 to 12% over the same period), and in fact appear to be better targeted at HSSP priorities than donor funds, with only around 30% of funds being spent on inputs costed in the HSSP.

When the HSSP was written it was not envisaged that Ministry of Finance (MoF) would set ceilings to include project funding. Since the plan was prepared, the following have had a profound impact on the SWAp: MAP (\$50m over 3 years), GAVI (\$50m over 5 years), GFATM (\$35m next FY and \$50m over the next 2 years). While there has been an appreciation of some additional resources flowing into the sector, the general consensus has been that these blockbuster projects have been extremely destabilising to Uganda's fledgling SWAp. Figures from MoF indicate that total donor project spend is meant to be \$80m next year – the inputs from these three global initiatives would be equivalent to over three-quarters of the health budget.

Coordination mechanism

The primary coordination mechanism is the Health Policy Advisory Committee (HPAC) which meets monthly under the chairmanship of the MoH. There are also six monthly joint reviews undertaken by MoH, Donors and other stakeholders, led by the Government. GoU has also taken the lead in amending the operation of these bodies. The budget process has also been an extremely important means to exercise leadership. Government's leadership role is increasing year on year, however Global Funding initiatives outside of the budget process are a threat to this trend. A formal MoU has been signed between GoU and Donors.

In addition to these mechanisms, a health sector donor group meets regularly, and other bodies / events outside of the immediate sector eg PRSC, Public Expenditure Review, CG influence coordination systems. NGOs participate in HPAC and joint reviews, and there is a dedicated Public-Private Partnership to improve working relationships, including policy formulation and monitoring. Politicians are also much more involved in policy through the budget process and participation in joint reviews of the sector. Extensive decentralisation legislation has greatly increased the participation of local government officials and politicians, which will increase following the implementation of a Fiscal Decentralisation Strategy in 2003/04.

The general trend is towards shared monitoring and reviews. 3 key indicators have been chosen by MoH and donors to be the PEAP (PRSC) indicators for health. A further 15 have been agreed as the HSSP indicators. However some donors have a tendency to push for their own indicators to be included, and separate project reviews continue, although they are less of a burden as the number of projects diminishes.

Management of funds

Donor funds are merged into the budget, but finance a special internal budget called the Poverty Action Fund (PAF), which is also funded by Government. Certain sectors, including health, have agreed PAF budget lines which can receive these monies. The budget process is led by the Government, but is consultative and guided by HSSP priorities. Donors are encouraged not to push their preferred programmes. In general donors appear satisfied that their budget support monies are being targeted at priority areas. It should be noted however that not all on-budget donor monies go into PAF, in fact WB PRSC funding is outside of PAF.

Donors still choosing a project funding approach tend to manage their funds independently but these resources are still regarded as part of the SWAp. However as the GoU budget appears to be more efficient at targeting priorities it is the intention to get as much funding on budget as possible. MoF is also intending to set sector ceilings to include project resources, so donor projects are coming under a lot more scrutiny to ensure compatibility with the HSSP and value for money. Global initiatives are once again an issue here.

GoU has stated that its preferred funding modality is general budget support, not earmarked to sectors. There is a general trend in this direction but some donors still chose to earmark to the health sector, however given fungibility issues this is largely an illusion. In the last budget speech, a projection of \$33m was stated as the earmarked budget support for health (excluding all general budget support financing), however it is not possible to give a definite figure. In terms of general budget support, the PAF is the mechanism used to channel resources to pro-poor budget lines in the social sectors. GoU is largely free to allocate between PAF lines in the different sectors. Projections for next FY show that aid will fund 47% of the overall budget.

Budget support funds are paid into the GoU's consolidated account. Given uncertain donor flows, Ministry of Finance does an excellent job (using reserves) in managing its cash flows to ensure regular GoU budget releases. Release performance for PAF budget lines is almost 100% on time. Non-PAF lines are more prone to cuts and delays. Early release systems were cumbersome and resulted in delays of funds down to districts and health units. Recently though, joint working between MoH, MoF and Local Governments has greatly improved rates of flows of funds. Bottlenecks persist though in some districts particularly in transferring funds from the district administration and in resources flowing to smaller health centres.

Health sector expenditure

| Funding source | 2002/03 (US\$ million) |
|--|-------------------------------|
| GoU (includes donor budget support) | 108 |
| Donor projects | 78 |
| Private (includes private for profit sector) | 154 |
| Total | 340 |

Almost a third (US\$ 108 million) of total funds are used to fund the HSSP (GoU and donor budget support). It is not possible to identify what proportion of all donor aid is used to fund the HSSP, as HSSP funds are included in the general budget figures. It is possible to see however that SWAp funds are increasing over time. The Government health budget has more than trebled in five years and this has largely been due to increased donor inflows. As donors (DFID, Development Cooperation Ireland, SIDA, NORAD, World Bank, EU) switch from project to budget support the pooled resources have certainly increased as a proportion of the total, however it is not possible to calculate by how much. However, large inflows from global initiatives threaten this trend.

Current issues for SWAp

Inadequate funding is by far and away the major constraint threatening the success of the HSSP. The HSSP Mid Term Review and the recent Public Expenditure Review found the HSSP to be 'relevant and appropriate' and that the SWAp is succeeding in delivering pro-poor health services more efficiently. However with the plan only 1/3 funded it will not be able to deliver expected outcomes, without large increases in resources.

Global funds are seen by some as the answer to plugging the funding gap, but this mechanism appears to have the usual drawbacks of projects and due to their relative size threaten the stability of the SWAp. Furthermore if the MoF succeed in setting rigid ceilings to include project funds the health sector risks losing more efficient budget funding if it accepts projects (including Global funds) above its agreed ceiling.

Most other key issues, including lack of human resources, insufficient drug supplies, poor infrastructure and transport and inadequate management and supervision are related to the financing problem. Performance

management at the district level is also an important issue, particularly as the country is just about to embark on another phase of decentralisation.

Current policy issues

- Chronic underfunding for the HSSP
- Ministry of Finance setting sector ceilings to include project funding
- Accommodating Global Fund monies on/off budget
- Increased decentralisation to districts
- Anti-retroviral treatment for HIV
- Hospital Autonomy and use of private wings in hospitals
- Public Private Partnership Policy
- Amending drug supply systems to be more demand driven

Key reference materials

- National Health Policy, 1999, MoH
- Health Sector Strategic Plan, 2001/02 - 2004/05, MoH
- Health Financing Strategy, MoH, 2002
- HSSP, Mid Term Review Report, MoH, 2003
- Efficiency and Equity in Government of Uganda Health Spending, MoH, Presentation to the Public Expenditure Review, May 2003

BURKINA FASO

Programme National de Developpement Sanitaire 2001-2010 (PNDS)

The PNDS was developed under the responsibility of a technical working group over 2 years. Different sectors and various levels of the health system participated. The programme was officially adopted by the Ministry of Health in July 2001, and implementation started in 2002. The SWAP was identified as an objective in the PNDS, and a thematic group has been initiated to reflect on the implementation of a SWAP. A Round Table consisting of donors to the financing of the PNDS has been established, which first met on 15 April 2003. The PNDS has been revised for the period 2003-2010, with a first triennial plan for 2003-2005.

Donors

The key players in the SWAP discussions are WHO, Netherlands (Coopération Pays-Bas), UNICEF, and UNFPA. WHO is the official leader of health partners, but the Coopération Pays-Bas is the main lead on the SWAP (currently providing financial support to districts and financing of the TB and AIDS programmes). Other important resource partners in the health sector, but participating more passively are The World Bank, Plan International, Save The Children (UK), SIDA, GTZ, Belgium and the World Food Programme. Those not involved at all yet include Coopération Française, Coopération Chinoise and Coopération Italienne.

Sector policy and strategy

The elaboration of the PNDS was preceded by the development and official adoption of the National Health Policy (PSN Politique Sanitaire Nationale) in September 2000. As such, they are completely linked, with no elements of the strategy not included in the sector programme. PSN mentions the role of the private sector and NGOs, but links with government are not clearly defined. A thematic working group is currently working on the private sector. Another unit works on the contractual side of involving the associations and NGOs.

Burkina Faso has both a Medium Term Expenditure Framework (CDMT Cadre de Dépenses à Moins Terme) and a Poverty Reduction Strategy (CSLP Cadre Stratégique de Lutte Contre la Pauvreté). The MTEF fits the PNDS well in terms of coherence of expenditure and allocations in the health sector, however there are some differences between the figures in the PRSP and in the health component of the MTEF, because the PRSP preceded both the PNDS and the MTEF, however there is a high level of coherence on the strategies.

All anticipated revenues, when they have a degree of concreteness, are included in the PNDS budget plans. The figures below show the budgeted amounts in the PRSP and the PNDS, and the potential financing gap:

| US\$ million | 2000 | 2001 | 2002 | 2003 |
|-------------------------|------|-------|-------|-------|
| PRSP (health component) | 9.0 | 21.2 | 23.2 | 20.8 |
| PNDS | 0.0 | 121.6 | 132.9 | 134.6 |

Coordination mechanism

There is no formal Code of Conduct or Memorandum of Understanding between the partners as yet, and no joint mechanism for monitoring and evaluating the sector. However, there are several strategic plans, economic and sectorial, which serve as reference points, in particular the PRSP. All reviews and evaluations are conducted by the government with the involvement of the partners, and although there are several parallel or vertical reviews initiated by the partners, the government is almost always invited to participate.

A range of stakeholders were involved in the development of the National Health Policy and the PNDS, and the General Assembly for Health is a forum for representatives from health and other sectors at all levels. The Minister of Health started an annual conference for partners who are principally involved in the health sector, to encourage consensus-building between Government and donors, and a forum for coordinating the actions of partners was also established to implement the PNDS, and elaboration of the triennial plans.

Coordination mechanisms are in place for specific areas such as EPI, HIV/AIDS, Malaria, Integrated Disease Surveillance, Epidemic Control, and Monitoring of the PNDS. It should be noted that, while coordination is working at central level, there remains little coordination at regional and district levels, where the planned mechanisms are not yet working. The plan is for stakeholders to participate in the development of annual health plans etc. via the Regional Health Technical Committee and the District Health Advisory Committees.

The leadership of the MoH in the partnership has traditionally been weak, due to lack of clear direction and lack of capacity at central level. However, this has been increasing since the implementation of the PNDS.

There are separate coordination mechanisms for development partners only both at a national level through the Common Country Assessment / United Nations Development Assistance Framework (CCA/UNDAF), and for the health sector, where coordination meetings are held every trimester, with the WHO as President .

Management of funds

There are no pooled funds in Burkina Faso as yet. The District Support Project of the Netherlands (PADS) could be seen as a SWAp-type mechanism, as their funds help finance the plans developed by the health sector at regional and district levels, however this is all. Funds from other donors still operate on a project basis, in separate accounts, although there is now some general budget support to the Ministry of Finance.

The European Union, the World Bank and the Netherlands all give budget support. The EU contribution was US\$4.65 million for 2002 for health sector budget support. General budget support is provided by the World Bank (US\$2.8 million per year for the period 2003-2005) and the Netherlands (US\$9 million per year).

At present, the mechanism for releasing funds is unique to each donor (based on separate bank accounts and expenditure reports). The District Support Project of the Netherlands releases funds every trimester to the accounts of the districts, on the basis of plans elaborated (and afterwards, provision of receipts/accounting).

Health sector expenditure

In recent years, the annual health budget of the Government of Burkina Faso has increased to about 2.3% of GDP, approximately US\$5.5 per capita per year, and about 10% of public expenditure (split equally between recurrent and investment expenditures). Salaries absorb around 50% of the recurrent budget, and the investment budget is largely financed by external aid, approximately US\$3 per capita per year (US\$34 million per annum). Most external support, both loans and grants, comes through health projects and programmes.

Additional sources of funds are local government, contributions of NGOs and associations, and user fees (including payment for drugs). The data on these are not highly reliable, but estimates put the private costs of healthcare at about US\$60 per household (7 people) per year, covering public and private health sectors. The table below shows the expected cost of the PNDS (in US\$ million) and financing sources (2001-2010):

| | US\$ million |
|--|---------------------|
| Total cost of public health services | 1401.5 |
| Additional costs of the 8 strategies of the PNDS | 729.1 |
| Financing of total costs | |
| Budget of Ministry of Health | 623.6 |
| Cost recovery from patients | 122.7 |
| Funds allocated to the health sector from HIPC | 123.3 |
| External financing (survey results plus anticipated) | 244.7 |
| Deficit not yet financed | 297.1 |

Current issues for SWAp

- Definition and implementation of the PNDS
- Joint monitoring and evaluation
- Committee for monitoring PNDS
- Financing mechanisms for PNDS
- Links and coherence between the planning of the budget, the MTEF, and the annual budget.

Current policy issues

Some factors limiting the development of the health sector include:

- Economic situation. In the context of the general poverty level, health care financing is confronted by many difficulties, including the financial access of the population to services they have to pay for.
- Low level of education of the population limits the impact of preventive and promotive activities in health
- Size of endemic diseases (malaria, acute respiratory infection, diarrhoeal disease, vaccine-preventable diseases) and emergency situations which make huge demands on the capacities of the MOH.
- Poor performance of health services due to weaknesses in organisation, management and functioning, lack of skills, low level of motivation of staff, low level of health service utilisation especially by the poor.
- Limited inter-sectoral collaboration and community participation in health service management.

However, there are some positive signs:

- A political will in favour of health development
- Health coverage plan which promotes equitable planning in allocating internal and external resources
- Decentralisation is a real possibility
- Some positive experience in community participation - the Health Management Committees (Comités de Gestion - COGES) which are community organisations
- Support to health development from a wide range of partners
- Manuals for financial management of the various development projects, which will in the future allow a harmonisation into a single manual
- The existence of a policy of essential (generic) drugs list and a national laboratory for public health
- The potential for a sector-wide approach

CAMBODIA

Sector-Wide Management (SWiM)

The Sector-Wide Management programme (SWiM) in the health sector is currently being implemented by the Royal Government of Cambodia (RGC) with the support of donors and non-governmental organizations (NGOs). This approach (SWiM) is described in the government's Health Sector Strategic Plan, 2003-2007.

Three main steps have been accepted in the process of developing a sector-wide approach to health sector reform in Cambodia namely: 1) preparation of a strategic plan; 2) preparatory steps to implementing the plan; and 3) actual implementation. SWiM is currently at stage 2-3, developing a plan for actual implementation.

Prior to 2001 there was a realisation that the strong partnerships between the RGC, the development partners and NGOs could form the basis of a sector wide approach to health sector reform. In 2001 six key themes were agreed as the basis for SWiM and a working group, with membership drawn from government, partners and NGOs, was formed for each key theme¹⁰. A secretariat ('Core Group') was established within the central MoH to provide support and resources for each working group and to coordinate the drafting of a Sector Strategic Plan. Submissions were made by each working group to national and regional seminars and the Draft Sector Strategy presented by the Prime Minister at the National Health Congress in mid-2002.

With the continued assistance of all key development partners, the MoH drafted a Strategic Plan in mid 2002 around the time that three of the key partners (the World Bank, the Asian Development Bank and DFID) began developing a joint package of support for the MoH. This package of support, the Health Sector Support Project (HSSP) is valued in excess of USD\$85m over 5 years, and is due to commence in 2003 to support the implementation of the Strategic Plan. The MoH is currently developing a new operational planning process for implementation in 2003 and this mechanism will be used to implement the HSSP.

The first phase of implementation will depend on the development and strengthening of new and existing management and financial systems in the MoH. Relationships at senior management level and within and between departments of the MoH are currently being redefined, and new steering and technical committees being established. The MoH has requested that HSSP implement the Sector Strategy using existing MoH departments, personnel and systems. The MoH is also currently receiving support to develop planning and budgeting, strengthen HR, and procurement, financial management and monitoring and evaluation systems.

Donors

Key donors include the World Bank, ADB, DFID, WHO, Unicef and GTZ. Each working group was supported by individuals from within government, donors and NGOs with specialisms in each of the respective areas. More passive donors included USAID and JICA. No donor remained outside the process.

Sector policy and strategy

A key element of developing SWiM was drafting the Sector Strategy and the MoH policies for improving health service delivery and health outcomes. The comprehensiveness of the strategy is notable, however the challenge for all stakeholders is to operationalise the strategy and attain the targets set in the strategy. The strategy covers the private sector and NGOs through a number of key areas, including regulation of private practitioners, the desire to improve quality and supply of essential drugs, and through contracting of services to able NGOs through continued use of performance contracts for district level service agreements.

The key challenge for the MoH at this time is to draft a Sector Programme which meets all the policy issues set out in the sector strategy document. The HSSP has developed a programme of work based on the sector strategy, and the MoH are developing an operational planning process to set out the workplan for the sector in years 2004 and beyond. A key challenge for the MoH is to ensure coordination between the centrally funded national (vertical) programs (some of which are about to receive substantial funding from global sources) and services delivered (to >80% of the population) at provincial, district and sub-district levels.

An MTEF for the MoH was developed in 2002 as part of the development of the sector strategy, and in response to a request to priority Ministries from MoF who have just embarked on a medium term planning and budgeting initiative, as part of a wider macro-economic and public financial management reforms

¹⁰ Key themes: 1) health service delivery; 2) behavioural change; 3) quality improvement; 4) human resource development; 5) health financing and financial management and 6) institutional development.

programme. A PRSP has also been developed for Cambodia and links are being forged through a social sector working group with membership drawn from the main stakeholders; RGC, partners and NGOs.

The MoH MTEF and the Sector Strategy are inextricably linked as the MTEF, however, the linkages between the MTEF, the sector planning and budgeting processes and any operational planning mechanisms that emerge are less clear. This remains the main hurdle for the SWiM process in Cambodia. The programmatic themes in the MoH MTEF reflect the main components of the sector strategy and some mapping of resource allocations has been initiated. The challenge, though, of using the sector strategy to inform operation plans, making resource allocation decisions based on the priorities set in this strategy and, of course linking these with the PRSP, remain a significant challenge for the MoH and development partners. At present, resource allocations across RGC and within the priority sectors remains unchanged from years gone by and may take further major efforts in years to come to reflect the priorities of the PRSP and sector strategies.

All the main activities and sources of funding envisaged at the time of drafting the sector strategy were included, however some funds, particularly from global initiatives were not included. The first draft of the MTEF, 2002, attempted to map all activities and funding flows. The effects of these initiatives on the SWiM and budgeting processes are less clear, as they often involve separate parallel processes of planning and budgeting at sub-sector level. The MoH are of the opinion that such issues should be addressed at a sector level through a common programme of work and the MoH MTEF and not by a separate endeavours.

The challenge for Cambodia, like other countries developing sector wide working, is to be able to assess and manage all activities and resources in the health sector. Cambodia is no different than others where a significant amount of funding is 'off budget' and outside the MoH accounting and reporting systems ('off accounts', 'off audit'). The next milestone for the MoH is to devise an operational plan, cost it and prepare an annual budget linked both to the sector strategy and the PRSP through the development of the MTEF facility.

Coordination mechanism

CoComm (national coordination committee of MoH and development partners) and to a lesser extent ProCoComm (provincial level coordination committee) have operated for several years in Cambodia and met bi-monthly and/or quarterly to ensure joint MoH-donor working. This may become the coordination mechanism for SWiM process. A 'Steering Committee' with representation from the MoH, MoF, development partners and NGOs, has also been formed to oversee the HSSP and ensure its workings within the SWiM process. MoUs have been drafted between the MoH and each of the three development partners involved in the HSSP. Nothing so formal underpins the wider SWiM process as it is viewed largely as a MoH initiative which the other partners outside HSSP will endeavour to support in their respective ways of working.

The MoH sought to ensure that the SWiM process and the development of the Sector Strategy has had the widest possible ownership across the MoH and donor community. This could be seen to run in parallel with the development and negotiations which have resulted in the HSSP (supported by just 3 donors). The two parallel processes have, however, been relying for the most part on the the same MoH personnel who have been active in both initiatives. HSSP will also strive to avoid the biggest criticism of previous initiatives in Cambodia where project coordination units planned, implemented and accounted for their separate activities.

The MoH has taken ever increasing lead role. Partners have been working to strengthen management and systems in the central MoH and in selected provinces. Two PCUs have existed in the central MoH to support the initiatives of the ADB and WB and other similar arrangements have existed, sponsored by individual donors, in the various national programmes. However, the joint drafting of the Sector Strategy and the multi-million dollar incentives provided by the HSSP partners, has put the lead emphasis back onto the MoH.

To date there have been a multitude of reporting, monitoring, accounting and review systems to support the agendas of each of the donors in the health sector. As a result of HSSP however, and on the basis of the drafting the Sector Strategy, all MoH departments are set to share the responsibility for the new joint-working arrangements. The MoH is currently getting support from various donors to strengthen the capacity of personnel departments and systems to manage sector wide working under these new arrangements.

Participation of stakeholders will be key in both policy formulation and monitoring and evaluation. These mechanisms are still in the design stage but it is clear that a Steering Committee, chaired by the Minister, will oversee all policy decisions in the health sector. The Steering Committee will comprise the MoH DGs, Secretaries of State of the MoH, MoF and MoP, representatives of the main development partners, NGOs and Civil Society. Each of these groups will have membership of the Technical Committee and continue to support, through technical assistance and funding, their various programmes and/or departments.

Management of funds

There will be no pooling of funds under SWiM. Health sector reform activities are currently funded through separate channels and will remain unchanged from previous years with the government budget budgeted, accounted for and reported separately from donor funding. Despite the common WB/DFID/ADB HSSP initiative, funding will remain separate. It is expected that, despite the desire of HSSP to use government systems and personnel, there will be departmentalised PCUs with a few individuals in each department, finance for example, specialising in accounting for the WB funds received with their normal day-to-day activities delegated to others in the department. A plethora of bank accounts exist in Cambodia each supported by individual donors but outside government systems of reconciliation and audit.

Because the HSSP is not yet up and running the specific funding mechanisms remain unclear. It is expected though that clearly costed programs of work will be analysed on their merits and funding will flow from commercial bank accounts with joint signatures required from MoH and donor personnel to release funding. Apart from this, funding of health sector is expected to remain unchanged in the near future. Budget support remains off the agenda and donors will continue to provide funding for specific aspects of the programme.

The annual round of Consultative Group meetings is where donors assess the performance of the RGC against predetermined criteria and pledge financial support for the year ahead. This is the only forum at the national level where conditionality is raised and macro-level support is discussed between heads of missions and the RGC senior ministers. Debate is intense surrounding the efficacy of the CG mechanism as it relates to Cambodia especially given the unusual situation in 2002 whereby, despite being criticised for lack of progress in certain key reform areas, the RGC was pledged more by donors than it had actually asked for!

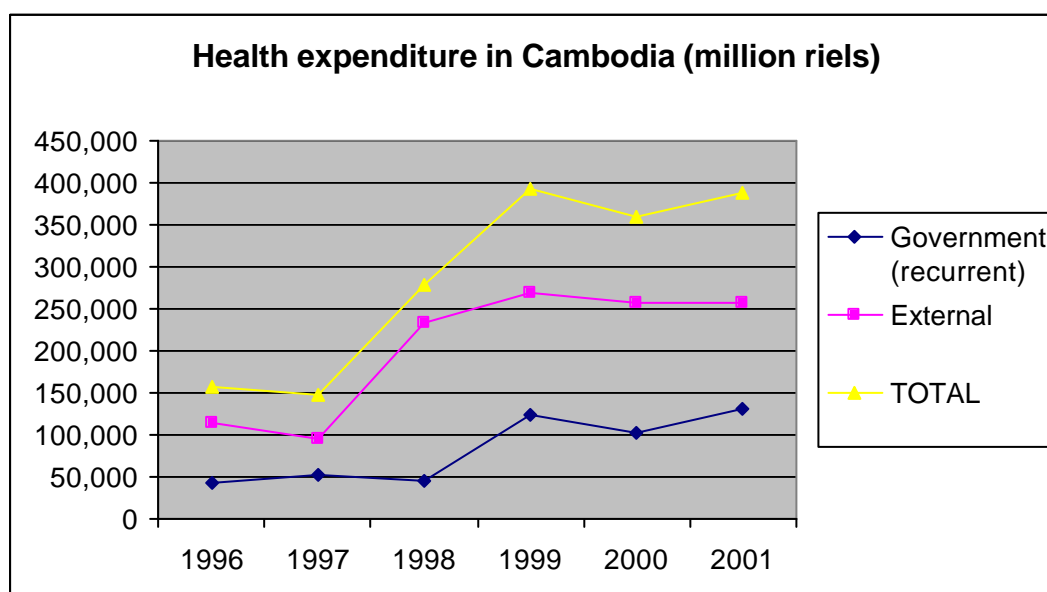
Health sector expenditure

The table below shows the government and external funds to the health sector for Cambodia 1996 – 2001.

| | 1996 | 1997 | 1998 | 1999 | 2000 | 2001 |
|------------------------------|----------------|----------------|----------------|----------------|----------------|----------------|
| Government (recurrent) | 42,713 | 52,061 | 45,606 | 124,998 | 102,049 | 130,294 |
| External | 114,658 | 95,729 | 232,985 | 268,575 | 257,298 | 258,112 |
| TOTAL (million riels) | 157,371 | 147,790 | 278,591 | 393,573 | 359,347 | 388,406 |
| Government | 27% | 35% | 16% | 32% | 28% | 34% |
| External | 73% | 65% | 84% | 68% | 72% | 67% |
| TOTAL (US\$ million) | 59.97 | 49.44 | 75.29 | 103.85 | 94.57 | 99.44 |
| Per capita spend (US\$) | 5.61 | 4.49 | 6.66 | 8.95 | 8.08 | 8.29 |

Source: Tim Ensor, The MoH MTEF, April 2002

The figure below shows that although the pattern of expenditure in Cambodia over the 6 year period has not been a smooth one, the funds allocated to the health sector have risen overall from 1997 to 2001, although the sector had yet to regain the level of funding it enjoyed in 1999 (almost \$9 per capita on health).



Current issues for SWAp

- Strong political commitment and good planning, supervision and monitoring systems at all levels of the health system for very specific cost-effective public health interventions
- Timely and adequate provision of funds and commodities
- Availability of essential drug supplies
- Adequate income for staff
- Active human resource management
- Extending services through outreach activities
- Mass media campaigns
- Community participation in health activities
- Flexible financing arrangements
- Regulatory measures through performance based contracting
- Partnerships with NGOs
- Appropriate technical, management and financial support from all partners

Current policy issues

The key policy issues that prevailed through out the drafting of the sector strategy and which underpin the HSSP include the following:

- Implement sector wide management through a common vision and effective partnerships among all stakeholders
- Provision of basic health services to the people of Cambodia with the full involvement of the community
- Provision of affordable, essential specialised hospital services
- Decentralization and de-concentration of financial, planning and administrative functions within the health sector
- Priority emphasis on prevention and control of communicable and selected chronic and non-communicable diseases, on injury, the elderly, adolescents and vulnerable groups such as the poor, and on managing public health crises
- Priority emphasis on provision of good quality care to mother and child especially essential obstetric and paediatric care
- Active promotion of healthy lifestyles and health-seeking behaviour among the population
- Emphasis on quality, effective and efficient provision of health services by all health providers
- Optimisation of human resources through appropriate planning, management including deployment and capacity development within the health system
- Increase promotion of effective public and private partnerships for effective and efficient basic and specialist care
- Effective use of the health information for evidence-based planning, implementation, monitoring and evaluation in the health sector
- Implement health financing systems to promote equitable access to priority services especially by the poor
- Further development of appropriate health legislation to protect the health of providers and consumers

Key reference materials

- RGC MoH Health Sector Strategy Volume 1
- MoH Medium Term Expenditure Framework
- Aide Memoire, World Bank, Appraisal Mission
- World Bank Staff Project Appraisal Document
- Minutes of MoH Working Group meetings
- Budget Adviser and member of HSR Team, WHO internal notes and documents

MALAWI

Malawi Sector Wide Approach

The 4th National Health Plan for Malawi (NHP), approved in 1999, signalled the intention to move to a SWAp for the health sector, based on delivering an Essential Health Package (EHP) that focused on addressing the most common causes of morbidity and mortality. Joint Implementation Plan (JIP) Committees, comprising MoHP and donor partner representatives were established to work together to help implement the NHP. These JIPs are arranged by strategic area and include a SWAp / EHP JIP. In 2001 this JIP commissioned external support to design a SWAp for Malawi. The report of the mission was presented in November 2002.

In December 2002 GoM opted to begin with a 6-month inception phase to undertake key activities, including restructuring the MoHP to take into account the EHP, SWAp and decentralisation; formulation of a joint programme of work (POW) for health service delivery based on the EHP, and formulation of a MoU between the MoHP and its partners. The POW will form the basis of a joint SWAp POW between MOHP, Christian Hospital Association of Malawi, development partners and hopefully civil society organizations and NGOs. Indicators for the SWAp have also now been selected, and are awaiting approval by MoHP management.

Although Malawi has taken the decision to develop and implement a SWAp, it is still at the early stages. However, there has been some lesson-learning through a DFID supported project. In 2002 the MoHP established a cross-ministry Budgetary Review Committee (BRC) to consider costed activity plans for MoHP capacity development using surplus DFID Capital Aid from the DFID support to the national Sexual and Reproductive Health Programme (SRHP). While the funds are from one donor only, in other regards the BRC, which is chaired by the PS, functions along SWAp-lines and is playing a valuable learning role in this regard. Likewise the SRHP itself is promoting a coordinated programme approach in this sub-sector, moving from discrete bilateral 'projects' to contributions to one 'programme' governed by one strategic framework.

Donors

DFID, EU, NORAD, Netherlands, GTZ, KfW and the Dutch Government were the key players in promoting the SWAp. The Dutch have recently stopped supporting the health sector in Malawi, and the EU Health Sector Reform Programme is due to end shortly. There are no plans to replace it, but they may contribute to budgetary support in future. UNICEF, WHO, UNFPA have participated in the process but not to the same extent, JICA have also participated but more passively. World Bank and USAID have had little engagement.

Sector policy and strategy

Malawi has a National Health Plan in place, based on delivering an Essential Health Package. It is generally regarded as reasonably robust, however it is ambitious (\$17 per capita), and will take a long time to roll out. The sector programme is strongly linked to the NHP. It is based on the provision of the EHP while the Joint POW revolves around the delivery of the EHP and a SWAp. Malawi also has both a MTEF and PRSP. It is intended that the POW will cover 6 years; two three-year rolling plan periods, synchronized with the MTEF. It will fully fit with the PRSP, as the EHP is seen as the main health strategy for poverty alleviation in Malawi.

As Malawi has not yet completed the POW, funds from global initiatives such as GFATM have been taken into account in the design of the SWAp, although there is recognition and acceptance that it will probably not be possible for these funds to be channelled through the SWAp modalities. The proposals for these funds were based on the EHP and departmental programmes of work of the MOHP. This means that these funds, although large, should effectively buy into and complement the resource envelope of the Joint / MoHP POW.

Government health policy formulation and monitoring has generally been an exclusive MoHP activity. The design of the SWAp framework, a fully consultative process aimed at providing a comprehensive policy and strategic framework for the sector was a new departure, as civil society groups, religious based health providers, NGOs and politicians were fully involved in the process. More engagement with stakeholders, NGOs and other non-government service providers is envisaged in the SWAp implementation process.

Coordination mechanism

The primary coordination mechanism for donor coordination has been the Joint Implementation Plan committees – especially the EHP / SWAp JIP which includes all donors, some NGOS, and MOHP. These committees do not function as effectively as they might as they deal both with operational and policy issues. The frequency of meetings is generally determined by the intensity of issues that need to be discussed. For example, during the SWAp development process they met much more frequently - fortnightly.

A draft MoU has been produced, and development of a code of conduct is one of the key inception phase activities. Within the context of the latter, and as part of the POW, new committee structures will be developed to take account of new ways of working and will include new structures for donor coordination. There is currently one donor forum, The Health and Population Sub Group, and all monitoring and evaluation has been via separate donor / project reviews. Joint reviews proposed under the SWAp design are planned.

The government is yet to be fully in charge of the process in Malawi. The thrust in the initial stages was from the development partners, however during the SWAp design process, leadership was largely in the hands of the MoHP with the head of the Design Team reporting directly to the Head of the Planning Unit, who in turn kept donor partners informed through the SWAP / EHP JIP.

Towards the end of the design phase, donor partner influence on the process became stronger when it became apparent that anticipated donor funding for SWAp implementation would not be available as soon as had been hoped. Unfortunately implementation of the inception phase activities has been sluggish, and some activities have had to be postponed. It is intended that the draft POW will be developed by the MOHP first and then shared for input with development partners. Appropriate committee structures to coordinate the SWAp process are also under discussion and will seek to facilitate the leadership role of the MoHP.

Management of funds

The SWAp process has not yet reached this stage. NORAD has recently started to provide direct financial support to the Districts (top-ups for non-salary recurrent expenditures in health), while DFID is considering a mix of direct district support to MoHP, budgetary support through the MoF and a TA fund to be managed by the MoHP. The conditions for budget support are evidence of key milestones such as PoW developed and in use, MoU etc. Several donors have general budget support available, but are held up by IMF restrictions.

Health sector expenditure

The per capita expenditure on health is approximately US\$ 12, with about US\$ 7 from donors.

Current issues for SWAp

- Small number of donors and related capacity issues
- Lack of capacity in the MOHP related to extreme under-staffing (health service at 50% of establishment)
- Lack of MoHP capacity in HR to implement change process and effective health care delivery at all levels remains a concern and is exacerbated by high HIV prevalence in working population
- Linked to capacity issue, urgent attention needs to be paid to strengthening financial systems to give donors confidence in committing funds in the form of budgetary or pooled support
- Lack of commitment by key donors to SWAp, though it is hoped that this can be mitigated by aligning their discrete inputs within Programme of Work/EHP framework and they will come on board over time
- Influx of GFATM funds might still undermine SWAp by reinforcing “vertical” approach.
- Need to effectively communicate change processes like SWAp and EHP to districts and other stakeholders outwith the central MoHP as most of their formulation has been at the central level

Current policy issues

- The decentralization process and restructuring the MoHP to align both with it and the SWAp
- Human resources projections and strategies – emergency training plan is in place
- Implementation of the EHP as the MOHP’s contribution to the Poverty Alleviation Strategy
- Quality Assurance issues
- Modalities for pooled funding at the district level
- HIV/AIDS and ARVs

Key reference materials

- Report by the SWAp Design Team (LATH, Nov 2002)
- Report by Dr Tinorgah on SWAp for Malawi (WHO, 2001)
- 4th National Plan for Health (MoHP, 1999)
- Vision 2020, (MoHP 1998)