



## **An overview of Sector Wide Approaches (SWAPs) in health**

**Are they appropriate for aid-dependant Latin American countries?**

**Silke Seco  
Javier Martínez**

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DFID Health Systems Resource Centre  
27 Old Street  
London EC1V 9HL  
Tel: +44 (0)20 7253 2222  
Fax: +44 (0)20 7251 9552  
Email: [enquiries@healthsystemsrc.org](mailto:enquiries@healthsystemsrc.org)  
Website: [www.healthsystemsrc.org](http://www.healthsystemsrc.org)

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## Abbreviations

EPI	Expanded Programme on Immunisation
EU	European Union
DFID	Department for International Development
HIPC	Highly Indebted Poor Countries
IMF	International Monetary Fund
MoH	Ministry of Health
MoF	Ministry of Finance
MTEF	Medium Term Expenditure Framework
NGO	Non-governmental organisation
ODA	Overseas Development Agency (now DFID)
PAHO	Pan American Health Organisation
PRSP	Poverty Reduction Strategy Paper
SDC	Swiss Development Cooperation
SWAP	Sector Wide Approach
UNICEF	United Nations International Children's Fund
WHO	World Health Organisation

## Executive Summary

This paper has been commissioned to provide background information on the concept of Sector-wide approaches – SWAPs- and their implementation. It is aimed at policy makers, donor agency staff and health professionals working in countries where SWAPs are either being considered or might be considered in the future. While the paper attempts to encapsulate the main conceptual and practical issues involved in SWAP development it does not pretend to be either a blueprint for implementation or to explain in detail the specific mechanisms, arrangements or steps that should be followed for establishing a SWAP. The authors draw mainly from unpublished literature, in the form of consultancy reports and evaluation studies. The Bibliography section provides information on all the documents used, so as to help those interested in pursuing more in depth reading.

In a sector-wide approach (SWAP) 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 a situation in which all funds are disbursed by governments, which are also accountable for the disbursement.

The rationale for SWAPs stems partly from a recognition of the problems inherent in traditional project and programme development funding. In contrast to a multiplicity of individual donor projects -with different and sometimes conflicting agendas and with their own planning and monitoring arrangements, SWAPs are seen as an opportunity for governments to oversee the entire health sector, develop policies and plans, and manage resources.

The core assumed advantages of a sector-wide approach are:

- greater efficiency and equity
- decreasing transaction costs
- sustainability of health policy and systems development.

At the heart of a sector-wide approach is a medium-term collaborative programme of work between governments and donors concerned with the following components:

### ***The Policy components***

A policy document that identifies and addresses major policy issues is the starting point of a sector-wide approach. This entails:

- defining sectoral objectives
- setting strategies about resource allocation
- identifying the institutional changes required and
- specifying the roles of different health care providers.

### ***The Expenditure components***

In a SWAP, a public expenditure programme is defined to reflect macro-economic policy and sector priorities in a transparent manner. Expenditure programmes are based on:

- medium-term projections of the resources available
- short-term budgets, which are reviewed annually and
- priority areas where spending should be protected

### ***The Institutional components***

The key objective of a SWAP is to build government capacity to lead the process of sectoral development. Accordingly, governments should gradually be able to:

- take the lead in strategic planning and policy
- manage budgetary and financial analysis
- develop systems and incentives to manage the health system in line with national policies and
- establish common management arrangements and systems.

### ***Decentralisation and SWAPs***

Designing sector programmes in decentralised political or health systems can be challenging. In particular, certain priority projects (vertical programmes) may be neglected as a result of shifting towards a sector approach. Earmarking sector priorities and ring fencing priority programmes can be a way of overcoming problems and concerns.

### ***Types of SWAPs***

SWAPs are not an absolute, and different funding arrangements are possible. In this document we use the terms 'tight' and 'loose' to refer to the extent to which financial resources from various donors are pooled together, even if these terms are not universally accepted and should be taken as the two poles of possible financial arrangements. In a 'tight' SWAP an agreed strategy and investment plan is delivered by government with pooled finance provided by government and external development partners. In a 'loose' SWAP there is a strategy agreed by donors and government but both may continue to fund separate programmes and projects. Funding agencies can provide their funding in one of these two ways, or using combinations of these extremes.

Although SWAPs are by definition sector oriented, they may initially focus on one or two subsectors (ie primary care or tertiary hospitals), or in specific programme areas (ie reproductive health or disease interventions), particularly in countries where capacity is low to manage the complexities of a whole sector.

### ***Implications of SWAPs***

The development of SWAPs entails major changes in donor-government relationships:

- The recipient government takes a stronger leadership role in the design of programmes and the allocation of resources.

- Donors give up their right to decide which projects to finance in exchange for the right to have a voice in the process of developing a sectoral strategy and overall resource allocation.
- SWAPs will only succeed if there is partnership and commitment to agreed aims from government and the donor community. For this, partnership agreements and working arrangements are needed.
- The objective is that governments are eventually able to use pooled funding for procuring goods and services. This implies the need to relax restrictions about rules pertaining the origin of funds and tied aid.

SWAPs should be an incremental process, not a blueprint for a single type of programme. They must also be implemented at a pace appropriate for the recipient country.

### ***Review of experience***

All current SWAPs have been started in low-income countries and have achieved very different degrees of success. Because implementation can be a long process the evaluation of SWAPs has only recently begun to shed some light on the pros and cons of adopting a SWAP, and this mainly in those countries where SWAPs were started in the early 90s such as Pakistan, Ghana and Zambia.

Most sector-wide approaches have concentrated on the role of the public sector within the health sector, and not on the health sector as a whole. All countries regard SWAPs as incremental processes, progressing towards more pooled financing as trust is built and experience develops. There are already some countries with common funding, although this tends to coexist in most countries with separate project funding. In these cases efforts are being made to ensure that project funding takes place only in priority areas identified through the SWAP process, and within the expenditure framework agreed for the SWAP.

Plans developed under SWAPs can be regarded as a success if they result in governments and donors looking at health problems and at health interventions together, around a table, improving the quality of the policy debate. In particular, there have been positive achievements reported in:

- Developing coherent priorities and plans for the health sector, and setting up systems to monitor performance.
- Strengthening the role of governments and ministries of health in the health sector.
- Enabling greater focus and continuity in policy implementation that counteract the risks linked to political and policy shifts.

On the other hand, developing a sector-wide approach is a complex undertaking spreading over several years that can be overwhelming and can strain governmental capacity. Unless there is compromise in reaching a balance between what is ideal and what can be realistically achieved given resource availability the process of preparing a policy document and a sector plan can be

prohibitively long. Even when there is a clear statement of intent from governments, it is often necessary to develop government capacity to carry out the planning process itself. The main reported problems have been delayed planning and sector appraisals, in part caused by donors persistently using over-detailed procedures and in part due to the said limitations in government capacity. While the focus has often been on strategic details and implementation plans more attention is needed on actual implementation and on results.

Finally, the fundamental problem of balancing investments within the health sector, and between the health sector and competing sectors has not always been resolved following introduction of SWAPs. For a start, most governments undertaking SWAPs do not have the resources needed to expand their population coverage on a sustainable basis. Even if the efficiency and cost-effectiveness of the health system were to improve considerably, most governments will continue to face resource shortages and depend on foreign aid in the medium to long-term.

### ***SWAPs and the health of poor people***

SWAPs are not pro or anti-poor in themselves, since they are just a mechanism for planning and managing the sector. Whether SWAPs benefit the poor depends on the actual policies and the record achieved in their implementation. Because SWAPs take place within broader health, public sector, social, economic and political contexts it can be predicted that SWAPs are more likely to have a positive impact on the poor in countries whose governments are committed to poverty reduction. In this sense, SWAPs could have a synergistic effect on poverty and the poor in countries where Poverty Reduction Strategies have been defined and condensed in so-called PRSPs, but PRSPs are too recent a feature to demonstrate such synergy in practice.

There is concern that sector-wide approaches can become too centralist and focused on macro-level policy and service provision issues that may take many years to cascade down the system and benefit service users, including the poor. In this regard, the choice facing donors is whether to channel development aid directly to those most vulnerable or to encourage the allocation of resources in ways that favour the poor in the negotiation of sector policies and strategies. In practice, both approaches can be followed simultaneously.

SWAPs are often said to have a negative impact on certain priority programmes in countries where these have been traditionally financed and implemented in a very vertical manner. Because priority programmes are often aimed at the poorest SWAPs have been said to have a potential negative impact on poor people. So far, there is no evidence of such effect actually taking place except, perhaps, for limited periods of time during early stages of implementation. Even in these cases other policies outside SWAPs, such as decentralisation or the introduction of new health financing arrangements, might have been responsible for the said negative effects. Besides, SWAPs can have a beneficial effect on certain priority programmes by standardising or streamlining

certain procedures which are common to several programmes. One such example is SWAPs resulting in more effective and faster procurement arrangements.

***Is there a case for SWAPs in Latin-America?***

In terms of context, many of the conditions under which other countries have initiated SWAPs actually exist in low-income Latin American countries. For example, the shortcomings linked to traditional project and programme aid are particularly felt in small, very poor countries whose health systems are heavily reliant on external aid, as happens to be the case in countries such as Bolivia, Honduras, El Salvador or Nicaragua. To the extent that there is a need for health sector reform and better donor coordination, and for enabling greater continuity in health and public sector policy implementation –a real problem in all of the above- there is a case to be made for sector-wide approaches in these aid-dependant countries of Latin-America.

While SWAPs have not yet been introduced in any Latin American countries, some building blocks for future SWAP development are already underway in Bolivia and Ncaragua. Whatever governments in Latin America decide to do, sector-wide approaches are long and complex undertakings where at least the following lessons should be born in mind:

- There needs to be a recognition among donors as well as governments that traditional project aid is often part of the problem rather than part of the solution, and that some of the problems can be effectively overcome through new partnership arrangements.
- Governments should favour longer term policy objectives and use the SWAP to ensure a sustained attention on these beyond political cycles.
- The focus should be initially on a few clearly-stated strategic objectives, or on a few priority programme areas, leaving more complex issues to be addressed later.
- Priority programmes should be included in the SWAP as these are the areas where donor involvement has been traditionally stronger.

# 1 Introduction

## 1.1 Overview

This paper has been commissioned to provide background information on SWAPs and their implementation. It is aimed at policy makers, staff from donor agencies and health workers in the health sector of countries where SWAPs are either being considered or might be considered in the near future. The paper does not pretend to be either a blueprint for implementation or to explain in detail the specific mechanisms, arrangements or steps that should be followed when establishing a SWAP. The paper draws mainly from unpublished literature, in the form of consultancy reports and evaluation studies. The Bibliography section provides information on all the documents used and should be of help to those willing to read further on the matter.

Sector-wide approaches (SWAPs) can be seen as an evolution of Sector Investment Programmes (SIPs) promoted by the World Bank since the late 1980s. In difference with SIPs, SWAPs soon received in the early 90s the support and interest of several bilateral and multilateral donors attracted by the opportunity of engaging in closer policy and institutional dialogue with recipient governments towards greater effectiveness and efficiency of aid.

SWAPs represent a new approach to development aid. As opposed to traditional project aid, with its multiplicity of individual and often uncoordinated projects, sector-wide approaches are based on a framework within which all resources in a sector can be managed in an integrated and coherent manner. In a SWAP, 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 a situation in which all funds are disbursed by governments, which are also accountable for the disbursement. Most sector-wide programmes currently in operation attempt to describe, and to the extent possible streamline all sources of finance in the sector, bringing ongoing projects in line with the SWAP, developing common procedures and increasing reliance on governments (Foster 1999).

To date, sector-wide approaches have been implemented in low income, highly aid dependant countries. In the health sector, SWAPs have mainly been initiated in Africa -Ghana, Zambia, Uganda, Mozambique, Sierra Leone, Tanzania, Senegal, Mali, Burkina Faso-, but also in Asia -Bangladesh, Pakistan, Vietnam (still in consideration), Cambodia (currently moving in that direction)-, Egypt and Yemen. They are also being considered in a number of low-income Latin-American countries (Nicaragua, Bolivia). Ghana, Zambia, Pakistan and Bangladesh are among the countries with the longest experience of SWAPs.

## 1.2 History and evolution of SWAPs in the health sector

The lack of progress in human development in much of the developing world has prompted a critical re-appraisal of development assistance during the past two decades. Much of the debate critique has focused on the effectiveness of aid and the impact of structural adjustment programmes. Arguing that the real objectives of development have been lost, studies have called for a re-focus on poverty alleviation (see for example: Cassen, 1986; Bergs, 1992; Cassels, 1996; World Bank 1998).

The rationale for SWAPs stems partly from recognising the problems inherent in traditional project and programme development funding. Programme aid (also known as budget support) encompasses foreign exchange, import credits, commodities or food, which are provided by donors to recipient governments to be sold by them to generate local currency. This can be used to support general expenditure or spending by a specific ministry. Programme aid is fungible and can be used flexibly by recipient governments, as it is disbursed through governments' budgets. In contrast, project aid is earmarked for specific purposes and can be fragmented, or divided among a variety of schemes (Cassels 1996).

Fragmented donor projects with different and sometimes conflicting agendas lead to large operating costs, duplicated efforts and a significant managerial burden for recipient governments. In addition, individual projects are often not in line with government policy priorities and can exacerbate inequalities through supporting particular regions, or lead to incoherent approaches to development. In this context, SWAPs are seen as an opportunity for governments to regain control over their fragmented health sectors, by focusing on government ownership and flexibility, breaking away from rigid and over-detailed, or externally designed projects.

Donors and governments have also recognised that the effectiveness of aid and individual projects depends on the policy, institutional and economic environment. Programme aid, usually in the form of fast disbursement of funds through national budgets, has been effective in meeting balance of payment needs, but less so in promoting long-term sectoral objectives and controlling efficiency and equity in resource allocation. This realisation has shifted the economic debate from overall structural adjustment toward public expenditure management and the role of government in the provision of basic public services, in an attempt to link the macroeconomic and microeconomic levels. There are however, fundamental constraints to be addressed that have been the objective of traditional project aid, such as assisting governments to develop their weak budgetary and management systems. In this sense, SWAPs can be

seen as a convergence of programme aid with its macroeconomic origins and sector-specific project aid (Cassels 1997).

It is important to note that the concepts of a SWAP are not new. What is new is the focus on partnership between recipient countries, donors, the private sector and civil society, with the recipient country taking the lead. It is believed that such an approach will strengthen governments' ability to oversee the entire health sector, develop policies and plans, and manage resources. The core assumed advantages of a sector-wide approach are therefore:

- greater efficiency and equity
- decreasing transaction costs
- sustainability and continuity in policy development and implementation.

### **1.3 Definition and components of SWAPs**

There is no single definition of a SWAP. It is therefore best to describe them by referring to their main characteristics, as outlined in Cassel's 1997 *Guide to Sector-Wide Approaches for Health Development*:

- A sustained partnership, led by national authorities, involving different arms of Government, groups in civil society and one or more donor agencies;
- With the goal of achieving improvements in people's health and contributing to national human development objectives;
- In the context of a coherent sector, defined by an appropriate institutional structure and national financing programme;
- Through a collaborative programme of work focusing on:
  - a) the development of sectoral policies and strategies, which define the roles of the public and private sector in relation to the financing and provision of services, and provide a basis for prioritising public expenditures
  - b) the preparation of medium-term projections of resource availability, sector financing and spending plans, consistent with a sound public expenditure framework
  - c) the establishment of management systems by national governments and donor agencies, which will facilitate the introduction of common arrangements for the disbursement and accounting of funds, procurement of goods and services, and monitoring sectoral performance
  - d) institutional reform and capacity building in line with sectoral policy and the need for systems development
- With established structures and processes for negotiating strategic and management issues, and reviewing sectoral performance against jointly agreed milestones and targets.

At the heart of a sector-wide approach is a medium-term collaborative programme of work between governments and donors concerned with the following components:

### ***The Policy components***

A policy document that identifies and addresses major policy issues is the starting point of a sector-wide approach. This entails the definition of sectoral objectives, setting strategies about resource allocation, identifying the institutional changes required and specifying the roles of different health care providers. Such a document therefore sets the agenda for capacity building and institutional development.

It is important to note that the development of a sectoral policy should not be a pre-requisite for donor funding but part of the collaborative programme of work, subject to revision as new issues emerge. The preparation of a clear *statement of intent* can be the first step to show a demonstrable starting point.

Underfunding, poor quality of service delivery and care, bias towards tertiary and urban care, untrained and unmotivated staff are common problems in the health sector of low-income countries. Health policy reforms therefore tend to address basic systemic issues, such as allocation priorities, the role of government, private and non-profit sectors, capacity building, organisation of delivery systems, content of services provided, etc. With SWAPs, policies should be more explicit and should outline real choices for the health sector (Foster 1999).

However, many of the policy instruments and institutional arrangements needed to improve health sector performance (e.g. decentralisation, changing staff incentives, setting social insurance systems) cannot be introduced by the ministry of health alone. It is therefore essential to assess the extent to which proposed changes are supported or opposed by other parts of government.

### ***The Expenditure components***

In a SWAP, a public expenditure programme is defined to reflect macro-economic policy and sector priorities in a transparent manner. This process is also intended to reinforce the national budget process. Expenditure programmes are based on medium-term projections of the resources available and short-term budgets, which are reviewed annually. These medium-term spending projections are also needed to identify areas where spending should be protected in the event of resource shortages. For the above reasons the existence of a Medium-Term Expenditure Framework (MTEF) will be useful when attempting to introduce a SWAP or when designing Poverty Reduction Strategies.

Given that a SWAP should, in principle, be concerned with the health sector as a whole, the expenditure programme should be based on comprehensive estimates of all available resources, private spending included.

The preparation of sectoral spending programmes should be preceded by dialogue with government about inter-sectoral priorities for public spending to avoid large fluctuations in resources. Governments may in turn ask donors to make their expected funding commitments explicit. The delicate and difficult issue of balancing resources between sectors needs to be addressed. All countries undertaking SWAPs have low and declining levels of public financing in the health sector and have focused on directing increasing funds toward the health sector. In addition, most operational SWAPs are concerned with allocation decisions at the macro-level, leaving detailed resource allocation decisions to the local level.

### ***The Institutional components***

The key objective for introducing a SWAP instead of a project approach is to build government capacity to lead the process of sectoral development and, through it, to achieve better health outcomes. Accordingly, governments should gradually be able to take the lead in strategic planning and policy, budgetary and financial analysis, the development of systems and incentives to manage the health system in line with national policies and the establishment of common management arrangements and systems.

The aim is not just to harmonise donor procedures but for donors to use national systems for monitoring performance, financial management and the procurement of goods and services.

### **1.4 Scope of SWAPs and their implications**

The development of SWAPs entails major changes in donor-government relationships, as well as several underlying implications:

- As opposed to traditional project funding, where the activities funded can be readily influenced by the funding agency, in a SWAP the recipient government takes a stronger leadership role in the design of programmes and the allocation of resources.
- In turn, donors give up their right to decide which projects to finance in exchange for the right to have a voice in the process of developing a sectoral strategy and overall resource allocation.
- SWAPs must be embedded in a sound macro-economic framework that takes account of (possible) unstable macro-economic conditions. Otherwise development assistance is unlikely to produce sustainable benefits.

- SWAPs should ultimately be concerned with the health sector as a whole, incorporating public and private expenditure, as well as for-profit and non-profit/voluntary organisations. However, it might be more feasible to start with sub-sectoral programmes (if problems of financial accountability and performance monitoring exist). Within this framework, donors can continue to fund non-public providers directly.
- SWAPs should be an incremental process - they should be seen as an approach to sectoral development, not a blueprint for a single type of programme. In accordance, the agreed policy, institutional and budgetary changes must be implemented at a pace appropriate for the country concerned.
- SWAPs will only succeed if there is partnership and commitment to agreed aims from government and the donor community. For this, partnership agreements and working arrangements are needed. These should include: mechanisms to provide guidance on emerging issues in the preparation of sector-wide programmes; necessary agreements at national level; a code of practice to handle disagreements and misbehaviour of both donors and governments; agreements about appraisal, planning and review issues.
- Donors need to review the appropriateness of systems that are currently used in dealing with governments. Rigid and over-detailed systems need to be avoided.
- The objective is that governments are eventually able to use pooled funding for procuring goods and services. This implies the need to relax restrictions about rules pertaining to the origin of funds and tied aid and agreement on common procurement procedures.

### ***Decentralisation and SWAPs***

SWAPs design and implementation can be more challenging in heavily decentralised political or health systems given the need to balance centrally defined policies with the responsibilities assigned to decentralised units. For example, it is feared that the centralising force of a SWAP might hinder the decentralisation process itself. There are also concerns about regional or district level capacity and accountability.

Cassels (1997) argues that, in principle, there is no reason why political decentralisation should not be compatible with a sector-wide approach in large federal countries. Earmarking sector priorities and ring-fencing certain priority programmes can be a way of overcoming some of the above concerns. In addition, capacity problems at district level need to be addressed in more and in less decentralised health systems to ensure that integrated services do not deliver a weaker standard of services than vertical programmes did in the past.

## **Scope of SWAPs**

SWAPs are not an absolute, and different funding arrangements are possible. In this document we use the terms 'tight' and 'loose' to refer to the extent to which financial resources from various donors are pooled together, even if these terms are not universally accepted and should be taken as the two poles of possible financial arrangements. In a 'tight' SWAP, there will be an agreed strategy and an agreed investment plan to be delivered by government with pooled finance provided both by government and external development partners. Financial support from the external development partners is used to enhance the government health sector budget. In a 'loose' SWAP there will be a strategy agreed by development partners and government but both may continue to fund or run separate programmes and projects to deliver parts of it. Funding agencies may provide their funding in these two different ways, or using combinations of these extremes. For example, some external development partners may provide financial support to the government budget (pooled funding) and others direct their funding support to specific items (parallel funding). The aim is to increase the proportion of resources channelled through common funds as trust and experience develop.

It is important to distinguish the term SWAP from Sector Investment Programme (SIP). The term SIP was originally used by the World Bank to refer to the generic attributes of a sector-wide approach to development. However, SIPs have more specific financial and legal implications and they have been seen as "the Bank's operational instruments for implementing the broad sector approach to investment lending." To avoid confusion, the term SWAP is used to describe *nationally-led sector development programmes*. When countries embark on a SWAP, they usually agree on a national term, as for example the 'Social Action Programme' or SAP in Pakistan.

A 'tight' SWAP with pooled funding operates like a SIP or budget support, in the sense that funding is managed by government, usually with funds reimbursed based on expenditure reports from government (Nabarro & Asamoah-Baah 1998). As mentioned earlier, in contrast with budget support or programme aid, a SWAP has explicit agreements on sector developments and overall resource allocation, and is intended to increase the amount spent in the sector over what governments would have otherwise funded.

### **1.5 Donor concerns**

Some donor agencies have expressed concerns with SWAPs, particularly those with particular interests and stakes in funding disease-specific programmes. These concerns include:

- That donors will lose the ability to attribute expenditure that is part of pooled funding to specific activity areas and that, as a result, the impact of aid will be hard to measure.
- That Priority programmes and poverty alleviation might be neglected if insufficient resources are allocated to this end as a result of shifting from vertical to integrated programme projects.
- A lack of confidence in government financial management systems, particularly internal and external audit mechanisms, necessary for donors to account to their respective governments/boards and ensure that funds are used appropriately
- A lack of confidence in government procurement and service provision .
- Absence of government capacity to contract with non-government providers and potential bias towards public providers. This situation is not intrinsic to all SWAPs but will depend on a country's context (i.e. how lack of public provision is tackled). Government capacity will have to be considered where donors have tended to channel funds through non-public providers and SWAPs might change established procedures.

Whilst these concerns are real, they can be overcome and many bilateral and multi-lateral development partners now consider that the potential benefits of sustainability and ownership outweigh the potential problems. In principle, the answer is for development partners to:

- Participate in the design process positively as early as possible to ensure that concerns are addressed.
- Recognise that the design must evolve from each country's specific circumstances.
- Understand the financing mechanisms and ensure that they allow progress from a loose SWAP to a tight one as government capacity is developed and demonstrated.
- Ensure that in the negotiation of resource allocation, sufficient funds are reserved to address major causes of ill-health. Government ring-fencing mechanisms can be used if necessary. In the event of disagreement, there can be separate sources of funding for priority programmes, but this should only be used as a last resort (Cassels 1997). See section on poverty for further discussion on priority programmes.
- Establish indicators to monitor performance, through negotiation with each country. Cassels proposes regular monitoring of individual cost centres and aggregate assessments of sectoral performance, including health outcomes of different groups, coverage, service quality, cost-effectiveness and consumer satisfaction (Cassels 1997).

## 2 Review of experience

### 2.1 Country overview

SWAPs in the health sector have been started in Africa -Ghana, Zambia, Uganda, Mozambique, Sierra Leone, Tanzania, Senegal, Mali, Burkina Faso, Ethiopia-, but also in Asia -Bangladesh, Pakistan, Vietnam (being considered), Cambodia (being considered) and in the Far East -Egypt and Yemen. They are also being considered in some Latin-American countries, particularly in Nicaragua and Bolivia.

The longest running programme is the Social Action Programme or SAP in Pakistan, which was established in 1992. Two of the often reported examples are Ghana and Zambia, where SWAPs have developed alongside health sector reforms and involved the donor community early in the development of sector strategies. Progress has also been made with the SWAP of Bangladesh. In other countries, especially those emerging from conflict situations, the reform processes –of which the SWAP is just one aspect- have progressed more slowly, as is the case in Mozambique, or is only at very early stages of planning, as is the case in Cambodia and Vietnam. These last three do not yet have sector-wide approaches in place but they are developing mechanisms and consensus towards their implementation.

All the countries implementing SWAPs have different political, social and health care system characteristics but face similar problems. They are all low-income countries facing high levels of poverty, severe resource constraints, demoralised and underpaid personnel, socio-economic and regional inequalities in the provision of health care, and are heavily reliant on donor funds for the provision of services. In all, SWAPs are intended to achieve improvements in people's health by improving the efficiency, effectiveness and sustainability of health care delivery.

Boxes 1, 2 and 3 summarise the main stages of change that Pakistan, Mozambique and Ghana have undertaken in their move towards a sector-wide approach in health. The three country cases show very different degrees of success and highlight the fact that progress towards the development of a sector-wide approach is best understood as an evolutionary process. In all, strategies have emerged and changed as negotiations and debate between stakeholders have progressed.

## **Box 1: Pakistan's Social Action Programme (Source: Brown 2000)**

Sector-wide approach adopted in 1993 to improve investments in basic social services.

**First phase (1993-1997):** Defined initially as primary health, including community services and basic health units, primary education, population welfare and rural water supply and sanitation.

**Second phase (1997-2001/2):** Extended to include all elementary education, health up to first level hospitals and more urban areas activities.

### **Positive conditions**

Government committed to improve resource availability, sector policies and strategies, together with institutional reform and coherent government agenda.

### **Process**

During the first phase, the World Bank acted as a lead donor, managing the dialogue with the government. The Bank's style and resources dominated and as a result, SAP was seen as a donor and World Bank construct. Donors focused too much on operational plans, and implementation plans were subject to detailed traditional project supervision, taking initiative away from the Provincial Government. Less attention was paid to sector policies, strategies and reforms. There was also a gap between the national perspective on macro-financing issues and the reality in the provinces. Donor leadership discouraged government ownership. The understanding of the programme was not spread down to implementation level and the public. A more collaborative approach was adopted during the second phase. Responsibility for SAP was shifted to a senior ministry official in Pakistan.

### **Achievements**

Improvements have taken place at the level of policy debate but lack of continuity and continued donor preoccupation with details of implementation plans have slowed progress towards an effective, government-led sector wide programme.

Increase of expenditure in the public health sector.

More coherent sector wide approach to policy development and planning.

Primary health care provision of essential medicines and contraceptives, staff attendance and performance and service quality all seen as priority areas.

Good planning, monitoring and management and effective and efficient use of budgets are beginning to be seen.

### **Problems**

- SAP has lacked strong enough focus on performance at service level management and practice.
- No evidence on significant impact on human development among the poorest.
- No wide political ownership: the originally intended budgetary shift from defence and non-social sector expenditures has not taken place. Further, budgetary control and planning lies at federal level, but social sector policy and implementation are a provincial responsibility. A successful sector-wide approach needs ownership and commitment at both levels.

## **Box 2: Mozambique's plan for a health SWAP (source: Brown 2000)**

Mozambique does not yet have a sector wide approach to health development. It does however have a number of building blocks towards one and the Ministry of Health has started developing a 5-year strategy and implementation plan. The country has learnt from experience in the past with pooled funding, budgetary support and donor co-ordination, all relevant to a SWAP process.

### **Prior experiences with joint working arrangements**

- 1992: Swiss Development Corporation (SDC) took on the role of lead donor, liaising between MoH and other funding agencies.
- 1994/5: SDC began budget support which was supported by an Integrated Provincial Planning process (IPP) to assist with resource management. Joint MoH-donor auditing began.
- 1996: donor co-ordination group started.
- 1996: pooling arrangements began for drugs and technical assistance, managed by donors.
- 1997: Ministry of Planning and Finance (MFP) began budget reform process at central and provincial levels, including introduction of Medium-Term Expenditure Framework (MTEF); MoH began review of health policy at request of donors.

In 1998, donors asked the MoH to initiate the development of a sector wide approach for health:

- May 1998: MoH and MFP started to develop a long term financing strategy
- MoH accepted recommendations of the Technical Advisory Group Policy Review which suggested the cautious development of existing initiatives into a sector wide approach. The MoH then signed a joint declaration of intent to this effect with donors.
- 1998: MoH set up a Technical Support Unit for Strategic Planning.
- 1999: MFP established a unit to help Ministries develop a SWAP.
- June 1999: government-donor meeting to build consensus on the way forward in the health SWAP.

As yet, there is no definite agreed process for drafting and finalising the health SWAP between MoH and donors. A draft proposal is under discussion.

**Box 3: Ghana's development of health sector-wide programme (source: Asamoah-Baah & Smithson, 1999. Addai & Gaere, 2001)**

Ghana has been developing a sector-wide approach since 1993, having undertaken significant health reforms years earlier.

**First phase: Dissatisfaction with traditional donor-inspired projects (late 1980s)**

Multiple donor projects, which had emerged during the 80s, were highly focused on specific tasks, hindering the building of capacity across all aspects of health. Regional inequities resulted from donors favouring support to certain areas and not others. Focus on primary care led to neglect of the hospital sector. Separate information systems resulted in insufficient and expensive data collection. Regular meetings between newly empowered managers were institutionalised (Regional Director's Conference), leading to recognition of the need for an integrated approach to health sector policy and management.

**Second phase: Advent of sectoral co-ordination (early 1990s)**

The health sector was restructured, creating a crucial new division: the Policy, Planning, Monitoring and Evaluation Unit, which provided co-ordinated contact with donors. In addition, the MOH budget was reformed around cost centres to match the new structure, and decentralised, giving district and regional managers more leeway to manage their own resources. However, low donor confidence meant that most funds continued to pass directly to projects. The MoH therefore identified financial management as a key area for reform. Accounting systems started to be strengthened. The British Overseas Development Agency (ODA – now DFID) supported the development of sectoral systems and capacity building. This was made possible through a relationship of trust between the ODA and the MoH.

**Third phase: Policy framework and medium-term plan (1993-1995)**

Need for a participatory process was seen as essential to engender a greater sense of ownership and facilitate implementation. A National Consultative Meeting on Health Development was organised. Initially, compromise was made to develop a Medium Term Strategic Framework for Health Development (MTSF) and a 5-year medium term health plan. This was further evaluated and after considerable negotiation, a 5-year programme of work was agreed

**Fourth phase: Gradual replacement of projects by a sector programme (from 1996)**

Further elaboration of common management arrangements, including planning and budgeting, disbursement and accounting, procurement, and monitoring and evaluation mechanisms. Agreement by major donors to have collective appraisal missions. As appraisals took place, the budget underwent revisions, e.g. to include development plans for the regional hospitals. The appraisal process was completed by early 1997 and a common health fund was set. A few donors continue to fund projects but all use a common financial reporting system.

**Lessons:**

1. Ownership – The whole process was internally driven, with strong leadership by the MOH, but consultative.
2. Dialogue – There has been a desire to confront key policy issues by government and donors alike.
3. Management development – investment in key areas like financing, procurement and auditing prior to the SWAP and subsequently have been instrumental. Training encompassed management development.
4. Links with broader public sector reforms need to be stronger.
5. Compliance by partners – Progress towards integrated systems to manage donor support has been slower than anticipated. Despite initial commitments a number of donors have not to date made any changes to their disbursement mechanisms and procurement procedures.

## 2.2 Progress to date

### **Overview**

Most sector-wide approaches have concentrated on the role of the public sector within the health sector, and not on the health sector as a whole. All countries regard SWAPs as incremental processes, progressing from a loser form of SWAP to greater financial and policy commitments as trust is built and experience develops. There are already some countries with common funding, although this coexists with separate project funding. For example, both Zambia and Ghana have managed to establish some pooled funding. Ghana has a substantial common account for donor funds that are used to finance non-wage spending, at both national and regional level. Zambia has a common basket account from donors to finance non-wage district level spending (although we could not assess whether this arrangement is still operational at the time of writing this review). Although common accounts are still under intense donor surveillance, the aim is to gradually relax controls, as well as phasing out separate accounts for individual donors. The focus has been on allocation decisions at national level or state level in larger countries, concerning the overall balance between capital and recurrent expenditure, wage versus non-wage expenditures and the like.

### **Achievements**

All plans developed under SWAPs are successful in what they originate from a structured policy debate between donors and governments around a common table. In particular, there are positive achievements in:

- Developing plans for the health sector and setting up systems to monitor performance. This has been possible when there has been agreement from all financing parties. SWAPs have worked best where there has been correspondence between the scope of the programme and the area of responsibility of a single ministry, agency or government with a single budget (Jones 1997, quoted in Foster 1999). It is very useful to have a clear picture of the overall pattern of services and resource flows, which can be done by compiling national health accounts, as in Bangladesh (Foster 1999).
- The role of governments and ministries of health in the health sector has been strengthened and expanded. There is a more clear and coherent view of the health sector, policy development and resource allocation. For example, in some countries governments have had to deal more directly with non-public providers. In Ghana, contracts have been drawn between the government and mission providers, who have traditionally played an important role in health care provision.
- The structure of public budgets has been strengthened. This is aimed at better monitoring of spending, and to allow for gradual establishment of pooled funds. As a result, health sector programmes are becoming more

integrated within the overall budget planning process and resource allocation is becoming more rationalised.

- The allocation of resources towards the health sector has increased (although it is of course difficult to predict what expenditure would have been without a SWAP!). For example, the expenditure plans worked out in Pakistan, Zambia, Mozambique, Senegal and Ghana have increased both donor and government levels of public financing for the health sector.
- There is a better understanding of barriers to the utilisation and improvement of health services, including increased awareness of corruption and incentive issues.
- Common procedures for the management of external funds are in place in numerous countries, including Bangladesh, Zambia and Mozambique, although these are limited to a few donors and to small amounts of funds (except in Bangladesh where these are very significant). In addition, financial procedures based on governments' systems are starting to be used, for example in Tanzania, to a certain extent in Mozambique. There are good prospects for this in Uganda (Foster, Brown & Conway 2000).
- Joint reviews of progress using common indicators are being put in place. In Bangladesh, the SWAP consortium has established the use of harmonised procedures (i.e. joint project appraisal and monitoring) and the use of common management systems that have been either newly established or pre-existed in government (i.e. project finance and audit office). (Walt et al. 1999)

## **2.3 Barriers to change**

### ***Overview***

Developing a sector-wide approach is a complex undertaking that can be overwhelming and which can strain governmental capacity. First of all, the process of preparing a policy document and sector plan can be considerably long. Even when there is a clear statement of intent from governments, it is often necessary to develop government capacity to carry out the planning process itself. The main danger is therefore for policy definition to result in 'planning paralysis'. For example, officials in Uganda have reported that a process of defining policy expected to take six months ended up taking three years (allegedly donors were mainly to blame for such slow progress – reported in Walford 2000). As a result, the focus has been on strategic details and implementation plans. More attention is needed on actual implementation and on results. Details of what specific problems have been encountered are given below.

### **Problems encountered**

- There have been difficulties for governments and donors to agree on expenditure programmes and plans. The most common reasons are technical problems to get data that fits all partners' expectations and the fact that reliable information is often not available. It is also difficult for donor agencies to separate administrative costs from programme funding, which is important to ensure that pooled funding does not include staff and other costs incurred by donors as part of their country operations. Finally, it can be difficult to agree on objectives and expenditure programmes. For example, attempts to ring-fence funds for tertiary hospitals in order to increase funds toward primary care have been very contentious. This has been the case in Bangladesh, Ghana, Mozambique, Pakistan, Sierra Leone and Senegal. In all countries, government leaders favoured a larger allocation of resources to the tertiary hospital sector and a compromise has been reached (Peters 1998).
- Although joint funding may be preferred by recipient governments and has been established in a few countries, it remains relatively uncommon. This is mainly due to the lack of donor trust about recipient countries' capacity to monitor and account for public expenditure. For this reason, much effort has been focused on improving governments' budgetary and monitoring systems. Ghana's quite comprehensive common account for donors has been made possible through substantial investments in financial management systems and regular supervision (Addai & Gaere). Another obstacle is that some donors and recipient governments have arrangements which prohibit the funding of recurrent costs. Softening the rigidity of traditional funding mechanisms and arrangements is thus an area that still needs to be addressed.
- In some countries, there is a dual budget system with one development budget and one recurrent budget. For instance, in the sector-wide planning process of Bangladesh, the focus is mainly on the development budget, managed by a special office, while the recurrent budget continues to be allocated through an incremental process, based on the traditional pattern of spending. This dual approach has disadvantages and it bears no relation to macro-economic reality constraints. Incremental recurrent costs of development spending tend to be included as project costs with no real planning for their eventual assimilation in the recurrent budget. The move away from the project approach has not really solved this problem (Foster 1999).
- The problem of balancing investments between the health care system and competing sectors is not solved. Most governments undertaking SWAPs do not have the resources needed to expand their population coverage on a sustainable basis. Even if external assistance can bring improvements it may not be sufficient to extend service coverage to the entire population. In 1997, for instance, it was estimated that 40% of the population of Mozambique had no access to the most basic services, and it was then accepted that extending coverage to all was not within the immediate reach

of government resources, even with donor support (Walt et al 1999). A similar situation was found in Pakistan, where it was estimated that funds were insufficient to extend the service package to the entire population, and it was thus accepted among donors and government that improvements in health status would not occur overnight and in all parts of the country.

- Approval processes are still too slow. In particular, donor delays in completing appraisals and disbursing funds have been common. This is partly because donors' procedures are often too rigid, and partly because there may be too much focus on the details of policies and on close supervision of implementation. Such was the case in the first phase of Pakistan's SAP, during which the World Bank's procedures and style dominated and resulted in the programme being widely perceived as a Bank initiative and in low level of country ownership. At the start of the SAP's second phase, responsibility for the programme was handed over to a local sector senior leader, and the donors agreed on a more collaborative and participatory approach. A similar situation emerged in Bangladesh, with the World Bank also acting as the donor leader. A common feature in these early stages was that sector appraisals were often undertaken with little direct involvement of government officers. A more effective arrangement seems to be for document preparation to be carried out by government officers followed by an appraisal conducted by an independent team of experts, acting on behalf of all partners.
- Participation within civil society and government in the design and planning of SWAPs has been limited. Obviously, in the case of Pakistan, the donor leadership militated against increased ownership, but political ownership within government was also weak. Furthermore, whilst Pakistan has a federal structure in which the provinces are responsible for most domestic expenditures, most income is raised centrally and overall fiscal policy is a federal responsibility. Thus, social policy and implementation rests with the provinces, whilst macro-financing, budgetary control and planning lies at the federal level. A successful sector-wide approach therefore requires ownership and commitment at both levels.
- There have been difficulties in developing and using national systems for procurement, accounting and auditing. This has been a result of a combination of factors including governments' limited technical capacity, the risk (whether real or potential) of corruption and the fact that most donors need to account for funds individually. In this respect, Ghana has made some progress by investing in the development and auditing of procurement systems. The country has also managed to negotiate increasing amounts of unconditional aid.
- It has been easier to monitor activities and financial flows than results and cost-effectiveness. On the whole, the design of monitoring systems has been difficult and remains unresolved for reasons relating more to the difficulties of measuring health systems performance than to SWAPs per se. For example, health outcome indicators are often too slow and lack the necessary sensitivity to be linked to health care interventions. A global move

is taking place for using proxy indicators that give a measure of governments and donors efforts and verifiable commitment to the policy directions set under the SWAP. Table 1 lists commonly used proxy indicators.

- SWAPs should ideally be concerned with the whole of the health sector, but many countries have initiated them at a sub-sectoral level. For example, Pakistan has focused on primary health care. Although this is far from an ideal approach, it might be a more realistic option than embarking on ambitious programmes when government capacity is insufficient.

**Table 1 Common monitoring indicators (source: Foster M et al. 2000)**

Indicators	Purpose	Examples	Possible sources	Comment
Impact indicators and proxies	What is the long-term impact of the programme on the health of the population?	<ul style="list-style-type: none"> <li>• Life expectancy</li> <li>• Infant and child mortality</li> <li>• Fertility</li> <li>• Maternal mortality</li> </ul>	Census; Demographic and Health Surveys	<ul style="list-style-type: none"> <li>• Tend to respond slowly to health sector improvement</li> <li>• May be driven by non-health factors in the short-term (e.g. drought)</li> <li>• Infrequently measured. Therefore need to rely mainly on service quality and outcome indicators as proxies</li> </ul>
Outcome	What are the immediate health effects?	<ul style="list-style-type: none"> <li>• Lower incidence of targeted diseases</li> <li>• Better health awareness</li> </ul>	Demographic and health surveys; MoH reviews	<ul style="list-style-type: none"> <li>• Responsive to successful delivery of outputs</li> <li>• Provide valuable information for programme management</li> <li>• Reliant on research capacity</li> </ul>
Output	Are more health services being provided?	<ul style="list-style-type: none"> <li>• Immunisation coverage</li> <li>• Outpatients seen per type of facility</li> <li>• Drug availability at clinics</li> <li>• Equity indicators (rural/urban, male/female, poor/non-poor)</li> </ul>	Administrative sources (e.g. MoH service statistics, HMIS); Demographic and health surveys; Non government health provider service statistics	<ul style="list-style-type: none"> <li>• Can be used as a proxy for service quality</li> <li>• Reliant on good quality health management information systems</li> </ul>
Service quality	Do service users perceive changes in quality?	<ul style="list-style-type: none"> <li>• Are facilities open at appointed times?</li> <li>• Are bribes sought? Are user fees acceptable?</li> <li>• Are patients treated fairly and with respect?</li> </ul>	Service Delivery surveys; CWIQs; Patient surveys; facility records; Supervisory visits; Participatory Poverty Assessments	<ul style="list-style-type: none"> <li>• Quality improvements are a proxy for outcome indicators</li> <li>• Valuable for identifying access barriers and service responsiveness</li> <li>• Increasingly used for annual SWAP programme monitoring e.g. Uganda, Tanzania and Bangladesh have systematically collected</li> </ul>

		<ul style="list-style-type: none"> <li>Distance to facilities</li> </ul>		data on the experience of those attempting to use services
Cost effectiveness	Do expenditures provide best value for money?	<ul style="list-style-type: none"> <li>Unit cost per outpatient visit</li> <li>Patient contacts per staff member</li> <li>DALYs</li> </ul>	Hospital and District/regional Health accounts; Health economics research	<ul style="list-style-type: none"> <li>Can be helpful in defining essential service package</li> <li>Can permit comparison between performances of service providers</li> <li>Requires reliable budget and activity data</li> </ul>
Activity/Process	Has the sector implementation work programme been completed on time?	<ul style="list-style-type: none"> <li>Agreed actions taken</li> <li>Policies implemented</li> <li>Next year's work plan developed</li> </ul>	Budget proclamations (Gazetting); MoH reports	<ul style="list-style-type: none"> <li>Reliant on effective staff supervision for monitoring</li> <li>Relatively straightforward to collect for MoH level activities, more difficult lower down system</li> </ul>
Input	Have financial disbursements reached the budget levels against specific categories of spending?	<ul style="list-style-type: none"> <li>Tertiary/primary Wages/non-salary Capital/recurrent</li> <li>Urban/rural</li> <li>Regional</li> </ul>	Government budget and donor statistics (MoH, district/regional Health and MoH Finance Division reports)	<ul style="list-style-type: none"> <li>Reliant on good quality budget information-often not available</li> <li>Can be difficult to distinguish between types of spending below district level, therefore usefulness of input indicators alone can be limited</li> </ul>

- Barriers to change on the part of health sector staff have been common. This is partly because health sector personnel often have no incentives to promote change (i.e. they might perceive that more work is required for little or no benefit), or because there are perceived advantages in maintaining the status quo. For example, vertical programme managers may lose perceived status, influence and some of the perks that often accompany such programmes. This was the case in Zambia and also in parts of Ghana during the initial stages of the SWAP. Also, a lack of understanding of the objectives of the reform and of the SWAP has been reported in Bangladesh as leading to a lack of perception of benefits by staff (Foster 2000).
- Links between the SWAP and other ongoing health reforms have often been weak, partly because design and implementation responsibilities for each of these may lie within different government departments and may each involve a different group of donors. In countries undergoing decentralisation this may lead to problems with service delivery and implementation of health sector reform, and may be linked to falling coverage figures in some vertical programmes such as EPI (Brown 2000). It is important to note that while there is no evidence linking reductions in coverage of vertical programmes with SWAPs implementation, SWAPs taking place within decentralised health systems may exacerbate some of the problems linked to decentralisation,

one of which may be a reduction in coverage of programmes hitherto conducted under a very vertical structure.

- There is also little evidence that priority programmes may suffer as a result of SWAPs. This would seem unlikely given that the use of pooled funding is still uncommon and that many donors are still financing individual projects. However, the following problems have been mentioned: staff can become overly focused on SWAP development at the expense of service delivery; vertical programmes are vulnerable to poor financial management and competing priorities when the budget shifts to sector-wide programmes; and there is not sufficient information on the impact of reorganisation on specific services.
- Transaction costs have actually increased as governments are having to deal with old and new development assistance procedures, and provide information for both systems. Ethiopia, for example is reforming its financial management systems but has had to introduce temporary reporting arrangements (Foster 2000). The same situation has been reported in Tanzania, without there being a clear indication of when transaction costs may decrease (Brown 2000).

## 3 SWAPs and the health of poor people

### 3.1 Are SWAPs pro-poor?

Contributing to poverty reduction is a major objective of development assistance, and ill-health is a major cause of poverty. In this sense any improvements in the efficiency of external aid and in the coverage and quality of essential services –two key objectives of most SWAPs- should have a positive impact on the health of poor people and on poverty. On the other hand, there is concern that SWAPs are too centralist and focused on policy issues and on the supply of services at a macro level and may take very long time to actually address the needs of poor people. In this regard, the choice for donors is whether to channel development aid directly to those most vulnerable, or to encourage that resources are allocated in ways that favour the poor in the negotiation of sector policies and strategies. In practice, donors and governments tend to take a midway approach and target certain resources to the poor while simultaneously addressing macro-policy issues.

Cassels recognises that reconciling a poverty-focused agenda for development assistance with a sector-wide approach to health development is not straightforward (Cassels 1997). A number of issues need to be considered:

- Donors have to recognise the pressures, political realities and responsibilities of recipient countries towards the rest of the population, and not just to the poor. As explained, involvement in SWAPs means that donors will influence overall spending decisions rather than those focused on specific groups.
- It cannot be assumed that funding specific areas under a SWAP, such as primary care or rural districts will immediately benefit the poor (i.e. different access by different groups).

While SWAPs may not be inherently pro-poor, neither are they anti-poor. Whether they benefit the poor will depend on the actual policies contained and implemented by each country. Consequently, a positive impact on the poor is more likely to be achieved by SWAPs in countries that are committed to and working actively towards poverty reduction. In this sense, there is potential for synergy between SWAPs and poverty reduction strategies that are being developed in all highly-indebted poor countries (HIPC) to access IDA/IMF funds.. PRSPs have been proposed by the World Bank and the International Monetary Fund as the central mechanism for developing and coordinating concessional lending to low-income countries. A poverty-reduction strategy paper will describe and diagnose poverty conditions in a country and present a medium-term action plan to reduce poverty and generate more rapid economic growth (World Bank 1999). PRSPs are formulated by recipient governments in consultation with stakeholders. Since the first interim PRSPs have been developed in the last two years only it is far too early to assess the real degree of synergy between SWAPs and PRSPs.

### 3.2 Experience with SWAPs in poverty reduction

Most sector-wide programmes in health have tried to shift resources towards primary and preventive health care in order to fund a package of essential health services. For example, Ghana, Uganda and Ethiopia all aim to increase the share of resources allocated to primary health care at the district level and below. In this regard, SWAPs should in principle lead to an improvement in the share of health expenditures benefiting the poor. However, there is limited evidence to support this claim

Allocating resources towards primary care facilities and capping tertiary hospitals' budgets is in practice very difficult. Zambia, for example, attempted to ring-fence the budget share for tertiary hospitals but this soon became unsustainable, partly due to opposition from staff but also because hospitals soon became under-resourced. The question of how to manage hospitals and make primary care reform sustainable therefore remains to be solved.

Foster has pointed out that the approach to improving access for the poor may have been too focused on the supply side. This might be at the risk of neglecting important issues on the demand side. For instance, some country programmes envisage an increased role of user charges. User fees are usually accompanied by exemptions for the poor but experience has shown that these exceptions are difficult to implement, and that user fees tend to reduce service utilisation particularly among the poor (Creese & Kutzin 1995).

In essence, the main problem is that in low income countries with limited government capacity, governments are unable to afford even an essential package of services for the whole of the population. Current and prospective levels of funding are not consistent with universal health coverage (Foster 2000). This is technically and politically a complex problem and unfortunately there are no easy solutions. Feasible ways to extend services might involve experimenting with new approaches to cost-recovery, social insurance and expanding contributions from the private sector. In addition, ensuring provision of services does not necessarily require governments to actually provide them. Non-governmental organisations, missions and the private sector provide significant health care services in many countries (e.g. role of missions in Kenya, and of NGOs in Mozambique and Bangladesh). In any case, there must be mechanisms to ensure that the poor are not excluded.

In the search for ways that the poor are not excluded from accessing essential health care attention should be paid to the following issues:

- Policies need to be informed by a good understanding of the health-seeking behaviour of the poor, the constraints they face to access services, and their willingness to use and pay for government services (i.e. mechanisms that encourage poor people's demand for, and access to health care). In this regard, it is important to assess what policies work best in specific national contexts (e.g. subsidies for primary care, user-fees, rural versus urban spending, distribution of health professionals, insurance schemes).

- Where there is a large private sector, governments should be concerned with the way private provision is managed, to avoid exacerbating inequalities.

SWAPs should be concerned with mechanisms by which governments become more responsive to the needs of the poor by targeting public subsidies to them. At the same time, increasing the participation of the poor in service delivery strategies and increasing the transparency and access to information on services, on health expenditure patterns and on the distribution of public subsidies are all important steps towards health strategies where poverty focus can be developed. Current steps in Uganda and Tanzania to publish and display user fees and funds represents an effort to increase transparency (Foster et al. 2000). In India, Bangladesh and in several African countries the publication of Incidence Benefit Studies is enabling governments and donors engage in more articulate discussions on how effectively is public expenditure targeting poor people.

Wherever public expenditures cannot be readily reallocated to the poor in the short term because of political, economic and technical reasons governments and donors should at least ear-mark support for health services that address major causes of ill-health. This special support could include drugs and supplies, such as vaccines, TB drugs and family planning supplies, and target certain geographical areas or support selected NGOs and community projects as an interim strategy during SWAP development.

## 4 The case for SWAPs in Latin America

### 4.1 Is there a case for health SWAPs in Latin-America?

SWAPs have been or are being introduced mainly in low-income countries of Africa and Asia, and there is hardly any experience of their application to middle-income countries. Most Latin American countries are categorised as middle-income countries, and SWAPs have not been attempted in any of them. Only Nicaragua and Bolivia, two among the poorest countries in Latin America are considering the introduction of a SWAP in their health sector. Two questions will be addressed in this section:

- Under what circumstances would a SWAP be beneficial to the health sector of a Latin American country?
- What might be the scope of a SWAP in a Latin American context, and what should be the building blocks for developing a SWAP?

In terms of context, many of the conditions under which other countries have initiated SWAPs actually exist in low-income and in some middle-income Latin American countries such as Nicaragua, Bolivia, Peru, Guatemala, Honduras and El Salvador. For example:

- Nicaragua, Bolivia and Honduras are highly-indebted poor countries (HIPC). Guatemala, El Salvador and Peru are middle-income countries but, like the former countries, they account for a high number of extremely poor people (living on less than US\$1/day).
- All these countries show significant inequalities in levels of income and in access to basic-services, including health. Furthermore, public expenditure in health tends to be low, with the added problem that public subsidies are ineffective in targeting either the poor or those public health problems that most affect them.
- Most of these countries (to a lesser extent Guatemala and El Salvador) are highly dependant on external aid for their health sectors, particularly for the provision of primary health care. The location and forms of aid are strongly linked to donors' preferences, with some geographical areas being favoured while others remain highly neglected.
- External aid is provided in the traditional ways and funds projects or specific line items (contraceptives, drugs) of the service delivery network. This increases the vulnerability of these countries to changes in policies and priorities by donors, more so when donors pull out of particular sectors.
- Lack of continuity and determination in health policy implementation is a major problem. With a few exceptions health policies tend to change as

least as often as election cycles (every four years). Health policies often reflect the aspirations of governments rather than depicting a rigorous work agenda to address shortcomings on the basis of available resources.

- A high proportion of health care is provided by the private sector and by non-government organisations, and yet working arrangements do not exist to channel public subsidies to these providers so as to make health care more affordable to the poor. Out-of-pocket expenditure in health tends to be high in most of these countries.

Country	GNP in US\$		High/Low 20% income ratio	Annual GDP growth rate	Expenditure on Health as % GDP*	
	P/C	PPP			Total	* Public
Bolivia	1,010	2,005	8.6	<u>4.7</u>	5.8	<u>1.1</u>
El Salvador	1,850	4,008	16.6	3.2	<u>7.3</u>	2.6
Guatemala	1,640	3,474	<u>30</u>	<u>5.1</u>	<u>5.2</u>	<u>1.5</u>
Honduras	<u>740</u>	2,338	17.1	3.0	<u>7.3</u>	2.7
Nicaragua	<u>370</u>	1,896	13.1	<u>4.0</u>	<u>13.3</u>	<u>4.4</u>
Peru	<u>2,440</u>	4,180	11.6	0.3	<u>4.9</u>	<u>2.2</u>

Source: PAHO – Health Situation in the Americas – Basic Indicators 200. \* is World Development Report, 2000/01, World Bank. Shaded and underlined figures set by the authors show maximum and minimum values in the range, respectively.

### **1.1 Circumstances where a SWAP might help.**

SWAPs can make external aid more effective and efficient, they can make such aid better aligned with government policy and they can contribute to a fruitful policy dialogue between governments and external donors. But SWAPs are also complex and long term processes - they require time and can use a disproportionate amount of local skills that are often in short supply. It seems therefore appropriate to ask under what circumstances should a country embark in a SWAP, and what should be the scope of interventions covered under a SWAP? To answer these questions the following issues should be taken into consideration:

- **The size of external aid to the health sector.** In countries where external aid represents a sizeable percentage of health sector financing, or where such aid is focused on key priority programmes there may be a case for considering a SWAP. In countries like Bolivia, Guatemala, El Salvador, Honduras and Nicaragua external aid plays a key role in supporting priority preventive services that governments might not be able to fund otherwise. The greater the proportion and size of external aid the more justification there is for ensuring that aid is properly managed.

- **The form of external aid (relative to the size of the country).** When external aid takes the form of project support, whereby each donor supports specific projects in different geographical areas or provide funding for specific line items, the effectiveness of aid can be seriously compromised.
- Firstly, the administration of such aid is likely to pose an important burden on the recipient government, as projects need to be designed and their performance monitored and evaluated by recipient governments. In Latin America Ministries of Health often cannot cope with the burden involved in 'dealing' with donors and their projects.
- Secondly, aid can introduce or make existing inequalities worse, as donors are allowed to chose among various geographical regions or among several line items that do not necessarily coincide with government priorities for targeting aid. In Nicaragua, the poorest country in Latin America with the highest number of donors and the highest proportion of the health budget linked to external aid large parts of the Atlantic region remain without essential services provided by either donors or government.
- Project aid in Latin America has important flexibility and sustainability implications. On the one hand it is difficult for projects mainly designed by donors (even if they use local expertise) to be adapted to the changing policy environment. Many so-called 'demonstration' projects do not actually demonstrate anything as there is little chance for lessons learnt to benefit and cross-fertilise to other projects and other geographical areas. The reasons for this are both a lack of government ownership of many donor-funded projects as well as the perceived difficulties of a government scaling up projects that were designed under previous administrations. The new government can always argue that government priorities have changed or that the resources required for scaling up are simply not available.
- In terms of sustainability governments rely on the continued support of donors for maintaining essential services. When donors pull out of a country or a sector, or when donors priorities change these services are badly affected. For example, when USAID pulled out of the health sector of many Latin American countries, or when it decided to channel sexual and reproductive health items through NGOs the supply of contraceptive services in government health facilities was greatly affected.
- The opportunity costs of project aid are greater in smaller countries where qualified human resources are scarce and where dependency on aid is higher.
- **The extent of continuity in policy implementation.** Lack of policy implementation has been The Problem behind the failure of many Latin American governments to introduce and sustain essential health care reforms. The political cycles taking place every four (or five) years often result in policy shifts and in changes in key personnel at senior level. These changes tend to seriously disrupt efforts and reforms initiated by the previous administration, including the perceived need for new governments to

'renegotiate' projects and priorities with the donor community. These changes in direction are frustrating for governments and donors alike as they have often lead to many reforms never getting beyond the stage of mere policy statements. And yet, none of the 6 countries cited above have the structures or mechanisms for donors and governments to engage in a fruitful policy dialogue that results in longer-term priorities and sector direction. When policy continuity is a problem, SWAPs represent an opportunity for donors and governments to define and maintain the focus on an agreed health sector agenda, and to pool resources towards its achievement. This process may take a long time, and expand beyond a single political term, but once donors back it up with commitment and resources the chances of policy regression would be greatly reduced.

- **The direction of public subsidies.** It is practically very difficult for governments to change the direction of public subsidies and ensure that they target those in greater need. In Latin America as elsewhere governments are subject to many pressures and may not be able to redress historical inequalities in resource allocation (even if they so wished) without the help and leverage that donors and external aid can provide. Targeting of public subsidies to those in greater need is critical in countries of Latin America where large inequalities in income distribution and in access to public services are known to exist. Failure to do so implies that inequalities are made worse by inequitable distribution of government and external aid resources. In this context it is the poor who are hit the hardest since policies never live long enough for improvements and resources to reach the areas where they live. In these circumstances a SWAP can lead to a process of reallocation of public and external aid resources based on negotiation and proper needs assessment.

#### **4.2 Scope of SWAPs in Latin America**

By definition SWAPs are sector-wide but, as this review has shown, some SWAPs have favoured particular sub-sectors (such as primary care) or interventions (such as priority programmes or basic health packages, as in Pakistan). There is not enough world experience to assess the comparative merits or otherwise of engaging in a full SWAP or in a more limited one. In principle, however, a more limited SWAP should probably deliver the benefits of a full SWAP within a narrower scope.

The possibility of embarking in more limited SWAPs is important in the context of Latin American countries, where the implications of a full SWAP may be seen (by both governments and donors) as overwhelming, too long term or impractical. On the other hand, there is clearly a need to get the policies and resources of governments and donors aligned within specific areas of health care policy. One such case is that of sexual and reproductive health in Nicaragua, where donors and governments have expressed the need to define a single national policy and strategy that would be supported by donors and government under a single administrative framework. This is what has been

termed as a 'mini-SWAP' or sub-sector SWAP in Sexual and Reproductive health (S&RH). Since S&RH is an emerging need in many Latin American countries, and since donors have been active in advocating for it and towards its financing the Nicaragua experience could prove extremely useful to other countries in the region.

#### **4.3 Building SWAPs in Latin America – what are the key steps?**

Whether a full or a partial SWAP are attempted the building blocks for a SWAP remain essentially the same. The following are some practical considerations for SWAP development.

- **Common definition and analysis of the problem or policy area to be addressed.** It is important that right from the early stages the analysis of the problem or policy areas is a joint effort by donors and government representatives. While Ministries of Health and Donor representatives should make the initial approaches, there may be other parts of the government that will need to become involved over time. Key among them will be the Ministry of Finance, the office for External Cooperation (if applicable) and other ministries, such as the Ministry for Local Government in more decentralised countries. A SWAP starts by a mutual, explicit commitment made by donors and government to approach one particular problem or need in a joint fashion. While 'Donors Groups' are a common feature in many Latin American countries and may well constitute a starting point, SWAPs development should always involve the government from an early stage. Since donors and government officers are usually busy and may not have the time, skills and resources required to engage in the problem analysis, a useful way to proceed is for donors to commit some funds towards the development of the SWAP. Such fund should enable the development of Terms of Reference and the hiring of technical experts to perform a detailed sector or sub-sectoral analysis of problems, financing and expenditure levels, options and possible ways ahead.
- **From problem analysis to consensus building: reaching a common agenda.** Once the problem analysis sheds light on the issues to be addressed, the population groups to be targeted, the services to be delivered and the role of various possible providers (public and private) there is a need to define a common strategy. Such strategy essentially commits the government, present and future, and the donors to a common understanding of objectives, strategies and processes involved in reaching a common agenda. Governments commit themselves to pursuing the proposed strategy over the period of time required for objectives to be met. This means most of the times defining longer term strategies that survive political cycles. Donors, on the other hand, commit themselves to endorsing the national strategy and providing the resources required and agreed with the government. Donors –present and future- also commit themselves to avoiding a 'pick and chose' approach in the concerned policy area.

- In most SWAPs the commitment of donors goes beyond the mere funding of additional expenditure and tends to move towards a form of pooled-funding. There are various degrees and forms of pooled funding (as has been discussed in a previous chapter) and it is for donors and government to decide on the funding mechanisms. What remains key is that arrangements for programme monitoring and review will be unified and will involve all donors, avoiding the need for governments to deal with each donor agency separately.
- **Defining the implementation strategy.** Once consensus has been reached there is a need to define the implementation agenda, the way financial commitments will be materialised and specific review and monitoring mechanisms that will take place. While annual joint reviews will be advisable most SWAPs will also require more thorough four-yearly reviews undertaken by independent consultants. The results of four yearly reviews will often be the indicators that point to areas where further commitment is needed or where adjustments to the SWAP strategy need to be made.
- **Defining and acting on capacity building needs for SWAPs to work.** This involves designing new planning and budgeting systems and developing local capacity in these areas. Equally important is to define MIS and baseline data, procurement procedures, financial management processes and skills, and to map out the transition from projects to programmes.
- **All these processes will inevitably take time.** It is important to remember that the process of developing a common policy has a value in itself as it forces governments and donors to draw plans together and makes both of them ultimately responsible for achievements and failures. It is important (as has been discussed in a previous chapter) not to get bogged down in unnecessary details and in over-detailed implementation strategies that hinder instead of facilitating the achievement of policy objectives.

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Contrast Project and Sector Programme Approaches

Approach	Self-contained	One implementing agency, one or a few financiers	Projects have own support systems
Project	Yes	Yes	Yes
Sector Programme	No	No	No

Implementation by a project unit overseen by a management committee Project has clear beginning and end Sector Program Open-ended and complex (covers many projects and activities) Many implementing agencies, many financiers Common support systems Project unit/management committee model cannot.

Second, a SWAp emphasizes strengthened health sector management through the development or adaptation of management tools, combined with strengthening of implementation capacity. For example, under SWAs greater attention is given to health sector planning, financial management, and improved health information systems. SWAs also tend to emphasize strengthening district level management capability within existing decentralization policies (e.g. Ghana, Uganda and the United Republic of Tanzania).

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