Helpdesk Research Report: Experience with Health SWAps
11.02.11

Query: What are the key determinants of success in donor/government Sector Wide Approaches (SWAps), particularly in the Health Sector? What are the institutional, political and contextual pre-requisites that make SWAps a success, particularly in the Health Sector? What are the different models of SWAps that have been used, and with what success?

1. Overview
2. SWAps: success factors
3. Different SWAp models: case studies
4. Sierra Leone
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1. Overview

The World Bank (2009) defines a Sector Wide Approach (SWAp) as ‘…an approach to a locally-owned program for a coherent sector in a comprehensive and coordinated manner, moving toward the use of country systems,’ although it should be noted that there is no universally-agreed definition. Experiences with SWAps have shown that they can have a positive impact on improved national ownership and leadership, donor harmonisation and alignment and greater coherence, transparency and accountability along the policy-result chain (World Bank, 2009). This query examines the key determinants and prerequisites for success in health SWAps. It also looks at the success of different SWAp modalities used in the health sector.

Determinants of successful health SWAps

Based on a study of six countries (Bangladesh, Ghana, Kyrgyz Republic, Malawi, Nepal and Tanzania), the World Bank’s Independent Evaluation Group (2009) concluded that there are four key success factors which determine a SWAp’s impact on the achievement of national health objectives:

1. Specific, prioritised, phased, and ambitious-but-feasible targets and programs of work (PoW) that assess the political economy of reforms.
2. Adequate systems and capacities are already in place for strategic management, including systems for planning, resource allocation, monitoring, tracking of expenditures and results.
3. Well-defined, well-functioning, complementary and productive partnerships among the actors and stakeholders, both national and international.
4. Reliable, predictable flows of assistance that are efficiently allocated and effectively used.

In addition, evidence suggests that successful SWAps have partners (including bilateral donors, multilaterals, NGOs, private sector, civil society) committed to ongoing transparent and open dialogue. For example, a key lesson to emerge from the Mozambique health
SWAp is that commitment, leadership, coordination and mutual accountability are dynamic variables requiring constant attention and renewed commitment from all parties to keep pace with a fast changing health sector and emerging challenges (World Bank, 2009).

Another important success factor, particularly in fragile states, is that donors are committed to long-term strengthening of the system. As Joel Negin at the University of Sydney observes, 'if you want results tomorrow, SWAps might not be the best avenue as it is more about building systems, discussion, learning – and often can distract from immediate service delivery impacts.' A study of health SWAps in Ghana, Malawi, Mozambique, Tanzania, Uganda and Zambia by the HLSP Institute (2007) warned that development partners should plan for a time-consuming process in setting up health SWAps. For example, Malawi’s SWAp took five years and Uganda’s three years.

Performance monitoring and the use of indicators are also key determinants of success. A combination of intermediate outputs such as numbers treated or vaccinated, as well as measuring progress in strengthening capacity and sustainability of results is recommended (Walford, 2007). For example, the Malawi health SWAp PoW suffers from a number of weaknesses: ‘the pillars in the PoW are input-oriented, and as a result planning, monitoring and reporting are equally input-oriented. It is very difficult to translate these inputs into programme outputs and outcomes, though “the SWAp M&E [monitoring & evaluation] framework makes an admirable attempt to do so”.’ (Pearson, 2010, p.8). In contrast, the Kyrgyz Republic health SWAp has a good balance between implementation and results, due to the establishment of good M&E capacity and of a strong results-focus prior to the SWAp implementation (World Bank, 2009).

Pre-requisites for successful health SWAps
The political and economic landscape is clearly important in determining the success of SWAps. Effective SWAps require political will, commitment and a supportive macroeconomic and budget environment to allow sector authorities to budget resources with reasonable confidence. Negin’s (2010) comparative review of the Samoan and Solomon Islands SWAps highlights the importance of political and economic context, government capacity, and relationships between donors and partner governments. While both SWAps are now facilitating positive developments, the experience in the Solomon Islands was initially more challenging and involved significant ‘growing pains’. The Solomon Islands SWAp had to overcome a difficult context of a history of political instability, ethnic tensions and social unrest, which in turn contributed to limited capacity within government ministries. It was also driven by external partners and characterised by initial tension until 2007. In contrast, the Samoan SWAp had a more positive foundation of strong policies, stability and capacity in the health sector. The SWAp was largely owned and driven by the government, with the support of a number of prominent donors.

SWAps in fragile and post-conflict settings
While stable, confident governments are more likely to be successful, it is possible to implement effective SWAps in fragile states. Canavan et al (2011) have identified the following preconditions for a successful health SWAp in fragile and post-conflict states:

- **Government leadership**: well articulated vision and mission for health sector growth; clear mapping of priorities and resources based on assessed needs; and regulation, stewardship and good governance manifesting in improved health outcomes.
- **A clear nationally-owned sector policy and strategy, derived from broad-based stakeholder consultation**: government owned; alignment of donor support with sector policy and aligned with MDGs/PRS; and sufficiently pro-poor.
- **Budget and expenditure framework**: consistency of policy with budget allocations & actual spending; existence of a supporting (multi-annual) budgeting process/MTEF;
well-resourced: sufficient domestic and external financing available; alignment & predictability of donor contributions; and access to service delivery by the poor.

- **Shared processes and approaches**: development assistance aligned with national plan; well coordinated and harmonised support with common arrangements; stakeholder mapping within the sector with coordination mechanisms (government, donors, private sector, NGOs); and joint, comprehensive capacity building approach.

- **Performance monitoring**: results focused and monitorable framework for the health sector.

- **Reliance on and commitment to building govt PFM systems**: aid using country PFM systems; improved budget processes & allocation & operational efficiency; use of (more aligned) aid modalities; contribution of aid modalities to health sector strengthening; and predictability in the availability of funds for commitment of expenditures to Ministries, Departments and Agencies (MDAs).

### Different SWAp models

By definition, a SWAp is an approach – a way of working – rather than an aid delivery instrument or modality. SWAps may involve a range of different models including pooled funding, sector budget support, and a mix of projects, although ‘implicitly it is assumed that over time an increasing share should be provided in the form of budget support as a means of reducing transactions costs’ (Pearson, 2010).

With regard to this query, Negin observes that: ‘Overall, SWAps are just a means to an end; they are most of all a process of interaction and collaboration. They are not a fixed tool. There is an increasing trend in SWAps to move away from strict adherence to pooled funding through government systems as the main prerequisite to an understanding of SWAps as emphasising harmonisation, discussion, sharing of information, transparency and joint planning’.

It is not possible to say from the literature whether one type of SWAp model is inherently more successful than others. However, one of the key messages emerging from the experience of other SWAps is the importance of adopting a *flexible* approach: ‘Insistence on pure SWAps may lead to stagnation, whereas accepting a degree of diversity and fragmentation may bring about a policy’s desired effects’ (van Donge, 2007). The Zambian example shows the benefits of flexible SWAps; it welcomes projects, provided that they do not contradict the SWAp’s overall policy, resulting in important innovations and more direct information-sharing. The flexible model also includes partners not contributing funds. Another advantage of a flexible approach is that the Zambian SWAps focus on annual work-plans that incorporate evidence-based policy-making, rather than an idealised, comprehensive policy designed by the sector and government in advance.
2. SWAps: success factors


This working paper from the World Bank’s Independent Evaluation Group (IEG) looks at the evidence of the impact of health SWAps from six countries: Bangladesh, Ghana, Kyrgyz Republic, Malawi, Nepal and Tanzania. While all the SWAps have largely succeeded in harmonising development assistance and establishing new, country-led partnerships and dynamics between government and donors, the authors conclude that the health SWAps have been only ‘modestly successful in achieving improved sector stewardship, as measured by the efficiency of resource use, the sector’s focus on results, and the definition and enforcement of sector-wide accountabilities’ (p.xii).

The authors note that there are four key success factors which determine the SWAp’s impact on the achievement of national health objectives:

1. **Specific, prioritized, phased, and ambitious-but-feasible targets and programs of work (PoW) that assess the political economy of reforms.** The report observes that ‘overly complex and ambitious PoWs that were not evidence-based, prioritized or phased, sufficiently assessed for risks, results-focused, and/or commensurate with national capacity to implement them, were less likely to achieve their objectives’ (p.xiii).

2. **Adequate systems and capacities are already in place for strategic management**, including systems for planning, resource allocation, monitoring, tracking of expenditures and results. For example, the author notes that the Kyrgyz Republic SWAp has a good balance between implementation and results, due to the establishment of good M&E capacity and of a strong results focus prior to the SWAp implementation.

3. **Well-defined, well-functioning, complementary and productive partnerships among the actors and stakeholders, both national and international.** The report emphasises the importance of the dynamics of the partnership – who is in the partnership; the main functions of the partnership and how effectively they are carried out; and how the partners interact. For example, SWAps frequently fail to include private sector and civil society organizations in planning and reviews. The paper notes that in the six countries studied, development partners (DPs) have ‘undermined the quality and productivity of dialogue and PoW implementation by being too rigid or dogmatic in some cases and insufficiently candid or rigorous in others. Memoranda of Understanding and Codes of Conduct provided little useful guidance for managing situations of discord and have been ineffective in holding DPs accountable for their commitments under SWAps. DP staffing, skills mix and inevitable turnover were not well managed, undermining the quality and reliability of their support. The quality and availability of national management capacity and leadership were also crucial to effective partnerships. Where sector leadership and stewardship were weak, SWAps were less likely to succeed. Strong leadership was better able to catalyze and manage all actors’ contributions and more likely to achieve results’ (p.xiv).

4. **Reliable, predictable flows of assistance which are efficiently allocated and effectively used.** The paper identifies the following factors which undermine resource predictability: inadequate estimation of PoW cost, financing, and financing gap scenarios; failure to include the non-governmental sector in costs and resource envelopes; macroeconomic instability; lack of alignment of DP planning, budgeting and expenditure cycles with country cycles; failure of DPs to commit to predictable medium-term financing; and the earmarking of various sources of assistance. For example, in both Ghana and Tanzania, while the flow of funds improved under the
SWAp health funds, it was not regular, fast or large enough in size to keep pace with the amounts budgeted to deliver services and implement plans.

The paper also identifies several important lessons to improve the effectiveness of a health SWAp:

- **The need for rigorous appraisal of the PoW** by government, other national partners and DPs to ensure it meets minimum quality standards.
- **Strengthen M&E capacity** prior to implementation and ensure systems are in place for accommodating pooled financing (procurement, financial management).
- **Ensure managers have the capacity at central, regional, district and peripheral levels** to draw on, interpret and utilize a range of information emanating from these systems, facilitating the strategic management of inputs, processes, outputs, results and accountabilities.
- **The value of incentives, whether rewards, sanctions, and/or pedagogical interventions**. The author observes that incentives can ‘strongly and positively affect a SWAp’s results focus. These involve monitoring performance, sharing performance data with the public, and using performance data to monitor and enforce accountabilities. The absence of these incentives has been cited as a factor seriously undermining a results focus’ (p.54).
- **Better management of local political economy issues**, for example strengthened technical, strategic decision-making, and service delivery capacity of health districts and facilities.

Negin, J., 2010a, ‘Sector-Wide Approaches for Health: an Introduction to SWAps and their Implementation in the Pacific Region’, Health Policy and Health Finance Knowledge Hub, Working Paper Series, Number 2

This is the first of three working papers produced by Joel Neggin at the Nossal Institute for Global Health at the University of Melbourne, Australia (funded by AusAID). The papers look at SWAps for health in the Pacific region, with a comparative study of experiences and lessons learned in Samoa and the Solomon Islands. In the first paper, Neggin examines the international literature and identifies some of the key components of successful sector-wide approaches:

- **Agreed health sector plan**, which is ‘evidence-based and developed through collaborative mechanisms involving a wide range of stakeholders in order to be complete, authoritative and effective’ (p.3).
- **Ownership by partner government**, with at least a ‘core of influential officials who share relevant donor perspectives, while understanding the political and administrative steps needed to secure effective commitment’ (p.3).

- **Partnership between all or most donors and governments**, with mechanisms for collaboration and dialogue, such as joint missions, sector reviews, and periodic meetings with scope for real discussion.
- **Increased funding availability and longer term commitments**, compared to previous short-term project-based models.
- **Efforts to streamline funding arrangements** – while pooled funding has traditionally been seen as the most important component of SWAps, Neggin observes that not all development partners are able to contribute to pooled funds and ‘the rapidly emerging emphasis is more on streamlining funding and, where possible, moving to pooled funding approaches’ (p.4).
- **Institutional capacity and good governance**. Although strong governance systems are important to SWAp success, the paper notes that in fragile and post-conflict
states without strong institutional capacity, SWAp and whole-of-sector approaches can help develop harmonised approaches to strengthening governance mechanisms.

- **Stability of donor and partners government personnel** is critical and a rapid turnover of the key players can undermine the strong relationships, continuity and stability needed for a SWAp to be successful.


The second of three working papers reviews the development of health SWAps in two Pacific countries, Samoa and the Solomon Islands. While both SWAps are now facilitating positive developments, the experience in the Solomon Islands was initially more challenging. The Solomon Islands SWAp had to overcome a difficult context of a history of political instability, ethnic tensions and social unrest, which in turn contributed to limited capacity within government ministries. The Solomon Islands SWAp was driven by external partners and characterised by initial tension until 2007.

The Samoan SWAp had a more positive foundation of strong policies, stability and capacity in the health sector. The SWAp was largely owned and driven by the government, with the support of a number of prominent donors.

Negin’s comparative review of the Samoan and Solomon Islands SWAps highlights the importance of understanding the political and economic context, government capacity, and relationships between donors and partner governments. The paper concludes that ‘in general, SWAs are complex and difficult arrangements to design and implement. Despite the frequent claims that SWAs reduce transaction costs and facilitate harmonisation, significant growing pains are inevitable, especially for the first few years’ (p.10).

Negin, J., 2010c, Sector-Wide Approaches for Health: Lessons from Samoa and the Solomon Islands, Health Policy and Health Finance Knowledge Hub, Working Paper Series, Number 4

The last of three working papers offers some lessons learned about sector-wide approaches for health. Using the six key components of SWAs identified in the first working paper, Negin produces a summary table of the key elements in Samoa and the Solomon Islands (see table below).
The author concludes that there can be no blueprint for implementation that suits every situation. SWAps should be a flexible process, with constant attention paid to the stability and strength of the relationships (both donor-donor and donor-government relationships). Negin observes that the notion of partnership has had a ‘contested meaning, between both donors and governments and between donors themselves... A major issue for SWAps is which organisations join in pooled funding and which remain outside. Clearly, the move from pooling to joint planning, harmonisation and alignment is a major one that must be viewed as an ongoing process requiring constant attention’ (p.7).


This report looks at the lessons from the implementation of health SWAps in Ghana, Malawi, Mozambique, Tanzania, Uganda and Zambia. The author notes a degree of concern that while in many countries the growth in global initiatives and vertical programme support in health has lead to increases in total funding for health, health SWAps have lost momentum and seen a levelling off or decrease in funding through SWAp-related mechanisms. In addition, the arrival of new initiatives and targeted programmes has complicated the task of managing health sectors and ‘distracted’ management and service delivery staff from the agreed priorities and sector working.

The paper identifies a series of lessons learned, based on current experience in implementing SWAps in health in Africa, including:

- **The political nature of reforms and policy implementation.** Major reforms are likely to face resistance and partners should ‘anticipate that implementation of these reforms will be difficult and political, and will not necessarily run smoothly’ (p.19). Examples of reforms which the paper identifies as likely to be controversial include:
contracting more services to non-state providers; reallocating resources to poorer areas; shifting staff to rural areas; changing the roles of doctors and nurses; and new standards for procurement. The author suggests the relevance of ‘good enough’ reforms, sequenced well.

- **The need to anticipate and deal with changes in personnel** in government and in development partners. Understanding, relationships and trust between partners are important to the success of SWAs and when new personnel join the partnership, time will need to be allowed to rebuild relationships and allow new staff to learn about the sector management processes and the specifics of the sector programme.

- **Appropriate skills and competencies for SWAp working:** The author identifies important skills, such as public finance management, health financing and procurement and public sector reform, as well as traditional health topics. Development partners should also show political sensitivity, and have negotiation and facilitation skills.

- **Planning for transition in aid instruments.** The experience from the African case studies shows that the move from sector funding arrangements (such as basket funds) to General Budget Support (GBS) has been challenging for ministries of health. Donors moving to GBS should plan the transition and prepare budget negotiations, as well as helping develop stronger links between Health and Finance Ministries more so they work effectively together.

- **Wide participation in sector processes:** The report identifies some examples of civil society participation in sector dialogue and oversight. For example, Malawi involving civil society in technical working groups; Tanzania inviting civil society to annual reviews, and Mozambique involving civil society in the sector coordination process.

- **Importance of performance monitoring and indicators.** A combination of intermediate outputs such as numbers treated or vaccinated, as well as measuring progress in strengthening capacity and sustainability of results is important.

- **Expect and plan for a time consuming process in setting up health SWAps.** For example, Malawi’s SWAp took five years and Uganda’s three years. This reflects time for developing the policy framework, setting up management and accountability frameworks, and once the SWAp is operating, many SWAps update and streamline their processes.

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http://books.google.co.uk/books?id=sNpznNsnaZsC&pg=PA45&lpg=PA45&dq=World+Bank,+Education+and+Health+in+Sub-Saharan+Africa:+A+Review+of+SWAps,+2001&source=bl&ots=5zgs-OyyP3&sig=QkQfgym6Iw9uHnDP4KcKtxKzNwg&hl=en&ei=1MxPTcfbMMmxhAee1IlDw&sa=X&oi=book_result&ct=result&resnum=1&ved=0CBYQ6AEwAA#v=onepage&q&f=false

This World Bank document reviews the early experience of implementing health and education SWAps in sub-Saharan Africa, with health case studies from Ethiopia, Ghana, Senegal, and Zambia. It identifies the following **essential prerequisites**, which are preconditions for World Bank funding of SWAps (see pages xi-xii)

1) **Policy framework developed**, based on rigorous sector analysis.
2) **Wide consultations with stakeholders** and agreement reached on priorities.
3) **Public expenditure review** or social sector expenditure review completed; overall **financial parameters defined** in terms of targeted intersectoral allocations and a budget envelope for the sector, and agreement on budget priorities for the first two years.
4) **Institutional capacity analysis** completed and agreement reached on how to fill any identified gaps.

5) **Mechanisms designed for joint reviews and problem resolution**, for example mechanisms for joint reporting, joint annual reviews of progress, budget planning and discussion of differences.

6) **Clarify the role of the ‘donor of last resort’** and a staged plan for pooling of resources among donors.

7) Risk analysis prepared as a basis for **detailed contingency planning** for changes in (a) the macro-economic climate; (b) the policy framework; and (c) key staff.

8) Provision of the **correct profile of staff and adequate resources**.

Desirable, but non-essential, prerequisites for funding include:

1) Donor agreements reached on pooling of funds

2) Financial incentives included for good performance

3) Harmonised procedures for financial management and procurement (a medium to long-term goal)


This report seeks to assess the efforts of the World Bank and its development partners to address tuberculosis (TB) in sub-Saharan Africa through SWAps. The report concludes that there is little evidence that SWAps are enabling improvements in health outcomes in effective, efficient, measurable, or sustainable ways. With regard to TB, only three of the 15 projects reviewed (20 percent) included indicators for improving both TB case detection and treatment success. The authors conclude that the World Bank and its development partners ‘urgently need to reduce the emphasis in SWAps on process and increase the emphasis on outcomes. They must also view SWAps as a means to achieve better health outcomes rather than as an end in themselves’ (p.5)

The report makes the following recommendations to ensure accountability for improving health outcomes within SWAps:

- Independent reviews of health programs at least once every two years
- Make public the Annual Joint Program Reviews that cover health projects that the World Bank supports.
- Rigorous monitoring and evaluation of SWAps to determine what is working and what is not. This information should be widely disseminated among all stakeholders, and the results of such research should be used to improve the implementation of SWAps over time

**3. Different SWAp models: case studies**


This HLSP paper looks at the lessons from the sector wide approach in health in Mozambique. The Mozambique health SWAp is often cited in international health policy circles as a success story, with the following advantages: enhanced government leadership;
improved sector policy and strategic focus; more effective use of aid to the health sector; and lower transaction costs.

The report concludes that 'the SWAP is not a panacea for sector coordination’ (p.1). As important as structures, processes and outputs linked to the SWAP are, ‘they do not per se guarantee its successful implementation. Attention needs to be placed on the quality of the policy dialogue, on enabling the government to exercise leadership without overburdening it, and on ensuring that all development partners play and abide by the same rules’ (p.7). A key lesson of the Mozambique health SWAP is that commitment, leadership, coordination and mutual accountability are dynamic variables, which need constant attention and renewed commitment from all parties to keep pace with a fast changing health sector and emerging challenges.


http://www.who.int/healthsystems/gf7.pdf

This HLSP policy brief examines the lessons learned from Mozambique’s experience of integrating the Global Fund model into a sector wide approach. The authors conclude that the ‘Mozambique experience – still ongoing – is a good example of how global programmes with a unique business model can fit with country led harmonisation and alignment arrangements’ (p.1).

The Global Fund to Fight AIDS, Tuberculosis and Malaria (a targeted, disease specific funding model) was integrated into both the Mozambique health SWAp and the health common fund in 2004. The Mozambique example is a pioneering one, because at the time, the Global Fund’s usual modus operandi disallowed cooperation on pooled funding and joint finance procedures. The paper identifies a number of prerequisites for integrating the Global Fund into a health SWAp, for example:

- Existence of a working common funding arrangement, preferably one that enables flexibility in resource allocation. The authors recommend the more ‘flexible’ all-purpose common fund compared to a basket funding mechanism where only predefined services are covered.
- A suitable annual national plan and budget that enable government to identify gaps and use common funds to cover these.
- A clear Code of Conduct and of harmonisation mechanisms comprising a strong donor group with common positions.
- Relatively robust and transparent reporting and accounting systems.
- An improving monitoring and evaluation system.
- Positions of influence on all sides occupied by individuals with the leadership, vision and determination to pursue this agenda.


This report looks at the impact of the health SWAp in Malawi. The report concludes that it is not possible to attribute results to DFID support or the SWAp: ‘the pathways are too complex and there are many confounding factors’ (p.8). The Malawi example demonstrates the importance of a good Program of Work (PoW): In practice, a SWAp is only as good as the PoW it supports. As the Mid-Term Review (MTR) points out the PoW, although undoubtedly a step forward, suffers from a number of weaknesses: ‘the pillars in the PoW are input-oriented,
and as a result planning, monitoring and reporting are equally input-oriented. It is very difficult to translate these inputs into programme outputs and outcomes, though “the SWAp M&E framework makes an admirable attempt to do so.” (p.8).


This HLSP policy paper examines the Uganda health SWAp – its early experience as a success story and then its subsequent decline. The author identifies several factors which have interacted with one another and contributed to the decline in performance: reduction in government health spending; changes in preferred aid modalities used by development partners; weak government leadership; and weak governance.

The paper concludes that the Uganda health SWAp offers valuable lessons about the need for a more balanced architecture of development assistance for health which:

1. ‘promotes active participation’ from global financing partnerships and other donors acting within the framework of common co-ordination structures and supports systems development;
2. supports long term macroeconomic balance and allocative efficiency, together with increased predictability both for project mode financing and budget support;
3. enables effective use of non-financial resources – particularly staff; and
4. is informed by financial planning frameworks (for the medium and longer term) with dependable data on donor finance, that integrate project funding in line with sector priorities.’ (p.6)

Summary found at: http://www.qsdrc.org/go/display&type=Document&id=2772

This study of the Bangladesh health sector programme looks at the experience of the world’s oldest and largest SWAp. The author concludes that although the Bangladesh health SWAp has positively affected government processes and reduced transaction costs, donors continue to dominate SWAp dialogue. The changing nature of aid globally and the advent of military rule in Bangladesh have both contributed to this trend. Lessons from the Bangladesh health SWAp for donors include the need to:

- Be patient and adopt a hands-off approach, so that a government has the space to develop its own strategies;
- Not be overly critical of government policy, recognising that donor preferences may be guided by international fads inappropriate for a local context.
- Consider how to be reduce or ‘mute’ demands.
- Invest in performance-based government M&E systems for their own reporting and accountability requirements.
- Adapt to local circumstances, in terms of both pace and characteristics.

Summary found at: http://www.qsdrc.org/go/display&type=Document&id=2777

This article from the Development Policy Review looks at the Zambian experience of SWAps. The author notes that while the Zambian agriculture SWAp is seen to be a failure, the health
and education SWAps are considered to have achieved moderate success. The Zambian example shows the benefits of a flexible SWAp. For example, the Zambian SWAps have welcomed projects, provided that they do not contradict the SWAp’s overall policy, resulting in important innovations and more direct information-sharing. The flexible model also welcomes newcomers and encourages partners not contributing funds. Another advantage is that the Zambian SWAps focus on annual work-plans that incorporate evidence-based policy-making, rather than an idealised, comprehensive policy designed by the sector and government in advance.

4. Sierra Leone


This methodological note by the Royal Tropical Institute (KIT) sets out the analytical framework for a study on health systems development in fragile states. In particular, the note describes the methodology KIT used to evaluate the readiness of the health sector in Sierra Leone to move towards a SWAp (see below). The findings will enable the Ministry of Health and partners to develop a roadmap for improved policy and management within the health system.


This paper examines the Sierra Leone health sector’s overall readiness to deliver a SWAp. It is part of a series of country studies undertaken by the KIT health team concerning
assessment of readiness for a sector wide approach for health in countries emerging from prolonged conflict.

Based on an analysis of the six elements of a SWAp – the key building blocks for the health sector – the study rated the Sierra Leone health sector within the low-medium level for all the critical elements. The table below highlights the findings from the SWAp assessment. The KIT team find that of the six SWAp elements, the most critical areas that require further work are in relation to budget and expenditure frameworks, shared processes and approaches, performance monitoring and reliance on and commitment to building government PFM systems.

<table>
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<tr>
<th>SWAp Element</th>
<th>Criteria</th>
<th>Assessment (1-low; 2-medium; 3-high)</th>
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<tbody>
<tr>
<td>Government leadership</td>
<td>Well articulated vision and mission for health sector growth</td>
<td>Medium. Leadership is now the first pillar of the new national health strategy with roles clearly delineated.</td>
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<tr>
<td>OVERALL: MEDIUM</td>
<td>Clear mapping of priorities and resources based on assessed needs</td>
<td>Low (but sub-sector for RH is medium) Competing and contradictory priorities between political and technical directives within the MoHS and other ministries</td>
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<td></td>
<td>Regulation, stewardship and good governance manifesting in improved health outcomes</td>
<td>Low Efforts towards improved regulation and accountability mechanisms have been challenged by changes in leadership and decentralization Shift from donor led approach to more ownership by the MoHS at the early stages of its maturity Effects on health outcomes not yet evident</td>
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<tr>
<td>A clear nationally-owned sector policy and strategy, derived from broad-based stakeholder consultation</td>
<td>Government owned</td>
<td>Medium. There are mixed experiences in who initiated the process and who drives the priorities Insufficient consultation with civil society with a focus on state level “ownership”. RCH strategy set a precedent for wider consultation processes – at the planning stage NHSSP was led by the MoHS and select agencies but slow to broaden the consultation process Decentralization has met with mixed results but has enhanced the control of resources and decision making by district councils</td>
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<tr>
<td>OVERALL: MEDIUM</td>
<td>Alignment of donor support with sector policy and aligned with MDGs/PRS</td>
<td>Medium There is growing policy coherence of the sector policy objectives with PRSP and MDG levels which will require continued translation in the form of results based prioritisation.</td>
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<td></td>
<td>Sufficiently pro-poor</td>
<td>Medium No in-depth poverty analysis underlying the policy framework. The RCH strategy has identified pro-poor priorities but not yet the means to achieve them. Pro-poor monitoring is only through the Public Expenditure Tracking surveys to date.</td>
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<td>Budget &amp; expenditure framework</td>
<td>Consistency of policy with budget allocations &amp; actual spending</td>
<td>Medium. Sectoral budget allocations and spending partially reflect sectoral priorities and PRSP priorities.</td>
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<td>OVERALL: LOW</td>
<td>Existence of a supporting (multi-annual) budgeting process/MTEF</td>
<td>Medium There is an orderly budget process in place and the MTEF fulfils basic functions of multiannual expenditure planning but strategic planning is undermined by a number of factors (i.e. budget incomprehensiveness, unpredictability, etc.)</td>
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<td></td>
<td>Well-resourced: sufficient domestic and external financing available</td>
<td>Low The budget is not well resourced, because of large commitment/disbursement gaps by donors, large differences between costing of sectoral priorities and current spending capacity, limited absorption capacity and complex and lengthy procurement</td>
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</table>
There is no overall strategy available yet for financing health sector priorities in a sustainable way.

**Alignment & predictability of donor contributions**

- **Low.**
  - Aid is generally aligned with PRSP and sector objectives but there is incomplete and infrequent information on aid by donors. Ability of donors and government to disburse aid on schedule is low both for project aid and general budget support.

**Access to service delivery by the poor.**

- **Low.**
  - The poor & vulnerable tend to benefit less from to health service delivery. Out-of-pocket expenditures are high and exemptions for the poor & vulnerable for paying for health services are partially observed.

### Shared processes and approaches

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<th>OVERALL: LOW</th>
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<tr>
<td><strong>Development assistance aligned with national plan</strong></td>
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<tr>
<td><strong>Medium</strong></td>
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<td>Partial alignment has been achieved to national plans and strategies – but with clear scope for further strengthening.</td>
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</table>

| **Well coordinated and harmonized support with common arrangements** |
| **Low** |
| Weak inter-ministerial and intra MoHS coordination and harmonisation. Harmonisation of procedures and systems is still poor. Coordination is growing but needs sustained efforts by all stakeholders. |

| **Stakeholder mapping within the sector with coordination mechanisms (government, donors, private sector, NGOs)** |
| **Medium** |
| Fragmented stakeholder mapping. Evolving inter-government/development partners coordination and communication – continued strengthening and harmonising required in moving to implementation and monitoring of the strategies. Technical coordination is gaining strength. |

| **Joint, comprehensive capacity building approach** |
| **Low** |
| No capacity building plan in place with fragmented approach to technical cooperation |

### Performance monitoring

<table>
<thead>
<tr>
<th>OVERALL: LOW</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Results focused and monitorable framework for the health sector</strong></td>
</tr>
<tr>
<td>No performance monitoring framework in place</td>
</tr>
<tr>
<td>Limited aid tracking – need for greater standardisation</td>
</tr>
<tr>
<td>Health service program monitoring is weak</td>
</tr>
</tbody>
</table>

### Reliance on and commitment to building govt PFM systems

<table>
<thead>
<tr>
<th>OVERALL: LOW</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Aid using country PFM Systems</strong></td>
</tr>
<tr>
<td><strong>Low.</strong></td>
</tr>
<tr>
<td>A small share of aid is using country PFM systems. Most aid is managed by parallel PIUs.</td>
</tr>
</tbody>
</table>

| **Improved budget processes & allocation & operational efficiency** |
| **Low.** |
| The overall PFM systems are comparable to other SSA countries and show an improving trend. But at the health sector level significant PFM capacity building is still needed. The introduction of the MTEF, IFMIS and district development planning has started and brought about some improvements in the budget process and the allocation of resources. |

| **Use of (more aligned) aid Modalities** |
| **Low.** |
| GOSL benefits from general budget support. Donors in health rely predominantly on project aid. But there are discussions underway to set up a pooled fund for supporting the RCH strategy. |

| **Contribution of aid modalities to health sector strengthening** |
| **Low.** |
| Some support to health systems strengthening has been provided by donors mostly in form of project aid (i.e. trainings, TA), but these efforts have been fragmented with uncertain effects on long-term capacity building. GBS has promoted overall PFM strengthening and stream-lining policy dialogue at central level, but with limited effects on the health sector (in financial and institutional terms). |

| **Predictability in the availability of funds for commitment of** |
| **Low.** |
| Resources from MOFED in particular salaries arrive relatively on time, however non-salary recurrent expenditures show |
Despite the low-medium rankings on the SWOT, the study concluded that Sierra Leone meets the initial conditions in which sector programmes are more likely to be successful (see table below). The report concludes by suggesting a series of priority recommendations which can function as a road map for the authorities and development partners in the health sector to improve policy, management and coordination arrangements.

**Initial conditions in which sector programmes are more likely to be successful (based on Foster, 2004)**

<table>
<thead>
<tr>
<th>Circumstances where sector programmes are likely to be more successful</th>
<th>Application to Sierra Leone’s health sector</th>
</tr>
</thead>
<tbody>
<tr>
<td>Where public expenditure is major feature of the sector.</td>
<td><strong>Partly.</strong> Public expenditure is low compared to high out of pocket expenditures, but a significant share of support from external development partners is not included in the budget.</td>
</tr>
<tr>
<td>Where donor contribution is large enough for coordination to be a problem, e.g. where aid accounts for more than 10% of GDP.</td>
<td><strong>Yes.</strong> Donor contributions included in the budget account for roughly 80% of the public health budget and 5% of GDP. But there is a large share of support from external development partners that is not included in the budget.</td>
</tr>
<tr>
<td>Where there is a basic agreement on strategy between government and donors.</td>
<td><strong>Yes.</strong> There is a basic agreement on the sub-sectoral strategy on promoting RCH, but agreement on the national health sector-wide strategic plan is currently discussed.</td>
</tr>
<tr>
<td>Where there is a supportive macroeconomic and budget environment to permit sector authorities to plan with reasonable confidence.</td>
<td><strong>Yes as regards the macroeconomic environment.</strong> Sierra Leone’s in on track with the IMF PRGF programme indicating relative macroeconomic stability. <strong>Partly as regards the budget environment.</strong> There is a MTEF in place promoting more strategic planning, but budget comprehensiveness, transparency and unpredictability remain a serious concern.</td>
</tr>
<tr>
<td>Where institutional relationships are manageable (e.g. single ministry, small group of donors)</td>
<td><strong>Partly.</strong> There is one ministry in charge for the health sector tasked to ..... The district councils are the main implementer of primary and secondary health care. Although the decentralisation has shown some improvements in service delivery, access to services remains limited and the decentralisation process has added to the complexity of the reform process. The number of main donors in the health sector is small, but the number of international and local NGOs is high.</td>
</tr>
<tr>
<td>Where incentives are compatible with SWAp objectives (e.g. in light of civil service reforms)</td>
<td><strong>Yes.</strong> There are no significant cuts in budgets &amp; staffs foreseen as part of the civil service reform process, which may be incompatible with the increased responsibilities and needs for more coordinated health systems strengthening and service delivery sector. But the decentralisation...</td>
</tr>
</tbody>
</table>
process has added to the complexity of the reform process, although greater coherence between policies spending- results and coordination of development partner support would greater enhance capacity at district levels.

Source: Canavan et al. (2009): p.52


This paper examines the preconditions for moving towards a health SWAp in three post-conflict states: Timor Leste, Sierra Leone and Democratic Republic of Congo (DRC). It looks at the progress that these three countries have made in putting in place the six major SWAp building blocks; the drivers and barriers to early SWAp development within these countries; and how to enhance health SWAp implementation in fragile states.

The study findings suggest that health SWAp efforts are still in an early stage in post-conflict contexts. The authors make several recommendations for moving forward towards a SWAp (p.v):

Recommendations for national priorities:

- A common understanding of health sector development priorities, as expressed in national policies and plans, is needed, which should lead towards a medium term expenditure framework for resource allocation.
- Strong institutional relationships with common procedures, systems and incentive mechanisms are vital to cementing alignment and harmonisation efforts.
- A broader government public sector reform agenda requires due attention as such an agenda plays an important role in determining the success of sector wide approaches.

Recommendations for development agencies:

- Predictable relationships built on trust can ensure that commitments are honoured.
- Promote sustainable institutional capacity building based on an agreed framework that supports medium term strategic plans in the health sector.
- Joint monitoring and evaluation for lesson learning and accountability to measure results.

The authors recommend a two-stage trajectory towards a SWAp in fragile states:

1. ‘Major attention should initially be geared towards three of the six SWAp elements, namely: policy formulation and coherence with strategic planning and implementation; sector wide coordination; and the development of a basic expenditure framework with cross-cutting institutional capacity building.
2. Investment in and a deepening of all six SWAp elements allowing a realistic and contextually specific timeframe that will service the interests of both the government and development partners.’ (p.v)
5. Additional information

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Principal websites visited
Google, GSDRC, Royal Tropical Institute, World Bank, World Health Organisation, Eldis, HLSP Institute, University of Sydney, Overseas Development Institute, ACTION, Health Policy & Health Finance Knowledge Hub, Development Policy Review

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