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Do Health Sector-Wide Approaches Achieve Results?

Emerging Evidence and Lessons from Six Countries

Bangladesh

Ghana

Kyrgyz Republic

Malawi

Nepal

Tanzania

IEG Working Paper 2009/4

Denise Vaillancourt



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***IEG: IMPROVING DEVELOPMENT RESULTS THROUGH EXCELLENCE IN
EVALUATION***

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Abbreviations and Acronyms

ADB	Asian Development Bank	HPSO	Health Program Support Office (World Bank Office, Dhaka)
AfDB	African Development Bank	HRM	Human Resources Management
AIDS	Acquired Immune Deficiency Syndrome	HSDP	Health Sector Development Project
ANC	Antenatal care	HSSP	Health Sector Support Project (in Malawi)
APL	Adaptable Program Loan	ICEIDA	Icelandic International Development Agency
AWPB	Annual Work Plan and Budget (Nepal)	ICR	Implementation Completion Report
BADEA	Banque Arabe pour le Developpement Economique en Afrique (Arab Bank for Economic Development in Africa)	IDA	International Development Association
BCC	Behavior Change Communication	IEC	Information, Education and Communication
BMC	Budget and Management Centers	IEG	Independent Evaluation Group
CAE	Country Assistance Evaluation	IHP	International Health Partnership
CBO	Community-Based Organization	IMR	Infant Mortality Rate
CDC	Centers for Disease Control and Prevention	ITN	Insecticide Treated Bednet
CDF	Comprehensive Development Framework	JICA	Japan International Cooperation Agency
CHAM	Christian Health Association of Malawi	LIC	Low Income Countries
CIDA	Canadian International Development Agency	MAU	Management and Accounting Unit
CPR	Contraceptive Prevalence Rate	MDGs	Millennium Development Goals
DAC	Development Assistance Committee	M&E	Monitoring and Evaluation
DANIDA	Danish International Development Agency	MHIF	Mandatory Health Insurance Fund (MHIF)
DCA	Development Credit Agreement	MICS	Multiple Indicators Cluster Survey
DFA	Development Finance Agreement	MKUKUTA	Tanzania's National Strategy for Growth and Reduction of Poverty
DfID	Department for International Development UK	MMR	Maternal Mortality Rate
DHMT	District Health Management Team	MoH	Ministry of Health
DHS	Demographic and Health Survey	MoHFW	Ministry of Health and Family Welfare
DP	Development Partners	MoHP	Ministry of Health and Population
DPT3	Diphtheria, Pertussis, and Tetanus vaccine, three doses	MOU	Memorandum of Understanding
EHP	Essential Health Package	MTBF	Medium-Term Budget Framework
ESP	Essential Service Package	MTEF	Medium-Term Expenditure Framework
EU	European Union	MTR	Mid-Term Review
FMR	Financial Management Reports	NAC	National HIV/AIDS Council
GDP	Gross Domestic Product	NCD	Non-Communicable Diseases
GHS	Ghana Health Service	NHA	National Health Accounts
GoB	Government of Bangladesh	NGO	Non-Governmental Organization
GoE	Government of Ethiopia	NPRS	National Poverty Reduction Strategy
GoG	Government of Ghana	NSF	National HIV/AIDS Strategic Framework
GoT	Government of Tanzania	OECD	Organization for Economic Co-Operation and Development
GTZ	<i>Deutsche Gesellschaft für Technische Zusammenarbeit</i> (German Technical Cooperation)	OPCS	Operations Policy and Country Services (World Bank)
HD	Human Development	OPEC	Organization of the Petroleum Exporting Countries
HIV	Human Immunodeficiency Virus	OPV	Oral Polio Vaccine
HMGN	His Majesty's Government of Nepal	ORS	Oral Rehydration Solution
HNP	Health, Nutrition and Population	ORT	Oral Rehydration Therapy

PAD	Project Appraisal Document	SIDA	Swedish International Development Cooperation Agency
PCC	Program Coordination Cell	SIP	Sector Investment Program
PDO	Project Development Objective	STD	Sexually-Transmitted Disease
PHC	Primary Health Care	STI	Sexually-Transmitted Infection
PLMC	Procurement and Logistics Monitoring Cell	SWAp	Sector-Wide Approach
PoW	Program of Work	TA	Technical Assistance
PoW I	First Five-Year Program of Work	TB	Tuberculosis
PoW II	Second Five-Year Program of Work	TFR	Total Fertility Rate
PPAR	Project Performance Assessment Report	USAID	United States Agency for International Development
PPE	Protected pro-poor expenditures	UN	United Nations
PRS	Poverty Reduction Strategy	UNFPA	United Nations Fund for Population Activities
PRSC	Poverty Reduction Support Credit	UNICEF	United Nations Children's Fund
PRSP	Poverty Reduction Strategy Paper	VCDP	Vulnerable Communities Development Plan
RHS	Reproductive Health Services	VCT	Voluntary Counseling and Testing
RIBEC	Reforms in Budgeting and Expenditure Control	VHC	Village Health Committee
SDC	Swiss Agency for Development and Cooperation	WHO	World Health Organization
SIA	Supplementary Immunization Activities		

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PREFACE

This technical paper distills the emerging experience and lessons of Sector-wide Approaches (SWAp) in the health sector, supported by the World Bank and other development partners (DPs), in six countries: Bangladesh, Ghana, Kyrgyz Republic, Nepal, Malawi and Tanzania. It draws on the findings of Project Performance Assessment Reports (PPARs) conducted by the Independent Evaluation Group (IEG) on health SWAp support operations in Bangladesh, Ghana and the Kyrgyz Republic, and of field-based case studies that assessed the Bank's lending and non-lending support to health, population and nutrition (HNP) in Malawi and Nepal, where SWAps are more recent. This paper also incorporates the findings of an evaluation of Tanzania's health SWAp, commissioned by the Government of Tanzania, and financed by DPs (Freeman and others 2007). The design, substantiation, and validation of the findings and lessons of this study have benefited from a review of the SWAp literature and vetting of preliminary findings and lessons with SWAp practitioners.

The PPAR and case study missions interviewed key Bank staff and a wide range of actors and stakeholders, undertook site visits, and reviewed evidence, including: (a) World Bank files; (b) country-based reporting and evaluation; and (c) epidemiological data, studies, surveys, and research on health, much of it generated in-country.

This study grew out of the SWAp portfolio review and the distillation of health SWAp experience to date, undertaken as input to IEG's recent evaluation of the World Bank's support to HNP, *Improving Effectiveness and Outcomes for the Poor in Health, Nutrition and Population: An Evaluation of World Bank Group Support since 1997* (IEG 2009a). The paucity of health SWAp evaluations in the literature, the richness and complexity of the preliminary findings, and the strong demand, inside and outside of the Bank for more distillation of SWAp experience and lessons all were justification for the undertaking of a more in-depth analysis.

EXECUTIVE SUMMARY

More than a decade ago, the World Bank and other donors proposed a new way of working with developing country governments to overcome inefficiencies, lack of government ownership, and a number of other problems that were constraining the impact of international support to developing countries. This new approach, eventually called the Sector-Wide Approach (SWAp), embraced many of the principles of harmonization and alignment that were later endorsed by the Paris Declaration on Aid Effectiveness in 2005 and subsequent international meetings.

The World Bank defines a 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. SWApS represent a ...shift in the focus, relationship and behavior of donors and governments. They involve high levels of donor and country coordination for the achievement of program goals, and can be financed through parallel financing, pooled financing, general budget support, or a combination.” While the literature offers a wide array of SWAp definitions, attributes, and interpretations, it is consistent in highlighting an evolving partnership between governments and development partners (DPs), coalescing around their joint support of nationally-defined programs and focused on results.

STUDY QUESTIONS, CONCEPTUAL FRAMEWORK, AND METHODOLOGY

This study distills evidence from six countries to address four questions regarding SWApS in the health sector: (1) Were the anticipated benefits of the *approach* realized? (2) Were the objectives of the national health strategies and programs of work (PoWs) achieved? (3) Did the *approach* facilitate the achievement of national health objectives? (4) In what ways did channeling support through a SWAp affect the World Bank’s efficacy? The pursuit of these questions aims to fill a gap in the literature, which is focused largely on definitions, advocacy, implementation issues and only the first of this study’s four questions, and largely neglectful of questions related to the development effectiveness of SWApS.

The conceptual framework for this paper underpins these questions by distinguishing between two types of outcomes anticipated from SWApS, often confused in design documents – the *achievement of the capacity and efficiency gains anticipated from the approach, itself*, in terms of improved sector coordination, better harmonization and alignment of development assistance, and enhanced sector stewardship, and *the achievement of national health, population, and nutrition (HNP) program objectives*, in terms of improved health system management, service delivery, and ultimately the health status of the population. Recognizing that the benefits of the approach alone may not necessarily result in the achievement of HNP program objectives, the conceptual framework posits four factors that affect the ability of SWApS to contribute to better health program outcomes: the quality and relevance of the program of work; the strength of country capacity for program implementation; the quality and functionality of the partnerships between government and the DPs, and among the DPs; and the predictability, flow, and use of sector resources, both domestic and external.

This study documents the emerging experience and lessons of health SWApS, supported by the World Bank and other DPs in Bangladesh, Ghana, Kyrgyz Republic, Nepal, Malawi, and Tanzania. These six countries were selected to include both early and mature SWApS, diversity in terms of trends in health outcomes, and geographic spread. They were the subject of field-based evaluations, the first five of which were carried out by IEG, and the sixth commissioned by the Government of Tanzania. Each of the country studies drew on evidence from: (a) World Bank files; (b) country-based reporting and evaluations; and (c) epidemiological and public expenditure data, studies, surveys, and research on health, much of it generated in-country. Each study also conducted site visits and interviews a wide range of stakeholders in country – including World Bank staff, government officials, health providers, development partners, and civil society. The conclusions for each of the country studies are based on a triangulation of the findings and their consistency with a plausible results chain linking the SWAp approach, the national strategies, program outputs, and results on the ground. The individual country studies were the building blocks for this cross-country analysis of performance and outcome data, informed by the SWAp literature and discussions with SWAp practitioners.

FINDINGS

Were the benefits of the approach realized?

The anticipated capacity and efficiency benefits of the approach were partially achieved. *Health SWApS have been largely successful in putting in place critical tools and processes for improved sector coordination and oversight*, including: (a) a medium-term PoW, grounded in national policy and strategy, meant to catalyze and coordinate all technical and financial support to the sector; (b) medium-term projections of resource availability and expenditure plans; (c) structures and processes for building and facilitating partnerships, especially between government and DPs; and (d) plans for strengthening national procurement and financial management capacity, based on capacity assessments. However, the assessment of monitoring and evaluation (M&E) capacities and systems and designs for their strengthening were relatively neglected.

All SWApS made some headway in improving the harmonization and alignment of development assistance, albeit with some shortcomings. They have largely succeeded in establishing new, country-led partnerships and dynamics between Government, in a leadership position, and a consortium of DPs, for the purposes of policy dialogue, joint annual planning and budgeting, and periodic reviews of sector performance. However, accountabilities of DPs and guidance on conflict resolution have been lacking. Some DPs were providing pooled financing, relying on common systems for procurement, disbursement and financial management. Reliance on national M&E capacity and systems was weaker, notwithstanding the regular convening of joint reviews. The net effect of SWApS on transaction costs in countries and among DPs is not known because they have not been clearly defined or monitored.

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. Nevertheless, budget execution rates are improving in some countries. Except for the SWAp in the Kyrgyz

Republic, they have not substantially strengthened the health sector's results focus or accountabilities, but in some countries these are reported to be slowly evolving.

Were the objectives of national health programs achieved?

In most of the six countries, national health objectives were only modestly achieved under the SWAp. Of the nine health PoWs supported by SWAps in the six countries, five have been completed. Health systems strengthening objectives were only modestly achieved in all five completed PoWs, and service delivery objectives modestly achieved in all but Tanzania (substantial). Results in terms of improving HNP outcomes were modest for the first PoWs in Bangladesh and Ghana. For Ghana's second PoW and Tanzania's first PoW, the achievement of health status objectives was substantial, but fertility objectives were only modestly achieved. Preliminary data from the 2008 Demographic and Health Survey (DHS) in Ghana released since the field evaluation do indicate some improvements in the coverage of a few key health services after a decade of persistently low levels, but recent improvements in health outcomes are also attributed in significant part to factors operating outside of the health sector. The objectives of Tanzania's first SWAp were less ambitious than those for most of the others, focusing on capacity building. Improvements in services and outcomes were to be the objective in later phases. Still, improvements in Tanzania's health services and outcomes have since been documented under its ongoing PoW. Mid-term reviews of the ongoing Bank support for the Kyrgyz Republic and Nepal operations document good progress in service delivery and indicate that most PoW targets will be met. Bangladesh's performance under its second (ongoing) PoW is reported to be improved over the first.

Did the approach facilitate the achievement of health objectives?

The SWAp effect on the achievement of national health objectives depends on the solid preparation and execution of four critical success factors.

First, PoWs that set specific, prioritized, phased, and ambitious-but-feasible targets and that assessed the political economy of reforms were more likely to achieve their objectives. 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. Most PoWs do not appear to have been appraised with sufficient rigor by the DPs investing in them. The risk of weak technical quality and evidence base of PoWs was only mentioned in Tanzania; design, while only three of the six countries considered the risk of the overly ambitious nature of PoWs vis-à-vis country capacity to be a risk. Mitigation measures focused on increasing country capacity with no attention to reducing or phasing plan activities.

Second, the strength of local capacities and systems used for common implementation arrangements determined the pace and efficiency of PoW implementation. In all but the Kyrgyz Republic, systems for planning, resource allocation, monitoring, tracking of expenditures and results were not well aligned, undermining their use for strategic management. The development and use of common systems for procurement, disbursement

and financial management caused significant implementation delays in the medium-term because of a steep learning curve.

The neglect of M&E capacity building and use relative to the strong emphasis on procurement, disbursement and financial management has resulted in an insufficient results focus in five of the six countries. The establishment of good M&E capacity and of a strong results focus prior to the SWAp in the Kyrgyz Republic led to a good balance in emphasis between implementation and results.

Third, country experience has revealed three dimensions of partnerships formed under SWAps that can enable – or undermine – the achievement of results: who is in the partnership; the main functions of the partnership and how effectively they are carried out; and how the partners interact. The involvement of Ministries of Finance has helped improve the dialogue and garner greater allocation of domestic resources for health. However, the failure to include private sector and civil society organizations in planning, reviews, and the PoWs has undermined the objective to improve service coverage and quality in all countries except the Kyrgyz Republic. Where the policy dialogue was infused with evidence, technical rigor and trust, the likelihood was greater for reaching consensus on sound policy. Suboptimal allocation of sector resources by the partnerships, largely attributable to lack of data, guidelines and procedures, has undermined both the efficacy and efficiency with which PoWs were carried out. Joint sector reviews represent important progress in consolidating M&E efforts among the partners, but the rigor and candor of these reviews, the tracking of accountabilities and follow-up action need strengthening. 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.

Fourth, the predictability, flow, and use of health sector resources – both domestic and external – have affected the efficacy and efficiency of PoW implementation. Resource predictability has been undermined by 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. Both the Ghana and Tanzania SWAp experiences indicate that general budget support undermined predictability of resource flows. The resulting uncertainty and inflexibility of the resource envelope has undermined planning and resource allocation of resources. The *flow of funds* to Ghana and Tanzania improved under the SWAp Health Funds, giving districts more liquidity to carry out their programs. But the flow was irregular, slow and not always commensurate with

amounts committed and budgeted, undermining districts' capacities to implement plans and deliver basic services. All countries improved flows as disbursement and financial management capacities were refined. The *allocation and use of these resources* at the local level has not been well documented, but there is indication that they were not fully reflective of nationally-established or local priorities. Capacity for technically sound resource allocation decisions and use and political economy issues at the local level were factors.

How did the approach affect the efficacy of the Bank?

The Bank has been an acknowledged leader and catalyst in the development and implementation of SWAps, but there is room for further strengthening its performance and contributions. During design, the Bank has played a leadership role in operationalizing the principles underlying the approach. It has supported or led the establishment of tools, processes, and mechanisms, stimulating the willingness of others to adopt the approach. It has assessed and strengthened national capacity and systems for procurement and financial management. Its policy advice has been increasingly blended with that of other partners, in some cases well-grounded in analytic work. However, the Bank has not performed well on M&E design. Its risk assessment and mitigation work was solid with regard to procurement, disbursement, and financial management, but neglectful of other risks: the quality of PoWs; M&E capacity; and the capacity to use funds effectively. During implementation, the Bank's supervision and oversight of procurement and financial management was staff-intensive and generally strong, but some weaknesses in the candor and rigor of its dialogue with government and performance reporting have been documented. The Bank was instrumental in bringing about the stronger involvement of Ministries of Finance in SWAps, but it has not sufficiently brought to bear its expertise and leverage in tracking expenditure patterns and their links to priorities and results.

SWAps have changed the way the Bank carries out its work and interacts with government. The Bank invests more time coordinating and collaborating with DPs, especially in countries where it plays a leadership role among DPs. The nature of its dialogue with government has changed from one that was primarily bilateral to one that is joint with other DPs. Tools for encouraging government action are less reliant on conditionality and more so on dialogue. While these changes should not necessarily lead to a dilution of the rigor and standards of the Bank's support, in some cases they have.

LESSONS

There is strong consensus among countries and DPs that more rational and country-led management of aid is a goal worth pursuing. But, as this study has demonstrated, the adoption of a SWAp does not automatically lead to improved development effectiveness. The importance of four main success criteria through which the approach can influence HNP outcomes was confirmed by the experience in the six countries. Beyond those findings, the following additional lessons may guide and support improved adherence to these criteria:

- ***The adoption and financial support of a PoW based primarily on the collaborative process for its preparation and/or its strong national ownership alone are not sufficient to ensure optimal health sector performance and outcomes.*** Government, other national

partners and DPs can contribute through rigorous appraisal of the PoW to ensure it meets minimum quality standards.

- ***The sequencing of efforts to develop and use local skills and systems can mitigate the risks of delayed implementation and a weak results focus.*** Building strong M&E capacity and setting up M&E systems prior to systems for accommodating pooled financing (procurement, financial management), appears to nurture and sustain a results focus (Kyrgyz Republic). SWAps that have attempted to strengthen these systems simultaneously often neglected M&E capacity building and focused more on process than results (Bangladesh, Ghana). The use of reliable interim procurement measures in low-capacity countries, with a view to protect and ensure the flow of essential drugs, supplies, and other support to frontline services while procurement capacity is being built, can prevent implementation delays.
- ***Management for enhanced development effectiveness requires the linking of resources to results.*** The efficient and equitable use of sector resources depends on the capacity of managers 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.
- ***Incentives, whether through rewards, sanctions, and/or pedagogical interventions, 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 seriously undermined a results focus.
- ***The effectiveness of SWAps at the local level can be improved through better management of local political economy issues and strengthening technical, strategic decision-making, and service delivery capacity of health districts and facilities.*** This has the potential of mitigating the neglect of high priority programs and services by decentralized entities observed in the six countries.

This study has also identified ***lessons specific to the Bank:***

- ***Respect for government sovereignty and leadership on matters of policy and strategy need not be inconsistent with rigor and candor of dialogue and policy advice.*** The Bank's support or direct undertaking of analytic work can be instrumental in deepening and sharpening a dialogue based on evidence.
- ***There is opportunity for the Bank to further strengthen and exploit its areas of comparative advantage crucial to the success of SWAps:*** enhanced dialogue and mutual trust between ministries of finance and health; economic and financial analysis of PoWs; building of country capacity to allocate sector resources and track expenditures; and development of management and implementation capacity.
- ***As the lead DP in many SWAps, the Bank has a critical role to play in strengthening their results orientation.*** The Bank's increased focus on health systems provides it with a platform and an opportunity to ensure viable M&E arrangements and capacities, and the tracking and enforcement of accountabilities for results.

1 Introduction

1.1 More than a decade ago, the World Bank and other donors proposed a new way of working with developing country governments to overcome inefficiencies, lack of government ownership, and a number of other problems that were constraining the impact of international support to developing countries. This new approach, eventually called the Sector-Wide Approach (SWAp), embraced many of the principles of harmonization and alignment that were later endorsed by the Paris Declaration on Aid Effectiveness in 2005 and subsequent international meetings.

1.2 This study addresses four questions – whether the anticipated benefits of the approach have been realized, whether the countries adopting it have seen improved health outcomes, whether the approach affected these outcomes, and the impact of the SWAp on the effectiveness of the Bank. This chapter reviews the definition and evolution of the SWAp approach, proposes a conceptual framework for analyzing its impact, proposes the evaluation questions, and reviews the methodology for answering them.

Definition

1.3 According to the World Bank’s Operations Policy and Country Services Vice Presidency (OPCS), a SWAp is “an approach to a locally-owned program for a coherent sector in a comprehensive and coordinated manner, moving toward the use of country systems. SWAps represent a ... shift in the focus, relationship and behavior of donors and governments. They involve high levels of donor and country coordination to achieve program goals, and can be financed through parallel financing, pooled financing, general budget support, or a combination.” (OPCS 2008) While the literature offers a wide array of SWAp definitions, attributes, and interpretations, it highlights an evolving partnership between governments and development partners (DPs), coalescing around their joint support of nationally-defined programs and focused on results.

1.4 *The Bank’s definition of a SWAp, and Cassels’ widely accepted list of basic attributes of a health SWAp (Box 1-1) may seem straightforward to the casual reader, but the SWAp literature reveals a wide array of definitions and attributes, and significant differences of opinion on their interpretation.* To cite one example, in his comparative study of Uganda, Zambia, and Bangladesh, Sunderwall (2005) found no explicit definition of SWAp in any of the relevant country documents, noting that it was discussed only in very general and ambiguous terms. He observes that SWAps take on different shapes and characteristics as experience unfolds in a particular country context: “SWAp is a clear label with unclear content”. Jeffrey and Walford’s (2003) review of 11 case studies identifies a sequence of events for launching a SWAp¹ noting that “...some consider all stages to be part of a SWAp, while others consider only the latter stages.” Even the World Bank’s OPCS states that “There are no strict pre-requisites for an approach to be called a SWAp. Rather, the SWAp is characterized by the intention and direction of interaction over time.” Various SWAp workshops and training events organized by the Bank and attended by experienced SWAp practitioners² acknowledge the absence of an operationally clear definition. The lack of consensus on a definition has made it particularly challenging for this study to define a portfolio of projects supporting SWAps and to evaluate them.

Box 1-1: Basic Attributes of the Sector-Wide Approach (SWAp) in Health

A sector-wide approach to health development is:

- a **sustained partnership**, led by national authorities, involving different representatives 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 program
- through a **collaborative program of work** (PoW) focusing on:
 - 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 prioritizing** public expenditures,
 - the preparation of **medium-term projections of resource availability and sector financing and spending plans**, consistent with a **sound public expenditure framework**,
 - the establishment of **management systems** by national government 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 of sectoral performance, and
 - **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.

Source: Cassels 1997.

Evolution of the Sector-Wide Approach

1.5 **By nature of its Articles of Agreement, the Bank has supported some elements of the SWAp from the very outset of its support to HNP.**³ Governments have always held primary responsibility for preparing and implementing Bank-financed HNP projects and for the management of project resources.⁴ Furthermore, the fact that Bank financing is in the form of a loan or credit, which must be repaid by the Borrower, has generated some degree of government ownership. This was in sharp contrast with the practices of many other development partners (DPs) supporting health (both bilateral and multilateral). During the 1980s and early 1990s, DPs largely provided grants,⁵ often prepared and implemented projects and managed project resources themselves, or through technical assistants hired by them, with limited involvement of government. The Bank has also had a long history of mobilizing and coordinating the financial and technical resources of other major partners through the cofinancing of large projects.

1.6 **In the late 1980s and early 1990s the World Bank's support evolved towards a more comprehensive approach to health sector support that embraced additional features of what would eventually be called a SWAp.** Trends noted in annual HNP sector reviews for 1990 and 1991 included: an increased focus on sector policy framework and programs and a better fit of projects therein; dialogue that was broader in scope (multisectoral and macroeconomic); more strategic and programmatic support; a focus on capacity building in policy reform, planning, and program (vs. project) design, implementation and evaluation; and facilitation of aid coordination efforts as a result of the policy/program focus (World Bank 1991, Vaillancourt and others 1992).

1.7 *In 1995 the World Bank defined a new lending instrument – the Sector Investment Program (SIP) – that encapsulated and codified these trends and promoted further movement in this direction* (Harrold and others 1995). A SIP encompassed six

Box 1-2: Six Principles of the Sector Investment Program

- Sector-wide in scope, covering all current and capital expenditures;
- Based on clear sector strategy and policy framework;
- Run by local stakeholders, including government, direct beneficiaries and representatives of the private sector;
- Adopted and financed by all main donors;
- Based in common implementation arrangements among all financiers; Reliant on local capacity, rather than on technical assistance, for implementation.

Source: Harrold and others 1995.

principles of sound project development that supported a “broad sector approach to lending” (Box 1-2) and was designed to address chronic problems in implementing health projects: insufficient local ownership and commitment; the lack of any noticeable demonstration effect from some projects with consequent limited national impact; low sustainability of benefits after initial implementation; confusion and dissipation of effort caused by the approaches pushed by different donors; excessive expatriate technical assistance; the weakening of government capacity by the proliferation of donor-financed project units; and unsatisfactory results from some adjustment operations in the allocation of public expenditure (Wapenhans 1992).

1.8 *In 1997 the first donor meeting to discuss the sector-wide approach took place in Copenhagen, co-hosted by the Danish Ministry of Foreign Affairs and the World Bank, focusing specifically on the health sector.* The meeting was prompted in part by discussions from a Forum on Health Sector Reform, chaired by the World Health Organization (WHO)/Geneva from 1993-1998, with the participation of Ghana and Zambia, two countries desiring broader sector support and enhanced partnership with donors. It was also prompted by the World Bank’s experience and interest. The meeting coined the term “Sector-wide Approach” and reached a consensus to commission a SWAp guide for the health sector,⁶ and to create an Inter-Agency Group to foster learning and promotion of health SWAp, with WHO as the chair.

Momentum continued inside and outside of the Bank in the late 1990s. Between 1997 and the new millennium, health SWAp were launched in Bangladesh and in numerous African countries, all with the support of the World Bank, along with other DPs.⁷ Across these countries the process of preparing and launching SWAp was initiated and encouraged by different parties in different ways. In most countries the move toward a SWAp was a long and incremental process. Annex 1 provides an overview of the genesis and chronology of health SWAp in the six countries that are the subject of this study. In 1999 President James D. Wolfensohn articulated the four principles of a Comprehensive Development Framework (CDF) to guide development and poverty reduction: a long-term holistic vision; country ownership; country-led partnership; and a results focus (World Bank, 2004b). These principles were both supportive and reflective of the SWAp and of ideas also being expressed by others in the international development community. All of these ideas and initiatives were in response to a growing international consensus on the constraints to aid effectiveness (Box 1-3).

Box 1-3: Issues Undermining Countries' Development Effectiveness that SWAps Aim to Address

- Marginal quality of sector policy or strategic framework, its limited use in catalyzing and prioritizing DP support
- Growing numbers of DPs designing and supporting numerous bilateral projects and initiatives irrespective of national policy and strategy of government involvement, undermining local ownership and commitment
- Resource allocation and priority-setting driven by DPs and their projects, instead of governments
- Health budgets that do not reflect spending priorities, unable to capture domestic and external financing
- Total health expenditures not fully or routinely tracked
- Weak management and implementation capacity, inhibiting the use of country systems, and encouraging parallel project management and implementation structures often staffed by technical assistants and consultants, bypassing line managers and responsible structures within which they work
- High transaction costs to government of aid coordination due to bilateral discussions and missions by DPs, pushing different priorities and initiatives, with limited coordination among themselves
- Multiple sets of project-driven objectives, targets, indicators, and M&E systems, diffusing a results focus
- Little coordination/consolidation of DPs' bilateral technical assistance and institution- and capacity-building efforts
- Low mutual accountability of international, national and local actors for overall sector results, with government project-level accountabilities primarily to the donor, and donor accountabilities to their headquarters and constituencies.

Source: Derived from Cassels 1997; World Bank OPCS (policies and guidelines); the general literature; and the design documents of the health SWAps in the six countries.

1.9 *The adoption of the Millennium Development Goals (MDGs) in 2000 was a landmark event in the international development community's quest for enhanced development effectiveness (or a results focus), providing further momentum for SWAps.*

The articulation of seven MDGs addressing different aspects of poverty (many of them relevant to health), with specific targets to be achieved by 2015, catalyzed efforts of multiple actors around the achievement of these ambitious goals and targets and spawned a series of international meetings to discuss and improve aid effectiveness and management for development results (Table 1-1).

1.10 These meetings all emphasized the need to cede to countries the leadership in determining and managing their development and the need for DPs and developing countries to form new partnerships for collaboration. Under the 2005 Paris Declaration, to which the World Bank is a signatory, developing countries and DPs commit themselves to the principles of: country ownership; alignment of donor support with the country situation; harmonization of their support with country systems; managing for results; and mutual accountability (rendering both national governments and DPs accountable for improved development processes and outcomes). In 2007 the International Health Partnership and related initiatives (IHP+) was established to promote and guide the application of the Paris Declaration principles in support of better health results. To this end it seeks to: mobilize donor countries and other DPs around a single country-led national health strategy with a view to better harmonizing DP funding commitments and improving the way DPs and developing countries work together. Based on an assessment of experience to date in implementing the Paris Declaration, the 2008 Accra Agenda for Action highlights three major challenges to improve aid effectiveness: strengthening country ownership; building more effective and inclusive partnerships; and delivering and accounting for results.

Table 1-1: International Meetings on Aid Effectiveness and Managing for Development Results

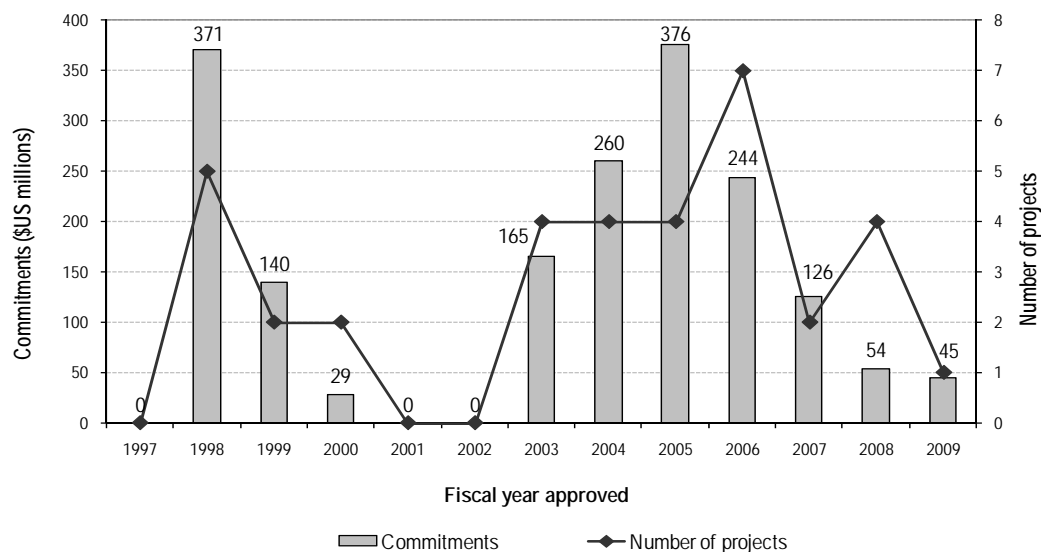
Year	Venue	Meeting	Discussions/Outcomes
2002	Monterrey	International Conference on Financing for Development	Concluded that more financing for development is important, but not enough. Donors and partner countries are seeking increased aid effectiveness, highlighting the need to measure and demonstrate results throughout the development process.
2002	Washington, D.C.	First International Round Table on Better Measuring, Monitoring and Managing for Development Results	Took stock of ongoing efforts to manage for results and highlighted the need to build demand and increase capacity for results-based approaches. Stressed the need for DPs to offer coordinated support for capacity building and harmonize approaches to results measurement and reporting. Discussed ways for DPs to develop results-focused corporate cultures and incentives.
2003	Rome	First High-Level Forum on Harmonization	Committed to improve the management and effectiveness of aid and set out an ambitious program to: ensure that harmonization efforts are adapted to the country context and that donor assistance is aligned with the recipient's priorities; and expand country-led efforts to streamline donor procedures
2004	Marrakech	Second International Roundtable on Managing for Development Results	Discussed the challenges of managing for development results (MfDR) and endorsed a set of core principles on how best to support countries' efforts to manage for results. A costed and time-bound action plan for improving national and international statistics was agreed upon, without which baselines cannot be established and progress measured.
2005	Paris	High-Level Forum on Aid Effectiveness	Endorsed the Paris Declaration, which committed to further: country ownership, harmonization and alignment of development assistance, managing for development results, and mutual accountability for the use of aid.
2007	Hanoi	Third Roundtable on Managing for Development Results	Reaffirmed the importance of the Paris Declaration. Central to this agenda is that all countries and donors should improve their management of resources to achieve better, verifiable results, guided by a commitment to mutual accountability.
2008	Accra	High-Level Forum on Aid Effectiveness	Reviewed progress made against Paris Declaration commitments for improved aid effectiveness and pointed to three major challenges to be addressed in order to further accelerate progress: strengthening country ownership; building more effective and inclusive partnerships, and delivering and accounting for results.

Source: Author, based on the literature.

World Bank Lending for Health SWAps, 1997-2009

1.11 *Between FY97 and the first half of FY09, the World Bank approved 35 HNP-managed projects supporting health SWAps in 28 countries.* Thus, in the 12 years following the launch of the approach, about 13 percent of all (266) approved HNP projects supported a SWAp (Annex 2). Nearly two-thirds (22) of the projects that supported health SWAps were in Sub-Saharan Africa, six were in South Asia, four in East Asia and the Pacific, two in Latin America and the Caribbean, and one in Eastern Europe and Central Asia. Support for health SWAps is mainly found in low-income countries, accounting for a fifth of HNP projects approved in Lower Income Countries (LICs), compared with only nine percent of those in lower-middle income countries, and none in upper-middle or higher income countries. Within this portfolio, 12 projects have been completed, self-evaluated, and rated by IEG (Annex 2).

Figure 1-1: The Evolution of World Bank Lending for Health SWAs, FY97-First Half of FY09



Source: IEG portfolio review.

1.12 These 35 projects were defined as having the following characteristics in their design documents: (a) explicitly reference support of a sector-wide approach; (b) appear to support a program or sector-wide approach, even without explicit reference to a SWA; or (c) provide for the pooling and joint management of donor funding. Among projects included in this initial list, those that were retained had: (d) mechanisms for coordination between the government and donors, and among donors; and (e) a common M&E framework for measuring program performance used by most donors and government and a mechanism for joint reviews of program performance.⁸

1.13 *In addition to health, the Bank has supported SWAs in a number of other sectors.* Based on the total portfolio of 100 country SWAs that the Bank was supporting in 2007, through ongoing investment loans and/or trust funds, 55 were in the social sectors (of which 25 in education, 22 in health, and 8 in social protection), 14 in economic policy/public sector governance, eight in infrastructure, seven in agriculture and rural development, and fewer than five each in a range of other sectors (Annex 2, Table 2c). Of these 100 SWAs the majority (65) were in Africa, 15 in East Asia and the Pacific, 7 in Europe and Central Asia, 5 in Latin America and the Caribbean, and 4 each in the Middle East and North Africa, and South Asia.

Study Objectives

1.14 Given that the Bank and other DPs have been supporting SWAs for well over a decade, it is striking that a review of SWA literature has revealed little evaluation of the efficacy of this approach, with regard to its impact on sector performance and outcomes. While a number of reviews of SWAs have provided some insights on how the approach is working, IEG found only one evaluation (Freeman and others 2007), in addition to those

carried out by IEG, that assesses both the *approach* and the extent to which it affected the achievement of *national health objectives*.

1.15 This study aims to fill this gap by distilling evidence from the six countries to address four questions: (1) Were the anticipated benefits of the *approach* realized? (2) Were the objectives of the national health strategies and programs of work (PoWs) achieved? (3) To what extent did the *approach* facilitate the achievement of national health objectives? (4) In what ways did channeling support through a SWAp affect the World Bank's efficacy?

Conceptual Framework

1.16 The conceptual framework for this paper, presented in Figure 1-2, underpins these questions by distinguishing between two types of outcomes anticipated from SWAps, often confused in design documents – the *achievement of the capacity and efficiency gains anticipated from the approach itself*, in terms of improved sector coordination, better harmonization and alignment of development assistance, and enhanced sector stewardship (top panel),⁹ and the *achievement of national health, population, and nutrition (HNP) program objectives*, in terms of improved health system management, service delivery, and ultimately the health status of the population (bottom panel).¹⁰ While HNP outcomes are included in virtually all statements of objectives, this framework points out that these outcomes are indeed a function of health sector investments and performance, but also a function of factors beyond the mandate of the health sector.

1.17 Recognizing that the benefits of the approach alone may not necessarily result in the achievement of HNP program objectives, the conceptual framework posits four factors that affect the ability of SWAps to contribute to better health program outcomes (middle panel, Figure 1-2): the quality and relevance of the program of work; the strength of country capacity and incentives; the quality and functionality of the partnerships between government and the DPs, and among the DPs; and the predictability, flow, and use of sector resources, both domestic and external. These factors were derived from the risk assessment and mitigation measures articulated in design documents and further distilled from the literature, exchanges with SWAp practitioners, and the experiences documented in IEG's evaluations (Annex 4).

Figure 1-2: SWAp Conceptual Framework: The Link between Anticipated Benefits of the Approach and National Health Objectives

Anticipated Benefits of the SWAp Approach		
Improved Sector Coordination	Greater Harmonization and Alignment of Development Assistance	Enhanced Sector Stewardship
<p>A medium-term program of work (PoW) grounded in national policy and strategy</p> <p>Medium-term projections of resource availability and expenditure plans</p> <p>Structures and processes for negotiating issues, allocating resources, and reviewing sector performance</p> <p>A plan for developing country systems and capacities for common implementation arrangements</p>	<p>A country-led partnership involving international DPs and national actors and stakeholders, within which strategic and management issues are negotiated, sector resources are allocated, and sector performance is reviewed.</p> <p>The use of country systems and capacities as the common management and implementation arrangements</p> <p>Reduced transaction costs</p>	<p>The efficient use of domestic and external sector resources in support of nationally-defined policies, strategies and priorities</p> <p>Greater focus on results</p> <p>Ability to define and track accountabilities for sector performance and results</p>

The Link Between the Approach and Better HNP Program Outcomes



National HNP Program Objectives		
Improved Health Systems Management/Health Reform	Improved Delivery of Programs and Services	Improved HNP Outcomes*
<ul style="list-style-type: none"> • Institutional/organizational reform, including: decentralization or deconcentration of health programs and services; reorganization/redefinition of central-level structures and roles; health district capacity building; restructuring of service delivery and purchasing; participatory management of health services. • Health financing, including health insurance and cost recovery schemes • Enhanced use/oversight of the private sector, including contracting • Strengthening systems for the provision and management of critical sector inputs (human resources, drugs). 	<p>Supply-side improvements:</p> <ul style="list-style-type: none"> • Access/coverage • Quality • Efficiency • Equity <p>Demand-side improvements:</p> <ul style="list-style-type: none"> • Awareness • Knowledge • Incentives/Behaviors 	<p>Sustained improvement and greater equity in:</p> <ul style="list-style-type: none"> • Health outcomes • Nutrition outcomes • Fertility outcomes <p>* A function of health sector performance, and also of non-health sector factors.</p>

Source: Author, based on the literature.

Scope, Evidence Base, Limitations, and Organization

1.18 The evidence base for the study comes from evaluations of health SWAp in six countries: Bangladesh, Ghana, the Kyrgyz Republic, Nepal, Malawi, and Tanzania (Table 1-2).

- The first five countries were purposively selected to capture different degrees of experience with the SWAp in countries with differing trends in health outcomes. For example, SWAps were set up in Bangladesh and Ghana more than a decade ago, while the experience in Kyrgyz Republic and Nepal is more recent and Malawi is in-between. Child mortality has been declining steadily in Bangladesh, Malawi and Nepal but stalled for most of the decade in Ghana. In-depth information was obtained on these five countries during IEG field studies – either project evaluations (Project Performance Assessment Reports, PPARs) or case studies.
- Tanzania was added opportunistically as the sixth country because it was the only country for which there had been a government-commissioned external evaluation of the Health SWAp that addressed similar questions. Tanzania’s first PoW began in 2000.

Table 1-2: Country Evaluations Serving as Primary Reference Documents

Country	Type and Status of Evaluation	WB Operations in the Evaluation Timeframes
Bangladesh	PPAR (IEG 2006) and background paper by for the Bangladesh Country Assistance Evaluation (Martin 2009)	<i>Fourth Population and Health Project (1992-1998)</i> Health and Population Program (1998-2005) HNP Sector Program (2005-10)*
Ghana	PPAR (IEG 2007)	<i>Second Health and Population Project (1991-1997)</i> Health Sector Support (1997-2002) Health Sector Support II (2003-2007)*
Kyrgyz Republic	PPAR (IEG 2008)	<i>Health Sector Reform Project (1996-2002)</i> <i>Second Health Sector Reform Project (2001-2006)</i> Health and Social Protection (2005-11)*
Nepal	IEG Country Case Study	<i>Population and Family Health Project (1994-2000)</i> <i>First Poverty Reduction Support Credit (2003-2004)</i> Health Sector Program (2004-10)*
Malawi	IEG Country Case Study and the project’s Implementation Completion and Results Report (ICR, World Bank 2009)	<i>Population, Health and Nutrition Sector Credit (1991-2000)</i> <i>Population & Family Planning Learning & Innovation Loan (1999-2003)</i> Multi-Sectoral AIDS (2003-8)* Health Sector Support (2005-8)*
Tanzania	Freeman and others (2007) and ICR (World Bank 2004c).	Health Sector Development Program (2000-2003) Health Sector Development Program Phase II (2003-2009)*

Note: Projects in italics are pre-SWAps. Projects marked with an asterisk were ongoing at the time of the field visits. Avian Influenza Control Projects in Nepal and Malawi, approved in 2007, are not included in the list since they are not SWAps and were recently approved.

1.19 Each of the country studies draws on information from: (a) World Bank files; (b) country-based reporting and evaluations; and (c) epidemiological and public expenditure data, studies, surveys, and research on health, much of it generated in-country. Each study also conducted site visits and interviews with a wide range of stakeholders – including World Bank staff, government officials, health providers, development partners, and civil society. The conclusions for each of the country studies are based on a triangulation of the findings and their consistency with a plausible results chain linking the SWAp approach, the national strategies, program outputs, and results on the ground. The individual country studies were the building blocks for this cross-country analysis of performance and outcome data, informed by the SWAp literature and discussions with SWAp practitioners.

1.20 The objectives and components of the Bank support for health SWAps in each of the six countries are presented in Annex 3, Table 3b, which compares program-level and project-level objectives, and documents the extent to which the SWAp is defined and SWAp objectives and indicators are specified in design documents. The documentation of SWAps in these six countries, for the most part, is weak: the objectives of the *approach* are not clearly articulated; design documents do not typically specify meaningful indicators to assess achievement of intended benefits or objectives of the *approach*; and program and project logframes do not articulate results chains that establish plausible links between these and national health objectives.

1.21 The purposive selection of the countries was designed to distill lessons from their varied experiences. Thus, the findings are not necessarily representative of the broader group of countries currently undertaking health SWAps. Furthermore, all six countries received World Bank support in the form of investment lending managed by the HNP sector of the Bank. Not included in the evidence base for this paper are countries with health SWAps supported by development policy lending (budget support) or managed by other parts of the Bank.

1.22 The focus of this study is on the achievement of national program objectives and the performance of government and DPs (including the Bank) in relation to their respective roles and comparative advantages. It is therefore not limited to the Bank's contribution, nor does it attempt to establish any particular attribution of program outcomes to Bank financing. This being said, the report does include a chapter that assesses the Bank's performance and efficacy in the context of its SWAp support. Annex 5 provides additional information on the scope, evidence base, and limitations of the study.

1.23 The report is essentially organized around the evaluation questions. Chapter 2 assesses the extent to which the expected benefits of the *approach* were realized. Chapter 3 explores the extent to which the health programs supported by the SWAp actually achieved their performance *and outcome* objectives; and Chapter 4 assesses the “SWAp effect,” the impacts that SWAps may have had on the achievement of national health objectives. Chapter 5 assesses *the efficacy* of the Bank's own support to SWAps. The study concludes with Chapter 6, which distills lessons and offers perspectives on future directions and the need for further research.

2 Were the Anticipated Benefits of the Approach Realized?

2.1 This chapter assesses the extent to which the objectives or anticipated benefits of the SWAp *approach* in these six countries have been achieved. Overall, these health SWAps have been largely successful in putting in place critical tools for *improved sector management and coordination*. They have also made some headway in improving the *harmonization and alignment of development assistance*, through strengthening and use of national capacity and systems, and improved coordination of DPs' advice and assistance, albeit with shortcomings. They have been only modestly successful in achieving *improved sector stewardship*, as measured by: the efficient use of sector resources in support of national strategies and priorities; a focus on results; and the ability to define and track accountabilities for sector performance and results. Overall, the objectives of the approach were not fully achieved because of weak country capacity and, in some cases, the neglect of certain elements of capacity building. The extent to which the benefits of the approach were achieved is highlighted in this chapter, while the effect of the approach on the achievement of health sector results is analyzed in depth in Chapter 4.

Improved Sector Management and Coordination

2.2 *Almost all of the tools for improved sector management and coordination were successfully developed and established in all six countries, though their quality varied greatly.* An important exception is the assessment of national M&E capacity and systems, and plans for their strengthening. This section provides a tally of the development and use of these tools in the six countries (Table 2-1:).

Table 2-1: Tally of the Development and Use of SWAp Tools for Improved Sector Management

Countries	Medium-term PoW grounded in national policy and strategy	Medium-term projections of resources and expenditure plans	Structures and processes for working partnerships	Plan for common implementation arrangements, based on capacity assessment	
				Procurement, disbursement, financial management	M&E
Bangladesh	√	√	√	√	
Ghana	√	√	√	√	
Kyrgyz Republic	√	√	√	√	√
Malawi	√	√	√	√	
Nepal	√	√	√	√	
Tanzania	√	√	√	√	

Source: Author, based on program performance data.

MEDIUM-TERM PROGRAMS OF WORK

2.3 *All six countries established at the outset a medium-term PoW grounded in national policy and strategy.* Annex Figures 1-a through 1-f present the PoWs and their timeframes around which SWAps were launched. PoWs were developed by the respective Ministries of Health (MOH), with the input and support of DPs and others, often through national participatory approaches. These PoWs set objectives and targets for a multi-year

period, outlined components and activities for their achievement and were linked to overall country development and poverty reduction plans. PoWs were focused primarily on the public sector, although they all mentioned the need for better integration, oversight and use of non-public services and facilities. While all of these countries had some form of strategies and action plans prior to the launch of their SWAs, the PoWs served as a collaborative framework for a consolidated dialogue with DPs and for the mobilization, coordination and allocation of DPs' financial and non-financial support. The quality of these PoWs and their coherence with the various components of strategic sector frameworks varied considerably across countries.

MEDIUM-TERM PROJECTIONS OF RESOURCES AND EXPENDITURE PLANS

2.4 *All of the countries prepared medium-term projections of resource availability and expenditure plans for implementing the PoWs.* Annex 6 summarizes the methodologies and shortcomings in their preparation. In all cases, *resource envelopes* were calculated on the basis of best estimates of government and external financing. Projections of government financing for health were grounded in macro-economic projections (GDP, GDP per capita, and total public revenue) and based on national targets and/or commitments on the share of the total government budget to be allocated to health.¹ Projections of external financing were based on the tentative commitments of the DPs for the timeframe of the PoW, whether in the form of pooled or earmarked funding.

2.5 *Expenditure plans* for five of the six countries were based on cost estimates of five-year PoW implementation; in Ghana, implementation plans were to be costed on a year-by-year basis. For the other five countries, the projected costs of the PoW exceeded available financing. Expenditure plans for all six countries identified priority areas to guide the allocation and use of resources, but most did not encompass all health sector costs. The design documents do not specify exactly what is included in these aggregated cost estimates. Many appear to be focused on the public sector only. Some do not include revenues from cost recovery, health insurance, or other risk pooling schemes. Some exclude important components of the health system. Many PoWs do not include all DP financing because the time horizons for their projects and financial commitments do not completely overlap with the timeframe of the PoWs and financial commitments for the PoWs' outer years are not always estimated at the outset. Furthermore, some DPs finance projects and provide direct support to NGOs and the private sector, and do not routinely report this financial support to MoH (see Annex 6 for more detail). All countries prioritized the delivery of a basic package of services² and measures to improve equity. The latter included shifting financing to poorer and underserved districts, correcting patterns of inequitable support across districts, and targeting the poorest and most vulnerable populations within districts. Expenditure plans also emphasized the need to increase recurrent financing relative to capital investments.³

2.6 The Bank's project design documents for the nine PoWs associated with the health SWAs in the six countries present the total estimated costs and financing of the respective PoWs (Annex 6). For seven of the nine PoWs, governments are financing more than half of the total estimated cost, the exceptions being Tanzania II (36 percent) and Malawi (29 percent). All nine PoWs were financed by a combination of pooled and non-pooled support. Most non-pooled financiers support activities falling within national PoWs through project or parallel financing, but a few still operate outside of the SWAp (Annex 6, Table 6b).

STRUCTURES AND PROCESSES FOR PARTNERSHIPS

2.7 *Structures and processes for partners to negotiate issues, allocate resources and review sector performance were established for all six countries.* All the health SWAp established mechanisms for governments and DPs to undertake jointly: (a) the annual review of expenditures and achievements against previously agreed expenditure plans, program targets, and indicators; and (b) the negotiation/ agreement of new expenditure and operational plans for the coming year, on the basis of the budget and financial commitments of external partners. Bangladesh, Malawi, and Tanzania have one major meeting each year, combining the two functions, while Ghana, Kyrgyz Republic, and Nepal hold two meetings (or Health Summits), one to assess the previous year's performance and the other to agree on the next year's plan and budget. In addition to these major joint planning and review exercises, each country has set up mechanisms for regular (usually quarterly) meetings between the MoH (chair) and the DPs to discuss technical and strategic issues related to sector performance and PoW implementation, as well as to ensure the coordination of joint and parallel technical and financial assistance. In some cases this group is further broken down into working groups that focus on particular issues in line with their comparative advantages.

2.8 *Agreements recording the intentions and commitments of the government and its partners under a SWAp have also been adopted.* Memoranda of Understanding (MoUs) have been cosigned by governments and DPs providing pooled funding in all of the countries. The MoUs document the general areas of agreement between the two parties, including: their financial and moral commitments to the SWAp; common implementation arrangements; and procedures for the use of country systems, especially for financial management, procurement, and disbursement of pooled funding. The MoUs also spell out the timing and mechanisms for joint planning and reviews of sector performance and for the other modes of coordination and exchange between government and DPs. In Bangladesh, Ghana, and Malawi there is also a *Code of Conduct* (in the case of Ghana, a Code of Practice) that outlines ground rules, expectations, and behaviors that should guide the interactions between government and all DPs in an effort to build trust and transparency.⁴

DESIGNS FOR MOVING TOWARDS COMMON IMPLEMENTATION ARRANGEMENTS

2.9 *Plans for the development of country systems and capacities for common implementation arrangements were developed in all of the countries.* The design of procurement, disbursement, and financial management systems and capacity building was carried out by the World Bank on behalf of all pooling donors who committed to their use. In line with Bank guidelines,⁵ this involved: the assessment of national capacities, procedures and systems; the assessment of risks and a plan for their mitigation; the development and implementation of a plan to strengthen capacity; development of procedures manuals; and a supervision plan. In doing so, the Bank also undertook to support the use of existing country systems and procedures to the extent possible, while ensuring appropriate fiduciary standards. While arrangements were designed with government under the leadership of the Bank, they were discussed and agreed by all DPs providing pooled funding and reflected in MoUs. All arrangements were designed to build on and, in some cases (Ghana and Kyrgyz Republic), to pilot and stimulate country-wide public sector reform. Close supervision by the Bank's fiduciary staff (procurement, disbursement, and financial management specialists) is

a design feature of all SWAp and SWAp support operations. Annex 6, Table 6-c, provides details on the disbursement and financial management arrangements, highlighting the extent to which these arrangements both strengthen and use country systems.

2.10 *In contrast, the assessment of monitoring and evaluation capacities and systems and the development of a plan for their strengthening were relatively neglected.* There is no evidence that systematic M&E capacity assessments, equivalent in depth and breadth to those undertaken for procurement and financial management, were carried out by any of the DPs, the Bank included, during the SWAp design stage. None of the risk assessments raised the issue of weak M&E capacity (Annex 4). All of the countries did, however, establish a process of joint, government-led annual reviews of sector performance against PoW objectives and targets, and all established a set of indicators that were agreed with some of the DPs for measuring and reporting on sector performance. These represented important steps forward, but were inadequate to the needs. The neglect of M&E plans and capacity building weakened the results focus of the SWAp in most of the countries and the ability to define and track the accountabilities of various actors.

Harmonization and Alignment of Development Assistance

2.11 *Two of the three harmonization and alignment benefits were substantially achieved by almost all of the countries, with some caveats.* Progress in reducing transaction costs was not systematically measured (Table 2-2:). This section highlights progress and shortcomings in achieving each of the three benefits.

Table 2-2: Improvements in Harmonization and Alignment of Development Assistance

Output	Efficacy				
	High	Substantial	Modest	Negligible	Not evaluable
1. Country-led partnership between government and DPs	Kyrgyz Republic	Bangladesh, Ghana, Nepal, Tanzania	Malawi		
2. Use of national systems/capacities for implementation		Bangladesh, Ghana, Kyrgyz Republic, Nepal, Tanzania	Malawi		
3. Reduced transaction costs ^a					Bangladesh, Ghana, Kyrgyz Republic, Malawi, Nepal, Tanzania

Source: Author's ratings, based on evidence from IEG fieldwork and Freeman and others 2007.

a. Not systematically measured in any country. Anecdotal evidence in all six countries points to both reduced costs in some dimensions and incremental costs in others, both for governments and DPs.

NEW COUNTRY-LED PARTNERSHIPS

2.12 *The SWAp in all of the countries have largely succeeded in establishing new, country-led partnerships and dynamics between governments and DPs.* Fragmented bilateral policy dialogues between government and individual DPs have given way to more consolidated policy discussions between government and a consortium of DPs. These

discussions are catalyzed around the SWAp processes and mechanisms that are being applied with regularity: the agreement to national medium-term collaborative PoWs; joint exercises to approve annual plans of action, confirm financing amounts and sources, and agree on the allocation of resources; the joint review of sector performance against nationally-set objectives and an agreed set of indicators; and regular (usually quarterly) meetings between government and DPs.⁶ In all six countries, the application of SWAp tools and mechanisms have positively influenced the way governments and DPs act and interact in support of health sector programs and goals. Communication, coordination and collaboration among DPs have become more regular and structured, and DPs as a group have become better organized for a consolidated partnership with government.

2.13 *Notwithstanding these achievements, the revolution in the way DPs interact among themselves and in the way they support and interact with government has generated new issues that threaten the SWAps' efficacy.* These include: a lack of clarity about the roles and responsibilities of DPs in a SWAp; the absence of guidance on the conduct of policy negotiations and decision-making in situations of disagreement; and the management of DP staffing issues under a SWAp (individual and collective staffing requirements and technical and strategic complementarities).

2.14 *Governments have assumed a leadership position in sector coordination and management.* In Bangladesh, government ownership and leadership were relatively weak in the early years of the SWAp. The annual performance review process was initially the responsibility of the donor-supported and Bank-run Health and Population Sector Office, and there was some perception that the SWAp was serving more the interests of the DPs than national interests (IEG 2006). But government leadership and ownership has taken hold over time, as evidenced by the strong performance of the Ministry of Health and Family Welfare (MoHFW) during the mid-term review of the second PoW in 2008 (Martin 2009). In the Kyrgyz Republic, the Bank chaired the first Health Summit to guide and demonstrate the review and planning process, but both the MoH and Ministry of Finance (MoF) rapidly assumed ownership and leadership of the process and have now understood that their goal is to satisfy broad national development objectives, not the donors (IEG 2008). Ghana's MoH assumed from the outset the leadership in convening two health summits per year, as well as other coordination meetings with DPs. In Nepal, the Ministry of Health and Population (MoHP) is reported to have made a strong shift from the administration of vertical projects to a more holistic stewardship of the sector, increasingly leading the dialogue and successfully steering the SWAp. The approach has also strengthened national ownership and leadership in Tanzania. However, in Malawi, government leadership has been more fragile and fleeting, due to weak capacity and high turnover of key staff.

2.15 *SWAps' engagement with national partners has been only partially successful.* Decentralized entities prepare local plans and budgets, and participate in national and regional planning and review. Ministers of Finance are becoming increasingly involved in strategic planning and reviews. But the failure to include the private sector and civil society organizations remains an issue.

USE OF NATIONAL SYSTEMS FOR COMMON IMPLEMENTATION ARRANGEMENTS

2.16 *SWApS have been largely successful in establishing national systems and capacities for procurement, disbursement, and financial management. In five of the six countries, pooling DPs rely on these systems and capacities.* The exception is Malawi, where the design of these systems may have overestimated the capacity; their sustainability appears to be in jeopardy since the Bank's decision to stop its financial support to the health SWAp (World Bank 2009).⁷ In addition, capacity building has largely been coordinated and coherent with public finance and procurement reform, most often with Bank support. In Ghana and the Kyrgyz Republic, for example, the financial management systems set up under health SWApS were improvements over existing public finance and disbursement systems and ultimately influenced public finance reform. However, these systems and capacities took considerable time to develop and become functional, in most cases causing important implementation delays. A process of learning and refinement is ongoing. Annex 6, Table 6c, details the extent to which financial management arrangements build on national systems.

2.17 *Monitoring has shown some progress, especially with regard to the routine organization of joint annual reviews, but weaknesses persist on other aspects of M&E implementation.* To the extent possible, monitoring and reporting rely heavily on data generated by the countries' health management information systems and supplemented by periodic surveys (most particularly the Demographic and Health Surveys, DHS) and special studies. Some health information systems have been strengthened (in Nepal, for example), but most have been unable to produce sufficiently reliable data to permit the meaningful analysis of trends and the M&E of sector performance, outputs, and outcomes. Some DPs still maintain separate M&E procedures.

2.18 *Program evaluation has received less emphasis than monitoring.* Nevertheless, evaluations of some health SWApS have been commissioned by governments and DPs. The governments of Bangladesh and Nepal, with the support of some DPs, commissioned mid-term evaluations. Ghana has commissioned evaluations and special studies for its annual reviews. They are candid about accomplishments and shortcomings with regard to implementation as well as program objectives, but the short timeframes covered do not provide for meaningful findings on outcomes.⁸ Tanzania appears to be the only country to date that commissioned an independent evaluation of the SWAp process and national program outcomes covering a substantial (seven-year) time frame (1999-2006).⁹

REDUCED TRANSACTION COSTS

2.19 *The extent to which SWApS have reduced transaction costs has not been systematically assessed in any country.* While the literature and country documentation consistently point to lower transaction costs as a strong rationale for adopting a SWAp, there is no agreed definition of the concept in the literature, nor are there clear definitions relevant targets, objectives, or indicators in the PoWs.¹⁰ It is thus not surprising to find that there are no data compiling and comparing the cost of doing business before and after the adoption of a SWAp, either for the government or for any of the DPs, including the Bank. Nor are there systematic assessments of the efficiency of staff time allocations across tasks before and after a SWAp. Impressions by those involved in the SWApS indicate a mixed picture of some

efficiency gains, on the one hand, and inefficiencies, on the other. The failure to collect and analyze data on transaction costs is striking, given that reducing them was central to many arguments in favor of SWAps.

2.20 *From the countries' perspective, there have been some efficiency gains, but new, incremental costs and inefficiencies have also surfaced.* All countries cite the reduction in the number of meetings with individual DPs, missions, projects, and project implementation units as a positive step, as well as the reduction in reporting requirements and the consolidation of M&E. Annual reviews and reliance on MoH line managers have been helpful in this regard.¹¹ However, the time and expense of preparing and holding Joint Planning and Review meetings – and the sheer size of these meetings -- along with the heavy day-to-day involvement of DPs in many aspects of sector management, involve large transaction costs for government and drain capacity (for example, the Bangladesh and Malawi AIDS SWAps). Continuing parallel structures caused by some donors' resistance to using country systems and common reporting requirements place demands on limited national capacity and engender inefficiencies. While Zambia is not covered in this review, a study of its long-established health SWAp found that the anticipated efficiency improvements were not attained: there was little evidence of improved administrative efficiency; transaction costs remained high after the launch of the SWAp; technical efficiency indicators actually worsened; and budget execution did not improve (Chansa, Sundewall, and others 2008).

2.21 *Although the distribution and use of the collective expertise of DPs is inefficient, efficiency gains have been noted in most countries as a result of increasing collaboration among DPs in line with their areas of expertise and comparative advantage.* World Bank supervision costs of the SWAp in Bangladesh are reported to be one-third of pre-SWAp investments because of fewer Bank staff and increasing reliance on DPs through joint missions. DPs in some cases are cutting their costs by opting to be silent partners, especially as they move toward general budget support. On the other hand, there are reports of additional demands of the SWAp on the time and administrative costs of DPs, especially in the early years. The Bank's supervision costs for the Kyrgyz Republic are believed to have increased under the SWAp because of the greater communication/collaboration with other DPs, responsibilities for procurement and financial management oversight and guidance, and investments in capacity building.¹²

Enhanced Sector Stewardship

2.22 *While the three measures of enhanced sector stewardship are consistently cited as anticipated benefits in health SWAp program and project documents and in the literature, they are not usually expressed as objectives* in PoWs or in World Bank SWAp support design documents (Table 2-3). They have thus eluded explicit measurement during SWAp design and implementation. The indicators and data on these anticipated benefits are inadequate, which makes it difficult to assess whether they have been achieved. This section presents available evidence on country performance and points to gaps in information.

Table 2-3: Achievement of Enhanced Sector Stewardship

Output	Efficacy			
	High	Substantial	Modest	Negligible
1. Efficient use of sector resources to support national policy and strategy		Kyrgyz Republic	Bangladesh, Ghana, Malawi, Nepal, Tanzania	
2. Results focus		Kyrgyz Republic	Bangladesh, Ghana, Malawi, Nepal, Tanzania	
3. Ability to define and track accountabilities		Kyrgyz Republic	Bangladesh, Ghana, Tanzania	Malawi

Source: Author's ratings, based on evidence from IEG fieldwork and Freeman and others 2007.

EFFICIENT USE OF RESOURCES

2.23 *Though the SWAps may have contributed to the mobilization of resources for health, there is little evidence on the efficient use of these resources to support national policy and strategies.*

2.24 *In most of the countries, the efficiency with which financial resources have been used under SWAps has not been well tracked, largely due to related gaps in logframes.* The objectives of the Kyrgyz Republic Health PoW are the most specific with regard to efficiency.¹³ PoWs in Ghana, Malawi, and Tanzania have efficiency objectives that are not very specific,¹⁴ while those in Bangladesh and Nepal do not include explicit efficiency objectives. The project logframes for most of the SWAps have very weak frameworks for monitoring spending efficiency. The logframes for SWAps in Bangladesh, Ghana, and Malawi each have one spending efficiency indicator, with neither baseline nor target values; Tanzania's SWAp logframe has no indicator for efficient spending.¹⁵ By contrast, the logframe for Nepal's SWAp includes three indicators and targets for spending efficiency and the one for the Kyrgyz Republic includes even more specificity.¹⁶

2.25 *Remarkably few data are available on spending efficiency and what is available does not permit cross-country analysis.* While the WHO National Health Accounts (NHA) data series compiled data on resource mobilization for all six countries, it did not compile data on indicators of resource allocation or expenditure efficiency.¹⁷ Some of IEG's country studies corroborate the lack of expenditure data. SWAps in Ghana and Malawi, for example, have not been accompanied by a series of health expenditure tracking exercises that would facilitate trend analysis and target setting. The Tanzania Joint Evaluation also points to the inadequacy of sector expenditure data for tracking trends, especially at the local level (Freeman and others 2007). Documentation of health expenditure trends is even weaker at the decentralized and facility levels. The following paragraphs suggest findings and trends based on a few expenditure indicators, with the important caveat that numerators and denominators may not necessarily be the same across time and across countries.

2.26 ***There has been a modest increase in funding for front-line primary health care, which was a stated priority in all PoWs, but the evidence on whether such shifts do improve efficiency is thin.*** Shifts in funding favoring front-line primary health care services are cited in SWAp documentation on most of the six countries as evidence of efficiency improvements,¹⁸ but tracking and reporting provide little or no evidence on the actual use of these resources at the decentralized levels. Two countries did provide spending trends on prevention and/or public health, which are more indicative of efficiencies. In Bangladesh the share of total health expenditure for prevention and public health services did not change between 2000-05, fluctuating between 12 and 13 percent. In Tanzania the share of total expenditures devoted to preventive services and primary health care rose from 40 to 45 percent, a modest but positive trend.

2.27 ***With the exception of the Kyrgyz Republic, it has been difficult to document any discernable progress in spending patterns that are supportive of poverty- and equity-related priorities in any of the PoWs.*** This is due to the lack of specificity in poverty and equity objectives and targets, as well as to the lack of baseline data and trends. Nevertheless, field studies have generated some evidence to indicate that such objectives are not being met. For example, in Ghana the funding of exemptions to the poor and other priority groups has been chronically insufficient.¹⁹ In contrast, the Kyrgyz Republic has been successful in allocating health resources to establish a State Guaranteed Benefits Package of essential services, including exemptions for poor and disadvantaged groups. This has, in tandem with other reforms, succeeded in reducing people's financial burden, improving their access to health services, and reducing out-of-pocket health spending. Chapter 3 provides more detail.

2.28 ***Most countries' budget execution capacities appear to have improved under SWAps.*** Actual health expenditures in Nepal as a share of the planned budget increased from 70 percent in 2004-05 to 81 percent in 2007-08.²⁰ Budget execution is also improving in Bangladesh, which spent 76 percent of its budget in 2004-05, increasing to 87 percent in 2005-06. In Tanzania, spending of on-budget funding has risen from about 80 percent in 2000 to close to 95 percent of plans in 2005. Use of available recurrent financing has been between 95 and 101 percent of plans from 2002-04. Implementation of development expenditure rose from 66 percent in 2002 to 100 percent in 2004. The rate of expenditure of off-budget financing has not been as good. However, in Malawi, continued problems with underspending remain an issue.²¹

RESULTS FOCUS

2.29 ***With the exception of the Kyrgyz Republic, the results focus of the health SWAps is modest, at best.*** The neglect of this important tenet of the Paris Declaration was addressed in the Accra Agenda for Action. For the purposes of this study, the five core principles emanating from the Second International Roundtable on Managing for Development Results, held in Marrakech in 2004, serve as a framework for assessing the results focus: (a) focus the dialogue on results at all phases of the development process; (2) align actual programming, monitoring, and evaluation activities with the agreed expected results; (3) keep the results reporting system as simple, cost-effective, and user-friendly as possible; (4) manage for, not by, results; and (5) use results information for management learning and decision-making, as well as for reporting and accountability.

2.30 ***In most of the countries reviewed, a strong emphasis on process tasks (setting up, using, and fine-tuning common systems for implementation, DP coordination and collaboration) distracted attention from health sector performance and the achievement of targets and objectives.*** This was a finding in Bangladesh, Ghana, Malawi, Nepal, and Tanzania and was a feature of both the dialogue and implementation. The Kyrgyz Republic is the only country that is reported to have kept a good balance between capacity building, on the one hand, and health outputs and outcomes on the other.

2.31 ***For the most part, the PoWs were not sufficiently results focused: while all of them specified outcome objectives, the content of these multi-year plans were largely input-oriented.*** The results chain of national strategies and PoWs were not fully articulated around a logical framework which clearly defines and links inputs, outputs, outcomes, and impacts.

2.32 ***Results reporting systems were neither simple nor user friendly.*** The indicators chosen to measure progress were not coherent with the strategic framework or PoW; baseline data were, in many cases, either missing or inaccurate, making it difficult to set viable targets and track trends.²² The SWAps in Bangladesh, Ghana, Nepal, Malawi, and Tanzania show a lack of synergy between management systems that would allow measuring and linking the components of the results chain.²³ The SWAps have lacked fully developed M&E strategies and plans and fail to define roles and responsibilities in carrying out this function.²⁴ Overall, M&E design in most SWAps is weak, with the exception of the SWAp in the Kyrgyz Republic.²⁵

2.33 ***The incentives to manage for results and to use results information for learning, improving, decision-making, and tracking accountabilities were weak for the most part.*** The Kyrgyz Republic and Tanzania stand out as exceptions. In Bangladesh, Ghana, Malawi, and Nepal, key recommendations emanating from joint review meetings were often not implemented, and were repeated in subsequent reviews, year after year.²⁶ More importantly, the use of data for decision-making was deficient at the peripheral levels. Resource allocations were weakly (if at all) linked with sector performance: stronger links are needed to calibrate spending with need and absorptive capacity, reward good performance, sanction poor performance and/or finance remedial action to improve weak performance (such as staffing, training, infrastructure, equipment, vehicles, and studies). Supervision was not strongly linked to results indicators.²⁷ Information on sector performance was not widely shared with the public at any level. Systems of rewards and sanctions of different levels of performance (financial and non-financial) against national program targets and objectives were either non-existent or, if they did exist, under-developed and not fully tested or implemented. All of these failures to value and use information on performance against targets and objectives, emanating from M&E efforts, have undermined the objective of sector-wide accountability, as described below.

SECTOR-WIDE ACCOUNTABILITY

2.34 ***SWAps have not been effective in establishing mechanisms and incentives to strengthen sector-wide accountability.*** The Accra Agenda for Action also noted the neglect of this tenet of the Paris Declaration and calls for intensified effort on this front.

2.35 ***First, sector-wide accountabilities remain ill-defined.*** SWApS in Bangladesh and the Kyrgyz Republic have clarified and strengthened the responsibilities of line managers in central-level ministries by their reduction of project implementation units (PIUs) and of decentralized managers and implementers through their local action plans. But there is no evidence in any of the SWApS of the development or fine-tuning of accountability frameworks that would define which actors are accountable for which outcomes, and the consequences of good or bad performance. Nor is there evidence that the incentives and accountabilities or the scope for improving them, within health sector or in the public sector in general, have been assessed. However, the government of the Kyrgyz Republic became increasingly aware under the SWAp that it should be less accountable to the DPs and more accountable to national constituencies, who developed and have a stake in the implementation of national health policy.

2.36 ***Second, performance information is not widely shared with civil society or the public at large.*** Only in the Kyrgyz Republic were performance results widely disseminated to the public at large, with positive impact on accountabilities (IEG 2008). The evaluations of the other five countries provide no indication of the public's knowledge of performance or their involvement in M&E. The inadequate involvement of civil society in sector review and oversight further reinforces the point. However, Ghana intends to strengthen civil society's involvement in sector M&E to improve the sector's accountability to the public.

2.37 ***Efforts to develop tools and systems to monitor and enforce accountabilities have been modest at best.*** In Ghana, a system of performance-based contracting between different levels of the MoH (districts, regions, central level) was envisaged, whereby a manager would sign a contract to commit his/her entire team to deliver on their annual action plans. While these contracts were indeed signed by the managers, they were never enforced by the MoH or used as a tool for monitoring and supervising staff. Furthermore, they were not discussed or shared with the teams responsible for delivering on the annual plans, and thus had little effect on incentives or performance. Under the second Bangladesh PoW, a small pool of money was set aside to provide bonuses to good performing units, but this has not yet been evaluated. In Malawi, despite substantial financial support made available by the Bank for M&E capacity building, the Health SWAp Secretariat admitted at the time of the Bank's project evaluation that it was not clear at the outset that the Health Ministry would be held accountable for achievement of targets. SWApS do provide the opportunity for managers to be held accountable for the performance contracts they sign because (a) the targets, objectives and activities are set by those managers at the local level, in support of the PoW; and (b) managers do receive resources to support plan implementation.

3 Were the Objectives of Health Programs Achieved?

3.1 As captured in the conceptual framework, all nine PoWs supported by health SWAps in the six countries articulated objectives and targets that consistently fall into three categories: (a) improved service delivery; (b) health systems management strengthening; and (c) improved HNP outcomes (see Annex 3, Table 3-b). In line with IEG’s methodology, each completed PoW (along with each completed Bank operation supporting it) was evaluated against its specific targets and objectives. The framework also highlights the fact that health outcomes are also a function of non-health sector factors, such as trends in income, poverty, women’s education, and rainfall, among others. Most of the evaluations of the completed SWAps have assessed to what extent outcomes may have been a function of non-health sector factors, in an attempt to tease out the relative contribution of PoW financing and implementation.

3.2 This chapter assesses the efficacy of SWAps in achieving PoW objectives, based on evidence from country-specific evaluations and other cited sources.¹ The results for each country are presented in chronological order of the effectiveness dates of the Bank’s first SWAp support operation. The country presentations are grouped into two sections: (1) those with completed and evaluated PoWs; and (2) those whose first PoWs are ongoing. These categories are somewhat fluid. Some countries in the first category have ongoing follow-on SWAps, while the Kyrgyz Republic, in the second category, has the benefit of two “pre-SWAp” operations that have supported some elements of the *approach* and contributed to outcomes documented under its ongoing SWAp. The country presentations take these aspects into account.

Countries That Have Completed a Program of Work

3.3 Table 3-1 summarizes the extent to which the five completed PoWs supported by World Bank operations have achieved their objectives. Country presentations in this section encompass performance under completed PoWs and progress under ongoing follow-on PoWs as gleaned from the evidence.

Table 3-1: Achievement of the Objectives of Completed PoWs Supported by the Bank

Country	Year	PoW Objectives		
		Health Services Delivery	Health Systems Strengthening	Efficacy in Improving HNP Status
Ghana (PoW I)	1997-2001	Modest	Modest	Modest
Ghana (PoW II)	2002-2006	Modest	Modest	Substantial (health status), Modest (fertility)
Bangladesh (PoW I)	1998-2005	Modest	Modest	Modest
Tanzania (PoW I)	1999-2002	Substantial	Modest	Substantial (health status), Modest (fertility)
Malawi Health (PoW I)	2003-2009	Modest	Modest	Not evaluable.

Source: Author’s assessment, based on the evaluative evidence, summarized in Annex 8, Table 8-a.

GHANA

3.4 ***Under the first and second PoW (1998-2007), Ghana's achievement of improved health services delivery and strengthened health system objectives was modest; achievement of the objectives to improve health status was modest under the first PoW but substantial during PoW II.***²

3.5 **Health Services Delivery: Modest (PoW I and II).** DPT3 vaccination coverage was already fairly high, at 72 percent in 1998, and rose to 80 percent in 2003, achieving the PoW I target of 80 percent. It rose to 84 percent in 2006, with some improvements in equity, and reached 89 percent in 2008, though falling short of the 95 percent target. Use of ante-natal care was consistently high under PoW I and II and its coverage equitable, as defined by high utilization rates across all income quintiles. Between 1998 and 2008, it rose from 88 to 95 percent.³ However, despite the high priority accorded to malaria prevention and control, fewer than 4 percent of children slept under an insecticide-treated bednet (ITN) the previous night in 2003, by the end of POW I. As of 2008, this figure had risen to 28 percent (32 percent under any net), far short of the PoW II target of 56 percent. The use of oral rehydration therapy (ORT) was inequitable and did not change significantly under PoW I, although its use among the poor increased under PoW II. In 2008, only about half (52 percent) of children with diarrhea who sought care at a health facility were given any type of ORT,⁴ short of the PoW II target of 80 percent. Under PoW I there was no improvement in coverage rates for deliveries attended by skilled workers, which had hovered around 50 percent, with high inequities;⁵ 2008 data show that coverage has since risen to 59 percent, nearly achieving the PoW II target of 60 percent. However, use of any method of contraception (modern or traditional) has stagnated, rising only from 22 to 24 percent from 1998-2008, substantially short of the target of 40 percent.⁶

3.6 **Health System Strengthening: Modest (PoW I and II).** Exemptions for vulnerable people may have had some success in lifting financial barriers to health services use, but they were insufficient and unsustainable.⁷ Plans to develop a quality assurance system were not fully implemented under either PoW I or II. Drug availability in facilities increased and then declined almost to the baseline level of PoW II. Program investments helped increase the production of doctors and nurses and their ratios to the population, but health facilities staffing was undermined by significant brain drain and inequitable distribution of workers. Health services efficiency did not improve. At the time of IEG's review, hospitals were still providing primary health care services and the potential for contracting with NGO and private sector service providers remained largely untapped. The objective to strengthen inter-sectoral coordination for better health was met only modestly. Government and DPs failed to address and correct inefficiencies, duplication, and competition between the MoH and the Ghana Health Services (GHS), undermining sector policy and oversight, and service delivery

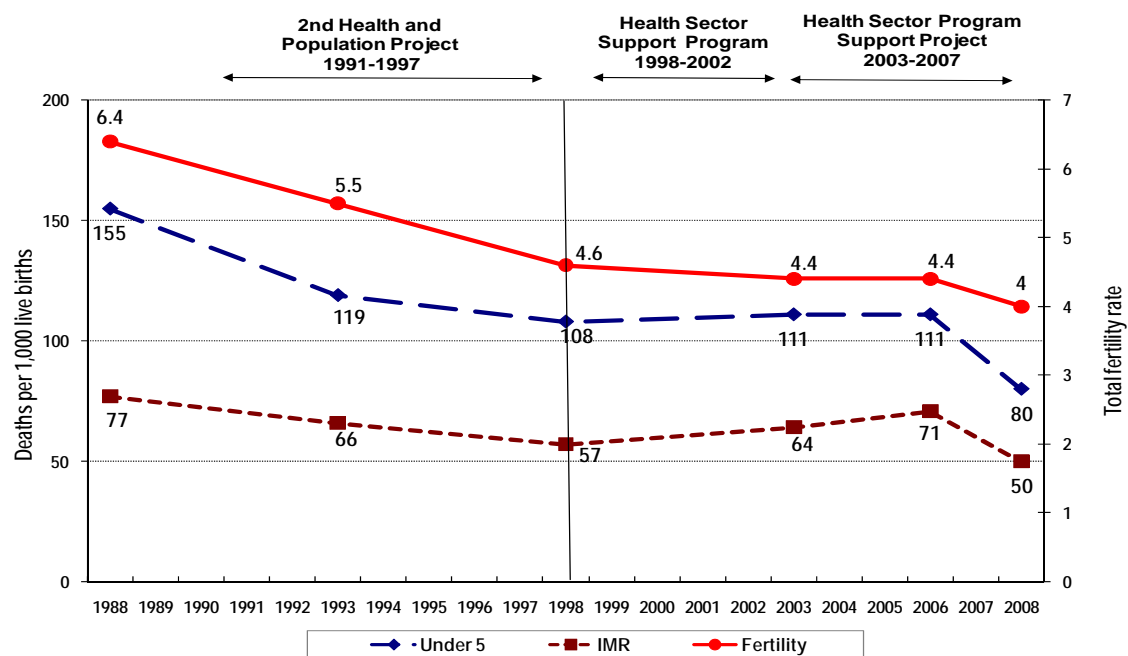
3.7 **HNP Status: Modest under PoW I; Substantial under PoW II.** Between 1998 and 2006 there were no statistically significant improvements in infant and under-five mortality, ending the long trend of improvements recorded since independence (Figure 3-1).⁸ Infant mortality *increased* from 57 to 71 per 1,000 live births,⁹ while under-five mortality was basically *stagnant*, rising from 108 to 111 per 1,000 live births.¹⁰ Likewise, there was no

statistically significant change in the total fertility rate during this period.¹¹ Maternal mortality has remained very high, the latest estimate being 560 per 100,000 births in 2005.¹² These were the data available at the time of the Ghana PPAR, which documented the modest efficacy of PoW I (1997-2001) and pointed to the modest efficacy of PoW II (2002-2006), and at the time of the Implementation Completion and Results Report (ICR) of PoW II.

3.8 Subsequent to those evaluations, preliminary data from the Ghana Demographic and Health Survey (GDHS) 2008 were released in April 2009, showing improvement in some health outcome indicators. The new estimate of infant mortality for the period 2004-08 is 50 per 1,000 live births, representing a decline in the high rates of the last decade and a return to the approximate level in 1998 (57 per 1,000 live births).¹³ Likewise, the new estimate of under-five mortality of 80 per 1,000 live births for the period 2004-08 represents a sharp decline below historic levels. The preliminary GDHS 2008 results also indicate a 10 percent decline in Ghana's fertility from 4.4 to 4.0 for the three years preceding the survey.

3.9 In contrast, GDHS data on child stunting and wasting reveal no major improvement, even when including preliminary data from the GDHS 2008. Stunting of children under 5 years in 2008, at 38 percent, is basically unchanged for a decade.¹⁴ Wasting also remained constant during the past decade.¹⁵ However, the GDHS 2008 data do indicate a decline in the share of children who are underweight, from 24 percent in 2003 to 14 percent in 2008.

Figure 3-1: Trends in Mortality and Fertility in Ghana



Sources: Ghana DHS (1988, 1993, 1998, 2003), MICS 2006 and Population Reference Bureau, and preliminary GDHS 2008 results, April 2009.

Note: The vertical line denotes the start of the first PoW supported by a health SWAp

3.10 **Factors outside of the mandate of the health sector created favorable conditions for improved health in Ghana over the past decade.** The share of Ghana's population living in poverty was reduced from 52 percent in 1991/92 to 29 percent in 2005/06, albeit unevenly

across regions. Female education and access to clean water and sanitation also improved between 1998 and 2003, with inequities. It is plausible to assume that these improvements should have contributed to improved health outcomes. High and growing coverage of immunization is likely to have contributed to gains in child health, along with modest increases in the use of ITNs for children.¹⁶ However, the failure to meet the ITN and ORT targets undermined the potential for even greater gains. High coverage of antenatal care and increased coverage of assisted deliveries had the potential to improve maternal health, but trends in maternal health were not tracked so it is unclear whether the improvements materialized. The continued low rates of contraceptive use have undermined the potential for further gains in reproductive and child health. Recent reductions in underweight children are difficult to attribute to PoW II, since increased coverage of nutrition activities is not documented in the ICR or in the preliminary GDHS 2008 report.¹⁷

BANGLADESH

3.11 *Under Bangladesh's first PoW (1998-2005) objectives for health service delivery, health system strengthening, and HNP outcomes were all modestly achieved.*¹⁸

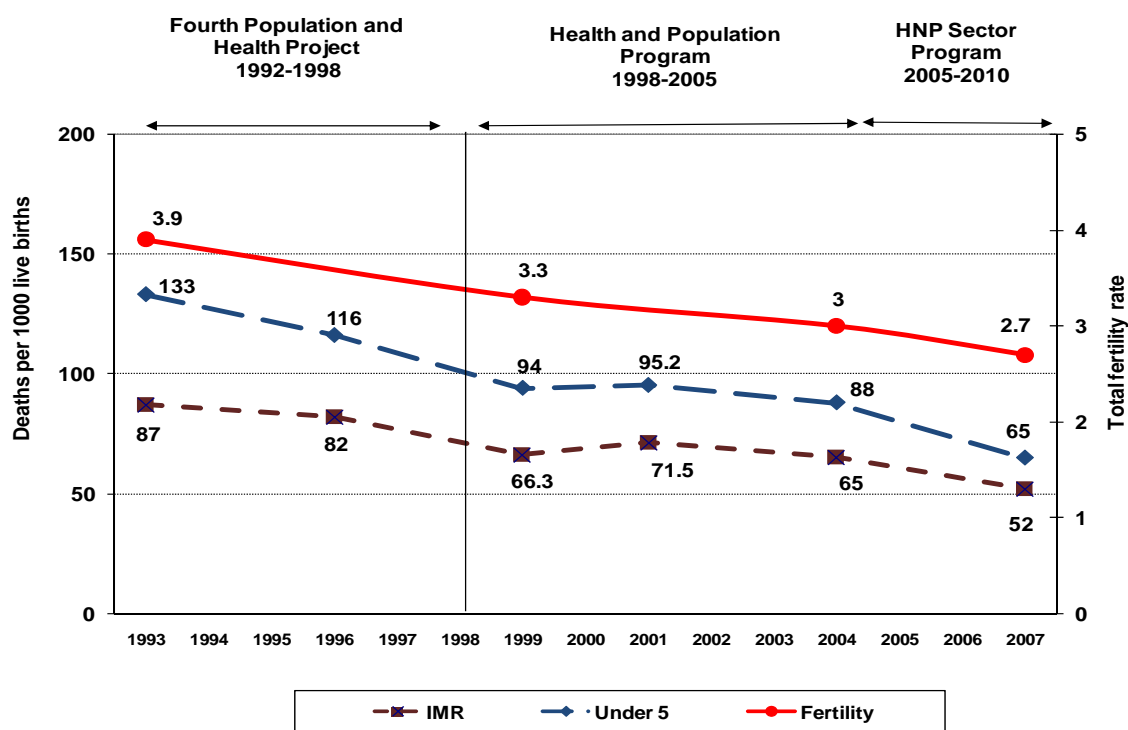
3.12 *Health Services Delivery: Modest.* Maternal and child health service delivery objectives were only modestly achieved under the first PoW. Between 1999 and 2004, the percentage of children fully immunized increased from 60 to 73 percent. However, the share of children with diarrhea who received any kind of oral rehydration therapy remained at about three-quarters from 1999-2004, despite substantial improvements in the years leading up to the SWAp (rising from 61 percent in 1997). The share of live births receiving antenatal care from a trained health professional increased from 24 to 31 percent, but remains very low. Neither the coverage of assisted deliveries nor delivery by a trained health professional has changed much from very low levels: the share of live births delivered at a health facility increased from 8 to 9 percent and the share of live births receiving assistance at delivery from a trained health professional remained constant at 7 percent. Family planning service indicators showed slight improvement. The share of married women currently using any method increased from 54 to 59 percent, while the unmet need for family planning declined from 15 to 11 percent. The use of public health facilities for curative services is extremely low: only 8 percent of patients who sought care for illness visited a public facility. Low use is due to poor quality of services and deficiencies in the quality and availability of critical inputs: drugs, equipment, and human resources. Preventive services offered by public facilities are much more frequented, comprising nearly 90 percent of all preventive visits. After decades of assistance, the National Nutrition Program covers only one-fifth of the upazilas, focuses on mothers, who are often not the decision-makers on child nutrition, and does not reach groups at risk.¹⁹

3.13 *Health System Strengthening: Modest.* The SWAp supported the delivery of the essential service package (ESP), but delivery was disrupted by systems issues that were not well or fully addressed. The decision to unify health and family planning services, which was part of the government's health plan supported by the DPs, was reversed with great political fall-out within the country, among DPs, and between DPs and government. Hospital management reform was also politically difficult and, except for training, was not implemented. Construction of a new type of public health facility – community health

clinics – was partially implemented, but very few became operational. Service delivery partnerships with NGOs and the private sector were not realized.

3.14 HNP Outcomes: Modest. In the years prior to the SWAp, Bangladesh made important headway in reducing infant and under-five mortality (Figure 3-2). But progress all but halted under the first PoW. Downward trends in mortality have since resumed, albeit at a slower pace than in the 1990s, under the ongoing second PoW. In the past few years the gaps in IMR between the poor and non-poor and between rural and urban populations were reduced, but this is due more to a stagnation or worsening of indicators among the less disadvantaged than to gains among the most disadvantaged. There are also inequities in health indicators across districts. Maternal mortality is high (400 deaths per 100,000 births), and there are conflicting data on trends over the past several years. Fertility declined by 0.6 children between 1993 and 1999, after which the rate of decline slowed substantially. Data for 2007 indicate an increase in the rate of decline, although still slower than in the 1990s. Fertility lags behind in some divisions, but it has been declining faster than the national average. Nutrition indicators in Bangladesh have stagnated since 1999 and are 90 percent higher than predicted by income levels. Vitamin A and iron deficiencies have declined dramatically; anemia remains high. Health and fertility outcomes have fallen short of national program targets under the SWAp.

Figure 3-2: Trends in Mortality and Fertility in Bangladesh



Source: DHS data.

Note: The vertical line denotes the start of the first PoW.

3.15 It is difficult to establish a strong link between the modest improvements in infant and child mortality and the financing and implementation of the national plan supported by the Bangladesh SWAp. The delivery of key services (especially immunization and family

planning) may have had some influence on child mortality. But newly constructed community clinics were not used; and public service delivery was disrupted²⁰ as a result of failed health reform, which may, in turn, have contributed to the stagnation in infant mortality. The bulk of expenditures under the PoW were on activities that were found not to have contributed to improvements in outcomes. Governance issues – drug shortages and pilferage, staff shortages, and absenteeism – continue to be a key constraint to improved service delivery. Factors beyond the health sector, on the other hand, are found to have played an important role in contributing to modest health and fertility improvements, especially continued economic growth, expanding female education, and improvements in water and sanitation. Micronutrient interventions achieved good coverage and prompted important declines in Vitamin A and iodine deficiencies.

TANZANIA

3.16 *HNP service delivery and health outcome objectives were substantially achieved under Tanzania's first PoW (1999-2002), but health system strengthening was only modestly achieved.*²¹

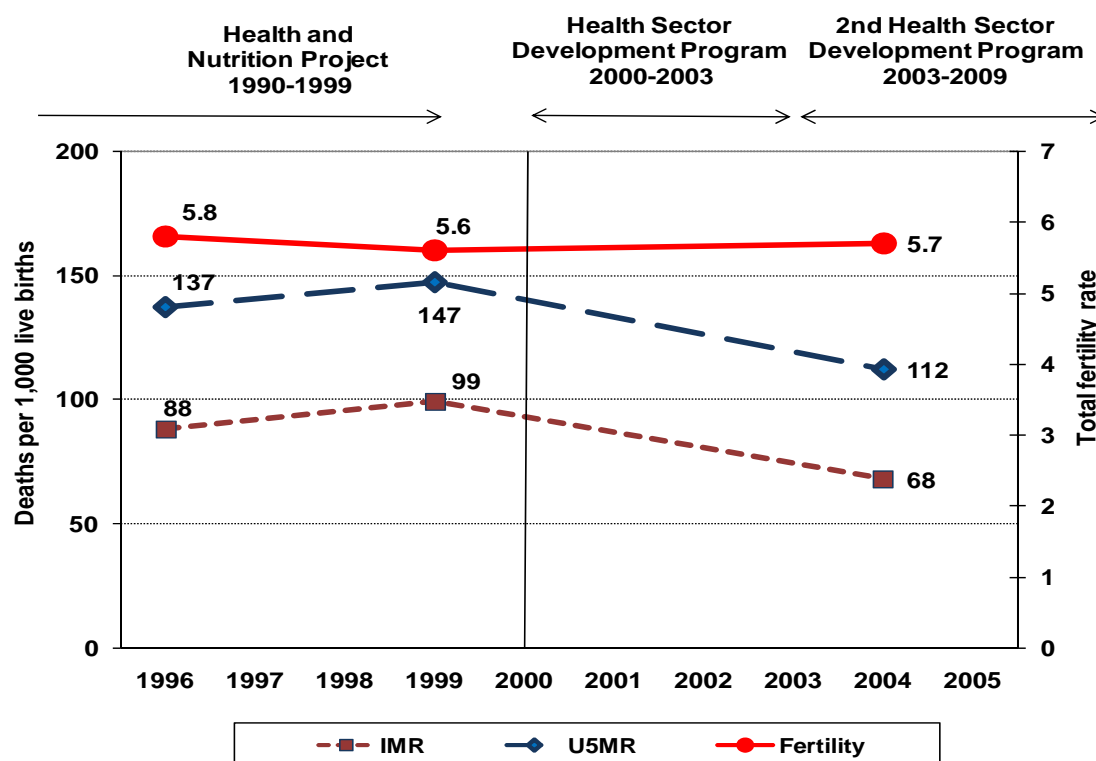
3.17 *HNP Service Delivery: Substantial.* Measles vaccination coverage remained high between 1999 and 2004 at 80 percent, falling slightly short of the national goal of 85 percent (Freeman and others 2007). Coverage of the 3-dose diphtheria, pertussis, and tetanus vaccine (DPT3), at 86 percent in 2004, sustained historically high levels and achieved the poverty reduction strategy (PRS) and the national development strategy (MKUKUTA) goal of 85 percent. Service quality improved in terms of: ability to deal with malaria and HIV/AIDS; cleanliness of facilities; and improved attitude and capacities of staff. Clients reported their perception of increased quality and value of services. There was modest progress in improving reproductive health services. The share of births attended by trained personnel increased from 36 to 46 percent from 1999-2004, with substantial distance to go to meet the MKUKUTA goal of 80 percent for 2010. Use of modern contraception edged upward from 17 to 20 percent of married women, with the public sector supplying more than two-thirds of current users. Twenty-two percent of married women have an unmet need for family planning,²² an indication of inadequate service coverage, access, and outreach. Family planning outreach and its inclusion in discussions between health workers and women visiting clinics are very low.²³ Factors undermining equity of access to services include: geographic isolation, poor transport links, weaknesses in emergency obstetric care, and poor coverage of cost-sharing and risk pooling mechanisms for those who cannot pay.

3.18 *Health Systems Strengthening: Modest.* There has been significant progress in decentralizing planning, budgeting, and management of health services to the local level, though planning is resource intensive and has yet to become fully participatory or to exploit cross-sectoral collaboration. There is little or no evidence of improvements in the referral system or in the management of ambulance services. The Ministry of Health and Social Welfare (MoHSW) has evolved its role as a policy and technical support body, but has yet to align its structure, policies, and processes with regional and local government. Notwithstanding some inputs, hospital reform (strengthened governance structure and management practices) has not progressed and hospitals remain under-resourced. The availability of drugs, supplies, and medical equipment has improved, albeit with some shortages and delivery delays. Human resources for health became a priority later in the

SWAp and severe staff shortages persist, despite modest improvements in workforce quantity and quality. Despite the significant role that non-government service providers play in the sector, little action and progress was made on public-private partnerships. In short, important headway in the reliable supply of essential inputs was made from a very low baseline, but more is needed to further improve service quality and coverage.

3.19 Health Outcomes: Substantial; Fertility Outcomes: Modest. Infant and under-five mortality rates declined from 1999-2004, reversing a trend of rising mortality during the late 1990s (Figure 3-3). Declines in infant mortality (from 99 to 68 per 1,000) exceeded the national poverty reduction strategy goal of 85 per thousand for 2003, and point to the possibility of reaching the MKUKUTA goal of 50 per 1,000 for 2010.²⁴ Likewise, the decline in the under-five mortality rate (from 147 to 112 per 1,000) exceeds the PRS goal of 127 for 2003; if trends continue, the MKUKUTA goal of 79 per 1,000 by 2010 could be met. There were also modest improvements in child nutrition during this period. Stunting in under-five year olds decreased from 44 to 38 percent; and moderate or severe wasting in this age group declined from 30 to 22 percent. In contrast, reproductive health indicators did not improve. Maternal mortality remains very high at 578 deaths per 100,000 births, up from 529 per 100,000 in 1996 and more than double the PRS goal of 265 for 2003. The total fertility rate has remained unchanged.

Figure 3-3: Trends in Mortality and Fertility in Tanzania



Source: DHS

Note: The vertical line denotes the start of the first PoW.

3.20 *The programs, projects, and activities implemented under PoW I likely contributed to improvements in health outcomes and to community-level health services in Tanzania* (Freeman and others 2007). Continued high immunization, improved micronutrient supplementation, improved diagnosis and treatment of malaria, improved drug availability, and increased use of ITNs are consistent with the observed improvements in infant and child mortality and nutritional status. Factors which undermined even better outcomes include continued shortages of health workers, poor infrastructure, intermittent shortages of drugs (despite the noted improvements), shortages of other medical supplies, and poor and inefficient use of transport. Negligible progress in emergency obstetric services and other maternal and reproductive health services probably underlie the failure to meet goals associated with neonatal and maternal mortality and maternal health. Non-health factors were not assessed in the Joint Evaluation, but increased primary school enrolment rates (from 51 to 98 percent from 2000-06), improved access to water (from 46 to 62 percent between 1990-2004) and a slight decline in rural poverty (from 39 to 34 percent between 2001-04) also probably contributed to improvements in child health (World Bank Country Database).

MALAWI

3.21 *Service delivery and health systems strengthening objectives established in Malawi's first PoW (2003-2009) were modestly achieved. The lack of trend data on HNP outcomes overlapping with the PoW implementation period made it impossible to assess the achievement of outcome objectives.*²⁵

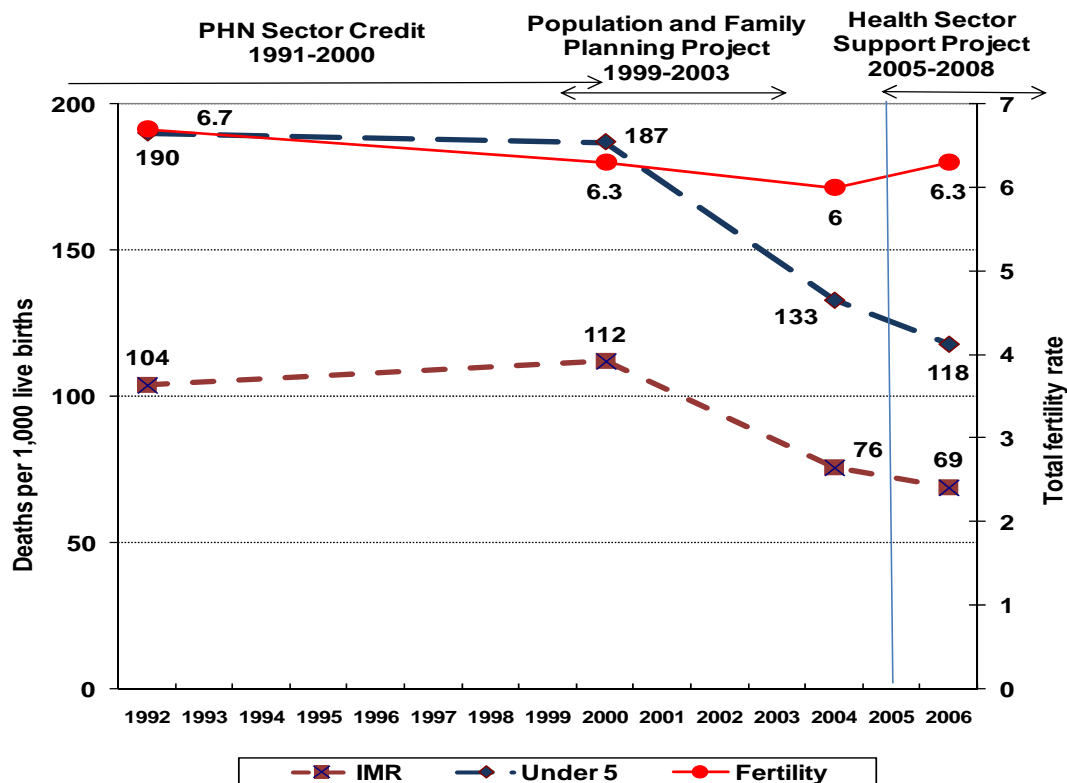
3.22 **Health Services Delivery: Modest.** The Bank's operation supporting the health SWAp (2004-08) set a modest objective of increasing from 10 to 15 percent the share of Malawi's health facilities that have the ability to effectively provide the essential health package (EHP). This objective was not achieved: only 12 percent of all facilities were considered able to deliver the EHP by the end of the operation. The program period nevertheless saw an increase in the use of government health services, with an increase in annual outpatient visits per capita from 0.8 to 1.2. This is most likely due to the government's decision during the SWAp to remove user fees from the maternal and child health program; evidence on any change in the quality and nature of these services was not available. The communicable disease programs all achieved their targets -- increased coverage of AIDS treatment, improved TB cure rate, and immunization coverage targets. The share of facilities offering emergency obstetric care increased dramatically, from 2 to 55 percent. The proportion of births attended by skilled health personnel rose from 38 to 45 percent but was still far short of the target of 60 percent.

3.23 **Health Systems Strengthening: Modest.** Malawi was unsuccessful in resolving chronic drug shortages. As of 2008, an estimated 25 percent of facilities experienced no drugs stock-outs, the same share as at the project's outset. Even vertical programs, which tended to be better resourced than other integrated programs, suffered critical stock-outs of antibiotics, HIV test kits, and ITNs. The government's Emergency Training Program increased the overall number of staff available. An estimated 48 percent of health facilities were staffed by the required number of nurses by 2008, up from 23 percent in 2003. Nevertheless, at the Bank project closing the share of health facilities that had achieved minimum staffing norms for all categories of health personnel was only 13 percent. The serious understaffing of government and NGO²⁶ facilities has caused less-skilled workers to

undertake technical and clinical work for which they are not trained and a substantial increase in the workload per health worker, creating untenable patient loads. Training of health workers was delivered, but never evaluated in terms of its impact on staff performance. Staff retention is highly unstable with significant migration to other countries. All of these human resources for health issues, combined with weak and infrequent supervision, have had serious effects on quality of care. The infrastructure at health facilities improved somewhat, with 60 percent reporting access to water, electricity and communication in 2009, compared to 46 percent in 2004. While improved quality of care was a goal of Malawi's PoW, the absence of clear indicators, baseline data, and targets has made it difficult to measure trends more systematically.

3.24 **HNP Outcomes: Not Evaluable.** Infant and under-five child mortality, stagnant for a decade, began a substantial decline in 2000, prior to the launch of the SWAp in 2004 (Figure 3-4). They show continued decline (particularly under-five mortality) from 2004-06. Given that this process was well underway prior to the SWAp and the modest improvements in health services, it is clear that something beyond health sector performance was operating. However, it is interesting to note that the Malawi case study points out that these declines

Figure 3-4: Trends in Mortality and Fertility in Malawi



Source: DHS and MICS data.

Note: The vertical line denotes the year of the first PoW.

happened during a time when little progress was being made against poverty reduction objectives,²⁷ and attributes these declines in some part to Malawi’s (pre-SWAp) success in maintaining high immunization coverage. Further, the mortality rates are computed for the five years leading up to the survey, reducing the likelihood that modest program improvements in the first two years of the SWAp could have affected the mortality rates measured in 2006.²⁸ In contrast, there has been no substantial change in Malawi’s very high fertility levels – over 6 children per woman – since 2000.

Countries Whose First Program of Work Is Ongoing

3.25 The Bank is supporting the first PoW of SWAp in the Kyrgyz Republic and Nepal, so there are not yet any end-of-project evaluations by the Bank or by IEG. While it is too early to measure health outcomes that may be attributable to these SWAp, interim progress against health service delivery and systems strengthening objectives can be assessed. Table 3-2 provides an overview of efficacy to date under ongoing SWAp, based on a PPAR for the Kyrgyz Republic (IEG 2008), the Nepal case study, and project files for both.

Table 3-2: Achievement of Objectives to Date for Ongoing PoWs

Country	Year	PoW Objectives		
		Health Services Delivery ^a	Health Systems Strengthening ^a	Efficacy in Improving HNP Status ^b
Kyrgyz Republic ^a (PoW I)	2005-11	Substantial	Substantial	Not evaluable
Nepal (PoW I)	2004-10	Substantial	Substantial	Not evaluable

Source: Author’s assessment, based on the evaluative evidence summarized in Annex 8, Table8-b.

Notes: a. As detailed in the Kyrgyz presentation below, some of the achievements to date recorded under the ongoing SWAp are the cumulative result of the Bank’s and other partners’ pre-SWAp investments, which supported many tenets of the SWAp, as well as to the full-fledged SWAp support of the ongoing PoW. b. Data on HNP status trends are available only for pre-SWAp period.

KYRGYZ REPUBLIC

3.26 *The substantial progress of the Kyrgyz Republic SWAp achieving its health service delivery and health system strengthening objectives is the result of the cumulative efforts of the government and contributions of the Bank and other DPs before the formal adoption of the SWAp by government in 2005.* Many of the SWAp principles were already operating under the 1996-2005 national Manas Health Reform Strategy (labeled PoW I here, although not formally a SWAp).

3.27 **Health Services Delivery: Substantial.** Survey data show evidence of progress achieved in: reducing people’s financial burden, improving their access to health services, reducing out-of-pocket health spending, and improving the transparency and efficiency of health services financing and delivery. The Kyrgyz Republic introduced clinical protocols and trained personnel for a cluster of primary health services delivered through family health practices. It put into place a network of family physicians and family group practices, combining treatment for adults, pregnant women, and children in one location and in many cases with one family practice physician. Excessive in-patient capacity has been significantly reduced, hospitals use their remaining capacity more efficiently, and the

quantity and quality of health services at the outpatient level has increased. The share of health spending on primary health care increased from 26 to 38 percent from 2004-07. However, targeted programs for hypertension and maternal care have yet to be fully implemented or scaled up.

3.28 Health Systems Strengthening: Substantial. The Kyrgyz Republic successfully implemented a package of health financing and service delivery reforms, launched under PoW I, with continued consolidation and refinement under PoW II. It established a Mandatory Health Insurance Fund (MHIF), as the single purchasing agency for health care services, and output-oriented provider payment schemes implemented across the country. Reforms also culminated in a State Guaranteed Benefits Package, which explicitly defines entitlements to health coverage, with a system of co-payments that exempt the poor and disadvantaged groups, to permit transparency and predictability in an environment that had been corrupted by demands for illegal out-of-pocket payments. In 2006, the poorest half of the population spent 27 percent less of their household budgets on health care, compared with 2004. In 2006, 3.1 percent of the population reported that health care was too expensive or too far, a significant decline from 11.2 percent in 2001. Survey data also reveal a decline from 2001-06 in the share of patients making informal payments to staff (from 70 to 52 percent) and for medicines (from 81 to 51 percent). Still, private payments continue to represent a significant share of total health spending.

3.29 A number of challenges to good health service delivery and system strengthening remain, especially for rural areas, including: shortages of human resources for health in rural areas; assuring service quality; adequate emphasis on prevention and early detection; the policy and leadership role of MoH; the independence of the MHIF and flow of funds for output-based financing; and MHIF's ability to contract with private and public providers. Another challenge is to reconcile the balance of entitlements under the State Guaranteed Benefit Package with the affordability of the package and exemptions to close the funding gap and improve transparency in its financing and resource allocation.

NEPAL

3.30 Performance data compiled and analyzed for the mid-term review of Nepal's first PoW (2004-2010) indicate substantial progress against health service delivery and health systems strengthening objectives.²⁹

3.31 Health Services Delivery: Substantial. Despite widespread civil conflict between 1996 and 2006, there were substantial improvements in the percent of children fully immunized (43 to 83 percent), DPT3 immunization rates (54 to 89 percent), modern contraceptive use (26 to 44 percent), and vitamin A consumption by women within two months of giving birth. Improvements were modest and absolute levels remained low for key reproductive health services, including the percent of deliveries with a trained provider (10 to 19 percent) and use of ante-natal care with a trained provider (38 to 44 percent).

3.32 With the support of the SWAp (launched in 2004, with the Bank's support from 2005), gains were made on reproductive health service delivery. The availability of family planning, antenatal and post natal care increased from 50 to 100 percent of public health facilities; basic emergency obstetric care became available in 80 sites in 56 districts, up from

35 districts at the outset; and comprehensive emergency obstetric care became available in 44 sites in 33 districts, up from 25 districts at the outset. Safe abortion services were put in place in 176 sites in 71 districts; and a safe delivery incentive program was launched in 2005. However, the modern contraceptive prevalence rate has remained unchanged as of 2006-07 (43 percent), short of the 2007-08 target of 49 percent. Access to maternal health services is egregiously low and unequal in Nepal: only 5 percent of women in the lowest wealth quintile benefited from assisted deliveries for their most recent birth, compared to (still insufficient) half of women in the wealthiest quintile. Immunization services became available in all public health facilities, up from 60 percent at the outset, and universal distribution of Vitamin A and deworming activities were achieved. Community-based integrated management of childhood illnesses was expanded from 6 to 55 districts and will cover the entire country (75 districts) within a year. Control and prevention of communicable diseases was also expanded to all districts: TB detection and treatment; immunization against Japanese encephalitis; leishmaniasis and filarial services; and HIV/AIDS prevention.

3.33 Health System Strengthening: Substantial. A quality assurance policy was adopted and district quality assurance teams have been formed in all districts. Public, NGO, and private-sector partnerships have been effectively implemented in a number of programs, including: family planning services (40 percent provided by the private sector); safe abortion (89 percent by the private sector, with training by the public sector); and vitamin A distribution, TB treatment, and HIV prevention (carried out by NGOs). Nepal has also succeeded in increasing the availability of essential staff in underserved areas and in strengthening its health management information system, which increasingly includes private providers, and whose results are very reliable (with results similar to those of DHS surveys). However, a few reforms did not proceed as planned. For example, in an effort to decentralize, the management of over one thousand facilities was handed over to communities, but the lack of elected bodies at the district and village levels stalled the process. Similarly, until recently, frequent MoHP leadership changes and the political context made for delays in ministry-level decision-making and implementation. In 2008 Nepal adopted a new policy that makes essential health care services offered at health posts and sub-health posts free of charge to all citizens of Nepal. This has raised concern among some DPs about the financial viability of the health system, and dialogue and analytic work to address this is ongoing.

4 Did the Approach Affect Program Results?

4.1 Health SWApS are undertaken with the ultimate goal of achieving sustainable improvements in health sector performance and health outcomes. The analytic framework highlights critical factors that can enable – or undermine – the achievement of results under a SWAp: (a) the quality and relevance of the PoW; (b) the strength of country systems, capacity, and incentives; (c) the quality and functionality of the partnerships; and (d) the predictability, flow and use of assistance. These factors were derived from the risk assessment and mitigation measures articulated in the Bank’s design documents (Annex 4) and the literature. This chapter distills country experience with regard to these factors. For each factor: a box documents good SWAp practice or standards;¹ evidence of performance in the six countries is presented against these good practices or standards and the effects of performance on the achievement of program results are assessed; and the adequacy of risk assessment and mitigation during the design phase is assessed.

Quality and Relevance of the PoW

4.2 Based on the SWAp literature, eight characteristics define the quality and relevance of a program of work (Box 4-1).²

Box 4-1: Characteristics of a Good Program of Work

- Strategic relevance: coherence with macro-economic, multi-sectoral and health policy, and with economic development and poverty-reduction objectives
- Relevance of objectives and design
- Rigorous appraisal from technical, economic, financial, institutional, political, equity, and social (or demand-side) perspectives; strength of its evidence-base; and cost-effectiveness
- Adequate reflection of issues, challenges, needs, perspectives, and priorities of front-line services and decentralized/deconcentrated entities and other key actors and stakeholders, implying a participatory process
- Clear results orientation and accountabilities: coherent results chain linked with development objectives, appropriate indicators, established baselines and targets, specificity about equity issues and goals and how they will be measured, an M&E strategy and plan, and mechanisms for tracking accountabilities
- Sound assessment of political and other risks and a plan for their mitigation
- Implementability: fit with available capacity and financing; clearly stated priorities and appropriate, strategic sequencing of actions (from political, technical and capacity perspectives); plan to strengthen implementation capacity based on capacity assessments
- Viable estimates of implementation costs,^a medium-term projections of resource availability, a medium-term expenditure framework and annual budget that are reflective of sector priorities

Source: Author, drawing on: Cassels 1997; IHP’s Guidance Note on Country Compacts; Paris Declaration 2005; Accra Agenda for Action 2008; and World Bank/OPCS, among others.

a. International Health Partnership Compact guidelines recommend the costing of three scenarios: needs-based, results-based, and resources-based.

PERFORMANCE AND EFFECT ON RESULTS

4.3 ***The quality and coherence of the various components of national strategic sector frameworks varied considerably across the countries.*** Some strategic frameworks supported under SWAp, although relevant to health sector challenges, were complex and overly ambitious, exceeding the capacities of the countries to implement them. They all prioritized the delivery of an essential package of cost-effective services designed to address the disease burden, especially among the poor and vulnerable. But most of them did not assess or manage the risks and political economy of the envisaged reforms, including the SWAp reform, nor did they provide sufficient guidance on the phasing or prioritization of interventions.

4.4 For example, while the Bangladesh program was largely relevant to key challenges facing the sector, it included reforms that were extremely ambitious given institutional capacity and the highly politically charged debates on whether or not to unify health and family planning services (Martin 2009). Ghana's PoWs included a number of very ambitious reforms, including: the establishment and functioning of the Ghana Health Service; the integration and decentralization of communicable disease control; the introduction of performance-based contracts; health financing reform; and new contractual arrangements with private and NGO providers, among others (IEG 2007). The challenges of health system strengthening and governance envisaged under Malawi's health SWAp were under-estimated relative to the weak capacity in the MoH, and in the country at large.

4.5 Nevertheless, some of the PoWs were stronger. While also ambitious, the Tanzania PoW was phased, focusing initially on capacity building tasks for nurturing and supporting the SWAp process. Tanzania's strategies, priorities, plans, budgets and programs were relevant to achieving goals and targets and identified systems constraints. An important exception is their weak links with maternal mortality and family planning goals. The Kyrgyz Republic's Manas Taalimi Health Reform PoW was largely well-targeted, technically sound, evidence-based, cognizant of the political economy of reform, and coherent with national goals and country implementation capacity. It was developed by an expert team from the Kyrgyz Republic and vetted by civil society and DPs; budgets and expenditure plans were largely consistent with the stated priorities. The mid-term review of Nepal's PoW in December 2007 concluded that PoW objectives, components and outputs were valid, as designed, and IEG's review of the program design documents corroborates this assessment.

4.6 ***The quality and realism of national strategies and PoWs had an important impact on success in achieving objectives.*** Overly complex and ambitious PoWs that were not prioritized or phased, sufficiently assessed for risks, results-focused, and/or commensurate with national capacity to implement them, were less successful in achieving their objectives. Those setting specific, prioritized, ambitious-but-feasible targets were more likely to be achieved. Many reforms and health systems strengthening objectives were not fully achieved in Bangladesh, Ghana, and Malawi, which undermined improvements in service delivery. In contrast, while the Kyrgyz Republic's Manas Health and Manas Taalimi Health Reform PoWs were ambitious, they were well assessed and tracked for political and other risks, well-phased, and appear to be culminating in the achievement of national health objectives. The relatively more modestly stated capacity objectives of Phase I of Tanzania's SWAp were largely achieved, and ultimately supported health systems strengthening and service delivery

objectives. Nepal’s first PoW, although still in progress, appears to have been realistic in its design and objectives; at the time of its mid-term review it was assessed to be on track for meeting, and in some cases exceeding, its targets (Foster 2007).

RISK ASSESSMENT AND MITIGATION

4.7 *A review of all the Bank design documents for SWAp support operations in the six countries reveals that only the Tanzania design considered the risk of weak technical quality and evidence base of the national strategy and plans, advocating technical criteria and M&E to mitigate this risk. Designs for three of the six countries (Bangladesh, Ghana and Nepal) mentioned the risk of the PoW being ambitious vis-à-vis national capacity. Mitigation measures included technical assistance, dialogue and advice through the partnership mechanisms provided for under the SWAp, and phased decentralization to districts. In essence, all the mitigation efforts were focused on raising capacity, and none on reducing or phasing activities in the plan.*

Country Capacity and Incentives Enabling the Use of Country Systems

4.8 A second main factor affecting the extent to which the SWAp approach ultimately affects HNP outcomes is the degree of country capacity and incentives for use of country systems (Box 4-2).

Box 4-2: Checklist for Strengthening Country Capacities, Systems, and Incentives
<p><u>Capacity building areas:</u>^a</p> <ul style="list-style-type: none"> • Planning, programming, budgeting/allocation of resources • Procurement • Disbursements and financial management • Expenditure efficiency/tracking of expenditures (PER) • Monitoring and evaluation; use of data for decision-making <p><u>Capacity building activities:</u></p> <ul style="list-style-type: none"> • Assessment of systems, capacity, incentives: <ul style="list-style-type: none"> ○ in the broader context of national public sector systems, capacity, incentives ○ against minimum standards for use, and ○ ensuring coherence and synergies of the management systems within the health sector. • Development of a design/plan for strengthening systems, capacity, incentives • Implementation of the design/plan, using a phased approach • Focus on peripheral-level, as well as central level capacities, systems and incentives
<p><i>Source:</i> Compiled by the author, drawing on various sources including: Cassels, 1997; IHP’s Guidance Note on Country Compacts; Paris Declaration, 2005; Accra Agenda for Action, 2008, World Bank/OPCS, among others.</p> <p>a. Essential capacities listed here are limited to capacities for SWAps/management. They do not include capacities for service delivery (HR for health), which is a sector-specific issue dealt with inside of the PoW, or sector stewardship, which is addressed as part of the Partnership factor).</p>

PERFORMANCE AND EFFECT ON RESULTS

4.9 *With some caveats, the SWAps in all six countries have strengthened and used country capacity in sectoral planning and budgeting.* The SWAp approach has encouraged and supported planning and budgeting at central, regional, district and peripheral levels. For example, regular planning and budgeting exercises at the district level in Ghana incorporated the proposed plans and budgets of Budget and Management Centers and their discussion and

consolidation at the district level. In turn, district-level inputs were discussed and consolidated at the regional level. Final consolidation and approval of plans and budgets at the national level involved representatives from districts, regions, central-level agencies, and DPs. National planning and budgeting capacity was thus strengthened and used at all levels, and the transparency of investment planning improved somewhat. In the Kyrgyz Republic under the framework of the Manas Taalimi strategy, the SWAp facilitated greater delegation of planning and decision-making from high-level to department heads and below, within the central ministry, and from central to decentralized levels, with the effect of further building and utilizing capacities and comparative advantages more broadly. In Bangladesh, line directors prepared annual operational plans and budgets and all SWAp funding was on budget, though with a separate account, a positive move from the pre-SWAp disparate, multiple projects. In Nepal, donors were supporting a common strategy, led by government, allocated increasingly on the basis of annual planning exercises supporting the strategy. Despite weak capacity and high staff turnover in Malawi, annual plans have helped encourage more coherent DP support; planning skills visibly improved at district and central levels. A big emphasis of the Tanzania SWAp was the decentralization of resources and strategic management to the district level and through this process capacities in planning and strategic management were strengthened.

4.10 ***On the other hand, with the exception of the Kyrgyz Republic, systems for planning, resource allocation, monitoring, tracking of expenditures and tracking of results were not well aligned or sufficiently linked among themselves or with high-order national objectives.*** This is reported to have resulted in a lack of coherence between the setting of objectives and the allocation and use of sector resources. The move toward a SWAp has highlighted this lack of coherence in the use of management systems and points to the need for improvement. For example, the absence of systems for regular tracking of public expenditure on health in Ghana and Malawi is recognized now as an important issue to address to enhance the SWAps. In Bangladesh the Medium-Term Expenditure Framework/Medium-Term Budget Framework (MTEF/MTBF) initiative aimed to ensure that policy and priorities were converted into sector allocations and then used as the basis for achieving clearly articulated outputs and outcomes. ***In short, despite some improved capacity for planning and budgeting, there was a persistently weak link between financing and results, which ran the risk of the neglect of sector priorities.*** An important consequence in all six countries was the relative neglect of maternal and reproductive health services, despite the high priority accorded them in national strategy and program documentation.

4.11 ***The development and use of common systems for procurement, disbursement and financial management caused significant PoW implementation delays in the medium term because of a steep learning curve in all cases except for the Kyrgyz Republic.*** In all of the SWAps, the disbursement of funds to decentralized entities was contingent on the timely submission of financial management reports. Especially in the early years, the late submission of reports and/or the inadequacy of these reports, due to inexperience and low capacity of these entities, delayed the replenishment of financing in five countries. This in turn had a negative impact on the liquidity of these decentralized entities and their ability to implement their action plans and to deliver essential services.³ The use of country procurement systems and capacities also delayed implementation, due to a protracted learning process, as well as to misprocurement leading to the reimbursement of funds.⁴

4.12 ***A process of learning and refinement is ongoing, experience and capacities are accumulating, and delays are being reduced, indicating that capacity building investments will culminate in longer-term gains.*** Financial management capacity and systems have been fine-tuned and institutionalized, as experience is gained. In the Kyrgyz Republic, for example, procurement and financial management capacity building was initially perceived as an imposition by some in government, but they now appreciate that these improvements enhance transparency and accountability.⁵ Nepal's procurement has improved as experience was gained and experts were hired. A new procurement law was enacted in 2007 and formed the basis for the preparation of the 2007-08 procurement plan. In Bangladesh, the internal audit of government, pooled, and parallel financing has been outsourced as agreed by the government and DPs. The audit's findings highlighted irregularities and flaws with regard to compliance with procurement and financial and treasury rules, safeguarding and use of program assets, and overall monitoring and supervision of the Ministry. It also pointed to fraud and corruption. These findings were discussed and addressed through established SWAp structures from which an effective action plan was developed and duly acted upon. The institutionalization of outsourcing of internal audits and the credibility of the follow-up action by MoHFW are expected to improve tracking and efficiencies.⁶

4.13 ***The Joint Review process was an important step in strengthening and consolidating national M&E capacity, but a number of shortcomings undermined the potential for strengthening and using national M&E capacity.*** Health information systems in the Kyrgyz Republic and Nepal have been strengthened,⁷ but most have been unable to produce sufficiently reliable data to permit meaningful analysis of trends and the M&E of sector performance, outputs, and outcomes.⁸ Some DPs still maintain separate M&E procedures. Under the first Bangladesh PoW, DPs participated in annual reviews but still maintained separate M&E procedures. In Ghana, Malawi, and Tanzania DPs, especially those operating outside of the SWAp, maintained separate M&E. The size of the Joint Review meetings in a few countries is reported to have grown so large that they cannot be efficiently run. While the joint reviews have been instrumental in catalyzing and consolidating M&E efforts, experience in a number of countries reveals that the process may be becoming stale and less meaningful and useful than they were initially (Walford 2007).

4.14 ***The heavy emphasis on procurement, disbursement, and financial management relative to M&E has resulted in an insufficient results focus of most SWAps.*** This is reflected in weak designs, which, with few exceptions, were not grounded in a well-articulated results framework with solid baseline data and performance and outcome indicators. The SWAps did not assess M&E capacity or sufficiently emphasize M&E capacity building and risks, relative to procurement and financial management capacity building. This is also reflected in implementation of the PoW. DP dialogue and activity, as well as SWAp tools and mechanisms, have focused largely on process (convening of coordination meetings, capacity building for planning, procurement and financial management, disbursement of pooled funds). There has been less emphasis on the use and tracking of financing for highest-impact interventions and results. As a result, two of the most important anticipated benefits of SWAps have yet to be achieved -- a results focus and sector-wide accountability. Nevertheless, the Kyrgyz Republic's SWAp demonstrates that it is possible to balance important process tasks with a focus on results. This is likely attributable to the fact that the Bank's and other DP's pre-SWAp support to the first health sector program was successful in establishing good M&E capacity. The Bank provided

substantial resources for M&E capacity building to Malawi under a supplemental grant, but the bulk of resources were not used, due to low interest and weak incentives on the part of government and inadequate technical support by the Bank, especially from its field base.

RISK ASSESSMENT AND MITIGATION

4.15 *The risk of inadequate M&E systems and capacity was not raised even once.*

Annex 4 summarizes the exhaustive risk assessment and mitigation plans associated with the strengthening and use of country capacities for procurement, disbursement, and financial management.

Quality and Functionality of the Partnership

4.16 A review of the literature and of country experience has revealed three dimensions of partnerships formed under SWAp that can enable – or undermine – the achievement of results: *who* is in the partnership; *what* are its main functions (and how effectively are they carried out); and *how* the partners interact. Box 4-3 provides indication of good practice with regard to partnerships, distilled from the evidence, and frames the discussion of this section.

PERFORMANCE AND EFFECT ON RESULTS

Who is in the partnership?

4.17 *SWAp have been largely successful in engaging Ministries of Finance in strategic sector management, most notably in the joint planning and review meetings.* This has helped improve communications and dialogue between the MoF and MoH and, in some cases, has garnered greater allocation of public resources for health. In Malawi, the health SWAp is credited with fulfilling the Abuja Declaration commitment to allocate 15 percent of the total government budget to the health sector. This has also earned credibility for the health sector in its efforts to improve the stewardship and governance of the sector.

4.18 *On the other hand, SWAp have not been very successful in engaging with some of the other key national partners, especially the private sector and civil society organizations.* Lack of inclusion of these partners has been observed in terms of their limited involvement in discussion of strategic sector management and policy dialogue, the limited integration of their programs and services with public sector activities, and limited subsidy, and oversight of them by the public sector.⁹ This neglect has substantially undermined health program objectives to improve service coverage and quality, given that non-governmental services make up a substantial part of all health services provided in these countries.¹⁰

Box 4-3: Components of a Good Partnership under a SWAp

Who is in the partnership?

National actors and stakeholders:

- Government (central, regional, peripheral levels, Parliament)
 - Ministry of Health
 - Cross-cutting ministries: finance, civil service, local government, etc.
 - Other relevant sectors: nutrition, education, social development, etc.
- Non-governmental
 - For-profit and not-for profit service providers
 - Other civil society organizations

All external development partners, no matter the modality of their support

To do what?

- Negotiate evidence-based policy/strategy ==>>>
- Allocate resources to sector priorities ==>>>
- Review sector performance and outcomes ==>>>

To what end?

- Coherent, coordinated sector policy
- Rational/flexible resource allocation
- Greater focus on results

How do they interact?

- Government in a leadership position, with adequate capacity and stability to fulfill its role
- DPs in a supportive position, with clearly defined roles, responsibilities, accountabilities and capacities
- Dialogue and decisions based on the generation of evidence rather than conditionality
- Mutual accountability of all partners for results based on performance benchmarks for each partner (or group of partners)
- Clear guidance and mechanisms for managing and resolving disputes
- Coordination/collaboration around one national health plan, one M&E framework, one review process.

Source: Compiled by the author, drawing on various sources including: Cassels 1997; IHP's Guidance Note on Country Compacts; Paris Declaration 2005; Accra Agenda for Action 2008, World Bank/OPCS, among others.

4.19 ***The financing modality of a DP has been an important determinant of its degree of participation.*** SWAps have created categories of DPs aligned around the mode of financing they are providing: non-pooled and pooled at the sector level, and general budget support (Table 4-1).¹¹ While non-pooled, parallel financing is an accepted mode of financing for SWAps, not all non-poolers are working within the SWAp framework, which causes inefficiencies and undermines government sector stewardship. Some provide bilateral financing directly to public and non-public implementing agencies without informing MoH or ensuring that their activities are reflected in sector budget, expenditure, and financing plans. Activities they support may or may not be included in the country's PoW, and these DPs are less likely to participate in joint policy and strategic discussions, some still preferring bilateral meetings with MoH. There are successful examples of non-poolers working within a SWAp framework.¹² Some financiers make the deliberate choice to finance earmarked activities in order to support activities (that may or may not be included in the PoW) that they believe to be critical and risk being neglected. Financial support to non-public providers is an example, as is direct support to vulnerable geographic areas and priority programs.¹³ However, the literature and field evaluations in Bangladesh and Tanzania highlight a range of issues and inefficiencies created by partners – in particular but not exclusively, global programs -- working outside of the framework.¹⁴ This has resulted in some cases in poor coordination and duplication, high transaction costs for government, variable degrees of country ownership, and lack of alignment with country systems.¹⁵

Table 4-1: Patterns of SWAp Participation of Pooling and Non-Pooling DPs

Extent of SWAp Participation	Non-poolers		Poolers	
	Outside SWAp framework	Within SWAp framework	Sector-level financing	General Budget Support
Financing reported to MoH and reflected in SWAp budget, expenditure, financing plans	Not necessarily	Yes	Yes	Yes
Financing channeled to and managed by MoH	Not necessarily	Not necessarily	Yes	Yes
Activities included in/supportive of PoW	Not necessarily	Yes	Yes	Yes
Common M&E procedures	No	Sometimes	Yes	Yes

Source: Synopsis of country tallies derived from field studies in Annex 6, Table 6-b.

4.20 DPs that provide pooled funding have had more access to government and greater leverage in the policy dialogue. This phenomenon is consistent across the six countries, with fine-tuning ongoing to enhance the participation of all DPs.¹⁶ Disincentives encountered in the country cases for not pooling include: lack of trust in country fiduciary capacity; the inability to associate any results with specific financing and for reporting back to their constituencies; DP policies discouraging or prohibiting pooling; and the sentiment that adhering to the Code of Conduct (which discourages bilateral discussions with government) diminishes their access to government compared with pre-SWAp practices and those operating outside of the SWAp, who still have bilateral discussions.

What are the partners’ responsibilities?

4.21 SWAps have created a forum for government and donors, as a coordinated group, to jointly undertake: (a) the negotiation of policy; (b) the allocation of resources; and (c) the review of sector performance. Governments have indeed taken on more of a leadership position on these three fronts. DPs’ collective opportunity to be involved in these three sector-wide tasks is provided with the understanding that they will reduce, if not eliminate, the pushing of policy and evaluation of performance linked to individually financed projects. But there has been little guidance on how these three tasks should be undertaken in practice. Experience in the six countries has pointed to the benefits of DPs collectively working at the policy level, but it has also revealed difficulties in the productive undertaking of these three tasks.

4.22 With regard to policy dialogue, in situations of disagreement or tensions on matters of policy or governance, experience has revealed a wide range of DP reactions and dynamics. In some cases DPs were perceived to have impinged on government sovereignty.¹⁷ In other cases, the DP dialogue had become too lax, or sanitized, reduced to a least common denominator.¹⁸ In still other cases, DPs intervened with candid, respectful dialogue, backed up by facts and analytic work, to encourage evidence-based decision-making.¹⁹

4.23 ***The consequences of the two extremes of donor behavior -- too interventionist or too lax -- are the same: a deterioration in the quality of the dialogue and the level of trust between government and the DPs; impasses on policy decisions; and a slowing of the rate and pace of implementation.*** Under the first Bangladesh PoW, DPs did not readily cede leadership to government, as evidenced by their dominance of the annual review process and the breakdown in dialogue and financial support following the government's reversal of policy on the organization of health and family planning services. The modest achievement of objectives under the first PoW is attributable in part to weak partnership. Where the policy dialogue is infused with technical rigor and trust, the likelihood is greater for well-informed, evidence-based policy. For example, the DPs' role has transitioned in the Kyrgyz Republic from taking decisions on behalf of government to continuous engagement, dialogue and persuasion, with the expectation that government will eventually mature to take the right decision (IEG 2008).

4.24 ***Experience in the six countries reveals a number of factors that undermine efforts to align resource allocation with sector policy, strategy and priorities.*** First, while general priorities (basic services) and equity concerns (improved services and health status for poor and vulnerable) may be a feature of all of the PoWs, the costs of an essential package of health services for all may far exceed the resource envelope. There is little to no indication of phasing or prioritization of these general objectives within a constrained budget. Second, baseline data on the current allocation of resources are scarce. Public expenditure reviews and/or NHA exercises are carried out infrequently. Third, the available domestic and external resource envelope is not well established at the time of the resource allocation exercises; these exercises occur before the approval of the domestic budget and the DPs are not in a position (or choose not) to provide adequate information on their commitments and the actual funding, whether in pooled or in parallel form. Further, the program and financing often excludes important coverage and resources of the non-governmental sector.²⁰ Fourth, the costs of PoW implementation are not fully or accurately assessed because of this exclusion. Fifth, the guidelines and criteria for the allocation of resources across districts and/or front-line facilities are not sufficiently precise. Allocations in Ghana and Nepal, for example, do not adequately take into account poverty levels or the higher investment and operating costs of activities in remote districts or in districts with a dispersed population.²¹ Sixth, there is no guidance or certainty that the resources allocated to districts and other peripheral entities will be used in line with evidence-based priorities and target groups. As noted in the Tanzania evaluation, the use of resources at the local level in a decentralized system is a decision of local government and local health authorities and facilities. Seventh, there is little incentive or accountability for the coherence of expenditures with national and local health priorities because these are infrequently tracked at decentralized levels.²²

4.25 ***The consequences of the lack of data, guidelines, and procedures for allocating resources are that scarce resources are not used efficiently.*** SWAps have helped in some cases to establish more transparency in the appraisal and choice of investment projects. During the preparation of the first PoW in Ghana, the donors were able to gain more leverage in checking and minimizing investment projects that were inefficient and whose recurrent cost implications were not sustainable. Furthermore, DP involvement in annual work planning and budgeting may be limited in some countries. In Nepal, DP involvement in annual work plan and budget discussions happens to a limited extent at the division level, but

the formal Joint Annual Review discussion happens too late in the process for them to have any real influence on it.

4.26 *Joint Reviews of sector performance have been a major step forward in consolidating the M&E efforts of government (MoH and MoF) and most DPs around a single set of program-level objectives, targets, and indicators. But there are still issues that undermine the full potential of these Joint Reviews, and scope for their further refinement.* Many Aides-memoire prepared by the DPs were found to be “watered down” in their language in an effort to smooth over differences in opinion among the signatories, making them less incisive and clear on what issues need to be addressed and how. Reviews of a series of Joint Review Aides-memoire over time showed that many recommendations were rolled over in subsequent Aides-memoire, an indication of little or no action taken to resolve issues and improve sector performance. The size and costs (staff and financial) of preparing and holding these reviews relative to their benefits have been flagged as an issue by representatives of all key national and international partners in the context of IEG’s evaluations. ***There is an emerging consensus within and across countries to assess the viability of less frequent and better planned reviews, more strategic coverage of themes and topics for review, and more strategic and selective attendance, while still ensuring adequate representation of actors and stakeholders and a participatory process.*** There is little evidence to show that the Joint Reviews have gone far enough in linking results to financing, to other parts of the results chain, or to the accountabilities of national or international partners. Country experience has also revealed that regions and districts find national-level joint reviews to have a “centralizing” tendency and to be less meaningful to their local level needs, interests, and realities.

How do they interact?

4.27 *The quality and availability of national management capacity and leadership were pivotal to program success.* Where sector leadership and stewardship were weak, SWAp were less likely to succeed. Where they were strong, they were able to catalyze and manage all actors’ contributions in line with their comparative advantages and more likely to achieve national program results. Governments assumed the leadership of sector coordination and management in all six countries. The successful outcome of the Kyrgyz Republic’s PoW I implementation, during a time when elements of the SWAp were gradually being launched, and continuing good performance under the ongoing PoW II, supported by a full-fledged SWAp, are attributable in part to the strong leadership and management capacity demonstrated by Ministries of Health and Finance.

4.28 *In a number of cases, capacity for strategic sector management fell short of needs, and turnover of staff in key leadership positions undermined government stewardship capacity.* Ghana’s decision-making and follow-through of issues raised in health summits weakened as the SWAp process became more routine, a significant number of staff turned over, and institutional issues remained unresolved (IEG 2007). While Malawi’s MoH did assume a leadership role in the conduct of Joint Donor Reviews and other aspects of the SWAp, its very low capacity, high turnover of key staff, and high vacancy rates for key positions have undermined its ability to carry out strategic management and oversight responsibilities. MoH’s high commitment at the outset waned at the time of the mid-term review and has remained low, and technical working groups met less frequently. Frequent

sector leadership changes and the difficult political context in Nepal made for delays in ministerial-level decision-making and implementation. Turnover of leadership positions in government and frequent changes of key staff in Bangladesh were also cited as threats to the health SWAp. An important and positive effect of the SWAp has been that MoH line managers were not undermined by the proliferation of project management units, but instead were increasingly involved and included in sector management, oversight, and implementation.

4.29 *MoUs and Codes of Conduct have provided little useful guidance on how donors and governments should interact in situations of disagreement. And they have carried little weight for enforcement purposes, as they are not legally binding and are overridden by bilateral legal agreements.* MoUs and Codes of Conduct lay out the general expectations of DP collaboration, focusing particularly on implementation and joint coordination arrangements.²³ Conflict resolution is mentioned, but is not sufficiently specific or enforceable.²⁴ SWAp experience in Bangladesh, Ghana, Malawi, and Tanzania corroborate this observation.²⁵ MoUs and Codes of conduct did not address the ambiguity and challenges of the elements of harmonization, arising from differences across the mandates, policies, and instruments of donors, and between DP policies and country systems.²⁶ Sunderwall has documented in Bangladesh, Zambia, and other countries that actors have different levels of understanding of what constitutes a SWAp and of the roles and expectations of various partners. He found that, as long as things run smoothly the differences in understanding and expectations do not pose a problem. But when disagreements arise, they can undermine the SWAp.

4.30 *The availability, mix, and pooling of DP expertise were found to be changing, but not always in a way that meets the needs of government.* The availability of DP expertise has eroded in some countries. In Ghana, with the move to budget support, the U.K. Department for International Development (DfID) eliminated its field-based health expert post, and is now represented by the Dutch Embassy. The European Union (EU) was also a “silent partner” represented by the Dutch Embassy. SIDA has removed its health adviser in Bangladesh, and when the second PoW encompassed the National Nutrition Program there was no nutrition specialist among the DPs. SWApS have created the need for an expanded skills mix among the partners. As Walford (2007) has noted, in addition to health expertise, SWApS also need skills in public finance management, public sector reform, political economy, negotiation, and facilitation and strategic sector management. Country experience indicates that, among the DPs participating in health SWApS, some generalists (or non-health specialists) were inappropriately involved in health matters and, conversely, some health specialists were working on management or financing issues in which they have no expertise. Roles and responsibilities have not always been distributed across the donors in line with their comparative advantages and expertise.²⁷ But there are good practices in this regard, as documented in the Kyrgyz Republic.²⁸

4.31 *The allocation and use of DP expertise was also at issue in many of the SWApS.* The focus of SWAp dialogue is expected to be at the policy level, but a number of DPs were reported to be too involved in the details of program design and implementation.²⁹ On the other hand, dialogue and joint reviews in some countries have been found to have a centralizing tendency and to neglect the needs of decentralized management and frontline programs and services for critical technical guidance and on-the-ground follow-up.³⁰

Missions to the periphery were joint and largely linked to the joint annual planning and review events.

4.32 ***Inevitable turnover in DP staff has, in many cases, undermined the understanding and working relationships among partners and the institutional memory of the partnership. Newcomers were not sufficiently briefed or trained – by the host government, the DPs or their respective agencies – causing disruption and setbacks.*** This is corroborated by Walford’s (2007) review of 11 SWAp, highlighting the consequences of poorly managed changes in personnel, both in government and among DPs, on the functioning of the SWAp. The Malawi health SWAp has weathered high turnover among all agency staff since its start. The first Ghana PoW was staffed with SWAp pioneers and champions, both in government and among DPs. But transitioning into the second PoW, there was massive turnover on both sides and a serious deterioration of trust and collaboration. On the other hand, the excellent collaboration among DPs and between DPs and government has been preserved in the Kyrgyz Republic, despite recent major turnover among national and DP actors.

RISK ASSESSMENT AND MITIGATION

4.33 ***The risk of inadequate harmonization and coordination of DPs was raised at the design stage in Bangladesh, the Kyrgyz Republic, Nepal, and Tanzania, but not in Ghana or Malawi.*** The nature of these risks centered on: projects hampering harmonization; donor neglect of national priorities; the continuity of donor cooperation; and donor commitment to the national program. Mitigation measures all focused on the agreement of partnership arrangements that would facilitate coordination and frequent exchanges and dialogue, the harmonization of DP logframes with program results frameworks, and shared evaluations.

4.34 ***The risk of inadequate partnership with civil society was raised in Bangladesh, Ghana, Nepal, and Tanzania, but focused mostly on partnerships for service delivery*** through contractual arrangements and less so on broader partnerships for strategy, program development, and performance monitoring. Of these four countries, only Tanzania mentions this broader perspective. Mitigation of these risks was largely centered on meetings and policy dialogue.

Predictability, Flow, and Use of Assistance

4.35 The fourth and final mechanism linking the SWAp approach with HNP outcomes is the predictability, flow, and use of assistance. These are affected by a number of factors addressed by the approach (Box 4-4).

PERFORMANCE AND EFFECT ON RESULTS

Predictability

Most of the factors underpinning the predictability of sector financing were not in place in the six countries. Uncertainty about the resource envelope for the full 5-year program undermined planning and resource allocation and, as a consequence, the efficacy and efficiency of PoW implementation. Governments have for the most part increased their financing to health, largely honoring their commitments to the sector. DPs have also increased their pooled and non-pooled financing. However, in all countries there are

persistent issues associated with DPs' ability and/or willingness to articulate their commitments for the entire program period, confirm their annual financial commitments, and ensure the timely availability of resources to the sector, aligned with country planning and budgeting cycles. This applied to poolers and non-poolers operating within the SWAp framework, as well as to non-poolers operating outside of the SWAp; it substantially undermined the overall predictability and reporting of financing for the sector.³¹ The unpredictability to the sector of general budget support funding, even on an annual basis, has been a problem in Ghana and Tanzania. Many of the traditional pooling donors, including the Bank, have recently transitioned or are in the process of transitioning, their support from sector-level pooling to general budget support. This move was of great concern to Ministries of Health and to most health DPs interviewed, because of anticipated threats to the predictability of financing and the need for more capacity building for MoH to enable them to attract and justify resources and to demonstrate results and their links to expenditures.³² The latest independent review of Ghana's 2008 POW (May 2009) found that the shift of pooled financing from the support of the Health Fund to sector budget support has resulted in the earmarking of funding within MoH. As other DPs apply earmarking in their funding as well, the funding of various programs within MoH has now become the dominant modality of funding in the health sector.³³

Box 4-4: Factors Facilitating Predictability, Flow of Funds, and Budget Execution
<p><u>Predictability of Overall Sector Funding</u></p> <p><i>Generic factors:</i></p> <ul style="list-style-type: none"> • A phased budget based on PoW cost scenarios that identify the financing gap -- MTEF • Inclusion of the non-governmental sector in cost and resource envelope estimates • Specification of the total and annual financial commitments for health of the government and all other financiers • A sufficiently strong budget and planning process, aligned with the country's budget cycle <p><i>Factors specific to domestic/government financing:</i></p> <ul style="list-style-type: none"> • Stable macroeconomic conditions • Firm government commitments on increasing domestic budget allocations to health at the outset of the PoW <p><i>Factors specific to external financing:</i></p> <ul style="list-style-type: none"> • Firm commitment of DPs' funding (amount, modality and timing) at the outset of the PoW • Agreed disbursement schedule linked to the PoW and national plan, and aid flows reported in national budgets • Annual releases of funding in line with commitments at the time of the annual budgeting exercise • Alignment of donor planning cycles, among themselves and with country planning and budgeting cycles • Commitment to predictable medium-term and long-term financing • Responsiveness to financing gaps identified in budget scenarios and the MTEF • Availability of resources in the timeframes described in the country health strategy and budget • Timely information on annual DP commitments and disbursements for monitoring accountabilities <p><u>Flow of Funds to Implementing Entities</u></p> <ul style="list-style-type: none"> • Timely disbursements to districts and implementing agencies in the amounts committed and budgeted • Simplified disbursement and financial management reporting and adequate capacity to implement it • Systematic measurement of capacity to manage and coordinate aid flows <p><u>Budget Execution and Use</u></p> <ul style="list-style-type: none"> • Systematic measurement of budget execution rate to monitor implementing entities' absorptive capacities • Systematic measurement of use of funds against national and local priorities.
<p><i>Source:</i> Compiled by the author, drawing on various sources including: Cassels 1997; IHP's Guidance Note, "Development of a Country Compact;" Paris Declaration 2005; Accra Agenda for Action 2008, World Bank/OPCS, among others.</p>

4.36 The Tanzania Joint Evaluation (Freeman and others 2007) is the only one that assessed the relative predictability of financing by aid modality (Table 4-2). It is worth presenting these findings here because it might be repeated in other countries and its findings are largely consistent with those documented in the other evaluations, albeit less systematically. Recent experience in some countries reveals that, as is the case for projects, there is scope and opportunity for global health program support to be more predictable and more aligned with the PoW.

Table 4-2: Advantages/Disadvantages of Different Aid Modalities in Tanzania

Aid Modality	Predictability	Timeliness	Freedom from Political Interference	Ownership
Projects	Disadvantage	Advantage	Advantage	Disadvantage
Global Health Programs	Disadvantage	Advantage	Advantage	Disadvantage
Sector Support	Advantage	Advantage	Disadvantage	Both ways
Basket Fund	Advantage	Disadvantage	Both ways	Advantage
General Budget Support	Disadvantage	Disadvantage	Disadvantage	Advantage
Technical Assistance	Both ways	Both ways	Disadvantage	Disadvantage

Source: Freeman and others 2007.

Note (from the source): The scores are not absolute. They merely indicate where advantages and disadvantages outweigh each other. Global Health Programs also include large bilateral programs. General budget support is listed as having a disadvantage in terms of predictability to the sector ministry (MoHSW) and local government authorities.

Flow of Funds from the MoH to Implementing Entities

4.37 ***Pooled funding under SWApS in Ghana and Tanzania brought more resources to health districts and primary health care services, facilitating the implementation of local-level plans.*** Tanzania’s Basket Fund and Ghana’s Health Fund were both cited as being pivotal in providing districts (and Health Councils, in the case of Tanzania) and frontline facilities with needed liquidity for carrying out their mandate (Freeman and others 2007, IEG 2007). But the flow was irregular, slow, and not always commensurate with amounts committed and budgeted. Some improvement on all of these fronts has been noted, as disbursement, financial management and financial reporting capacities are strengthened through on-the-job learning and other pedagogical support.

4.38 ***But the allocation and use of these resources at the local level have been difficult to track and do not appear to be fully reflective of stated priorities.*** Decentralized entities did not always demonstrate the capacity for effective use of funds for priority services. The lack of links between planning, on the one hand, and budgeting and resource allocation systems, on the other, and difficulty tracking the use of pooled financing, especially at the local level, have been highlighted. Where the financing could be tracked at the local level, the highest priorities were not always well-resourced. For example, in Ghana the failure to improve coverage of ITNs and assisted deliveries under the first PoW reveals a mismatch between expenditures and priorities. Reproductive health services appear to be under-resourced in all countries except for Nepal. ***Failure to track and systematically improve the allocation and use of SWAp resources for the highest-priority, highest-impact interventions has***

undermined the achievement of health objectives. The lack of progress in reducing maternal mortality and high fertility is indicative of a neglect of reproductive and maternal health services under all SWAps.

RISK ASSESSMENT AND MITIGATION

4.39 ***The risk of low predictability of funding was not specifically raised in ex ante risk assessments, although the risk of slow flow of funds was addressed in two countries.*** The risk of delay, diversion or cash rationing by the treasury was raised for the Kyrgyz Republic and was to be mitigated by regular reporting and intense monitoring, including annual operational audits with a specific focus on the internal control framework. This appeared to help flow of funds. In Tanzania, the risk of delayed disbursements to the health basket was to be mitigated by closer adherence to a six-month health planning process and the approval of plans at the start of the fiscal year. Indeed, districts and peripheral facilities are reported to have been regularly resourced.

4.40 ***The risk of inadequate allocation of resources was raised for Bangladesh, Ghana, Nepal, and Tanzania.*** Mitigation measures centered around continued dialogue and close monitoring of resource allocation, including the joint review of capital investments. These mitigation measures were not sufficiently clear or rigorous or focused on decentralized/deconcentrated levels and frontline services to be effective.

5 How Has the Approach Affected the Efficacy of the Bank?

5.1 This chapter highlights strengths and weaknesses of the Bank’s performance in supporting the design and implementation of health SWAp in the six countries and reflects on the impact of the approach on the Bank’s efficacy as a partner. IEG rated the Bank’s performance – based on program design and quality of supervision – in the satisfactory range for three of the five SWAp support projects in the six countries that closed (Table 5-1).¹ The findings point to opportunities for the Bank to be more effective by exploiting more fully its comparative advantages in full partnership with other DPs, adapted to the very particular context of each country and the actors therein.

Table 5-1: Bank Performance Ratings for Five Operations that Supported Health SWAps

Bank Performance Rating					
Highly Satisfactory	Satisfactory	Moderately satisfactory	Moderately Unsatisfactory	Unsatisfactory	Highly Unsatisfactory
	Tanzania	Ghana (PoW I) Malawi	Ghana (PoW II)	Bangladesh (PoW I)	

Source: IEG.

Note: The Bank performance rating is based on quality at entry (reflecting program design) and quality of supervision.

Program Design (Quality at Entry)

5.2 ***The Bank is a recognized leader and catalyst for SWAps.***² Even in Malawi, where it was a latecomer to the health SWAp, the Bank played a leadership role in its operational design and launch. The Bank has been especially effective and appreciated by other DPs for its role in assessing and strengthening national capacity and systems for procurement and financial management, which gave some DPs the confidence to provide pooled funding. While its performance in this regard was strong for the most part, the Bank’s fiduciary assessment during the appraisal of the Malawi health SWAp focused almost exclusively on central MoH capacity, with limited focus on district fiduciary capacity, despite the decentralized implementation strategy. This is in contrast with the Bank’s considerable design work to strengthen the financial management capacity of districts in Ghana and their certification upon the demonstration of requisite skills. During the first Ghana PoW, the Bank was proactive in advocating internal Bank changes in procurement, disbursement, and financial management to promote creativity, flexibility, and client orientation.

5.3 ***When conducted, the Bank’s analytic work contributed to viable program design.*** In the Kyrgyz Republic, Bank analytic work underpinned the SWAp and established viable baselines: detailed burden of disease analysis; cost-effectiveness analysis; assessment of STDs, TB, maternal and perinatal health, acute respiratory infection; and analysis of health spending. This work drew heavily and built on excellent analytic work carried out by other DPs, including WHO and USAID. On the other hand, in Ghana the Bank failed to conduct sufficient analysis and evaluation that could have informed project design, especially with regard to institutional analysis, equity issues and public expenditure.³ Bank analytic work linked to SWAp preparation was not mentioned in the evaluations in the other four countries.

5.4 ***The Bank's technical, financial, and economic appraisal of PoWs appears to have been inadequate in a number of countries.*** In Malawi and Nepal, the PoWs were more input- than outcome-oriented. The PoWs in Bangladesh and Malawi were overly-ambitious and complex. However, in the case of the Kyrgyz Republic, the Bank jumped into an opportune situation of a well-conceived national strategy, with strong ownership and in-country champions, and grounded in good analytic work of other DPs, especially WHO and USAID.

5.5 ***Reviews were mixed on the adequacy of Bank inputs and processes during the design stage.*** The Bank's team in Ghana had strong technical capacity and credibility, providing valuable technical input and guidance to the preparation of the PoWs. It acknowledged the leadership capacity of MoH, was an effective listener and respectful and supportive in its approach. The Washington-based task team leader was often present in the country and deeply involved in the SWAp design, but also well-placed to advocate reforming Bank procedures to facilitate a SWAp. In Tanzania and the Kyrgyz Republic the composition of the Bank's pre-appraisal and appraisal teams was strong, including the appropriate expertise, and demonstrating the Bank's serious commitment to the SWAp. However, in Malawi the Bank's limited technical presence in country was found to have undermined its contribution to the health SWAp preparation. The Bank had no in-country expertise at the Bank's office in Bangladesh, but the Health Program Support Office (HPSO) was located in the Bank's premises, causing confusion about the ownership and leadership of the SWAp.

5.6 ***Bank contributions to the preparation of M&E were weak.*** Inadequate M&E was not cited as a risk in any of the SWAp-support projects, nor was M&E capacity fully assessed. In contrast to the extensive guidelines for appraisal of and capacity building for procurement and financial management under a SWAp, the Bank had no guidelines for M&E capacity assessment and strengthening. Except for some support to health management information systems, M&E fell through the cracks as anyone's (not the Bank's or anyone else's) primary responsibility. There were no specialized staff to design and guide M&E capacity building and no specialized supervision support. As a result, in Ghana there was a failure to guide and support the development of a sector-wide logframe with a well-articulated results chain and viable M&E plan and system for effectively tracking sector performance and outcomes. M&E in the Kyrgyz Republic appeared to be strong, but was supported by DPs other than the Bank. An important exception was Malawi where the Bank granted \$5 million in supplemental financing for strengthening program-wide M&E capacity. But government interest and incentives were low, and there was insufficient Bank expertise on the ground to guide and oversee the implementation of this supplemental financing, the bulk of which was ultimately cancelled.⁴

Quality of Supervision/Implementation Support

5.7 ***The Bank's focus on development impact and proactivity has been mixed.*** The proactivity of the Bank appears to have been the strongest under the Kyrgyz Republic SWAp. Task team leaders and, when necessary, the Country Director, were willing to wield the leverage of Bank support to make sure implementation remained on track; they did not hesitate to raise issues at the highest levels to ensure political commitment and follow-through and protection of the integrity of the reform from elements within government that

wanted to move in a different direction. The Bank’s team supporting the Nepal SWAp was reported to be proactive in operationalizing the SWAp and in promoting a results focus. But in Ghana, the Bank was not sufficiently proactive in assessing program performance with respect to equity and or in assessing expenditures in relation to stated priorities. ***The Bank’s supervision of procurement and financial management aspects was strong, as expected in all six countries.***

5.8 ***The Bank was weak in the candor and quality of performance reporting.*** In Malawi, reports on the performance of the programs/projects were overly optimistic and neglected to raise issues and concerns.⁵ It is likely that the lack of candor in reporting on program performance was also reflected in its dialogue with government. In Bangladesh and Ghana, with the preparation of joint Aides-memoire emanating from joint review meetings, the Bank abandoned the practice of issuing its own Aides-memoire. The messages of the joint reports tended to be diluted as language was reduced to the “least common denominator” acceptable to all of the partners.⁶

5.9 ***The adequacy of supervision inputs and processes is difficult to assess overall.*** The extent to which they were needed from the Bank depended on the skills mix of other DPs, their comparative advantages, the clarity and coherence in the allocation of their roles and responsibilities and, most importantly, the needs and demands of government. Further, the number, skills mix, location, and turnover of Bank staff are not raised systematically in the evaluations of the six countries, making it impossible to draw conclusions, or even to summarize findings. Good inputs and processes were cited in Ghana, the Kyrgyz Republic, and Tanzania,⁷ while weaknesses were cited for Malawi.⁸

5.10 ***Bank staff may be spending too much time in meetings and too little time in the field.*** Under the SWAp approach, DPs undertake joint visits only in connection with the preparation of annual reviews, in all other cases leaving supervision visits to MoH. The Bank, therefore, does not travel to the field as frequently and extensively as it did in its previous, non-SWAp support. While this practice acknowledges the role of MoH, Bank and district staff in some countries indicated that it limits Bank’s knowledge and understanding of the field and thus its ability to support the SWAp more effectively. It also reduces opportunities for pedagogical supervision and support. The allocation of the time of the task team may warrant a closer analysis.

5.11 ***It is striking that the contribution of the Country Director was only mentioned once in all reviews of Bank performance.*** In the Kyrgyz Republic, the World Bank Country Director’s interventions were highly effective and strategic. This may suggest the underutilization of Country Directors in health SWAp dialogue and oversight in other countries.

5.12 ***None of the evaluations assessed the costs of the Bank’s support to SWAps at the country level, the availability and use of trust funds and administration budgets, or the skills of staff teams: mix, and distribution to field- and Washington-based offices.*** A study on the Bank’s staffing of SWAps and their costs, financing, and financing sources would be an important value added, but was beyond the budget of this study.

Implications of a SWAp for the Bank's Efficacy

5.13 *SWApS have changed the way the Bank carries out its work and how it interacts with government.* While the administrative costs of the Bank's support to SWApS has not been systematically assessed, Bank staff, especially task team leaders, have consistently reported devoting a greater share of their efforts and budget resources to coordination and collaboration with other DPs, compared with traditional project support, especially given the leadership role the Bank plays among DPs in many countries. The nature of the Bank's dialogue with government has changed profoundly from one that was primarily bilateral to one that is joint with other partners. Furthermore, tools for encouraging government action and policy change are much less reliant on conditionality and more reliant on dialogue in acknowledgement of government leadership and sector stewardship.

5.14 *While these changes should not necessarily lead to a dilution of the rigor and standards of the Bank's technical and financial support to client countries, in some cases this has been the case.* The criteria for Bank performance are still relevant to the context of a SWAp. During the design stage, the dialogue and program content would benefit from solid analytic work to ensure its evidence-base and realism. National strategic frameworks are likely to be enhanced by rigorous technical, financial and economic appraisal. It appears that appraisal has not been as rigorous as that under traditional projects because of the principle of government leadership and ownership. The results orientation of national programs and strategies could be significantly strengthened by the establishment of M&E arrangements, including a good results chain, indicators, definition of roles and responsibilities and plan and system for data collection, analysis and use. During implementation a proactive focus on the development impact is still called for under a SWAp, including the candor and quality of performance reporting. An important, and heretofore neglected, aspect of reporting, especially in the context of a SWAp, is the routine tracking of expenditures vis-à-vis the priorities and highest-impact interventions defined in national programs at national, regional, district and local levels. This neglect is especially surprising, given that analysis of public expenditure is an area of Bank comparative advantage. The quality and quantity of the Bank's inputs and processes need to be rigorously monitored, and ensured; they will depend on the country context.

6 Findings, Lessons, and Future Directions

Findings

6.1 The health SWAps in these six countries have been successful in putting in place tools and processes for improved sector coordination and oversight. They have made headway in improving the harmonization and alignment of development assistance, notably in: (a) the establishment of country-led partnerships between governments and DPs to facilitate joint policy dialogue, planning, resource allocation, and the joint review of sector performance; and (b) the strengthening and increased use by pooling DPs of common systems for procurement and financial management, with an emphasis on the development and use of local systems and capacities. These health SWAps have been only modestly successful in achieving improved sector stewardship, as measured by: the efficiency of resource utilization; the sector's focus on results; and the definition and enforcement of sector-wide accountabilities, both among national actors and stakeholders and among external partners. The majority of PoWs that have been completed have made only modest progress in achieving their nationally-set development objectives, in which governments and DPs were collectively investing.

6.2 SWAps are more likely to contribute to the achievement of national health sector development objectives when four success criteria are satisfied : (1) a high-quality, feasible, results-based PoW; (2) adequate systems and capacities to ensure the efficient and reliable functioning of common implementation arrangements, encompassing not only procurement and financial management but also M&E and the definition, tracking and enforcement of accountabilities for results; (3) well-defined, well-functioning, complementary and productive partnerships among the actors and stakeholders, both national and international; and (4) reliable, predictable flows of assistance that are efficiently allocated and effectively used. Evidence shows that strong performance on these criteria has facilitated improved sector performance and outcomes, while weak performance has tended to undermine sector performance and outcomes. A distillation of good practice on each of these criteria, gleaned from field experience and the literature can guide the design and fine-tuning of health SWAps.

Lessons

6.3 Drawing on this analysis, the following lessons may guide and support improved performance:

- ***The adoption and financial support of a PoW based primarily on the collaborative process for its preparation and/or its strong national ownership – important as these are – does not necessarily ensure optimal health sector performance and outcomes.*** Government, other national partners and DPs, alike, can contribute to the enhanced success of health SWAps through their rigorous appraisal of the PoW to ensure it meets minimum quality standards.
- ***The sequencing of efforts to develop and use local skills and systems for sector management and implementation can mitigate the risks of delayed implementation and a weak results focus.*** Building strong M&E capacity and setting up M&E systems prior

to systems for accommodating pooled financing (procurement, financial management) appears to nurture and sustain a results focus. SWAp that have attempted to strengthen these systems simultaneously are reported to neglect M&E capacity building and to focus more on process than results. The use of reliable interim procurement measures in low-capacity countries, with a view to protect and ensure the flow of essential drugs, supplies and other support to frontline services while procurement capacity is being built can prevent implementation delays.

- ***Management for enhanced development effectiveness requires the linking of resources to results.*** It is not enough to develop viable systems for planning, budgeting, procurement, financial management, expenditure tracking, and M&E. The efficient and equitable use of sector resources depends on the capacity of managers at central, regional, district and peripheral levels to draw on, interpret and use a range of information emanating from these systems, facilitating the strategic management of inputs, processes, outputs, results, and accountabilities.
- ***Incentives, whether through rewards, sanctions, and/or pedagogical interventions, 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.
- ***The most productive partnerships in terms of their effective support of SWAp goals and national health objectives were those that: specified and tracked mutual accountabilities; strategically included essential national partners and stakeholders; and operated on the principles of mutual trust and respect, technical rigor, candor, and transparency.***
- ***The development effectiveness of SWAps can be improved at the local level through better management of local political economy issues and strengthening technical and strategic decision-making and service delivery capacity.*** This has the potential of mitigating the neglect of high priority programs and services that has been observed in the six countries.

Future Directions

6.4 There is a strong consensus among countries and DPs alike that more rational and country-led management of aid is a goal worth pursuing. This is evident in the conviction of all six countries that the SWAp is the right approach to take, despite the challenges and shortfalls in the achievement of SWAp and program objectives. It is also evident in the broad-based endorsement of the 2005 Paris Declaration on Aid Effectiveness, signed by more than 100 countries and donor organizations. But this study has shown very clearly that the development effectiveness of a SWAp should not be assumed. The following actions might help underpin efforts for improved development effectiveness.

- The development of guidance on what constitutes a good PoW and criteria for its rigorous evaluation.¹
- The devotion of adequate expertise and resources to develop guidelines and standards and to strengthen country capacity for results-based planning, programming, review, monitoring and evaluation.²
- The development of country capacities for tracking and analyzing sector resource allocations and expenditures and their links with results.

Lessons for the Bank

6.5 The review of the Bank's experience and contributions in six countries has also distilled the following lessons.

- ***Respect for government sovereignty and leadership on matters of policy and strategy need not be inconsistent with rigor and candor of dialogue and policy advice.*** The Bank's support or direct undertaking of analytic work can be instrumental in deepening and sharpening a dialogue based on evidence. This applies to program preparation and appraisal stages, as well as throughout implementation.
- ***There is opportunity for the Bank to further strengthen and exploit its areas of comparative advantage crucial to the success of SWAps,*** among which: the enhancement of dialogue and mutual trust between ministries of finance and health; the economic and financial analysis of PoWs; the building of country capacity to allocate sector resources and track expenditures for optimal impact; and the development of management and implementation capacity consistent with in-country public sector and public finance reform.
- ***In light of its recognized leadership among DPs under most SWAps, the Bank has a critical role to play in strengthening their results orientation.*** Indeed the Bank's increased focus on health systems provides it with a platform and an opportunity to support and ensure the establishment of viable M&E arrangements and capacities, as well as the definition, tracking and enforcement of accountabilities for results throughout the health system.

Areas for Further Study

6.6 A number of topics and challenges warrant further research with a view to better understanding and improving the development effectiveness of SWAps. They include:

- Financing modalities and financial flows and how they affect the allocation and use of resources and the delivery of health programs and services;
- Modalities for defining the accountabilities of DPs, for holding them to account for their commitments under SWAps, and for guiding conflict resolution among DPs and between DPs and government;
- The compilation and analysis of transaction costs before and after SWAps, for government and DPs, and the pursuit of opportunities for their further reduction;
- Challenges and opportunities of SWAp design, implementation, monitoring and evaluation in decentralized systems;
- Districts' technical capacity to manage, oversee and deliver quality basic health services under a SWAp and interventions to strengthen capacities and provide needed technical backstopping and quality assurance; and
- Quality, strategic timing, design and implementation of analytic work and the effect on policy dialogue and policy change.

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Notes

CHAPTER 1

¹ The three stages are: (a) decision between government and its development partners to move to a SWAp; (b) preparatory activities, including the development of a sector strategy and program, design of shared processes (monitoring and reporting), strengthening of financial systems; and (c) implementation.

² For example, the OPCS brown bag lunch series on SWAps in 2006 and 2007, and the SWAp training course offered at the World Bank in November 2008 and March/April 2009.

³ The Bank started lending for population in 1970, for nutrition in 1976, and for health in 1980.

⁴ This being said, the Bank, in many cases, would provide technical assistance and support to government through the pre-appraisal and appraisal process and through its supervision mission and/or would include project financing of needed technical assistance to government. Many projects would be implemented by project units set up within MOH.

⁵ Important exceptions are the regional development banks.

⁶ Issued as Cassels 1997, and cited in Box 1-1.

⁷ Ethiopia, Ghana, Guinea-Bissau, Lesotho, Mali, Mauritania, Senegal, and Tanzania (see Annex 3).

⁸ Support of a sector policy and program is another fundamental characteristic of a SWAp, but is also a common feature of non-SWAp Bank support, so was not used, by itself, as a defining criterion. Likewise, the cofinancing of a share of eligible expenditures under a government program can be a feature of a SWAp, but does not, by itself, define a SWAp.

⁹ Notwithstanding the lack of clarity in definition, the literature and design documents reveal that SWAp objectives and/or intended benefits are quite consistent across countries (Cassels 1997; World Bank OPCS Guidelines and literature; OECD DAC literature on program-based approaches; project design documents; Paris Declaration on Aid Effectiveness 2005; Accra Agenda for Action 2008).

¹⁰ These groupings of objectives are distilled from the PoWs, policies and strategies of the six countries, drawing on the original country documents and on project design documents. Annex 3 synthesizes program and project objectives for each of the six countries.

CHAPTER 2

¹ Economic analyses of the SWAps are in the World Bank design documents.

² Essential services package in Bangladesh; primary health services in Ghana; state guaranteed basic benefits program and outpatient drug package in the Kyrgyz Republic; essential health package in Malawi; essential health care services in Nepal; and essential health package in Tanzania.

³ The PoWs in Tanzania and Malawi specified that no investments in new infrastructure would be made during the program period; in the case of Tanzania, the PoW called for growing the non-salary recurrent budget relative to salaries.

⁴ These tallies are based on a word search (“Memorandum of Understanding,” “Code of Conduct/Practice,” “Statement of Intent”) of the Bank’s project design documents. It is possible that countries with no mention of codes of conduct in their Bank project design documents may well have had them in place, or have developed them subsequently.

⁵ “Fiduciary Arrangements for Sectorwide Approaches (SWAp): Interim Guidelines to Staff,” issued by the Financial Management and Procurement Sector Boards, November 22, 2002. These guidelines are coherent with guidelines for traditional Bank-financed projects. The first operations to support SWAp in Bangladesh, Ghana, and Tanzania pre-dated these guidelines and were experimental in nature, but nevertheless adhered to the Bank’s fiduciary standards and provided the basis for the SWAp-specific guidelines. The follow-on operations supporting SWAp in these countries complied with the new guidelines.

⁶ The exception is Malawi, where key Technical Working Groups, the Health Sector Review Group, and the Senior Management Committee did not meet regularly (World Bank 2009). Nevertheless, the Joint Annual Reviews took place regularly and their content is reported to have improved over time.

⁷ The Bank previously provided oversight and technical support to fiduciary functions, on behalf of all pooling donors. Since the Bank is no longer involved, the government has recruited a firm to take over this role.

⁸ IEG 2009b, 2007, and Nepal mid-term review documents.

⁹ The joint external evaluation was proposed by several members of OECD’s Development Assistance Committee as a complement to Joint Annual Health Sector Reviews. The direct costs were financed by Belgium, Canada, Denmark, Germany, the Netherlands, and Switzerland. Workshops on various stages of the evaluation, chaired by the MoF, permitted interaction between the evaluation team and a broad range of stakeholders. Its design and implementation took four years and cost US\$1 million. While it relied on existing data, which were weak, dated, and limited, the evaluation stimulated a critical discussion of shortfalls in implementation and outcomes, which helped shape the follow-on PoW.

¹⁰ For the purposes of this study, a broad working definition of transaction costs was used: the human and financial resources devoted to the management, coordination and oversight of government and DP interactions associated with policy dialogue, analytic work, and the design, implementation and evaluation of DP-supported projects and programs.

¹¹ For example, under the Bangladesh SWAp over 120 projects have been replaced by a single program, creating more efficient lines of accountability and simpler, more consolidated planning and reporting mechanisms.

¹² Data on the Bank’s project design and supervision costs before and after a SWAp have not been systematically analyzed. Such an analysis would need to factor in the use, relative costs, and trends in the mix of international staff (both Washington- and field-based) and locally recruited national staff, as well as the use of trust funds (accounted for separately) that supplement supervision budgets. The costs of analytic work underpinning SWAp dialogues might also be appropriately factored into costs. An OPCS staff member working on aid effectiveness noted that an in-depth study of the costs of working in a SWAp mode has not yet been undertaken, but would be an important contribution.

¹³ To improve health status in the Kyrgyz Republic by improving access, financial protection, efficiency, equity and fiduciary performance in the Kyrgyz health sector; to ensure sufficient and reliable financing for the health sector; and to strengthen the targeting of social benefits by developing effective administration and information management systems to improve access to social services in general (IEG 2008).

¹⁴ The Ghana PoWs (I and II) include an objective to improve the efficiency of service delivery; the Malawi Health PoW includes an objective to improve health services efficiency; and the Tanzania PoWs (I and II) include an objective to improve resource management.

¹⁵ Bangladesh PoW II: percent of expenditures allocated to the poorest districts; Ghana PoW II: percent of capital and recurrent expenditures by level; Malawi PoW: percent of the MoH budget allocated to districts.

¹⁶ Nepal PoW spending efficiency indicators: 35 percent of recurrent financing allocated to non-salary costs; 90 percent rate of budget execution; and 67 percent of health expenditures for essential health care services. Spending efficiency indicators in the Kyrgyz Republic PoW: transfer for vulnerable populations from Republican Budget to the Mandatory Health Insurance Fund (MHIF): total, per capita, as percent of minimal standards for State Guaranteed Package and Outpatient Drug Benefit; execution of budgets as percent of

planned; total consolidated government health expenditure: per capita, as a proportion of GDP, as a proportion of the Medium-Term Budget Framework (MTBF) target, as a proportion of planned budget and as a proportion of total government spending; share of government health spending by levels of health care delivery system; more efficient and better targeted social assistance benefits; and regional breakdown in spending.

¹⁷ This NHA data base draws on NHA exercises and public expenditure reviews (PER) in each country. Only the Bangladesh country data included some trend data on spending efficiency, which are cited in this section. See Annex 7 for more detail.

¹⁸ For example, the following had been cited as evidence of efficiency improvements. In Ghana, efforts to shift non-salary recurrent financing increasingly to districts in support of basic health services were successful. Forty-eight percent of the non-wage health budget was spent at the district level, exceeding the target of 42 percent. However, growth in the wage budget has not been matched by an increase in the service budget (which finances non-salary recurrent expenditures), causing an underfinancing of critical supplies and operational costs. In Malawi expenditures at district and rural hospitals, health centers, and dispensaries represented 72 percent of MoH recurrent expenditures in 2004-05, up significantly from 55 percent in 1998/1999, but this cannot be attributed to the PoW supported by the SWAp, which started only in 2004. In Nepal, expenditures on essential health care services increased as a share of total health expenditure from 64 percent in 2004-05 to 68 percent in 2007-08 (Annual work program and budget, interview with World Bank task team leader).

¹⁹ Maternal exemptions were only partially implemented when funds abruptly ran out mid-year. The national health insurance scheme is expected to replace the exemption policy, but this will take time. There is some indication that the benefit-incidence of public spending at health clinics has improved to a point where it is equally distributed across income groups, but distribution of public spending at hospitals changed little, still favoring richer segments of the population (World Bank 2007a). Inequitable geographic resource allocation is raised as an issue, but the data are not sufficiently disaggregated at the district level to assess the equity of spending patterns. Design of the new DHS to better measure equity objectives and the addition of an explicit equity objective in the next strategic plan are both envisaged.

²⁰ Annual work program and budget, interview with TTL.

²¹ Case study, based on a review of public expenditure reviews and NHAs.

²² For example, in Ghana, monitoring of process, outputs, and outcomes is not linked with inputs and activities. Failure to define a results chain for the sector and to establish links between inputs, outputs, outcomes, and outputs makes it difficult to assess the effectiveness of various approaches or to establish causality between approaches and outcomes. The 20 indicators to monitor the PoW were mainly process-related, with only modest overlap with program indicators. Both SWAp and health indicators were important and, together, may have filled out the results chain. The program and project logframes were incomplete and baseline data were inaccurate or missing. There was no requirement to track expenditures annually vis-à-vis program outputs and outcomes. In Tanzania, strategic priorities identified for the sector were not explicitly linked to verifiable targets or an integrated M&E system.

²³ In Nepal, information and systems are scattered, making it difficult to profile a coherent picture on the evolution of outputs and how they relate to outcomes. The same is true for Bangladesh, Ghana, Malawi, and Tanzania. Planning, financial management, procurement, and performance monitoring systems are not synergistic, thus undermining sector management capacity. The monitoring of processes, outputs, and outcomes is not linked with inputs and activities.

²⁴ In Ghana, the M&E plan, strategy, methodology, roles, and responsibilities were not specified. In Tanzania, an overall framework for M&E is lacking and the roles and inter-relationships between the health management information system, Sentinel Surveillance Surveys, National Census Data and specific studies are not clear.

²⁵ In the Kyrgyz Republic, M&E was a strong feature of the SWAp, benefiting especially from the support of WHO and the UK Department for International Development (DFID). It was sector-wide from the outset and had a package of well-defined indicators in three functional categories: dashboard indicators for broad sector

monitoring (for policymaking and donors); performance/outcome indicators related to program objectives (health status, access, equity, financial protection, quality of care, efficiency); and implementation indicators (corresponding to components). However, there was not always an exact match between project and sector-wide M&E.

²⁶ In Nepal, there was little progress on recommendations over three years, with the same recommendations appearing in follow-up reporting on each joint annual review. In Malawi, the health SWAp lacked follow-through on key recommendations emanating from joint reviews (for example, the reduction of drug stock-outs). This problem was also found in Ghana and Bangladesh.

²⁷ In Ghana, regional staff reported that supervision missions did not assess performance or take remedial action to improve it.

CHAPTER 3

¹ The full set of evidence and evaluative analysis underpinning these evaluation results are not possible to capture in these brief presentations of findings, but are well-documented in the full evaluation reports.

² The primary sources are: IEG 2007 for PoW I and IEG 2007, World Bank 2007a, and preliminary results of the 2008 Ghana Demographic and Health Survey (GDHS).

³ The target of 70 percent coverage was exceeded, but it was even lower than the 1998 baseline (88 percent. Use of antenatal care was 92 percent in 2003.

⁴ Includes ORS from packets, prepackaged ORS liquids, and recommended home fluid.

⁵ Between poor and nonpoor, rural and urban, and for northern populations, compared with Ghana as a whole.

⁶ Use of modern contraceptives rose under PoW I (1998-2003) from 13 to 19 percent, but declined to 17 percent in 2008. Use of any method in 2003 was 25 percent.

⁷ During PoW implementation Ghana moved to national health insurance, which is expected to assume the costs of covering the poor.

⁸ For the preceding five-year period

⁹ The GDHS provides the 95% confidence interval for the 10-year infant mortality average for 2006, but not for the five-year average, which is more appropriate for this assessment. The 95% confidence interval for the 2003 rate is 55-73 per 1,000 live births.

¹⁰ The GDHS 1998 does not provide the 95% confidence interval for the five-year average of under-five mortality. The confidence interval for the 2003 rate is 99-123 per 1,000 live births. Within this general trend of no change, there is indication of possible modest improvements in child health among the poorest 40 percent of the population (World Bank 2007a).

¹¹ The GDHS 95% confidence intervals for the TFR are 4.3-4.8 for 1998 and 4.2-4.7 for 2003. The 1998 TFR is the average for the five years preceding the survey, while the 2003 rate is for the three preceding years.

¹² MoH statistics as reported in World Bank 2007a and UNICEF statistics.

¹³ Preliminary GDHS 2008 data do not provide confidence intervals, so it is not possible to ascertain whether the 2008 IMR of 50 is significantly different from the 1998 rate of 57.

¹⁴ Severe stunting (more than 3 standard deviations below median height for age) was 9 percent in 1998 and 11 percent in 2003. Moderate stunting (from 2 to 3 standard deviations below median height for age) was 26 percent in 1998 and 27 percent in 2003.

¹⁵ Severe wasting was 1 percent in 1998, 1.3 percent in 2003, and 2.2 percent in 2008; moderate wasting was 10 percent in 1998 and 2003, and 9 percent in 2008.

¹⁶ The Nutrition and Malaria Control for Child Survival Project, which became effective in 2007, provided intensive support for the purchase, distribution and promotion of ITNs country-wide, and likely contributed to these results.

¹⁷ The ongoing Bank-financed Nutrition and Malaria Control for Child Survival project may have contributed to improvements, but this has yet to be documented.

¹⁸ Sources for this section: IEG 2006; Martin 2009; and DHS data.

¹⁹ Bangladesh's Nutrition Program functioned outside of the first SWAp and received Bank financing under a standalone nutrition operation. It was incorporated institutionally and financially into the second SWAp.

²⁰ Use of government facilities fell and home visits dropped dramatically.

²¹ The sources for this section are Freeman and others 2007 and World Bank 2004c, unless otherwise cited..

²² Unmet need for family planning is defined as the percentage of married women who want to space their next birth or stop childbearing entirely, but are not using contraception.

²³ Tanzania National Bureau of Statistics with ORC Macro 2005.

²⁴ Tanzania's national development strategy.

²⁵ The primary source is World Bank 2009. The unpublished case study provided some context, but is based on field work that took place one year before the closing of the project and did not attempt to evaluate the SWAp.

²⁶ Christian Health Association of Malawi (CHAM) facilities.

²⁷ According to the Malawi case study, slightly more than half of the population was below the poverty line in both the 1997/98 and the 2004/05 Malawi Integrated Household Surveys.

²⁸ The Bank's SWAp support operation became effective in 2005 and began disbursing in 2006.

²⁹ Sources for this section: DHS 1996, 2001, and 2006; Shaw 2009; and World Bank 2008b.

CHAPTER 4

¹ These synopses of SWAp good practices or standards are consolidated from a wide range of sources in the literature, among which several figure prominently: Cassels 1997, the commitments and indicators of the Paris Declaration and the Accra Agenda for Action [Annex 1], the World Bank's OPCS policies and guidelines, and background material from the World Bank's SWAp Training Course, organized by the Human Development Network. While they are helpful in framing the discussion of countries' performance for the purpose of this chapter, they are not the final or official word on good practices or standards. Ongoing efforts, especially under the auspices of the IHP+, are developing more specific guidance. Some will be cited, where appropriate.

² In the context of its ongoing efforts to develop a Joint Assessment tool for assessing national health strategies and plans, IHP+ is defining the attributes of a good national strategy (www.internationalhealthpartnership.net).

³ Financial management under the Nepal SWAp was unsatisfactory during the first two years of SWAp implementation, due to delays in financial management reports, inadequate follow-up action and lack of progress in capacity building, but there is a continued trend of improvement. Financial management and procurement capacity in Malawi has modestly improved, but still remains very weak.

⁴ For example, both in Bangladesh and Malawi the learning process for procurement has caused significant delays and even negative disbursement when funds had to be reimbursed to IDA due to misprocurement.

⁵ In Ghana, government systems and capacities were developed at central, regional and district levels in procurement and financial management. Reliance on these systems enabled the consolidated management of the public budget and pooled financing. The certification of Budget and Management Centers (BMCs)

facilitated the decentralization of planning, budgeting, financing, financial management and monitoring. The procurement unit established within GHS has become increasingly competent in carrying out national and international competitive bidding. Disbursements were initially slow because of weak financial reporting, but as capacities were strengthened, financial flows resulted in greater liquidity for districts. In the Kyrgyz Republic, fiduciary strengthening in the health sector has begun to influence the overall governance of the country. Other sectors are discussing transitioning to the use of internationally-accepted procedures for procurement, financial management and audit. The MoF has noted its appreciation of the rigor of the SWAp, backed up by Bank procedures, in insulating them from corruption. Twinning of the public audit entity with experienced auditors is also supporting capacity building. Under the Bangladesh SWAp all procurement is now being handled by government, a considerable improvement in capacity. Bangladesh had previously relied on UN agencies. Improving financial management under the Nepal SWAp has been a challenge as some obstacles are government-wide and beyond the health sector to address. Nevertheless, budgeting and financial management processes in the SWAp account for government, pooled and non pooled resources, indicating progress in improving financial management within the domain and under the control of the SWAp.

⁶ Source is internal Bank reporting.

⁷ Nepal's health information system has been strengthened and its data are increasingly consistent with the DHS. The Kyrgyz Republic's information system was also substantially strengthened under the SWAp.

⁸ Under the Malawi SWAp, substantial financing was made available to strengthen its health management information system and M&E capacity, but very little of it was used and capacity did not improve. In Ghana, the quality of the health data was low because of issues of capacity and incentives at the peripheral level, resulting in inaccurate and incomplete data.

⁹ In Bangladesh the balance of DP and government resources has shifted towards increasing support to the public sector, with less direct funding through NGOs; NGOs have not benefited from DP coordination and pooled funding. Under the Ghana SWAp only one MoU was signed very late in implementation with one umbrella NGO group for mission hospitals (Christian Health Association of Ghana), resulting in very little progress to date in engaging the non-governmental sector in health services provision. Private facilities are still not accounted for during health sector planning or budgeting, nor are they included in efforts to monitor progress in the sector. Established partnerships for the health sector do not yet include the adequate participation of civil society in sector reviews and planning. Likewise, in Tanzania faith-based organizations, civil society, and private providers have been relatively excluded from sector planning and coordination, despite the significant role that non-governmental service providers play in health.

¹⁰ For example, in Ghana non-governmental health services make up over half of all services.

¹¹ Annex 6, Table 6b, provides a breakdown for each SWAp of the DPs by the type of financial support provided: poolers, non-poolers participating in the SWAp, and financiers operating outside of the program.

¹² USAID has worked effectively as a non-pooling SWAp partner in Bangladesh and the Kyrgyz Republic, supporting PoW goals and objectives and participating in joint coordination and policy discussions. Yet, it worked primarily outside of the SWAp in the case of Ghana.

¹³ One example among many is the Bank's decision to support a free-standing malaria and nutrition project after a decade of supporting the health SWAp in Ghana and in parallel with its transition to general budget support (IEG 2007). "Parallel donors" (who are not formally part of the SWAp in Bangladesh) have found ways to complement what the pooled and non-pooled donors participating in the SWAp are financing.

¹⁴ In Bangladesh, global programs have the potential to undermine the agreed priorities of the sector program and are not aligned with the planning cycle (IEG 2009b). In Tanzania global health initiatives and large bilateral programs threaten to destabilize health sector planning and prioritization as they remain largely outside established coordination and alignment mechanisms (Freeman and others 2007).

¹⁵ High-Level Forum on the Health MDGs 2005. Global health programs have the potential to overwhelm central capacity and weak health systems (Caines and others 2004).

¹⁶ In Ghana, all DPs are invited to attend the health summits, but until recently only those pooling funds co-signed the Aide-Memoires that summarize agreements and make recommendations. In Bangladesh, donors not pooling under PoW I reported that they were excluded from sector management and requested not to speak at meetings. USAID, a non-pooler, has been allowed to be a part of the donor consortium, providing for some degree of involvement in coordination tasks. While this hierarchy is not ideal, informants note that it is an improvement over the pre-SWAp situation, characterized by a high degree of cooperation among the project cofinanciers, led by the Bank, but with other donors (USAID and major UN agencies) left out of these arrangements. Likewise, in Nepal the two pooling DPs (the World Bank and DfID) are reported to have greater access to MoF and MoH, with other DPs complaining of having secondary influence. Nevertheless, DPs are reported to be participating fully in the SWAp, in terms of supporting a common strategy, and several envisage pooling their funds with the MoHP.

¹⁷ When Bangladesh decided not to unify health and family planning services as was envisaged in its national strategy, largely for political reasons, the DPs were split in their reactions. Some acknowledged GoB's sovereign right to make or change policy and were willing to support government's decision. Others, including the Bank, considered this a violation of the SWAp and threatened to withdraw their support. The Bank suspended disbursements for a certain period of time and others withdrew their support on this basis. Reviewing this case, Sunderwall and others (2006) conclude that disagreements under a SWAp can undermine working relationships and highlight the lack of clarity in roles, responsibilities, and accountabilities of all partners.

¹⁸ Ghana had established the Ghana Health Services as an implementing agency for the delivery of services on behalf of the MoH, but these institutions became competitive, inflated, and weak, not in keeping with the original and potentially workable principle of separating policy/stewardship from service provision. The issue festered over the years and impeded service delivery; it was not addressed vigorously in the DP dialogue with Government. In Malawi, donors were divided about how to manage serious issues of misprocurement in the context of pooled funding, which the Bank was overseeing on behalf of all poolers. The 2007 Procurement Audit identified more than \$800,000 in misprocurements, but the Bank could only demand repayment of IDA's very small contribution of US\$33,000 (4 percent of the total). None of the other partners formally acknowledged the misprocurement or demanded reimbursement of the remaining 96 percent. The Bank's role in fiduciary oversight and enforcement was not clear. Review of the Joint Aide-Memoires prepared after health summit meetings and joint missions, and interviews with country informants representing a range of actors and stakeholders, reveal that some were watered down to eliminate candid discussion of difficult issues on which there was no consensus

¹⁹ When the MoF in the Kyrgyz Republic made a decision to pass on the substantial savings generated by efficiency gains in the health sector to other sectors, the Bank intervened to get that policy "punishing" the good performance of the health sector reversed. Nepal's recently announced policy of free care at sub-health and health posts, with phased expansion to hospitals, was seen by DPs as posing serious risks to the financial sustainability of the health system. Yet they understood it to be a politically motivated and, on some levels, justified "peace dividend" following years of conflict and social exclusion by the poor. DPs are working closely with government to assess the costs of the new policy as well as its impact on previously well performing programs, such as the Community Drug Programme, which employed user fees.

²⁰ In Nepal, important programs are not fully reflected in expenditure programs. For example, the costs and budget provisions for free basic services are not included in work plans and budgets.

²¹ The MTR of the Nepal SWAp noted that issues such as geographical resource allocation need to be addressed when the political process permits, as one of many ways to address inequality of access. In Ghana, the formula for resource allocation across districts needs to take into account: the size of catchment areas, distances from the capital and related costs of operations, population size and distribution in the catchment areas, epidemiology, and baseline needs in infrastructure, equipment, and other essential inputs (IEG 2007).

²² Rigorous financial management requirements enable the accounting of all financial resources received by expenditure category, but there is no similar requirement to report expenditure with regard to its coherence with priority interventions and target groups.

²³ According to the Bank's Legal Department, MoUs typically specify: parties; scope of application; legal status of the MoU (representing a moral commitment, but not legally binding as are bilateral agreements between the DPs and government); general objectives and activities; institutional and implementation arrangements; annual planning and budgeting; disbursement; eligible expenditures; fiduciary provisions; M&E and reporting; remedies (for bilateral agreements); entry into effect and termination; joining and withdrawal; consultation and dispute resolution; and special provisions (such as human rights and anti-corruption)

²⁴ World Bank Legal Department's Training Module on the Legal Aspects of SWAps, presented as a part of a World Bank Health SWAp Training Course, delivered in November 2008 and again in April 2009,

²⁵ For example the Code of Conduct for the Bangladesh SWAp does not offer guidance on the issues on which all DPs should agree, on what issues might there be allowance for dissent, and what are agreed conflict resolution mechanisms.

²⁶ World Bank Legal Department's Training Module on the Legal Aspects of SWAps, presented as a part of a World Bank Health SWAp Training Course, delivered in November 2008 and again in April 2009.

²⁷ In Malawi, most of the bilateral representatives in the health pool are not technical specialists and there has been heavy reliance on the Bank to provide this expertise. Under the first Bangladesh PoW it was reported that bilaterals did not trust the Bank to manage and support implementation issues and that the division of labor among DPs was not clear.

²⁸ In the Kyrgyz Republic, DPs have agreed with Government and fulfill their roles and responsibilities. Parallel financiers provide specialized day-to-day assistance to the MoH. The World Bank is the leader among donors, provides fiduciary oversight, and leads policy dialogue. WHO, UNICEF, and the U.S. Centers for Disease Control and Prevention provide technical expertise. Budget and fiduciary issues are handled by the Bank and DFID, while community development is the domain of the Swiss Agency for Development Cooperation (SDC) and the Swedish International Development Cooperation Agency (SIDA). Cross-cutting component support is the responsibility of USAID (IEG 2008).

²⁹ In Bangladesh, health sector DPs spend more oversight time on governance issues and national-level policy debates to the neglect of programmatic causes of reduced effectiveness and efficiency. While the HNP Forum meets with relative frequency, technical working groups more closely linked to program outcomes and impacts receive less attention, an example being the recent start of technical meetings on maternal mortality. While DPs in Ghana carried out joint missions to the field, feedback from district managers and service delivery staff indicated that they were not sufficiently or frequently supported with technical guidance and backstopping.

³⁰ Foster's (2000) review of health SWAp experience concludes that DPs do not stand back from detail because they do not trust the review process to be rigorous enough and have not yet adapted to the SWAp mode. He reports that Tanzania and Uganda health officials felt that DPs became too enmeshed in details. Findings from the first Bangladesh PoW corroborate this point, observing that DPs may not be fully occupied with the policy dialogue and joint reviews and may feel more comfortable in their traditional role of technical support.

³¹ For example the unpredictability of DP financing was raised as a serious issue during the mid-term review (MTR) of the Nepal SWAp, having serious consequences for the ability of MoHP to sustain and develop critical public health programs. DP commitments were made too late in the budget preparation process, too short-term for planning purposes, and unreliable in terms of the conversion of promises into disbursements. The MTR called for firmer commitments and more rigorous accountability mechanisms for the DPs to honor these commitments (Foster 2007).

³² After a decade of health SWAp support to Ghana, the Bank and other poolers transitioned to general budget support, leaving the MoH and health DPs uncertain about the predictability of funding and MoH's capacity to manage and engage with the MoF under this new mode of financing. A slower transition was preferred (IEG 2007). The same trepidation is expressed among SWAp stakeholders in Tanzania at the prospect of transitioning to general budget support (Freeman and others 2007).

³³ IEG's recent evaluation of Poverty Reduction Strategy Credits (PRSCs), which provide budget support, found improved consistency of financing with *annual* budgeting and expenditures, but this is distinct from predictability of financing for multi-year PoWs raised in this report (IEG forthcoming).

CHAPTER 5

¹ Bank performance on *quality at entry (or design)* for investment operations is rated against: strategic relevance and approach; technical, financial and economic aspects; poverty, gender, and social development aspects; environmental aspects; fiduciary aspects; policy and institutional aspects; implementation aspects; M&E arrangements; risk assessment; and Bank inputs and processes. Bank performance on *quality of supervision* is rated against: focus on development impact; supervision of fiduciary and safeguard aspects (where applicable); adequacy of supervision inputs and processes; candor and quality of performance reporting; and role in ensuring adequate transition arrangements after loan/credit closing. Of the twelve completed and rated health SWAp support projects, the Bank's performance was in the satisfactory range for seven (Annex 2, Table 2b).

² This is also corroborated in the literature, one example among many being Jeffreys' (2003) review of 11 health SWAps.

³ Weak analytic underpinnings were specifically cited in the Bank's self-evaluation of its performance in ICRs for SWAp support to Ethiopia and Mali.

⁴ IEG evaluations of support for SWAps in Bangladesh and Nepal do not comment on the adequacy of M&E arrangements at the time of design.

⁵ The ICR notes that the Bank could have been more candid in reporting bottlenecks in performance, particularly earlier during supervision, when the project was consistently rated as satisfactory (World Bank 2009).

⁶ The ICR for Tanzania reports a decline in documentation of Bank supervision missions through Aides-memoire, and the reliance instead on annual Joint Review Meetings, but no mention is made of their rigor and candor (World Bank 2004c).

⁷ In Ghana, supervision missions were timed around health summit meetings. The quality of the technical team was consistently high, despite changes in task team leaders. The Kyrgyz Republic supervision team brought consistent and appropriate oversight and expertise with important support from the Country Director, as necessary, through high-level interventions involving operations and instruments in other sectors. Bank support was provided by three team leaders, but supervision and policy dialogue continued seamlessly. Initially the team leader for Tanzania was based in Washington, backed up by a local expert. Later, posting of international staff in Tanzania allowed closer involvement with all other stakeholders in Annual Joint Review Meetings. Financial and procurement specialists in the field provided useful support.

⁸ Support for Malawi's health SWAp's three and one-half year implementation period saw three Bank team leaders, four procurement specialists, and four financial management specialists. Further, the Bank significantly reduced its staff allocation to the Malawi health and AIDS SWAps over time, from 3 to 0.3 full-time equivalents. With no technical staff in the field, the Bank was largely absent from key country-level technical working group discussions, with the exception of annual reviews, which were attended by Washington-based staff. The overall demands on the Bank's procurement and financial management team were much higher than expected, the Bank having the fiduciary oversight role for all pooled funding under the SWAp.

CHAPTER 6

¹ An IHP Working Group is developing a "Joint Assessment" tool to this end, which may contribute to this effort.

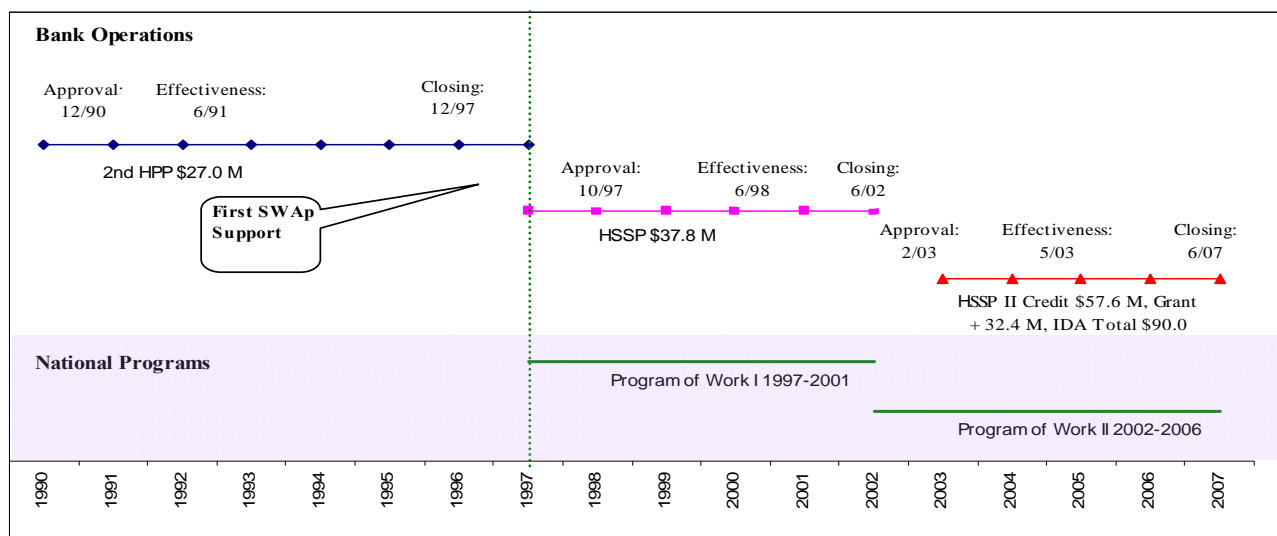
² The Global Initiative to Strengthen Country Health Systems Surveillance (CHeSS), under the leadership of WHO, has been launched to this end.

ANNEX 1. GENESIS OF HEALTH SWAPS AT THE COUNTRY LEVEL

The adoption of health SWApS has been rooted in the desire to improve the development effectiveness of health sector financing and technical support, especially that provided by external DPs. It was seen as means of addressing inefficiencies in the status quo. However, the process was initiated and encouraged by different parties in different ways across countries. In most countries the move toward a SWAp was a long and incremental process, its building blocks often supported by the Bank and others through “pre-SWAp” operations, analytic work and dialogue. This section briefly traces the genesis and chronology of health SWApS in the six countries.

Ghana’s adoption of a health sector SWAp in 1997 represented a strong consensus and conviction on the part of both MoH officials and its key DPs. *Ghana*’s evolution towards a SWAp was a long, dynamic and incremental process, spanning more than 15 years. Some of the seeds of the SWAp were embedded in the design of the Bank-financed Health and Population II project, a “pre-SWAp” pre-dating the launch of PoW I (and the Bank’s first health SWAp support for *Ghana*) by six years. This design envisaged the establishment of medium-term projections of resource availability and sector financing and spending plans, the conduct of annual health public expenditure reviews and a system of performance monitoring, but these actions were in the form of credit conditionality, an approach reported to have undermined government ownership and leadership. After its mid-term review and under the leadership of a new task team leader, this project was rendered more flexible, supporting critical SWAp features, including the preparation of a medium term health strategy, the PoW I and the first three Summit Meetings.

Figure 1-a: World Bank’s Pre-SWAp and SWAp Support to Ghana

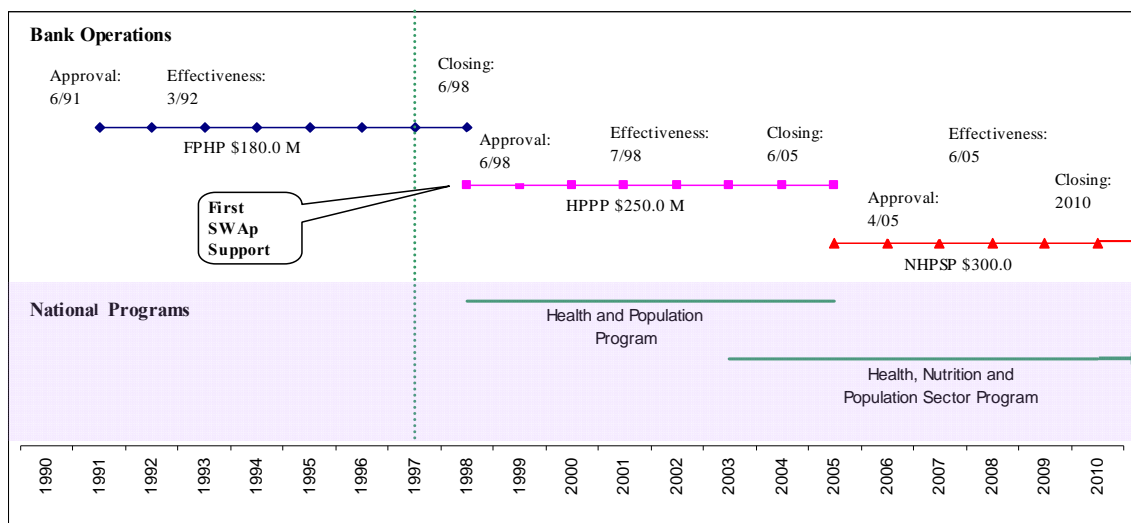


Source: Author, based on program documentation.

Note: “First SWAp Support” label indicates the Bank’s first operation that supported the implementation of national health PoWs with other DPs, through a SWAp mode.

The move toward a health SWAp in *Bangladesh*, adopted in 1998, evolved over a period of some twenty years. Between 1975 and 1998 the Bank supported a series of four population and family health projects, which were cofinanced by up to eight other DPs. Cofinancing arrangements supported to some extent coordination among key DPs and the channeling of their resources to common objectives. Over the course of these four projects government's share of the total project costs grew and DPs were invited to contribute as technical advisers to strategy formulation. Recurrent costs were increasingly supported by DPs; and the scope of these projects evolved from primarily a family planning focus to a broader health sector focus. Other trends included the increasing complexity of these projects (the fourth one comprised of 66 subcomponents)¹ and the growing number of cofinanciers. The SWAp was promoted by DPs to address concerns about policy coherence across projects and high transaction costs to government managing some 120 donor-financed projects.

Figure 1-b: World Bank's Pre-SWAp and SWAp Support to Bangladesh

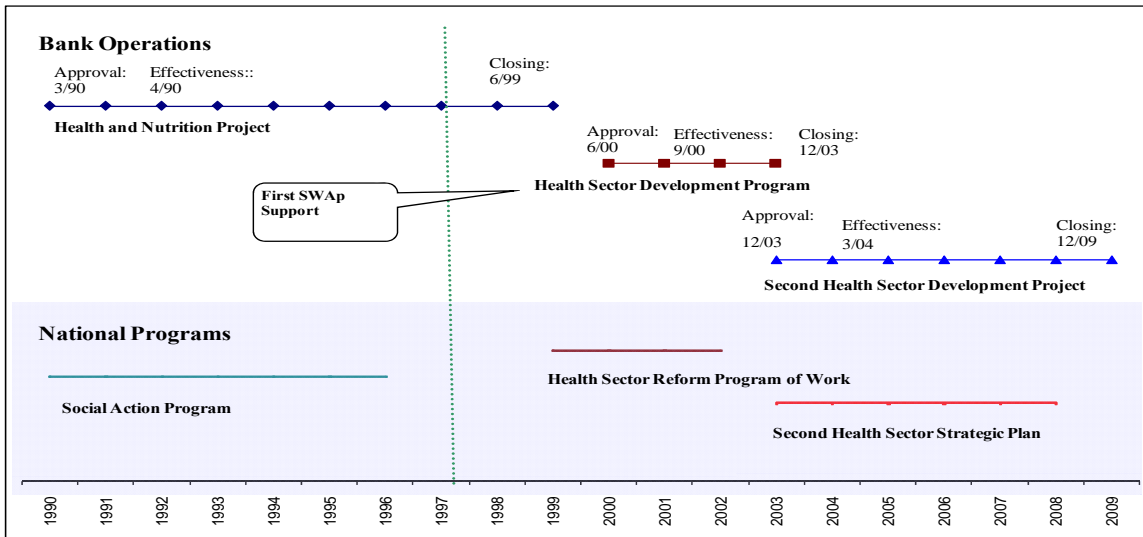


Source: Author, based on program documentation.

Reflecting generally the same timing as for Ghana and Bangladesh, in the mid-1990s the Government of *Tanzania* convened a joint planning mission and launched a process that culminated in the establishment of critical inputs to a SWAp, most notably: the first major health sector strategic plan, the health sector PoW covering the period 1999-2002 and an agreement with its major DPs that support to the health sector would take place in the framework of a SWAp. The (“pre-SWAp”) Bank-financed Health and Nutrition Project was extended by one year to support GoT in its decision to move toward a SWAp.

¹ Beyond these 66 subcomponents, which were managed as separate projects, each with its own project manager, there were an additional 60 projects financed and managed outside of the cofinanced projects.

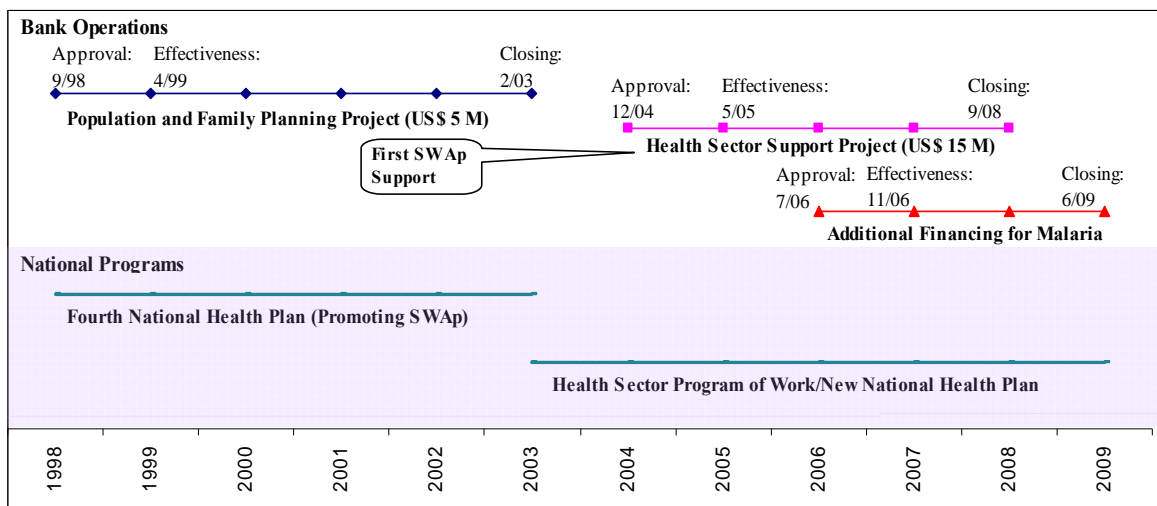
Figure 1-c: World Bank's Pre-SWAp and SWAp Support to Tanzania



Source: Author, based on program documentation.

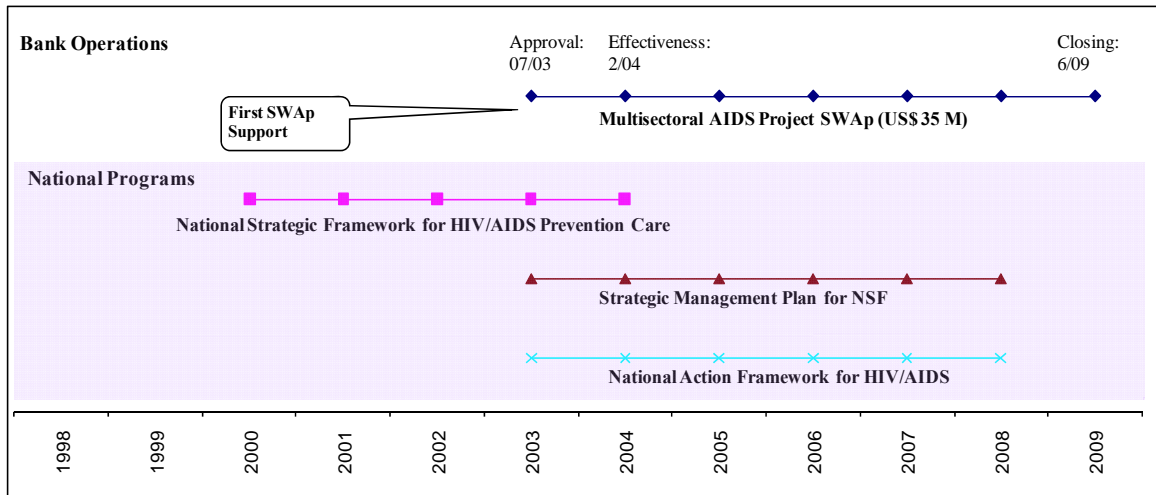
Already in the early 1990s with the design and appraisal of the PHN Sector Credit in *Malawi*, the Bank was evolving its project support with an increasing emphasis on sector policy and donor harmonization. The Credit was placed within the context of a larger sector investment program and policy framework; and the Bank, as chair of the donor health group at the time of appraisal, worked to generate parallel financing. But this early pre-SWAp effort did not culminate in a SWAp, due in part to deteriorating macroeconomic environment and in part to an underestimation of the task. After withdrawing its support to the health sector in the late 1990s, the Bank re-joined the health sector dialogue and the government's ongoing efforts to establish a SWAp, through a 2003 project to support an HIV/AIDS SWAp, and a 2005 project to support the health SWAp.

Figure 1-d: World Bank's Pre-SWAp and SWAp Support to Malawi: Health



Source: Author, based on program documentation.

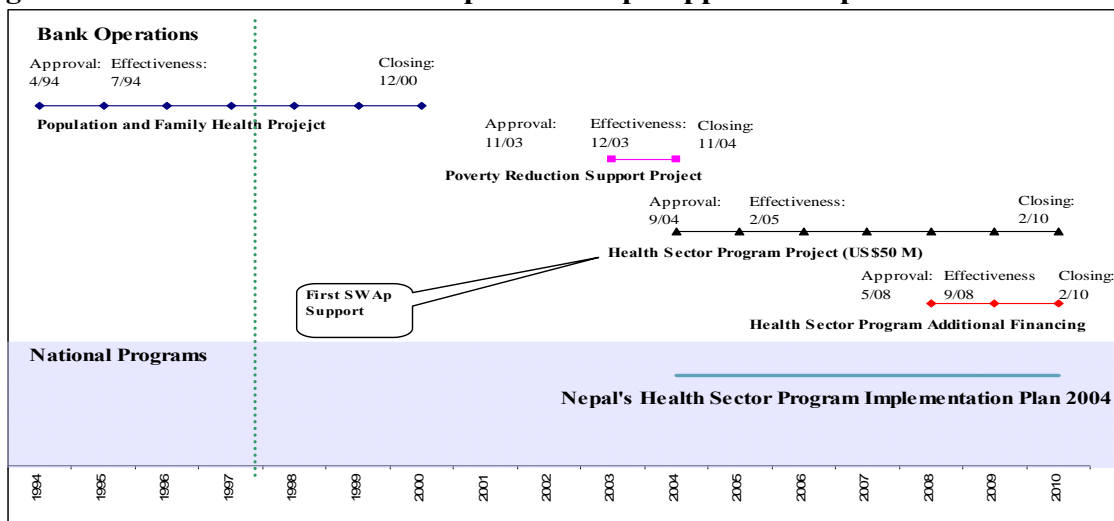
Figure 1-e: World Bank's Pre-SWAp and SWAp Support to Malawi: HIV/AIDS



Source: Author, based on program documentation.

Nepal's move to a health SWAp was rooted in a 2001 OECD/DAC review of aid in that country, which urged national actors to take charge of their own program and to mitigate fragmented and uncoordinated donor efforts. Other ensuing factors which encouraged and facilitated Nepal's move towards a health SWAp were: its adoption of a promising education sector SWAp; its PRSP, which advocated nationally-led reform efforts and supportive partnerships; a relatively strong coalition of DPs working together to support government's program with a shared vision of health sector priorities. Nepal launched the SWAp in 2004 in support of its new multi-year Health Sector Program Implementation Plan. The Bank's support represented a renewal of its health lending, which had stopped several years before with the closing in 2000 of the Population and Family Health Project.

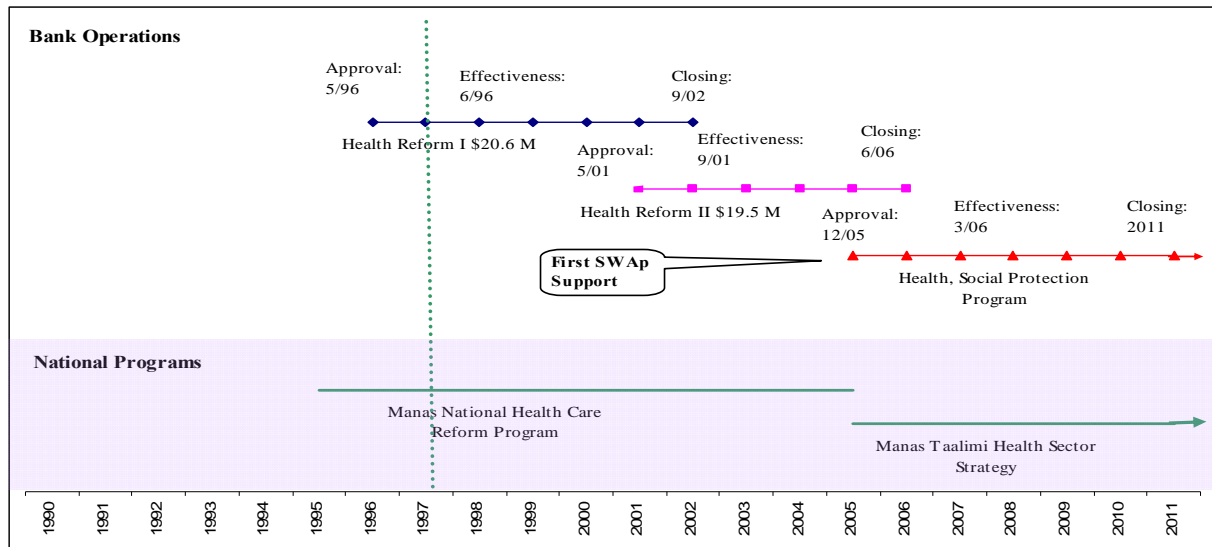
Figure 1-f: World Bank's Pre-SWAp and SWAp Support to Nepal



Source: Author, based on program documentation.

The genesis of the *Kyrgyz* health SWAp lay largely in the fact that many of its elements had already been in place for years. The government-developed sector strategy dates back to 1996, and strong donor coordination and policy consistency were longstanding. Nonetheless, the SWAp approach in the health sector was controversial when it was first introduced in 2004, with several players concerned about the level of corruption in the country and its lack of overall institutional development. The Bank team was instrumental in encouraging other players to move forward, in particular convincing them that the SWAp was an effective instrument for institutional capacity building and for facilitating meaningful donor support. While the government’s move to a SWAp was launched in 2004, centered around its Manas Taalimi Health Sector Strategy, the Bank’s two previous operations and other DP support were already undertaken in the spirit of a SWAp: grounded in the first health care reform program, and working in a coordinated and supportive role.

Figure 1-g: World Bank’s Pre-SWAp and SWAp Support to Kyrgyz Republic



Source: Author, based on program documentation.

ANNEX 2. WORLD BANK SWAp PORTFOLIO DATA

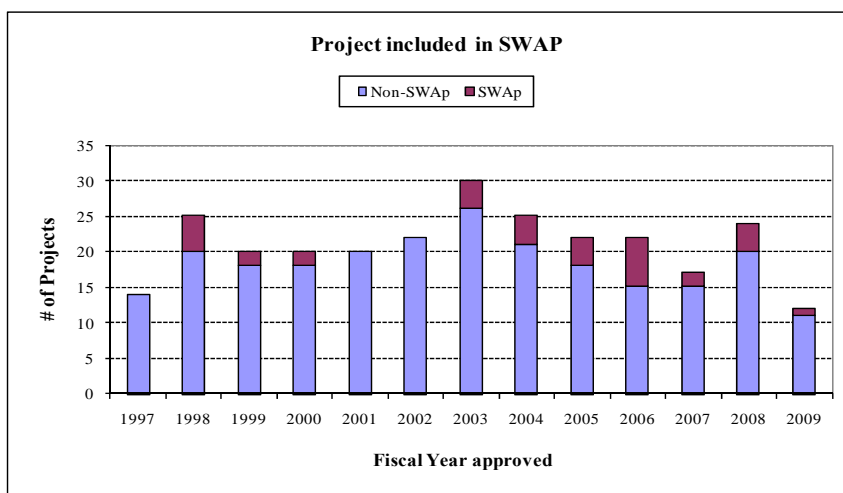
Table 2-a: Bank Operations Supporting SWAp, approved 7/1/1997-12/31/2008

Country ^a	Project ID	Project Name	FY approved	Closing Date ^b	Pooled?	Amt ^c (\$m)
Bangladesh	P037857	Health and Population Program	98	6/30/2005	√	250.00
	P074841	HNP Sector Program	05	12/31/2010	√	300.00
Brazil	P083013	Disease Surveillance and Control 2 (VIGISUS II)	04	12/31/2009	√	100.00 ^d
Burkina Faso	P093987	Health Sector Support & Multisectoral AIDS	06	1/31/2013	√	47.70
Cambodia	P070542	Health Sector Support	03	12/31/2008	√	27.00
Cameroon	P104525	CM-Health Sector Supp. SWAP	08	3/31/2014		25.00
Ethiopia	P000756	Health Sector Development Program	99	06/05/2006		100.00
Ghana	P000949	Health Sector Support	98	06/30/2002	√	35.00
	P073649	Health Sector Support 2	03	06/30/2007	√	89.60
	P105092	Nutrition & Malaria Control Child Survival	08	3/31/2012	√	25.00
Guinea-Bissau	P035688	National Health Development	98	12/31/2007		11.70
India	P078539	Tuberculosis II	07	3/31/2012		115.70
Kyrgyz Republic	P084977	Health and Social Protection	06	6/30/2011	√	15.00
Lesotho	P053200	Health Sector Reform	00	06/30/2005	√	6.50
	P076658	Health Sector Reform Phase 2	06	3/31/2009		6.50
Madagascar	P103606	Sustainable Health System Development	07	12/31/2009	√	10.00
Malawi	P073821	Multi-Sectoral AIDS – MAP	04	12/31/2008	√	35.00
	P083401	Health Sector Support	05	9/15/2008	√	15.00
Mali	P040652	Health Sector Development	99	12/31/2006		40.00
Mauritania	P035689	Health Sector Investment Program	98	12/31/2004		24.00
	P094278	Health and Nutrition Support	06	12/31/2009		10.00
Mozambique	P099930	Health Service Delivery	09	2/28/2014		44.60
Nepal	P040613	Health Sector Program	05	7/15/2010	√	50.00
Nicaragua	P078991	Health Sector II	05	11/30/2009	√	11.00
Niger	P083350	Institutional Strengthening & Health Sector Support	06	6/30/2011	√	35.00
Nigeria	P080295	Partnership for Polio Eradication	03	4/30/2009	√	28.70
Pakistan	P081909	Partnership for Polio Eradication	03	06/30/2006	√	20.00
Philippines	P075464	NP Support for HNP	06	6/30/2011	√	110.00 ^d
Samoa	P086313	Health Sector Management Program Support 2	08	12/31/2013	√	3.00
Senegal	P002369	Integrated Health Sector Development	98	06/30/2005		50.00
Sri Lanka	P050740	Health Sector Development	04	6/30/2010		60.00
Tanzania	P058627	Health Sector Development	00	12/31/2003	√	22.00
	P082335	Health Sector Development 2	04	12/31/2009	√	65.00
Timor-Leste	P104794	Health Sector Strategic Plan Support	08	6/30/2013	√	1.00
Zambia	P096131	Malaria Booster Program	06	1/31/2010	√	20.00

Source: IEG 2009a.

a. Projects in bold are those that have been completed and self-evaluated by the Bank's operations team and the Borrower (ICR) and reviewed/evaluated by IEG. b. Closing dates are as of June 2009. c. Unless otherwise noted, all amounts are for IDA. d. Amount is IBRD.

Figure 2-a: Share of Total Approved Projects That Are SWApS, FY97 –mid-FY09



Source: IEG analysis of HNP portfolio data .

Table 2-b: Distribution of 12 Completed Operations Supporting Health SWApS by IEG Ratings

Rating	Highly satisfactory	Satisfactory	Moderately satisfactory	Moderately unsatisfactory	Unsatisfactory	Number MS or higher (%)
Outcome^a	Pakistan (Polio)	Tanzania	Lesotho Mauritania	Ethiopia Ghana I Ghana II Guinea-Bissau Malawi Mali	Bangladesh I Senegal	4 (33)
Bank performance		Lesotho Mauritania Pakistan Tanzania	Ghana I Guinea-Bissau Malawi	Ghana II	Bangladesh Ethiopia Mali Senegal	7 (58)
Borrower performance		Lesotho Mauritania Pakistan Tanzania	Ethiopia Ghana I	Ghana II Mali Malawi	Bangladesh Guinea-Bissau Senegal	6 (50)

Source: IEG data.

a. The *outcome* rating is based on the extent to which the operation (in this case the PoW that was supported) achieved or is expected to achieve its relevant objectives efficiently. Thus, it is based on three elements – relevance of objectives and design, efficacy (achievement of objectives), and efficiency. In these cases, each operation supported a PoW with program-specific targets and objectives set by the individual countries and agreed by the DPs, including the Bank. These are the objectives against which the support was evaluated.

Table 2-c: Sectoral Breakdown of SWAps Supported by the Bank in 2007

Sector	No.	Sector	No.
Agriculture and Rural Development	7	Social Sectors, of which:	55
Economic Policy/Public Sector Governance	14	<i>Education</i>	25
Energy	3	<i>Health, Nutrition and Population</i>	22
Environment	3	<i>Social Protection and Development</i>	8
Financial and Private Sector Development	2	Transport	2
Infrastructure	8	Urban Development	1
Poverty	1	Water Supply and Sanitation	4
Total		100	

Source: World Bank OPCS, Aid Effectiveness Unit, as input to 2008 Survey on Monitoring the Paris Declaration.

Note: The number of SWAps (as defined by the country) receiving disbursements of Bank investment loans and/or Trust Funds in 2007. These data do not include SWAps supported by DPLs

ANNEX 3. PROGRAM AND PROJECT OBJECTIVES AND SWAp-SPECIFIC CONTENT

In keeping with the conceptual framework for this evaluation, this section assesses the extent to which SWAp *process* objectives and national health program objectives, respectively, are articulated in SWAp design documents, covering both (a) documents for Bank operations supporting SWAps and (b) national strategic program documents. This analysis draws on Table 3-a, which lists the project development objectives (PDOs) for each of nine Bank-financed health SWAp support projects and on Table 3-b, which presents the SWAp-specific content of these projects, as well as the health objectives and SWAp-specific content in the relevant national strategic frameworks. The main finding from this analysis is that, while health objectives are for the most part systematically articulated, both at the project and program levels, the objectives (or anticipated benefits) of the SWAp are not. Furthermore, not all projects or programs spell out SWAp-specific outputs or performance indicators, or include specific components (plans and resources) for achieving and measuring them.

All of the *national program objectives* are articulated around health outcomes and health sector performance objectives (including improvements in health services delivery and health systems strengthening). But none of the national statements of program objectives specify objectives or anticipated benefits of the SWAp *approach*. Only one of the ten statements of national program objectives (Malawi Health) mentions SWAp at all, but only as the means of achieving health objectives, not as an interim objective.

All of the *Bank's nine PDO statements* commit to health objectives (outcomes and/or delivery of services), reflective of those articulated in the national programs supported by these operations.¹ Of the 10 PDO statements, three make specific mention of the SWAp. The design documents for projects supporting the second Bangladesh HNP PoW and the first Malawi Health PoW mention the SWAp as the means to achieving health objectives, while the PAD for the project supporting the Kyrgyz SWAp states that the objective of the SWAp is "...to formalize the excellent donor collaboration under an explicit definition of the government's policy and program directions through periodic, formal, structured meetings for sector monitoring and donor coordination." Some of the program/project objectives include objectives that may be relevant, but not exclusive, to a SWAp. The project supporting the second PoW in Bangladesh aims to improve health sector management and stewardship. Kyrgyz' program aims to enhance capacity in policy formulation, priority setting, policy-based budget planning and monitoring and evaluation. Likewise, the Malawi Health SWAp aims to enhance capacity for stewardship and policy development.

¹ One of them does so indirectly. The objective of second Bangladesh Health SWAp support operation is to assist government in the implementation of its sector investment program without specifying any health or other objectives. But the Government's program, which this operation is designed to support, does articulate the goal of improving health, nutrition and family welfare status of the population, especially the poor, vulnerable, women, children and the elderly (World Bank 2005).

Table 3-a: Basic Data on Projects Field Assessed by IEG

Project/ Board Date	Project Development Objectives	Ln/Cr/Grant (US\$m) (% of Program Cost)	Program Cost (US\$m)
Bangladesh Health & Population Program Project: 06/30/1998	To assist the GoB to improve the health, nutrition and family welfare status of the population, particularly vulnerable women, children and the poor, and to reduce mortality and slow population growth (DCA). In the PAD the overall objective is “better access to essential services for the poor, lower maternal mortality and morbidity, and continued improvements in child health and family planning.”	250.0 credit (9%)	2,896
Bangladesh Health, Nutrition and Population Sector Program: 04/28/05	The project assists GoB in the implementation of its Sector Investment Program 2003-2010 for the HNP Sector Program. It will do so in cooperation with a large group of DPs through a SWAp.	300.0 credit (7%)	4,306
Ghana Health Sector Support Project: 10/21/97	To assist the Borrower in implementing subprograms under the PoW to: (a) provide universal access to basic health services and improve the quality and efficiency of health services; and (b) foster linkages with other sectors in the Borrower’s economy to reduce the population growth rate, reduce the level of malnutrition, increase female education, increase access to water and sanitation and reduce poverty. (DCA & PPAR)	35.0 credit (5%)	773.4 (Govt estimate)
Ghana Health Sector Program Support Project II: 02/06/03	To support the Borrower’s Program (the second Health Programme of Work for 2002-07 – PoW II) to improve the health of the Borrower’s population, while reducing geographic, socio-economic and gender inequalities in health and health outcomes. (DFA & PAD)	57.6 credit 32.4 grant (8%)	1,113
Kyrgyz Republic Health and Social Sector Program: 12/15/05	To improve health status in the Kyrgyz Republic by improving access, financial protection, efficiency, equity and fiduciary performance in the Kyrgyz health sector; to ensure sufficient and reliable financing for the health sector; and to strengthen the targeting of social benefits by developing effective administration and information management systems to improve access to social services in general. The project will support implementation of the Manas Taalimi Reform through a SWAp. (PPAR)	15.0 grant (2%)	652.0
Malawi Health Sector Support Project: 12/14/04	To contribute to the overall aims of the government’s SWAp program and within that to ensure that the minimum essential package of health services is provided throughout the country at facility and community levels, and that the decline in the health sector human resources position is arrested and reversed. (For additional grant: improve effectiveness, efficiency and quality of the essential health care delivery system provided to the poor, women and children. (draft case study)	15.0 grant + 5.0 additional grant (3%)	735.0
Nepal Health Sector Program Project: 09/09/04	To expand access to, and increase the use of, essential health care services, especially by underserved population. (PAD)	10.0 credit + 7.70 grant (4%)	498.28
Tanzania Health Sector Development Program: 06/15/2000	To support Phase I of Tanzania’s Health Sector Development Program (HSDP), which aims to accelerate sector reforms and emphasize institutional capacity development, focusing on: strengthening human resource capacity to manage and adapt to changing roles and responsibilities; developing and piloting systems to improve quality and delivery of services to improve health status; and improving resource mobilization and management. (ICR)	22.0 credit (3%)	654
Tanzania Second Health Sector Development Project: 12/16/03	To support Phase II of HSDP, which aims to expand the reforms and systems/capacity development, focusing on: improvements in the provision of quality health services through continuing to support the reforms, capacity development and improved management of resources, while focusing on quality. (PAD)	65.0 credit (7%)	963

Source: World Bank project design documents.

Note: Shading indicates projects not field assessed by IEG, but still included in this analysis because of the availability of other evaluation sources.

Program/project indicators capture a few building blocks of SWApS, but do not articulate anticipated benefits either fully or systematically. The Nepal PAD includes among its milestones for sector policy reforms the harmonization of donor assistance to the health sector, measured by: a logframe for the joint annual reviews; an operational health partner forum; joint annual reviews; a code of practice for DP procedures; MoH leadership and a single annual plan and budget for health; and increased programmatic financial support. The PAD for the Bank project supporting the second Bangladesh PoW also provides some indicators of aid management: an MoU that is agreed, signed and implemented; and the establishment of a well-functioning office to support SWAp management. The first Ghana PoW includes indicators of decentralized capacity for the preparation of local-level plans and budgets, including and linking all activities and all financing sources, and for the preparation and submission of quarterly reporting. The second Ghana PoW includes an indicator to track the percentage of DP support that is pooled, which is expected to increase over time. The Bank projects supporting the Tanzania SWAp were unique in that they were designed as APLs identifying SWAp-related performance triggers for moving, respectively, from the first to second phase, and from the second to the third phase, and for accessing successive IDA credits to support these phases.

Six of the ten SWAp support projects financed by the Bank include *SWAp-specific components or subcomponents* designed to build national capacity for establishing or sustaining a SWAp. The Bank's support to the first Bangladesh PoW (Bangladesh Health and Population Program Project) included a Sector Program Management subcomponent to develop MoH capacity to manage a SWAp. The program design documents described the SWAp as having the following features: (i) existence of a clear sector policy and strategic framework; (ii) clear links between strategies and expenditure plans; (iii) annual operational plans specifying activities under each strategy with appropriate budgets; (iv) annual program reviews; (v) integrated management of activities under the responsibilities of the line departments rather than as separate projects; (vi) performance monitoring and reporting for operational plans rather than separate projects; (vii) funding the plans from pooled funds of donors and government without earmarks; and (viii) harmonization of donor requirements for reporting, disbursement, procurement and financial management and the use of government systems. Program support included capacity building of the SWAp Secretariat and the establishment of a Program Coordination Cell in the Ministry responsible for coordination, resource mobilization and the organization of annual reviews. The follow-on Bangladesh Health, Nutrition, and Population Sector Program also supported a component to improve health sector management and stewardship capacity, focusing on planning, budget management, aid coordination, the use of pooled and non-pooled funds, reporting, information management for M&E and fine-tuning of interventions and local-level planning.

The Bank's support to the Malawi Health SWAp includes a component to strengthen SWAp implementation. Central-level support included policies, coordination and regulatory frameworks, organizational structures, procurement and financial instruments, information, M&E systems to enable MoH to effectively steward the multi-year Program of Work and to manage the process of decentralization. District-level support aimed to strengthen local level coordination and planning, including training and

orientation about the SWAp and its implications. The Bank project supporting the Nepal SWAp includes a program component to strengthen MoH's capacity to undertake a SWAp and to manage the sector more efficiently, focusing on: division of labor; planning, programming, budgeting and monitoring; and resource management. The two Tanzania operations support components to strengthen MoH stewardship in line with the SWAp. The remaining four programs/projects do not have SWAp-specific components.

All 10 Bank operations do address the key elements of the SWAp approach under their *implementation arrangements*, specifying particularly: regular joint planning and review meetings, consolidated reporting requirements, use of country systems for common management arrangements (especially for procurement, disbursement and financial management of pooled funds, and, to a lesser extent, program M&E).

Table 3-b: Project and Program Objectives and SWAp-Specific Content in Design Documents

Project Supporting a SWAp	Bank SWAp Support Operations		National Strategic Frameworks	
	Project Development Objectives	SWAp-specific content in project design	National Health Objectives	SWAp-specific content in Government's Strategy/Plan
Bangladesh Health and Population Program Project (FY98)	<p>Overall objective (from DCA): To assist the GoB to improve the health, nutrition and family welfare status of the population of Bangladesh, particularly vulnerable women, children and the poor, and to reduce mortality and slow population growth. In the PAD the overall objective is given more concretely as “better access to essential services for the poor, lower maternal mortality and morbidity, and continued improvements in child health and family planning.”</p> <p>Specific objectives (from PAD): (1) technical support and funding to improve coverage and quality of essential health and family planning services for vulnerable groups, particularly women and children; (2) support public sector reorganization and reform efforts to achieve more cost-effective service delivery, elimination of duplication, improved quality and better utilization; and (3) laying the groundwork for broader health reform, including greater involvement of NGOs and the private-for-profit sector in service delivery, decentralization, cost recovery and new approaches to financing. <i>Source: Bangladesh PPAR</i></p> <p><i>No specific mention of SWAp</i></p>	<p>Under subcomponent 2 (b) Sector Program Management: The Ministry would introduce “sector-based programming” (a sector-wide approach, SWAp) with the following features: (i) existence of a clear sector policy and strategic framework; (ii) clear links between strategies and expenditure plans; (iii) annual operational plans specifying activities under each strategy with appropriate budgets; (iv) annual program reviews (APRs); (v) integrated management of activities under the responsibilities of line departments rather than as separate projects; (vi) performance monitoring and reporting for operational plans rather than separate projects; (vii) funding the operational plans from pooled funds of donors and government without earmarks. An additional feature would be that donor requirements for reporting, justification of disbursements, procurement regimes and financial management regimes would be harmonized and would use government systems to the extent possible for executing these functions. The program would also reinforce the capacity of the Secretariat to manage the sector, supported by a donor-assisted Program Coordination Cell (PCC) embedded in the Ministry, responsible for program coordination, mobilization of resources for the various activities to be undertaken, coordination of technical assistance and organizing and carrying out APRs. <i>Source: PAD and ICR</i></p>	<p>Five-Year Plan's Main Objective is to ensure universal access for the people of Bangladesh to essential health care services of acceptable quality and to further slow population growth. Reduction of infant mortality and morbidity, reduction of maternal mortality and morbidity, improvement of nutrition status and reduction of fertility so as to reach replacement-level fertility by the year 2005 are key goals. <i>(PAD)</i></p> <p><i>No specific mention of SWAp</i></p>	<p>Government's Development Policy Letter of April 1998 aims to improve service quality and cost-effectiveness through the introduction of a sector-wide approach to managing the health sector instead of the (continued) support of projects. Key features of the SWAp include: a clear sectoral policy framework, as articulated in the Strategy; clear links between policies and expenditure plans, with annual operational and financial plans for each major component of the sectoral program; pooling of resources from various sources and disbursements against review findings, and ensuring use of non-pooled resources consistent with policies and plans; integrated management of activities under line managers; reporting of activities, expenditures and results using common performance indicators and reporting arrangements; restructuring and strengthening of (national) support systems, including improved procurement and logistics management capacity and management information systems on service delivery, logistics management, personnel management, financial management and epidemiology; and management of aid and DP coordination increasingly by MoHFW. <i>Source: PAD</i></p>
Bangladesh Health, Nutrition and Population Sector Program	The project assists GoB in the implementation of its SIP, 2003-2010, for the HNP Sector Program. It will do so in cooperation with a large group of DPs	Component 3a: improving health sector management and stewardship capacity will focus on: planning and monitoring to ensure that PIP and operational plans are	The main purpose of The HNP Strategic Investment Plan 2003-2010 (HNP SIP) is to increase availability and utilization of user-centered,	SIP policies for reducing health inequalities: (1) improving equity by shifting resource allocations to poorer districts (or districts with poor health

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	<p>through a SWAp.</p> <p>The project will have three components: (1) accelerating achievement of HNP-related MDG and PRSP goals (maternal mortality, neonatal mortality, childhood morbidity and mortality, fertility, reducing TB, malaria and HIV/AIDS); (2) meeting emerging HNP sector challenges (reduction of injuries and implementing improvements in emergency services; prevention and control of major NCD, urban health service development, improve the HNP response to disasters); and (3) Advancing HNP modernization (health sector management and stewardship, decentralization and local level planning, health sector diversification, stimulating demand).</p> <p><i>Mention of SWAp as a means.</i></p>	<p>prepared and implemented in coherence with SIP; improved budget management through an MTEF process; improved aid management responsible for the coordination of aid proposals and proper use of pooled and non-pooled aid funds and the provision of respective activity and expenditure reports; information management for monitoring and evaluating sector performance and for identifying priority interventions to improve efficiency, equity and effectiveness; development of alternative financing mechanisms; decentralization and local-level planning.</p>	<p>effective, efficient, equitable, affordable and accessible quality services, be it the Essential Services Package, improved hospital services, nutritional services or other selected services.</p>	<p>outcomes); (2) targeting and demand-side subsidies; (3) diversification of service provision; and (4) intersectoral collaboration. To achieve these objectives, the program will focus on three major reform areas: (i) <i>strengthening public health sector management and stewardship capacity</i>, through the development of pro-poor targeting measures as well as strengthening sector-wide governance mechanisms; (ii) <i>health sector diversification</i>, through the development of new delivery channels for publicly and non-publicly financed services; and (iii) <i>stimulating demand</i> for essential services by poor households through health advocacy</p> <p>Outcome indicators (for GoB & DPs): proportion of total MoHFW expenditure allocated to the 25% poorest districts (increasing to 40%); utilization rate of ESD of the two lowest income quintiles (from 55% to 65% by 2010); proportion of births attended by skilled personnel (from 25% to 40% by 2010); TB case detection rate (from 41% to 70% by 2010); % children 1-5 receiving Vit. A supplements during last 6 months; share of total government expenditure allocated to MoHFW expenditure (from 5% to 10%); NCD strategy developed and implemented as per details in results framework; proportion of contracts awarded within initial bid validity period (95% from 2006 onwards); HS, FP and P-MIS delivering management information according to specifications; DSF pilots on schedule as per details in results framework. Indicators of aid management: memorandum of understanding agreed, signed and implemented; % of performance-based finances disbursed; Program PSO established and functional.</p>

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Ghana I	<p>“To assist the Borrower in implementing subprograms under the PoW to: (a) provide universal access to basic health services and improve the quality and efficiency of health services; and (b) foster linkages with other sectors in the Borrower’s economy to reduce the population growth rate, reduce the level of malnutrition, increase female education, increase access to water and sanitation and reduce poverty.” The project was designed to support achievement of program targets for 2001: (a) increase life expectancy from 58 to 60 years; (b) reduce infant mortality rate from 66 to 50 deaths per 1000 live births; (c) reduce under-five mortality from 132 to 100 per 1000 live births; (d) reduce maternal mortality from 214 to 100 per 100,000 live births; (e) reduce annual population growth rate to 2.75 percent; (f) reduce total fertility rate from 5.5 to 5.0; and (g) reduce the proportion of children with severe malnutrition from 12 to 8 percent.</p> <p><i>No SWAp-specific objective.</i></p>	<p>The SWAp was expected to culminate in improved sector stewardship and management by achieving: country leadership and ownership of the policy framework and its implementation; coherence of sector goals, policy, strategy, priorities and spending; comprehensiveness of scope, strong and effective partnerships between government and its partners for improved coordination and rationalization of technical and financial inputs and for an improved, open dialogue; flexible, performance-based financing; efficiency gains through reduced transaction costs; improved local systems and capacity and their effective use for common management arrangements; and sustainability of sector investments.</p> <p>20 indicators, including some process (e.g., % of BMCs w/ 1998 budgets and plans following an agreed format where all sources of financing are used to link budgets and activities).</p> <p>SWAp more prominent in program implementation arrangements: financial flows, financial management, program M&E; joint review meetings and planning and budgeting.</p>	<p>First Health Sector Five-Year Programme of Work (PoW I) Policy goal: to improve the health status of all Ghanaians</p> <p>Objectives: increased geographical and financial <i>access</i> to basic services; better <i>quality</i> of care in all health facilities and during outreaches; improved <i>efficiency</i> in the health sector; closer collaboration and <i>partnership</i> between the health sector and communities, other sectors and private providers, both allopathic and traditional; <i>increased overall resources</i> in the health sector, <i>equitably</i> and <i>efficiently distributed</i>.</p> <p><i>No SWAp-specific objective.</i></p> <p>Partnership objective is focused on internal partnerships (MoF, NGOs and private sector, other sectors, decentralized entities, etc.).</p>	<p>Strategies: to strengthen primary health services; to re-orient secondary and tertiary services delivery to support primary health services; to develop and implement a program to train adequate numbers of new health teams to provide and manage these services; to improve capacity for policy analysis, performance monitoring and evaluation, and regulation of service delivery by health professionals; to strengthen central support systems for human resources, logistics and supplies, financial and health information management; to promote private sector involvement in the delivery of health services; to strengthen intersectoral collaboration.</p> <p>SWAp expectations of government are the same as those itemized under the project (column 2 of this entry), because both Ghana and its key development partners (Bank, WHO, DfID and DANNIDA) were instrumental in defining and promoting a SWAP leading up to and including the 1997 meeting in Copenhagen (Text Box ...).</p>
Ghana II	<p>“To support the Borrower’s Program (PoW II 2002-2007) to improve the health of the Borrower’s population, while reducing geographic, socio-economic and gender inequalities in health and health outcomes.” Key performance indicators for measuring program performance are grouped under five categories, in line with the five strategic objectives of PoW II: access, quality, efficiency, partnership and financing.</p>	<p>Program implementation arrangements under PoW I were continued under this second SWAp support, notably: implementation through regular channels and systems of government, common implementation arrangements for the MoH and a core group of DPs, and a MoU between government and these DPs. Anticipated benefits are the same as under PoW I.</p>	<p>Vision: Improved overall health status and reduced inequalities in health outcomes of people living in Ghana. Policy Goal: Working together for equity and good health for all people living in Ghana. Strategic Objectives: To improve <i>quality</i> of health delivery; to increase <i>access</i> to health services; to improve the <i>efficiency</i> of health service delivery; to foster <i>partnerships</i> in improving health; to improve <i>financing</i> of the</p>	<p>Key Program Components: strengthening and support of priority health interventions; developing human resources for health; enhancing infrastructure and support services; fostering partnerships for health; promoting private sector participation in health service delivery; improving regulation; reforming organizational arrangements; improving health sector financing, including the introduction of national health insurance; improving management systems; strengthening</p>

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	<i>No SWAp-specific objectives</i>		health sector. <i>No SWAp-specific objectives.</i>	management information systems and performance monitoring; improving links and synergies with traditional and alternative medicine.
Kyrgyz Republic Health and Social Protection Program	<p>Project objectives: To improve health status in the Kyrgyz Republic by improving access, financial protection, efficiency, equity and fiduciary performance in the Kyrgyz health sector; to ensure sufficient and reliable financing for the health sector; and to strengthen the targeting of social benefits by developing effective administration and information management systems to improve access to social services in general. The project will support implementation of the Manas Taaalimi Reform through a Sector-Wide Approach. <i>Source: PAD</i></p> <p><i>SWAp mentioned as a means.</i></p>	<p>The SWAp in the Kyrgyz health sector context was defined as having four core elements: (1) a government-led process to define the vision for the health sector in the form of an explicit health sector strategy with clear goals, priority interventions, and costs; (2) a medium-term budget framework (MTBF) to program annual spending with mechanisms to ensure that annual budgets will correspond to the MTBF, and that budgetary execution matches agreed commitments; (3) a joint sector performance M&E system, integrated with the MTBF and the national poverty reduction goals; (4) a formalized government-led aid coordination mechanism with MoH responsible for overall coordination of DPs and for setting up system of regular meetings, forum for discussing, negotiating and joint review meetings.</p> <p>Component 1.: support for the Manas Taaalimi Health Reform Program & PoW through a SWAp. <i>Source: Kyrgyz Republic PPAR</i></p> <p>The Bank is in agreement with the main goals, objectives and priorities of the Manas Taaalimi Program and the corresponding Program of Work.</p> <p>Requirements for annual IDA transfers include: annual sector performance review and discussion with civil society and partners and endorsement of findings and conclusions; draft Annual Program of Work for upcoming year, its endorsement by all core donors and review/clearance by</p>	<p>Objective of Manas Taaalimi Health Reform Program: To improve health status through the creation of an effective, comprehensive, and integrated delivery system of individual and public health services, and through increased responsibility of every citizen, family, society, and public administration bodies for the health of each person and for society as a whole. It explicitly aims to institutionalize the reforms initiated under the previous (Manas I) program and to strengthen the parts of the health care system that were relatively less emphasized under the earlier strategy. In particular, it seeks to strengthen the targeting of resources and interventions at groups with worse health outcomes, including MDG outcomes; implement structural improvements in the public health and health promotion systems; enhance capacity in the MoH and other relevant institutions in policy formulation, priority setting, policy-based budget planning and monitoring and evaluation; and strengthen quality of care with a focus on priority health problems including maternal and child health, cardiovascular disease, respiratory illnesses, HIV/AIDS and TB. <i>Source: Kyrgyz Republic PPAR</i></p>	<p>No specific mention of SWAp in government program noted in PPAR or PAD. But PAD does note that the SWAp approach is a choice of government. An (implicit) objective of the SWAp is to formalize excellent donor collaboration under an explicit definition of the government's policy and program directions – i.e., the PoW – and through periodic, formal, structured meetings for sector monitoring and donor coordination. <i>Source: PAD</i></p>

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		<p>the Bank of a 3-year rolling procurement plan; submission of annual MoH budget to parliament; acceptable operational, procurement and financial management audits and action plans to address issues identified. <i>Source: PAD</i></p> <p>Three formal mechanisms of partners coordination are anticipated: (1) two Health Summits a year; (2) a detailed Memorandum of Understanding or "Joint Financing Agreement" among the joint financiers and the government; and (3) Joint Supervision Arrangements to minimize administrative efforts for government. <i>Source: PAD</i></p>		
Malawi Health	The development objective of the project is to contribute to the overall aims of the government's SWAp program and within that to ensure that the minimum essential package of health services is provided throughout the country at facility and community levels, and that the decline in the health sector human resources position is arrested and reversed	<p>A component aims to improve the effectiveness and efficiency of the health system and the referral network to support delivery of the EHP and SWAp implementation. Central level support will strengthen institutional process, including policies, coordination and regulatory frameworks, organizational structures, procurement and financial instruments, training programs, information, monitoring and evaluation systems that would enable MoH to effectively steward the PoW. Support would also help central operations manage the process of decentralization and be geared towards effective support of the devolved district health system. District-level support will strengthen coordination and planning (and training/orientation about SWAp and EHP) to enable the effective delivery of EHP in the districts, both MoH and NGO services.</p> <p>Principal outputs expected are: (a) improved availability of quality health care and EHP for the poor and vulnerable; (b) improved human resources, especially</p>	<p>The long-term <i>objective of Malawi's sectoral program</i> (which is being supported by the World Bank, among others), as stated in the PoW, is to establish – through a health sector-wide approach – a health delivery system responsive to the needs of the people of Malawi by improving the effectiveness and efficiency of health services and providing a minimum package of essential health services – the EHP – targeted at the poor, women and children. The GoM's program does not envisage a radical reform of the sector (although it has elements of reform). Instead, the focus of the EHP will be on increasing the efficiency, quality and equity of health services in Malawi. <i>PAD p. 10</i></p> <p>The ultimate goal of the health sector in Malawi is to address the three MDGs of reducing child mortality, improving maternal health and contributing to the reduction of poverty by protecting the poorest and the vulnerable from economic loss due to ill health and</p>	The sector-wide approach is specified in its national health program and was adopted at the initiative of the GoM.

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		<p>skilled personnel; © strengthened health systems through equitable health financing, increased human resources, reliable pharmaceutical and supplies logistics and effective M&E; (d) enhanced capacity of MoH for stewardship and policy development; (e) strengthened district health management systems for planning, budgeting and delivery of quality health services; and (f) community participation in the delivery of essential health intervention.</p> <p>Output indicators to monitor the “Bank project components:” overall: proportion of GoM budget allocated to/received by the health sector at the national and district levels; trends in per capita government allocations to the health sector; % of health facilities with ability to effectively provide EHP; proportion of population within easy reach of EHP; delivery of EHP: % facilities without 7-day stockouts of essential EHP drugs; % fully immunized at one year; % births attended by skilled attendant; TB cure rates; human resource and management: comprehensive HRM plan; % facilities with minimum staffing norms; % established positions filled; % new graduates from training colleges employed in the health sector in Malawi; health support and referral systems: % facilities offering EmOC; proportion of MoH budget allocated to districts; proportion of budget allocated to health centers; % facilities regularly supervised by DHMT; No. of VHCs established and functioning as evidence of community participation in delivery of EHP.</p>	<p>disability. It will also contribute to a fourth MDG, combating HIV/AIDS.</p> <p>Outcome indicators for assessing the long-term impact (to be disaggregated by income, gender and geography) include: IMR, MMR, CPR, TFR, prevalence of HIV in antenatal clinics and among youth, and percent of low birth weight newborns.</p>	
Malawi HIV/AIDS	The development objective of the national HIV/AIDS program, which the proposed MAP will support, is to reduce the transmission of HIV, to improve the	IDA will pool its funds with others in a common basket. Distribution of basket funding among the subprograms will be agreed each year on the basis of rolling	The National HIV/AIDS Strategic Framework (NSF) aims to: reduce the transmission of HIV, improve the quality of life of those infected and	In addition to the GoM, the external DPs will finance the implementation of the joint PoW. Rules of engagement between NAC and the DPs are captured in a multi-donor

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	<p>quality of life of those infected and affected by AIDS, and to mitigate the impact of HIV/AIDS in all sectors and at all levels of Malawian society.</p> <p>Key performance indicators: % of people who are HIV-infected (by gender, age, residence); % of orphans and other vulnerable children to whom community support is provided (by gender and residence); percent of sexually active respondents who had sex with a non-regular partner with the past 12 months (by gender, residence); percent of population expressing accepting attitudes towards persons living with HIV/AIDS.</p> <p><i>No specific mention of SWAps.</i></p>	<p>annual work plans and stakeholder decisions and will finance those elements of the national program which are not being funded by ear-marked contributions</p>	<p>affected by AIDS and mitigate the impact of HIV/AIDS in all sectors and at all levels of Malawian society. It includes nine themes identified as the main areas for attention: (1) facilitating changes in cultural values/norms to reduce the spread of AIDS; (2) strengthening dialogue with youth to promote responsible behavior; (3) empowering vulnerable groups to resist behavior harmful to their health status; (4) promoting love, care and support for those infected by or living with HIV/AIDS; (5) implementing effective, multi-sectoral mitigation plans in the home, hospital and work place; (6) caring for orphans, widows and widowers; (7) strengthening the effectiveness of HIV prevention programs; (8) establishing a comprehensive and effective IEC strategy to reduce the spread of HIV; and (9) increasing accessibility of VCT services for men, women and youth. PoW components: (1) prevention and advocacy; (2) treatment, care and support; (3) impact mitigation; (4) sectoral mainstreaming; (5) capacity building and partnerships; (6) monitoring, evaluation and research; and (7) national leadership and coordination.</p>	<p>Memorandum of Understanding.</p> <p>A National Leadership and Coordination component of the PoW supports policy development and monitoring, advocacy and resource mobilization, strategic planning and annual review exercises.</p> <p>Annual work planning will be carried out as part of an integrated exercise covering assistance from all DPs who channel their assistance through the NAC.</p> <p>Pooling donors have agreed on a common approach to program oversight, which takes advantage of the shift to joint work programming and joint reporting, organized around monitoring processes that are country-managed and country-owned. External oversight is linked to the quarterly review schedule and to the stakeholder events planned for September and March each year.</p>
Nepal Health Sector Program	<p>To expand access to and increase the use of essential health care services, especially by the under-served population. (PAD)</p> <p>Project objectives same as program objectives. (elsewhere in the PAD)</p> <p><i>No specific mention of SWAp.</i></p>	<p>Bank is committed, together with DfID, to disburse its funding through the government system and in support of the government program. The proposed program will disburse against a share of the annual health sector medium-term expenditure framework (a three year rolling plan supporting Program implementation).</p> <p>Component 2a. aims at strengthening</p>	<p>The Nepal Health Sector Program Implementation Plan (NHSP-IP) was endorsed as the framework for development assistance to the health sector, forming the core of the five-year (FY05-09) Health Sector Program. Both the HSS and the Program focus on demand, care-seeking and client satisfaction, recognizing that supply side improvements are insufficient to achieving the MDGs.</p>	<p>The Nepal Development Forum of 2004 has highlighted donor harmonization. Partners in the health sector (as in the education sector) are being encouraged to harmonize procedures and approaches, and to channel their assistance through the government system in support of national strategies. Program components include: (1) <i>Strengthened Service Delivery</i>, including (a) essential health care services; (b) greater local authority and responsibility over</p>

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		<p>MoH capacity to undertake a SWAp and manage the sector more effectively.</p> <p>Implementation Arrangements include partnerships, MoH leadership for coordination and implementation, M&E, fiduciary systems and reporting.</p>	<p>The <i>Program development objective</i> is to expand access to, and increase the use of, essential health care services, especially by underserved populations. <i>Key performance indicators</i> include changes between 2001 and 2009 in: contraceptive prevalence rate (39% to 47%); proportion of normal deliveries conducted with skilled attendance 8% to 35%); proportion of children who have been immunized against measles and DPT3 71% to 85%; proportion of women and men who can correctly identify one method of preventing HIV infection (38% to 75% of women; 51% to 85% of men).</p>	<p>service provision; (c) public private partnerships; and (2) <i>Institutional Capacity and Management Development</i>, including, (a) sector management; (b) sustainable health financing; (c) drugs, supplies and equipment; (d) human resources development; (e) monitoring and evaluation.</p> <p>Component 2a (sector management) aims at strengthening MoH's capacity to undertake a SWAp and manage the sector more efficiently, focusing on (a) the division of labor among key actors in the sector; (b) the key management tasks of planning, programming, budgeting and monitoring; and (c) resource management – financial, human and physical. The MoH will review the roles and functions of different sector entities, including its own structures, to reduce gaps and overlaps, clarify responsibilities and improve accountability. A management training program will support the development of vision, strategy and action plans and the budgeting and implementation of those plans.</p> <p>Among indicators in the NHSP-IP's Logical Framework for the joint annual reviews and MTR are Swap-related: harmonization of donor assistance to the health sector based on the Aid Integration Process adopted at the Nepal Development Forum, 2004, specifically: For Year 1: Health Sector Development Partner Forum operational; system of joint annual reviews in place; and an action plan to implement the Statement of Intent 2004, together with a Code of Practice for DP procedures; For Year 3/mid-term: Full harmonization at the program level with joint planning, review and reporting led by MoH and a single annual work plan and budget for the sector; ; and For Year 5/end of Program: expansion of harmonization at the financial modality level with increased</p>

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Tanzania Health Sector Development Program (FY00)	<p>To support Phase I of Tanzania's Health Sector Development Program (HSDP), which aims to accelerate sector reforms and emphasize institutional capacity development, focusing on: strengthening human resource capacity to manage and adapt to changing roles and responsibilities; developing and piloting systems to improve quality and delivery of services to improve health status; and improving resource mobilization and management. (ICR)</p> <p>Phase I performance indicators centered around improved resource management at the central and district levels, and quality of care, including: at least 50 percent of donor resources reflected in the MTEF; central-level performance-based budgeting and monitoring introduced and tested; district systems and financing linked to performance, outputs and outcomes; tools for essential health package in place; functional institutions for HIV/AIDS, increased immunization rates and satisfaction of population with services.</p> <p>Long-term program indicators (2011): Reduced IMR, especially among poorest; reduced U-5 mortality; improved life expectancy at birth; reduced TFR and MMR.</p>	<p>Components:</p> <p><i>Strengthening Service Delivery:</i> (a) district health services; (b) second and third level referral hospitals; and (c) public private mix.</p> <p><i>Strengthening MoH and Central Support Systems:</i> (a) role of Central MoH & Sector-wide management; (b) central support systems; (c) human resource development and management.</p> <p>Implementation will emphasize the development of national systems and capacity through a SWAp. Common procedures and implementation mechanisms will move toward program support, whereby external funds will be channeled through the existing but enhanced GoT mechanism to support the program mainly as budgetary support. MoH and Local Government will coordinate SWAp planning and performance evaluation. Districts are accountable to Local Authorities and will develop plans based on local needs and priorities. Pooled (or "basket") financing will be used at both central and district levels. Joint fiduciary systems to be established.</p>	<p>To improve health status and government management capacity, the PoW (1999-2002) aims to deliver the essential health package (EHP) and drastically transform financing, management and delivery roles by emphasizing quality, empowerment of local authorities and the beneficiary and greater use of non-government agents.</p> <p>Strategies (or components) of the PoW are: (1) district health services; (2) back-up referral hospital services; (3) redefining the role of the central MoH; (4) appropriate roles for public and private services; (5) human resource development; (6) central support systems; (7) sustainable health care financing; and (8) sector-wide approach, including partnerships with donors, common systems for planning, implementation, monitoring and evaluation to streamline and harmonize activities and funding. (PAD)</p>	<p>programmatic financial support.</p> <p>The reform process will be flexible and able to accommodate new and innovative ways of managing the sector. The adaptable nature of the proposed credit would serve well for this purpose. The long-term goal is that the government will have full capacity and reliable systems to develop a comprehensive sector program and annual budgets, as well as to implement it with full accountability and transparency. In the short- to medium-term, it is recognized that: (i) capacity building and systems development will take many years; (ii) the current project financing arrangements will continue for a while, whilst donors will increasingly support the process by adjusting their program design and their country policies in line with a SWAp; (iii) common implementing arrangements will be gradually developed, tested and adjusted through a series of incremental changes as soon as concrete information and methods are agreed; and (iv) the policy of the government is to use its local capacity and skills as much as possible, rather than to rely on long-term foreign technical assistance, which is unsustainable and expensive. Short-term technical assistance will be requested on terms and conditions agreed to by the government and its development partners.</p> <p><i>(Tanzania Health Sector Development: Statement of Development Policy, 2/25/00, as reproduced in the PAD).</i></p> <p>Performance triggers for moving to Phase II: (1) a health sector program integrated in GoT's MTEF, with at least 50% of donor resources for the sector reflected in the MTEF; (2) district-based health planning and management system and its financing through block grants that are linked to outputs/outcomes and performance, operational and tested in at least 30% of the</p>

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	Project Development Objectives	SWAp-specific content in project design	National Health Objectives	SWAp-specific content in Government's Strategy/Plan
				114 districts; (3) national guidelines for EHP completed, costed, district management teams trained in its use, and quality assurance program for basic services in place; (4) high-level national bodies to oversee the HIV/AIDS multi-sectoral response strengthened in staff and fully functional; (5) common disbursement, reporting, monitoring and evaluation systems developed and tested; and (6) at least 75% of Phase I credit disbursed or committed. (PAD)
Tanzania Second Health Sector Development Project (FY04)	To support Phase II of HSDP, which aims to expand the reforms and systems/capacity development, focusing on: improvements in the provision of quality health services through continuing to support the reforms, capacity development and improved management of resources, while focusing on quality. Phase II indicators: increase in government's health budget; increased attended births; patient satisfaction; TB cure rate; improved malaria drugs stocks; increased use of child health services; decreased malnutrition. (PAD)	<p>Components focused on: improving district level health services; strengthening the management of referral hospital services; and strengthening the central-level stewardship role at regional and central levels.</p> <p>Implementation of the SWAp (adopted under Phase I) will continue to strengthen national systems and capacity: common procedures and implementation mechanisms; basket financing; partner joint financing shares of total expenditures; joint fiduciary functions.; MoH in leadership; joint annual reviews; joint monitoring and evaluation. (PAD)</p>	In support of the overall objective of improving health status, and the overall vision of assuring quality services are accessible to all Tanzanians and responsive to their needs, the strategic framework for 2003-08 focuses on health services delivery, mainly at district level, but also at secondary and tertiary hospitals. All other (central and regional-level) inputs are perceived as necessary support to health service delivery. Program components include efforts to strengthen capacity and services at: district level; regional level and central level. (GoT, Second Health Sector Strategic Plan 2003-2008)	<p>Implementation arrangements trace the basic tenets the SWAp, including: government leadership; semi-annual reviews; performance monitoring; coordination; basket funding; districts' roles; and reduction of transaction costs.</p> <p>Input, process, output, outcome and impact indicators are specified, but do not measure SWAp capacity and efficiency objectives. (GoT, Second Health Sector Strategic Plan 2003-2008)</p> <p>Performance triggers for moving to Phase III: (1) a health sector program integrated in GoT's MTEF, which includes at least 75% of donor resources for health; (2) performance-based budgeting for a health sector program instituted and operational; (3) all districts and all hospitals have full decision-making authority on resource use and management of their programs, and are accountable for their outputs and outcomes; (4) cost-effective essential package of basic health services adequately financed and implemented; (5) all essential drugs and supplies available at all public facilities; and (6) at least 75% of the Phase II credit disbursed or committed. (PAD)</p>

Source: Author, based on program documentation.

ANNEX 4. RISK ASSESSMENT AND MITIGATION MEASURES

This study analyzed the risk assessment and mitigation plans in the nine Bank operations supporting a health SWAp in the six countries. (The tally is available in IEG files for further reference.) The risks are clustered largely around two concerns. The first cluster of risks centers on *national capacity to implement* the SWAp itself (the *approach*) and the ambitious national programs. Of all the capacity risks raised for SWAp implementation, those concerning fiduciary aspects predominated; the risks of low capacity, low performance and inexperience in procurement, financial management, and auditing tasks were cited for all six countries. Mitigation measures included close monitoring and oversight (by the Bank and, in some cases, DfID), technical assistance, hiring of specialized staff and consultants, regular audits, dialogue, and (in the case of Ghana and Malawi) an incremental approach for building the capacity of decentralized entities. Risks were largely a reflection of DPs' concerns, but in the case of the Kyrgyz Republic, there was also serious concern expressed by the MoH about corruption, generating an exceptionally extensive set of mitigation interventions. Additional risks of countries' abilities to implement a SWAp were raised, but only in very general terms; mitigation measures (also stated in general terms) included dialogue and support through joint partnership arrangements, technical assistance, training, and learning-by-doing. In contrast to great concern about fiduciary capacity, weak M&E capacity was raised in only one operation as a risk, in the Malawi HIV/AIDS SWAp. Weak capacity for service delivery was mentioned for all countries, but in incomplete and different ways. Design documents for projects in Ghana, Malawi, and Tanzania raised the issue of human resources and envisaged training, incentives, and use of NGOs among the mitigation efforts. The project in Bangladesh envisaged training and quality assurance measures to improve the client-focus and quality of services, and the project in Nepal suggested the involvement of communities in planning, behavior change, and feedback through surveys to address access issues.

The second cluster of risks concerns the *political commitment* of government and other national stakeholders *to reforms* inherent in the SWAps and other health reforms envisaged in the national programs. All design documents raise the risk that governments could renege on reform commitments (organizational and structural reform, health reform, decentralization) due to the pressure of various national stakeholders who stand to lose from reform measures. All design documents also raise risks of the government reneging on its financial commitments, both in terms of the level of domestic resources committed to health and in terms of the allocation and use of all financial resources available under the SWAp. These risks were expected to be mitigated by high-level government agreement to reforms, phasing of reform measures, communications/advocacy, stakeholder involvement in program design, technical assistance, close monitoring of performance, and dialogue. The Ghana and Kyrgyz Republic project designs also include the option of suspending disbursements if all else fails.

The risk of *DPs not fulfilling their commitments under the SWAp* was also raised in design documents for projects in five of the six countries, but risks were much more generally stated and given less prominence than the risks of inadequate national capacity and commitment. The design document for the project in Bangladesh raised the risk of inadequate coordination and harmonization of procedures among DPs, and included the partnership arrangements and efforts to harmonize the various logframes as mitigation measures. In the design document for the project in Kyrgyz Republic, the risk of donors neglecting sector strategy priorities was to be mitigated by MoH-led donor coordination around a strongly owned and explicit program and frequent meetings. The risk of insufficient external financing for the Malawi HIV/AIDS SWAp was to be mitigated by transparent accounting of resources. In Nepal, the signature of a Statement of Intent by the DPs was considered an adequate mitigation of the risk of discontinuation of donor cooperation. In Tanzania, continuous dialogue and a system for collecting DP data were expected to mitigate the risk of non-integration of DP support into the MTEF. Neither the design document for the Ghana nor that for the Malawi Health SWAp raised any risk related to weak donor performance or commitment.

Only the project design document for the Tanzania SWAp raised the risk of the *technical quality and evidence base of the national strategies and plans*, advocating technical criteria and M&E to mitigate this risk.

ANNEX 5. SCOPE, EVIDENCE BASE, AND LIMITATIONS OF THE STUDY

This study's review of experience and lessons of health SWAps in six countries is not limited to the World Bank's contribution to SWAps, nor does it attempt to establish any particular attribution of program outcomes to World Bank financing. Rather, the focus is on the achievement of national program objectives and the performance of government and DPs (including the World Bank) in relation to their respective roles and comparative advantages. This being said, the report does include a chapter which assesses the Bank's performance and efficacy in the context of its SWAp support.

Malawi and its DPs are supporting two health-related SWAps, one designed around its Health Sector PoW (2004-2009), and another designed around its Strategic Plan for the fight against HIV/AIDS (2003-2008). The coverage of Malawi in this report is limited to the Health Sector PoW.

The choice of the six countries covered in this review is a simple function of the availability of field-based assessments or evaluations of their health SWAps, those carried out by IEG and an additional one identified through the literature search. Text Table 1-2 lists the countries covered, the assessments and evaluations that serve as primary sources of evidence, and the Bank-financed SWAp support operations that overlap with the SWAp timeframes. These country-level evaluations are supplemented and updated with additional country-level data and reports, including the design documents, completion reports, DHS data series and other updates. Other sources of evidence include a review of SWAp literature and exchanges with SWAp practitioners, supplemental to those carried out in the context of IEG field-based evaluations. Each is briefly described below.

IEG Field Studies. Three Project Performance Assessment Reports (PPARs) have evaluated a series of projects, encompassing pre-SWAp¹ operations and follow-on SWAp support operations, respectively, in Bangladesh, Ghana and Kyrgyz (IEG 2006, 2007, 2008). For the purposes of learning and accountability, PPARs assess program/project outcomes against their respective statements of objectives. All three PPARs were "enhanced," allowing for greater depth of analysis, the interview of all key stakeholders and the focus on the overall program versus the Bank-financed project. They are based on fieldwork conducted by IEG and involve: the examination of project files and other documents, including the Implementation Completion Report (ICR), a self-evaluation by the responsible Bank department, with Borrower input; interviews of parties involved in program implementation (government officials and staff, other national stakeholders and beneficiaries, development partners, and Bank managers and staff), and in-country travel to validate and augment the information provided in the ICR. Prior to their publication and disclosure to the public, they are peer reviewed by a technical expert, reviewed by an IEG evaluation expert, reviewed by the responsible Bank department and amended with

¹ While designed as traditional projects, pre-SWAp operations supported some of the building blocks of a SWAp.

factual corrections, and reviewed by the Borrower.² The findings of the Bangladesh PPAR have been updated by additional fieldwork undertaken in late 2008 in the context of an IEG Country Assistance Evaluation (CAE).³

The two case studies conducted in Malawi and Nepal for the IEG evaluation of Bank Group support for HNP (IEG 2009a) assessed the relevance, efficacy and efficiency of the totality of World Bank's lending and non-lending support for HNP during the period 1997-2007, including the support of SWAp. The case study methodology includes: a literature and document review; analysis of available data; interviews with key actors and stakeholders; and field visits. Both cases are currently in draft.

Literature Search. More than 100 academic, operational and evaluation papers and articles on SWAps – health-specific and general – were reviewed for this study to: (a) identify any other health SWAp evaluations that link SWAp benefits to national health results; (b) trace the history and evolution of SWAps; (c) inform and shape the overall study design; and (d) inform the study's findings. For the purposes of (a), (b), and (c), the search encompassed major health and development journals, other academic publications, as well as operational studies and documentation produced by stakeholders participating in SWAps (governments and DPs). The documentation and evaluation of international movements supporting SWAp-like principles, such as the Paris Declaration and Accra Agenda for Action, were also reviewed. Other than IEG's three PPARs that are the subject of this study, only one additional evaluation was identified in the literature as having attempted to evaluate the achievement of SWAp objectives, the achievement of national health objectives, and the plausible links between the two – the *Joint External Evaluation of the Health Sector in Tanzania, 1999-2006* (Freeman and others 2007). This evaluation provides additional evidence on the development effectiveness of SWAps supported by the Bank and other partners in Tanzania. Supplemental evidence on the performance of the health SWAps in the six countries was gathered to complement the evaluation reports, fill information gaps, and deepen the analysis. Country-specific evidence included trend data on health sector performance and outcomes, analyses of budgets and expenditures, and other reports on the health SWAp experience and results.

Vetting of Findings with SWAp Researchers and Practitioners included: interviews with relevant Bank staff (supplemental to those conducted by the authors of the PPARs and case studies); technical discussions with the authors of the PPARs and draft case studies; and vetting of preliminary findings with operational staff.⁴ Broad consultations were also carried out to fill information gaps and gather insights.

² The Borrower is given the option to include its feedback in an Annex to the published version of the PPAR.

³ IEG 2009b covering the periods of the 2001 CAS, the 2004 Progress Report, and the 2006 CAS, draws on fieldwork conducted in September/October 2008.

⁴ Vetting activities included: participant feedback on the occasion of the presentation of preliminary findings from field work at an IEG Session on "Lessons from Three Approaches to Improve Outcomes," delivered on November 5, 2008, during the Human Development (HD) Forum; (b) feedback from Lead Health Specialists serving as discussants and a plenary discussion concluding an IEG Module of a two-day SWAp Training Course Session, delivered on November 11, 2008, during HD Learning Week and again on April 2, 2009.

Limitations of the Study

Of the three PPARs carried out by IEG, only two (on Bangladesh and Ghana) were undertaken where: SWAp PoWs supported by Bank operations had been completed and self evaluated, including the generation and assessment of end-of-program outcome data. The third PPAR, on the Kyrgyz Republic, focused on two completed operations that supported the national health program and contributed to the adoption of the SWAp. But the Bank's first full SWAp support operation was barely at its mid-point at the time of IEG's assessment (Table 1-2). IEG's case study on Malawi focused on the full range of the Bank's lending and non-lending support during the decade of 1997-2006, its field work occurring a full year before the completion of the Bank's first full SWAp operation there, and well before end-of-project data and analysis were available. The subsequent publication of the ICR (March 2009) and IEG's follow-up interview with the task team leader have helped to fill in some gaps. Likewise, IEG's case study on Nepal covered a full decade of the Bank's lending and non-lending support; and field work was conducted around the mid-term of Nepal's first PoW. Notwithstanding these limitations, even those IEG studies conducted in countries where PoWs and projects have not yet been completed or evaluated provide insights and lessons about SWAp design and implementation.

Table 5-a: Coverage of Completed Health SWAps in Three PPARs

Country	Completed pre-SWAp	Completed SWAp	Ongoing SWAp ^a
Bangladesh	1	1	1
Ghana	1	2	^b
Kyrgyz	2	0	1
Total	4	3	2

a. Assessed but not evaluated. b. SWAp support was in transition from sector-specific program support to general budget support at the time of the PPAR. General budget support was not reviewed.

IEG's case studies and PPARs were commissioned as input to the main HNP evaluation (IEG 2009a). While data and information have been gleaned from these studies, some were unable to address these questions in sufficient depth. Neither the vast amount of qualitative information (not all of which was objective or well substantiated in the general literature and self-evaluations), nor the smaller amount of quantitative information, is amenable to quantitative methods to summarize, analyze, and compare the results across countries. This study did not include budget for follow-up field work or validation, but it did attempt to update information and data through limited and selective review of additional reports and data on specific countries that became available after IEG's field work was completed.

While the documents that served as primary sources of evidence were vetted with policy makers and relevant DPs, the synthesis of these evaluations, as presented in this study, were not. The synthesis provides emerging lessons from these six countries, which were purposively selected, and thus may not be representative of all countries with SWAps.

ANNEX 6. PROGRAM COSTS AND FINANCING AND FIDUCIARY ARRANGEMENTS

Costs and Financing. The Bank's design documents for the nine operations supporting health SWAs in these six countries present the total estimated costs and financing of the respective PoWs, in which the Bank and others invested. These are summarized in Table 6-a. With the exception of two PoWs, the total program costs of the remaining seven, as presented in the design documents, are equal to the total available financing; the second PoW in Bangladesh and the first in Malawi, both indicate a financing gap of 6 percent. This would indicate that total costs for the other countries already reflect the trimming of original cost estimates to match available resources.¹ While they are provided here for information, it is not likely that these estimated costs are reflective of the full health sector costs. The design documents do not specify exactly what is included in (and excluded from) these cost estimates. Many of them appear to be focused on public sector only. A number of them do not include revenues from cost recovery, health insurance, or other risk pooling schemes, or out-of-pocket expenses. Some exclude important components of the health system. For example, Bangladesh's public facilities in the urban areas are excluded from the health SWA because they are under the responsibility of Ministry of Local Government. The first Bangladesh PoW excluded the National Nutrition Program, but the PoW includes it. Many PoWs do not include all DP financing because the time horizons for their projects and financial commitments do not completely overlap with the timeframe of the PoWs; the financial commitments for the PoWs' outer years are not always estimated at the outset. Furthermore, some DPs finance projects and provide direct support to NGOs and the private sector and do not routinely report this financial support to MoH. Costs in the design documents are provided in such an aggregate form that it is not possible, from a quick desk study, to understand how reflective they are of full costs.²

Available data (Table 6-a) indicate that, for seven of the nine PoWs, government is financing more than half of the total estimated cost, the exceptions being the second Tanzania PoW (36 percent) and the Malawi health PoW (29 percent). By the same token, all external financing combined (including IDA's share) makes up less than 50 percent of total financing for seven PoWs, the same exceptions being Tanzania PoW II (64 percent) and the Malawi health SWA (65 percent). The IDA allocations vary widely across SWAs, ranging from \$15 million each for Malawi Health and Kyrgyz to \$300 million for the second Bangladesh health PoW. As a share of total PoW costs, IDA's

¹ Indeed the financial and economic analyses of the Kyrgyz Republic, Nepal, and Tanzania SWAs find that original cost estimates of the exceeded the available resources.

² National Health Account exercises are available for: Bangladesh (96/97, 96-2001, third round not yet available); Malawi (98/99, 02/03 – 04/05, and 2006); Nepal (01/03); and Tanzania (99/00). The search for and analysis of the detailed data on the costing and financing of these PoWs and the comparison of these data with NHA data, and PER data where it is available, would be likely to culminate in a more complete and more reliable information base. But these analyses were not done in the IEG studies and are beyond the scope and resources of this synthesis piece.

contributions ranged between 2 and 10 percent. As a share of total external financing, IDA's contributions ranged from 3 to 35 percent.

All nine PoWs were financed by a combination of pooled funding and non-pooled support. IDA provided pooled funding for all nine, but four of the projects³ also allocated some of the funds under the IDA credit to disbursement categories that would allow direct support of discrete activities (for example, support to NGOs, funds for communities, subprojects) and/or bulk procurement in complement to the majority of funds allocated to pooled financing.) Other poolers also provide project financing in parallel. Most non-pooled financiers supported health sector development activities falling within national PoWs through project or parallel financing, but a few still operate outside of the SWAp. Table 6-b itemizes poolers and non-poolers for each SWAp.

Procurement. In line with the Bank's guidelines, national capacities, procedures, systems, and regulations for procurement were assessed, on which basis plans for their strengthening were developed. Procurement arrangements included: the regular updating of a rolling procurement plan; the use of donor international procurement procedures for high-value (international competitive bidding - ICB) contracts and the setting of thresholds for ICB; requirements and thresholds for national competitive bidding and local shopping in borrowing countries, aligned to the extent possible with national procurement rules; reporting requirements; a post-review supervision plan; and technical and procurement audits and procedures.

Disbursements. For all six countries with SWAps, poolers channel their funds into a foreign exchange account in the name of the MoF, but the funds are held for the purposes of and managed by the MoH in line with Treasury rules. These funds are transferred on a monthly basis in the form of local currency to a local account for disbursements, pooled with the government's budget resources, to various spending units throughout the country. Poolers' disbursements to the foreign exchange account are usually made on a quarterly basis. All poolers finance a percentage of health expenditures, fixed at annual Joint Meetings. Initial deposits are based on estimated expenditures, while subsequent disbursements are based on actual expenditure reporting and/or forecasts for the following year. The Bangladesh and Kyrgyz Republic SWAps have slightly different disbursement arrangements, whereby DPs channel their pooled funding through the Bank in the form of trust funds. The Bank, in turn, disburses all pooled funding to the government's foreign exchange account. Table 6-c provides details on disbursement arrangements for each project.

Financial Management. All nine PoWs use government systems for the financial management of pooled funds. These systems were strengthened to meet IDA's standards for financial management, through training, recruitment, contracting out certain functions, technical assistance, and close supervision. Both assessments and capacity building in all six countries take into account and support ongoing public finance reforms. Financial management exigencies include: internal control; financial reporting; internal and external audits; a financial procedures manual; and adequate staffing. Table 6-c provides details on the use and enhancement of government systems for each country with a health SWAp.

³ Bangladesh PoWs I and II, and Tanzania PoWs I and II.

Table 6-a: SWAp Program Costs and Financing (US\$ millions)

Country/ Project	Total Program Costs	Gov't Amount & Share of Total	Beneficiaries Amount & Share of Total	All External Financing & Share of Total (including IDA)	Financing Gap	IDA Contributions		
						Credit Amount	As Share of Total Program Costs	As Share of Total External Program Financing
Ghana								
HSSP 1997--2001	773.4	537.2 (69%)	36.2 (5%)	200.0 (26%)	-	37.8	5%	19%
HSPSP II 2002-2006	1,113.0	638.0 (57%)	75.0 (7%)	400.0 (36%)	-	90.0	8%	23%
Bangladesh								
HPPP	2,895.9	2,191.2 (76%)	-	704.7 (24%)	-	250.0	9%	35%
HNP Sector Program	4,306.2	2,726.0 (63%)	-	1,319.3 (31%)	260.9 (6%)	300.0	7%	23%
Tanzania								
HSDP	654.0	369.1 (56%)	17.5 (3%)	267.5 (41%)	-	22.0	3%	8%
HSDP II	963.0	350.0 (36%)	-	613.0 (64%)	-	65.0	7%	11%
Malawi								
Health	735.0	212.0 (29%)	-	480.0 (65%)	43.0 (6%)	15.0	2%	3%
Nepal								
Health Sector Program	498.3	285.6 (57%)	-	212.7 (43%)	-	50.0	10%	24%
Supplemental Financing: 09-10	400.0	200.0 (50%)	-	200.0 (50%)	-	50.0	25%	13%
Kyrgyz								
H and SP project	652.0	440.0 (67%)	-	212.0 (33%)	-	15.0	2%	7%

Sources: Country-specific Bank design documents and IEG studies.

Table 6-b: SWAp Financiers*(US\$ millions)*

Country/ Project	Program Financiers		Other Financiers Operating Outside of the Program	Cofinanced or Pooled Funds Managed by Government?
	Poolers	Non-Poolers		
Ghana				
HSSP	IDA, DANIDA, DfID, the Netherlands and the Nordic Fund (to Health Fund)	AfDB, BADEA, CIDA, GTZ, JICA, OPEC, Saudi Fund for Development, UNFPA, UNICEF, USAID	Most financiers operate w/in Program, with a few exceptions: EC Balance of Payments support for non-wage social expenditure; USAID: \$14 million in general support and \$14 million direct support to NGOs	Yes
HSPSP II	IDA, DANIDA, DfID, EU, the Netherlands (to Health Fund) Note: World Bank, DfID and the European Union (EU) transitioned to general budget support after HSPSP II.	(same as above)	Global Fund, USAID	Yes
Bangladesh				
HPPP	World Bank and those pooling their money with World Bank through cofinancing grants: IDA, DfID, EC, the Netherlands, SIDA, CIDA, KfW, GTZ	ADB, Japan, UNFPA, UNICEF, USAID, WHO	Not noted in evaluation sources.	Yes, but cofinancing grant arrangements channel funding through the World Bank, which disburses to Government.
HNP Sector Program	World Bank, and those pooling their money with World Bank through cofinancing grants: IDA, DfID, EU, the Netherlands, SIDA, CIDA, UNFPA Every year pool financiers will contribute an agreed—upon proportion of actual MoHFW expenditure as baseline financing (PAD p. 83)	Non-pooled financing (using Bank rules): CIDA, KfW/GTZ, Japan, UNICEF, UNFPA, WHO, SIDA-Sweden	Parallel HNP Projects: ADB, SIDA-Sweden, DfID, DU (all contributing to Urban Health under Ministry of Local Government); and USAID (supporting private sector and NGO services under Ministry of Financing)	Yes, but cofinancing grant arrangements channel Canadian, EU, and German funding through the World Bank, which disburses to Government.

Country/ Project	Program Financiers		Other Financiers Operating Outside of the Program	Cofinanced or Pooled Funds Managed by Government?
	Poolers	Non-Poolers		
Tanzania				
Health Sector Development Program	DANIDA, DfID, GTZ, Ireland Aid, Netherlands, NORAD, SDC and IDA	IDA (large procurements and activities not incorporated into pooled funds, e.g., national health insurance and community health fund); Bilateral agencies (USAID, JICA, CIDA); multilateral agencies (AfDB, EU, WHO, UNICEF,		Yes
Health Sector Development Program II	DANIDA, KfW, Ireland Aid, the Netherlands, SDC and IDA (DfID switched to general budget support)	France, Japan, USAID, WHO, UNICEF, UNDP, AfDB (earmarked for program elements).	DfID through general budget support. Global Fund, ILO	Yes
Malawi				
HIV/AIDS	IDA, CIDA, NORAD, DfID, Global Fund (case study “pooled funding signatories)	UNDP, AfDB, CDC/USA (case study “discrete funding signatories)	EU, USAID, UNICEF, UNFPA, and possibly others (case study “non-MoU signatories”)	Yes
Health	IDA, DfID, Germany, Global Fund, NORAD, UNFPA (case study “pooled funding signatories)	Christian Health Association of Malawi, GTZ, ICEIDA, UNICEF, WHO (case study “discrete funding signatories)	Same as above.	Yes
Nepal				
Health Sector Program 2004-2009	IDA, DfID	GTZ, JICA, UNFPA, UNICEF, USAID, WHO (support PoW and participated in developing the strategy, program and implementation plan)	GAVI, Global Fund, KfW, SIDA (also noted to support health sector, but not actively involved in SWAp)	
Kyrgyz				
H and SP project	KfW, DfID, SDC, SIDA, IDA PPAR. Signatories of MoU: WB, Germany/KfW, Sweden, DfID, Switzerland, UK and US	ADB, GFATM, DfID, JICA, KfW, SDC, UNDP/UNAIDS, UNFPA, USAID	(PPAR: Pooled financiers: KfW, DfID,* SDC,* SIDA,* WB. Asterisk indicates channeled through World Bank. USAID not pooling, but participating in strategy. WB funds will flow to and be comingled w/ Kyrgyz budget to a foreign currency account in name of MoEF. Others to do the same.	Yes, but with support from the Bank. DfID, SDC and SIDA financing channeled through the World Bank. All disbursements, including KfW, are subject to Bank’s approval, ensuring a coherent and harmonized approach.

Sources: Country-specific Bank design documents and IEG studies.

Table 6-c: Disbursements and Financial Management

Project	Disbursements	Where disbursements will be deposited	Financial Management: Use/Enhancement of Government Systems?
Bangladesh I	PAD Annex 6: IDA and other DPs (Netherlands, Sweden and DfID) pooled funds administered by IDA will finance a part of government's expenditure in the health and population sectors. Allocations to different categories will be made on an annual basis based on the work program agreed with the DPs. Under Category 1 and 6 (90% of Funds) IDA and Pooled Funds will reimburse a portion of all eligible expenditures incurred annually. Under Categories 2-5, disbursements will be on a pro rata basis against specific contracts for goods and services.	Borrower to open two Special Accounts: (1) only for eligible expenditures under Category 1 (reimbursing a % of Government expenditures); (2) for eligible expenditures under Categories 2-5. IDA and other pooled funding managed by IDA will be deposited into these accounts.	Yes: GoB's Reforms in Budgeting and Expenditure Control (RIBEC) system to be further modified and piloted by MoHFW's newly established Management and Accounting Unit (MAU), for which permanent staff (and TA) will be recruited. Key aspects of financial management system include: Internal control system, financial reporting, audits and performance audits.
Bangladesh II	PAD Annex 6: IDA and other DPs (CIDA, AFID, Netherlands, EU, SIDA, UNFPA) pooled funds. Under Category 1 (25% of Funds; also 25% of IDA allocation) IDA and Pooled Funds will reimburse a portion of all eligible expenditures incurred annually. Under Categories 2-5, disbursements will be on a pro rata basis against specific contracts for goods and services.	GoB and pool funds to be channeled through Treasury system, accounting will follow Comptroller General of Accounts system. Pooled money to be channeled to a foreign exchange account for the project at the Central Bank, for pooling together w/ Gob's budget system (including GoB resources) and make these available to spending units. Account to be replenished on basis of financial management reports. Same disbursement categories as B I.	Yes: Based on a capacity assessment Mohawk's financial management system (a pilot of government reform) was further strengthened in line with an agreed action plan. The Accounts Code, the Treasury Rules and General Financial Rules of Government will form the basis for accounting. Internal Controls, internal and external audits
Ghana I	Transfers of IDA funding to Health Account to be made semi-annually, on the basis of reimbursement of expenditures already incurred out of the GoG funds for the health sector, documented in financial management reports. H Funds available for all non-wage categories of expenditures, as long as these conform to annual budget and work program. Two disbursement categories: (1) for retroactive financing for 1997 expenditures; (2) unallocated category. (100% of funds for partial financing of expenditures under PoW).	Pooled funding channeled to a central Health Account, from which funds are distributed to all eligible BMCs (Budget Management Centers). Health Fund will be put into a Bank account under the direct control of MoH and the Controller and Accountant General.	Yes. Accounting and reporting of expenditures for GoG funds takes place within the MoH structure in accordance with government procedures. GoG procedures will be changing as the Ghana Public Sector Financial Management Reform Program is being implemented, and the Health SWAp intends to implement and even test elements of this reform. The health SWAp decided to set up viable systems, with the involvement of the MoF, that could (and eventually did) inspire and strengthen public finance management across sectors. Audits will cover Health Account, selective BMCs utilizing Health Account and cost recovery funds.
Ghana II	Same general arrangement as above, except transfers to be made on a quarterly basis. (100% of funds for partial financing of expenditures under PoW).	As is case for first project, no IDA special account will be established. There will be one bank account in US\$ into which IDA and other pooled funds will be paid into. Two accounts in a commercial bank: (1) in US\$ into which contributions from pooling partners will be paid; (2) for draw-downs in Ghana Cedis from the Health Account transferred once a month to meet forecast expenditures.	Yes: Financial management arrangements under this project influenced public finance reform in Ghana.

Project	Disbursements	Where disbursements will be deposited	Financial Management: Use/Enhancement of Government Systems?
Kyrgyz	Bank funds will flow to and be co-mingled with the Kyrgyz budget. Disbursement expected to occur in four tranches per year. Contingent on government approval of MoH's budget for the year, with level of disbursement adjusted periodically based on sector performance and budget execution. One disbursement category (100% of IDA funding) to reimburse a portion of expenditures.	Bank funds will flow directly into a foreign currency-denominated designated account opened at the national bank, in the name of MoEF, specifically for receiving Bank funds. Foreign currency will be sold by MoEF for local currency, which will be deposited in one of the 40 or so local currency Budget accounts managed by the Treasury. This will enable the Bank clearly to confirm that its resources have co-mingled with the budget. Neither Bank nor Budget funds will be separately identifiable.	Yes: A Country Financial Management Assessment for Kyrgyz show that there is extremely weak public sector financial management, including public sector budgeting accounting, reporting and auditing. Ongoing Bank support is assisting GoK to strengthen the public sector to ensure effectiveness, accountability and transparency in the use of public resources. Strengthening of systems for this project including: financial management staffing, accounting policies and procedures refinement, internal control and internal audit; financial reporting, accounting and information systems and external audit. A time-bound action plan developed to strengthen existing capacity and provide additional fiduciary safeguards. Successful implementation of the action plan will strengthen mechanisms for monitoring financial flows through the Treasury system, tracking resources and expenditures under the program and reporting on program expenditures and will provide mechanisms for third party assurance on the use of program resources.
Malawi HIV/AIDS	Disbursements to the pooled US dollar account will be made on the basis of financial management reports, with each disbursement made by IDA recorded as an advance. Initial advance based on IDA's share of cash forecast for first six months' activities; subsequent advances based on quarterly financial reports and NAC's disbursement request for the ensuing six-month period. Report-based disbursements. Expenditures will be recorded on the basis of IDA's share of the previous quarter's eligible expenditures as reported in the quarterly financial report. Two disbursement categories: "unallocated" (91% of funds); and subprojects (9% of funds).	There will be three Bank accounts for the basket funds. Pooled funding partners will deposit their contributions into a pooled US\$ account, held in a local commercial bank. The GoM will transfer their counterpart funds to a holding account in the Reserve Bank of Malawi. NAC will immediately transfer the GoM funds to the pooled local currency account in a commercial Bank. As required, generally on a monthly basis so as to minimize foreign exchange losses, NAC will transfer funds from US\$ account to the pooled local currency account for purposes of the agreed work plan.	Yes. Country Financial Accountability Assessment identified critical areas needed to strengthen sound financial management and financial accountability in the public sector. IDA funded Financial Management Transparency and Accountability Project focuses on strengthening expenditure accountability, coupled with other efforts for improved governance. Action plan agreed to mitigate high risks and increase financial management capacity, including: recruitment of qualified staff; training of existing staff; computerization of financial management systems; functioning of newly established internal audit unit in NAC; close supervision.
Malawi Health	One disbursement category: "Subprograms." (100% of IDA funds for financing a share of expenditures).	Pooling donors disburse quarterly to a foreign exchange account opened by GoM with Reserve Bank of Malawi. Transfers from this account to be made monthly in proportion to amount required to finance the program, through the MoF on advice of MoH into a Malawi Kwacha holding account, from where disbursement to various stakeholder accounts will be made. First deposit on the basis of a portion of six-month plan, subsequent transfers quarterly on the basis of FMRs. GoM's share also made directly to this account on a monthly basis.	Yes. Assessments of financial management and accounting capacity reveal very weak government systems. An action plan to mitigate against high risks of using government systems is agreed. Ongoing reform of government systems will be incorporated, along with capacity building measures (training, recruitment, TA). Bank exigencies include efforts to use/strengthen: internal audit function of MoH; accountability of disbursed funds; quarterly financial management reports; internal and external audits

Project	Disbursements	Where disbursements will be deposited	Financial Management: Use/Enhancement of Government Systems?
Nepal	One disbursement category that will finance a percentage of eligible expenditures to be determined annually based upon the Joint Annual Review of sector performance and the MTEF. (100% of IDA funds for financing a share of expenditures).	Government to establish a foreign exchange account in US\$ with Nepal Rastra Bank to which the pooling donors will contribute funds to be utilized exclusively for the health sector program. An initial deposit will be based on estimated expenditures for first two trimesters. For each trimester thereafter, poolers will replenish the FE account based on the financial management reports and the cash forecast for the subsequent two trimesters.	Yes. Government and pooling donors have agreed on a time-bound financial management improvement plan to address weaknesses identified in the financial management assessment, and to further strengthen capacity in MoH.
Tanzania I	Three disbursement categories: (1) Central sub-programs, including (a) pooled funds financing expenditures; (b) IDA financing expenditures; and (c) community health fund grants; (2) Local authority grants; (3) HIV/AIDS Fund grants; (4) refinancing of PPF Advance; (5) unallocated. (Categories 1a and 5 amount to 61% of total allocation.)	IDA would operate through a Special Account, and disbursements would be triggered by the quarterly approval mechanism under the control of the BFC (basket financing committee). Poolers would make available funding to the GoT's consolidated fund, based on the annual commitment agreed prior to the commencement of the program year. A joint donor fund holding account denominated in US dollars to receive pooled money. IDA funds advanced initially from SA to US\$ holding account. Subsequent disbursements will be made against quarterly reports for total expenditures, of which IDA will disburse a portion at a pre-determined percentage.	Yes. Aim is to use a common mechanism for financial management, within the government system. Studies culminated in the details of joint financing arrangements, following as closely as possible the government accounting system. Consultants and accounting manuals to facilitate joint disbursement systems and financial management, backstopped by a risk management approach.
Tanzania II	Four disbursement categories: (1) pooled funds (expenditures financed under the subprograms); (2) non-pooled (direct financing of expenditures under subprograms); (3) community health fund matching grants; (4) unallocated (85% of entire credit). Categories (1) and (6) make up 91% of total IDA allocation.	MoH to open and manage Special Account to cover IDA's share of eligible expenditures (for non-pooled and community health fund grants). Disbursements for pooled funds will be made semi-annually via direct payment to the US dollar holding account in Bank of Tanzania on the basis of Annual Work Program.	Yes. Government assessed to have strengthened its financial management system, which is considered to be sound. Staffing, internal controls, computerized systems adequate. Internal audit in need of strengthening, to be supported under this operation.

Source: Bank project design documents.

ANNEX 7. TRENDS IN HEALTH FINANCING AND EXPENDITURES IN SIX HEALTH SWAp COUNTRIES¹

Available indicators point to a trend of increasing levels of health expenditure across countries with SWAps (Tables 7a-g). Total public and private per capita health expenditure increased across all six countries during their SWAp implementation periods (Table 7-b). In 2006, Ghana and the Kyrgyz Republic had the highest total per capita expenditure, at US\$35 and US\$34, respectively, and Bangladesh had the lowest (US\$13) and the slowest growing. Government expenditures per capita² on health increased under the SWAps in all six countries. Malawi and the Kyrgyz Republic show the highest government per capita expenditure in 2006 (US\$15), with Bangladesh and Nepal having the lowest (US\$5).

However, there is uneven performance in the share of total government expenditure devoted to health under the SWAps: it increased in Bangladesh, Nepal, and Tanzania, but decreased in Ghana and did not change substantially in the Kyrgyz Republic or Malawi. Of the three African health SWAps, only that in Malawi seems to have achieved the Abuja declaration target of at least 15 percent of government resources to health.³ Data reported by the Bank's operational teams show higher shares of total government budgets allocated for health.

It is difficult to compare budget data reported by operational teams with actual expenditures reported in the National Health Accounts (NHA), without clarifying the extent to which external financing is included in the budgets. It is beyond the scope of this paper to explore and reconcile these discrepancies, but a few are worth noting here.⁴ Total expenditure on health as a share of GDP did not change substantially from pre-SWAp levels in any of the countries (Table 7-a). As a share of total health expenditures, external financing made up a larger share for Bangladesh, Ghana, and Tanzania than pre-SWAp levels, while the share of external financing did not change substantially in the Kyrgyz Republic, Malawi, or Nepal. IEG evaluations indicate that the mobilization of domestic and external resources may be partly and plausibly linked to the SWAps, as in the case of Malawi. On the other hand, the strong, world-wide commitment to the MDGs

¹ This section draws on WHO National Health Account (NHA) Series for the six countries and public expenditure reviews. Budget and expenditure data reported in IEG's country studies are also cited to corroborate or qualify NHA data, but are less comparable across countries.

² Total expenditures net of private expenditures. Under NHA, government expenditures include all external financing for public facilities, and private expenditures include as well any external support to the private sector, which is likely to be very small, given that most private expenditure is out of pocket.

³ Under the Abuja Declaration of April 2001, African governments pledged "...to set a target of allocating at least 15 percent of their annual budgets to the improvement of the health sector." The measures provided in Table 7-c are provided in terms of expenditures.

⁴ Ghana reports that the health budgets for 2005 and 2006 represent 15 and 18 percent, respectively, of the total government budgets for those years (World Bank 2007a)I, over twice health's share of actual expenditures reported in NHA. The healthcare budget in the Kyrgyz Republic approved by the Parliament for 2007 is reported as 11.0 percent (0.2 points short of the 11.2 target for that year, specified in Manas Taalimi).

has generated unprecedented increases in global aid for health and government commitments to increased resource allocations for health. It is likely, therefore, that increases in health expenditures might have occurred even in the absence of SWAp, although it is possible they not might not have been quite as high.

Table 7-a: Total expenditure on health as % of GDP

Country	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Bangladesh	3.3	3.1	3.2	3.1	3.2	3.1	3.1	3.1	2.8	3.1
Ghana	6.8	6.9	7.3	7.4	7.1	6.5	6.2	6.2	6.2	6.2
Kyrgyz	6.0	6.6	5.8	4.7	4.8	5.4	5.4	5.7	6.0	6.4
Malawi	7.8	9.1	8.0	6.1	7.8	10.0	12.8	12.8	12.2	12.3
Nepal	5.5	6.6	5.9	5.4	5.3	6.1	5.8	5.7	5.8	5.7
Tanzania	3.5	4.0	4.3	4.1	4.1	3.9	4.2	4.3	5.1	5.5

Source: WHO National Health Accounts Series

Notes: Shaded areas indicate SWAp implementation periods.

Table 7-b: Total Expenditure on Health Per Capita (US\$)

Country	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Bangladesh	11	11	11	11	11	11	12	13	12	13
Ghana	25	27	29	18	18	19	22	25	30	35
Kyrgyz	22	22	15	13	15	17	20	25	28	34
Malawi	20	15	13	9	11	16	18	19	19	20
Nepal	12	13	12	12	12	13	13	14	16	17
Tanzania	9	10	11	11	11	11	12	13	17	18

Source: WHO National Health Accounts Series

Notes: At US\$ exchange rate for each year. Shaded areas indicate SWAp implementation periods.

Table 7-c: Government Expenditure on Health as % of Government Expenditure

Country	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Bangladesh	6.2	5.7	4.9	5.3	5.8	5.6	6.4	6.2	5.5	7.4
Ghana	9.1	10.2	11.6	10.9	8.7	9.3	9.0	6.9	6.9	6.8
Kyrgyz	11.3	12.2	9.6	8.3	8.9	8.9	8.6	8.2	8.4	8.7
Malawi	7.3	9.0	10.6	7.3	14.0	17.6	20.3	20.5	16.6	18.0
Nepal	8.1	13.7	10.1	7.7	6.6	9.4	8.2	8.7	8.4	9.2
Tanzania	15.3	13.5	14.6	11.2	11.2	11.1	11.9	10.1	12.6	13.3

Source: WHO National Health Accounts Series

Notes: Shaded areas indicate SWAp implementation periods.

Table 7-d: Government Expenditure on Health as % of Total Health Expenditure

Country	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Bangladesh	33.1	31.6	28.2	26.5	26.6	26.3	28.7	29.0	29.1	36.8
Ghana	38.6	42.0	39.1	41.0	40.0	37.2	41.5	37.4	34.1	36.5
Kyrgyz	47.8	53.8	50.0	44.3	41.1	39.6	37.9	39.7	39.5	43.3
Malawi	29.7	35.2	45.9	43.8	61.7	73.1	74.5	74.7	71.3	72.1
Nepal	26.7	38.6	30.0	24.9	24.0	29.4	26.1	27.5	28.1	30.5
Tanzania	47.3	43.8	43.4	43.9	43.4	44.0	48.3	48.0	56.9	59.2

Source: WHO National Health Accounts Series. Includes external financing.

Notes: Shaded areas indicate SWAp implementation periods.

Table 7-e: Government Per Capita Expenditure on Health (US\$)

Country	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Bangladesh	4	3	3	3	3	3	3	4	3	5
Ghana	10	11	11	7	7	7	9	9	10	13
Kyrgyz	11	12	7	6	6	7	8	10	11	15
Malawi	6	5	6	4	7	12	13	14	14	15
Nepal	3	5	4	3	3	4	3	4	4	5
Tanzania	4	5	5	5	5	5	6	6	9	11

Source: WHO National Health Accounts Series. Includes external financing

Notes: At US\$ exchange rate for each year. Shaded areas indicate SWAp implementation periods.

Table 7-f: External Resources on Health as % of Total Health Expenditures

Country	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Bangladesh	11.1	12.1	12.1	19.4	14.9	13.8	15.5	14.9	12.2	14.6
Ghana	5.0	4.9	4.8	9.3	13.9	15.8	30.8	32.2	26.0	22.4
Kyrgyz	12.1	1.6	8.3	9.9	8.1	16.0	9.1	15.3	7.6	6.1
Malawi	19.5	29.0	32.5	26.9	42.4	44.5	61.6	59.4	61.2	43.2
Nepal	11.0	25.5	20.4	15.2	13.7	18.5	16.2	17.3	16.4	15.7
Tanzania	16.6	17.4	29.3	25.6	17.1	11.1	20.4	24.5	27.8	35.4

Source: WHO National Health Accounts Series

Notes: Shaded areas indicate SWAp implementation periods.

Table 7-g: Private Expenditure on Health as % of Total Health Expenditures

Country	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Bangladesh	66.9	68.4	71.8	73.5	73.4	73.7	71.3	71.0	70.9	63.2
Ghana	61.4	58.0	60.9	59.0	60.0	62.8	58.5	62.6	65.9	63.5
Kyrgyz	52.2	46.2	50.0	55.7	58.9	60.4	62.1	60.3	60.5	56.7
Malawi	70.3	64.8	54.1	56.2	38.3	26.9	25.5	25.3	28.7	27.9
Nepal	73.3	61.4	70.0	75.1	76.0	70.6	73.9	72.5	71.9	69.5
Tanzania	52.7	56.2	56.6	56.1	56.6	56.0	51.7	52.0	43.1	40.8

Source: WHO National Health Accounts Series

Notes: At US\$ exchange rate for each year. Shaded areas indicate SWAp implementation periods.

ANNEX 8. ACHIEVEMENT OF NATIONAL HEALTH OBJECTIVES IN SIX HEALTH SWAP COUNTRIES

Table 8-a: An Overview of IEG Efficacy Ratings for Completed and Evaluated SWaps

Country	Health Status	Health Services Delivery	Health Systems Strengthening	Health Sector and Other Factors Affecting Outcomes
Bangladesh	<i>Modest:</i> Modest declines in IMR, U5MR, MMR, and TFR, but slower than in previous (pre-SWAp) years and falling short of national targets. Stagnation in child nutrition indicators but dramatic declines in vitamin A & iron deficiency. Gaps in IMR between poor and non-poor and rural and urban populations reduced, but due more to stagnation or worsening of indicators among the less disadvantaged.	<i>Modest:</i> Improved immunization and micronutrient coverage; modest improvements, but still low coverage of antenatal care, assisted deliveries; no change in treatment of diarrhea; very low use of public facilities for curative care; low coverage of National Nutrition Program (covering one-fifth of upazilas and not well targeted).	<i>Modest:</i> ESP delivery undermined by: political fall-out of reversal of policy decision to unify health and family planning; failure to implement hospital reform and partnerships with non-governmental sector; and low completion rate and use of (new) community health clinics.	<i>Health sector:</i> Modest performances in service delivery and systems strengthening. <i>Other:</i> Economic growth, expanding female education, improvements in water and sanitation likely affected HNP outcomes more than health sector investments.
Ghana	<i>Modest under PoW I; Substantial health outcomes, modest fertility outcomes under PoW II.</i> No change in IMR, U5MR, MMR, or TFR under PoW I, but declines in IMR and U5MR were achieved during PoW II, according to preliminary GDHS data. Possible modest improvements in child health among poorest 40 percent. No significant change in stunting and wasting during PoW I and II but some improvement in underweight rates during PoW II.	<i>Modest:</i> Vaccination coverage was already high and increased, but targets not met. Some increase in percent of children sleeping under ITNs, no significant change in ORT, neither target met. Use of antenatal care services consistently high. Assisted deliveries remained at 50 percent and highly inequitable under PoW I, but increased to 59 percent under PoW II. No improvement in contraceptive use, which is highly inequitable.	<i>Modest:</i> Exemptions for vulnerable partially successful, unsustainable. Drug availability increased, then declined. More HR produced, but inequitably distributed. Hospital reform, collaboration with NGOs, inter-sectoral collaboration and institutional reform not realized. Resource allocation & expenditure tracking poverty-insensitive.	<i>Health sector:</i> High coverage of immunization and ANC services may have influenced health of all children, including the poorest children. Low (albeit increasing) coverage of assisted deliveries, consistently low levels of contraceptive use and high inequities in RH services likely undermined gains in MMR. <i>Other:</i> Lower poverty, higher levels of female education and improved access to water and sanitation.
Malawi Health	<i>Not evaluable:</i> Modest declines in IMR and U5MR over past ten years, with 2010 targets unlikely to be achieved. MMR persistently high and very high levels of child malnutrition.	<i>Modest:</i> High immunization rates maintained. Slightly increased utilization rates and TB cure rate. Modest increase but still very low levels of assisted deliveries and persistently low levels of pregnant women starting ANC in first trimester. No improvements in quality or coverage of essential package of services.	<i>Modest:</i> EHP not sufficiently strengthened; chronic drug stock-outs; despite training, severely understaffed government and non-governmental facilities, with scarce skilled workers undertaking technical and clinical work for which they are not trained, handling untenable patient loads; weak and infrequent supervision; severely lacking health infrastructure.	<i>Health sector:</i> Substantial investments of financial and technical support did not culminate in substantial improvements in services delivery or in health systems strengthening. <i>Other:</i> Poverty remained largely unchanged over the past decade, with an estimated 55 percent living below the poverty line and more

Country	Health Status	Health Services Delivery	Health Systems Strengthening	Health Sector and Other Factors Affecting Outcomes
				than 20 percent unable to meet basic daily food needs. Population highly vulnerable to annual rainfall variability, chronic food insecurity and widespread malnutrition.
Tanzania	Substantial. Notable declines in IMR and U5MR, exceeding 2003 national goals. Modest decline in child malnutrition. No change in high fertility or maternal mortality. Factors undermining service access: geographic isolation, poor transport links, weaknesses in emergency obstetric care, ineffective cost-sharing and risk pooling.	Substantial: Continued high immunization coverage; improved micronutrient supplementation; increased use of ITNs. Some improvement in service quality (diagnosis/treatment of malaria, cleanliness, staff capacities & attitude). Increased assisted deliveries, but short of national goal. Inadequate coverage of services/outreach.	Modest: Strengthened policy/technical role of MoH with continued reform needed. Improved availability of drugs, supplies, equipment in facilities. Modest improvements in staff quantity and quality. Little progress in collaboration with NGOs, hospital reform and referral system.	Health sector: Better health outcomes due to improved quality and coverage of essential services. Inadequate coverage of RH services, shortfalls in RH targets. Other: Lower poverty, increased enrollment rates for girls, improved access to waters.

Source: Author, based on country program documentation and evaluations.

Table 8-b: Interim Efficacy Ratings of Ongoing SWAps

Country	Health Status ^a	Health Services Delivery ^b	Health Systems Strengthening ^b	Attribution of Outcomes to the PoW
Kyrgyz (Pre-SWAp and SWAp phases)	Significant declines in IMR, U5MR and stunting over the last decade.	Significant: Reduction in patient financial burden; significant reduction in financial barriers to access; decline in the share of patients making informal payments for services and for medicines; increase in use of health services, especially primary health care; progress in TB mortality and incidence in some areas.	Significant: Health financing reforms and single payer system effective at channeling funds to services and providing fair, transparent, modest and balanced benefits package for the population. Expansion in State Guaranteed Benefit Package (SGBP) provides entitlements primarily for women and children. Network of family physicians and family group practices put into place. Issues still to be addressed: HR, service quality, greater focus on prevention/early detection, MoH policy and leadership role; move towards output-based; scaling up maternal care.	Strong. Financing made available under SWAp enabled the expansion in entitlements under SGBP, improved access, and affordability.
Nepal	Substantial declines in fertility, IMR, U5MR and malnutrition.	Significant: Skilled birth attendance increased, but still low. Further increase of high immunization coverage. Universal distribution of Vitamin A and deworming. Significantly improved availability of services in health facilities (especially RH and child health services). Essential package free of charge to all at peripheral health facilities. No change in CPR.	Significant: Increased availability of essential staff in underserved through creation and filling of posts. Strengthened, reliable health information system. Progress in establishing partnerships with NGO and private sector service providers. Decentralization undermined due to lack of elected bodies in periphery when management of over 1000 facilities was handed over to communities.	Strong: PoW implementation has positively impacted MoH's success in improving service coverage and availability.

a. Trends prior to the SWAp. b. Improvements since the SWAp support.

Source: Author, based on country program documentation and evaluations.