

# Rethinking Health Sector Wide Approaches through the lens of Aid Effectiveness

Andrew McNee

## Abstract

Sector Wide Approaches (SWAs) are an approach to aid management that aim to support recipient government leadership. Health aid has grown rapidly in the past 20 years and in this time SWAs have become an important health aid delivery approach. However, the empirical evidence is that the performance of health SWAs is, at best, mixed. Outcome and impact benefits of health SWAs are inconclusive, and overall process level performance is poor. The key insight offered by this paper is that a divergence has developed between the underlying theory of change of health SWAs, and their implementation. The paper argues the theory of change underlying SWAs is highly consistent with effective aid, however the practice is not. Health SWAs have been characterised by cumbersome architecture that is partially implemented and used, and which does not facilitate government ownership and commitment to indigenous institutional development. A core stream of the analysis as to why this is the case relates to technical shortcomings within the SWAp architecture itself, however this is not sufficient to understand the reasons for the limited success of SWAs. Rather it is clear there are a range of broader incentives and understandings within both donors and governments that have shaped the implementation of SWAs at a process level. The paper concludes with some suggested actions which may assist in realigning health aid with the underlying SWAp theory of change, whilst taking into account at least some of the incentives and understandings that have cut across SWAp implementation. The essence of the proposed approach is a more realistic understanding of the nature of health systems, combined with a more politically informed set of strategies to support the development of these systems.

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# **Rethinking Health Sector Wide Approaches through the lens of Aid Effectiveness**

## **1. Introduction**

Health aid has increased in size nearly six-fold from \$5b in 1990 to \$28b in 2011 (Duran & Glassman 2012), and is now provided by over 40 bilateral donors, 26 UN agencies, 20 global and regional funds, and 90 global health initiatives (Sridhar 2010). In this time, Sector Wide Approaches (SWAs) have become an important health aid delivery modality for donors, and have been influential in shaping international aid effectiveness agendas (Dickinson 2011). However, empirical evidence generated by the evaluation of health SWAs has revealed that their performance is mixed at best. This paper considers why this is the case and what might be done about it. The key insight offered is that a divergence has developed between the strategic intent of SWAs and their implementation. The paper argues that while the theory of change underlying SWAs is highly-consistent with effective aid, in practice the approach has failed to realise its potential. In essence, the theory of change maintains that robust, legitimate institutions are central to the sustainable development of effective health systems, and that these institutions will only develop through deeply-embedded local, political and cultural contestation and processes. Conceptually, SWAs are intended to facilitate the emergence and development of these institutions by removing the damaging effects of project aid, and creating the space, incentives and accountability for government to lead and own the development process. However in implementation, SWAs have become defined by the technical production of SWA architecture (national plans, expenditure frameworks, sector coordination mechanisms etc.), rather than actions that unambiguously advance government ownership and commitment to indigenous development processes. Furthermore, the overly technical approach of SWAs, often implemented regardless of politics, context or evidence, amplifies many of the failings of the forms of aid that SWAs were intended to replace.

In support of this position, the paper traces the history and rationale of the development of health SWApS, and critically appraises the growing body of evidence of their performance resulting from international reviews. A core stream of this analysis is the technical shortcomings within the SWAp architecture itself: quality of plans/expenditure frameworks, capacity constraints, partnership difficulties, and resource blockages. This paper argues that this analysis is valuable but insufficient to understand the reasons for the limited success of SWApS. Drawing on an aid effectiveness framework and relevant literature, the paper finds that there are a range of incentives among donors and governments that have so constrained the implementation and understanding of SWApS at a process level, that it is possible to argue that they have not been implemented as they were intended. This conclusion is also informed by the authors' experience of supporting the development and implementation of a health SWAp in Papua New Guinea over a ten year period.

There is no magic bullet to overcome this situation. However, the paper concludes with a possible approach for moving forward which attempts to realign health sectoral aid with the theory of change underlying SWApS. This approach builds on an aid effectiveness framework and purposefully tries to account for some of the incentives and understandings that have cut across implementation. In terms of health policy/ resource allocation, a more iterative, evidence-based, and politically-informed approach is suggested. In terms of delivery modalities, the approach advocates the use of government systems as a priority (including budget support), but only to the extent that capacity and performance suggests this is warranted. However rather than leaving projects to fill the void when government and donor systems struggle, donors are encouraged to coordinate around a number of 'hybrid' sector delivery mechanisms for aid. These mechanisms should unobtrusively, efficiently and accountably provide inputs at the service delivery level (be that government, NGO/faith based, or private providers) alongside government financed/ provided inputs. The overriding intention of this approach is to provide the space, opportunity and incentives for government to lead sustainable, organic,

sector development processes, and for donors to be able to play a more efficient, strategic supporting role.

The paper proceeds in six inter-linked sections. Section Two locates the development of SWAs in the broader literature of aid effectiveness and debates around forms of aid. In particular, it introduces an aid effectiveness framework. It also discusses the limitations of project aid as a pre-cursor to the development of sector wide approaches. Section Three formally defines and describes SWAs, including the architecture of SWAs and the theory of change underlying them. It also outlines recent global developments aimed at strengthening the approach. Section Four reviews the evidence from the international literature on the effectiveness of health SWAs. This literature is substantial and consistent in its findings that the performance of health SWAs have been largely disappointing. Section Five considers the analysis offered by the literature on the reasons for the mixed effectiveness of health SWAs. Finally, Section Six builds on the preceding analysis, and in the context of aid effectiveness, aid incentives, and an understanding of the nature of health system development, presents an alternate approach to health aid that is more in line with the strategic intent of SWAs.

## **2. The aid effectiveness debate**

There is much debate about the effectiveness or otherwise of aid. The academic literature on the subject contains views which range from the negative, to the marginally positive, to the positive if applied in the right way, in the right situations, at the right levels (Howes 2011).

The more limited academic evidence on the effectiveness of health aid follows a similar, if somewhat more consistently negative picture. A number of studies have applied cross country regression analysis to investigate the link between health aid and health outcomes in developing countries. They found that health aid made no significant contribution towards improved health outcomes (Williamson 2008; Wilson 2011), nor to increased government spending on health (Lu et al. 2010). In slight contrast, Mishra and Newhouse (2009) found that health aid had a small positive effect on infant mortality, with on average a

doubling of health aid leading to a 2% reduction in infant mortality. This effect has weakened since 1990 (from when health aid increased substantially) though, and the authors found that health aid is more effective in countries with higher quality policies and institutions. A World Bank Impact Evaluation summary of health concluded that the “unprecedented” increase in health aid over the past 10-15 years “has not led to the expected improvements in outcomes” (World Bank 2011).

As this literature does not specifically address SWAps and may have some methodological limitations (Howes et al. 2011), it is not the intention of this paper to discuss it in depth. What the literature provides is a consensus that aid is not an automatic or unproblematic good, and that how aid is situated and managed is a critical determinant of its effectiveness.

Classically aid has been transferred in the form of projects. The essence of a project approach is an engineering/rational logic of problem identification, reduction and marshalling of resources to fix specific problems. Often projects are managed by external companies, organisations, or special Project Implementation Units (PIU’s) within ministries. In isolation, projects may make sense. When multiple donors in a sector are designing and managing numerous projects to fix specific problems, a range of serious issues are created (Negin 2010; Hollway et al. 2011), including:

- High transaction costs: Countries deal with numerous separate projects – many of which have their own management teams and separate implementation and reporting requirements. This takes a tremendous amount of time and diverts government officers from their core business.
- Fragmented analysis: Projects do not facilitate a whole of sector view – either in terms of addressing the full range of constraints to improvement, or in achieving an optimal allocation between sectoral priorities, or between capital and recurrent expenditure.

- Non sustainable benefits: Project approaches do not sustainably improve capacity or services, Considerable resources are often devoted to fixing a specific problem but are not sustained at the completion of the project. This leads to the oft quoted 'islands of excellence in sea of dysfunction' analogy.
- Hollowing government capacity: Projects and donors often employ the brightest and best from within government to implement projects, leading to a net loss of government capacity.
- Poor quality partnerships: Donors can feel they are being 'played-off' against each other, and government can feel that donors are making contradictory demands.
- Undermining government legitimacy: Due to the locus of control within projects being with donors, and the sheer number and visibility of projects, projects can contribute to a sense – both within government and the broader populace – that the government is not capable of meeting population needs. This undermines the general legitimacy of government, and undercuts efforts to build government capacity.

Against this backdrop, Howes (2011) has argued that it is impossible to say definitively if aid is effective or not, and that it is more useful to attempt to understand how aid can be made more effective. Others agree but emphasise that at minimum aid should do no harm (which project aid clearly does) (Birdsall 2007). Based on the evidence of the determinants of aid effectiveness, Howes (2011) has developed a framework to assist in understanding and organising actions to improve aid effectiveness. The framework focuses on recipient government performance, donor performance, and the interaction of the two. A summary is provided below.

## **2.1. An Aid Effectiveness Framework**

### **2.1.1. Improving recipient government performance**

The logic underpinning the importance of recipient government performance to development (and hence to the effectiveness of aid's contribution to development) lies in the widely-accepted view that the strength and legitimacy of domestic institutions are the primary determinant of economic and social development (Easterly 2008; Rodrik et al. 2004; Evans 2004; Booth 2011; Leftwich & Hogg 2008; Pritchett & Woolcock 2004). For aid, this logic leads to a focus on building 'good governance' as a major strategy to build or support strong institutions necessary to underpin effective development outcomes.

The importance of the good governance agenda is reflected in two ways in the practices of aid agencies. The first is to direct more aid to better-governed countries in order to maximise the impact of aid (approximately twice as much aid per capita goes to countries that perform well than to poor-performing countries). The second is to attempt to use aid to generate good governance in poor-performing or 'fragile' countries. The limits to the first approach lie in the quandary that reducing aid to poor-performing countries punishes their population. As for the second approach, none of the possible strategies for building good governance – technical assistance, conditionality, demonstration of innovation/good practice, and strengthening civil society – have provided strong evidence of effectiveness (Howes 2011; IDS 2010; Booth 2011; Grindle 2011a).

The most promising role for aid vis-à-vis the emergence and development of robust and legitimate institutions, appears to be for aid to provide support in a politically informed, non-intrusive way to existing, indigenous-driven and owned movements for change (Howes 2011, Kelsall 2011; Booth 2011; Grindle 2011a). This position is linked to a growing body of literature that argues for a more realistic approach to building good governance. In particular, it suggests that not all governance deficits need to be (or can be) tackled at once, and that it is unrealistic to aim in the short to medium term for best practice governance institutions (Grindle 2011, Pritchett et al. 2010). Rather, the concept of 'good

enough' governance has been proposed which, "directs attention to considerations of the *minimal* conditions of governance necessary to allow political and economic development to occur" (Grindle 2011). A key strand of this thinking is to build from the bottom up within existing contexts, in terms of indigenous institutions for governance improvement efforts. This means moving from 'best practice' to 'best fit' in the creation of 'practical hybrids' that fuse elements of traditional and modern institutions. (Booth 2011; Shivakumar 2005; Adler et al. 2009; Easterly 2008; Evans 2004; IDS 2010)

### **2.1.2. Improving the donor agency performance**

There are a variety of ways that the practices of aid agency can undermine aid effectiveness. Aid agencies can reduce the legitimacy of the governments they are trying to support through overt branding or 'planting their flags' (Easterly & Williamson 2011). Also the breadth and complexity of the issues they deal with, and the number of countries they operate in, increases the difficulty of finding staff with adequate skills to effectively manage their support. This weakness is magnified by the oft observed phenomena of the high turn-over of staff in posts and headquarters (Howes 2011).

The key strategies offered by Howes (2011) to improve the performance of aid agencies is greater public scrutiny of aid agency performance (at an input and program level); increased selectivity in the choice of countries, sector and interventions; changes in human resource practices towards more local recruitment, and longer term and higher level staff being posted in program management roles.

### **2.1.3. Improving donor-recipient interaction**

The final grouping of aid effectiveness issues revolves around how government and donor agencies interact. A key issue here is the proliferation of a large number of agencies providing multiple activities that demands the time/attention of limited government staff, and which are not coordinated with

each other or with national programs (Howes 2011; Easterly & Williamson 2011; Birdsall et al. 2011)<sup>1</sup>. This is the classic transaction cost argument.

Howes (2011) identifies harmonisation and alignment as per the Paris Declaration of Aid Effectiveness as key strategies for progress in this area. Actions toward harmonisation are selectivity of aid interventions by donors (i.e. donors focusing and coordinating their support to avoid overlap and duplication) and, maximising opportunities to work together (joint missions, projects, assessments etc.). Alignment involves donors acting under government leadership; maximising the use of government systems (where accountability is acceptable); and supporting existing reform efforts (not creating or pressuring new reform efforts) (Ibid). Other strategies identified as having the potential to reduce the burden on government is for donors, within an agreed context, to direct resources outside of government (private sector and community driven development). If this is done in a coordinated and policy consistent manner it need not undermine government legitimacy, and could both reduce the demands on government and stimulate developments complementary to government performance (Ibid; Schell et al. 2007; Pritchett et al. 2010).

### **3. Development of health SWAp's**

Health aid has been the subject of intense international scrutiny over the past 15-20 years due to its rapid growth and reported poor performance. Of central concern is the association of health aid projects with the criticisms about project aid identified above (Cassels & Janovsky 1998). This was one of the prime drivers for the development of SWAps as an alternative form of aid. SWAps were seen as an appropriate 'middle ground' between the pitfalls and over-prescription of projects, and undirected budget support (Ibid).

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<sup>1</sup> The average number of donors per country rose from 12 in the 1960's to 33 in the 2001-2005 period, and the number of individual activities has also risen from 20,000 in 1997 to 60,000 in 2004 (Howes 2011).

### 3.1. Definition

The classic, first definition of a SWAp developed by Cassels (1997) which is still widely used today is:

“An approach that involves all significant funding for the sector supporting a single sector policy and expenditure program, under government leadership, adopting common approaches across the sector, and progressing towards relying on government procedures to disburse and account for all funds”.

In a similar vein, the World Bank (2009) 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 behaviour 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”.

These formal definitions stress that SWAps are literally an approach to aid management which aims to locate leadership responsibility for sector improvement unambiguously with the recipient government. They are not presented as a blueprint but rather as a way of working towards improved aid management. Both Cassels’ and the World Bank definitions stress the idea of ‘moving towards’ the use of government systems, with the World Bank being explicit that sector programs can be supported via multiple modalities (parallel – i.e. projects – pooled or budget support). The key conceptual point is that the SWAp is about aid being managed in such a way that it ultimately supports government leadership of sector development, without being prescriptive about how this is achieved.

### 3.2. SWAp Theory of Change

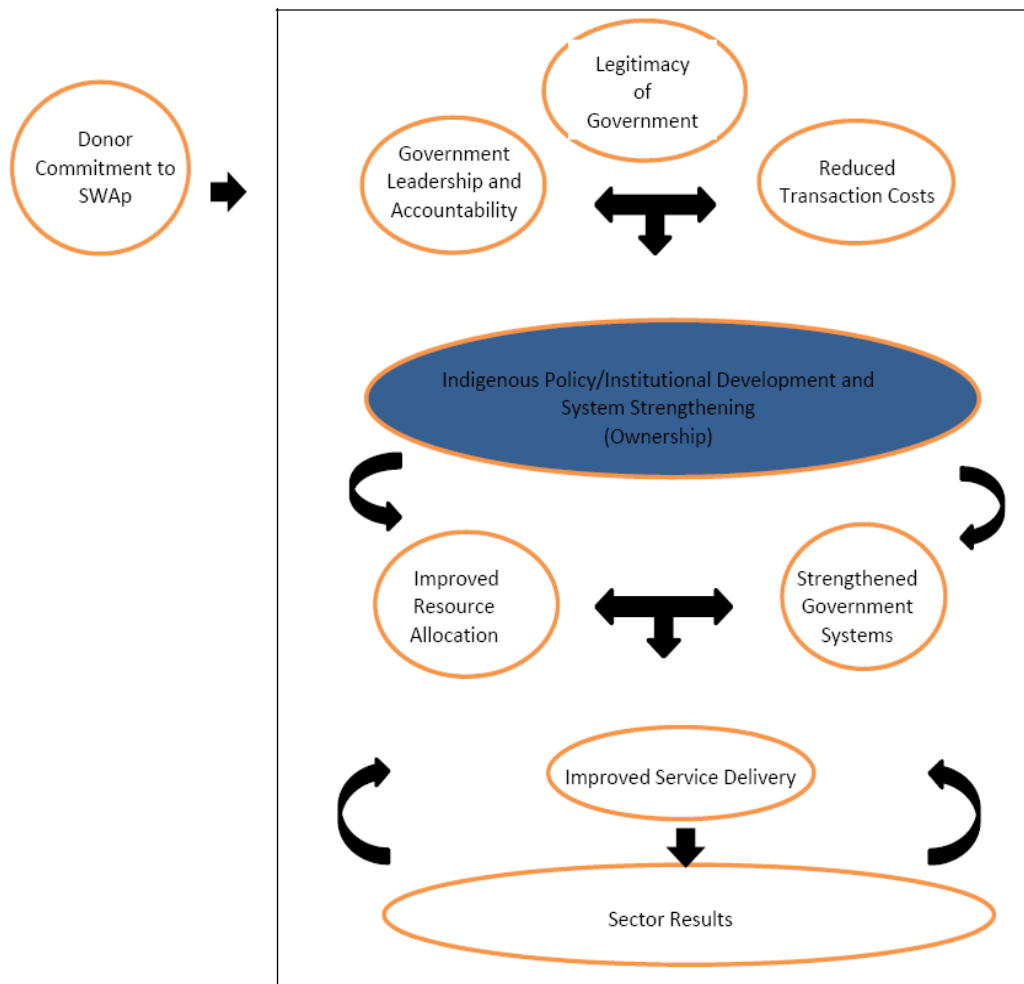
Although often not articulated, it is possible to discern a clear theory of change underpinning SWAp. This is described and summarised below and in [Figure 1](#).

In this theory of change:

1. A SWAp has three catalytic, strategic effects.
  - It places government in a leadership role in terms of directing and being accountable for sector development and implementation (noting leadership and implementation here could mean regulation, funding, and/or delivery).
  - It enhances government legitimacy by reducing donor visibility in the delivery of services/inputs at the expense of government.
  - It reduces the transaction costs of government interacting with donors, and hence more time/resources are made available for their core business.
2. The assumed effect of government having clear leadership and accountability, enhanced legitimacy, more time, and an expectation of performance is that it then engages in actions that promote indigenous sector policy and institutional development. It is expected that since these actions are being driven internally, there should be a higher degree of ownership. The resultant policies, plans, budgets or other improvements will therefore be stronger, more realistic, and hence more sustainable.
3. These internally grounded/owned policies, plans, budgets, actions should lead to more efficient resource allocation (both in terms of focus and volume) and strengthened government systems (be these regulation, funding or delivery), which will contribute to improved service delivery and sector results.

4. A robust and timely performance information system feeds information on performance back into service delivery and policy development processes to continually calibrate and improve performance.

**Figure 1: SWAp theory of change**



This SWAp theory of change are consistent with the aid effectiveness framework introduced above. The theory clearly aims to provide space for the development of strong domestic institutions and policy approaches, while reducing transaction costs and promoting the progressive strengthening of government systems. Donors are assumed to play a supportive, catalytic role through their initial action of supporting the SWAp (and all that comes with this as outlined in the theory of change), and are not assumed to be involved in the detail of the change process itself.

This theory of change is also consistent with emerging aid quality measurement frameworks such as the Quality of Official Development Assistance Assessment, which measures the fostering of institutions, efficiency, transparency and learning, and the reduction of burden (Birdsall et al. 2011).

### **3.3. SWAp Architecture**

In implementation, a relatively standard set of elements or architecture have been developed and are often used to define a SWAp. The architecture includes:

- Single National Policy/Plan – based on an understanding of whole-sector constraints and opportunities, this provides the framework to direct all sector resources to agreed priorities.
- Single Expenditure Framework – often in the form of a Medium Term Expenditure Framework or Programme of Work that reflects current and projected resources for priorities, and covers both capital and recurrent budgets.
- Common Management/Administration Systems - ideally government (or if this is not immediately possible, at least common) planning, financial and reporting systems.
- Common Funding Arrangements – ideally using the government financial system but often as an interim step towards a pooled/basket funding that follows common procedures.
- Core performance indicators – usually a limited range of core indicators that provide a snapshot of sector performance at various stages/levels, and which can be used to assess and diagnose sector performance. Performance is often independently assessed/ analysed by an Annual Sector Review process.
- Sector Management/Coordination mechanisms – can take a variety of forms but will normally involve some elements of Government/Donor

Agreement, Donor Codes of Conduct, High Level Summits, and joint management/business meetings.

### **3.4. Recent SWAp Developments**

In recent years, the international community has developed a number of global approaches to push harder from above (inter-governmental agreements/fora) in support of the implementation of SWAps. The International Health Partnership (IHP) formed in 2007, and the Health Systems Funding Platform formed in 2009, have a similar intent and modus operandi – single national plan, single donor assessment, single fiduciary assessment, single monitoring and evaluation framework, and an overarching compact or agreement to cover financing support (which would be provided as budget support) (Schaferhoff et al. 2009; Glassman & Savedoff 2011; IHP 2011; Conway et al. 2008). These approaches have been described as ‘SWAps with teeth’ or a way to achieve SUPER (Scaling Up Partnerships for Effective Results) SWAps (Conway et al/ 2008).

## **4. The performance of health SWAp’s**

This section offers a review of the substantial body of international literature on the effectiveness of health SWAps. Both the substantive literature and its measurement constraints are discussed below.

### **4.1. Measurement Issues**

There is a growing body of review and evaluation literature on health SWAps. As an introduction to this literature, it is important to note that there are a range of complex measurement issues that reduce the power of many of these findings (OECD 2011; Walford 2007; World Bank 2009; Duran & Glassman 2012).

First, there are no randomised trial/evaluations of SWAps. If these were available, they would provide a gold standard but the complex reality of whole of country aid, and the difficulty of comparing intervention/non-intervention countries means that no such randomised trials have been attempted.

Second, even 'before and after' comparisons of SWAp performance have proved difficult to establish. This is because SWAps are often incrementally designed and (partially) implemented, with no defined start date. It is also difficult in country environments to distinguish between the effect of this form of health aid and other political, social and economic factors. Further SWAps are often implemented without a comprehensive monitoring and evaluation system to allow for measurement over time (OECD 2011).

Third, health SWAps have been introduced during a time of substantial increase in the volume of health aid (as discussed above). In this context, without more powerful studies, it is difficult to disentangle the relative effects of form and volume of aid towards positive/negative trends in health sector performance.

An important consequence of these measurement issues is that no study or meta study can or does claim a definitive, causal link between a SWAp and improved health service coverage or improved health status. A number of studies point to a correlation between SWAps and improvements in either health service coverage and/or health status (OECD 2011, Walford 2007). However, as previously argued, when more rigorous statistical methods are applied this association disappears, and factors beyond aid become significant (OECD 2011; Williamson 2008; Syverson 2010; Wilson 2011).

On this basis, the OECD (2011, p. 39) argues that given the "difficulties of drawing a direct causal link between inputs and outcomes ... it would be more realistic to assess the contribution of aid effectiveness to health through creating the conditions for sustainable impact i.e. through its effect on health systems strengthening, on transformation of institutions, and accountability ..." This study follows this approach and focuses primarily on the performance of SWAps at the process-level. At this level there is a rich body of primarily qualitative review literature that draws heavily on the perspectives of actors involved in health SWAps. This is supplemented with an observation of the performance of SWAp elements by independent reviewers.

## **4.2. SWAp Process Performance**

The overall assessment of health SWAps at a process-level is poor.

A World Bank (2009) review of SWAps in Bangladesh, Ghana, Kyrgyz Republic, Nepal, Malawi and Tanzania found the:

‘... anticipated capacity and efficiency benefits of the [SWAp] approach were partially achieved ... [and] ... In most of the six countries, national health objectives were only modestly achieved.’

Similarly a desk review of SWAps in Ghana, Malawi, Mozambique, Tanzania, Uganda and Zambia concluded:

‘... there has not been consistent progress towards closer sector wide working and increasing use of government systems ... In several countries there is concern that the SWAp has lost momentum’ (Walford 2007, p. 9).

Finally, the OECD (2011) found that while there is a correlation between some SWAps and improved coverage and outcomes (see measurement issues above), significant process-level constraints remain:

‘Many of the constraints to aid effectiveness identified by the ... interim report persist. This includes the complexity of aid architecture, lack of donor alignment with country priorities and systems, poor donor harmonisation and difficulty in maintaining momentum once mechanisms are in place. Recent developments, in particular the emergence of new donors, also represent challenges to aid effectiveness’ (Walford, 2007, p. 9).

These overall assessments of SWAps can be further disaggregated:

### **4.2.1. SWAp Architecture**

Health SWAps have been “largely successful in putting in place critical tools and processes for improved sector coordination and oversight” (World Bank 2009).

This SWAp architecture includes policy frameworks, medium term expenditure frameworks/ programmes of work, structured donor and government meetings, and common funds. However there are concerns about the realism/ quality /integration of some of these mechanisms (Sundewall et al. 2006; World Bank 2009; Walford 2007; Chansa et al. 2008; Dickinson 2011; Negin 2010a; Bowie & Mwase 2011, AusAID 2009, Agha 2008).

#### **4.2.2. Harmonisation and Alignment**

There was “uneven progress in harmonisation and alignment with a substantial gap between commitments and practice”. These reviews particularly noted an uneven commitment from donors to use tools/processes, with considerable reluctance from donors to use government systems (OECD 2011; Chansa et al. 2008; AusAID 2009). Further, there is evidence that ‘common funds’ (i.e. arrangements for pooled donor funding in parallel to government financing) remain common within SWAps, but they do not appear to facilitate the transition to, or the strengthening of, government systems (Agha 2008).

#### **4.2.3. Transaction Costs**

There is no evidence that SWAps have decreased transaction costs, and in fact some evidence that they have led to an increase (World Bank 2009; OECD 2011). The new architecture associated with SWAps – plans, summits, donor coordination, policy conditions, and common funds – can impose new forms of transaction costs, particularly in the early stages (Killick 2004; OECD 2011; Agha 2008, AusAID 2009). There is also evidence that stand-alone projects remain, and in some cases are increasing, outside of pooled arrangements (Chansa et al. 2008; Walford 2007; Negin 2010a). In fact, the evidence suggests that in many countries, donors provide funds to both SWAps and projects. In Malawi, more than 20 donors fund more than 100 health projects outside the health SWAP. In Mozambique, only 22% of health aid to the country goes through the common fund (OECD 2011).

#### **4.2.4. Sector Stewardship**

A six country review conducted by the World Bank (2009) found that SWAps were only “modestly” successful in achieving improved sector stewardship. The review found some evidence of improved ownership of plans, but concern remained about the realism/quality of the plans. Others reported a similar finding (Walford 2007; Negin 2010a; White 2007). Further planning and management tended to focus on inputs rather than results, and results reporting systems were found to be complex and difficult to use. SWAps have also been ineffective in establishing incentives to strengthen sector wide accountabilities, with public sector management responsibilities not assessed or addressed, and sector performance information not widely shared with civil society (World Bank 2009; AusAID 2009; Walford 2007). Performance agreements – both between governments and among levels of government – were not enforced (World Bank 2009; AusAID 2009).

#### **4.2.5. Service Delivery Funding**

Reviews have found only limited evidence of increased allocation of resources to front-line facilities/prevention, and despite evidence of improved overall budget execution, there was little or no evidence of increased expenditure of front-line service (World Bank 2009; Chansa et al. 2008; AusAID 2009). Furthermore, the nature of this expenditure in terms of its poverty/equity focus had not changed (World Bank 2009). This finding was reinforced by other studies, which identified limited capacity at a district-level and below and poor funds flows and implementation at a service delivery level (Ibid, Walford 2007; Pearson 2010; AusAID 2009).

A number of reviews have pointed to the positive process and possible output benefits for health of budget support (both sectoral and general) (Williamson and Dom 2010; IDD 2006). However importantly, these observations of improved service delivery coverage are qualified by the fact there was no evidence of corresponding improvement in service quality or equity (Ibid). Further budget support has not been broadly accepted by donors or government

and remains only a small proportion of total aid flows, even for the most committed donors (Agha 2008).

## 5. Understanding poor SWAp performance

This section reviews the range of possible reasons for the generally poor performance reported for health SWAps.

It is possible to categorise the analysis of poor performance into two groupings. First, there are a group of reasons that can be broadly classified as technical i.e. which relate to the quality or nature of how the SWAp architecture was designed and implemented. Second, there are a group of reasons which can be classified as underlying or incentive based, i.e. the fundamental factors that drive or shape government and donor behaviour in the provision of aid, including SWAps. It is a key position of this paper that both sets of arguments are relevant to understanding the poor performance of SWAps, but while technical arguments are important, they are not sufficient as an explanation. Rather, it is the underlying incentives of donors and governments that are the key determinants of the difficulties experienced in the use of SWAps.

### 5.1. Technical Factors

The World Bank (2009) review found that there were four critical, technical factors that were likely to facilitate/undermine health SWAps. These technical factors can also be found in varying degrees in other reviews (Walford 2007; AusAID 2009; Dickinson 2011). They are:

- *Quality of plans/expenditure frameworks*: Expenditure programs needed to be specific, realistic, prioritised and feasible, and the political economy of the proposed program needed to be assessed. The review found that most programs of work were not appraised with sufficient rigour by donors, and many were overly ambitious and inadequately resourced.
- *Insufficient local capacity*: In many countries, the use of government systems often over the short to medium term led to significant implementation delays due to increased volume, and heightened scrutiny

from donors (audits etc.). This finding applied to all core government systems – including planning, resource allocation, procurement, financial management and monitoring.

- *Quality and nature of partnerships:* Generally SWAs were criticised for not adequately involving civil society and the private sector, and for having mixed relationships with central agencies. Donor partnerships generally were problematic, and while joint sector reviews were found to encourage harmonisation, they have been uneven in the quality of dialogue and tracking accountabilities. In addition, donor codes of conduct were not followed and were not useful in managing conflicts.
- *Predictability, volume and allocation of resources:* Unpredictable resource flow – both government and donor – to programs of work is often uneven due to poor costing of program work, rigidity around accountability requirements, system weakness, and donor/government not making or not following through on multi-year commitments.

## **5.2. Incentive Factors**

There are a range of underlying incentives which both contribute to the prevalence of these technical factors, and to the poor performance of health SWAs more broadly. This section discusses these factors based on the aid effectiveness framework categories of donor performance, government performance, and government-donor interaction.

### **5.2.1. Donor performance**

Donor incentives negatively affect the implementation of SWAs in a number of important ways.

First, there is very clear evidence that despite the official rhetoric towards harmonisation and use of common systems, many donors continue to be driven by the need to ensure the profile of their agency. The evidence suggests that this need is stronger than a donor's official commitment to SWAs (OECD 2011), and this can be seen in a variety of ways. The very proliferation in initiatives and

agencies providing health support, often in the form of vertical, disease control programs (such as the Global Fund for Malaria, TB and HIV, or the GAVI), is driven in part by the need to closely link input with a clear impact. Also, donors continue to provide assistance through projects, earmarking within pool funding, or brand support precisely so that they may have the results attributed back to them (Ibid; Negin 2010a; Walford 2007; Agha 2008).

The effect of this need for visibility and attribution is to work against a SWAp being implemented as intended, and in fact, it greatly complicates implementation. It does this by increasing the management challenge for government (having more donors to deal with); greatly reducing the effectiveness of donor coordination mechanisms (more voices with narrow issues); and the proliferation of vertical programs can cut across the integrity of government health policies and approaches – particularly those that stress integrated primary health care, rather than selective primary health care. Also, the requirement for individual agencies and initiatives to maintain visibility and tracking of their inputs through government or common systems both undermines the operation of these systems, and complicates their management (further taxing already limited capacity) (Agha 2008).

Second, donors are driven by the need to meet annual expenditure targets. This is once again a result of the institutional imperative to prove to funding agencies that they can spend allocated funds, and should subsequently receive the same, or ideally an increased budget. In health, this imperative is amplified by the political commitments made by governments to meet the Millennium Development Goals, and the associated analysis that a significant strategy to meet these goals is to fill the funding gap (Clemens et al. 2007).

The consequence of this imperative is a very significant increase in pressure on aid modalities to disburse year on year increases in health aid. The problem for SWAps is that disbursements may be slow in the early stages of using government or common financial and management systems. The imperative to spend then produces one of two problems: either too much funding is provided too early, which if systems are not ready can create a loss of confidence and

further bottlenecks; or donors decide too quickly that government systems are inadequate and develop parallel systems (often projects) that undermine the strategic intent of strengthening government systems through use.

Third, and in some ways related to the first two negative impacts of donor incentives, is that donors are extremely impatient for results in the health sector (Agha 2008; Clemens et al. 2007). There is an expectation that increased levels of donor resources should lead to improved outcomes as soon as possible. Domestic audiences (ministers, treasuries, managers, and the general public) can then be convinced of the effectiveness of aid, and will continue – or ideally increase – levels of funding. The consequence of this for SWAp is once more a rush to circumnavigate poorly-performing government systems before the intended effect of donors using the systems has had the chance to build sufficient pressure to improve them (OECD 2011; Negin 2010a; Pearson 2010).

Fourth, donor staffing practices can undermine SWAp effectiveness. Donor agencies typically have postings of 2-3 years in-country and the turnover of staff at headquarters can be even more frequent. This makes it extremely difficult to establish the requisite partnerships among donors or between donors and government. It also increases the chances of discontinuity in approach as new staff, driven by institutional imperatives to make a mark on a relatively short posting, review or change earlier decisions and take a new direction. There is also an issue with staff qualifications and their expertise and experience. Many aid agency staff working on health SWAps are either development generalists or health technical staff, many of whom do not have the seniority or experience of dealing with the sectoral-level policy, political, financing and performance issues that SWAps produce (Negin 2010a; White 2007).

Finally, a small SWAp consultancy industry has developed and been influential in reviewing and advising on SWAp development around the world. This is partly due to the absence of strong internal capacity within donor agencies, and also to the nature of the aid industry itself. Given the short term input of this type of review, and the impossibility of knowing a lot about the country in question, the tendency has been to revert to provision of concrete advice about developing the

specific elements of the SWAp architecture (SWAp ‘best practice’), rather than fully understanding the dynamics and relationships of a particular country context. As Pritchard et al (2010) observed about aid practice at a slightly broader level:

‘... it is often the same set of people that are involved with similar issues in many countries, and have acquired tremendous comparative knowledge in their field. By contrast, they have little understanding of the particularities of each country, are often on short-term assignments with prescriptive terms of reference, and face the pressure of having to design comprehensive programs in short time spans. They are often well aware of the importance of context, but their caveats and small print are often not read by donors and policy makers.’

In conclusion, the OECD (2011; 9-10) regarding donor behaviour vis-à-vis health aid concluded:

‘Donor pressures to demonstrate results and retain accountability, concerns about losing influence, and inflexible rules and system limit harmonisation and use of common arrangements. Donor constraints to longer term aid predictability include unwillingness to commit funds beyond the current term of office, preference to retain political leverage and the flexibility to respond to changes in foreign policy priorities, and domestic rules and processes. Concerns about fiduciary risk and short term planning horizons in recipient countries reduce incentives to provide multi-year commitments.’

### **5.2.2. Government performance**

There are also a range of incentive issues within developing country governments that undermine the implementation of health SWAp.

First, it is not always universally true that all players within government value the transparency in resource allocation and use that accompany SWAp. A clear intention of SWAp is to increase the level of donor influence over sector policy

and resource allocation. This may well be resisted on nationalist grounds (the sense that the donor is impinging on sovereignty by 'ganging up' on government); or it may be resisted on the basis that SWAp may reduce the opportunity for corruption or patronage practices (White 2007; Goodard et al. 2006; Booth 2011).

Second, there are likely to be individuals who – within both central and line agencies – enjoy the benefits associated with project aid that will be lost under a SWAp. These benefits include the higher paid/status positions given to project staff and opportunities for travel and study. There is also the possibility that some managers (with projects in their areas) may be enjoying, at least temporarily, a more assured resource flow that will be jeopardised by a reliance on resources flowing through weak government systems (Agha 2008).

Third, SWAp can get caught in central/line agency and national/provincial politics, where a sectoral agency is seen to be 'too far in front' and is therefore resisted. They can also be affected by inevitable changes in the political and bureaucratic leadership of central and health agencies, whereby different leadership groups will have different priorities and may or may not wish to continue their predecessor's policies.

Finally, in many countries there is a power imbalance between government and donors, with government feeling – for a variety of cultural and political reasons – which it cannot say no to individual donor requests for particular activities. This greatly undermines the collective strength of a SWAp.

### **5.2.3. Government – Donor Interaction**

The third level of underlying factors constraining SWAp performance relate to how donors and governments have interacted to interpret (and hence operationalize) SWAp. This section argues that there are three key understandings of health SWAp constructed by governments and donors through practice, which have contributed to their poor implementation performance:

- i) an overemphasis on the importance of macro-level sector policy, planning, and priority setting/resource allocation;
- ii) a privileging of the role of government in service delivery;
- iii) an overestimation of the capacity and commitment of government.

Each of these is discussed in more detail below.

### *Sector Policy, Planning and Resource Allocation*

Sectoral level policy, planning and resource allocation is a central tenant of SWAp (Donge 2007; IHP 2011; Negin 2010; World Bank 2009). An essential aspect of all SWAp definitions is that their perceived value lies in analysing, supporting and reviewing performance at a systematic level, because the sectoral perspective offers the opportunity to identify, and where necessary, challenge/change the systemic constraints on performance. These constraints could be political, institutional, technical, or related to policy, financing or human resources.

‘... born out of a concern of aid effectiveness, the aim of the introduction of SWAp ... was to make aid more effective ... But this is, of course, not the ultimate aim: The ultimate aim is to make country or sector development processes effective for poverty reduction. In this wider perspective, the SWAp becomes a domestically owned and driven approach for effective sector development management ... In essence a sector-wide perspective is simply a common sense planning tool that can help politicians and planners to better divide (public) resources over priorities. Whether these resources are from domestic or foreign sources is important, but not the key point’ (Boesen and Dietvorst, 2007, p. 14-15)

The key issue glossed over in this understanding is the inherent complexity, sensitivity, and difficulty in sustainable, legitimate health sector development. In essence what flows from this understanding is a highly ambitious objective that SWAp are the vehicle for sector reform with a particular objective – poverty reduction (Boesen & Dietvorst 2007; Walford 2007). The melding of SWAp and

sector development in this way leads to the strong focus within SWAps on the upfront policy, planning and associated program of work design work to get the sector policy and resource settings “right” before resource can flow (Donge 2007; IHP 2011). This, in turn, leads to a number of problems.

First, attempting comprehensive, up-front policy, planning, resource allocation processes can impose a considerable obligation on key government and other stakeholders (Negin 2010a; Donge 2007), which creates additional transaction costs. It can also contribute to criticism that SWAps get bogged down in high-level policy and planning, and sufficient attention is not paid to getting resources/support to front line service delivery (Negin 2010a; World Bank 2009; AusAID 2009; Walford 2007).

Second, this policy driven approach is premised on a misguided view of the nature of health systems as coherent, rational, bureaucracies that are amenable to purposeful, top-down direction and control. There is also a tendency within this view to export models of how health systems operate in developed countries to developing countries, with little questioning of their appropriateness or adaptability (Bloom and Standing 2008; Mills et al 2001). Pritchett and Woollock (2004) contest this approach, arguing that health services are largely discretionary and transaction-intensive, and hence not amenable to the logic of large scale, routinized, administrative control. Others argue that health systems, as institutions more broadly, should develop from within a country’s own political, historical and cultural contexts, and therefore, solutions to how health services are financed and delivered cannot be imposed from outside (Easterly 2008; Saltman 1997; Wilsford 1994; Roemer 1993). WHO (2007) argues that health systems comprise a set of “building blocks” (health workforce, information, medical supplies/ equipment financing, infrastructure, leadership/ governance, models of care and demand for care) which pursue a range of goals and delivery and financing mechanisms based on the national context. Mills et al. (2001) argue that in countries with very weak capacity, these basic building blocks should be supported, as they will be necessary regardless of the form of service organisation that is adopted.

Third, there is the risk that policy and planning of this nature, because it is not organic or grounded in indigenous processes, becomes primarily a technical, paper-based, 'theatre' undertaken to 'keep the donors happy', which ignores the political and cultural dimension of sector development (Woll 2008; Hoffstaedter & Roche 2011; Killick 2004). For example, Woll (2008), in analysing the planning process required by donors in Ghana to accompany general budget support, concluded:

'... the GPRS [Ghanaian Poverty Reduction Strategy] was primarily formulated with a view of pleasing the donors in order to be eligible for debt relief. The origin of financial flows weighed more than the inputs provided by participatory processes or even the government's own development agenda ... Although most donors were aware of the gaps between declared and actual priorities, they seemed not to realise the consequences of such a situation. If formalised arrangements are partly a facade, change cannot be easily achieved by reforming them ... That is why donor supported reform attempts are doomed to fail, so long as they do not take actual patterns of everyday politics into account' (Woll, 2008, p.84).

Finally, macro-level planning and resource allocation of this nature is extremely problematic, both conceptually and practically. There is a large body of work which argues that the big picture, planning-driven approach to policy development and the associated rational allocation of sector resources (particularly those premised on cost-effectiveness analysis) is both conceptually flawed and has practically failed (Robinson 1999; Williams & Bryan 2006; Goodard et al. 2006). This research argues that decisions related to health priority setting and resource allocation are better mediated through embedded political, institutional, organisational and cultural practice and processes (Goddard et al. 2006; Reichenbach 2001; Jan et al. 2003; Marmor & Boyum 1999). Therefore, the processes developed to influence/ shape these decisions need to be much more procedural in nature, and informed by an in-depth political understanding (Roberts et al. 2004; Buse 2008).

Given the above, it is simply not realistic or sensible to think that all the things required for sustainable, appropriate sector-policy development and/or resource allocation can be put in place in a time-bound process at the behest of donors, particularly in low-capacity environments (Donge 2007; Grindle 2011). It is rather more likely that sector change will emerge through local, institutionally embedded policy processes and contestation (Roberts et al 2004, Buse 2008). Yet this is a lesson that SWAp practice appears not to have internalised, as can be seen in particular through the dominant role of single/comprehensive national plans in SWAps around the world (IHP 2011). As Sridhar and Craig (2011) conclude:

‘... in what might be argued to be a ‘managerialist’ approach to emerging complexity, we have seen the emergence of such coordinative modalities as SWAps. But as in wider development contexts, these devices, which function on the ground as working and technical committees, have focussed on planned coordination at the expense of both renegotiating the politics of health aid, or the fragmentation tendencies inherent in the aid modalities.’

### *The role of government*

There is a lively debate about the appropriate public/private mix in health service financing and delivery (Hanson et al. 2008). In reality, there are few if any health systems in the world today that are exclusively public sector or exclusively privately financed and delivered. Even health systems that are predominantly public have some elements of private financing and delivery, and in particular health systems in poor countries often have a vibrant private/non-government or contracted sector operating alongside, and often within, the existing public sector (Bloom et al. 2009; van der Gaag & Stimac 2008). Furthermore, there is now a considerable body of emerging empirical evidence that on the key measures of outcomes, aggregate financing and even equity, there is no particular evidence as to which system – public or private – performs best (Ibid).

Yet within SWAp practice, supporting government systems has often been equated with government delivery. This can be seen through the often repeated criticism that SWAps have not allowed sufficient engagement with non-state actors (World Bank 2009). This relative privileging of the role of government in the financing and delivery of health services under SWAps has a number of important consequences.

First, it has meant that SWAps have not come to terms with the implications of the body of evidence showing that simply increasing levels of public spending on health does not automatically lead to an overall increase in aggregate spending, nor indeed in the desired impact on health outcomes (Filmer & Pritchett 1999; van der Gaag & Stimac 2008). This evidence in fact highlights that growth in public health services can lead to a shift from private to public services with no net growth in services – the so called ‘crowding out effect’ (Ibid). Further, there is clear evidence that it is often the better-off who shift from private to public, and hence capture more of the benefit of public spending on health (Castro Leal et al. 2000; van der Gaag & Stimac 2008).

Second, an over-reliance on government delivery can limit the uptake (or at least the exploration) of potentially more efficient and equitable ways of health services being funded and provided (e.g. contracting, vouchers, and conditional cash transfers) (Peters et al. 2008; Morris & Pryke 2011).

Third, it may divert donor funding away from a range of investment areas, which the evidence suggests are beneficial for health sector development (e.g. female literacy, community development), but are not necessarily supported by/through the government health delivery (Schell et al. 2007; Casabonne & Kenny 2011).

To reiterate: it is not an inherent or necessary part of SWAps that government financing must ‘crowd out’ alternative forms of health financing and delivery. The original intention of the approach was to foster government leadership and the progressive use of government systems. This does not preclude a more nuanced and sophisticated understanding of the role of government – e.g. as a leader of sector development, a regulator, financier, or one of a number of

delivery channels. Rather an overemphasis on Government delivery has arisen due to how SWApS have been interpreted in practice.

*The capacity and commitment of government*

The conceptual work of Lant Pritchett and his colleagues on the mechanics of 'persistent implementation failure' and 'premature load bearing' offers some important insights into the capacity of government vis-à-vis SWApS (Pritchett et al. 2010; Pritchett & Weijer 2010).

The essence of Pritchett's argument is that there is a tendency for fragile, poor-performing countries (which are usually also highly aid-dependent countries) to mimic external organisations through the adoption of 'best practice' in order to accelerate development. Operating under a cloud of 'wishful thinking', those introducing reform then ask too much, too soon of fragile organisations and implementation failure follows. It is assumed that function will follow form, but it rarely does. This phenomenon is described as 'premature load bearing'. Pritchett argues that such failure becomes persistent due to a range of incentives that operate on both internal and external actors to keep searching for best practice, while measuring progress of inputs/outputs rather than outcomes, and not looking for alternatives. This can lead to a recurrent dynamic of failure and a 'capability trap' (Pritchett et al. 2010; Pritchett & Weijer 2010).

Pritchett's analysis resonates with the significant volume of health SWAp review evidence referred to above. A clear and consistent finding of this body of work is that capacity constraints within government were "underestimated" or "not adequately" planned for (OECD 2011; World Bank 2009). SWApS exhibit an imperative to spend, which can lead either to providing too much funding too early, and if systems are not ready, this can result in loss of confidence and further bottlenecks (premature load bearing); or donors deciding too quickly that government systems are inadequate and hence parallel systems are developed (often projects), which undermines the strategic intent of strengthening government systems through use. Government is then in a situation of having the double burden of attempting to fix weak government

systems as project aid continues (with the associated transaction costs), and in fact increases. Further, there is not an active search for an alternative 'middle ground' approach based on a more realistic sense of government capacity, which can provide more organic, sustainable growth of capacity. Pritchett articulates some elements of this 'middle ground':

'The only way forward is to allow for a more organic process of change, thus ensuring that institutions are embedded in the local context from which they obtain the necessary robustness to cope with stresses. More policy space is required for contextual solutions that may diverge from international best practice' (Pritchett & Weijer 2010).

Implicit in this is the need for the state to adopt a more realistic and strategic view of what it can, and critically needs to do. In the short to medium term others should, temporarily at least, take on parts of the functions of the state:

'... the role of the state is crucial for development assistance, and therefore we have to treat the state capability as a scarce resource, or perhaps even a binding constraint on development ... State capacity should be used in those spheres where it is most crucial and strategic, and that tasks should remain within the limits of what can genuinely be accomplished ... Non-strategic functions can be outsourced, and a strategic plan can be put in place for a slow and gradual transfer of responsibility back to the state.' (Pritchett & Weijer 2010)

Booth (2011) introduces a more explicitly political dimension to the issue of state capacity, arguing it is not uncommon for government actors to be driven mainly by their own short-term, political self-interest rather than broader public or developmental interests. Such motivation is not an issue of capacity but rather an issue of the commitment of government, and thus a simplistic approach to using and strengthening government policies and systems, which are really a 'façade' for anti-developmental purposes, is likely to be both ineffective and damaging. In this context, efforts to improve governance should focus on bolstering the emergence of local development leadership, supported by 'policy - entrepreneurs' with the incentive and capability to solve local political and

collective action problems (Ibid; Meijerink & Huitema 2010; Bruce & Tolentino 2010). Furthermore, the role of aid should be less about financial support to fill gaps, and more about facilitating or brokering solutions to collective action problems at a national, meso, and micro level (Ibid; Unsworth 2009).

The views of both Pritchett and Booth suggest a more cautious and nuanced approach to the use of government systems than SWAp practice has advocated. Both views are consistent with a progressive move towards the use of government systems, and are premised on an assessment of performance rather than uncritical assumptions about the capacity and nature of government systems. This view contrasts with the evidence that SWAps have been unrealistic in their expectations of government capacity and commitment.

## **6. Rethinking health SWAp's**

A key assumption within this section is that the lack of success of SWAps does not change the need for them (or more accurately the underlying strategic intent of the approach). If anything, the increase in the volume and proliferation of agencies and activities in the sector increases the requirement for effective ways to better coordinate and align donor support to recipient health systems. The issue is not whether this should be done, but rather how it can be done effectively.

As argued above, the international community's response to the limited effectiveness of health SWAps has been to develop the IHP and the Health Systems Funding Platform. Yet to date there is no evidence that these enhanced, internationally-driven approaches have overcome the previous constraints on SWAps. In relation to IHP's, the OECD (2011) concluded:

'... some major donors are not IHP+ signatories, IHP+ compacts have been established in relatively few countries, their impact on country ownership has not been rigorously evaluated and it is yet unclear whether compacts will lead to improvements in aid effectiveness.'

In relation to the Health Systems Funding Platform, Glassman and Savedoff (2011) argue:

‘After a year of implementation and significant investments of time and money, it is not clear that the Platform will realize its aims ... Essentially, the Platform is addressing the same coordination problems that remain unresolved by previous efforts, without distinguishing itself in any structural way from the earlier initiatives’ (Glassman & Savedoff, 2011, p. 2-4).

It is also clear that the new global approaches to SWAps enshrine more forcefully the architecture approach, particularly the primacy of macro-level policy, planning and resource allocation, which has been argued above to both conceptually and practically limited.

Given these concerns, this paper proposes an alternative approach to the provision of more effective sector-based health aid, which attempts to account for the lessons learnt from what has worked/not worked vis-à-vis SWAps to date (and the reasons underpinning this performance).

### **6.1. Health SWAp Problems Revisited**

This paper maintains that a range of powerful incentives – from both donors and government – have shaped the interpretation and implementation of SWAps to the point where their effectiveness has been constrained, and the strategic intent of the approach has been compromised. In summary, the paper has argued that:

- The core problem(s) that SWAps aim to address at a strategic level – lack of government accountability/leadership; donor undermining of government legitimacy; and high transaction costs – are key problems to be addressed if the effectiveness of health aid is to be improved.
- The way that SWAps have been implemented to date has not effectively addressed these core problems, and has in fact created a situation that can intensify the original problems.

- The key factors constraining the effective implementation of SWAps have been:
  - Donor incentives around agency profile/attribution; expenditure and result imperatives; and poor staffing practices;
  - Government incentives around scrutiny avoidance; project “rents”; and institutional politics; and
  - SWAp interpretations which i) overemphasise top-down, technical policy and program approaches to sector development (and de-emphasise the role of politics); ii) privilege the role of government in health service delivery; and iii) overestimate the capacity and commitment of government.
- These factors have contributed to the development of cumbersome SWAp architecture that is partially implemented and used, and which does not facilitate government ownership and commitment to indigenous institutional development. Rather, projects continue to proliferate as donors search for ways to deliver aid despite weak government commitment and capacity.
- The net effect of this situation can be a worsening of the original strategic problems the SWAps were designed to address, particularly high transaction costs and weak, non-indigenous policies and institutions.

Given these concerns, this paper proposes a possible alternate approach to the provision of more effective sector based health aid which attempts to take account the lessons learnt from what has worked/not worked vis-à-vis SWAps to date (and the reasons underpinning this performance).

## **6.2. An alternative approach to health SWAps**

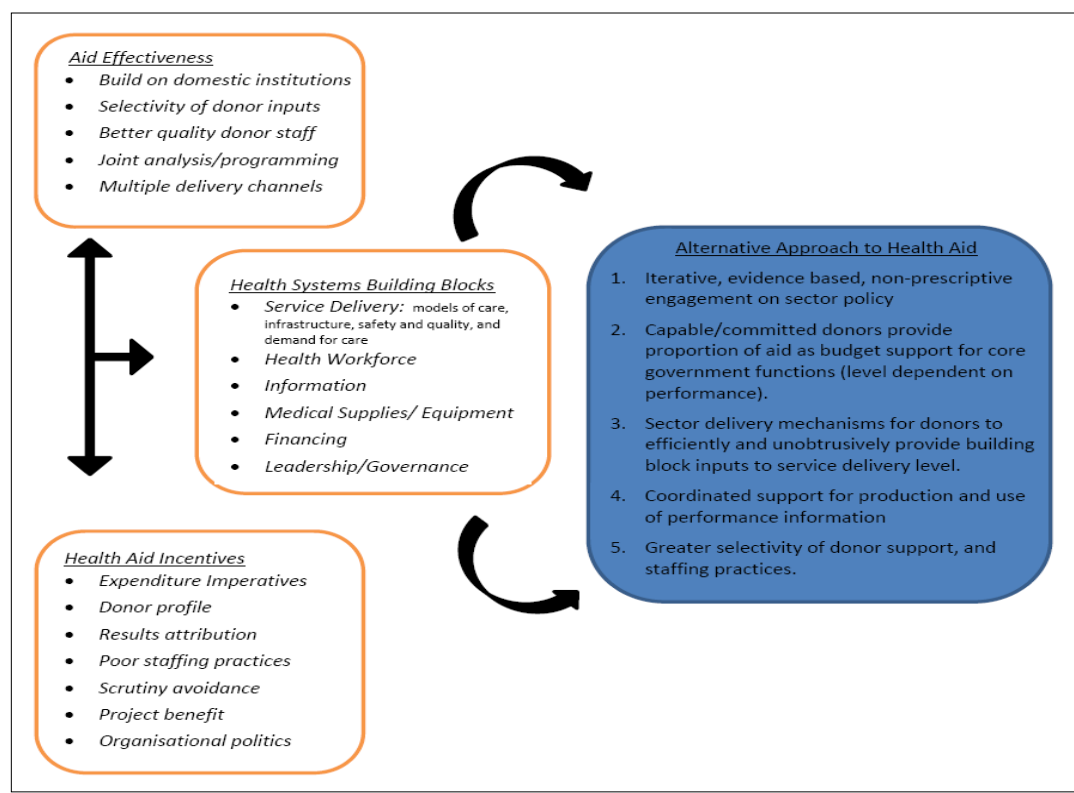
The approach to improve health SWAps suggested here differs to the SWAp architecture approach in how it operationalizes the interplay between three key

understandings – aid effectiveness, the nature of health systems, and aid provision incentives. Specifically:

- Aid effectiveness is understood to revolve around the ability of aid agencies to efficiently and effectively support or facilitate the emergence of robust and legitimate domestic institutions;
- Health systems are understood to be institutional forms that cannot simply be designed from the top down through imported ‘best practice’ policy, programs and systems, but should rather be the product of ‘building blocks’ interacting in each country’s unique historical, political and cultural context. Further, it is likely that every health system will have a variety of delivery channels beyond government, and that in many situations government itself may lack the capacity and commitment to finance and provide efficient and equitable health services;
- The incentives that have cut across health SWAps to date will not simply disappear. If health aid is to be improved and the strategic objectives of the underlying theory of change are to be achieved, aid delivery strategies need (to the extent possible) to account for these incentives, and devise approaches which remove or at least accommodate them.

The interplay between these key understandings is depicted in Figure 2 below.

**Figure 2: A conceptual framework for a revised approach to health SWAp**



In combining these understandings, the proposed approach aims to deliver more buy-in from key stakeholders (donor and government); provide a more efficient and appealing set of arrangements for the coordinated delivery of resources to the service delivery level; provide a clear, performance-based, politically-informed pathway for the progressive strengthening and use of government systems; and, on the back of these benefits, ultimately provide the space and opportunity for the emergence of policy and institutional forms that are more robust and domestically legitimate.

This approach is not presented as a panacea, but rather a strategy for an incremental improvement in aid effectiveness. The key elements of the approach are summarised below.

### **6.2.1. Focus 1: An iterative, incremental, politically informed approach to health policy/resource allocation**

Health aid should place less emphasis on the development of up-front, comprehensive sector policies and resource allocation frameworks. The focus

should be on supporting more iterative, incremental processes that aim to develop 'good enough' policies and associated systems and resource allocation. Central to this should be recognition of the primacy of domestic political contestation and settlement in the design and implementation of policies, systems and resource allocation decisions.

Donor support for this process should be through invited analysis, possible pilot/reviews in a few negotiated/agreed areas (with the access of the poor/marginalised to services being of high priority), and possible 'brokering' support to facilitate the emergence of developmental leadership and policy entrepreneurs in pursuing policies/actions which solve collective action problems (Booth 2011).

The desired incentive effect of this focus is:

- To provide space to develop indigenous contestation/ ownership of sector improvement strategies that are informed by ongoing reflection/refinement based on an understanding of performance/evidence, and the political context;
- To reduce time and pressure constraints on key government staff by not developing up-front policy documents (that in fact have little substantive meaning), and hence freeing these people to focus on implementation and incremental improvement actions;
- To meet the need for (some) donors to engage in policy dialogue, particularly focussing on the poor, through the more limited avenue of coordinated support for selected policy pilots/reviews;
- To possibly increase the commitment to health from central agencies and other stakeholders (if the perception is that change is being driven internally rather than by donors).

### **6.2.2. Focus 2: Sector 'building block' delivery mechanisms**

Health aid should be provided via a twin funding/delivery track which recognises:

- i) the primacy of government leadership in health system development (as a regulator, funder, and one of a possible range of providers);
- ii) that government commitment to effective development outcomes is not a given;
- iii) that even if government commitment is present, there may be the need to progressively build government capacity without premature overloading.

In this context, the first track would be budget support in order to provide more resources for government to fulfil its core business (be that regulation, financing or provision). To this end, a proportion of donor funding should be provided as budget support (if basic fiduciary standards are met). However, the level of aid provided as budget support should be dependent on performance (fiduciary and substantive) i.e. as evidence of effective management of funds and service coverage and quality increases/decreases/ plateaus, so should the level of donor budget support.

The second track would be a series of sectoral delivery mechanisms for the coordinated, unobtrusive, and accountable provision of key inputs (building blocks) to the service delivery level for clinical and public health services – be these government, NGO/faith, or private providers. As per the ‘building blocks’ understanding of health systems described above, one could envisage as few as five mechanisms providing the bulk of peripheral facility service delivery needs: 1) models of care/facility management support; 2) medical supplies/basic equipment; 3) facility maintenance/ renovation; 4) training; 5) funds for supervision/outreach/ referral. There could also be an additional technical assistance/capacity-building mechanism to support broader system strengthening, which can be thought of as ‘hybrids’. From the provider’s perspective these mechanisms should, as much as possible, look like and have the same requirements as government financing/ delivery, but they would have an element of external (donor financed/managed/contracted) oversight, delivery and accountability. These mechanisms would also differ fundamentally from project or even program-based assistance in that the inputs would be for

the whole system, not a selected part, and donors would be encouraged to jointly finance them (rather than developing individual projects).

These twin funding tracks would also differ from 'common fund' arrangements, criticised for increasing transaction costs and not facilitating a transition to government systems (Agha 2008) in two ways<sup>2</sup>. First, in this proposal budget support is the ultimate, preferred channel for donor support and there would be a clear, performance-based path to increase support. The proposed sectoral delivery mechanisms are meant to be an efficient 'fall back', providing the space to support service delivery while government systems strengthen. Second, given that the sector delivery mechanisms are not at the core of building government administrative capacity, there should not be a need for too much government time to be invested in the form of the mechanisms. The test is that the inputs to providers should appear as if they are from government.

Within this framework it is also conceivable that a relatively small number of the required sector support elements will not be adequately covered by the service delivery input elements described above (e.g. pre-service training, research, or community engagement/development). When the majority of donor support is being channelled through the above mechanisms, it is possible that these other areas could be provided for in the form of more traditional projects/ programs (noting that it is often the volume of projects that do harm, rather than projects per se).

It is also conceivable that donors, wishing to further enhance their visibility, could provide additional support to particular sub-national areas (provinces/districts). This form of support should be relatively easy to coordinate, as in general donor activity is less onerous at lower levels than at national levels.

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<sup>2</sup> Although it also needs to be recognised that there is some evidence that these parallel common fund or delivery mechanisms can positively influence core government system, with for example, in Bangladesh the World Banks procurement processes being adopted across Government (White 2007).

The desired incentive effects of this focus are:

- To provide an alternative to budget support and projects and to enable donors to offer appropriate levels of support to a sector, meet annual expenditure targets, and have some degree of attribution (if required).
- By including budget support as one (and the ultimately preferred) financing method and linking levels to performance, it gives (interested and capable) donors a stake in the performance of that system, and an incentive to government to improve performance (if indeed there is a desire within Government to strengthen its own system). Assuming performance can be transparently demonstrated, it also reduces the excuses for donors not to provide budget support.
- To provide additional/secure resources at the service delivery level in a way that does not undermine government financing/ provision or is inefficient (as is the case with the project modality), and hence provide the opportunity for improved morale, uptake of other efforts at that level, and the possibility of improved service delivery results.
- There is also the potential strategic effect that the provision of quality and consistent resources to local-level health services will build skills by ‘doing’ rather than planning, and in this process “create high energy processes, which build confidence and awareness and ignite self-organisation at the micro-level” (Hoffstaedter and Roche 2011).
- This approach does not prematurely overload government, and rather provides the space for government to identify and respond to performance issues, and improve the capacity of existing approaches in a more sustainable way or to develop new approaches.

### **6.2.3. Focus 3: Donor selectivity and staffing practices**

A sector framework as described above –iterative policy/resource allocation; and streamlined financing and delivery mechanisms – should also make it possible for donors to be more selective in their choice of interventions.

Only the most committed and capable donors would be expected to contribute to budget support as the performance engagement requirements that flow from this are likely to be demanding. In these situations, there will be a requirement for senior level staff with long-term country knowledge and high-level policy and political analysis skills.

Donors could also coordinate around the provision of key inputs into sector delivery mechanisms as described above – e.g. focussing on a particular input (e.g. training or medical supplies), or choosing to contribute to a number of inputs. These more generic inputs could be managed by generalist staff, or if donors wish to specialise, the choice of input would provide a clear focus for the desired skill set of staff.

This more flexible sector framework allows for a limited role for projects and/or geographic specialisation. This is an additional basis on which donors could focus their support and manage their staffing.

The desired incentive effect of this focus is to:

- Encourage donors to focus their support on fewer areas as a way of reducing the conceptual demands on their staff (hence potentially needing less staff, and being able to tailor staff more clearly to the type of support being provided);
- Provide a range of ways that donors are able to operate within a sector framework that can, if necessary, operate within existing donor staffing practices (i.e. they do not necessarily require higher-level or longer-term staff). Alternatively, a higher degree of specialisation of donor support clarifies the type of expertise/staffing that is required.

#### **6.2.4. Focus 4: Coordinated production and use of performance information**

Good health aid should have at its heart a robust and legitimate framework that produces timely and relevant information on the performance of the sector and its key actors (including donors). This information should be widely distributed to leaders, managers, providers, consumers, and have multiple mechanisms

which allow it to be considered and fed into policy and practice. The particular approach to aid delivery advocated here is critically dependent on a robust performance information system that is used by government to assess and calibrate improvement strategies.

The desired incentive effect of this focus is:

- To provide public scrutiny of the performance of actors in the sector in order to drive improved performance.
- To allow managers/donors with specific programmatic interests – (e.g. malaria, safe motherhood) to be able to maintain a focus on the systems performance in these areas by monitoring results rather than attempting to manipulate inputs.

## **7. Conclusion**

This paper has grappled with the apparent contradiction that lies within health SWAps between an approach to health aid that is conceptually sound, yet in practice has not lived up to expectations. The theory of change underpinning health SWAps is consistent with evidence of effective aid. In practice, the desired changes have not been evident. The paper has contended that health SWAps have been compromised by a range of powerful donor and government incentives and by particular understandings of the nature of SWAps and of health sector development more broadly. While there is no panacea for fixing this problem, there are good conceptual and practical grounds on which to consider re-thinking SWAps . This means moving away from unrealistic and onerous expectations of rational, 'best practice', policy-driven approaches to sector development, toward a focus on actions that support the emergence and sustainable development of robust, legitimate indigenous policy and institutional development processes. Suggestions have been made for how health SWAps could be reformed to provide more of this kind of support in a way that is more congruent with the incentives that frame donor and government support to the sector.

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