

Renewing the case for SWAp in health Donor darlings and strained partnerships – and what about aid orphans and participation by the poor?

Note from the panel discussion held in London on 27 September 2006

Over 50 people – from academic institutions, NGOs, DFID, and consultancy firms – gathered to participate in a panel discussion on sector wide approaches, organised by the HLSP Institute. The event also celebrated the launch of a new CD-ROM learning resource to promote sector wide approaches (SWAp) in health.

Background

New funding for AIDS, TB and malaria has resulted in a doubling or more of the health budget in many countries, mainly paying for targeted programmes to tackle these diseases. Some donors are putting non-earmarked resources through the general budget. Meanwhile, core health system functions, such as human resources and information systems, are often chronically under-funded.

In this environment, what benefits does a SWAp bring? How can a SWAp be most effective in harmonisation and alignment efforts? Can targeted programmes go hand in hand with sector wide approaches? And how can different stakeholders make the most of a SWAp?

The three speakers (speaking independently of their organisations) offered civil society, government and donor perspectives. They were: **Ms Robinah Kaitiritimba**, co-ordinator of the Uganda National Health Consumers Organisation, **Professor Sam Adjei**, Deputy Director General of the Ghana Health Service and a former Director of Research in the Ministry of Health, and **Dr Jorn Heldrup**, Senior Health Adviser in the Ministry of Foreign Affairs in Denmark. **Dr Ken Grant**, the HLSP Institute's Director, chaired the event.

A government perspective: the case of Ghana

Professor **Sam Adjei** focused on progress with the Ghanaian SWAp, describing national sector reform objectives and achievements over two five year programmes of work, supported by well established donor-MOH dialogue and review processes. In particular, there has been a shift of funds from central and tertiary levels to regions and districts. For example, district level allocations have increased from only 22% in 1996, to 44% in 2006. Systems strengthening has taken place with decentralised Budget Management Centres, together with improved financial management and funding releases, and drugs and supplies management.

However, continued constraints in overall budgets and human resources, and slow institutional change, mean that utilisation and health dividends are not increasing as hoped. The government-donor partnership in the SWAp is under pressure. As with all relationships, it requires good “marriage counselling” to prevent trust from fading. Continual earmarking means that transaction costs are still high.

Sam shared some revealing perspectives on the SWAp:

- “The one who dreamt about District Pooled Fund had a good dream” (District director);
- “You mean we will have to tell the MOH all about our salaries and allowances and use of our monies? That will be difficult! (Donor agency);
- “They will collect your money and put it in a basket and you will not be able to get it again!” (Vertical programme manager).

More rigorous evaluations are needed, together with better evidence-based decision making. Donors must work together and avoid conflicting signals on strategies, and ownership of government is paramount. System strengthening should not be an afterthought. The health sector will continue to face constraints, and health reforms appear to be the way to go for such resource constrained countries. Outstanding questions remain on harmonising global level resource mobilisation strategies with country led approaches, and community education and empowerment.

The view from civil society

The Uganda National Health Consumers Organisation (UNHCO) is, along with many other civil society groups, taking an active role in building awareness of rights and obligations among health service consumers and providers in Uganda, from local community groups to the highest level. With financial support from DFID, the organisation is also receiving support for consumer participation in high level health sector working bodies.

Ms Kaitiritimba acknowledged the progress made in Uganda through the SWAp, including more funding for pro-poor health interventions, decentralisation to districts, and stronger management at the centre. She stressed the importance of good governance in access to quality and affordable services - increased transparency, participation and inclusion. There is chronic lack of community empowerment for participation in government programmes, together with limited accountability, a lack of a supportive legal framework and mechanisms for timely redress of complaints. This is coupled with continued inadequate capacity at the district level for planning, management, budgeting, and M&E. There is a heavy focus on curative and clinical aspects of health rather than wider public health concerns, and limited partnerships with non-clinical partners, such as civil society groups, for advocacy and health promotion objectives

Robinah reminded the audience that poor people define poverty beyond income, to include “a sense of powerlessness, inability to influence what is happening around them” and that “limited progress has been made in empowering communities to take responsibility for their own health” (Uganda MOH).

Vivid examples showed how people experience the health system...

- *“The health workers are never there on time, and they take a very long time to act, and they are very abusive, so women find it better to visit the traditional healers”.*
- *“The reason why mothers do not come to deliver here and instead go to traditional birth attendants is because there are no curtains and our right to privacy is violated.”*

...and how small changes in informing and empowering local people can make a difference:

- *“Now we can tell when drugs are supplied to the health centre and when they are not available, since everything is put on the notice board, unlike other times when we were just told to go and buy from the pharmacy without any explanation”.*
- *“In one of the community dialogue meetings with the health workers organized by UNHCO, we found out that the patient’s right to privacy was being violated. We decided to ask the health unit to make partitions so that patients are separated by sex and types of illnesses suffered.”*

Robinah also provoked debate by advocating for better co-ordination both within and across SWAps, pointing to the many multiple structures at community level linked to numerous health programmes (malaria ITN distributors, parish development committees, village health teams, HIV/AIDS initiatives), as well as structures linked to water and agriculture. This proliferation does not make sense for people, and fails to address gender, poverty and other underlying factors contributing to inequality.

A donor’s perspective

Dr **Jorn Heldrup**, from Danida, described the value of a SWAp in scaling up support through existing arrangements, especially in so called “donor darling” countries, with the development of country-driven, fully costed, long-term national programmes for health sector development, compatible with the overall development strategy (PRSPs/MDGs). However, harmonization and alignment between health and HIV/AIDS responses continue to be critical to address in scaling up for better health. A more systematic framework is needed for addressing key health system development issues. This would include issues such as policies, priority setting, planning, financing, links with the HIV and AIDS agenda, and human resources for health.

Transparent and independent monitoring, and joint reviews are required to promote the accountability of recipient governments, national stakeholders and development partners. It would be useful to develop a results-based operational framework for more effective harmonized bilateral support to health sector development, in the context of scaling up to achieve better health outcomes – a “SWAp-plus”. A critical mass of lead development partners can offer useful leverage. For example, partnership is needed to develop pooled funds for technical assistance.

Global health partnerships (GHPs), with their targeted programme funding, offer challenges and opportunities. GAVI’s Health Systems Strengthening (HSS) is one of a number of new initiatives, which has the potential for proving that targeted GHPs can go hand in hand with SWAps. But GAVI and GFATM should not be driving forces of HSS – they need to be part of broader global efforts for a more systematic approach to HSS. GHPs may need to move an increasing proportion of their aid from earmarked funding to non-earmarked funding to secure a balanced funding of the health sector.

Jorn offered the following food for thought:

- Should high cost interventions, such as antiretrovirals for AIDS treatment, the pentavalent Hib vaccine and artemisinin combination therapy be provided as commodity support for low income countries – is there a need for one Global Commodity Fund? The development of UNITAID appears to be following that path for AIDS, TB and malaria.
- Should there be support for the establishment of a global forum/partnership for health systems development in scaling up an essential set of health interventions (linked to PRSPs/MDGs)?
- Do we need a new more inclusive health sector development approach for the health sector, especially for fragile states and aid orphans? The health MDGs will not be reached if we continue business as usual here. Increased aid funding for health has already been committed, but scaling up support may require innovative mechanisms and funding streams (with a special role for multilaterals and GHPs).
- Is additional support needed to develop new, or to expand existing, bilateral and multilateral financing vehicles that can deliver predictable funding?

Discussion

The presentations were followed by a lively debate, with several issues raised by the audience.

- How does a citizen-consumer group manage the complexity and compromises of being “in bed with” the government and/or with donors, as well as being associated with very high and unrealistic consumer expectations? It is important to set, and stick to, a clear strategy without being distracted by either government or donors, to be flexible, and to develop a clear understanding of what a rights based approach means in a low income country.
- The all important issue of politics and institutional relationships needs to be taken into account – it can be helpful to map and monitor these as the SWAp develops.
- The role of the multilaterals needs to be strengthened, including management and ability to deliver measurable results, for example in capacity building and advocacy to government.
- Given the importance of enabling the inclusion of targeted programme funding, we need to think about “soft” and “hard” earmarks in the SWAp, and how funding can be provided from the global level in a way that complements other sector funding, and is linked to results rather than inputs.

Note

A SWAp can be defined as an arrangement whereby donors work with government to deliver a commonly agreed health policy and strategy, with the view to building ownership, enhancing aid effectiveness, and reducing transaction costs.

The learning resource ‘Effective Development Assistance: A Guide to Sector Wide Approaches’ is a new CD-ROM providing step by step guidance on the aims and principles of SWAps, and their operation in the wider aid financing environment. It is aimed at users who are both experienced and less familiar with SWAps, and is available free of charge from the HLSP Institute.

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