



Royal Tropical Institute

**Moving towards a sector-wide approach
(SWAp) for health in fragile states:
Lessons learned on the state of readiness in Timor Leste,
Sierra Leone and Democratic Republic of Congo**

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Acronyms and abbreviations

DACO	Development Assistance Coordination Office
DFID	UK Department for International Development
DGIS	Dutch Ministry of Foreign Affairs
DRC	Democratic Republic of Congo
EC	European Commission
GAVI	Global Alliance for Vaccines and Immunisation
GBS	General Budget Support
GDP	Gross Domestic Product
GFTAM	Global Fund Tuberculosis, Aids & Malaria
GoSL	Government of Sierra Leone
HIPC	Heavily Indebted Poor Countries
HRM	Human Resource Management
HSSP	Health Systems Strategic Plan
ILO	International Labour Organisation
KIT	Royal Tropical Institute
MDG	Millennium Development Goal
M&E	Monitoring & Evaluation
MOF	Ministry of Finance
MOH	Ministry of Health
MoHS	Ministry of Health and Sanitation
MOP	Ministry of Planning
MTEF	Medium Term Expenditure Framework
NGO	Non Governmental Organisation
NHDP	National Health Development Plan
NHSS	National Health Sector Strategy
OECD/DAC	Organisation for Economic Cooperation/Development Assistance Committee
PEFA	Public Expenditure Financial Accountability
PETS	Public Expenditure Tracking Survey
PFM	Public Financial Management
PIU	Programme Implementation Unit
PNDS	Plan National de Développement Sanitaire
PRSP	Poverty Reduction Strategy Paper
RCH	Reproductive and Child Health
SIHSP	Support to Implementation of Health Sector Investment Program
SRSS	Stratégie de Renforcement du Système de Santé
SWAp	Sector Wide Approach
UN	United Nations
UNICEF	The United Nations Children's Fund
USAID	United States Agency for International Development
USD	United States Dollars
WB	World Bank
WHO	World Health Organisation

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Full responsibility for the contents of this paper remains with the authors. The contents of the paper do not necessarily represent those of the government authorities or development partners consulted.

Executive summary

Why explore readiness for a Sector Wide Approach (SWAp) in post-conflict contexts?

Evidence demonstrates that when shifting from a humanitarian to a development mode, more streamlined and coordinated policy and management processes can assist in strengthening health systems and service delivery in recovery settings. Based on a comprehensive literature review conducted as a precursor to this study, there is a notable paucity of evidence on the application of a sector wide approach (SWAp) in post-conflict contexts. A more systematic understanding of progress made in moving towards a sector wide approach as well as identifying the determinants of success for recovering health sectors is required.

Sector wide approaches aim to broaden government and national ownership over public sector policy and resource allocation decision making and practice within the sector. This increases coherence between policy, spending and results which consequently reduces transaction costs. This is clearly described by the definition of the term: *"All significant funding for the sector supports a single sector policy and expenditure programme, under government leadership, adopting common approaches across the sector and progressing towards relying on government procedures for all funds"* (Foster, M. 2000).

What is the scope of the field studies and this synthesis paper?

The country studies as undertaken in 2009-2010 aim to generate a better understanding of the basic requirements for a sector wide approach while assessing progress already made in early recovery health sectors including attention to the approaches adopted to strengthen health systems and service delivery. The opportunity to conduct field assessments enabled the research teams to explore the current conditions for moving towards a sector wide approach to the health sector in three post-conflict states: Timor Leste, Sierra Leone and Democratic Republic of Congo (DRC). This study addresses key lessons learned with regards to the desirability and feasibility of SWAps in post-conflict health sector settings; the progress that these three countries have made in putting in place the six major SWAp building blocks; the drivers and barriers to early SWAp development within these countries; and how to enhance SWAp implementation within health sectors that are in transition from humanitarian to development aid.

What methodological framework captured the aim and objectives of the study?

A three stage process was carried out. This included a desk study, field research in three countries and a synthesis paper. A full review of the essential components of a sector wide approach, with a concrete assessment of the existing structures and processes that are regarded as SWAp elements, was also undertaken. The conceptual framework included all six elements of a SWAp and an assessment of the breadth and depth of each element was undertaken in each context:

- 1. Government leadership of the sector through sustained partnership*
- 2. A clear, nationally-owned sector policy and strategy, derived from broad-based stakeholder consultation and which is supported by all significant funding agencies*
- 3. A (medium term) budget and expenditure framework which reflects sector policy*
- 4. Shared processes and approaches for planning, implementing and managing sector strategy*
- 5. A sector performance framework monitoring against jointly agreed targets*
- 6. Commitment to move towards greater reliance on government financial management and accountability systems*

In addition to the analysis of these six elements, a cross-cutting approach to assess institutional capacity within each Ministry of Health, as well as an analysis of the external forces/determinants (e.g. changing political dynamics, public-private partnership reform) was undertaken. The studies involved analysis of country level primary and secondary data, interviews with government and development partners and (de)briefing workshops with all key stakeholders.

What do the field studies in Sierra Leone, Timor Leste and DRC reveal?

Findings from the field studies highlight that SWAp is not a universally endorsed approach and, consistent with findings in more stable contexts, it is indeed an iterative process and not a panacea that will resolve fragmentation and incoherence. Rather, it moves towards more coherent sector wide engagement through a process that involves trial and error. It is frequently challenged by the existence of diverse aid modalities, fragile government leadership and capacity and unpredictable donor policy and behaviour. Given the complexity of the ways in which post-conflict aid architecture interacts with mixed motivations, attention to both process and mechanisms for improved partnership and coordination are key to achieving better results. For these reasons, SWAPs require the continued commitment of all partners, along with sustained efforts for capacity building along the continuum of the six core SWAp elements.

In summarising the findings from the diverse contexts studied, general findings emerged regarding strengths, opportunities, weaknesses and threats to the trajectory of a SWAp in early recovery settings. The key strengths identified include the existence of sector and sub-sector wide strategies supported by both committed donors and implementing agencies; improved leadership/ownership of policy formulation and planning processes and products; the existence of basic sector coordination processes which focus primarily on information sharing; and the existence of basic budgeting processes and procedures at national (and in some cases at sub-national) levels. Opportunities for further strengthening of the approach also exist. These include a notable shift from relief to development modes in all cases; the commitment of a few large donors to supporting sector programme implementation through a multi-year plan; political commitment to decentralisation (which can enable better resource allocation, improved accountability and capacities at the local level); and the existence of vertical programme funds that represent a considerable amount of funding which can be used for systems building.

Despite these promising developments that prevail in virtually all of the contexts studied, there are also weaknesses and threats that can undermine both readiness and progress. These include poor sector stewardship with a gap between expressed national and sub-sector policy priorities and subsequent results; harmful donor practices (off-budget, unpredictable, un-harmonised aid); limited use of country Public Financial Management systems; lack of capacity in budgeting/finance processes; and limited use of government and development partner data (individually driven monitoring/evaluation occurs instead). Some major, prevalent, threats to current investments which require ongoing risk analysis were also identified: rapid political change and flux with implications for management turnover (both within government and donor agencies); breakdown of governance structures and/or lack of basic accountability/transparency processes; continued unpredictable and problematic external aid; and significant amounts of vertical funding earmarked for specific disease programming, thus potentially creating financial and technical distortions in the system.

What are the recommendations in moving forward towards a SWAp?

Overall, the study illustrates that sector wide efforts in health in post-conflict contexts are in the early stages of development. Considering the national impact of fragility, and an overall vacuum in government capacity, expectations for health sectors in recovery will need to be reconsidered in terms of both pace and the sequencing of sector-wide development milestones. From a national perspective, a common understanding of health sector development priorities, as expressed in national policies and plans, is needed. This will further clarify partnership expectations and resource support needs. This, in turn, needs to be translated into a medium term expenditure framework for resource allocation. Secondly, strong institutional relationships with common procedures, systems and incentive mechanisms are vital to cementing alignment and harmonisation efforts. Finally, a broader government public sector reform agenda requires due attention as such an agenda plays an important role in determining the success of sector wide approaches.

From the perspective of development agencies, several key recommendations are critical to strengthening partnerships and aid coordination. Predictable relationships built on trust can ensure that commitments are honoured – a key principle as embodied in the Paris Declaration on Aid Effectiveness (2005). Both donors and governments need to promote sustainable institutional capacity building based on an agreed framework that supports medium term strategic plans in the health sector. In order to measure results, joint monitoring and evaluation for lesson learning and accountability is required. This is the weakest link in all contexts.

In order to achieve a trajectory towards a SWAp, a two-stage approach is recommended. Major attention should initially be geared towards three of the six SWAp elements, namely: policy formulation and coherence with strategic planning and implementation; sector wide coordination; and the development of a basic expenditure framework with cross-cutting institutional capacity building. This should be followed with investment in and a deepening of all six SWAp elements allowing a realistic and contextually specific timeframe that will service the interests of both the government and development partners.

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1 Introduction

Since the signing of the Paris Declaration on Aid Effectiveness in 2005¹, enhancing aid effectiveness has played an increasingly important role in promoting stronger partnerships between developing country governments and development partners to achieve the Millennium Development Goals (MDGs). A central theme on the agenda is how the agreed principles of the declaration can be translated into improved approaches to aid as well as appropriate funding modalities that aim to strengthen the institutional capacity of partner governments and foster better results in the fight against poverty. In the health sector, recent initiatives have proliferated with the goal of strengthening national health systems and promoting more efficient and effective practices among development partners. At a global level, the International Health Partnership², the Catalytic Initiative³ and others are underway. At regional and national levels, there is a growth in institutional mechanisms towards improving accountability for results.

One priority step for moving forward with health sector reform is the promotion and development of sector wide approaches (SWAs). These, by their very nature, foster government and development partnership. Using a systems approach, they strengthen national ownership and improve coherence between policies, spending and results. At the same time, they attempt to reduce transaction costs⁴. SWAs can be supported by one or more sector programmes which, in turn, can be financed by donors using different aid modalities (e.g. general/sector budget support, pooled funds, project aid, debt relief). Experiences with SWAs in more stable developing country contexts have shown that they can indeed contribute to improved national ownership and leadership; donor harmonisation and alignment; and greater coherence, transparency and accountability along the policy-result chain⁵.

A number of post-conflict countries have also initiated early steps towards SWAs. Evidence demonstrates that when shifting from a humanitarian to a development mode, more streamlined and coordinated policy and management processes can assist in strengthening health systems and service delivery in recovery settings. The fragility of a country, however, has major implications for governments and development partners who wish to move together towards an improved approach to partnership. This fact is widely articulated in the literature on fragile states, state building and aid effectiveness⁶. Particular attention needs to be paid to the determinants that influence (re)building sustained, meaningful partnerships that are underpinned by trust. A more systematic understanding of the progress made moving towards a sector wide approach in fragile states, as well as noting determinants of success, is required. There is, in addition, a paucity of literature on the application of SWA in such contexts. Such literature has the potential to both catalyse, and create stronger coherence within post-conflict health sectors.

In this framework, the Royal Tropical Institute (KIT) has undertaken formative research on the subject of improving aid effectiveness. Aside from two pre-cursor studies, KIT has also carried out a series of assessments in post-conflict countries to determine readiness for transition to SWAs in the health sector. This paper explores the current conditions for a sector wide approach in three

¹ The Paris Declaration, endorsed on 2 March 2005, is an international agreement to which over one hundred Ministers, Heads of Agencies and other Senior Officials adhered and committed their countries and organisations to continue to increase efforts in harmonisation, alignment and managing aid for results with a set of monitorable actions and indicators (www.oecd.org).

² Established September 2007 with initial funding from Norad and DFID.

³ The Catalytic Initiative to Save a Million Lives is a global investment in child and maternal health focusing on the MDG goal of reducing child mortality rate by two thirds by 2015. Partners include various governments, UNICEF, WHO, WB and private foundations.

⁴ Foster, M. 2000.

⁵ World Bank, 2009.

⁶ Canavan, A. and Vergeer, P. 2008.

post-conflict states: Timor Leste, Sierra Leone and Democratic Republic of Congo (DRC). It addresses key lessons learned regarding the desirability and feasibility of SWAp in post-conflict health sector settings; the progress that these countries have made in implementing the six major SWAp building blocks; the drivers and barriers to early SWAp development; and how to enhance SWAp implementation in fragile states.

It should be noted that, despite broad international agreement on what constitutes the basic features of a SWAp, there are variations in its basic components, working methods and management arrangements. In general, SWAps are considered to be shaped by principle rather than prescription⁷. In other words, SWAps are an approach, not a blueprint⁸. They are, above all, a process whose nature depends on the specific circumstances of a particular country. Therefore, this paper regards SWAp readiness as an organically maturing process that involves the evolution of a number of key components – rather than a specific set of minimum conditions which need to be fulfilled.

⁷ Cassels and Janovsky, 1997.

⁸ Cassels, 1997.

2 Methodology

The significant findings highlighted in this paper are derived from a three-stage process. First, an extensive literature review was undertaken. This documented past and present SWAp experiences in contexts around the world which informed the development of an assessment methodology for SWAp readiness in fragile states⁹. In Timor Leste and Sierra Leone, a comprehensive readiness assessment was undertaken; in DRC a study on aid mechanisms and their contribution to the health sector was carried out, based on a concurrent study commissioned by the World Health Organisation (WHO) on the contribution of debt relief to the health sector. The DRC study findings were further augmented by IDPM in 2010 during a follow up visit. The overall approach, at both global and national levels, consisted of analysing primary and secondary data, conducting interviews with government and development partners and, in the case of Sierra Leone, fieldwork at the central level and in two districts. This synthesis is based on collective experiences across diverse contexts with the aim of assessing SWAp readiness in post-conflict environments.

Based on a cross-donor comparison of SWAp definitions, KIT used the six core elements that are commonly accepted as the key building blocks for a sector wide approach:

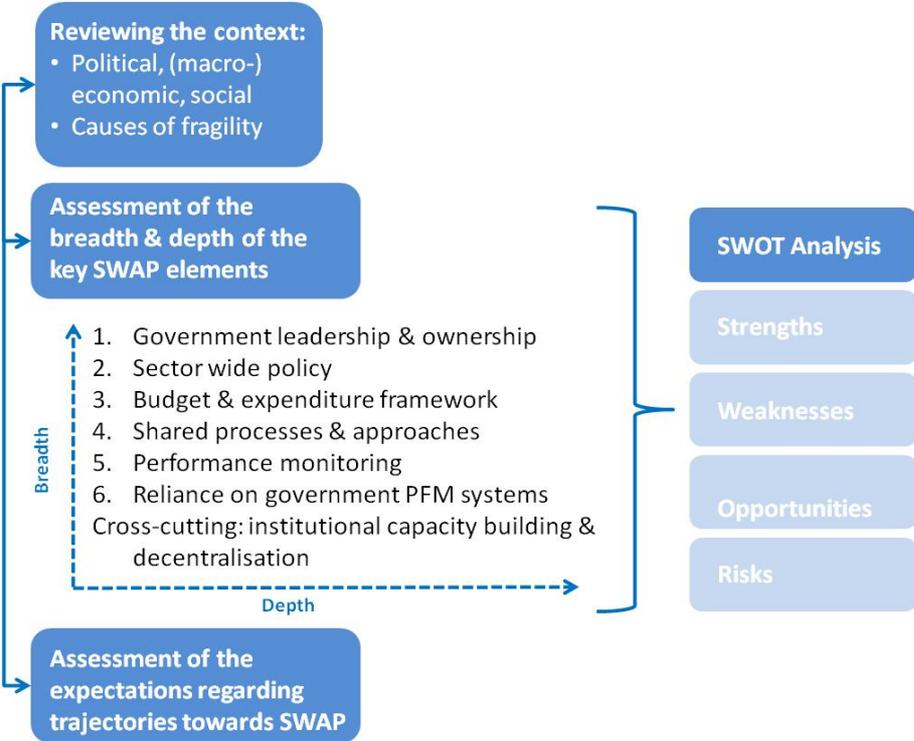
1. Government leadership of the sector through sustained partnership
2. A clear, nationally-owned, sector policy and strategy that is derived from broad-based stakeholder consultation with the support of all significant funding agencies
3. A (medium term) budget and expenditure framework which reflects sector policy
4. Shared processes and approaches for planning, implementing and managing sector strategy
5. A sector performance framework monitoring against jointly agreed targets
6. Commitment to move to greater reliance on government financial management and accountability systems

The review also consisted of an assessment of both the breadth and depth of a SWAp for all of the above six elements. Breadth refers to whether a sector has achieved all or some of the elements while depth refers to the effectiveness with which these core SWAp elements are being implemented. Each SWAp element was discussed and rated against a set of criteria as shown (Tables 1 – 7) and a summary of the aggregate picture of breadth and depth is shown in Table 8. These results however only reflect the developments up to the time of field visits; (Sierra Leone (July 2009) and Timor Leste (September, 2009) and DR Congo (2009-2010). This excludes some later health reforms that were planned in some cases, but not yet implemented (eg, launch of Free Health Care Initiative (FHCI) in Sierra Leone, Health Sector Reform Project Phase II in Timor Leste (January 2010).

An in-depth review of the key contextual factors (political, (macro) economic and social environment and the causes of fragility) also provided valuable insights with regards to the assessment of SWAp readiness. Cross cutting developments including institutional capacity and the progress of decentralisation were also assessed as key contributions to advancing health sector development. Along with a review of the expectations of different actors, with the aim of strengthening sector wide efforts, the analysis generated strengths and weaknesses in relation to current policy, management and coordination arrangements in the health sector. It also identified future opportunities and risks. The analytical framework is presented in *Figure 1* below.

⁹ Canavan, A. Rothmann, I. 2009.

Figure 1: Analytical framework



Source: Canavan, A. Rothmann, I. (2009) *Assessment of readiness for a Sector Wide Approach in fragile states: A methodological framework*, Royal Tropical Institute of the Netherlands (KIT) December 2009.

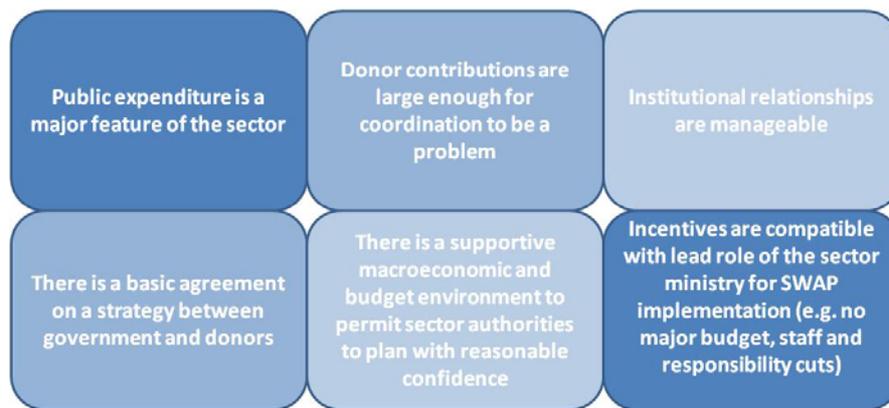
This paper also provides insights into the key drivers and barriers to SWAp readiness given government and donor policies. It identifies key determinants inherently critical to enhancing early SWAp development in post-conflict contexts. It addresses the conditions and groundwork necessary to pave the way for the introduction of more coherent planning and implementation that can ensure optimal health services are delivered to populations recovering from conflict.

3 Desirability and feasibility of SWAp in post-conflict health sector settings

Experiences with SWAp in more stable developing country contexts show that they can contribute to improved national ownership and leadership; donor harmonisation and alignment; and greater coherence, transparency and accountability along the policy-result chain. Working with SWAp, however, has not proved consistent with a rational linear model. It is, rather, characterised by iterative processes – a ‘trial and error’ approach. Even more stable environments are only in the early stages of SWAp development and their design and success formulas have varied across countries. Working towards a SWAp therefore requires continued commitment by all partners and persistent capacity building along the continuum of the six core SWAp elements.

Mick Foster (2000)¹⁰ argues that there a number of circumstances under which SWAp are desirable and feasible (*Figure 2*) and that most traditional developing countries working with SWAp comply with these conditions. An important question is, however, whether this is also the case in post-conflict contexts.

Figure 2: The Foster criteria for SWAp desirability and feasibility



Source: M. Foster, 2000.

When comparing the health sectors in the three countries, initial findings highlight the need for changing the ways in which governments and development partners coordinate when shifting from humanitarian relief towards development aid modalities. In a previous study¹¹, the flexibility and complementarity of aid mechanisms were found to be important determinants for enabling longer term health sector planning. Simultaneously, flexibility and complementarity also ensure the continued delivery of essential health services. Donors, however, tend to use parallel funding modalities due to unstable and high risk environments in recipient countries. The result of this is variable progress related to both time and sequencing in the transition towards a more developmental approach. Given a development focus, attention is geared towards more streamlined and coordinated policy, finance and management processes, as well as to supporting the rebuilding of long term government capacity. As uncertainty and risk become more manageable, donors may be willing to incrementally shift to more aligned aid modalities that use government systems.

¹⁰ Foster, M. 2000.

¹¹ Vergeer, P. Canavan, A., & Rothmann, I. 2009.

SWApS can assist at these important cross-roads as an organising framework. They can act as an anchor for efforts that aim to facilitate strengthening health systems through more streamlined, coordinated and coherent processes in terms of spending, policy and results. Using the Foster (2000) feasibility and desirability of SWApS criteria, the following observations were made;

1. *Public expenditure is a major feature of the sector:* In all three countries, a public-private partnership modality characterises the “modus operandi” for the delivery of health services. Per capita national health expenditure in 2007 was USD 2 in Timor Leste, USD 1.64 in Sierra Leone and USD 1.99¹² in DRC. However, the overall contribution of the public sector to health service financing does not meet the needs of the population. There exists a major shortfall in the volume of aid required to meet the MDGs¹³. Private, out-of-pocket, expenditures are remarkably high and this has a negative impact on poor and vulnerable people in particular. In the post-conflict context, NGOs play a relatively more important service delivery role than in other developing country contexts.
2. *While donor contribution is high, coordination is a problem:* Health is typically a focus for many donors in the three countries but the diverse initiatives of the United Nations (UN), multilateral and bilateral operations as well as private non-profit project aid (NGOs) are fragmented and uncoordinated. In the case of DRC, the situation is further complicated as health-related development aid runs parallel to emergency aid financing. In fact, high risk environments prompt donors to use parallel funding mechanisms.
3. *Manageable institutional relationships:* Relationships within the sector are potentially quite manageable, as the main budget responsibility lies with a single ministry, the Ministry of Health. There are examples of donors increasingly working towards joint approaches which facilitate sector management, but delegation of responsibilities among donors is still rare and each of the main donors demands a strong voice in policy dialogue.
4. *Agreement on sector strategy:* In all three countries, there is basic agreement between government and development partners on a national policy and sector strategy.
5. *Supportive macroeconomic and budget environment:* Macroeconomic environments in these three countries are relatively stable and each country is on-track with regards to their respective IMF programmes¹⁴. A basic budget process is in place in all three contexts with efforts to work with Medium Term Expenditure Frameworks (MTEFs) and to strengthen wider Public Financial Management (PFM) capacity building. Strategic planning and budgeting is weak, however, and volatile resource access undermines the ability of health sector authorities to plan and budget with confidence.
6. *Compatible incentives to SWAp reform:* Wider incentives around civil service reform, staffing, budgets and responsibilities are reasonably compatible with the lead role the Ministry of Health is expected to play during SWAp implementation. Overall objectives for improving health service quantity, quality, equity and access are also compatible. The availability of budget resources is undermined by both weak and volatile domestic revenue mobilisation and high aid unpredictability. In an attempt to address urgent service delivery needs, governments are in favour of early decentralisation of primary health service delivery. The decentralisation process, however, adds to the complexity of sector wide management due to changes in the roles and responsibilities of central and sub-national authorities.

¹² Government of DRC, 2010a.

¹³ The WHO Commission for Macroeconomics and Health estimated that spending of USD 38 per capita is needed to achieve adequate health services.

¹⁴ DRC was off track between June 2006 and July 2009.

The application of the Foster criteria also highlights that the constraints associated with fragile states have major implications for SWAp readiness in these three countries. Sector wide management is undermined by political uncertainty and this has implications for sector leadership, policy direction and operational management. Institutional relationships between the main actors in the sector are often in need of (re)building trust and confidence in order to move forward. Chronic conflict destroyed essential government capacities along the entire policy-budget-result chain. In some cases, such as in DRC, these essential capacities may never have been in place even prior to the ensuing conflict. There is a lack of understanding and information of how the sector and its main actors operate. Typically, the overwhelming task for a nascent ministry is one of addressing numerous and often competing priorities for service delivery and capacity building. This makes it difficult to agree on priorities and to convince donors to commit to joint approaches and predictable, long term funding. Another major obstacle is the lack of predictable domestic and external revenues that arises from fragility. For this reason, uncertainty arises for medium term sector wide strategic planning and budgeting. The approach and effectiveness of wider public sector reforms (e.g. in human resource and financial management and decentralisation) add to the complexity of SWAp implementation.

While SWAps seem desirable in the three post-conflict country situations, there are uncertainties with regards to their feasibility due to the legacy of pre-war gaps in state capacity, compounded by their institutional status as they emerge from prolonged conflict. For this reason, we extend our analysis to a review of the progress that each country has made in moving forward with SWAps and in incrementally building the six major elements as described above. From this review, we identify the major drivers and barriers to SWAp feasibility and implementation.

4 Progress in putting the six major SWAp building blocks in place

4.1 Government leadership for health sector development

A core element for effective SWAp design and implementation is sound and sustained government leadership for health sector development. Important determinants of government leadership are leadership capacity and ownership over the sector reform process. Good leaders have appropriate management skills. They are equipped to plan, budget, coordinate and monitor and are able to influence, build and motivate teams. They are able to provide direction, support and standards for accomplishment, communication, hiring and staffing and can offer a compelling vision for the sector¹⁵. SWAps can foster the development of leadership capacity through improved dialogue and harmonisation of management procedures between governments and donors¹⁶.

All three countries have developed a health sector strategy to guide health sector reform measures over the medium term. Timor Leste and DRC both work with an approved health sector strategy. The Ministry of Health (MOH) in Timor Leste is in the process of defining "Vision 2030" in order to move towards sustainable development. In DRC, the National Health Development Plan (NHDP) (2011-2015) is the first multi-year implementation plan for the National Health Sector Strategy (NHSS). Its planning cycle is aimed to coincide with that of the newly developing Poverty Reduction Strategy Paper (PRSP). Sierra Leone has more recently developed a national health strategy (ratified in 2009). This was preceded by a Reproductive and Child Health (RCH) policy and strategy at the sub-sector level has catalysed multi-year donor commitments. The level of ownership by the Ministries of Health for national sector policy development has noticeably improved in recent years. All health sector strategies have been developed with strong support by donors. The Health Ministries demonstrate concerted initiative and leadership regarding strategy development and consultation and debate processes.

Ownership over resources and implementation by the Ministries of Health is undermined by the fact that most resources are externally financed by development partners whose aid is very fragmented, uncoordinated, off-budget and only partially aligned with government systems and strategies. Although donors pay lip service to government strategy, their approaches are often not in line with national health sector strategy. Governments lack leadership in terms of aligning donor interventions with their own strategy. They tend to accept all donor-proposals, even those that are clearly at odds with their own formulated strategy (such as vertical approaches). At the same time, the share of domestic revenues allocated to the health sector are small and internal sector revenue mobilisation efforts (e.g. through user fees) are often inefficient and unenforced. Programme implementation is hampered by weak institutional capacities, skills and knowledge within the health workforce. The adoption of parallel project implementation units, (often with separate staff for planning, administration and finance), further challenges a streamlined approach to building institutional capacity. The phenomena of Program Implementation Units (PIU), which have proliferated with the advent of global fund partnerships and multilateral funding arrangements, are a barrier to embedding financial management systems within government institutions. The hiring of senior government staff at competitive salaries has also created a brain drain effect on the mainstream operations of the health sector.

¹⁵ Hogan, R., Kaiser, R. 2004.

¹⁶ Shepherd, A., Cabral, L. 2008.

Frequent changes in leadership, at both political and technical levels, further challenges sustained development. New government decision-makers need time to gain experience, understand sector processes and align with new government vision. This often has significant implications for the realignment of work mandates. New strategic directions and political priorities are not always well received by technical staff and can lead to delays in health policy and strategy endorsement. In DRC, changes to ministerial and directorial portfolios at national and provincial levels have undermined ownership and delayed implementation of health sector programmes. In Timor Leste, the appointment of the new Minister of Health in 2007 led to major internal restructuring and a shift in the roles, responsibilities and relationships of authorities at both political and technical levels. The new minister plays a strong leadership role and has a high profile at an operational level. Meanwhile, the Director General and senior department directors are insufficiently harmonised in their approach to coordination and their delivery of management directives. This results in both a fragmentation of efforts and vertical programming. In Sierra Leone, the election of a new government in 2007, along with a subsequent reshuffling of the cabinet and additional changes within the MoHS in 2008, has led to administrative and staffing changes (e.g. the appointment of a new Chief Medical Officer and Primary Health Care Director and the establishment of Reproductive and Child Health department). Strategic priorities have changed, as have institutional arrangements, sub-sector leadership and staffing dynamics. In DRC, given occasional ministerial portfolio changes, no similar shift in policy has occurred within the time period studied.

Central to sector leadership capacity is the availability of adequately skilled human resources and the presence of appropriate structures and systems necessary for managers and staff to function effectively. All three countries struggle with a severe lack of skilled personnel. Conflict has eroded crucial capacities and induced a massive brain drain out of the country. Low remuneration and poor working environments also make it difficult to attract and retain people with valuable skills and knowledge. Existing organograms for the structure of Health Ministries reflect a dual arrangement that splits technical and administrative line management. Such structures have not yet taken into account decentralisation-related organisational changes. Usually, cross-department work does not take place in a streamlined way. Internal collaboration and coordination are not formalised and are dependent on personal discretion and engagement. The absence of competent staff at middle and peripheral management levels means that senior management staff are overwhelmed with both macro and micro management decisions. This very "thin layer" of senior expertise (usually only at the central level) does not allow for the accelerated implementation of national plans and strategies developed by national policy makers. Neither does it allow for "good enough governance" with regulatory mechanisms in place such as accountability structures and adequate monitoring.

Transparency and accountability are an important means through which SWAPs can foster sector leadership. These, however, were found to be weak in all three countries. Regular annual health sector reviews take place in Timor Leste and DRC while in Sierra Leone it is unclear whether such processes have taken place since 2004. In all three countries, the "voice of civil society" in planning and monitoring and evaluation processes is still nascent, although in DRC, civil society has been consulted at the district level and is in the process of drafting a NHDP for 2011-2015¹⁷. Decentralisation processes aim, in theory, to promote greater local accountability. In practice, however, it will take many years for processes and systems to be built at sub-national levels that hold authorities accountable for service results. Little cognisance of local power structures and minimal inclusion of local power authorities in government administrative decision processes limit the transparency and accountability of government services vis-à-vis local constituencies. In Sierra

¹⁷ Government of DRC, 2010a.

Leone, experiments relating to performance-based management at senior levels of the health sector have taken place. As a result, the president introduced performance-based management for all line ministries. This management strategy calls for quarterly reporting against key performance results. Such approaches are results-focused and stimulate greater upward accountability. However, they do need to be more consultative, better aligned with priorities laid out in national health sector strategies and verified against the real achievements of the sector. In DRC, the government involved sub-national authorities, provinces and health zones to draft the NHDP. The Provincial Health Development Plans that resulted from this process have been approved by their respective provincial governments and now function as provincial health sector plans¹⁸.

Overall, well-articulated vision and slow-growing government ownership within each country's health sector (at both central and peripheral levels) emerged. Limited time and resources, unfortunately, did not permit a full enquiry at decentralised levels. Interviews and reports reveal efforts to promote local government for health service management while recognising that capacities are still weak. This undermines the ability to be consistent when accounting for the results of investments by donors and government departments.

Table 1: Sound and sustained government leadership for health sector development

Features	Timor Leste	Sierra Leone	DRC
Well articulated vision for health sector development	Medium	Medium	Medium
Government ownership over policy, resources and implementation	Medium	Low	Low
Transparency & accountability for health results	Low	Low	Low
Overall	Medium	Low	Low

Scale: Depth of a SWAp rated as low, medium or high.

4.2 Sector policy

Another basic cornerstone of a SWAp is government owned sector wide policies. These are characterised by broad-based consultation with development partners. They are aligned and coherent with national priorities and sub-sector strategies. However, the reality of national health policies and plans also needs to be put to the test, particularly in post-conflict countries. For a sector policy to anchor sector wide efforts, an overarching strategic framework for the sector must be provided and linked to resources. As well, it should be supported by the most significant funding agencies. An appropriate policy further defines roles in public and private sectors with regards to both the financing and provision of healthcare and the identification of policy instruments. It also sets out which institutional arrangements will be required to achieve sector objectives. The policy should include an agenda for capacity building and institutional development as well as provide guidance for prioritising government and donor expenditures from both public and private funds.

All three countries have undergone intensive processes of strategic vision development in their respective health sectors in addition to systems strengthening with support from donors for analysis, consultation and formulation. The Health Systems Strategic Plan (HSSP) in Timor Leste and the National Health Sector Strategy (NHSS) in DRC both aim to provide overarching strategic sector wide frameworks¹⁹. In DRC, the NHSS has been operationalised in a 5-year NHDP (2011-

¹⁸ Government of DRC, 2010a.

¹⁹ The DRC defined health coverage via 515 health zones (an increase from 306 zones in 2001). Each zone covers an average of 110,000 people. There are questions about the viability of some of the health zones, especially in poorer provinces, specifically with respect to many of the new zones.

2015) while concurrently implementing the health pillar of the presidential programme (known as the 5 Chantiers). The government's new PRSP is also currently being elaborated. In Sierra Leone, policy and strategic planning efforts began at the sub-sector level with the development of a comprehensive Reproductive and Child Health Strategy 2008-2011. This strategy proved to be one of the more in-depth analytical processes in the history of the MoHS, but reservations were expressed due to lack of integration of Reproduction and Child Health priorities with a broader essential health services package aligned with other strategies and objectives. While the strategy serves as a catalyst for sector wide efforts, the Sierra Leone MoHS is aware of potential "verticalisation" at the programme level. For this reason, a separate department has been established to manage the implementation of Reproductive and Child Health efforts. How this will link with other departments and other (sub) sector policies is unclear. By the end of 2009, the MoHS and its development partners were still in the process of determining specific funding modalities and management arrangements. This resulted in delays to committed donor funds. Recognising multiple risks, including program verticalisation, the need for attention to health systems strengthening and a critical need for an overarching sector wide strategy, the MoHS was called to draft and develop, with external support, a National Health Sector Strategic Plan 2010-2015. This plan is intended to provide an overarching guide for Sierra Leone's health sector's development and unify the Reproductive and Child Health strategy and other sub-sector programmes into one framework.

The Ministries of Health have increasingly taken greater initiative and leadership in strategy development and implementation processes. In all three countries, the costing of sector strategies is generally weak and undermines assessing the feasibility of policy actions that meet the needs of the poor. It also undermines the feasibility of strategy implementation that takes resource availability into account. In the case of Sierra Leone, the Reproductive and Child Health strategy has been fully costed and large gaps between resource needs and availability have been indicated. In DRC, the Plan National de Développement Sanitaire (PNDS) involves a macroeconomic framework and a realistic medium term projection of available resources with a division between different funding sources based on actual contributions (in 2008).

Sector wide strategies are based on broad-based consultation and discussion with donors, focusing primarily on central government ownership. Consultation, however, is slow to include other actors such as those in civil society. Sector wide strategies lack clear prioritisation of feasible and affordable activities and translation into rapid results and associated operational work plans. In Timor Leste, for example, a comprehensive Health sector strategy was developed in 2008 with articulated priorities and a focused approach to central and district health systems strengthening. However, a change of government, and the subsequent internal restructuring of the Ministry of Health, has resulted in a major institutional transition and so, by the end of 2009, the approach had not yet been consolidated. The newly appointed Minister of Health assumed a strong and active role in the realignment of priorities in health sector strategy to include a community based approach. Negotiations with donors initially led to a health sector support project (2008-2012) managed by the World Bank in support of the roll out of national health strategy priorities. Bilateral donors (USAID, the European Commission, Irish Aid etc), however, directed funding vertically and off-government budget to other health systems components. This fragmented the arrangements to support sector strategy. The apparent lack of harmonisation is now being addressed in the subsequent generation of donor funding.

In DRC, the National Health Development Plan has been set up in consultation with district level civil society and donors. Donors have made a political commitment to align interventions with government strategies. This political commitment, however, has not been implemented as donor financing remains highly fragmented and often vertical with off-budget interventions. Although government is critical of these donors on paper (see, for example, their first NHSS), government objectives are not always addressed. Governments have a tendency to accept all donor-proposals, even those directly at odds with their NHDPs. A revised NHSS incorporates a new strategic axis in an attempt to strengthen inter and intra sector partnerships. Donors on their side, like the Global Fund Tuberculosis, Aids and Malaria (GFTAM) and the Global Alliance for Vaccines and Immunisation (GAVI), have integrated a health strengthening component into their programmes but it is still too early to see indicative results.

More widely, we found growing alignment and policy coherence between sector wide strategic objectives and the PRSPs and Millennium Development Goal (MDG) 4 and 5. This is reflected in the national plans of all three countries. Detailed costing of sector strategy, clear prioritisation and closer institutional links between sectoral and national level planning and budgeting will be required to improve alignment and policy coherence. Policy coherence of sector strategy with other sub-sector strategies and vertical programmes, however, is poor in all three countries. Many sub-sector strategies are out of date and lack uniform implementation plans. Coherence with the basic service package is weak and, originally, vertical programmes such as the GAVI, Global Fund, and GFTAM were undermining sector wide development efforts due to concentrating resources on HIV/AIDS, TB and malaria disease programmes. As noted above, recent efforts are shifting focus towards health systems strengthening. It is, however, encouraging to note that the DRC's health system strengthening strategy, *Stratégie de Renforcement du Système de Santé (SRSS)*, is strongly critical of disease-specific programmes and financing mechanisms. It emphasises that relevant interventions need to be integrated into a minimum service delivery package.

The development of sector wide strategies has promoted joint sector reviews of policies and results. It has stimulated dialogue regarding the feasibility of joint donor programming which supports sector wide strategies. In the case of Timor Leste, the major donors (AusAid and World Bank) are channelling Health Systems Strategic Plan financing through a pooled fund which will be further augmented by European Commission funding as of 2010. In Sierra Leone, the World Bank, DFID and Irish Aid have pledged funding for Reproductive and Child Health strategy implementation and are considering a basket fund. In DRC, the European Commission is promoting joint funding arrangements at the provincial health sector level. Despite these encouraging efforts, however, most external financing continues in the form of project aid and vertical funding – undermining harmonisation efforts. There are 22 different donor alliances in DRC's health sector, 15 in Sierra Leone and 12 in Timor Leste according to the Aid fragmentation index (2010).

SWApS were not designed specifically to enhance the inclusion of the poor. They are, however, expected to support a sector policy consistent with national poverty reduction efforts. There has not, to date, been any in-depth poverty analysis in these countries' sector policy frameworks although the Plan National de Développement Sanitaire in DRC has been indirectly influenced by the poverty analysis that underpins the country's PRSP. Strategies commit to addressing the needs of the poor and, in some instances, identify pro-poor priorities. They do not, however, identify the means by which these needs and priorities can be addressed. Pro-poor monitoring remains weak in these contexts although some monitoring tools do exist. In Sierra Leone and DRC Household

Income and Expenditure Surveys²⁰, Multiple Indicator Cluster Surveys²¹ and Public Expenditure Tracking Surveys²² have all been implemented.

Table 2: Nationally-owned, widely consulted and supported health sector wide policy

Features	Timor Leste	Sierra Leone	DRC
Government-owned sector wide strategy	Medium	Medium	Medium
Based on broad-based consultation	Low	Low	Low
Clear mapping of priorities and resources based on assessed needs	Medium	Medium	Medium
Alignment with national/MDG priorities and sub-sector health strategies and coherences across sector strategies	Low	Low	Medium
Supported by most significant agencies	Medium	Medium	Medium
Costed and realistic	Low	Low	Medium
Sufficiently pro-poor	Low	Low	Low
Overall	Medium	Medium	Medium

Scale: Depth of a SWAp rated as low, medium or high .

4.3 Sector budget

The third major element of a SWAp is the sector budget. It translates sector policy priorities into appropriate resource allocations. The sector budget should reflect sector priorities and strategies, embrace all resources for the sector and preferably do so using a realistic, medium term perspective. Key to the sector budget is a planning and budgeting process that supports the development of a coherent national approach to medium term sector expenditure planning with a focus on reaching the poor.

Sector policy priorities are, to a limited extent, translated into appropriate budget allocations in all three countries. Actual spending deviates significantly from budget allocations. Public Expenditure Financial Accountability (PEFA) assessments indicate that the presence of a basic planning and budgeting process ensures policy-based budgeting. These processes are much more robust in Timor Leste and Sierra Leone (see section 4.6). Sierra Leone and Timor Leste are currently working with the basic pillars of a Medium-Term Expenditure Framework (MTEF). In DRC, the Ministry of Health has been selected as one of five pilot sectors through which a newly established steering committee, under the auspices of the Ministry of Budget, aims to initiate the MTEF development process. Beginning in October 2010, the draft health MTEF (2011-2013) has been circulated for discussion and validation. The Ministry of Health and Sanitation MTEF in Timor Leste (2008) and the Sierra Leone MoHS Medium term Rolling Plan & Budget (2009) serve as the basis for expenditure decisions and present three-year rolling estimates. Medium term expenditure planning of sector wide resources, however, is still incremental in nature and a number of challenges undermine the full potential of the MTEF process to become a truly robust strategic planning and budgeting instrument.

²⁰ Household Income and Expenditure Surveys help generate data on a range of topics concerning private households.

²¹ Multiple Indicator Cluster Surveys assist countries in collecting data on a range of statistically sound and internationally comparable data on health, education, child protection and HIV/AIDS. They have helped inform basic policy decisions and programme interventions.

²² Public expenditure tracking surveys aim to get a better understanding of how public resources are distributed to finance pro-poor services.

First, information pertaining to both on and off-budget aid is incomplete, irregular and differs across various sources (e.g. MoHS, Ministry of Finance (MOF), donors, sub-national authorities). While sector-specific estimates are currently unavailable, the Paris Declaration indicators demonstrate that at national levels the share of aid included in government budget estimates is 54% in Sierra Leone and 21% in DRC (2007)²³. These estimates can be used as a proxy for the health sector. Although in the case of DRC most health sector donor funding is off-budget, Heavily Indebted Poor Countries (HIPC) funds are, by definition, on-budget and constitute about 46% of public budgetary expenditures (2009)²⁴. It is estimated that more than 50% of aid to the Timor Leste and Sierra Leone health sectors is not included in the ministries' budget estimates. For DRC, the World Bank estimated that aid related to the health sector was more than six times higher than overall government health spending in 2006 – most of this being off-budget²⁵. A limited picture on overall resource availability hampers realistic and predictable strategic planning of sector resources. There are efforts in all countries, both at central and sector levels, to gather more systematic information on aid flows but, as outlined in more detail in section 4.4, these efforts have yet to result in a comprehensive and regular mapping of aid volumes and modalities for the health sector. In DRC, these efforts have led to the development of an information system in the Ministry of Planning that can provide an overview of all aid by donor, sector and aid modality²⁶. The use of this system is, however, not well institutionalised within the health sector.

Second, health sector authorities have limited confidence when it comes to planning resource allocations. This is due to the high unpredictability of domestic resources (in particular, non-salary recurrent and development expenditures) and aid from development partners. In Sierra Leone, for example, while health workers' salaries are irregularly but fully paid, over 30% of health workers are still "volunteers" awaiting civil service registration approval. Non-salary recurrent expenditures accounted for 70% in 2006 and encountered large disbursement delays. Spending by development partners as a share of total public health spending amounted to 78.1% in 2007 and tends to be highly unpredictable. There are significant gaps between donor commitments and disbursements. In Sierra Leone, the World Bank committed USD 23 million and DFID committed USD 16 million for three sectors in 2007 (health, education and water and sanitation) but this funding had not translated into actual health services by the end of 2009. Such delays can have a negative impact on established partnerships and the trust between development partners and government. Timor Leste also struggles with unpredictable aid. Donor support to the health sector increased in recent years to USD 39 million (2008) but is expected to sharply decline by 2012 (to USD 16 million). This reflects the volatility of aid flows in such contexts. The development of a community health strategy, such as in Timor Leste, which is strongly endorsed by the government, calls for donors to spread available funds across the spectrum of health service delivery and community based initiatives. For this reason, funding gaps are anticipated. In DRC, most donors have large amounts of funds committed to the country, but absorptive capacity and administrative obstacles limit the possibilities of effectively spending the money. As a result, disbursement rates are (sometimes) extremely low.

In all three countries, the government is the main implementer of health services. The overall financial contribution of the public sector to health services falls significantly short, however, in comparison with the needs of the population. As expressed earlier in this paper, current levels of per capita expenditure by the public in the health sector are far below the USD 38 estimated by the

²³ OECD DAC, 2008.

²⁴ Government of DRC, 2010b.

²⁵ World Bank, 2008.

²⁶ Government of DRC, 2010c.

WHO Commission for Macroeconomics and Health. National government contributions to recovering health sectors are frequently challenged by competing priorities and political prerogatives. Such factors include the limited capacity of health systems to implement current levels of financing while absorbing rapidly scaled up interventions, governance concerns and inefficient health service delivery systems. As a result of limited public health spending, private out-of-pocket expenditures account for 69% of total health expenditure in Sierra Leone and 38% in DRC²⁷. These numbers are remarkably high and can negatively impact the poor and vulnerable rigorous monitoring of access to health services by the poor is not in place. NGOs play a relatively more important role in service delivery than in more stable environments because they have formed the “backbone” of humanitarian services during conflict and have continued services post-conflict in each country by an extension of relief aid. This has been due to protracted periods of transition, primarily as a result of donor delays in shifting aid modalities from humanitarian to development aid. The lack of a well-established transition mechanism to a more structural approach often gives this kind of humanitarian aid a structural character, as exemplified in eastern DRC over the last twenty years.

The ministries in the three countries do not have an overall strategy outlining how they aim to finance health service provision in a sustainable manner in the future – and what implications this will have for mobilising domestic revenues and external donor support in other ways. The major difficulty is how to balance the objective of providing access to affordable health services for the poor and vulnerable while ensuring that sufficient and predictable (domestic and external) revenues are raised over the medium term to finance quality health services. In Sierra Leone, supported by the DFID²⁸ and ILO²⁹, discussions by government and development partners are now being held regarding the most suitable health financing strategy and options. In the case of DRC, the Plan National de Développement Sanitaire medium term financing strategy foresees a reduction of expenditures by households³⁰.

Experience shows that the poor and vulnerable tend to benefit least from health service delivery. This is due to the opportunity costs of healthcare (travel, food, childcare etc), unregulated user fee policy and limited attention to alternative health financing options (e.g. health insurance). As demonstrated in Sierra Leone, the poorest quintile of the population utilises both primary and secondary care substantially less frequently than the wealthier quintiles, and benefit from only around 14% of the spending³¹. Health users qualifying for exemptions (elderly, pregnant women, etc.) are regularly charged for health services because of limited revenue at local health facilities. Less than 10% of clinics reported giving free health care to these groups³² and there is currently no country-wide fee guidance by the MoHS³³. In the case of DRC, the government’s strategy is certainly pro-poor but actual prioritisation of expenditures tends to contradict this strategy by favouring urban services over rural.

²⁷ Government of DRC, 2010a.

²⁸ The DFID study, undertaken by OPM, concluded that transition to lower cost services for the population is key and suggested to focus on a facility-based approach. As universal health care in Sierra Leone is not currently affordable, the study proposed to abolish user fees for certain groups at primary health care facilities (OPM, 2008).

²⁹ The ILO study reviewed the possibility of introducing a unitary national social health insurance scheme to cover the whole population. There would be free health service provision at point of delivery and the costs of this scheme would be financed through a mixture of various tax and non-tax revenues with contributions from donors (ILO, 2008).

³⁰ Government of DRC, 2010a.

³¹ OPM, 2009.

³² IRCBP, 2007.

³³ OPM, 2008.

Table 3: A (medium term) budget and expenditure framework in support of sector policy

Features	Timor Leste	Sierra Leone	DRC
Consistency of sector policy with budget allocations & actual spending	Low	Medium	Low
Existence of a supporting (multi-annual) budget process	Medium	Medium	Low
Well-resourced: sufficient domestic and external financing available	Medium	Low	Low
Predictability of donor contribution	Medium	Low	Low
Poor are benefiting from health service delivery	Low	Low	Low
Overall	Medium	Low	Low

Scale: Depth of a SWAp rated as low, medium or high.

4.4 Shared processes and approaches

The direct aim of shared processes and approaches is to share planning, implementation and management of sector strategy between various actors in the sector. Central to this aspect of the strategy, and in accordance with the aid effectiveness agenda as laid out in Paris (2005) and revisited in Accra (2008), are harmonisation and alignment. Harmonisation should be seen as the coordination and merging of processes, institutions and systems among aid agencies. The components of harmonisation are threefold: the establishment of common arrangements; simplifying procedures to reduce the burden on governments; and sharing information to promote transparency and improved coordination. Alignment is characterised as a coherence of development assistance that integrates with recipient government systems and institutions. Alignment uses the government's agenda and its systems. This section will explore alignment with sector strategy. The alignment of aid with government systems will be dealt with in section 4.6.

Aligning development assistance in the health sector with sector wide policy has systematically improved in both fragile and stable countries over time. However, there is often a major bottleneck at the point where sector wide strategy is translated into operational plans and management arrangements which guide donor financing. Post-conflict environments struggle comparatively more with highly fragmented, uncoordinated aid – although there have been efforts in recent years to work towards joint programming and funding modalities in support of sector wide strategy. Coordination mechanisms at national and sector levels are increasingly seeking ways to harmonise project support. Consequently, vertical funds and traditional project providers such as USAID are gradually increasing their participation in donor coordination meetings in order to engage in dialogue regarding improved alignment and coordination of sector strategy with other donors. Defining operational priorities and agreeing on funding and management mechanisms, however, have often delayed both strategy implementation and the provision of associated donor support. A rethinking of health priorities occurred in Timor Leste in 2009 due to the president's call to develop a 2030 development vision. This caused the revising of previously approved health sector strategy and risked diverting existing donor commitments. Such strategic tidal shifts challenge the pace of alignment and can risk further fragmentation of national sector efforts. In DRC, the National Health Sector Strategy is formally supported by major donors but with a strong donor focus on disease-related interventions -- about 50% or more of all aid according to the World Bank (2008). Such a figure does not align well with an emphasis on health systems strengthening. In 2007, public

budgetary health expenditures were about USD 90 million (of which 70% was HIPC-funded). In addition, estimated off-budget total international donor funding to health was USD 270 million, of which 37 million was earmarked for HIV/AIDS. The two major vertical funds, the GAVE and GFTAM, accounted for a total of USD 27 million, and were expected to be scaled up in future commitments. All this support is channelled through numerous projects. Between 2007 and 2008, the Ministry of Planning in DRC counted 247 different projects used by 20 donors to channel aid. 187 projects were set up by only four donors (Belgium, the EC, the UN and the World Bank).

In all three countries, coordination mechanisms are in place to manage relationships at inter and intra ministerial levels (e.g. the Ministry of Health vis-a-vis the Ministry of Finance); between government and development partners; and between central and peripheral actors in support of decentralisation. Inter and intra ministerial coordination mechanisms are often undermined by frequent staff changes at political and senior technical levels. Coordination and cooperation of aid effectiveness efforts between national and sector coordination units tend to be weak. In Sierra Leone, for example, the Development Aid Coordination Office (DACO), under the auspices of the Ministry of Finance, is tasked with promoting general aid coordination and effectiveness while the donor/NGO liaison office at the MoHS interacts strategically within the MoHS and externally with development partners for better application of the Paris principles at sector level. Both have focused on setting up a database that maps aid flows at national and sector levels respectively, but efforts have not been well coordinated. This has led to duplication of activities and incoherence between national and sector data. In addition, significant aid is not reported through International NGOs, faith based organisations and UN agencies, leading to major oversights by governments with regards to total aid flow to the health sector.

Government-donor sector coordination groups exist in all three countries. These are led by departments or units within the MOH that are specifically tasked with leading this process. These departments, however, struggle significantly due to staff shortages and a lack of the capacity building support they require to effectively perform their assigned functions. Ministry of Health leadership in convening and managing sector coordination efforts is notably underway in all three country contexts but will continue to require strengthening. In DRC, for example, the government, in collaboration with donors, is currently setting up a "Cellule d'Appui et de Gestion" (CAG) whose staff will monitor aid interventions. This mechanism includes someone responsible for monitoring fiduciary risks. Once established, it may function as the Global Fund's CCM and the GAVI and the EU may channel funds through it. Meanwhile, efforts to map various stakeholders within the health sector and its associated resource flows and management arrangements are in an early stage of development. To track health sector performance, and to fulfil the information requirements of development partners, national health sector reviews have been undertaken in Timor Leste and DRC. In Sierra Leone, however, it is unclear whether such a process has taken place since 2004. Development partners hold internal monthly coordination meetings to oversee processes and harmonise work practices. Members in all three countries highlight the need to reinvigorate sector coordination. There is also a need to shift from information sharing towards greater strategic discussions in order to forge alliances and a shared vision among development partners regarding priorities, aid approaches, modalities and support to health systems capacity building. Frequent staff turnover among development partners can also undermine continuity and consistency in policy dialogue – as well as relationship and trust building which are central to SWAp efforts. In DRC, donors have set up a health sector donor coordination group (GIBS). In this group, donors exchange information but do not make joint decisions. Further, geographical coordination exists

between donors. With regards to emergency relief, donors have established a much more elaborated collaboration mechanism: a pooled fund that operates in parallel to the government.

With the advent of decentralisation, planning and management functions for health service delivery have (or are beginning to) shift towards local councils at peripheral administrative levels. This growing autonomy requires new structures and systems that can accommodate the transfer of responsibilities and resources. District authorities often possess a limited understanding of aid architecture, resource flows and the criteria for monitoring and managing aid efficiently and effectively. The proliferation of NGOs, donors and private actors operating at service delivery levels (in light of the weak capacity of sub-national authorities) undermines coordinated strategic dialogue and information sharing. The introduction of district level planning in Sierra Leone has demonstrated the potential for improving communication and coordination among actors at the sub-national level if there is strong leadership within the district, and sustained financial and technical resources to district authorities. In DRC, the constitution foresees a delegation of spending towards provincial authorities. At present, this spending authority is limited because the lion's share of health spending, personal expenditures is kept at the national level.

A coherent and comprehensive institutional capacity development framework is absent from all of the health sectors studied here. National systems have often been decimated and the needs for services are immediate. There is also a lack of the "right size and right skill mix of health staff", a fact further exacerbated by a lack of adequate training institutions that can produce new cadres of health workers. In general, high attrition from the limited pool of skilled staff is common and working conditions and incentives for employees are poor. Little attention has been paid to human resource recruitment, development, remuneration and retention. Human Resource Management notably lags behind all other major strategic developments. This will undoubtedly interrupt the progress of achieving the ambitious targets set out in the sector. As Brinkerhoff³⁴ highlighted, the approach to capacity development differs in fragile states because it takes longer to achieve an increase in capacity. He emphasises that efforts towards change are more difficult and complex in these contexts due to their hyper-politicised operating environments. As well, the magnitude of change that donor intervention seeks to achieve is much greater and will require gradual incremental reform rather than quick-fix approaches.

The central challenge in these contexts is to move beyond temporarily filling capacity gaps towards building sustainable capacity over the medium to long term. Support for capacity building in fragile health sectors is relatively limited, reflecting a strong focus on disease-related interventions. Support so far has focused on strengthening general and financial management skills (e.g. policy formulation, budgeting, accounting and procurement) and has come primarily in the form of technical assistance. Experience over recent years has shown that much of this effort has been limited in coverage, projectised, fragmented, donor-driven and unpredictable. The approach to capacity building has been more ad hoc and short-term in nature. It is also un-coordinated and often builds the capacity of individuals rather than (re)building the functions of the health system for the longer term. As a result, little knowledge and skills have been sustainably transferred to local counterparts and changes to institutional capacity has been slow. In Timor Leste, for example, there have been several initiatives to review experiences with technical assistance. Development partners are also discussing the creation of a more joined-up and effective approach to capacity development. The Sector Investment for Health Program in Timor Leste was initiated to provide direct support for institutional capacity building in the health sector. It has boosted the ability of

³⁴ Brinkerhoff, D. W. 2007.

the Ministry of Health through a five year plan for technical assistance for the development of national policies and strategies. Other donors have focused on strengthening implementation at service delivery levels. The next phase of the Health Systems Strategic Plan, supported by AusAid, World Bank and the EC, aims to promote joint programming with common objectives and more aligned technical assistance inputs. It is, however, unclear to what extent programming priorities of existing support programmes have been influenced by lessons learned regarding past cases of capacity development. In DRC, capacity building initiatives were largely driven by uncoordinated donor initiatives. Following the Belgian Cooperation approach of gradually tackling the problem by focusing on one department at a time³⁵ donors are coordinating support for the setup of the Cellule d'Appui et de Gestion, an incentive that could act as a pilot project for collaboratively moving towards a more coordinated approach.

Table 4: Shared processes & approaches

Features	Timor Leste	Sierra Leone	DRC
Alignment of aid with sector strategy	Medium	Medium	Medium
Well coordinated and harmonised support with common arrangements	Medium	Low	Low
Effective sector coordination mechanisms with clear stakeholder mapping	Medium	Low	Low
Joint, comprehensive capacity building approach	Low	Low	Medium
Overall	Medium	Low	Low

Scale: Depth of a SWAp rated as low, medium or high.

4.5 Sector performance monitoring framework

Monitoring, evaluation and research are critical elements to strengthening health systems and moving towards a sector wide approach. A variety of performance indicators should be chosen, reflecting progress in health access, equity, quality, effectiveness and efficiency. This necessitates collection, analysis and interpretation of reliable health data and therefore requires revitalised health management information systems in order to improve monitoring and accountability. Palmer³⁶ describes three levels of information required to form a comprehensive approach to monitoring sector reform: routine service data at the operational level; monitoring data for resource allocation; and monitoring of the sector as a whole.

Sector wide strategies and relevant sub-sector policies articulate priority areas for the health sector as well as relevant sets of indicators. However, there is generally no systematic and comprehensive monitoring of health sector performance in the three countries studied. Monitoring is reactive and ad hoc and usually reflects donor requirements. Most health information is project driven rather than acquired through a systematic Monitoring and Evaluation (M&E) framework led by the Ministry of Health. PIUs undertake their own reviews and evaluations and conduct separate data collection and performance reporting. Data collection for national programmes functions better due to investment by vertical programme donors while other critical sub-sectors (e.g. Maternal and Child Health) are often neglected. Opportunities for alignment of M&E systems are undermined by vertical programmes that collect monthly data to satisfy their own needs. Information collection

³⁵ Beginning with the key Department of Planning and Research, the département d'études et planification (DEP).

³⁶ Palmer, 2007

through national Health Information Systems (HMIS) is limited and not well understood by district health management teams or health facility managers. This leads to a multiplicity of reporting systems and fragmented data monitoring. Limited resources have been made available by development partners so far to provide technical assistance for supporting the development of an integrated performance monitoring system and financial resources for investing in hardware and software databases and relevant staff skills.

Table 5: A sector performance framework monitoring against jointly agreed targets

Features	Timor Leste	Sierra Leone	DRC
A comprehensive monitoring framework that is results-focused, based on jointly agreed targets for health services. A government framework for aid effectiveness that reflects key targets for health as a sub-sector.	Low	Low	Low
Overall	Low	Low	Low

Scale: Depth of a SWAp rated as low, medium or high .

4.6 Use of country Public Finance Management systems

A good Public Financial Management (PFM) system³⁷ ensures that policy priorities have a chance to be reflected in budget allocations, stimulates value for money in public spending and helps to promote fiscal discipline. In the framework of a SWAp, it is important that PFM capacity supports the implementation of the sector's policy and budget. Development partners can promote this by supporting PFM capacity building and increasingly using national country PFM systems and more aligned aid modalities. In fragile states, a major challenge is balancing the use of parallel implementation structures in light of fiduciary risks³⁸, as well as using government systems and procedures to promote the strengthening of health systems.

Since the end of conflict, all three countries have made progress in rebuilding PFM systems. Centrally-led PFM reform programmes by each country's Ministries of Finance and Planning are focussing on strengthening PFM systems throughout the entire budget cycle. The preparation of national development plans, sector strategies and district development plans and the gradual introduction of MTEFs show that relatively more success has been achieved in the strategic planning and budget preparation phases. Budget comprehensiveness, transparency and predictability, and capacities relating to payroll management, accounting, internal controls, and procurement and audit functions still present major bottlenecks.

Public Expenditure Financial Accountability (PEFA) assessments provide opportunities to systematically evaluate and score the quality of PFM systems across various budget principles and functions at a nationwide level over time. These scores indicate that Sierra Leone and Timor Leste compare relatively well with other low income countries. Half of their PEFA scores are higher than C+ (medium)³⁹. Timor Leste struggles somewhat more with low capacity in accounting and internal control in comparison with Sierra Leone. Its scores are higher with regards to orderliness and

³⁷ See, for example, the Strengthened Approach to Supporting PFM reform, as articulated by the PEFA Secretariat: www.pefa.org.

³⁸ Risks of a lack of transparency and accountability in public financial management.

³⁹ PEFA scores range from A (high) to D (low). Countries with A scores have a good basic PFM system in place while countries with D scores experience serious system deficiencies.

participation in the budget preparation process and the application of multi-annual budgeting. PFM capacity in DRC is extremely low, with a majority of scores ranging from D+ - D.

Centrally-led PFM reforms are complemented by PFM capacity building support in the health sector, especially with respect to budgeting, procurement and accounting skills. Sector level PFM capacity building is, however, not systematically included in donor support programmes, is rarely linked with centrally induced PFM reforms and should be more coordinated and needs based. Improving PFM at the health sector level could have been promoted more by piloting new PFM approaches initiated by MOFs in support of health sector development.

There is evidence that donors use health sector PFM systems only to a very limited extent due to weak PFM capacity and associated fiduciary risks. The Paris Declaration indicators reflect this situation (see *Table 6*). This, however, needs to be interpreted with care as information is not always representative of the situation due to limited data availability.

Table 6: OECD/DAC Paris Declaration Monitoring 2008

	Timor Leste	Sierra Leone 2007	DRC 2007
Are disbursements on schedule and recorded by government?	n.a.	35%	5%
Are government budget estimates comprehensive and realistic in terms of aid?	n.a.	54%	58%
How much aid is programme based?	n.a.	27%	21%
How much aid uses national PFM systems?	n.a.	20%	0%
How much aid uses national procurement systems?	n.a.	38%	1%
How many PIUs are parallel to national structures.	n.a.	2	146
Overall	Low	Low	Low

Source: OECD DAC 2008 Survey on Monitoring the Paris Declaration Sierra Leone, 2008.

OECD DAC 2008 Survey on Monitoring the Paris Declaration Timor Leste, 2008.

A significant share of aid by development partners remains off-budget and some donor programmes have established separate project implementing units to manage their projects, usually with separate finance, accounts and audit staff. This promotes fragmentation and duplication and seriously undermines health sector capacity strengthening. This is illustrated in Sierra Leone, where budget allocations to the health sector are relatively small compared to other sectors and other countries – in spite of the provision of general budget resources to the health sector. Allocations to the health sector were 4.7% in 2000, rising to 8.3% in 2003 and declining to 3.8% in 2007. The main reason for this, as stated by a senior Ministry of Health And Sanitation (MoHS) representative is as follows:

“General budget support did not translate into action to reach our health sector objectives. The government assumes that many donors are supporting the sector and therefore general budget support is not allocated to the health sector”.

Once general budget support resources intermingle with domestic resources in the treasury, it is hard to tell why resource allocations to the health sector have not shown significant growth between 2000 and 2007. In any case, it is a resource allocation decision taken up by the Government of Sierra Leone. The Sierra Leone example demonstrates, however, that large off-

budget aid to the health sector can negatively influence resource allocation decisions, the orderliness and integration of the entire budget process and the strengthening of institutional relationships between the Ministry of Finance/Ministry of Planning and line ministries. Hesitation to allocate resources to the health sector in light of high off-budget aid is, perhaps, a rational choice by the Ministry of Finance in the short term, but this situation has serious consequences for the health sector. As a result, large shares of off-budget aid to these sectors are highly uncoordinated, fragmented, and unpredictable and there are huge gaps in financial information. This, in turn, inhibits the MoHS' ability to undertake effective and efficient strategic planning and budgeting of resources over the medium term. In the case of DRC, data from the Ministry of Budget show that for all sectors, only 6% of externally financed projects are executed by the government. The setup of the Cellule d'Appui et de Gestion within the Ministry of Health is, up to now, the only example of donors trying to make better use of a country's PFM system at the health sector level.

Moreover, donors are not extensively using programme-based approaches and more aligned aid modalities. The governments of Timor Leste and Sierra Leone have both benefited from general budget support. In the case of DRC, general budget support is not used as a structural aid modality, but has been provided by a number of donors such as the World Bank, EC and the Belgian Technical Cooperation (BTC) during the economic crisis to support the government's budget. The only type of structural budget support in DRC is the interim HIPC debt relief, which DRC benefited from between 2003 and 2010. This debt relief increased from USD 90 million in 2003 to about USD 376 million in 2009⁴⁰. At the health sector level, the predominant aid modalities are projects and technical assistance. Only in the case of Timor Leste has a pooled fund modality been established (with AusAid/EC funding) to support the implementation of the Health Systems Strategic Plan. In DRC, such a pooled fund exists for emergency aid but operates in parallel to the government. Discussions in Sierra Leone and DRC are in progress regarding possibilities for joint programming, management and funding modalities in the context of sub-sector strategies. Reproductive and Child Health strategy implementation in Sierra Leone along with efforts by the EC to establish province-level joint funding mechanisms in DRC will reveal the potential for new aid modalities.

Experience with different aid modalities which contribute to health sector strengthening has been mixed at best. While the provision of general budget support has had streamlining effects on central policy dialogue and has drawn attention to strengthening PFM capacity, the ramifications for this on the health sector remain uncertain. In Sierra Leone, for example, the general budget support has not led to an increase in budget resources for the MoHS. In light of increasing general budget support resources to Sierra Leone since 2004, education spending as a percentage of recurrent expenditures has increased from 19.4% in 2000 to 22.5% in 2007. Health spending has increased from 4.7% in 2000 to 8.3% in 2003 but sharply declined to 3.8% in 2007. GBS conditionality has arguably scrutinised certain health sector reforms through the performance assessment framework (which contains tracer indicators relating to the health sector reform), however, it cannot be expected that GBS policy dialogue be a vehicle for health sector monitoring processes.

Pooled funds promote joint programming, management and funding in support of a SWAp. However, as experiences in all three countries demonstrate, consensus between government and

⁴⁰ International Monetary Fund and the International Development Association, 2010.

among donors with different agendas in terms of policy priorities and management procedures proves very difficult and takes time. When these processes are prolonged they result in delayed funding. This, in turn, can undermine trust and relationships between governments and donors. If pooled funds are considered to be intermediate steps in moving towards budget support, one needs to weigh the benefits and risks of using such modality, including the predictability of funding commitments, administration and transaction costs of set up and maintenance, as well as tendering procedures that will follow the contracting of implementors. Pooling funds, therefore, requires significant design and capacity efforts throughout implementation. There should be ample focus on promoting government systems alignment and designing flexible and responsive procedures to avoid creating parallel structures and unpredictable funding.

Table 7: Use of country PFM systems

Features	Timor Leste	Sierra Leone	DRC
Improved budget processes & allocation & operational efficiency	Low	Low	Low
Aid using country PFM systems	Low	Low	Low
Use of (more aligned) aid modalities	Medium	Low	Low
Contribution of aid modalities to health sector strengthening	Low	Low	Low
Predictability in the availability of domestic and external resources	Medium	Low	Low
Overall	Low	Low	Low

Scale: Depth of a SWAp rated as low, medium or high.

Technical assistance can take many forms and is frequently used as a “catch all” to describe the provision of technical support through the establishment of a project support unit (PSU/PIU); making short and long term experts available to support knowledge and skill building; and the provision of know-how to execute a project to substitute for local gaps in capacity. Experiences with technical assistance across the three case study countries indicate a common trend of filling essential public service capacity gaps. Technical assistance, in early post-conflict stages, was generally found to be a case of “substitution” linked to project aid. This created fragmentation and resource unpredictability. Most efforts operated independently of one another and separate project management structures and diverse approaches were used for channelling technical assistance.

5 SWOT analysis of SWAp readiness

Analysis of the six major building blocks of SWAps demonstrates that there is high variability in the progress and overall sequencing of SWAp elements in the selected post-conflict countries. Results are mixed. In all cases, there is a level of engagement of both government and development partners to shift away from humanitarian to development modes. More streamlined and coordinated policy and management processes are considered key drivers for enhancing service delivery and strengthening health systems. Based on the review of the major SWAp elements, *Figure 3* below summarises a SWOT analysis for SWAp readiness in the three countries under review.

Figure 3: SWOT analysis of SWAp readiness

<p>Strengths:</p> <ul style="list-style-type: none"> • Existence of (sub) sector-wide health strategies, with commitment and support of main donors • Improving leadership and ownership over sector policy formulation • Basic sector coordination processes in place • Macroeconomic stability and basic budget process in place for authorities to plan & budget with some confidence 	<p>Weaknesses:</p> <ul style="list-style-type: none"> • Harmful donor practices (off-budget, unpredictable, un-harmonised aid flows) • Broad-based lack of capacity throughout policy and budget processes • Weak capacity building approach • Limited attention to (rapid) results and action planning. • Limited use of country systems and more aligned modalities
<p>Opportunities:</p> <ul style="list-style-type: none"> • Shift from humanitarian towards development mode • Paris declaration & Accra Agenda for Action • Donor commitment to aid effectiveness agenda & scaling up of aid • Commitment of few larger donors to support sector programme implementation • Decentralisation process if institutional roles and responsibilities are clarified, resource allocation is improved and intensive capacity building takes place 	<p>Threats:</p> <ul style="list-style-type: none"> • Rapid political changes with implications for frequent staff changes at political and technical level • Breakdown of governance structures • End of significant donor support in some cases • Large volumes of vertical funds using parallel implementation structures • Financial crisis

Much has been invested in the formulation of jointly agreed and supported sector wide strategies for health. Significant efforts have also been made in terms of fostering dialogue between government and development partners regarding a shared vision for health sector development and systems strengthening. Sub-sector strategies can be useful starting points for creating momentum for SWAps, but these strategies need to avoid the risks of “verticalisation” at the programme level. Simultaneously, government and development partners have sought to promote shared processes and approaches with an emphasis on establishing basic policy dialogue and coordination mechanisms. Sector coordination is under way in the three countries but appears to lack strategic drive, focusing instead primarily on information sharing. Coordination bodies are the most essential structure for bringing together key health sector stakeholders. In Sierra Leone and Timor Leste, they have fostered unified support for the formulation of sector wide strategies in healthcare. These strategies can be supported and further strengthened by the introduction of joint funding mechanisms.

Progress of the other SWAp elements (leadership, sector budget, M&E, PFM) has generally been slower. The major weaknesses in these areas arise from rigid donor policy and behaviour, weak approaches to capacity building and poor sector stewardship with limited attention to achieving results based on agreed priorities. Yet, there are opportunities which have the potential to stimulate greater uptake of SWAps in the three countries. These opportunities include a general commitment by donors to translate an aid effectiveness agenda into action and the readiness of certain major donors to support a significant share of sector programmes through more aligned modalities. While the decentralisation process, focused on the creation of more accountable governance structures and has potential to leverage improved service delivery to local populations, it can only do so if roles and responsibilities are defined more clearly, resource allocation processes are improved and intensive capacity building takes place. Major threats to the SWAp process arise from political uncertainty, weak governance (including corruption), fragmentation induced by large volumes of vertical funds and the adverse impact of the financial crisis on aid budgets.

Overall, we can conclude that all three countries have worked on all six SWAp elements (breadth of SWAp) with increasing depth in terms of developing a sector wide policy and establishing basic sector coordination processes. However, limited depth is evident for other elements and most significantly in relation to the strength of sector budget processes and overall management, use of government PFM systems and sector performance monitoring.

Table 8: Breadth and depth of health SWAp

		Timor Leste	Sierra Leone	DRC	
Breadth	✓	Government leadership	Medium	Medium	Low
	✓	Sector policy	Medium	Medium	Medium
	✓	Sector budget	Low	Low	Low
	✓	Shared processes & approaches	Low	Medium	Low
	✓	Sector performance monitoring	Low	Low	Low
	✓	Use of government PFM systems	Low	Low	Low
Depth					

Note: for a detailed application of the criteria to the case study countries, see Annex.
 Scale: Breadth of SWAp: ✓ Yes. Depth of a SWAp rated as low, medium or high.

6 Health SWAp readiness: drivers and barriers in fragile states

The analysis of the progress that the three countries have made in putting the major six SWAp building blocks in place highlights a number of key drivers and barriers which determine the readiness of their health sectors. These determinants include the need for strong government leadership and ownership; the need to (re)build trust between partners; and the need for institutional capacity development. They also demonstrate a need for greater coherence between policy and implementation within the wider public sector and sector level reforms.

Experiences in and comparison of the three countries that were studied in this paper illustrate that strong leadership and ownership by Health Ministries is key to initiate, drive forward and maintain momentum and commitment to strengthening health systems. Appropriate leadership capacity is not automatic and also depends on political arrangements and priority allocation of resources for basic services by the government. Leadership capacity among state and non-state actors in the health sector to contest vested interests is generally limited in the three countries. It is hampered by poor governance, variable levels of trust between partners and is further exacerbated by fragmented aid practices. Government ownership over the policy-result chain has improved with the Health Ministries taking greater initiative for policy formulation. Ownership over resources is, however, more limited due to choices of aid modalities with large shares of off-budget aid -- most of which use parallel implementation systems.

Conflict can lead to a breakdown in trust between partners. This is an obstacle to moving forward with a SWAp. This comparative analysis has highlighted a number of essential determinants for (re)building trust between partners. First, a common understanding of health sector development priorities (by both government and development partners) and good communication are important to clarify partnership expectations and resource support needs. The formulation of (sub)sector wide strategies has helped to develop more transparent strategic directions among partners and has stimulated movement towards a common vision. The major challenge in fragile health situations is, however, that everything is priority. Existing capacity is weak and there is only a limited window of time to show results. The analytical work undertaken in preparation for sector wide strategies has helped identify support needs and has fostered general commitment by development partners. However, expectations regarding the delivery of specific health results and the associated financing needs of the Health Ministries have not yet been articulated clearly enough, particularly in light of weak target setting, M&E arrangements and the absence of health financing strategies.

Second, building trusting relationships can be promoted if partners act predictably and accountably. Once specific targets have been set, it is vital that government authorities have a track record of good performance. Development partners also have to prove that they are in partnership for the longer term. They can demonstrate this with more predictable funding. Health sector reviews in Timor Leste were initially driven by the World Bank but, in the past three years, there has been a notable shift to "put the Ministry in the driving seat" to set the agenda and take forward strategic planning and implementation. Such processes take time and require building the capacities within nascent ministries. These processes also require tenure stability among senior staff both within the government ministries and the development partners agencies.

Sound institutional capacity and strong institutional relationships, with qualified staff, procedures, systems and incentive mechanisms in place, are a third important driver for building the trust necessary for SWAp implementation. Capacity gaps in fragile situations have undermined early

progress in reconstruction as local administrators lack the knowledge, skills and experience to sustain or replicate successful outcomes. Although the health sectors in these three countries received significant volumes of aid during post-conflict transition years, experience shows that these funds can dry up quickly if a government is unable to absorb them and demonstrate progress. In some cases, a vicious cycle develops whereby governments cannot secure aid because they do not have the capacity to use it – and they do not have the capacity to use it because they do not have the resources to develop it. For this reason, attention to a systematic, long term partnership for capacity development is important. However, in all countries' experiences show that institutional capacity development has often been ad hoc rather than an integral part of main sector programmes – although health systems strengthening has clearly been identified as the central theme of the three health sector wide strategies. Typically, donor funding via project aid has determined the provision of technical assistance rather than a basket fund approach based on actual needs assessments that signal which capacities need to be strengthened and to what level. It is evident that, to date, while provision of advisory capacity has filled essential gaps, capacity building approaches have focused narrowly on technical assistance provision. There is a lack in the sustainable transfer of skills to local counterparts as well as a lack of use of appropriate exit strategies.

Moreover, experiences between countries suggest that a broader government public sector reform agenda plays an important role in determining the success of SWAp. Civil service reforms, in particular changes towards modern human resource management (pay and remuneration, recruitment, results-based approaches, etc.), public financial management and decentralisation have all shaped the health of SWAp implementation process. Lack of systematic linking with centrally-led reforms and policy dialogue on strategy, resource allocation and implementation challenges have limited the benefits for related capacity development in the health sector. While the decentralisation process has shown some positive results in improving the volume of health service provision, it has added to the complexity of sector management and created unrealistic expectations towards the capacity of district authorities to deliver results. While central government capacities remain weak and delivery systems immature, accelerated decentralisation can jeopardise agreed-upon plans and strategies while undermining public confidence in the sector. Striking the balance between accelerated planning and implementation; known as 'the big bang approach' and fostering a more sustained vision with carefully orchestrated translation to achieve incremental results is the greatest challenge faced by countries in post conflict recovery. The health sector therefore needs to allow for a realistic and contextually specific timeframe building systems while ensuring a sustained trajectory towards its goal.

7 Key steps towards improving health SWAp readiness

Our analysis has illustrated that health sector SWAp efforts in fragile states are in early development. Considering the impact of fragility, it is unrealistic to expect that national health sectors in recovery can reach accelerated development milestones. Hence, recommendations on steps forward need to be focused on putting in place the basic stepping stones which can, in turn, be guided by the six SWAp elements. Given the state of SWAp development in fragile health sectors as well as the scope of the reform process, we recommend a two-stage approach. During the initial stages of SWAp development, both government and donors need to focus on policy development, sector coordination and a basic expenditure framework with strong support to capacity building. Once these essential elements are maturing, further investment should be directed to performance monitoring, and strengthening of government PFM systems. Government leadership and ownership should thereby cross-cut with continued deepening of all six SWAp elements. A programme of action is recommended as follows:

- *Development partners should seek to promote greater aid coordination (including NGO activities)*⁴¹. This will include setting up formal aid coordination mechanisms, mapping aid flows to the health sector and ensuring regular and comprehensive reporting on aid flows are incorporated into the national sector budget and expressed in the medium term expenditure plan. Priority to increased alignment of project support in conjunction with health sector priorities is also critical to success.
- *Government authorities should work towards developing a sector wide strategy which provides an overarching framework for sector wide reform with ample attention to health systems strengthening.* Given the overwhelming support needs of fragile states, ministries should, nevertheless, focus on tangible results supported by action planning and financing strategies. Appropriate policy dialogue structures should be in place during formulation and implementation of the strategy to allow for sufficient broad based consultation, consensus-building and joint monitoring of key performance results.
- *Government authorities should work towards an expenditure framework which translates sector wide strategy into resource allocations and identifies financing needs for donor support.* This will provide opportunities for some donors to work towards more aligned funding modalities and highlight the need for ministries to strengthen processes and structures which facilitate strategic planning and budgeting.
- *Government and development partners need to pay ample attention to promote sustainable institutional capacity building over the long term.* Recent research⁴² highlights that capacity development in fragile states should focus more on intensive leadership capacity and multi-stakeholder coalition building; structured learning; knowledge exchange (practitioner exchange, peer learning and benchmarking); and promoting and sharing innovative approaches. Given the fragmented arrangement that currently prevails, concerted efforts by governments and development partners is urgently required to re-direct resources in this manner.

While this two-stage process and the hierarchy of actions can help shape the sequencing of the next steps, all six SWAp elements are considered essential and mutually enhancing for the purpose of achieving a fully-fledged SWAp.

⁴¹ In DRC, it remains an open discussion at what level this health aid coordination should best be organised. Some suggest that aid coordination is more easily accomplished at the provincial level.

⁴² Pradhan, 2009.

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Annex: Review of case study country experiences with analysis of the six SWAp elements

Sector leadership	Sierra Leone	DRC
Well articulated vision for health sector development	The Health policy (2002), the Reproductive & Child Health Strategy (2008) and the recently drafted National Health Sector Strategic Plan (NHSP) (2010-2015) form the core strategic documents. The latter aims to anchor various sub-sector health strategies. It remains to be seen, however, what the buy-in will be. Leadership is now the first pillar of the NHSP. MOH recognises major gaps in its institutional capability to regulate, coordinate and oversee implementation of NHSPs.	The National Health Sector Strategic Plan (NHSS) provides the overarching strategic sector wide framework. It was concluded in 2006, updated in 2010 and integrates the country's PRSP. The National Health Development Plan (NHDP) 2011-2015 was validated by the Ministry of Health and development partners on March 31, 2010. The NHDP is the first multi-year implementation plan for NHSS and its planning cycle is aimed to coincide with that of the PRSP. In practice, there is a lack of leadership within the MOH. Implementation is delayed, partly due to a high turnover rate of ministers (both at national and provincial levels).
Government ownership over policy, resources and implementation	The level of ownership has improved in recent years. MOH has taken greater initiative in strategy formulation process. Ownership over resources and implementation is, however, limited. 78% of health expenditures is financed by fragmented, uncoordinated and off-budget external aid. Weak institutional capacity, limited skills and minimal government knowledge, as well as the use of parallel implementation systems by donors, undermines government ownership over implementing health services and key reforms.	Strengthening government ownership and leadership is one of the strategic interventions in the revised NHSS. NHDP was finalised under the leadership of the Prime Minister. MOH has taken the lead in these processes. The health sector donor coordination group (GIBS) made a political commitment to align their interventions with government strategies. However, in practice, government ownership is hampered by weak institutional capacities and significant fragmentation in terms of donor activities. The government has a tendency to accept all donor-proposals even if these are completely misaligned with the goal in the NHSS-NHDP.
Transparency & accountability for health results	Efforts towards improved regulation and accountability mechanisms have been challenged by changes in leadership and by decentralisation. The President has introduced performance based management for all line ministries but political priorities need to be better linked with technical priorities. Health sector reviews have not taken place in the recent past . A results-focused M&E system does not exist for the health sector.	A results-focused M&E system has been integrated within the framework of the PNDS, with regular monitoring processes at all levels (zone, district, province, national), but is not yet operational. For the moment, the monitoring systems consists of parallel monitoring processes at the individual program and project level. These parallel processes have placed a high demand on the country's M&E system, crowding out their own evaluation processes.

Sector policy	Sierra Leone	DRC
Government-owned sector wide strategy	There is increased government ownership over sector strategy formulation, but experiences have been mixed in terms of who initiates the process and who drives priority setting. Decentralisation has met with mixed results but has enhanced resource control and aided decision-making for district councils.	Government ownership over the sector strategy is broad-based. The NHDP is not only the implementation of the health pillar of the Presidential programme, known as the 5 Chantiers, but also of the government's PRSP.
Based on broad-based consultation	There is insufficient consultation with civil society with a focus on state level "ownership", although RCH strategy process has set a precedent for wider consultation at the planning stage.	The NHDP was developed through a participatory process involving all levels of the health system (zone, district, province, national) and was elaborated based on the provincial health development plans (PHDPs) that were themselves based on provincial health zone development plans. The WHO has supported the participation of civil society in the process of moving towards the NHDP. Civil society is, however, poorly structured and therefore is not representative of the nation's diverse
Clear mapping of priorities and resources based on assessed needs	There are competing and contradictory priorities between political and technical directives within the MoHS. There are some efforts to identify sustainable health financing options.	On paper, government priorities are well defined and broadly owned. In practice, the government accepts donor interventions that do not align with these priorities. The NHDP incorporates a medium term projection of available resources.
Alignment with national/MDG priorities and sub-sector health strategies and coherences across sector strategies	There is growing policy coherence of sector policy objectives with PRSP and MDGs. Links between sub-sector strategies are limited.	The NHSS is strongly critical of disease-specific programmes and financing mechanisms and emphasizes that the relevant interventions need to be integrated into a minimum package of services delivered by the health system. Therefore, one of the strategic axes of the revised NHSS is that of strengthening of inter and intra sector partnerships. Although vertical interventions now integrate a health strengthening component into their programs (GFTAM, GAVI), a significant portion of donor funding does not follow the health-zone-based government strategy.
Supported by most significant agencies	Health sector priorities are generally well supported by major donor agencies.	The health sector donor coordination group (GIBS) politically supports the priorities set by the government.
Costed and realistic	Costing of (sub-)sector health strategies is limited although the RCH strategy has been fully costed and costing of the NHSP is planned. Current public health funding is very low in comparison to needs..	The costing of the PNDS is realistic, with a division between different funding sources based on actual contributions (2008). Provincial health development plans (PHDPs), as well as health zone development plans, are less realistic -- essentially acting as more of a "wish list" than as set of achievable objectives.
Sufficiently pro-poor	An in-depth poverty analysis underpinning policy framework does not exist. RCH strategy has identified pro-poor priorities but does not yet have the means to achieve them. Pro-poor monitoring is weak though but some monitoring tools exist (PETS, HIES, MICS).	The country's PRSP is based on a consistent poverty analysis. The PNDS is the sectoral translation of the national PRSP. Pro-poor monitoring of the strategy by the country itself is weak although some tools exist, such as the DRC multiple indicator cluster survey (MICS) of Unicef, of which a new survey is about to be completed.

Sector budget	Sierra Leone	DRC
Consistency of sector policy with budget allocations & actual spending	Sectoral budget allocations and spending reflect, to some extent, sectoral priorities and PRSP priorities.	As the sector budget mainly consists of personnel expenditures, there is limited room for actually linking budget to government plans.
Existence of a supporting (multi-annual) budget process	There is an orderly budget process in place. The MTEF fulfils the basic functions of multiannual expenditure planning but strategic planning is undermined by a number of factors (budget unpredictability, etc.)	The MOH has been selected as one of five pilot sectors through which a newly established steering committee, under the auspice of the Ministry of Budget, aims to initiate the MTEF development process. A draft health MTEF (2011-2013) is now being circulated for discussion and validation. It links up with the PNDS (2011-2015).
Well-resourced: sufficient domestic and external financing available	<p>The budget is not well resourced, because of large commitment/disbursement gaps by donors; large differences between the costing of sectoral priorities and current spending capacity; limited absorption capacity; and complex and lengthy procurement procedures.</p> <p>There is now some understanding of the resources required to finance sector priorities thanks to the costing of the RCH strategy. An overall strategy is not yet available for financing health sector priorities in a sustainable manner, though some research has been done by DFID and ILO.</p>	Taking into account the needs of the sector, the health sector is under-financed but absorptive capacity constraints limit the county's ability to spend the necessary funds. The overall government budget is very low when compared with the possible revenue base. This limits resource availability to the health sector. Most government health spending is based on remuneration. This means that most provinces do not possess the necessary resources to ensure the functioning of basic health services. Donors have committed more money but spending is limited due to the health sector's poor absorptive capacity. Efforts to include all aid in the budget are undertaken in the context of the Plateforme de Gestion de l'aide. Because of the lack of resources from external resources and the government, out-of-pocket payments by the population represent nearly 40% of health financing.
Predictability of donor contribution	The ability of donors and government to disburse aid on schedule is low for both project aid and general budget support. Aid unpredictability is a problem both at central and district levels.	Due to problems with absorptive capacity, donors do not disburse promised expenditures. Disbursement rates vary between the technical partners (UNICEF, WHO, WB,) (which disburse more readily due to disbursement pressures) and financial partners.
Poor are benefiting from health service delivery	Pro-poor spending is not meeting PRSP promises. Poor and vulnerable people tend to benefit less from health service delivery than other sectors of the population. Out-of-pocket expenditures are high and payment exemptions for the poor and vulnerable are partially observed.	Due to limited health expenditures by government and development partners, out-of-pocket expenditures by households constitute a major portion of health financing. The government strategy is certainly pro-poor. Actual prioritisation of expenditures, however, does not often retain this focus – such as the priority given to urban hospitals.

Shared processes	Sierra Leone	DRC
Alignment of aid with sector strategy	Partial alignment with national plans and strategies has been achieved with a clear need for further strengthening.	Although the health sector donor coordination group (GIBS) has officially adopted health sector strategies, many specific disease-related interventions persist. ..
Well coordinated and harmonised support with common arrangements	Most aid is projectised and off-budget. The RCH strategy formulation process has prompted donors to review joint-financing mechanisms. Major delays, however have been encountered in the design of such options. This has led to major funding gaps. General budget support has been provided which has benefitted the health sector to a limited extent.	Historically, most aid has been project-oriented with project-specific implementation mechanisms. This created significant fragmentation, duplication and generates high transaction costs. To create a common arrangement, without risking high levels of fiduciary activity, the Ministry of Health, in collaboration with the donor community, is setting up a Cellule d'Appui et de Gestion through which the Global Fund, GAVI through with the EU is considering channelling funds. This cellule includes a responsible monitoring of fiduciary risks. Geographical coordination between donors exists. General budget support and sector budget support does not exist in a structured manner. The EU and the World Bank are currently considering the disbursement of general budget support. Apart from that, debt relief can be seen as a form of disguised budget support. With respect to emergency aid interventions, a pooled fund is operational and operates in parallel to the government.
Effective sector coordination mechanisms with clear stakeholder mapping	Major coordination structures are in place although most are limited to information sharing and do not extend to strategic analysis and joint decision making. There continues to be a discrepancy between the expectations of the MoHS and donors. The MoHS perceives strategic decisions regarding aid allocation to be donor driven while donors are awaiting decisions made by the MoHS. This results in a stalemate that hampers positive outcomes in the health sector. There is weak inter- ministerial and intra MoHS coordination and harmonisation. Harmonisation of procedures and systems is still poor, there is fragmented stakeholder mapping. There is evolving central-peripheral coordination in district development planning processes as well as a District Inter-agency Coordination Mechanism	Between donors, a health sector donor coordination group (GIBS) exists. The group discussions are, however, limited to information exchange. In 2008, the government set up thematic groups, two of which relate to the health sector. These groups, each with a particular area of focus, are supposed to function as the prime forum for policy dialogue between donors and government. Although the constitution foresees a delegation of spending towards the provincial authorities, provincial and national authorities have agreed to keep personnel expenditures, (the lion's share of expenditure), at the national level.
Joint, comprehensive capacity building approach	Capacity building is fragmented with variable levels and predictability at central and district levels. There is no capacity building plan in place and there is a fragmented approach to technical cooperation.	Up to now, the government has not elaborated a comprehensive capacity building strategy. Therefore, donors act individually and a multitude of uncoordinated donor initiatives support capacity building in the sector at different levels. The coordinated support for the setup of the Cellule d'Appui et de Gestion (CAG) could act as a pilot project to move towards a more coordinated approach.

Sector M&E	Sierra Leone	DRC
<p>Comprehensive monitoring framework in place against jointly agreed targets, which enables monitoring of aid effectiveness, health service programmes and resource allocation, and is results-focused</p>	<p>There is no comprehensive and integrated M&E framework in place but there are plans to create one based on the NHSP.</p> <p>Sector tracer indicators on PRS, MDGS and Paris monitoring are provided to DACO but there is no joint and standardised monitoring of indicators. Health service programme monitoring is weak.</p> <p>Attention to monitoring vertical programmes and to NGO support projects risks undermining the scope for a systems approach.</p> <p>Health Metrics Network has supported piloting HMIS in selected districts since 2005, but these efforts have been undermined by a lack of staff capacity (to record, collate, analyse and use data) as well as limited capacity building measures, limited resources for further scaling up and poor data quality.</p> <p>There is also limited aid tracking. There are parallel initiatives at MOF/DACO and the NGO/aid liaison office at the MoHS and therefore greater need for standardisation and coordination.</p>	<p>In the case of the NHDP 2011-2015, a results-focused M&E system has been integrated into regular monitoring processes at all levels (zone, district, province, national). This system is, however, not yet operational. At present, monitoring systems consists of parallel monitoring processes at individual program and project levels. These parallel processes place a high demand on the country's M&E system, crowding out the country's own evaluation processes.</p> <p>The Direction de Coordination des Ressources Extérieures is responsible for the monitoring and evaluation of the Paris Declaration.</p>

Use of PFM systems	Sierra Leone	DRC
Improved budget processes & allocation & operational efficiency	<p>The overall PFM systems are comparable to other SSA countries and show a trend of improvement. At the health sector level, however, significant PFM capacity building is still needed.</p> <p>The introduction of the MTEF, IFMIS and district development planning has started and brought about some improvements in the budget process and the allocation of resources. Major bottlenecks remain, however, regarding budget comprehensiveness; transparency and predictability; capacities relating to payroll management, accounting, internal controls, procurement; and audit functions.</p>	<p>The overall PFM system is well below SSA standards and practice.</p> <p>Line ministries do not participate effectively in processes of budget formulation. They are informed of an overall budget envelope but not of the indicative envelope allocated to them. They do not make an effort to produce a realistic and credible budget proposal based on a sectoral strategy because past experience tells them that most of the spending proposals will not be approved – and even when they are, funds fail to materialise.</p> <p>The recent MTEF, integrated into the NHDP, can improve coordination between sector strategy and the annual budget.</p>
Aid using country PFM systems	A small share of aid uses country PFM systems. Most aid is managed by parallel PIUs.	Aid does not use country PFM system (with the exception of debt relief).
Use of (more aligned) aid modalities	GoSL benefits from general budget support. Donors in the health sector rely predominantly on project aid, which is mostly off-budget. There are discussions underway, however, about setting up a pooled fund in support of the RCH strategy.	The setup of the CAG is (with the exception of debt relief), up to now, the only example of donors trying to use the country's PFM system
Contribution of aid modalities to health sector strengthening	<p>Some support for the strengthening of health systems has been given by donors – mostly in form of project aid (i.e. trainings, technical assistance). These efforts, however, have been fragmented with uncertain effects on long-term capacity building. GBS has promoted the overall strengthening of PFM and streamlining policy dialogue at the central level but this has had limited effects on the health sector (in financial and institutional terms).</p>	Some support to strengthening of the health sector has been provided by donors in the form of fragmented interventions. As donors do not use more aligned aid modalities, however, they undermine rather than enforce health sector strengthening efforts.
Predictability in the availability of domestic and external resources	Non-salary recurrent expenditures and aid show high unpredictability.	Personnel expenditures, which make up nearly 80% of domestic health expenditures, are highly predictable. Non-salary recurrent expenditures and aid show high unpredictability.