Managing external resources in the health sector: are there lessons for SWAps?

GILL WALT,1 ENRICO PAVIGNANI,2 LUCY GILSON1,3 AND KENT BUSE1
1Health Policy Unit, London School of Hygiene and Tropical Medicine, UK, 2Independent Consultant, Maputo, Mozambique and 3Centre for Health Policy, Johannesburg, South Africa

Drawing on the case studies presented in this issue, from Bangladesh, Cambodia, Mozambique, Zambia and South Africa, and examples from other countries, this paper asks what general conclusions can be drawn about the management of external resources, and specifically what lessons could inform the future implementation of sector-wide approaches (SWAps) in the health sector. Factors constraining the management of aid by ministries of health are grouped under three themes: context and timing, institutional capacities, and the interplay of power and influence in negotiations over aid. Two factors, often underplayed, were found to be important in facilitating management of resources: the inter-relationship of formal and informal relationships, and the extent to which incremental changes are tolerated. The main conclusion is that coordination and management of external resources is inherently unstable, involving a changing group of actors, many of whom enjoy considerable autonomy, but who need each other to materialize their often somewhat different goals. Managing aid is not a linear process, but is subject to set-backs and crises, although it can also produce positive spin-offs unexpectedly. It is highly dependent on institutional and systemic issues within both donor and recipient environments. In promoting sector-wide approaches the key will be to recognize context-specific conditions in each country, to find ways of building capacity in ministries of health to develop and own the future vision of the health sector, and to negotiate a realistic package that is explicit in its agreed objectives. The paper ends with identifying crucial actions that will enable ministries of health to take the lead role in developing and implementing SWAps.

Introduction

A central aim of the papers in this special issue was to explore, through a series of case studies, the factors that have influenced countries' experiences of aid coordination, and to draw lessons from their similarities and differences. In the overview paper that introduces the issue we argued that the concept of coordination has given way to one of 'management', best encapsulated in the concept of the sector-wide approaches (SWAps) for health development. SWAps represent a ‘next generation’ approach to aid, and set out to provide a broad framework within which all resources in the health sector are coordinated in a coherent and well-managed way, in partnership, with recipients in the lead. Are there lessons to be drawn from the case studies on Bangladesh, Cambodia, Mozambique, Zambia and South Africa, or from others’ observations of different countries, for the implementation of SWAps?

Before looking at potential lessons, it is worth examining what factors constrain or facilitate the Ministry of Health’s willingness and ability to manage external resources. This discussion is conducted within a theoretical framework which sees the state in the centre, as the ultimate enforcer of policy. Thus the focus is on the MoH as the most salient state actor in the health sector. Fors (1995) suggests five of the most common constraints occur where there is a lack of common values and norms concerning the purpose of activities; where responsibilities are diluted, and processes of work unclear; where information is not available; where there are variations in administrative systems and procedures; and where coordination is perceived as a threat. These factors affect both donors and recipients, and are mediated through cultural and language differences, ideological values and strategic interests, variation in levels of resources and autonomy, and differences in perceived status. Constraining factors can be grouped under three themes: context and timing, institutional capacities, and negotiations over power and influence, although any distinction between these headings is to some extent arbitrary.

Constraints on coordinating and managing aid

Context and timing

Very poor countries are disproportionately affected at times of upheaval, whether through natural disasters (floods in Bangladesh), or wars (Cambodia and Mozambique), or political and economic change (South Africa, Zambia). Cambodia’s policy environment during the early years of the 1990s, as the international and national community tried to establish peace and move towards the UN-sponsored elections, was extremely fragile: with four different factions (and individuals within them) jockeying for power, with institutions incapacitated and
weak after years of trying to survive, and with considerable donor hostility and distrust both within the donor community, and between donors and the Cambodian state. It took a few years, and resolute leadership, to move towards a more conducive policy environment, in which the MoH and some donors actually worked well towards a coordinated plan of action for the health sector (Lanjouw et al., this issue; Heng & Key, 1995). Cambodia’s experience contrasts with Mozambique’s moves towards peace, when the donor community’s relief effort was successfully and effectively coordinated under the umbrella of the UN (Colombo, 1994), and the MoH undertook a comprehensive policy review of the sector (Noormohamed & Segall, 1992).

Once a measure of stability is ensured, opportunities for change in recipient–donor relations are enhanced. In Zambia, it was clear that a change in government, democratic elections at the beginning of the decade, and some enthusiasm for reform among key Zambian policy-makers, especially in the health sector, provided new room for manoeuvre. Political change among key actors, and additional resources promoted an enabling environment, in which donors and Zambian policy-makers worked well together. Pooling resources in the ‘basket’ for district-level activities provided an opportunity to encourage newly introduced decentralization policies, and to respond to the call for integrated services at the district level. Sustaining this energy and goodwill a decade later, as reforms were implemented and disbenefits became more apparent (for example MoH staff insecurity in relation to jobs), was more difficult, and relations between government and donors became more strained (Lake & Musumali, this issue). Similarly, South Africa’s first democratic elections opened possibilities for reform and shifts in power, and created a climate of some goodwill, with donors regarding the country as a ‘favoured nation’ (Schneider & Gilson, this issue). The problem for the future will be one of sustaining change.

The political and economic context in Bangladesh affects aid management in a completely different way (Buse, this issue). There it seems that a long period of military rule followed by blatancy and economic corruption, non-accountable public institutions and social upheaval provided the impetus within the donor community to ‘keep a tight rein’ over the use of aid resources.

These examples underline the point that each country’s context is unique, its history determines its legacy, which in turn influences systems of government and people’s attitudes and behaviour, including that of donors, to resource management. Measures taken to coordinate and manage resources need to be flexible enough to respond to that uniqueness; and their effectiveness is partially governed by the uniqueness. Further, as contexts change, coordination which may be effective in one period, may not be in another.

**Institutional capacities to coordinate and manage aid**

The interdependence of the institutional capacities of recipients – in particular the MoH – and of donors is an essential equation in understanding the way in which external resources are managed. Evidence from the case studies suggests that this has been a somewhat unequal relationship, although criticisms are levied at both recipients and donors.

One of the recurring themes of the late 1980s was around issues of governance in the public sector of developing countries, and the way authority is exercised in the application of government policy and in the management of the public sector (Healy & Robinson, 1992). Criticisms were commonly made of over-extended public sector systems, characterized by a lack of accountability, transparency and participation. Consequently, many governments were forced, as part of conditions on World Bank or IMF loans, to address such concerns, and as a result, many countries have formulated policies to reform the civil service (for example, by retrenchment, improving selection and performance monitoring) and to decentralize functions (to enhance accountability), among other things. It may be that, as donors have perceived governments introducing such reforms, and moving towards ‘good’ government, they have been willing to relinquish some of their controls over the coordination of external resources, and replace them with management tools. However, it is also true that as recipient systems were exposed as wanting and weak, some donors may have felt further legitimized to continue their support for individual and donor-led aid management arrangements.

Institutional capacity is highly dependent on the robustness of existing public administration systems, as well as the capacities of individuals within them. Indeed, although many of the papers in this issue refer to the MoH as an actor, this is conceptual shorthand for a number of different players within the institution, who may take opposite or contradictory positions. Ministries of health are complex organizations, all the more so with reforms such as decentralization and changes in functions (e.g. contracting out service delivery), and within the MoH people belong to different departments or divisions, with differing interests, core competencies and functions. Trade-offs on aid may occur within the MoH, as well as between the MoH and other government ministries, donors or NGOs dealing with aid relationships. Consensus within the institution cannot be assumed, nor can coordination of action between MoH departments or central and local health institutions be taken for granted. The paper on South Africa observes that the lack of clarity regarding the roles and responsibilities between the national and provincial spheres in the quasi-federal system in that country, affected relationships as differences over access to, and transparent funding of, aid were contested (Schneider & Gilson, this issue).

That people matter is undoubted. The case studies in this issue show that individuals – whether top politicians, middle level project managers, or experts or consultants, within and outside government – affect relationships within the policy environment in a myriad of ways. Many have observed that the absence of leadership combined with the rapid turnover of top politicians or civil servants (Lucas et al., 1997; Van de Walle & Johnston, 1996) are factors which constrain policy development and formulation. In South Africa, Zambia and Mozambique, successive Ministers of Health have played crucial leadership roles – demonstrating their ability to mobilize
government (and public) support for changes in the health sector for example. Processes for planning and utilizing aid need time for negotiation and consultation to ensure effective implementation, and if there is poor continuity in personnel, negotiations and learning from practical experience may be threatened. In Zambia, a conscious effort was made by some donors to maintain the length of service in country and the seniority of key donor representatives, and this continuity, as well as the force of certain personalities, was seen to be a contributing factor to the support offered to the MoH in reforming the health sector (Lake & Musumali, this issue).

At middle levels, individuals also affect the management of aid. For example, technical managers in task networks are affected by changes in the political and economic environment. Where the economic situation is such that they are struggling to keep up living standards, or where civil service rules are unclear or not adhered to, or personnel are demoralized, they may perceive the introduction of mechanisms to improve coordination or management of external funds as a threat, a personal loss of control. Managers may lose the close contact with specific donors, relationships which often bring both personal and financial rewards. These may be more symbolic than anything else – shared interests in a project’s expansion – but may also include access to fax machines or vehicles, refurbished offices, trips overseas to attend meetings, training opportunities, and even monetary incentives. The loss of these patronage systems, however well intentioned, may result in behaviours that resist or undermine coordination attempts.

Thirdly, experts or consultants involved in technical assistance (TA) may affect the way in which aid is coordinated or managed. In South Africa, for example, Schneider and Gilson’s research (this issue) suggests that the experience of technical assistance was both positive and negative. On the one hand, the continuous location of health advisers in DFID, the EU and USAID was a major factor in generating a high level of support orientated to national priorities, but on the other there was considerable disarray between a series of different South African and international consultants all introducing planning and managerial processes, who were poorly coordinated with each other and with government. This was Cambodia’s experience in the early 1990s too. While TA for building systems (as in South Africa) is generally deemed more useful than TA for filling particular gaps (as in Cambodia), some recipients are concerned about the sense of national ownership and pride in sustaining systems largely initiated or devised by outsiders, and about the possibility of the inappropriate imposition of ideas and approaches originating in different systems and contexts. Short-term consultants are often seen as a waste of financial resources and time. However, much depends on the context and timing – short-term TA may preserve systems that would otherwise be dismantled, and it is often much harder to start a new system than to improve or reform one which is underperforming. There are, likewise, controversies over the hiring of nationals by donor agencies, seen on the one hand to be an indication of trust in local capacity, but on the other, to have the potential for creating tension, or even resentment in the recipient authorities, who may mistrust the loyalty of nationals who staff aid offices. There are also debates about moving competent national managers to donor advisory positions, and thus weakening state systems.

While considerable attention has been paid to principles of good governance within the institutions of developing countries, much less scrutiny has been paid to donor agencies. This is largely because donors work within constitutional frameworks of rules and regulations (Casson, 1986), to which they can be held accountable and which are only occasionally broken. However, they can be dauntingly bureaucratic, and ponderous – in this issue Schneider & Gilson report an interviewee as describing the EU’s reporting requirements as ‘death’, and recipients have also complained of lack of timeliness, lack of transparency, and few opportunities for local participation in agency decisions which affect the country (Cliff, 1993). Donors are often perceived by recipients to be unreliable, defaulting on pledged funds, minor and major (Pavignani & Durão, 1997; Daura & Mulikelela, 1998).

Further, there are great differences between donor agencies in terms of mandates, financial and technical capacity, agendas, approaches, and freedom to manoeuvre. The relatively clear division within and between bilateral and multilateral agencies broke down in the 1980s, and as criticisms of the UN organizations mounted (Lee et al., 1996), bilateral lost some of their confidence in the UN and increased their technical capacity at the country level. While technical people only advise the diplomatic policy-makers in country offices, they can have considerable influence in the policy process at sectoral level.

Donors’ strengths and weaknesses are perceived very differently by each other and by recipients. For example, an unpublished survey of 14 donors in Mozambique, which asked each donor to judge, on a scale of one to four, a range of other donors’ attributes from flexibility and transparency to reliability and visibility to the public, demonstrated distinctly different perceptions. Thus the World Bank was perceived by most of the other agencies to be strong in influence, wealth and defined policy, but relatively inflexible, non-transparent and closed. Certain bilaterals (largely the Nordic, but not only) were judged to be less influential, less visible to the public, and weaker in policy development than the World Bank, but strong in characteristics such as flexibility, reliability, collaboration, networking, implementation and risk-taking (Pavignani & Durão, 1997). USAID, on the other hand, in both Zambia and Mozambique, was perceived to be constrained by domestic rules and regulations, albeit with strong technical skills. Some donors are also seen to be more favourably inclined towards coordination than others (e.g., in many countries, the World Bank is often viewed as an agency that values and pursues coordination, while USAID is not).

However, donors can hold different reputations in different countries. Whereas most agencies have developed quite elaborate strategies for intervention world-wide, the stringency and uniformity of their application varies greatly. The judgement of the local representative may often be the crucial factor in determining how and when to implement global
strategies – as was the case in Mozambique in the 1980s, when a programme promoted by UNICEF on oral rehydration therapy was not introduced because it contradicted local policy. As already observed, aid relationships are strongly mediated by particular personnel in country offices and their involvement in the aid process, in both positive and negative directions. For example, UNICEF and USAID have not been major players in coordination in Mozambique over the past decade, but have had important roles in Zambia and Malawi respectively (Pavignani & Durão, 1997). After changes in donor personnel in both of these agencies in Mozambique in 1997–8, their interest in, and commitment to, coordination increased significantly.

Donors’ levels of influence are not necessarily consonant with their levels of funding. In the late 1980s and early 1990s UNICEF and WHO played a strong supporting role to the Zambian MoH (Lake & Musumali, this issue). In Mozambique, Swiss Development Cooperation played a central role as ‘lead donor’ in supporting the MoH to manage external donors through the 1990s, even though it was not the largest contributor of overseas development assistance (ODA). It has also provided an example to other donors in its preparedness to provide budget support for recurrent costs. In Cambodia, WHO and, to a lesser extent, UNICEF were designated lead agencies in 1992–3, although later WHO and DFID (then the UK’s Overseas Development Administration) provided special lead support to the MoH in Cambodia (Heng & Key, 1995). However, other donors sometimes regard the role of lead donor as collusive and marginalizing. In Bangladesh, for example, there existed an ongoing tension within the consortium over how accurately messages were being conveyed by the Bank to the government and whether these reflected more closely the views of the Bank as opposed to those of the consortium as a whole (Buse, 1999).

What is clear is that donor–recipient relationships are not static, but change over time. How a given agency becomes influential in the policy arena depends on a variety of factors, including financial weight, technical capacity, innovative approaches, negotiating skills, consistency and willingness to take risks. Excellence in only one dimension may not be sufficient to turn an agency into a leading player, whereas a balanced mix of the appropriate strengths may achieve it. The Swiss Development Cooperation’s role in Mozambique seems to have been in this position in the early and mid 1990s.

Negotiating power positions: the willingness and interest to coordinate and manage aid

Donors have power through their control over resources, and often behave relatively individualistically. It appears to hold true, irrespective of whether or not aid resources are scarce or abundant (i.e. an excess of aid offers over absorption capacity), that there is competition among donors and opportunistic behaviour among recipient authorities. An evaluation of aid coordination in five countries of West Africa suggested that where national self-interest is the defining motive in aid-giving and receiving, coordination is likely to be of marginal interest to both donors and recipients (Brown et al., 1998), and indeed, in those five countries (Burkina Faso, Cameroon, Cote D’Ivoire, Senegal and Togo) coordination mechanisms were found to be extremely weak.

At times, aid coordination and management is viewed by donors as a strategy to enhance their own influence over the development process. Some donor agencies have been explicit in this regard. A recent World Bank discussion paper, for example, states that ‘priority will be given to leveraging our finance and advice by partnering with others...’ (World Bank, 1998a). The case studies provide evidence from the country level of how this plays itself out in practice and how, at times, naked attempts to utilize coordination to increase agency leverage does not lead to the type of systems outcomes which are being sought. In Bangladesh, for example, some have questioned whether the investment of substantial financial and technical resources in the Bank’s population and health office to manage project aid (and coordinate the activities consortium members) has not been at the expense of, or even obviated the need for, strengthening governmental systems to manage resources (Buse, 1999).

Donors also bypass existing structures to advance their own priorities or to ensure disbursement of funds where recipients either cannot, or choose not to, prevent donors from acting in this way – as is graphically described in the Cambodia case study in this issue, where the questionable legitimacy of the interim administration led donors to channel support through NGOs rather than existing public administration sectors (Lanjouw et al., this issue). Saasa & Carlsson (1996) suggest that donors are often allowed ‘exaggerated latitude’ by recipients to follow their own technical procedures rather than the government’s. Some donors make a practice of acting alone. The Japanese agency, JICA, often takes this position, and in Bangladesh, USAID and other bilateral agencies have preferred not to join the World Bank-led consortium of donors in the health sector because this would circumscribe their strategic or operational autonomy (Buse, 1999). Recipients often comply with donors who insist on controlling their own ODA. Either way, both donors and recipients play one off against the other.

On the one hand, Van de Walle and Johnston (1996; 110) suggest that until ‘governments are willing to turn down donor aid that is granted through channels that undermine government coordination, donors will continue to use the procedures that suit them best’. As the case studies suggest, governments only seldom reject aid, although the South African case study offers examples of where aid was only agreed after negotiation, and as long as it met locally defined needs. In many cases, however, although poorly coordinated assistance may be a burden to the health sector as a whole, it is nonetheless tolerated and perpetuated because of the benefits it brings to vested officials and agencies.

On the other hand, Pavignani & Durão (1997) suggest that donors may fear that if they are too demanding they may be bypassed by the MoH in favour of other, more lenient agencies. To resolve this apparent prisoner’s dilemma, some donors with common approaches have created strong groups (for example, the consortium in Bangladesh and ‘like-minded’ groups in other countries), and often use such coalitions of interest to influence policy. For instance, in 1987 following then
President Kaunda’s decision to abandon the structural adjustment programme, several bilaterals suspended aid to Zambia (Lake & Musumali, this issue). Similarly in 1992 donors froze all non-humanitarian aid to Malawi because they were concerned about basic human freedoms (Mvula & Munthali, 1997). Hence, while competitive donors may on the one hand, bypass coordination arrangements to advance their corporate interests, they may, at other times, agree a common approach, or enter into coordinated arrangements so as to enhance their leverage to pursue particular issues.

The extent to which donors are prepared to negotiate over their inputs with other donors as well as recipients, or to concede some autonomy, are clearly issues which will affect SWAps. Successful sector-approaches depend on as many donors as possible buying into a sector-wide plan, although a SWAp may be initiated with a few significant donors, and will only be effective if all investors and the government negotiate and agree common goals and objectives, as well as uniform management arrangements. These case studies suggest that there are significant differences between donors and between donors and recipients in overall aid objectives, which may well undermine SWAps. This is borne out by the discrepancy demonstrated between the vocal optimism and support for SWAps from donors, bilaterals in particular, and their actions at the country level. The survey among donors and Bangladeshi government officers conducted by Buse (1999), in which positive attitudes toward the theoretical SWAps give way to cautious and sceptical responses in practice, suggests that this area needs further consideration. In particular, there is a pressing need to design and test processes through which negotiations over country strategies can become more inclusive and broadly owned.

The power to take risks

A recurrent theme underlying many of the case studies is the notion of power, in the sense of taking risks in the management of aid. Risks are taken by recipient authorities, as well as by donor agencies. However, the risks incurred by each side are qualitatively different. Recipient authorities live with the uncertainty and the disruptions induced by donor pledges and commitments which sometimes do not materialize, and with changing fashions in donor preferences for aid. They are also aware that certain policies (strongly supported by donors) may hurt vested interests, and induce political backlashes. The risk-taking of donor agencies is often less dramatic: jobs are seldom on the line, although reputations and careers may be. Sometimes, risks entail the breaking of some bureaucratic rules, or failing to deliver the promised outputs. At the end of the 1980s, providing financial support for recurrent costs to recipient governments was against the received wisdom of the time, and implied a considerable initial risk for the first agencies willing to experiment (see Pavignani & Durão, this issue). Proponents of the SWAp advocate the introduction of time-slice finance, whereby investors (including donors) make annual contributions up-front for a proportion of the agreed expenditure plan, a proposal which is currently seen as far too risky for most donors but one which a select few are willing to assume (e.g. the World Bank, Sida and DGIS in Bangladesh).

Risk is perceived as such when the odds for failure are estimated to be relatively high, where most advisers are against the proposed move, and where the implications of failure are serious, visible and possibly documentable. The findings from these case studies suggest that some failures in coordination efforts may have had their roots in the conservative risk-avoidance of some managers. Alternatively, risks may not always be recognized until after a crisis has occurred, as the Sarafina case in South Africa demonstrates, where new, and relatively inexperienced policy-makers at the MoH underestimated donors’ concerns with detail and due process (see Schneider & Gilson in this issue).

Both recipients and donors may be tempted to minimize risk by taking (or not) measures which in fact undermine coordination. For recipients, diversifying the sources of financing for the same activity is an insurance against donor defaulting, and a way of potentially rewarding particular MoH personnel, but makes coherence and, therefore, coordination, much more difficult. For donor agency officials, adhering to rules is a strategy for reducing criticism from HQs and blaming the recipient for failure. However, risk avoidance, as suggested by these examples, also may constrain the partnership, reducing room for manoeuvre, partly because recipients and donors are usually uneven in their adherence to rules and regulations. It is easy for donors to delay or block decisions, using home regulations as the reason, or the lack of an adequate system in the recipient country, putting recipients at a greater disadvantage and possibly undermining an already weak system. Many public administration systems in low-income countries are not well developed, lack clear management practices, procedures and regulations, and donors often lack confidence in them. The ‘basket’ system in Zambia was slow to put in place because the donors wanted to be assured not only that the financial management system (FAMS) was efficient and could be monitored, but that it conformed to the different expectations of each donor. While, the ‘basket’ system can be seen as a strategy of relatively limited risk, given the small portion of funds put into it (15% of the health budget) it could be argued that it represents some risk to government, having to expend huge effort for only a small proportion of the health budget. One of the likely delays to widespread and substantial donor involvement in SWAps will be strengthening weak public administration systems so as to reassure donors that resources will be properly utilized and accounted for.

Recognizing that these three areas of constraints to active management of external resources exist – uniqueness and timing, system failures, and asymmetry of power, all of which make the context of aid management inherently unstable and dynamic – what do the case studies suggest may facilitate the management of aid?

Facilitating aid management by recipients

Two factors, often underplayed, were found to be important in facilitating the management of external resources: the inter-relationship of formal and informal relationships between recipients and donors, and the extent to which incremental changes were tolerated in management systems.
There is a fundamental, ongoing tension between the formal mechanisms established to coordinate aid, and the acknowledged importance of informal communications and relationships between the various actors, in making coordination and management work. Others have provided evidence of considerable informal networking between key policy-makers or managers in both donor and recipient organizations (Nolke, 1993). Informal interaction was perceived to be absolutely essential at nodal points of decision-making, to understand practice, to ensure implementation or to keep dialogue open. However, at certain stages, informal mechanisms were also important in the implementation of aid instruments.

The Mozambique case study suggested, for example, that at the point of introduction of a new instrument (such as budget support), when little experience existed on how to move forward, it was helpful to avoid blueprints, to have few rules, and to allow considerable flexibility in the management of the particular tool being introduced. This allowed for exploration and learning, and from such experience more robust mechanisms evolved, which conformed to internationally agreed norms, standards and rules. Trying to devise a perfect system a priori can dissipate enthusiasm and energy, and lead to a narrow focus on means rather than ends. Some have suggested that organizational reforms in Zambia suffered somewhat from this approach – with more attention given to the establishment of the system (which took a great deal of time) and less to the impact of decentralized management on health delivery (and ultimately on health outputs) at the district level. Lake & Musumali in this issue show that while FAMS provided more information on district systems, reports were limited to the degree of timely achievement of planned activities, rather than providing details of service delivery or utilization or health status.

Despite the importance that informality plays, particularly in relation to initiating and sustaining most mechanisms, experience simultaneously underlines the need for formal agreements. For example, misunderstanding and conflict over roles, responsibilities and accountability arose on a continuing basis among consortium members in Bangladesh (Buse, 1999), the response to which involved the increasing formalization of the processes underpinning the consortium arrangement (i.e. expanding the range and coverage of written agreements and records of discussion). Similarly, a general agreement exists that the SWAP is to be based on a series of formal (but unique) partnership agreements at the country level, including a statement of intent, a document setting out a collaborative programme of work, a memorandum of understanding among key stakeholders, and an agreed code of practice (Cassels, 1997). These are deemed to be necessary so that an agreed division of labour within the partnership is explicit as are the mutual and reciprocal responsibilities. However, achieving these formal agreements may be difficult – they have been reached in both Ghana and Zambia, although at the time of writing the Memorandum of Understanding had not been signed in Zambia (Lake, 1999).

There may be limits to the extent to which formal agreements can induce improvements in aid management. Although the processes underpinning the consortium in Bangladesh became increasingly formalized and institutionalized, problems relating to roles, responsibilities and accountability persisted, stemming from differential interpretations of existing agreements, which suggest that formal arrangements cannot substitute for the willingness to engage in partnership. And that willingness will be highly dependent on individuals and their abilities to function at quite informal levels.

The other suggested facilitating factor in the management of aid by recipients in the 1990s – incremental introductions of health reforms – was also characteristic of the case studies. The different attitudes, ranging from enthusiastic to reluctant approaches, have influenced the attitudes and responses of policy-makers in both donor and recipient organizations in complex, synergistic inter-relationships. Where an MoH has driven reform, donors have often been patient at points of difficulty (for example, in Zambia) in supporting the health sector when good governance issues were blocking aid negotiations with the government. In Malawi in the 1990s, where none of the same confidence or commitment to change was apparent in the MoH, donors were at a loss to know how to support the MoH (Mvula & Munthali, 1997). In contrast, South Africa stands out among these case studies as being more certain of what it wants, and with the pre-election Reconstruction and Development Plan (RDP), presented a strong basis for negotiation on its own terms, which was respected by donors.

Donors have often been blamed for the fragmentation and inefficiency affecting the health sector. As has been said, donors are sometimes seen as cynically ensuring a lack of coordination because they are keen to preserve their autonomy, their visibility and their agendas, and are resentful of controls exercised by recipient authorities. This may be true for some agencies and some officials in certain countries. However, some of these case studies suggest a different picture. There has often been commitment and a positive stance towards the MoH leading and managing external resource utilization, although this has differed over different periods. Many donors have fully endorsed government plans, and when conflicts have arisen, it is sometimes because of donor pressure on MoH officials to fully adhere to chosen strategies.

In Bangladesh, the lack of leadership by the MoH was cause for concern among donors. While it did not lead to the malaise among donors described by Mvula & Munthali (1997) in Malawi, the move towards a sector-wide plan for health in 1997 and 1998 was eventually welcomed by most donors in the Consortium as a positive move, and not a usurpation of their control (Merrick, 1997). It seems that, far from enjoying the additional autonomy that a weak recipient provides to them, donors may prefer to work with ministries that are resolute and have a plan of action. South Africa used its Reconstruction and Development Plan to keep donors’ commitments within national priorities; Zambia won high praise for its ‘vision’ for the health sector. If this pattern holds in different contexts, the potential for recipient responsibility in triggering the donor actions and reactions which facilitate aid management and coordination is even more important than commonly accepted. The lesson here is that donor
recognition of recipient leadership is not granted on grounds of sovereignty, but earned through hard work, consistency and clear, convincing ideas. This depends, of course, on MoHs having considerable capacity, even if only among a small number of high-level cadres, and having consistent government processes and procedures. The Ministry of Finance or Planning, for example, usually has more influence within the government than the MoH, and can undermine or contest MoH policies, or delay implementation through non-release of funds.

Coordination is inherently unstable in nature. It involves many players, who enjoy a considerable level of autonomy (who may have to cede some in order to cooperate on shared practices), but need each other to materialize their (slightly different) goals. Relationships, agreements and deals evolve or are suddenly altered by players, according to perceived convenience and opportunity. The coordination arena is similar to the financial markets, even to the stock exchange floor, with its rapid ups and downs, its outbursts of optimism followed by disappointment. Thus the disillusion occasioned by the Sarafina debate in South Africa (see Schneider & Gilson this issue) may have been replaced by a more realistic understanding of the aid relationship on the part of both government and donors. Moreover, when new coordination arrangements or management tools are introduced, a period of system disruption is likely to ensue, as old mechanisms are abandoned and new ones are not yet operational. This gives room to criticism by parties hostile to change, and a strong pressure for returning to the status quo. If the new instruments are eventually successful and take root, another period of stability and achievement follows, with the system performing at a higher level, until a new wave of change takes place.

Figure 1 below tries to depict this evolution in a schematic manner. This suggests that aid management is not a linear process, with clear progress towards an effective, agreed system, but a relatively changing, continuing negotiation between different actors, with a relatively high level of discontinuity among the various players. It is highly dependent on systemic factors, some of which the MoH cannot control (political upheaval or fragility, economic downturns, movement of key individuals and managers, changing donor agendas and priorities), some of which are, in turn, affected by the wider characteristics of the public administration and corporate donor systems, which shape attitudes and behaviour. The figure shows waves of change, both upwards and downwards, as managing external resources is influenced by crisis and change. It also suggests that there may be unexpected consequences from the introduction of new aid instruments aimed to improve coordination, the emergence of positive side-effects, or spin-offs.

In Mozambique, for instance, the provision of recurrent budget support led to a detailed revision of the criteria by which government budget resources are allocated, for example between hospitals and primary health care. But, to be applied meaningfully these criteria required a dramatic strengthening of information about available inputs and service outputs. Once the MoH had collected and disseminated the necessary information, many donor agencies repositioned themselves, often spontaneously, to cover funding gaps, previously not apparent, and to limit duplication. These gains were not envisaged at the time budget support was introduced. Another crucial point of the whole process is that success creates its own momentum, leading to the progressive introduction of more ambitious schemes.

Lessons learned and what they suggest to future SWAps

From these and other case studies, what lessons are generalizable to other contexts, and which may have relevance for SWAps?

![Figure 1. The ups and downs of aid management](https://academic.oup.com/heapol/article-abstract/14/3/273/606592/16-December-2018)
What is a SWAp?

Sector-wide approaches (in the form of programme aid) have been promoted by the World Bank since the late 1980s, although it is only since the mid-1990s that they have been more generally supported by bilateral agencies and some recipient governments. Derived from sector investment programmes or sector expenditure programmes, SWAps are instruments through which to deliver agreed-on health policies and to manage aid and domestic resources in a rationalized and optimal way.

What makes SWAps attractive is that they are perceived as being able to strengthen governments’ ability to oversee the entire health sector, develop policies and plans, and allocate and manage resources. They envisage a different and expanded role for MoHs, for example, where policy-makers will look beyond the public sector, to explore the potential role of other stakeholders, whether service deliverers in the private sector or financiers. Peters and Chao (1998) give the example of Ghana, where performance contracts have been developed between mission providers and government, and where, like Zambia, public providers are being moved from employment through the civil service, to another public agency, with different terms and conditions of employment.

SWAps entail a number of additional implications. For one, they propose that donors will ‘give up the selection of which projects to finance in exchange for a voice in the process of developing sector policy and allocating resources’ (Peters & Chao, 1998: 188). Thus, SWAps are seen as being organized around a negotiated programme of work, and will only succeed if there is sufficient commitment to shared goals on the part of government and key players in the donor community. Reaching agreement on such goals may be extremely difficult, given the range of motivations driving the different organizations involved in negotiation. Most crucially, they are predicated upon national leadership and ownership, which requires that donors provide recipient authorities with the space and time to think, experiment, fail and try again, and that recipients are able and willing to assume this risky challenge. They are seen as being implemented over the medium to long term, thus reinforcing the requirements for long time-horizons, continuity and commitment. Moreover, SWAps aspire to the use of national systems for managing resources which will require not only significant strengthening of existing resource management arrangements but also structural and organizational reforms in the donor agencies. Finally, it is argued that SWAps will only be successful under relatively stable macro-economic conditions (Cassels, 1997). From the foregoing analysis of the different case studies, what chances are there for SWAps in the future?

Lessons learned

1. It is clear that lack of coordination affects the whole health sector, jeopardizing the efforts of all stakeholders because of resulting inefficiencies and fragmentation. It is also arguable that the effectiveness with which aid is coordinated and managed depends on the number of stakeholders who take a positive and active part in partnership arrangements. As such, effective aid management should rank high on the agenda of all involved actors. In countries where the health sector is highly dependent on external support, recipient and donor authorities should work together toward more effective management systems. Thus, coordination should be perceived as an issue owned and shared symmetrically on both sides of the aid relationship. Unfortunately, the case studies suggest that often coordination is resolutely (if sometimes rhetorically) promoted by donor agencies (but by no means all), and tolerated by recipient authorities. While it is easy to understand that this arises from the asymmetrical power relationship between relatively weak recipients (who see improved management as a threat to their own autonomy) and relatively powerful donors, it is likely to be negative for health sector development. This problem can be overcome only through frank dialogue and the patient nurturing of mutual trust.

SWAps demanding a commitment to a longer-term, broader sectoral vision, may be strongly resisted by those who have gained from the spoils of fragmentation (whether they are officials in recipient organizations, or donor representatives, or aid agencies themselves) where they feel that coordination constrains their ability to pursue explicit or hidden individual or corporate agendas. Rapid personnel changes in both MoH and donor agencies may also militate against the development of longer term visions, and the ability to build on institutional memory of what works and what does not. Donor representatives seldom spend more than five years in one country, and the turnover of top level staff in MoHs is notorious (Lucas et al., 1998).

2. Ironically, coordination is particularly desirable, but most difficult, where recipient resources are scarce and management capacity is weak. In such situations, there is little to lose, and attempts at some level of coordination may be worthwhile. However, any effort has to be within the framework of a slow, time-consuming and labour-intensive process. Success will ensue only if the right mix of commitment, stability, technical skills, and sustained leadership is in place within both recipient and donor agencies. Further, progress is never assured. Change will hurt vested interests, who may fight back as opportunities arise. It will be necessary to put in place a long-term capacity-building strategy, to build up technical and managerial skills, and to strengthen public administration within government institutions so as to allow a SWAp to take root and inspire donor confidence. Experience with SWAps to date suggests that this remains not only a major challenge to widespread participation in SWAps but also an attribute which provokes considerable scepticism (Peters and Chao, 1998).

3. The reputation of the recipient is of central importance to the successful reform of aid management processes. To believe in the national authorities, donors need to find in place (or to participate in the development of) convincing plans and expenditure programmes, built on solid information. Donors need to feel that plans are consistently implemented in an open and transparent environment,
and that the chosen policies are followed over time by stable government staff which provide continuity to the process. Sector-wide planning is a complex process, and MoHs in low-income countries may need significant assistance in building up information, financial and surveillance systems to allow them to formulate realistic plans, set priorities, devise sensible indicators, and then to monitor the whole process. SWAps are based on the OECD (1992) principle of putting the recipient in the driver’s seat, but these case studies show that leadership cannot be ‘given’ by well-meaning donors. It has to be demonstrated and exercised through competence and commitment by the MoH and other involved government departments. Where leadership is lacking, donors should be helping to build capacity through improving the information and management systems that provide the basis for the confidence required to plan ahead. As noted above, whether or not donors can additionally provide recipients with sufficient latitude to take up the demanding task of leadership and whether or not recipients rise to meet the challenge remains a moot point. What seems incontestable is the poor prospects for SWAps where this does not occur.

4. To feel comfortable with donor agencies, recipient authorities need to be reassured that donors understand the local picture and are sympathetic and supportive of recipient efforts, that they are prepared to adapt to local needs and procedures, and are able to lobby their headquarters for more leeway, flexibility and support to trials of resource coordination and management by recipient authorities. It would appear that much more thought and effort needs to be expended in the area of finding acceptable ways of monitoring aid programming and utilization which are not disruptive and taxing on local capacity and which strengthen indigenous systems. Donor agendas should be explicit and acceptable, with conflicts and divergences dealt with frankly and explicitly. The recipient should not feel hostage to powerful donors. The case studies suggest that many of these conditions are not being met, and are often highly influenced by particular individuals. If SWAps demand developing a consensus around a programme of work and the use of common management arrangements, much will need to be done to change the attitudes and behaviour of both recipients and donors.

5. Just as the context of each country is unique, so these case studies demonstrate that ‘blueprints’ are not useful: there is no particular recipe or path for successfully managing external resources. Each sector and country has to work out its way by trial, error, adjustment and re-trial. Much will depend on the organizational capacity and stability of the public sector in general, and of the health system in particular. This evolutionary and process-oriented approach to aid management has several implications. First, initiatives can be taken even when enabling conditions are not apparent. If pressure is maintained over a sufficient period, joint working can, of itself, induce the emergence of a favourable environment. Second, the donor–recipient relationship provides a crucial learning ground for all partners by building trust and demonstrating the resolve to overcome difficulties and move forward. Moreover, constraints are thereby identified, skills acquired, and (hopefully) solutions found. These are long-term and incremental processes, and officials need to have sufficient time to see processes through. Third, there is no intrinsic upper limit to effective management of resources. Once the first stumbling blocks have been removed and the picture has improved, new requirements, previously not obvious, emerge.

There are subtle implications for SWAps: they should not be seen as setting gold standards, but be built on the basis of comprehensive, visionary plans, developed in each country in accordance with local capacities and actors. The lessons should be learned from aid instruments already tried and tested, and SWAps should, therefore, be built on their foundations in an incremental rather than radical way. Then if SWAps go out of fashion, as donor preferences change, something will be left behind.

6. Coordination through better management of external resources should improve the efficiency and the effectiveness of a given health sector. This statement has an intuitive appeal, but, as discussed in the first paper in this issue, it is difficult to support with hard evidence. One example may be that health sector coverage in Mozambique expanded dramatically during the period 1993–96, in a situation of stable or even faltering external finance. During the same period, several coordination mechanisms were put in place, and the findings suggest, ceteris paribus, a link between increased coordination and greater efficiency (e.g. in the allocation of funds). SWAps will face the same difficulties in demonstrating their effects on the outcomes of the health system – and monitoring processes will be of great relevance in judging how well this form of management is working.

7. While it is critical for both sides to take a long-term perspective of the aid relationship, finding ways of sustaining the impetus is also essential. Sector-wide approaches may assist in establishing longer horizons for development management, but should be robust enough to sustain some of the ups and downs described in Figure 1. While there is considerable emphasis being put on SWAps as the way forward for better health aid management, there is still little experience in their implementation – not surprisingly, given that they are conceived as a long-term measure. However, the findings from these case studies suggest that useful lessons have been learned in different countries through implementing coordination mechanisms and the introduction of certain aid management instruments. Such experience may well lead to a recognition that these mechanisms could be modified and revitalized so as to coalesce in a broader, stronger and more rational approach, as conceptualized in a SWAp. However, the case studies also suggest that this process needs to be incremental and evolutionary and will not work as envisioned if merely imposed on recipients and sceptical donors. As the Bangladesh survey of stakeholders suggests (Buse, 1999), donors have mixed attitudes to SWAps: they support them in theory, but doubt them in practice, and they are fearful that they may restrict their ability to pursue their corporate mandates or...
introduce favoured interventions, particularly if these are vertically organized. A long-term and step-by-step process is crucial to building trust and expertise between partners.

8. Improvements in aid coordination and management practice are dependent on changes in the structures of the organizations involved as well as in the ways they do business. Donors may, for example, need to develop an internal culture that promotes partnership, through the creation of incentives for staff and changed operational procedures. They may also need to support different types of activities within the health sector (e.g. capacity building in the area of financial management) and be prepared to allow rates of disbursement to slip, at least while systems are developed. As noted throughout this paper, recipients will also have to undergo significant change and take considerable risks. A substantial agenda for reform confronts all parties.

Conclusions

The focus of interest of this special issue has been to identify ways in which ministries of health could be assisted in their management of external resources, and as such the focus has been on the ministry of health. However, where public policy environments are seen to be wanting, suggestions are increasingly made to engage civil society in the utilization of aid. For example, the World Bank (1998b: 104) suggests that where the government is failing to provide supportive policies and services, effective aid depends on ‘supporting civil society to pressure the government to change or to take service provision directly into its own hands (or to do both)’. The case studies in this issue underline how important it is to define what is to be done in context-specific terms. Civil societies are made up of many different groups, wanting different outcomes, often displaying conflicting values. Bangladesh and South Africa have active, competitive, civil society groups, which contest government but also disagree strongly among themselves, while civil society in Mozambique and Zambia is still relatively under-developed. Generalizations need to be made cautiously, each country’s situation is unique, and coordination to manage resources more effectively in a situation of asymmetrical power is not easy. There are, nevertheless, a number of actions that the papers identify that could be taken up by MoHs and donors alike, to improve aid management. Many of these are equally relevant to recipients interested in pursuing SWAPs.

- One of basic problems identified in a number of the countries is the lack of a country-led strategy around which donors can coalesce. Hence, one of the most important lessons is that the MoH needs to develop a vision, or a health policy, which includes well thought through plans, expenditure programmes and an implementation strategy for the health sector. With so much recent emphasis on strategic plans there will now be tremendous pressure on ministries to fill this gap, as well as the desire among well meaning staff to get these in place as rapidly as possible. In Bangladesh, for example, donors, and particularly the Bank, were so keen to see the MoH prepare a plan, that when civil disturbances threatened to stall the process, a suggestion was made that a small number of government and donor officials meet outside the country to undertake the required work.

Although this idea was ultimately rejected as it represented poor development practice, it does point to dangers of promoting ends over means. Evidence suggests that if these visions and plans are going to make a difference, a core group of recipient officials must truly own them. The start can be difficult. Officials in MoHs may feel powerless toward aggressive and powerful donors, and lack the technical capacity of designing a global plan for the whole health sector. Two strategies could be pursued. The first is to acknowledge that, at the beginning, plans do not necessarily need to be comprehensive. They can be sub-sectoral, addressing, for example, human resources, drugs, financing. Progressively, each piece can fall into place, within a broader framework. Secondly, the MoH can request donors to assist in the development of planning skills, but the ‘vision’ must be developed and owned nationally. Such assistance may take several forms: visits to neighbouring countries which have initiated or implemented successful planning processes; regional meetings to discuss the components and process of developing such plans; technical assistance from those who have themselves been involved in the preparation of credible plans. Case studies suggest that donors prefer to work with MoHs that know what they want and where they are going, and building capacity in this sort of planning would be therefore welcomed.

- Ministries of health need to be prepared to devote substantial resources, time and energy to coordinating and managing external resources. Operating the consortium in Bangladesh cost over US$ 1 million per year and employed 11 officials in 1997 (Buse, 1999). The case studies demonstrate that benefits will materialize later than expected, so persistence is crucial. Again, donors can be called on to help, for example, by earmarking resources for aid management and coordination initiatives. Alternatively, if the MoH does not have adequate capacity, a lead donor agency may be identified to act as facilitator between the MoH and other donors. However, the long-term implications of such a decision should be taken into account. Other donors may be suspicious of the lead agency’s motivations, and there is the danger that lead agencies become exclusive in their relationships with the recipient. Continuity of key officials in both agencies is crucial to stabilize the aid relationship and strengthen collective and institutional memory. Coordination is not a smooth process, and both MoH and donors have to be prepared to tackle setbacks and crises.

- Focusing on a specific, perceived problem on which there is some agreement between MoH and donors, and one in which most agencies can participate, is helpful for embarking on a course of positive management of resources. This will provide a learning ground for everybody, and a space where actors meet each other and, hopefully, mutual trust is built. However, if consensus is not forthcoming, a few committed agencies may be coopted, at the same time leaving the door open to the others. Wherever possible it is
better to discuss problems within and outside the MoH frankly and openly, and not to be defensive. In such an environment frank discussion of donors’ own constraints can be admitted, and a more equal relationship established.

- The first steps are likely to meet with widespread scepticism. Success at the early stages is therefore crucial, to show that coordination is attainable in practice. Each successful initiative will raise the stakes of the game. Thus, at the beginning, practical problems, perceived as important by most players, are a more suitable and realistic target than systemic and often more intractable ones. Incremental change is likely to achieve more over the longer term than a radical plan which meets resistance in its implementation.

- Building the knowledge base of the MoH will help to establish authority and reputation, essential factors that strengthen MoHs in their negotiations with donors, and help to establish their competence to lead. Strategic data collection, interpretation, analysis and dissemination are crucial. Without robust data, discussions will be endless, erratic and ideological. Most MoHs also need to build or strengthen monitoring capacity. Information should be shared, and where necessary, donors should be requested to help build capacity in systems development, for data collection, analysis and dissemination.

- Attempts to influence donors are more likely to be successful than attempts to control them. Building an understanding of the constraints within which donor agencies work, while promoting mutual adaptation to each other’s needs, will lead to better relations between donors and recipient authorities. The appointment of nationals to positions in donor agencies may enhance mutual understanding of particular constraints, and is increasingly part of donor recruitment policy.

- Ministries should pay particular attention to internal coordination. Many large organizations are internally fragmented, where departments, sections or programmes formulate their own strategy, which may not be consistent with the overall MoH plans. Such fragmentation can undermine efforts by the MoH to manage external resources, resulting in conflicting signals to donors, who may then exacerbate the situation by establishing and maintaining relationships with particular MoH personnel or specific projects. However, internal coordination can be very difficult, especially in situations where fragmentation has served particular interests well; only resolute leadership in establishing consensus within the MoH will change this situation. However, initiating comprehensive plans for the sector can be one way of developing consensus and establishing loyalty to the broader aims of the MoH.

In conclusion, the papers in this issue have reviewed the multiple factors that promote or hinder the effective management of external resources in the health sector. The case studies demonstrate clearly that the desirability of coordination is mainly systemic – that the expected benefits will be enjoyed by the whole sector. However, privileged groups with power or influence, in both recipients and donors, may well perceive that coordination efforts work against their direct (or bureaucratic) interests. This holds for agencies, but particularly for individuals who may lose certain privileges or access to those perceived to be powerful. The conflict between systemic gains against individual (or sub-sectoral) losses may explain why progress in coordination is so difficult to achieve and maintain, especially in view of the time the benefits take to materialize.

There is no obvious solution to these problems, other than making it clear that effective management of external resources depends on addressing systemic inefficiencies, within both donor and recipient environments. Building alliances that can pre-empt negative reactions and avoid resistance to change may be possible, especially in situations of absolute shortages of resources, with resolute leadership and robust action on the part of both MoH and donors. In promoting sector-wide approaches, the key will be in recognizing the need to tackle broad systemic issues and the value of incremental change built on experience in the long term; accepting that commitment and time for coordination are central; and so is the willingness to take some risks and to ride the inevitable ups and downs, successes and failures, of coordination mechanisms and different aid instruments.

References


Lape S. 1999. (Personal communication).


Merrick T. 1997. (Personal communication).

Acknowledgements

We would particularly like to thank the colleagues who participated in the research, and who wrote the reports on which this, and the first paper in this issue, are based: in Malawi, Alister Munthali and Peter Mvula; in Zambia, Cosmas Musumali; in Mozambique, Joaquim Durão; and in South Africa, Helen Schneider. They not only wrote reports jointly with some of us, but took an active part in the research process. Their contributions were central. We would also like to acknowledge the invaluable help given by Gerard Howe, now Social Development Adviser at DFID in New Delhi, India, who coordinated and managed the study, and also took part in discussions and early drafts of the final report. We are also grateful for the financial support for the study received from the Department for International Development, UK, which is not responsible for the views expressed in the paper.

Biographies

Gill Walt is Reader in Health Policy in the Health Policy Unit at the London School of Hygiene and Tropical Medicine. Her main research interests are in policy analysis, and in particular, the relationship between international and national policy-makers. She has lived and worked in South Africa and Mozambique, and undertaken research in a number of other countries in southern Africa.

Enrico Pavignani has worked in Mozambique since 1980, first as a district doctor, and subsequently as a trainer of mid-level health workers. From 1991–1998 he was based at the Ministry of Health in Maputo as senior planner and policy adviser. Now an independent consultant, his main interests are resource allocation, health sector financing and evaluation of health services.

Lucy Gilson has a joint appointment as Senior Lecturer within the DFID-funded Health Economics and Financing Programme at LSHTM and Deputy Director of the Centre for Health Policy in Johannesburg. She has worked primarily in Africa, in Swaziland, Tanzania and South Africa, with particular interests in health financing, health care management, political economy and policy analysis.

Kent Buse is a Research Fellow in the Health Policy Unit at the London School of Hygiene and Tropical Medicine. He is a political-economist with an interest in health-sector policy analysis at the global and national levels. He has worked with non-governmental organizations, research institutes and multilateral organizations in Africa, south-east Asia and the south Pacific. He has also served as a consultant to a range of UN organizations.

Correspondence: Dr Gill Walt, Health Policy Unit, London School of Hygiene and Tropical Medicine, Keppel Street, London, WC1E 7HT, UK.