Technical approach paper

Implementing a sector wide approach in health: the case of Mozambique

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The strengths and weaknesses of the sector wide approach have been extensively analysed, but much less has been written on country experience to inform good practice elsewhere. This technical paper draws some lessons from the sector wide approach in health in Mozambique.

The Mozambique sector wide approach to programming (SWAP) for health has been in existence since 2000, and has often been cited as a demonstration of all the advantages of working sector wide: enhanced government leadership, improved sector policy and strategic focus, more effective use of aid to the health sector and lower transaction costs.

Yet, these days both government and development partners recognise that the health SWAP is not a panacea for donor coordination, and cannot address deep-rooted constraints typical of a young national health system.

This paper explores how the key elements of the SWAP have been developed, how processes and mechanisms are working now, and looks at some of its successes and challenges. The main lesson is that in a rapidly changing health policy and financing environment, leadership, drive, coordination and mutual accountability require constant efforts and renewed commitments from all parties.

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Introduction

In the year 2000 the Government of Mozambique and its development partners made the strategic decision to establish a Sector Wide Approach to Programming (SWAP) in health. The Mozambique health SWAP soon became widely cited in international health policy circles, particularly as the agreements and processes linked to it – the partner code of conduct, sector strategy, coordination and review mechanisms – were developed and implemented fairly rapidly. To many external observers, the health SWAP in Mozambique epitomised all the advantages of working sector wide: improved government leadership, greater sector policy and strategic focus, more effective use of aid to the health sector and lower transaction costs.

Yet, government and development partners recognise these days that the health SWAP is neither a panacea for donor coordination, nor can it by itself address the deep-rooted sector constraints of a very young national health system that had to be entirely rebuilt after many years of civil conflict. Perhaps the main lesson emerging from the Mozambique health SWAP is that leadership, drive, coordination and mutual accountability are variables that change over time: they require constant efforts and renewed commitments from all parties to adapt to a fast changing health sector.

This paper describes the evolution of the Mozambique health SWAP, and reviews its achievements, limitations and emerging challenges.

Overview of the health SWAP

Mozambique, one of the poorest countries in the world, gained independence from Portugal in 1975. Later, years of civil war devastated much of the country's social and economic infrastructure. The health system inherited at independence was highly fragmented, severely biased towards urban and curative services, and civil war further reduced its reach. The signing of the peace agreement in 1992 brought increased donor funding, most of which went towards reconstruction work and was delivered through projects.

The trend to operate through projects, with donors taking responsibility for entire districts or provinces, led to greater fragmentation of the national health system. This was made worse by a weak Ministry of Health (MOH) that was only beginning to define its role and to regain "control" of the national health system after the years of civil war. It was in this context that the Mozambique health SWAP was initiated.

In Mozambique, the health SWAP is not, strictly speaking, a *programme* with defined outputs and milestones, and a predefined expenditure package or framework. Rather, the SWAP was initially defined as a "Sector Wide Approach to Programming", emphasising its incremental, progressive nature and its focus on developing an open, inclusive arrangement where the MOH and its development partners could share a set of common principles, objectives and working arrangements.

These include:

- a **health sector strategic plan**, endorsed by all development partners and including a set of indicators to evaluate policy implementation and health sector progress;
- a **code of conduct** (originally known as the Kaya Kwanga agreement) signed in 2000 and revised in 2003, setting the basic rules of engagement for the MOH and its partners;
- a **set of mechanisms and working arrangements that enable structured dialogue and consensus building** between the MOH and development partners – these include the Sector Coordination Committee, the SWAP Forum and various SWAP-related working groups around thematic areas;
- a **sector financing framework** (which formed part of the health strategic plan and the code of conduct) highlighting the expectations of the Government in relation to aid modalities and financial instruments to be used by development partners in the health sector – they point to the need to increase the government health expenditure, and for donors to increasingly place development assistance for health into common funding and budget support mechanisms;
- a **set of review mechanisms** to evaluate health sector progress and commitment to the objectives of the strategic plan, consisting of a joint annual review and six-monthly meetings of the Sector Coordination Committee (CCS).

A chronology of the development of the Mozambique health SWAP can be found in table 1.

Table 1: Key milestones in the development of the Mozambique health SWAP

1975	Mozambique becomes an independent country. Independence is followed by a long civil war.
1992	UN-backed peace agreement is signed. First multi-party elections are held in 1994.
1996	PATA (Pooling Arrangement for Technical Assistance) becomes the first Common Fund to be established in the health sector of Mozambique. It is managed by the MOH, administered by the UNDP and funded by the governments of the Netherlands, Norway and Switzerland.
1998	A consultative technical group recommends that the health sector in Mozambique should adopt a sector wide approach. MOH signs a declaration stating its intention to move in that direction. The Sector Coordination Committee (CCS) is formed. The Common Fund for Pharmaceuticals is established following a successful initiative launched a few years earlier by the Swiss Agency for Development and Cooperation (SDC). A common fund for developing and launching the health strategy is created and funded by various donors.
1999	The Provincial Common Fund is formally established following a successful initiative launched by SDC a few years earlier. Resources are allocated on the basis of the Provincial Integrated Health Planning processes adopted by all provincial health authorities in the mid 1990s. The Ministry of Planning and Finance sets up a unit to support the development of the health sector SWAP.
2000	The Kaya Kwanga Agreement is signed: this is the code of conduct for government and development partners in the health sector. The agreement makes explicit reference to the intention of government to set up a SWAP.
2001	The TORs for the SWAP Technical Group (or GT-SWAP) are prepared and adopted. The GT-SWAP is the formal forum for dialogue on the SWAP by the MOH and donors. Mozambique reaches completion point of the HIPC initiative in September 2001. The GoM presents the Action Plan for the Reduction of Absolute Poverty (PARPA) to the international financing institutions.
2001	The Strategic Plan for the Health Sector (known as PESS 2001-2005-2010) is formally approved by the Council of Ministers and endorsed by all members of the SWAP. The Strategic Plan becomes the reference document for government and partners to prioritise funding and interventions.
2003	The PROSAUDE health common fund is established in November 2003 (it substitutes the first common fund for the Plan). The Kaya Kwanga agreement (Code of Conduct) is revised – some donors active in the health sector do not sign it.
2004	The Provincial and the Medicines Common Funds are put entirely under management by MISAU. Existing arrangements under the SWAP are reviewed from November 2004. A decision is made for the monies from the Global Fund to Fight AIDS, TB and Malaria (GFATM) to be channelled through the PROSAUDE common fund. Mozambique becomes the first country in the world to place GFATM money into a common funding, on-budget arrangement.
2005	The Mid Term Review of the PESS takes place in July-August. The revised TORs of the SWAP are finally approved: the GT-SWAP is renamed “SWAP Forum”.

The code of conduct

In May 2000 the MOH and partners signed a code of conduct (known as the Kaya Kwanga agreement) and agreed to adopt a sector wide approach to bring together resources, to focus attention on shared objectives, and to monitor developments in the health sector against previously agreed benchmarks. It was recognised that the process should be based on coordination, communication, commitment and trust.

The code of conduct established that the SWAP should be an important mechanism to:

a) establish a common vision for health reform and development;
b) set priorities and improve the allocation of resources to achieve those priorities;
c) improve the efficiency and accountability of resource use; and
d) rationalise and improve the coordination of external assistance.

A health sector strategy endorsed by all

Following a joint effort by the MOH and its partners, the Strategic Plan for the Health Sector (PESS 2001-2005-2010) was drafted, endorsed by all development partners and approved by the Mozambique Council of Ministers on 24 April 2001. The Strategic Plan became the basic strategy document for government and external partners to work towards a common vision. It contains a comprehensive set of indicators for annual review.

The Plan was drafted more of less concurrently with the first Action Plan for the Reduction of Absolute Poverty (the PARPA), the name by which Mozambicans refer to their Poverty Reduction Strategy Paper (PRSP). Because of their simultaneous launch, the Plan is generally consistent with the PRSP and with broader government policy.

Arrangements for improved dialogue and consensus building

Implementation of the SWAP objectives set out in the Strategic Plan and in the code of conduct required development partners and the MOH to maintain a regular and open dialogue. Three levels and structures for dialogue and consensus building were established:

Sector Coordination Committee (CCS). Formally established in 1998, the CCS meets twice in a year, is chaired by the health minister and comprises his/her cabinet, all provincial health directors and the representatives from development partners active in health. The role of the CCS is to endorse key reports and recommendations (such as those emerging from the joint annual reviews of the Strategic Plan) and to inform development partners of significant issues or decisions relating to health sector policy, including the focus and composition of the MOH Annual Operation Plan for the following year.

SWAP Forum. The SWAP forum has replaced the former SWAP MOH-Partners Working Group, set up in 2001. It was expected that this forum would provide a good opportunity “for a small group of representatives from MOH and the community of external partners to deal with some critical issues in a more informal forum”.

Working Groups. Working groups (and ad-hoc task groups) provide an opportunity for development partners and the MOH to jointly review or oversee specific areas of health policy where more in-depth analysis is required prior to their adoption or consideration by the broader SWAP Forum.

Critical perspectives

The arrangements, outputs and processes described above are perceived by the Government and its development partners as excellent instruments for consensus building. They have resulted in a stronger national health system, with more rigorous policy making and more robust annual planning, budgeting and monitoring systems. Yet, successes of recent years have been faced by new challenges that have put the SWAP-related mechanisms, structures and processes to the test. Some of the key issues that concern the sustainability of the SWAP are reviewed below.

The health sector strategy

The Strategic Plan is regarded as a “first generation” health sector strategy, in the sense that, rather than focusing on a set of sector priorities (as sector strategies often do) it provides a broad medium to long

term agenda for the sector. At times, such an agenda has been considered too broad or unspecific for the purposes of setting clear overall direction and for holding government accountable on policy implementation. For example, part of the Plan includes innovations (such as the creation of a national health system) and reforms (such as the institutional development plan) that have not been attempted or given serious consideration in subsequent years. It is often hard to tell what is essential and should be done, from what may be desirable and might be attempted or piloted.

The Plan has also been criticised at times for being too "centralistic" in its focus, and for failing as a driver for policy implementation in Mozambique's provinces. To address this issue, provincial offices drafted their own "Provincial Plans", but these plans were often found to be rather theoretical and failed to provide the necessary planning framework in most provinces. The lack of a coherent policy framework at provincial level, coupled with the absence of provincial health staff in the SWAP's mechanisms for dialogue has reinforced the impression that the SWAP has not reduced the centralistic nature of the Mozambique government. Lack of adequate policy frameworks at provincial level has also enabled some development partners to continue operating in the provinces in ways that are not in line with the spirit of the SWAP and its code of conduct.

Such observations are reflected in recent annual reviews of the Plan. It is noted that the 2003 joint annual review recommended that it should remain "a living document providing orientation to annual plans", an indirect recognition that the Plan is no longer a document driving policy. A mid-term review in 2005 recommended the MOH to focus on fewer strategic priorities. The review concluded that there are still too many "health plans" coexisting in various parts of the MOH, and that these should be streamlined, simplified and merged into a single annual plan and budget.

Nevertheless, in spite of its limitations the Strategic Plan became and still is a key reference document for the health sector. Thanks to it, government and donors have been able to engage in more meaningful health policy dialogue about sector and resource allocation priorities. It has also strengthened planning and budgeting capabilities within the MOH, by ensuring that Annual Operational Plans better reflect sector priorities and allocate resources accordingly.

Leadership, dialogue and decision making

All elements of a SWAP, from the code of conduct to its review processes, aim at enabling mutual accountability between government and its key development partners in a particular sector. The mutual accountability lines built into a SWAP imply that government and development partners should demonstrate to each other that commitments and agreements reached are transparently and effectively implemented.

When this is not the case, or when one side perceives that the other side is at fault, the mechanisms for dialogue that are part of the SWAP architecture become essential. In the case of the health SWAP in Mozambique, there is a generalised perception among development partners and MOH officers that the mechanisms for dialogue set as part of the SWAP have not always worked to the desired standards. It is important to understand the reasons for this.

A review of the SWAP arrangements undertaken in 2004[1] highlighted that the SWAP Forum was not a homogeneous structure where all partners work towards or abide by the same principles. The example of some development partners participating in the SWAP Forum, but not abiding by its decisions was noted. This was often in relation to commitments to harmonise aid instruments and to make aid more predictable, two imperatives of the code of conduct that some development partners simply appear to ignore. The SWAP Forum was also seen to fail in ensuring that the MOH incorporate recommendations made in a number of reports, including sector reviews. This was often attributed to lack of leadership, combined with unclear decision making, implementation channels and procedures within the MOH.

The inaction or slow pace shown by the MOH to act on certain agreements reached within the SWAP often led to tensions among partners that the SWAP Forum was unable to address effectively. This was in part because correctness and diplomacy would rule out the possibility of these issues being discussed and debated openly, or simply because the SWAP Forum – an information sharing and consensus building structure – did not have the powers for holding its members accountable. In addition, some government officers interviewed in the course of the 2003 review of the SWAP commented that

[1] Martínez J (2004) Taking the Health SWAP to the Next Level (unpublished consultation document).

government leadership was often compromised by the sheer number and influence of donors, which often resulted in a certain disempowering of government.

Similar concerns were expressed with regard to the working groups, where too many insufficiently analysed issues would reach the SWAP Forum, but not lead to clear recommendations for government or development partners.

In essence, the SWAP Forum was beginning to be seen as failing to combine openness and inclusiveness with the required effectiveness to solve problems and provide accountability. This situation was enabling the coexistence of various degrees of commitment to the SWAP principles among both development partners and different MOH departments.

The review of the SWAP undertaken in 2004 recommended that while the inclusiveness of the "SWAP group" should be maintained, the commitment to the code of conduct and the objectives of harmonisation should become compulsory and explicit for all its members. The review also recommended that the SWAP Forum should set clear and measurable steps to achieve the objectives of harmonisation, alignment, transparency and accountability.

Health financing issues

At the time the SWAP was being established, health sector financing was extremely fragmented, with an abundance of vertical programmes and projects, and little (if any) on-planning or on-budget external funds. The Strategic Plan and the SWAP were seen as a means to rationalise and improve the coordination of external assistance. In fact, the SWAP in Mozambique was not directly linked to a predefined sector expenditure programme and medium term expenditure framework. Rather, the main objectives were to increase government health expenditure over time, and to increase the proportion of external funding channelled through common funding and budget support arrangements.

Happily, this has been greatly achieved. In a few years the health sector in Mozambique has substantially changed its health financing structure along the lines that both development partners and MOH set in the Plan. As Table 2 shows, public expenditure for health has more than doubled between 2001 and 2004, thanks to the spectacular increase in the volume of common funds, helped by moderately increasing government expenditure. However, as the table also shows, close to one third of total health expenditure is still provided through earmarked, vertical funding arrangements. Rather than decreasing, as the Government would wish and has repeatedly asked for, vertical funding has remained constant, and in fact it has begun to increase again in the last couple of years, largely as a result of increased availability of vertical funding for HIV/AIDS through programmes such as the US Government's PEPFAR.

Table 2: Health Financing by Source 2001-2004 (rounded up millions of US$)[2]

	2001	2002	2003	2004	2005
Total Expenditure	**165**	**178**	**209**	**252**	**356**
Government Budget	**70**	**82**	**96**	**105**	**112**
Common Funds	**17**	**20**	**37**	**63**	**113**
Vertical funding	**75**	**75**	**75**	**85**	**130**

Many watch the increases in vertical health funding in Mozambique with concern. They represent a failure to move in the direction set in the SWAP, and contribute to the tensions among partners in the various SWAP groups. It is not uncommon to hear both development partners and MOH officers ask questions such as: Why should some development partners make the effort to align and harmonise their development assistance while others do not? Why is the government not exerting greater pressure on

[2] Source: Ministry of Health, Directorate for Planning and Cooperation. MTEF data was compiled by Stijn Broecke. 2005 figures correspond to the POA 2005 estimate.

certain donors to abide by the principles and practices set in the code of conduct? And why, in spite of structures such as the SWAP Forum and the CCS, are these situations hardly discussed in the open, giving the impression that they are tolerated?

Those issues would seem to cast a shadow of doubt on the effectiveness of the health SWAP to better align and harmonise sector financing in Mozambique. Clearly, there is still significant health financing that is not captured in the budget, such as considerable funds channelled by certain donors directly to NGOs. There is also earmarking by certain development partners to ensure a response to their priorities rather than those of government. As a result, the government still experiences problems in allocating resources to some of its own priorities.

However, these and other issues relating to health financing must be looked at in the light of the recent evolution of the Mozambique health system. From that perspective, the successes of the Mozambique health SWAP in terms of aligning health financing and harmonising donor practices become obvious. For example:

- common funding has enabled the MOH to cover resource allocation gaps on the basis of priorities that are now better reflected in annual operational plans and budgets (two instruments that have been really strengthened within the last five years);
- the robust nature of the health financial management system and the steady progress in annual planning and budgeting procedures have enabled Mozambique to be the first country in the world where resources provided by the Global Fund to Fight AIDS, TB and Malaria have been integrated within the health sector's common fund (known as the Prosaude);
- greater harmonisation in financing has enabled the SWAP to also focus on more harmonised forms of procurement, an area where substantial progress has been achieved thanks to the combined efforts of government and development partners.

In conclusion, while more may need to be done in the coming years to better align and harmonise health financing, the level of progress achieved to date is impressive and unprecedented, particularly given Mozambique´s recent history. The SWAP has been the process that has enabled such progress to take place on the basis of an effective collaboration between the government and its development partners.

Measuring progress: sector review mechanisms

A key concern raised in a recent mid-term evaluation of the Strategic Plan[3] relates to the limited effectiveness and high transaction costs linked to health sector review mechanisms established under the SWAP. Key sector review mechanisms include the Joint Annual Reviews of the Plan and the six-monthly meetings of the Sector Coordination Committee (CCS). These are some of the issues that were raised by the mid term review team:

Limitations in follow-up of annual reviews? A serious concern has been the lack of systematic follow up by MOH (and at times by development partners) of the recommendations made in the joint annual review reports. These problems suggest limited capabilities in monitoring and policy implementation, which should be two priorities for a central MOH in the context of a SWAP. The work of the CCS has also come under scrutiny, as it seems to have lost some of its relevance: endorsement of reports such as joint reviews is not followed by implementation plans. The issues put up for discussion are also covered in the SWAP Forum, and reach the CCS following insufficient debate and analysis.

Many, poorly integrated review processes and weak indicators? Consultants and MOH staff involved in annual reviews have systematically complained about lack of availability, and poor quality and reliability of indicators. It has also become problematic for the MOH and for the government in general to integrate a number of different review processes. In addition to those specific to the health sector (reviews of the Plan, the CCS and the National HIV/AIDS Plan) there are other processes that also look at health sector performance, including the reviews of the PRSP and that of the Performance Assessment Framework (PAF) of Programme Aid Partners (those providing budget support). These review processes are costly and often cumbersome to organise - the PAF reviews alone involve no less than 23 working groups! Each of them invariably results in a long list of recommendations for the government to act upon. Perhaps unsurprisingly the government is often found to be at fault in terms of implementing recommendations agreed in previous reviews. This situation has become so acute that

[3] Ministry of Health (2005). Mid Term Review of the Health Sector Strategy Plan (PESS 2001-2005-2010) (in Portuguese). Prepared by J. Martínez, T. Lizana, P. Mole, S. Ferreira and H. Chissano (HLSP).

some observers consider that lack of integration of monitoring systems within and across sectors is seriously weakening the government's ability to monitor policy implementation and its accountability to external partners and to the Mozambican society.[4]

Are transaction costs being reduced? As a result of the health SWAP some transaction costs have been reduced, but others have either remain unchanged (those linked to disease interventions) or even increased (those linked to review processes and to the SWAP forum and its working groups). In addition, several bilateral donors continue to field separate missions for each of the sectors, which further increase transaction costs. While detailed information for the health sector is lacking, a recent report estimated no less than 143 missions to Mozambique by the G-16 donors (those providing budget support) during 2004.[5] This excluded World Bank missions, as the Bank did not provide this information to its G-16 partners. These ways of working seriously undermine the capacity of governments to devote sufficient time and energy to the one task that governments should perform: the definition and implementation of policy.

Conclusions

The SWAP is not a panacea for sector coordination. Degrees of commitment to its ethos and values (as set out in the code of conduct) vary greatly among external partners and among senior government officers. While structures, processes and outputs linked to the SWAP need to be in place, they do not per se guarantee its successful implementation. Attention needs to be placed on the quality of the policy dialogue, on enabling the government to exercise leadership without overburdening it, and on ensuring that all development partners play and abide by the same rules. A key lesson is that while SWAPs can become excellent platforms for improving harmonisation and alignment, this will not be achieved unless pursued in a proactive and explicit manner. As important as ensuring government accountability is to ensure that development partners are accountable themselves to the principles of the SWAP.

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[4] Programme Aid Partners Mozambique, Aide Memoir 2005

[5] Killick T, Castel-Branco C and R Gerster (2005). Perfect Partners? Donors performance in Mozambique. Department for International Development (DFID), UK.