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Addressing Malaria Sector-wide

***Improving co-ordination and
management of external support***



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**Addressing Malaria Sector-Wide:
Improving co-ordination and management of external support**

**A background paper for the Fourth RBM Global Partners Meeting
18-19 April 2001, Washington DC**

**including country experiences in Bolivia, Cambodia, Ghana, Tanzania
and Uganda**

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Executive Summary

This paper was prepared as part of a commission from the RBM Cabinet Project in Geneva to prepare background papers on key issues for the 4th Global Partners meeting in Washington in April 2001. The study investigated the relationship between RBM's focus on ambitious global and regional targets, and country determined development of Sector Wide Approaches (SWAp) with particular reference to case studies in five countries at different stages of SWAp development: Bolivia, Cambodia, Ghana, Tanzania and Uganda.

It is intended that the paper should raise issues for discussion in Washington, and assist those involved in RBM development and those involved in SWAp development to understand each other's approaches and needs better, and to highlight the areas where joint development is needed.

The study was short and the paper is not intended as an in-depth analysis of all the issues surrounding this topic. Instead it presents an overview of the current situation from the country perspective and an impression of the experiences so far with SWAps and RBM and relationships between them, together with opinions and ideas that are developing in the countries studied.

Overall, as might be expected from their different contexts, there are marked variations between the study countries and their levels of commitment towards sector-wide initiatives. Similarly, progress in implementation of SWAps is historically linked to the overall pace of reforms and thus is occurring at differing rates: rapid change in Uganda and largely incremental change in Ghana.

The RBM initiative is encompassed by all and has built on previous malaria control plans and actions, providing a framework for enhancing collaboration and considerable potential for raising the profile of malaria. The combined effects of SWAps and RBM have to varying degrees been mutually beneficial: planning is more strategic and inclusive across the sector, improvements in financial control are evident and there are encouraging signs of greater stakeholder involvement and country ownership. Future opportunities for increasing wider ownership and political support for poverty-sensitive interventions in health are promising.

However, the introduction of SWAps has highlighted the difficulties in providing health care and defining priorities for essential interventions within chronically under-funded systems. The SWAp is clearly the preferred mechanism in Africa for strengthening district services and considerable resources have been invested in its development. This presents significant challenges for RBM internationally in expanding malaria control and prevention to improve overall outcomes, especially where the transitional effects of reforms and SWAps expose further vulnerability.

Optimal malaria control is dependent upon functioning and adequate systems in terms of staff resources and incentives, quality drug supply, and sound planning complemented by sensitive indicators for monitoring and evaluating outcomes. In those countries that are establishing, albeit slowly, the processes and systems required for tackling these issues and taking control of the problems, the initiatives deserve support. The challenge is defining and planning the mixture of approaches to assist transition of responsibilities and promote ownership whilst ensuring that the gains achieved are not lost.

Key questions coming out of the country studies, and set out in more detail in Section 5 cover the following issues:

Questions for further discussion

How to tie in international and regional templates and funding mechanisms in with an integrated funding approach at country level and country leadership on planning and budget allocation? How flexible and responsive can funders be?

How can *local* solutions emerge and be supported and disseminated?

How to deal with the unexpected, especially epidemics?

How to increase the growing partnerships with the private for profit sector and NGOs and civil society? How to make this less opportunistic and more part of a national strategy?

How to make RBM commitment to support for health sector development and capacity building real in terms of funding flows?

How can RBM partners build on a rising (but often still too low) profile for malaria at country level?

How can the monitoring and evaluation needs of global initiatives and of country sector-wide plans be rationalised?

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Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
EPI	Expanded Programme on Immunisation
EU	European Union
HSR	Health Sector Reform
HIV	Human Immunodeficiency Virus
IEC	Information, Education, Communication
IMCI	Integrated Management of Childhood Illnesses
MTEF	Medium Term Expenditure Framework
NGO	Non-Governmental Organisation
PRSPs	Poverty Reduction Strategy Papers
RBM	Roll Back Malaria
SWAp	Sector Wide Approach
SWM	Sector Wide Management (Cambodia)
TB	Tuberculosis
WHO	World Health Organisation
UN	United Nations

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This paper attempts to represent the views, ideas and experiences of people working in the country studies, and information provided by them. However, the authors remain responsible for any errors of fact or interpretation.

1. Introduction

1.1 Background and purpose

In preparation for the fourth meeting of Roll Back Malaria (RBM) global partners in April 2001 (GP4), the WHO RBM Cabinet Project requested the Malaria Consortium to prepare a background paper describing country experiences on the relationship between RBM's focus on ambitious global and regional targets, and country determined development of Sector Wide Approaches (SWAs).

The purpose of this discussion paper is to contribute to the expansion of the capacity of the RBM partnership to go to scale by describing the interaction of RBM and SWAs in selected countries, and to highlight key issues for discussion during the GP4 meeting. The paper will consider SWAs as a method of improving capacity, management and resource mobilisation, and how this can support RBM. The paper will also consider how RBM, as a pathfinder for health sector reform, can strengthen SWAs. The paper addresses real and potential areas of conflict between SWAs and RBM, for example, with regard to country ownership of planning versus globally co-ordinated efforts, and long-term capacity building versus shorter-term health targets.

It is intended that this paper will both stimulate discussion, and assist those involved in RBM and SWA development to understand each other's approaches and needs better, highlighting the areas where joint development is needed.

Terms of Reference are at [Annex 1](#).

It includes a brief review across countries and an analysis based on case studies of the following countries: **Bolivia, Cambodia, Ghana, Tanzania and Uganda**.

Summaries of these case studies are at [Annexes 2-6](#). Detailed reports of the country case studies are available from the Malaria Consortium.

The paper is not intended as an in-depth analysis of all the issues surrounding this topic. In the time available, it was possible to obtain an overview of the current situation and flag up issues. The paper provides an impression of the experiences so far with SWA and RBM processes, together with opinions and ideas that are developing in the countries studied. It flags up some issues that appear to be common across countries, some indicators of success and apparent constraints, and topics worth discussion at the Washington meeting and for possible further study.

There is some overlap with the background paper on Poverty Reduction Strategy Papers (PRSPs) and RBM¹. While not all countries that have PRSPs have a health SWA (and vice versa) there are many mechanisms and issues in common. Some of the issues raised here are discussed in more detail in the PRSP paper.

1.2 Methodology

¹ Malaria and Poverty: Opportunities to Address Malaria through Debt Relief and Poverty Reduction Strategies. A background paper for the Fourth RBM Global Partners Meeting, 18-19 April 2001, Washington DC. Malaria Consortium, April 2001

This discussion paper is a synthesis of evidence compiled from the five country case studies. Each country was visited for an average of one week during March 2001, when interviews were held with government officials, donor and NGO representatives. The case studies and this synthesis paper are based on analysis and conclusions drawn from these interviews and reviews of secondary documentation. A week is a short period in which to explore some of the complexities around sector-wide approaches and thus the case studies and this synthesis represent a snapshot of key impressions rather than a comprehensive picture.

Importantly, some factors limited the scope of the field visits. Three of the visits coincided with major missions and national conferences, with the result that the availability of appropriate interviewees varied considerably. Additionally, two countries had minimal notice of the consultant's visit.

The five case study countries are at different stages of development and reform. Collectively, the countries chosen reflect the varying stages of the SWAp process. For the purposes of this synthesis, and where country processes are at an initial stage, attempts have been made to assess future influences and impact. It should be recognised that such observations are, therefore, somewhat speculative, based on current factors and thus may change over time.

2. The context of SWAps

2.1 Evolution of SWAp development¹

Essentially, the concept of sector-wide approaches has evolved from a combination of two reform directions:

- ◆ Macro-economic perspectives reflecting concerns around overall allocation and expenditure of resources and the balance between sectors. The central aim is to use the single sector strategy to reflect national priorities and co-ordination of budget processes to include all sources of funding, and:
- ◆ Recognition by health professionals that the proliferation of donor projects was placing unreasonable demands on a weak infrastructure and limited human resources in country, with questionable levels of equitable national coverage and implications for long-term sustainability.

Thus, there is some common ground between donors and international financing institutions who have concerns about the effectiveness of aid, and recipient countries who could benefit from the improved co-ordination of funding.

2.2 Definition of the SWAp

Several definitions of a sector wide approach exist but all have some common features. Cassels, (ibid) suggests some of the basic parameters:

- a partnership of Governments, donors, NGOs and civil society, with strategies and policies outlining the funding and supply of services and highlighting priority areas for intervention, led by governments, with the aim of improving health and development objectives

¹ Cassels, 1997, a guide to sector-wide approaches for health development: concepts, issues and working arrangements. WHO

- in the context of the whole sector, which is supported by relevant structures & finance and outlined in a collaborative programme of work identifying:
 - strategies and policies outlining the funding and supply of services and highlighting priority areas for intervention
 - development of financing and expenditure plans, together with projections of available resources consistent with national priorities in the public sector
 - common arrangements for the disbursement and accounting of funds and the monitoring of performance by both governments and donors
 - capacity building and institutional development that take account of overall strategic direction and consequent systems requirements
- with jointly agreed targets and timeframes and suitable processes for performance review.

Whatever the arrangements, the underlying principle of sector wide approaches is that they are an *approach*, which can be part of the health sector reform process. Critically, although the above features may typify a SWAp, there are no hard and fast criteria, and development of the process varies in process and timescale.

The above framework and mechanisms provide a useful reference point to assess development and progress over a range of countries at different stages.

As with any new initiative, there are both positive and negative aspects; some of the more important positive aspects include:

- increased joint policy dialogue around sectoral strategies led by government
- agreed common management arrangements for monitoring and evaluation
- strengthening of financial systems and priority planning.

However, the required levels of capacity can take time to develop and resistance to new approaches is possible if those affected see no advantage, or loss of advantage, in for example resources or ability to influence. These concepts will be discussed in more detail in section 3.

2.3 Status of country SWAps¹

The countries studied are at different stages in developing a sector wide approach and each is at a different point in reforming the health sector.

In **Bolivia** a comprehensive overall cross-sectoral development strategy was established in 1997 (and Bolivia has been a pilot country for development of a Comprehensive Development Framework), and the health sector is an integral part of overall reforms, within a decentralised system. A strategic health plan aims to build the Bolivian health systems and provide universal access based on primary health care. Malaria is included in the minimum basic package of integrated service delivery at district level. A sector-wide approach as described above is not fully in place.

Cambodia agreed in 2000 to develop Sector Wide Management, namely working towards developing joint strategies and policies and common management arrangements, but not the pooling of resources. To date, a Sector Wide Management Committee is already in place and the first joint sectoral review in draft is complete. The next steps will be to formulate the joint strategic direction and develop a five-year plan for the sector.

¹ Further information is given in the case study summaries at [Annexes 2-6](#) and in the full case study reports.

Ghana has the longest-standing arrangements for a SWAp of the countries studied - in place since 1997. The arrangements, which have largely grown out of many years of incremental reform in the health sector, include the Medium Term Health Strategy and a five-year Programme of Work (1997 to 2001). An annual Program of Work complements these. Common management arrangements are outlined in the document covering the programme of work for the period and include reviews, summits and joint meetings. Disbursement to districts originates from the combined Health Fund, although earmarked funding is still in existence for particular activities as well as some donor directly controlled projects.

Tanzania committed to a SWAp in 1998 as part of wider public sector reform. There is a medium term strategic plan 2000 to 2004 and a health sector programme of work 1999 to 2002, complemented by annual health sector plans of action. In March 1999, agreement was reached to partially pool resources in the joint basket account for the forthcoming financial year in support of priority activities outlined in the plan of action. The review process is similar to that of Ghana.

Uganda has a highly integrated, though relatively new, approach to sectoral development. The sector wide approach outlined in the National Health Policy of 1999 is detailed in a five-year strategic plan for health (2001 to 2005) and links to a wider poverty eradication action plan and a Medium Term Expenditure Framework (MTEF). Pooled funding in the health sector began in 2000/01. Across sectors there has been a shift in Government budget allocations towards poverty sensitive activities including those in health. Donors are encouraged to fund the health sector strategic plan through central government support although, in practice, the transitional arrangements include a mixture of national and district budget support and donor directly funded projects. Review procedures include twice-yearly joint missions using performance indicators and draft plans to agree on forthcoming priorities and resource allocation.

3. The relationship between SWAps and RBM

There are difficulties in assessing the impact of two relatively new initiatives on each other. The policy environment in each country is unique and each has already developed health policies and strategies to fit local circumstances. Moving from one set of arrangements to another is fraught with complex and interrelated factors. Judgments on the SWAp process need to be set in the wider context of overall reform. Many of the constraints that exist are long-standing issues that remain unresolved. They have been brought into sharp focus, but not necessarily created by, new developments like SWAp and RBM. Nonetheless, some key themes emerge as common issues and some interesting approaches to overcoming constraints and promoting good practice have been adopted.

The following sub-sections illustrate some of the key points emerging and highlight areas for discussion.

3.1 Ways in which SWAps do or could catalyse the RBM process

a) Raising the profile of malaria across the sector

Disease profile is most likely to affect priority ranking where there are competing priorities for limited resources within a sector. In sub-Saharan Africa, unlike the other regions, malaria has

historically been neglected compared with some other programmes (for example HIV/AIDS in Uganda, EPI in Ghana).

Across case studies, the concept of RBM was not widely understood at the periphery and outside the health sector. It seems that existing messages are not broadening awareness and ownership and the idea of RBM as a partnership and broad-based movement rather than say a funding initiative with prescribed interventions is not there.

In all countries, at least on paper, there was evidence that the profile of malaria is important as part of a basic health package. For example, malaria is the first named priority in the Ugandan national health strategy and the national programme has received increased and protected funding through a Poverty Action Fund. For those countries with a pooled funding mechanism, such pooled funds are increasingly used to fund district services, bringing resources under country control. Within SWAPs, there is the potential for those involved in malaria control to have a longer-term view of available resources, and to be less dependent on individual donor project cycles. In Uganda, this is contributing to a perception of overall optimism for the future, in terms of increased job security and improved skills, for example in planning services. Nonetheless, at district level, where the overall resource is limited there is a need to prioritise key interventions coherently in line with strategies to ensure that critical interventions are carried out and contingency planning is available for epidemics and unforeseen demands.

b) Enhancing inter-sectoral working and mobilising political support

Malaria control and prevention is complex, requiring sound planning and co-ordination of activities from curative intervention to preventative strategies involving wider community participation. There is potential for RBM to capitalise on some of the links already forged as part of SWAP processes as well as those that are part of wider reforms. For example, there is increasing devolution to local government level in Bolivia, Tanzania and Uganda, where the complexity of planning malaria strategies at the district level necessitates the need for joint approaches to common problems, cutting across sectors such as education and agriculture. In Ghana, following detailed research projects, considerable progress has been made on working with primary school teachers to recognise and advise on simple malaria, in order to support health workers in areas where outreach facilities are stretched.

The active involvement of different sectors in malaria has the potential to broaden the base of advocacy on behalf of malaria and heighten awareness and recognition that a multi-sector perspective is required.

Accordingly, there is the potential for capitalising on this more broad-based political support for malaria and reducing the perception that it is a health problem alone. This potential is likely to develop still further with the advent of poverty reduction strategies.

c) Integration of complex activities and promoting working partnerships

The intention to integrate activities at the level of district services underpins a number of strategies, and has the potential to improve the management of activities for malaria. There are plans in Cambodia to integrate some of the activities of the national programme with district provision for EPI, in line with the intended strengthening of districts, and similarly, the planned expansion of IMCI in Tanzania. The focus on integrated services, together with the basic packages of care that include priority diseases, and the integrated management of childhood diseases, all contribute to a more inclusive approach to complex diseases like malaria.

The integration of national programmes to deliver the basic package of healthcare in Uganda has resulted in closer integration of IMCI and malaria at national, district and subdistrict level with joint strategies, capacity building, supervision and implementation. The national malaria control programme, as with other national programmes, is moving towards a more advisory remit. There are implications here for the level of skills and type of development required by both programme managers and peripheral staff to fulfil new and challenging roles, and the costing of human resources to support this transition.

d) Linking plans with monitoring and evaluation

All of the countries visited have district systems in place to monitor health indicators, although problems with accuracy and completeness are commonly recognised. In theory, inclusion of core national indicators will support the aims of RBM to establish baseline information as a means of monitoring progress and impact. Evidence in Ghana indicates an improvement in financial awareness and controls as a result of SWAps. Reviews in Tanzania and Ghana have identified a lack of sufficient emphasis on measuring outcomes, rather than activities. The reviews indicate that improvements to the sensitivity of indicators can only come with considerable system development (and so may take time), and that there is scope for improvement in order to measure impact.

Ultimately, there is potential to include a significant amount of RBM monitoring within district systems. In the interim, there is the very real risk of creating parallel systems in Africa in order to monitor the range of RBM indicators, especially as there is likely to be specific funding available. This was a concern in all 3 countries in the region, although it was recognised in Ghana that some baseline information would be valuable. There is a need to rationalise the core indicators according to resources and needs of the individual country and considerable scope for improving monitoring. Apart from ad hoc surveys, the priority of sectoral approaches is to work with and improve current systems and it seems unlikely that parallel systems will prove sustainable in the longer term. In the course of the fieldwork, there was a country preference for more resources to implement established and agreed monitoring mechanisms, or support in defining those that were most appropriate given local monitoring constraints.

e) Initiatives in health reform

To date the role of the private sector in malaria treatment is universally acknowledged but the scope of SWAp initiatives is typically confined to the public sector. Given the importance of private providers in treatment of malaria and the role of for-profit drug vendors in all of the countries visited, national initiatives to increase partnership have been particularly welcomed.

Tanzania is developing a sectoral public-private partnership strategy and Ghana has actively involved the private sector as part of a separate social marketing foundation, which has responsibility for increasing the demand for insecticide treated materials across the country. Although complex and hard to manage in unregulated environments, these are promising developments in reaching out beyond the public sector and forging new partnerships. Additionally, Uganda and Ghana have set up private sector partnership offices, demonstrating the importance of creating new ways of working. (Further discussion of this from the malaria control perspective is outlined in the final section.)

Bolivia, Tanzania and Cambodia have piloted a number of financing and contracting initiatives with the aim of increasing internally generated revenue and improving service provision. Whilst these initiatives are generic across the sector, there is the potential of

increasing sustainability of funding, which, in turn has the potential of supporting malaria control.

f) Role of NGOs

SWApS potentially offer a framework for improved co-ordination between Governments and NGOs who have traditionally been funded by donors on projects. With more funding coming through the Government system and a need to improve capacity to deliver services, there is the potential for Governments at national and local level to contract out to NGOs work set out in sector plans. Examples of this happening are given elsewhere in this paper but there is a recognition that skills and systems for letting and managing contracts need to be developed. NGOs are finding themselves in a funding gap between donor projects winding down as they move to budget support and governments reaching a point where they can contract out on any scale. Currently, many governments are focusing on adapting to new systems and responsibilities internally, and are not yet able to focus fully on this issue. Interestingly, levels of concern in those NGOs interviewed around SWAp developments were lower than anticipated, especially in Ghana and Cambodia. In part, this may reflect the minimal involvement of NGOs in malaria in Ghana and the absence of the potential “threat” of pooled funding in Cambodia. However a fall off in funding was noted by one NGO interviewed in Uganda.

3.2 Ways in which SWApS and RBM do or could conflict with each other, and how these conflicts have been, or should be resolved.

Potential conflicts between RBM and SWApS exist. In the course of the field visits to those countries with a more developed SWAp, many of the issues raised were partially attributable to fundamental and long-standing (pre-SWAp) problems of the sector in terms of chronic under-funding, low institutional capacity and inherently weak systems and incentives. These issues were not necessarily specific to RBM alone, but were common to many of the disease control programmes.

It was not always possible to differentiate between factors at work, for example to separate out professional concerns from preferred ways of working, resistance to change or seeking the most expedient sources of funding. Similarly, difficulties may be initial “teething problems” as distinct from those likely to persist over time. The points raised are not new. The Cambodian and Bolivian studies found similar concerns if sector-wide approaches developed further. The following areas cover specific points raised in the course of the work.

a) Institutional capacity and human resources

The study countries all demonstrate issues of urban and curative bias in terms of available human resources and preferences for curative intervention. The intention to correct this imbalance is there in plans, but affordability issues of providing services in remote rural areas remain, exacerbated by weak incentives for equitable staff allocation. The pace of change in reform generally, and to some extent that of SWApS has exposed the gaps in capacity at all levels. Capacity to take on the new responsibilities involved in implementing a sector-wide approach is largely insufficient; ability at district level to cope with all the competing demands is a common problem. Planning abilities varied between countries: Ghana has probably the most comprehensively developed and inclusive process, with clear understanding of requirements at all levels, although inter-sectoral planning at the periphery remains a weak

link. Ugandan planning is still weak at district level, complicated by the recent changes in sub-districts, and by fragmented central support though this is changing.

District and regional level staff were also lacking the facilitation and advocacy skills required to work effectively with a number of different partnerships, and loss of well qualified and experienced staff was compounding this effect, especially in Ghana.

National and local capacity for contracting out is also critical if moves towards budget support continue. As already noted above, NGOs involved in service provision or technical support and capacity building are seeing a reduction in donor-funded contracts.

There is scope here for RBM to support countries in defining the skill and capacity mix needed to deliver malaria control at each level (as part of a basic package) and to assist with designing the appropriate training and professional development. Further, training on succession planning (i.e. planning ahead for staff replacement following retirements and resignations) would be of benefit where capacity is thin or staff turnover high.

b) Resource constraints and disbursement issues

Hard budget constraints and problems with disbursement of budget were keenly felt at district level. The mechanisms for disbursement of funds varied but perceptions of control programme managers in Ghana and Tanzania were that disbursement was more uneven and access to funds slower than before the introduction of a SWAp. Slow disbursement of funds has been a marked problem in the first year of pooled funding in Uganda. There was also a general perception across countries about lack of donor transparency over fund availability outside the pooled resource. Further, anecdotal evidence from Ghana suggests that late disbursement of pooled funds contributes to the overall lack of interest in the more complex outreach activities in malaria control, and encouraged a curative bias.

In Tanzania and Ghana for example, there is clearly the intention by some donors using the pooled resources to protect activities at district level during transition by continuing to channel funds outside of the pooled mechanism. However, whilst planned off-line support in transition is pragmatic and sensible, the extent to which this is occurring in a phased and coherent manner is questionable. In practice, decisions are driven, in part at least, by some individual donors' ability to participate in pooled financing as well as the ad hoc phasing out of project support in favour of budget support, leaving some districts vulnerable. In the longer term, it raises issues of country ownership if large quantities of funds are continuing to be directed outside of established government mechanisms. There is some evidence that this is an emerging concern in Ghana, where this may be contributing to resistance to change at district level in particular, where late disbursement and tight budget constraints seem to be encouraging districts and the malaria programme to continue to seek direct donor support.

The critical question here for RBM is how to scale up RBM whilst working within established mechanisms in individual countries and using available funds to support local needs in developing capacity and covering resource gaps. For example, is there scope within SWAp mechanisms to cover the transitional aspects of contingency planning for epidemics to compensate for increasing donor preferences for budget support?

c) Conditionality

In a decentralised system the potential loss of control over resources may undermine ownership and accountability at local level.

There is some evidence, largely from Uganda, that conditionalities applied to districts are placing an excessive burden on district managers and service provision. There are benefits in Uganda linked to the protection of funds intended for poverty-sensitive interventions in health. Donor releases of funds to the pooled fund are contingent upon the MoH meeting targets.

Initial issues of conditionality over excessive capital expenditure on tertiary facilities in Ghana appear to have resolved.

d) Malaria profile

The previous section discussed the potential for sector-wide approaches to enhance the profile of malaria control. This is very much the case in Uganda. On the other hand, there is a feeling in Ghana and Tanzania that in spite of solid planning, the malaria programmes have too low a profile in the MoH and that malaria control activities are not sufficiently prioritised at district level. This may partly reflect factors such as lack of capacity and budgets that are not yet fully operationalised. Whilst there may be a trade off between building systems capacity and direct interventions, it seems to be a concern that the overall profile was low in some countries, in spite of recent RBM efforts.

The ambitious and comprehensive RBM Strategy in Ghana has raised expectations of additional funding, to the extent that some districts would require estimates of up to 75 % of the total budget for malaria activities alone. Budget management against tight ceilings is intended to hone skills in prioritisation – and thus favour priority programmes. In Ghana, capacity development in this regard is hindered by cumbersome financial line item reporting procedures that are linked neither to activities nor to outputs. Although there are other factors to take into account, such as weak incentive systems, it appears that the current focus on the more intangible proxy indicators is at the expense of output-based budgeting and priority planning. There is some risk that malaria (and other disease priorities such as TB) is somewhat lost in this mix of different mechanisms. The SWAp approach favours outcomes being supported across the board by all partners in the programme of work and monitored by appropriate, agreed indicators.

3.3 Ways in which RBM does or could promote the development and success of SWAps

Although RBM is in an initial stage of development, and thus an assessment of impact is probably premature, there are a number of ways in which RBM can and already does support the sector-wide approach

Many of the objectives of RBM echo and reinforce those underpinning common management arrangements at country level, notably increasing partnership and strengthening health systems.

In terms of increasing the diversity and breadth of partnerships, work in Ghana and Tanzania by the malaria programme on the promotion of insecticide treated mosquito nets has already created visible product demand whilst actively involving commercial partners and a range of other stakeholders such as NGOs. The inter-sectoral approach of the Bolivian control programme has the potential to be a pathfinder for introducing broadly-based co-ordination at all levels.

Other initiatives are also worthy of note, in particular the Cambodian national malaria programme partnership with 23 other stakeholders in Government ministries, UN organisations and numerous NGOs to distribute nets to remote populations. The programme is less integrated than many but critically, this has not precluded the building of partnerships within the sector, although many had been in place before the advent of RBM. More recent achievements include the social marketing of hammock nets for migrant forest workers in collaboration with the World Bank and commercial sector. Other examples are: the piloting of blister-packed combination antimalarials for distribution to the private sector in collaboration with the MoH and the EU, and potential for further collaboration with pharmaceutical companies in developing appropriate combination paediatric formulae.

There is also scope for RBM and SWApS to be mutually re-enforcing. Just as a sector-wide approach provides a framework within which cross-cutting issues can be addressed, malaria provides the ideal example to illustrate how this can be achieved. The difficulties of co-ordinating and providing the range and depth of malaria control activities reflect some of the complexities inherent in horizontal approaches to service delivery. Much can be gained from better co-operation, closer working and genuine dialogue to build system capacity and ease the transition. Globally, if RBM can capitalise on the current momentum of political support, there is an opportunity locally to assist in reinforcing some of the activities involved in the planning and execution of malaria, in order to boost capacity and system performance.

4. Factors beyond SWApS and RBM that may be contributing to the issues raised

The emergence of the RBM movement and the development of sector-wide approaches need to be seen in the wider policy context. As such, there are a number of influences that impact on malaria control and prevention. Some of the more dominant factors in the study countries are discussed briefly below.

Lack of capacity and gaps in resources have major implications for both SWApS and RBM in all the study countries. This is part of a wider problem concerning the affordability of public health care provision against levels of comprehensive coverage.

Changes in government and shifts in policy direction can present new uncertainties. The incoming political administration in Ghana has indicated an intention to remove point-of-service fees. On the one hand, this may reduce costs for individuals with malaria seeking treatment at the regional level but it will inevitably affect the overall funding base in the sector and possibly overall expenditure on malaria. Similarly, a new decision in Uganda to remove cost-sharing is likely to increase overall pressures on the total budget.

Internationally, many countries have been successful in reducing or revoking import and sales tax and levies on insecticides and mosquito nets. This issue is particularly important where there is no established local manufacturing base, or it is insufficient to meet demand. In the study countries, this was still an issue in Ghana in spite of considerable high level lobbying. There is a risk that the efforts to increase demand through social marketing and other approaches are being undermined by deficiencies in supply.

5. Outstanding questions for discussion and some potential solutions

The countries studied represented a broad spectrum of the stages of SWAp development and moves towards new ways of working that take time and involve considerable changes to established mechanisms and approaches. Some important points have already been addressed in terms of new approaches; however, some critical areas require further discussion and agreement on the way forward. These have wider implications for disease-orientated programmes generally, not just RBM, and may affect subsequent global initiatives, although the solutions were not immediately obvious in the study countries.

The questions set out below are those that arose in the course of discussions at country level and reflect the questions that are exercising those involved in SWAps and RBM.

There is a need to clarify the role and appropriateness of parallel mechanisms and their future direction, recognising that there may be a role in some countries for centralised services alongside integrated approaches:

- In the case of internationally supported global initiatives, how do international and regional templates tie in with supporting and increasing country ownership and the trends towards central budget support funding an integrated systems approach? Those countries with a well developed SWAp are concerned that external funds should use the new mechanisms established.
- Given global resource constraints, which planning and funding frameworks and mechanisms should/could dominate, and to what extent are they compatible in terms of approach? How flexible are RBM funders and is there scope for changing ways of working to fill gaps and/or support developing country mechanisms?
- How genuinely to bring together fundamentally different approaches without compromising outputs. How can pragmatic, local solutions emerge and be supported and disseminated?
- What are the appropriate mechanisms for contingency planning for emergency interventions such as epidemics? How can contingency planning be improved and costed in the long term and what should the interim arrangements be?
- What further efforts need to be made to increase the growing partnership between the public and private for-profit sectors? How can this be initiated and owned by governments? Is there more scope for making NGO collaboration less opportunistic and more part of a national strategy? Service provision is largely supply driven; what is the scope for RBM to escalate the role of civil society in improving demand for quality malaria services?

The following suggestions are ideas and options, amongst many, for the meeting to consider, based on country-level concerns raised in the course of the fieldwork.

Partnership-building processes are lengthy processes and in the context of on-going health reforms require high levels of capacity for planning, prioritisation against budget constraints, monitoring and evaluation. As systems and processes change the skill requirements of staff involved in malaria control are shifting towards those of advocacy facilitation and supervision, and away from direct implementation.

Is there scope for RBM to take the initiative in supporting SWAps and systems in transition? RBM aims and objectives suggest the answer is yes – how to translate this into funding flows? Findings suggest that transitional arrangements need to be both explicit and specific in terms of:

- Overall levels of capacity, skill-mix and skills required to deliver complex malaria services. Could RBM assist in supporting national programmes to define these

requirements, ensuring that they are included in policy and supporting technical capacity at each level in support of joint objectives? The arrangements for integration of activities such as supervision should be made clear, as should the specific activities, which will need to remain more centralised.

- The design of specific training modules in priority planning, contingency planning, advocacy, facilitation and change management in order that control programme staff are equipped with the necessary skills to engage with a broad group of stakeholders.

In spite of the stated importance of malaria in policy documents, there is evidence of relatively low priority in some African control programmes. Internationally, can the RBM movement assist programmes to raise the profile of malaria by means of high-level advocacy at country level? If so, how best might this be achieved, building on some encouraging signs of increased attention to malaria in plans and budgets?

There is a risk of developing parallel systems for monitoring and evaluation of RBM separately from sector wide country-owned monitoring plans. Given the existence of other major global initiatives with their own monitoring and evaluation needs, this may place an overwhelming burden on local systems struggling to improve. Findings suggest the need for clarification on policy at regional and country level on how to deal with the monitoring and evaluation aspects of global initiatives within country systems. How can RBM partners best advocate for and help support the measurement of outcome-based indicators linked to overall planning and building on current systems?

In sum, there is evidence of achievements to date in building partnerships in both RBM and SWAps. Given the complexity and extent of inherent problems they are impressive. A good base for scaling up is being established but there is a lot to be done. It will be important to capitalise on the current momentum and political support for RBM internationally in order to maximise the added value of continuing co-operation and genuine promotion of country ownership, and to translate these into meaningful dialogue and *practical solutions* beyond the broader intentions.

Annex 1: Terms of Reference for the study

Consultancy to develop a background paper for the Fourth Global Partners' Meeting of Roll Back Malaria

Roll Back Malaria Targets in relation to the Sector Wide Approach

1. Background

The Fourth Global Partnership Meeting to Roll Back Malaria will be held in Washington, DC, USA on 18 and 19 April 2001 hosted by the World Bank.

The objective of the meeting is: "expanding the capacity of the RBM Partnership to get to scale". It will aim to address the following: How can malaria-affected countries and their partners mobilise action beyond malaria control programmes, beyond the public health sector and beyond the public sector?

In preparation for the meeting the WHO Cabinet Project has requested the Malaria Consortium to prepare a background paper describing country experiences on the relationship between RBM's focus on ambitious global and regional targets, and country determined development of Sector Wide Approaches (SWAs).

2. Purpose of the paper

To contribute to expansion of the capacity of the RBM partnership to go to scale by describing the interaction of RBM and SWAp in selected countries, and to highlight key issues for discussion during the GP4 meeting. The paper will consider SWAs as a method of improving capacity, management and resource mobilisation, and how this can support RBM. The paper will also consider how RBM can strengthen SWAs in its role as a pathfinder for health sector reform. The paper will address real or potential areas of conflict between SWAs and RBM for example with regard to country ownership of planning versus globally co-ordinated efforts, and long-term capacity building versus shorter-term health targets.

It is intended that the paper will assist those involved in RBM development and those in SWAp development to understand each other's approaches and needs better, and will highlight the areas where joint development is needed.

3. Output

A discussion paper with:

- a) clear descriptions of the SWAp developments and mechanisms discussed and their place in health sector reform and development generally
- b) a brief review of the status of SWAs and likely future developments
- c) analysis of key issues and lessons learnt, including the following areas:
 - ways in which SWAs do or could catalyse the RBM process
 - ways in which SWAs and RBM do or could conflict with each other in the short or long term, and how these conflicts have been or could be resolved
 - ways in which RBM does or could enhance the development and success of SWAs
 - factors beyond SWAs and RBM which may be contributing to the issues raised
- d) outstanding questions and actions for RBM and for wider policy development.
- e) summary of recommended discussion points for the GP4 meeting

It will include a brief review across countries and more detailed analysis in case studies of the following countries: Bolivia, Cambodia, Ghana, Tanzania and Uganda.

The country case studies should include discussion of:

- status in country of RBM and SWAs, including targets and a profile of donors' strategies, and briefly other relevant health sector reform developments
- future plans for ?RBM and SWAs or just SWAs
- relationship between RBM and SWAs showing impact in both directions and covering the issues listed above
- stakeholder analysis (public sector, NGOs and civil society, private sector)
- common lessons and issues

4. Tasks

1. Identify key informants, stakeholders, and sources of information
2. Gather and examine information that can be collected without country visits
3. Develop discussion tools for key informants and stakeholders
4. Visit countries listed above to discuss the issues already identified, and identify and discuss any new issues
5. Write draft paper to submit to WHO by 30 March 2001
6. Finalise paper by 13 April 2001 following feedback.

5. Management arrangements

Consultants will be contracted by the Malaria Consortium for a total of 34 days between 19 February and 13 April 2001. Country visits of approximately 3 days each will be made to the countries listed above, plus approximately 3 days per visit for travel, preparation and write-up. A team leader will be designated to have overall responsibility for collation of the country reports and other inputs, and production of the overall paper, an additional 3 days (included in the 34 days). A Malaria Consortium Task Manager will have responsibility for briefing and co-ordinating the work, additional technical input and quality control.

Annex 2: Country Case study summary – Bolivia

(Note: additional information is provided in the full case study report)

Economic and political environment

In 1982 Bolivia began one of the longest democratic periods since its foundation in 1825. In the mid-80's the country entered a series of Structural Adjustment Programmes (SAPs) that led to economic stability and important changes in the social structure of the country, the so-called "first generation state reforms". In the early 90's, a second set of reforms focused on Decentralisation and Community Participation. This process has provided the framework for the development of "state public policies" as opposed to "government public policies" particularly in the health field.

The current government took office in 1997 and will leave in 2002.

Poverty Reduction and Sustainable Development are top priority in the administration's agenda. The government designed in 1997 a 5-year General Plan for Economic and Social Development (PGDES, *Plan General de Desarrollo Económico y Social*) which consists of four pillars:

- a) Opportunity Pillar. The objective of this pillar is to allow economic growth
- b) Equity Pillar. Its objective is to improve the living conditions of the population, particularly those of the poor.
- c) Institutionality Pillar. The objective of this pillar is to articulate specific programmes oriented towards developing the institutions of the country and the population's confidence on them.
- d) Dignity Pillar. The objective of this pillar is to place Bolivia outside the coke-cocaine circuit.

Health sector background and development of the sector-wide approach

In the mid 90s a Health Sector Reform (HSR) process with a strong emphasis on health sector capacity building and maternal and child health (MCH) began. Later, intra- and inter-sectoral collaboration was added and endemic diseases such as malaria, Chagas disease and tuberculosis were gradually given more importance.

The Administrative Decentralisation Law transferred competencies to the Departmental Governments (Prefectorates). In this context the MoH designs policies, regulates and supervises health activities in the country, but the Prefectorates implement health management.

Within the framework of the PGDES, the MoH elaborated the Strategic Health Plan (PES, *Plan Estratégico de Salud*). The objective of the PES is to build the Bolivian Health System; with universal access based on PHC. In order to achieve this objective it promotes social participation and control, in a process that will lead to a Health Law, turning *government* policies into *state* policies.

The PES consists of the following strategies:

- A Basic Health Package (SBS, *Seguro Básico de Salud*) covering:
 - o Maternal Care
 - o Prevalent diseases of the under 5 year-old group
 - o Prevalent diseases of the whole populationThere are no user charges for care falling under the package.
- Epidemiological Shield. This is an initiative to fight endemic diseases such as Chagas disease, malaria, tuberculosis, immuno-preventable diseases and others according to

the epidemiology of the different municipalities. The complete Strategic Plan Against Malaria (SPAM -see below) is part of this initiative.

- Community and Family Health.
- Reform of the Social Security System, which now covers ¼ of the population and accounts for ½ of the total health expenditure of the country.

A new set of reforms within this process recently joined the MoH agenda. These include changes in the payment mechanisms of the SBS. The Decentralisation and Popular Participation Laws now provide the framework for SWAps. Under this new legal scenario, the number of stakeholders in health management has expanded to regional and local governments and civil society,

Malaria and Development of RBM in Bolivia

Bolivia has 3 main ecosystems: highlands, valleys and the amazon region. The last two are malaria endemic regions and together comprise 75% of the territory. Eight of nine administrative departments experience malaria. The country is divided into three epidemiological regions (high, medium and low risk of transmission).

A Strategic Plan against Malaria (SPAM) is situated in the context of the equity pillar of the PGDES, since it is the result of profound historic and social inequities. In order to improve health care delivery in malaria endemic regions, an investment of 3.9 million US\$ for more than 700,000 treatments is needed. There are four other components that will require 10. 6 million US\$ in total.

Since the PGDES is coming to an end in 2002, the survival of SPAM relies heavily on the place malaria gets within the Health Law that will be analysed and passed in August this year, at the beginning of the last year of the current government's term. Lobbying activities both at the political and technical levels are needed.

The SPAM was developed in 1999, a time when the RBM strategy was presented to Latin America, therefore the concepts of the RBM initiative were included in its design right from the beginning. The SPAM has six main components:

- Decentralisation and deconcentration. This component seeks to strengthen the management of malaria in all levels:
- Community participation. There are various aspects in which the community organised in an effective manner can participate in the SPAM:
- Transectoral Co-ordination - intra-, inter- and extra-sectoral co-ordination, involving the following institutions: Ministry of Housing, MoH, Ministry of Defence, Donors, Different enterprises, NGOs, community organisations, surveillance committees, municipal and district health councils.
- Integrated management. It is important to work with the integrated management of diseases included in the Epidemiological Shield
- Joint binational efforts.

Following a Logic Framework structure, the purpose of the plan is:

"To reduce morbidity and to prevent mortality caused by malaria in Bolivia through the improvement and strengthening of local, regional and national management capacity, in the period 2001 – 2005". (Note that the current government will be in office until 2002).

There are 5 outputs in the SPAM:

- All cases detected in the country are successfully diagnosed and treated free of charge by the health system and community agents between 2001 and 2005.

- Prevention actions and vector control methods are developed in areas of active transmission and higher risk, between 2001 and 2005.
- A process of applied research has allowed a constant adjustment of proceedings, new inputs for diagnosis, treatment, prevention and vector control of malaria between 2001 and 2005.
- There is an information sub-system for surveillance and management of the programme, integrated to the SNIS in all the country by 2005.
- Information, education and communication (IEC) activities have been conducted in order to motivate and compromise the population of the endemic regions, towards wide participation in the SPAM. To promote a change in attitudes and practices that will maintain and sustain achievements of the 2001 – 2005 period.

The cost of the SPAM is 10,699,452 US\$, and the Bolivian government (GoB) will contribute with US\$4,800,000 (44,8% of the total). Donor still manages their own funds although the epidemiological shield committee inform each other about the state of implementation of their own plan every few months.

The purpose of the RBM initiative in Bolivia is “*to avoid mortality caused by malaria, particularly in indigenous people in the period 2000 – 2004*”, which is similar to that formulated by the SPAM. Approaches include:

- *Successful management of cases, including outbreaks of the disease.*
- *Early diagnosis and treatment.*
Resistance to drugs is being monitored in some districts and some findings show that new combinations and therapy are needed, but the drugs included in the SBS are not likely to change in the near future.
- *Multiple Prevention.*
- *Focused research*
- *Sector-wide approach.* The Epidemiological Shield provides the scenario for the sector-wide approach and for intersectoral collaboration within the parameters of fight against vector transmitted diseases.
- *Strategic Alliances.* The Epidemiological Shield provides the framework for building strategic alliances, but has not yet achieved the capacity to build a complete SWAp for the implementation of the RBM/SPAM.

RBM partner agencies in Bolivia include: WHO/PAHO, UNICEF, Interamerican Development Bank (IDB), Population Services International (PSI), USAID, PROCOSI: an umbrella organisation of around 20 health NGOs, IRD.

Together, investment by all funding organisations amounts to US\$ 9m (approx. 90% of the total needed to the complete 5-year plan). None of these funds however are put into a basket.

Ways in which SWAps could or do catalyse the RBM process in Bolivia and vice versa; strengths and obstacles

The following arose as important issues in discussions with key informants.

Before the SPAM was developed, the country depended on scattered donations with little that had overall impact on malaria and other vector transmitted diseases. Health authorities could not develop an integrated plan due to the lack of funds and planning capacities

The country is making efforts to start and consolidate SWAps. Many projects were developed before SWAps were conceived, so it will take some years for the government and all donors to adapt and change their agendas to a more sector wide oriented approach. A weakness is

poor communication within the different Departments within the MoH. On the other hand some changes are beginning to occur, at least on paper.

There are some important facts that need to be introduced in the SPAM/RBM to assure its success in the long run:

- A long term approach with high political support. Although this is in the SPAM/RBM, and local governments seem to have put emphasis to malaria, there is room for improvements at higher levels. Malaria will only be successfully controlled with greater levels of socio-economic development, but until then the country needs to sustainably fund malaria control activities.
- The implementation of isolated strategies, such as social marketing of ITMs, the financing of diagnosis and treatment or education to target groups alone will not have the impact that is needed
- A true intersectoral approach has not been achieved (e.g. in terms of bringing in the private sector, and exploiting the comparative advantages of other ministries such as education). A balance needs to be achieved between intersectoral and specific interventions in order to attain both sustainability and impact of actions.

There are still some major underlying factors the country must consider in order to be successful in the fight against malaria:

The political commitment of the next government is crucial to continue to implement the SPAN as it has been conceived. Effective co-ordination must take place among stakeholders with a clear leadership by the Ministry of Health. The capacity for such leadership needs to be developed so that the process is not mix of spread efforts, but as a truly integrated approach with a shared objective. There is felt to be room for improvements in the design of the relationship between the MoH and regional and local governments.

The logistics of all the activities included in the SPAM must be considered as of high importance. The country has developed, in conjunction with its partners, a detailed and precise plan that if implemented adequately, is likely to have an enormous impact in the fight against malaria; but if logistics at the local levels are left to existing capacities, the plan will not reach the population.

The impact SWAp are likely to have on RBM depends of the degree of enforcement the GoB puts in effectively applying the former at all levels. There is still the issue of capacity to implement a sector wide approach, together with the activities RBM has in its design. On the other hand if the government at the central level does not take the lead in enforcing RBM, every stakeholder will continue to work separately. Exchange of information is a step forward but not yet felt to be enough to achieve the SPAM's objectives. On one side there is the Plan with a clear purpose, outputs and activities with a detailed budget that adds up to 10 M US\$. On the other, a similar sum is planned to be spent by development partners in the next 5 years, but this is not firmly set against the plan, although some activities coincide.

Roll Back Malaria in Bolivia has become an important initiative that is included in the Strategic Plan Against Malaria (SPAM). RBM is seen as an opportunity to further implement reforms stated in the legal framework and in the overall process of HSR, and to have the potential to improve SWAp co-ordination. RBM could be used as an instrument to help the government and its partners truly develop SWAps, for the benefit of the fight against malaria as well as other public health problems of the country. First however, all stakeholders need to participate in the RBM, that is, participate in the SPAM.

Annex 3: Country case study summary: Cambodia

(Note: additional information is provided in the full case study report)

Cambodia's decision to move towards improving external aid co-ordination is relatively recent. Although formerly agreed in late 2000, the sector-wide debate has been an integral part of the overall reform discussions since 1997. The process has been steady and consultative, with careful exploration of all the available options, benefits and constraints of sector-wide working, resulting in the agreement to move forward with Sector Wide Management (SWM) to define the much needed common vision for the sector. Notably, Cambodia's approach includes developing the first joint sector-wide strategic plan and an expenditure framework but without commitment, at this stage, to pooled funding mechanisms.

Critically, a number of contextual issues have been fundamental in adopting this approach. Cambodia is a poor, post-conflict nation where humanitarian and short-term projects have proliferated in the last decade. Following the genocide, bureaucratic and technical capacity is still patchy and the capacity required to lead and synchronise the project cycles of the more than 100 organisations active in health is considerable. Historically, many departments and programmes within health have operated semi-autonomously, especially those with significant donor funding, including malaria. Further, the donor profile in Cambodia is less conducive to pooled funding mechanisms as many of Cambodia's most significant donors are unable or unwilling to participate. The national budget for health, although improving, started at a very low base. Affordability is a major concern, and external assistance seems likely to continue in the mid-term. Issues remain around access to budget and the inadequacy of financial controls and the unregulated private sector. Nonetheless, the Ministry's decision to adopt SWM represents a milestone in what has been to date a largely fragmented sectoral approach and has the potential to assist in strengthening systems and consolidating the integration of services at the periphery in line with reform objectives.

As the SWM approach is in its infancy, difficulties arise in accurately assessing the potential affect, or influence to date, of SWM on Roll Back Malaria (RBM). Much will depend on the decisions taken as part of the joint sectoral review (draft, March 2001) and the overall strategic plan yet to be developed. Notwithstanding this, the fieldwork indicated a number of positive points, namely:

- Moving towards a more strategic approach has initiated the first comprehensive annual progress report of the national malaria control programme and the development of the first 5 year strategic plan to feed into the forthcoming national strategy
- The participation of Provincial Governors at the national malaria conference has the potential to be mutually re-enforcing in terms of developing the necessary intersectoral links required for effective malaria control, improving trust and broadening the levels of political support for RBM.
- There is potential for SWM to provide a coherent framework to build on the plans for more a more inclusive approach to central missions with provincial staff to increase joint working with districts where malaria is included in the basic package of activities. This will have the added benefit of fostering capacity at the periphery. Similarly, this in turn, has the potential to provide fora for the provinces to participate much more in the planning of malaria activities, a critical necessity if systems are to develop and work towards sustainability.

- Improved strategic direction associated with SWM is likely to increase national, and especially the MoH's ownership and control of projects. There are some 18 organisations involved in malaria activities, including numerous NGOs, who largely work outside of government structures. It is possible that some rationalisation of incentive payments and *per diem* scales will be possible within a new strategic framework, reducing the level of competition between projects.
- SWM is likely to improve co-ordination and communication at all levels, but also within the MoH, where, in common with other ministries, inter- and intra-departmental communication has traditionally been weak. This is likely to have a positive impact on the need for malaria to improve collaboration between the other national programmes such as IEC.
- Recent reform proposals such as “boosting”¹ have the potential of mobilising resources for malaria in selected districts and provinces. Although it is premature to judge the sustainability of this initiative, it has the potential to increase the planning, curative and preventative capacity of peripheral staff.

Similarly, it is equally difficult to predict the ways in which RBM and SWM may conflict with each other and how such conflicts could be resolved. Moreover, many of these concerns are not unique to malaria control: other control programmes will be affected. Some of these issues are inherent to chronically under-funded systems and many post-conflict countries. Interviews did raise concerns at the country level, and in particular:

- The national control programme, with the collaboration of multiple partners has achieved some considerable successes in the reduction of malaria prevalence in key intervention areas and overall mortality in public sector hospitals. Depending on how far Cambodia's sector-wide approach develops in the future, for example, towards budget support, may have implications for the national programme as it is currently organised. As malaria transmission is largely in remote rural areas (with the weakest health infrastructure) there is likely to remain a role for a more centralised approach to control activities than would be appropriate elsewhere, especially with tight budget constraints. However, the increasing emphasis on building capacity in systems is likely to prevail. Thus, the debate is not so much about one approach or another but more about which combinations of approaches are likely to be both the most cost-efficient and effective in controlling malaria.
- Nationally capacity at the periphery is weak and health centres lack staff resources and budget to comprehensively tackle the intricacies and complexities of malaria interventions. If transitional capacity building is to be achieved whilst safeguarding the considerable achievements to date then the transition needs to be both planned and gradual. Specifically, the capacities at district and central levels need thorough analysis and gaps need to be identified. The advent of RBM has increased collaboration between a number of partners, especially international partners. The control programme staff are already recognising that their remit is likely to change – shifting the focus from implementation towards more advisory and supervisory work. Inter-sectoral links need to be forged at the district level, but the advocacy and facilitation skills required need to be developed at *all* levels to effect a smooth transition. This will require a comprehensive transition plan, which should include, for example needs assessment, skill –mix requirements, strategic planning in co-ordination with other control programmes, training especially in advocacy and facilitation, and clear plans on how to effectively manage activities such as supervision.

¹ The pooling of a small group of donor funds at the province level to increase financial resources.

In Cambodia, the impact of RBM on SWM is perhaps easier to gauge. Even before the advent of RBM, there was a strong national programme with good funding and a collaborative approach with multiple partner involvement (albeit largely donor-driven) in order to reach the more remote and sometimes insecure regions of the country. There have been many achievements, among which, the following are opportunities on which to capitalise, in order to catalyse further sector-wide thinking in Cambodia:

- Extensive involvement with the private sector in the social marketing of hammock nets for migrant forest workers; collaboration with local and international pharmaceuticals to pack combination antimalarials in Cambodia to improve compliance and minimise exposure to ineffective alternatives in the public sector; and the generation of interest from a number of commercial partners to research and develop a paediatric formula. A pilot to produce and market the commercial equivalent adult dose anti-malarial is complete. The importance of these innovations is hard to over-emphasise given the extent of private-for-profit provision and demonstrates excellent opportunities for future work in other parts of the sector.
- The extent and experience of working with so many different partners within different ministries, UN organisations and NGOs has the potential of being a good practice example. It also provides opportunities for improving the overall co-ordination of malaria throughout the country, as well as continuing to maintain the profile of malaria across a number of sectors.

Annex 4: Country case study summary - Ghana

(Note: additional information is provided in the full case study report)

The Sector-Wide Approach (SWAp) in Ghana is well established - in place since 1997, with disbursement to the pooled fund commencing that year. The Ghana SWAp is firmly rooted in the overall health reforms, which have been incremental in pace, with gradual implementation over the past decade, resulting in deconcentration to district level. There are a number of generic positive benefits resulting from the SWAp, perhaps, most notably, the reported sense of increased ownership nationally and improvements in capacity for planning and financial controls. However, although more donors have joined the pooled funding mechanism and the pooled fund has increased, overall additional resources for the sector have not been mobilised and concerns around the possible revocation of point-of service fees as part of the new administration's policy will have implications if enacted.

Nonetheless it is possible to attribute some positive effects on RBM as a direct result of implementing a more cohesive approach embodied in the SWAp arrangements, and in particular:

- Staff at all levels in the Ministry, the national control programme and districts reported enhanced abilities in planning integrated services
- Establishing performance budgeting to assist in prioritisation in integrated service planning, including planning malaria activities
- Following enhanced training in planning and financial management the decentralised Budget Management Centres at all levels are operational and managers have direct control over resources, including pooled funding.
- Improved financial systems and financial controls have increased donor confidence in Government systems, theoretically increasing the potential for additional resource mobilisation across the sector.
- The SWAp approach to supporting integrated systems at district level has provided a framework for further facilitating a more cohesive approach to the planning and implementation of complex malaria interventions, by means of inter-sectoral working, although there was a perception at country level by staff at many levels that this was historically weak and could be further exploited.

Additionally, there were perceived to be areas where SWAps and RBM are in conflict with each other, although on analysis many of the problems were fundamentally due to chronic sector under-funding, combined with weak incentives. Moreover, most of these issues were not unique to malaria: typically, other disease control programmes were variously affected, for example:

- The ability of budget managers to adequately prioritise between competing priorities was reported as problematic and due to a complex array of factors:
 - Late disbursement of funds combined with late budget ceiling release from the Ministry of Finance
 - Capacity for prioritisation is not well developed

Anecdotal evidence suggests that these factors are contributing to the overall lack of interest in the more complex outreach activities in malaria control, heightening the historically weak profile of malaria as a control programme, encouraging a tendency towards a curative bias and the seeking of expedient (often donor-direct) forms of funding.

In essence, the interdependency of these variables and their relative weight is difficult to judge. The principles of performance budgeting are designed to promote prioritisation but success is contingent on timely resource release. Further, the RBM secretariat has prepared a comprehensive, if somewhat ambitious national strategy, and assisted districts in drawing up plans. Some districts estimated that the projected costings would amount to between 30% and 75% of district budget totals. There is a risk of unmet expectations if funds do not materialise.

Overall, monitoring the impact of SWAp on health interventions and outcomes is hampered by a number of factors. The current 5-year Programme of Work (due to end 2001) has failed to focus on outcome measurement. To date there has been insufficient focus on activities based budgeting. Expenditure is reported by line item and thus clarity on expenditure for malaria is absent. To some extent, this is due to the focus on the crosscutting issues such as quality intrinsic to the reforms, not SWAp per se. The risk is that health outcome measurement will be poor and lack of prior knowledge on previous expenditure will constrain realistic and accurate budgeting. This has already been recognised and modifications to the forthcoming national plan are under consideration.

The impact of RBM on SWAps is less easy to judge since RBM is a new initiative, however many of the initiatives in malaria are part of long-standing arrangements. Perhaps the most obvious impact is the opportunity for malaria control to complement SWAp by encouraging inter-sectoral approaches and working through new partners. This will require new skills in advocacy and facilitation as the roles of staff at programme level shift towards more advisory remits. These skills will need to be taught and practised and gaps in skill-mix or resource adequately assessed. To date, sensitisation meetings and workshops have begun the process, ably supported by senior staff in public health, although broader ownership and recognition of malaria as a cross-cutting challenge is needed for scaling up, which is likely to require changes in outlook and established ways of working across ministries.

The Ministry recognises the important role of the private sector. Encouragingly, a private partnership office has been set up and Ghana Social Marketing Foundation has made progress on increasing the demand for insecticide treated materials. However, the supply side has proved problematic with a weak local manufacturing base, and hefty import tax levies which are limiting imports at affordable prices for Ghanaians. RBM has the potential to mobilise wider political support using the health partners and inter-sectoral links as well as RBM internationally to facilitate a solution.

Annex 5: Country Case study summary – Tanzania

(Note: additional information is provided in the full case study report and in the background paper on PRSPs and RBM)

Economic and political environment

Tanzania experienced a severe economic downturn in the early 1980s. The economic reforms which began in the mid 1980s have brought about positive economic growth, but implementation of structural adjustment measures has been slow. This has held back private investment and made public investment less efficient. The average GDP growth of 4% per annum is below the country's potential, and only slightly higher than population growth. Macroeconomic management is variable; and Tanzania has undergone several periods of severe macroeconomic fluctuation since the late 1980s. Tanzania is one of the poorest countries in the world with a per capita GNP of about US\$240 in 1999 (World Development Report, World Bank 2000). Government estimates suggest that over half the population, approximately 16 million are poor and 36 percent are very poor (classified as living on less than US\$1 per day).

Health sector background and development of the sector-wide approach

Tanzania's Health Sector Reform (HSR) was initiated by the Government in 1994 and outlined in the '*Proposals for Health Sector Reform 1994*'. This new strategy recommended that the Ministry of Health should: strengthen its role with respect to regulation and policy development; develop an essential health package that would reflect Tanzania's burden of disease; and devolve responsibility for health planning and delivery of health services to the district, with all reforms implemented at the local level being the responsibility of local government. The reforms were approved by the Cabinet in 1996 and subsequently gained the approval of development partners.

Following a series of joint mission and consultative meetings, a Health Sector Programme of Work (HSPOW) was developed which translated the blueprint for the reforms into an implementation plan. Annual Health Sector Plans of Action (HSPOA) have been produced since 1999 (Financial Year 1999/2000) and are currently based on the Health Sector Programme of Work (HSPOW) July 1999 – June 2002. These are jointly approved by the Government of Tanzania (GoT) and development partners at the annual Joint Review meetings in March of each year. The current blue print for Health is the Medium Term Strategic Plan, 2000-04 (July 2000), which is a considerably more sophisticated plan than earlier ones, acknowledging the weaknesses of Tanzania's health system. It proposes that "the Ministry will continue to do further restructuring so as to change from its traditional role of provider of health services country-wide into that of facilitator and regulator of implementation of health services."

The Sector Wide Approach (SWAp) in Tanzania is at a relatively early stage – pooled funding began in 1998 with disbursement of funds to the central and district Ministry of Health (MoH) beginning only in March 2000. In its second year, the partners – MoH, donors and multilaterals – have more clearly identified the challenges of implementing the SWAp in what has been an inherently weak and poorly funded health system. Health sector reform in Tanzania has taken the form of devolution of responsibility for health and now resources to local government at the district level. At central and district levels it demands a high level of capacity for planning, budgeting, monitoring and evaluation. Developing those capacities, which are currently weak, is a gradual process and will be prioritised within the SWAp during 2001-02.

Total health expenditure for 2000/01 was estimated at US\$94.6 million, or about US\$2.7 per capita, and at about 6% of total government expenditure. Recurrent health expenditure is about 43% of total health expenditure. There continues to be considerable uncertainty around budget projections, as government is uncertain about the level of future funding commitments by donors, especially for funds that are outside of the Basket. In principle, however, indicative commitments by pooling donors of the level of funds they will contribute to the Basket do provide GoT with greater certainty in its projections.

Malaria and Development of RBM in Tanzania

Roll Back Malaria (RBM) in Tanzania is being implemented by the National Malaria Control Programme (NMCP), under the Department of Epidemiology where it is directly responsible to the Directorate of Preventive Services. Because of the limited number of staff at the central level (11 posts plus technical support from WHO), wholly responsible for supporting RBM at the district level, it feels overstretched in meeting the challenge of implementing a RBM national strategy within a reforming health sector.

RBM Status

The new antimalarial drug policy, changing 1st line treatment from chloroquine to sulphadoxine pyramethamine (SP), was agreed as a priority and milestone at the March 2000 MoH-Donor Annual Review meeting. Policy implementation is slow and training of front-line health workers in the revised case management is due to take place in the middle of 2001. There is some concern that chloroquine will have been withdrawn from the system before the new 1st line drug policy has been fully implemented.

Malaria accounts for 30% of the total burden of disease; and approximately 75% of expenditure on malaria prevention and treatment is by households in both the formal and informal private sector. One-third is spent on anti-malarial drugs, and almost half on nets, insecticides and coils.

The MoH has set-up a special task force with key donors and NGOs to scale-up insecticide treated net (ITN) coverage in Tanzania. In the third quarter of 2000, the Task Force appointed a Management Co-ordinator and an ITN technical group of experts to develop a national strategy. Funding – approximately \$4.1 million dollars – is needed to kick-start this strategy, but has not yet been secured.

A national level Situation Analysis of RBM in Tanzania was conducted in 2000, which reviewed how malaria control fits into national health policy (see Annex VI).

The MoH (NMCP) with the support of WHO has produced a Plan of Action (POA) for Implementing Roll Back Malaria in Tanzania, 2000/01 (August 2000). Specific targets have been included in the POA. However, baseline data from the districts (to be collected in a forthcoming district situation analysis) are needed for these targets to be meaningful:

Targets

1. To reduce by 30% the 1999 Malaria Case Fatality Rate in Health Facilities in 70 districts implementing health reforms by the end of one year.
2. To reduce by 20% the 1999 incidence of severe malaria in children aged less than five years in 70 districts implementing reforms by the end of one year.
3. To reduce by 10% the 1999 incidence of malaria in children aged less than five years in 70 districts implementing health reforms by the end of one year.
4. To reduce incidence of malaria by 30% should malaria epidemic occur.
5. To reduce malaria related mortality by 80% should malaria epidemic occur.

Targets 2 to 5 require population-based data. It is expected that the Regional Core Indicators, operationalised in table 3.4 of *Roll Back Malaria initiative in the African Region, Monitoring and Evaluation Guidelines* (WHO, Harare 2000), will be used to refine and improve the types of targets set by the NMCP. These include input, process, output and outcome indicators that will reflect the quality of malaria control services and can be routinely collected at health facilities; and population morbidity and mortality indicators that will require household surveys.

The NMCP, supported by WHO, started conducting a district malaria situation analysis on 19 March 2001, which will continue for 3 weeks. The situation analysis will collect health service and household malaria indicators in seven districts. This will be the first time that accurate baseline data will become available by which trends and the impact of RBM in Tanzania will be measurable. Currently, targets are set on the basis of uncertain information.

The principle donors / partners supporting malaria control include: WHO, UNICEF, JICA, DFID, DANIDA, Royal Dutch Embassy and the World Bank. The principal NGOs involved in malaria control are Save the Children Fund (SCF), Population Service International (PSI), AMREF and Care International. PSI and SCF are running ITN social marketing projects. The principal Government of Tanzania (GoT) sectors involved in malaria control, along with Health and RALG, are Finance, Agriculture and Community Development.

Ways in which SWAPs could or do catalyse the RBM process in Tanzania and vice versa, strengths and obstacles

The National Malaria Control Programme (NMCP) is responding to the challenge of the SWAp and has conducted a national situation analysis that has fed into a Plan of Action, and is currently conducting a district situation analysis that will further inform the development of a national malaria control strategy. Targets for malaria control will be based on up-to-date data on the malaria burden and the performance of districts in malaria control. Malaria control is viewed by MoH and donors alike as a priority within the essential health package, and will be prioritised in the implementation of Tanzania's Poverty Reduction Strategy (PRS), utilising some of these additional resources for malaria control.

The NMCP, with support from WHO and a range of donors and NGOs, has been centrally involved in supporting and implementing a range of malaria control activities in Tanzania, which pre-date RBM by many years. Currently, however, it feels some marginalisation within the MoH despite its profile in sector plans. Other major control programmes may also have that experience, during a period where more emphasis is on building generic systems capacity at the central and district levels. The RBM movement could assist the NMCP through high level advocacy to ensure that malaria control is prioritised in funding and staffing levels, through assisting it in building technical expertise at the regional and district levels to ensure that malaria control is of high technical quality, and through strengthening its capacity to work with a wide range of public and non-public stakeholders. Malaria control in Tanzania has already demonstrated its ability to develop strategies for working with the private sector to increase ITN coverage. RBM now has the potential to be a pathfinder in strengthening many of the essential elements of an efficient, high quality health system.

Prior to the implementation of SWAPs, national control managers perceived that they had quicker access to funding outside of the 'Basket' from donors who are now in the Basket. The NMCP experiences donors responding more slowly to requests for funds for activities that have not been included in the MTEF, with donors citing their commitment to the SWAp disbursement procedures. MoH budgeting weaknesses and lack of donor transparency have meant that there is insufficient clarity around what funds will be available, especially for funds that come from outside of the Basket. It would probably be true to conclude that current SWAp and GoT budgeting procedures, where funds are allocated to departments /

directorates rather than to specific control programmes, are more complex and difficult to implement than the traditional programme support that preceded the SWAp.

District offices do not have the capacity to cope with the different demands placed on them – they are now planners and implementers of population health programmes, such as malaria, while continuing to have clinical and administrative duties. Parallel demands from the central level – from donors and MoH – are more often associated with vertical programmes than with SWAps. In Tanzania, this probably represents a transition phase in the evolution of SWAps. As adherence to the principle and approach of SWAps improves, a more coherent and co-ordinated central management of the process should evolve.

The SWAp is the preferred vehicle of the Government of Tanzania (GoT), MoH and most of the major donors for strengthening the health system in Tanzania. It can be seen as a stage in the development of Tanzania Poverty Reduction Strategy, which aims to address the priority health problems of the population, especially the poor. RBM can play a central role in this process, both supporting the SWAp and being supported by it to achieve its malaria control goals. Over the longer term, some donors plan to move towards providing the bulk of their development support in the form of direct budget support to the GoT, within the overarching framework of the PRS. The SWAp, in the context of ongoing health sector reforms, is building the capacity of the GoT and MoH to use these resources efficiently. The RBM movement could support the ongoing implementation of the SWAp and the forthcoming implementation of the SWAp, so that the RBM / international development targets are not only reached, but that the achievements are sustained across the health and social sectors.

Annex 6: Country Case study summary – Uganda

(Note: additional information is provided in the full case study report and in the background paper on PRSPs and RBM)

Economic and political environment

Following many years of conflict and economic decline, Uganda experienced relative stability and economic growth (around 6% per annum) during the 1990s. Absolute poverty has declined from 56% in 1992 to 35% in 1999/2000 but remains a major concern. In recent years a strong poverty focus has emerged in Government policy with a Poverty Eradication Action Plan¹ (PEAP) providing the framework for government policy linked to a Medium Term Expenditure Framework (MTEF).

Health sector background and development of the sector-wide approach

Health improvement is a main feature of the PEAP. Health indicators have not kept pace with economic improvements, and remain among the lowest in the region. Access to adequate health care is constrained by shortage of facilities, trained staff and supplies, and by cost and quality of service. Only 49% of the population live within 5km of any formal health facility.

Stronger partner co-ordination through a sector-wide approach is a major feature of the National Health Policy published in 1999. The sector-wide approach and the delivery of a minimum health care package were elaborated in the Health Sector Strategic Plan (HSSP) for 2001/02 to 2004/05. This was prepared as a collaborative undertaking by the Ministry of Health, related ministries, development partners and other stakeholders, within the framework of Uganda's Poverty Eradication Action Plan, the Medium term Expenditure Framework and the national health policy.

The HSSP is overseen by a Health Policy Advisory Committee, which has a broad representation of stakeholders. MoH HQ is responsible for policy, setting standards, supervision, monitoring, technical support and resource mobilisation. Local authorities are responsible for service delivery. Development partners are strongly encouraged to fund the HSSP through central budget support as part of the Medium Term Expenditure Framework (MTEF). However, the MoH takes the pragmatic approach that for now, funding mechanisms will include central budget support, district budget support and donor directly-funded projects. Twice yearly joint missions review sector performance, and agree priorities and allocations based on draft central and district plans.

The health budget has been increasing in absolute terms and as a proportion of the GOU budget. It is 116 billion shillings (US\$70m) in 00/01 or 8% of the total GOU budget. A proportion of the health budget (53% in 00/01) is provided by the Poverty Action Fund², which provides protected funds for poverty sensitive activities (it includes donor contributions to SWAPs and is part of MTEF). This includes the Primary Health Care Conditional grant and support to national programmes including Malaria. The Ministry has also reported increased direct donor investment. The HSSP is still however short of the resources needed to meet its objectives. A recent decision to remove cost-sharing will create additional pressures on the health budget. This may affect funds available for malaria activities and interventions.

¹ Uganda's Poverty Eradication Action Plan: Summary and Main Objectives, Ministry of Finance Planning and Economic Development, Kampala, March 2000

² Fighting Poverty in Uganda: The Poverty Action Fund, Ministry of Finance Planning and Economic Development, Kampala, February 2001

Malaria and Development of RBM in Uganda

Malaria is one of the main causes of morbidity and mortality in Uganda. A 1995 Burden of Disease study (ref) indicated that 15.4% of life years lost to premature death were due to malaria. A recent MoH update on malaria in Uganda (2000) reported an increase in the percentage of outpatient attendances due to malaria over the 1990s. A household survey in 1999/2000 showed that Ugandans were reporting more illness than they were in 1992 and particularly more malaria - 28% reported illness in the 30 days preceding the survey; 56% of those stated malaria/fever as the cause. This rise has been attributed to epidemiological shifts due to climate change, increasing resistance to drugs, as well as to cost and quality of treatment in the formal and informal sectors.

Improvement in the priority attached to malaria began before RBM but has almost certainly been accelerated by it. The Malaria Control Programme (MCP) was established in 1995. Uganda signed a statement of intent to support the RBM movement in 1999 and the Abuja Declaration in 2000. Legislation to waive taxes and tariffs on ITMs was passed in 2000. Regular meetings between the MoH and main malaria donors began in 1999 and an Interagency Co-ordinating Committee for Malaria was established in 2000 representing key stakeholders at national level (departments and programmes within the Ministry, other ministries, development partners and NGOs). The Committee has appointed task forces in key areas for action.

Malaria is the first named element of the minimum health care package. One of the 20 core indicators for monitoring the HSSP nationally is malaria-specific mortality in the under-five population, with a target of a 50% reduction from 37/1000 by 2005. National targets for 2005 are:

- Increase from 30% to 60% the proportion of the population that receive effective treatment for malaria within 24 hours of the onset of symptoms
- 60% of pregnant women receive protection against malaria through intermittent presumptive treatment with SP
- Increase from 5% to 50% the proportion of children under 5 protected by ITMs
- Reduce malaria case fatality at hospital level from 5% to 3%

The first three of these closely match the Abuja targets for the same year.

The MCP received an increase in its running cost budget (non-wage) from 80m shillings in 99/00 to 540m shillings in 00/01. Malaria control should also benefit from an increased primary health care conditional grant: from 12 billion shillings in 99/00 to 28 billion shillings in 00/01 with further increases beyond then. A current issue for the MCP is the recent recommendation (June 2000) to change the antimalarial drug policy in the light of rising levels of resistance to CQ and SP. The recommendation has not yet been implemented and resistance continues to rise. Rising resistance has considerable long-term budget implications, which the GOU budget will find it hard to meet.

Ways in which SWAp could or do catalyse the RBM process in Uganda and vice versa

The more systematic priority setting that has characterised the SWAp has certainly helped raise malaria up the agenda. Its key position in the basic package gives malaria a higher priority in planning at district level and below. This higher profile within the HSSP has contributed to the increased GOU funding for malaria. The absorption of Abuja targets within the HSSP greatly increases the prospects of support financially and politically (internally and externally) for activities to meet these targets. HPAC's task forces have been important in addressing issues relevant to implementing malaria plans such as drug costs.

The partnership building processes that characterise both the SWAp and RBM in Uganda have been mutually reinforcing. Key features of the SWAp are echoed in the pillars of Roll Back Malaria in Africa. The increased co-ordination of malaria strategy and funding between donors and the MOH during 1999 and 2000 was partly stimulated by the SWAp and also helped to integrate malaria better into the SWAp. Development of a malaria work plan in consultation with all major partners in 1999 fed through to budget setting for 2000/01. The work plan was used as a model for other programmes. The new Interagency Co-ordinating Committee for RBM partners provides a forum for discussing malaria strategy and funding issues (for all partners not just the MCP) within the SWAp framework.

Until now, the MCP has spent large amounts of time negotiating with individual donors, often for small items. This continues to a large extent. Once new systems settle in, a single source of basic running costs should minimise administration and make forward planning easier. However restrictions on what types of expenditure Poverty Action Funds may be used for may continue the problem. The question of future replacement of vehicles and other equipment traditionally provided by donors has not yet been adequately addressed. The MCP has been less involved in the budget setting process this year than it was last year and malaria control staff were little involved in the current joint mission. This is partly due to the recent malaria epidemic diverting manpower but also to a need to adjust to the shift from direct reliance on traditional donors to reliance on MOH funds. Understanding of the importance of such involvement needs to be built. There is a recognised need to create better awareness among programmes of wider strategic thinking and issues and better awareness in the central planning department of technical and operational issues. Plans to address this through greater cross-department working are being developed. This raises issues for RBM and other global initiatives – this kind of awareness needs to be there at all levels.

Better integration of national programmes (in particular malaria and IMCI) has been promoted by the need to support the basic health package. Annual plans for all parts of MoH HQ have been collated into a single document and unified planning guidelines produced. MCP plans at central level are more realistic than before but still overambitious compared with capacity: the need for greater emphasis on involving more partners at all levels and much less direct involvement in implementation is recognised.

Monitoring and evaluation has been rationalised, so that collection of data on core indicators for the HSSP is co-ordinated centrally (through HMIS, sentinel sites, or periodic surveys). However these are a minimal set of indicators for tracking progress and impact of the HSSP as a whole. For planning purposes at district level or at the level of national programmes there is a feeling that they need to be supplemented with more specific data collection.

Ways in which SWAps and RBM do or could conflict with each other in the short or long term in Uganda, and how these conflicts have been or could be resolved

The adoption of a sector-wide approach is requiring immense changes in responsibilities. In practice capacity development and adjustment to new responsibilities will take time. Support from the centre has been fragmented and responsibilities at each level need to be more clearly mapped out. This is recognised as a weakness in the HSSP and is being addressed. There is increasing recognition that the SWAp now needs to focus more on health outcomes and less on process.

Donors have traditionally supported malaria control activities through contracting out work to NGOs as well as funding government activities. NGOs involved in direct service delivery are supported from GOU funds but release of funds is extremely slow and with many conditions attached. Currently other NGOs (e.g. AMREF) are seeing a fall off in donor contracts from

donors now committed to budget support, and as yet little Government capacity at central and district level to contract work out to them. This is an issue for RBM partners: can they help develop the capacity of government to contract work out or will they continue to contract with NGOs directly?

The MCP still receives the majority of its funds direct from donors but this will be short-lived as traditional donors such as DFID are now committed to budget support. The costings that went into last year's work plan suggest that probable funding through the MOH budget is unlikely to meet all the shortfall. The tendency for Districts and programmes to seek support directly from donors remains. There are considerable implications for RBM and other global initiatives here – circumventing the SWAp is not encouraged. Even if funds are not channelled as budget support the activities can still be part of the SWAp. This concept is largely accepted by partners in country, and their regional and global HQs support country led approaches and health systems support on paper but there is a question whether many can change actual funding practices to reflect this. (A recent review sponsored by UNICEF on the role of UN agencies in SIPs/SWAp in Uganda may be important here. It was not available at the time of this study.) Funds from development partners not signed up to the Memorandum of Understanding will not flow through the government system at least in the near future. Funds for malaria from such partners are potentially substantial with implications for the SWAp and country ownership. Sustainability beyond current MTEF horizons was raised as an area that needs to be better mapped out, particularly in terms of investment by those donors outside the SWAp.

The MCP and IMCI teams in the Ministry of Health are currently analysing AFRO proposals for scaling up RBM and IMCI and developing a framework for Uganda and implementation plan to involve all stakeholders. Particular questions in Uganda concern whether new funds coming available to AFRO countries for scaling up IMCI and RBM can support the SWAp rather than use parallel mechanisms. Questions include: whether funds can be channelled to respond to the Uganda scaling up plan and to filling resource gaps rather than being used to promote a uniform region-wide approach; whether funders can respond to gaps in systems development or infrastructure development as well as funding specific interventions; how much flexibility there will be in spending such funds.

There have been major problems of disbursement of PHC conditional grants to the districts. These are only partly temporary problems associated with adjustment to new mechanisms and accountability processes, inadequate mechanisms for dealing with capital expenditure, and the rapid pace of public sector reform and decentralisation in Uganda. It may take considerable time for capacity to be built at district level and the new systems to settle down, but the MOF has been willing to relax rules to allow poverty-sensitive funds to flow. Even then there is some feeling that the mechanisms place far too great a burden on districts. There is also a perceived lack of capacity in accounts in the Ministry. Conditionality of funds to districts carries benefits and constraints. The protection of funds for specific poverty-sensitive activities provides clear benefits for the health sector, which are described in more detail in the paper on PRSPs and RBM. However Districts may feel that they have less local control over funds than they had prior to the SWAp. There are tensions between the SWAp and the decentralisation process. New proposals currently under debate on fiscal decentralisation (which would take away sector earmarking in funds to districts) further complicate the debate on the appropriate balance between the protection to funding flows afforded by conditionality and the need for local flexibility and decision-making. However these issues are well recognised and the disbursement problems were to be addressed during the joint mission that was taking place at the time of this study.