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Sector wide approaches in the health sector: A desk-based review of donors' experience in Asia and the Pacific

Office of Development Effectiveness

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Acronyms

AIDS	Acquired Immunodeficiency Syndrome
APR	Annual Performance Review
APPR	Annual Progress Performance Report
AusAID	Australian Agency for International Development
AWPB	Annual Work Plan and Budget
CAPF	Comprehensive Aid Policy Framework
CPR	Contraceptive prevalence rate
DFAT	Department of Foreign Affairs and Trade
DFID	Department for International Development (UK)
DHS	Demographic Health Survey
DP	Development partner
EDPs	External development partners
EGVNP	Equity, Gender and Voice, NGO participation
EHCS	Essential Health Care Services
EU	European Union
GAAP	Governance and Accountability Action Plan
GESI	Gender, equality and social inclusion
GEV	Gender, Equity and Voice
GON	Government of Nepal
GOS	Government of Samoa
HIS	Health Information System
HISP	Health Services Improvement Program
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HPNSDP	Health Population and Nutrition Sector Development Program
HR	Human resources
HRH	Human resources for health
HSDP	Health Sector Development Programme
HSIP	Health Services Improvement Program

HSP	Health Sector Plan
HSSP2	Second Health Sector Strategic Plan
HSSP	Health Sector Support Program
ICDDR,B	International Centre for Diarrhoeal Disease Research, Bangladesh
ICR	Implementation Completion Report
IHP	International Health Partnership
IEC	Independent Evaluation Committee
IHP	International Health Partnership
JAPR	Joint Annual Program Reviews
JAR	Joint Annual Review
JFA	Joint financial agreement
JPA	Joint partnership agreement
M&E	Monitoring and evaluation
MCH	Maternal and child health
MDG	Millennium Development Goal
MHMS	Ministry of Health and Medical Services
MICS	Multiple Indicator Cluster Survey
MMR	Maternal mortality rate
MNCH	Maternal, neonatal and child health
MOH	Ministry of Health
MOHFW	Ministry of Health and Family Welfare
MOHP	Ministry of Health and Population
MTEF	Medium term expenditure framework
MTR	Mid-Term Review
NCD	Non-communicable disease
NDOH	National Department of Health
NGO	Non-government organisation
NHSP	Nepal Health Sector Program
ODE	Office of Development Effectiveness
OECD	Organisation for Economic Co-operation and Development
PER	Provincial Expenditure Review

PFM	Public finance management
PIP	Program Implementation Plan
PNG	Papua New Guinea
POW	Programs of work
SAT	Samoan Tala
SBS	Sector budget support
SWAp	Sector wide approach
SWiM	Sector-wide Management
TA	Technical assistance
TB	Tuberculosis
TOR	Terms of Reference
TRD	Training, research and development
UN	United Nations
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
US	United States
WHO	World Health Organisation

Executive summary

This report presents the findings from a desk-based review of evidence on the effectiveness of donor support for the health sector through the use of sector-wide approaches (SWAps), sector budget support and government systems. Six countries in the Asia Pacific region where the Australian aid program has used such approaches and/or systems were reviewed in detail—Bangladesh, Cambodia, Nepal, Papua New Guinea, Samoa, and Solomon Islands. The findings are discussed in the context of the broader international literature.

It is important to note that this report is based on the findings of donors' (including Australia) experience in supporting sector-wide approaches in Asia and the Pacific. It does not evaluate the effectiveness of Australia's broader interventions in health system reform.

This evidence review

In recent years SWAps have been increasingly implemented in the Asia Pacific region. There is limited analysis or evidence of their effectiveness, or their related financing instruments. This paper reviews the evidence, mainly from experience in six Asia Pacific countries where the Australian aid program is using these approaches or providing funds through government systems.

SWAps have been in existence for more than 20 years. They were developed in response to widespread dissatisfaction with fragmented donor-funded projects and overly prescriptive assistance. There are various definitions and interpretations of SWAps, but the literature is consistent in characterising them as an evolving partnership between governments, other national actors and development partners coalescing their joint support of nationally-defined programs, to be managed and implemented through increased reliance on country systems and capacities, and with a strong results focus.

SWAps are intended to bring about improvements both in development outcomes and processes, such as better harmonisation and alignment of assistance, and strengthened institutional capacity. They are also intended to reduce transaction costs for governments by removing their need to deal with the individual mechanisms and processes of multiple development partners.

Key Findings

The evidence available

While the literature on SWAps is prolific we found a **limited volume of evidence of sufficient quality** in the period covered by the review (2008-2014). We also found that SWAps that were developed relatively recently, such as those in the Pacific countries (Samoa, Solomon Island and Papua New Guinea) have not yet generated sufficient or sufficiently robust evidence. Several evaluations and structured reviews focused on the early stages of SWAps, which limited our ability to analyse their effectiveness. We expected to find a stronger evidence base from the Asian countries (Bangladesh, Cambodia and Nepal) where SWAps are more mature, but in practice this was not the case as we found only a small number of specific evaluations. The annual sector and program reviews that we

used as main sources often made assumptions about the attribution of the results to the SWAp when, in fact, such attribution is problematic.

We also encountered **evidence gaps in baseline data**, such as limited or no baseline information focusing on the SWAps components. Although there was a substantial amount of data relating to health outcomes (or intermediate outcomes/outputs), these data were often not presented systematically, or there was no evidence of their reliability. Some of the documents show ***lack of internal coherence and confusion between indicators, results and monitoring and evaluations arrangements.*** This has made it difficult to determine whether the SWAps achieved what they set out to. Further, the expectations of what should be achieved are often implicit rather than explicit.

It is important to emphasise ***that an assessment of effectiveness cannot be proven to be directly attributed to SWAps or related financing instruments,*** neither is it likely to be feasible if additional research is undertaken. In some cases it has been possible to document some of the results that have been achieved and to make limited judgements about what role the SWAp and related instruments might have played, but such judgements, while made in good faith, cannot be considered as 'evidence'.

The **lack of qualitative assessments of financing and aid management decisions** was a main gap while attempting to document how or why the Australian aid programme had adopted a SWAp (covered in Chapter 2). The evidence for assessing the operational approach adopted by the Australian aid program was limited to aid program performance reports and other internal documents. While useful, these documents do not permit an assessment of financing decisions linked to the allocation of health aid in that particular country, which would have required in-country work that was out of the scope of this review.

Overall, among the evidence that was available, an **evidence bias** was detected in that a large part of the literature focused on what was not working rather than on what was working well. This is likely to have impacted on our findings.

The effectiveness of SWAps

Assessing the evidence available on the use of SWAps has been challenging due to the inherent limitations of measuring the effectiveness of health SWAps, as widely acknowledged in the international literature and discussed at length in Chapter 1. There are many descriptions (in the form of case studies, literature reviews, and synthesis papers) of the rationale, progress and challenges of implementing SWAps in different settings. There are also country program reviews, and donor-specific documents describing and reporting on the program supported. However, there are very few robust, country or multi-country evaluations systematically looking at the effectiveness and performance of SWAps, and whether they achieved their intended benefits. These types of assessments are difficult because of the following methodological issues and evidence gaps which are widely described in the international literature:

- SWAps are highly context specific and linked to the political economy of the countries and to the aid policies of the donors supporting the SWAp. Comparisons across countries are extremely challenging or even unfeasible.
- The multidimensional nature of SWAps, where different components often interact with each other in unclear ways.
- The difficulties of establishing 'before and after' comparisons, because SWAps are often designed and implemented incrementally, with no defined start date.

- The absence of baselines on the situation predating the SWAp, of result chains (showing the intended progression from inputs to outputs and outcomes) and of a counterfactual.
- The absence of explicit objectives to be achieved by the SWAp in terms of aid effectiveness or the limited amount of monitoring on whether the stated objectives are being met.

Limitations of the SWAp

The limitations of SWAps as a development approach have been widely described in the international literature. Common issues include:

- A focus on upstream policy and monitoring processes (both by SWAps and sector budget support) rather than on addressing implementation capacity constraints—the so-called 'missing middle' in service delivery.
- SWAps do not always serve as a common framework for all external aid. In most countries there are still substantial volumes of resources outside pooled arrangements, and out of sync with SWAp or national planning frameworks.
- Efforts towards implementing 'standardised' SWAp processes, have perhaps reduced the focus on rooting the approach in a thorough assessment and understanding of the political economy of countries' health sector.
- SWAps are highly dynamic, context specific processes that require governments and donors to work in new ways and to develop skills that are different from the ones traditionally used to manage project-based aid. An under-estimation of the new competencies needed to adapt to new ways of working has been often described in the international literature and can lead to poorly managed SWAps. Imbalances in the competence base may affect the government side (often overwhelmed with the 'nitty gritty') or on the donor side (i.e. having to engage around new technical and policy issues that may be poorly understood).

Participation in health SWAps by the Australian aid program

The Australian aid program's choice of SWAps and related financing instruments appears to have been both strategic and contextual. Although a desk review does not provide sufficient or robust enough insights into this, it appears that in all the six countries the Australian aid program chose what was considered the best option in the circumstances (particularly if other key donors were doing the same), and it aligned its aid policies and country operations to the prevailing international focus on aid effectiveness:

- In Papua New Guinea, Samoa and Solomon Islands the Australian aid program led by example and used an inclusive approach to aid delivery, involving other donors in order to achieve greater leverage with the government and to balance risks in the aid portfolio.
- In Nepal and Bangladesh Australia participated actively in the existing health SWAp and (from 2008) pooled risks with other donors supporting the pooled fund.
- In Cambodia, jointly with the United Kingdom and the World Bank, Australia adopted a cautious approach to aid delivery after the peace agreements, avoiding the risk of placing the pooled funds on budget, by using a separate funding mechanism and working with other donors to gain leverage with the government and to manage risks.

The Australian aid program triggered and commissioned a considerable amount of analysis on the progress achieved by the SWAp or the health sector and on some of the available aid financing options, which we found to be of high quality. This has increased its visibility, relevance and adherence to the aid effectiveness principles.

Managing SWAps at the country level was challenging for Australia because it was a new approach that took time to set up and implement.

This review finds that Australia's participation in health SWAps in the six countries has delivered reasonably against various measures of aid effectiveness. For example, they have been found to have contributed to:

- setting up processes for cooperation among governments and donors
- increased policy dialogue (though the quality of this dialogue was found to be mixed)
- establishing common monitoring arrangements (though weaknesses remain in country information systems)
- better alignment of aid objectives with country health sector priorities (though alignment of funding with country level funding priorities remains less clear except where there are pooled funds for a health plan or program of work)
- stronger country ownership, with many processes increasingly being country-led.

Based on these findings, it appears that the theory of change and principles underpinning SWAps remain consistent with the principles of aid effectiveness and are highly relevant.

Did SWAps increase the use of government systems?

One of the objectives of health SWAps and a key principle underpinning the aid effectiveness literature is that health SWAps should lead towards an increased use of government systems by development partners. It has been challenging to assess whether there is evidence supporting such a claim in the six countries covered in this review. The picture is mixed and the evidence inconclusive, in part because the use of government systems is often a long term objective that is not always translated into intermediate indicators, and in part because the six countries are at different stages of development regarding whether their public finance management systems are robust enough to guarantee minimum levels of accountability on the use of external aid. Finally, there are many types of government systems linked to planning, budgeting, procurement of goods and services and so forth, so it is not possible to summarise the situation without oversimplifying complex country-level realities.

The overall picture suggests that while use of government systems cannot be directly attributed to SWAps, they often acted as an enabling environment in some countries. Another important finding is that the use of pooled funds –a common funding modality in most of the health SWAps covered in this review- did not necessarily imply the use of government systems, as some pool funds used parallel structures for planning, spending or accounting. The following snapshots summarise what this evidence review was able to document:

- Three out of five pooled funds (Bangladesh, Nepal and Samoa) supported the government program financially, and only two (Bangladesh and Nepal) used government systems for financial accounting and reporting.
- In Cambodia and Papua New Guinea a program managed by a Project Management Unit co-managed by the government and one or more donors- was supported by pooled funds. It used separate accounting and financial management procedures, not the government's. According to DFAT sources, the situation in Papua New Guinea has changed since 2013 and Australia's pooled funding now supports the government's program and uses government systems for accounting and reporting – there is not a separate project management unit in place anymore.

- Sector budget support was found in only one country (Solomon Islands), where only the Australian aid program provided un-earmarked funds (as well as earmarked funds, along with other donors). Earmarked sector budget support is an unusual approach, little discussed in the literature, which may warrant further study.
- Only one country (Samoa) exclusively used government systems for procurement of goods. In two others (Solomon Islands and Nepal) government and donor procurement were used.
- Technical assistance was procured directly by donors in all countries.

Some of the findings above may not apply anymore, particularly in Pacific countries like the Solomon Islands and Papua New Guinea where increased use of government systems seems to be the trend.

Finally, the available literature did not permit the reviewers to assess whether decisions by development partners (including the Australian aid program) on the adoption of government systems were always guided by public finance management or fiduciary risk considerations. This was probably a reflection of the methodology used in this evidence review, which relied solely on documentation and did not allow for more in depth assessments with key informants at country level. In depth, country level assessments might have helped explain why, for example, different donors integrated in the same SWAp structure took very different positions and decisions in relation to the use of government systems. Likewise, the often quoted justification for not using government systems -that these are weak or risky, or that other agencies can procure better and with less fiduciary risks- could not be substantiated by the evidence found in available evaluations and reviews.

Gender focus

We also looked at whether country and Australian aid program documents had a gender equality focus. A clear focus on gender was apparent in the national health plans or SWAp arrangements of Bangladesh, Nepal and Cambodia, with regular reporting on progress (although sometimes incomplete). For the other countries we found limited reference and/or inconsistent reporting on gender issues in the documents reviewed. Reporting on gender progress within the Australian aid program was somewhat limited and uneven.

1 Introduction and findings on the available evidence

In recent years the Australian aid program has increased the use of sector wide approaches (SWAps)[1] and allocated a small but not insignificant portion of funding through sector budget support and partner government systems.

However there seems to be limited analysis or evidence of their effectiveness. This study reviews the available evidence on the use and effectiveness of these approaches and instruments in strengthening the health sector, with a focus on six countries in the Asia Pacific region where the Australian aid program has supported these approaches and/or instruments—Bangladesh, Cambodia, Nepal, Papua New Guinea, Samoa, and Solomon Islands.

The report starts by discussing the methodology, analytical tool and measurement issues encountered (Section 1). It then looks at how and why the Australian aid program has used SWAps, sector budget support and government systems in the countries under review (Section 2). The synthesis of evidence on the effectiveness of SWAps and use of country government systems follows in Section 3, and is supported by in-depth analysis included at Appendix 3. The report concludes with a summary of findings on whether SWAps increased the attention of the government and its partners on gender equity and equality in accordance with the aid policies of the Australian government.

1.1 Background

SWAps have been in existence for more than 20 years. They were developed in response to widespread dissatisfaction with fragmented donor-funded projects and overly prescriptive assistance. There are various definitions and interpretations of SWAps, but the literature is consistent in characterising them as an evolving partnership between governments, other national actors and development partners coalescing their joint support of nationally-defined programs, to be managed and implemented through increased reliance on country systems and capacities, and with a strong results focus.[2]

SWAps are intended to bring about improvements both in development outcomes and processes, such as better harmonisation and alignment of assistance, and strengthened institutional capacity. They are also intended to reduce transaction costs for governments by removing their need to deal with the individual mechanisms and processes of multiple development partners.

There is no prescribed approach to financing a SWAp, which is often financed through a mix of different instruments including project aid, pooled funds and sector budget support. Sector budget

[1] SWAps and their related instruments are defined and explained in Box 1.

[2] D Vaillancourt, *In sweet harmony? A review of health and education sector wide approaches in the South Pacific*, World Bank, Washington DC, 2012.

support is designed to use partner government systems (e.g. planning, budgeting, accounting and auditing systems) to channel aid to all or part of the health sector plan.

The characteristics of SWAps are consistent with the principles of aid effectiveness and good practices which have emerged over the past decade or more, and to which most development partners and developing countries have committed. Definitions of the key terms used are in Box 1.

Box 1 Definitions

The **sector wide approach (SWAp)** is an approach to aid delivery, to doing business[3], or, as defined by Cassels[4], an *aid modality.* The defining characteristics of a SWAp are that all significant funding for the sector supports a single sector policy and expenditure program, under government leadership, adopting common approaches across the sector, and progressing towards relying on government systems to disburse and account for all funds and to procure commodities and services.

Sector budget support is a financing instrument referring to the transfer of aid funds directly into the national treasury or equivalent, for allocation to the national health budget. This usually requires a Medium Term Expenditure Framework and can be best assessed when the country can produce national health accounts for the sector. Sector budget support usually takes place within the context of a SWAp but there are cases where a donor may provide sector budget support in its absence.

Pooled funds are where two or more donors pool their financial aid to contribute to a national program or health sector plan, in full or partially. A number of financial management arrangements may support a pooled fund, for example a Multi Donor Trust Fund administered by one of the development partners, usually the World Bank, or a Joint Financing Agreement signed by the pool funders.

The term **government systems** in this context refers to a variety of instruments and systems, such as planning, budgeting, financial management and procurement, which may or may not be part of a SWAp.

In this report we use the terms **development partners/donors** interchangeably. Donors (donor agencies) strictly speaking are the bilateral, multilateral or global organisations providing grants, credits or loans to a country. Development partners, on the other hand, are a wider group comprising donors, technical agencies (i.e. UN organisations) and, in some countries, national, international and civil society organisations.

In recent years SWAps have been increasingly implemented in the Asia Pacific region. However there is limited analysis or evidence of their effectiveness, or their related financing instruments. This paper reviews the evidence, mainly from experience in six Asia Pacific countries where the Australian aid program is using these approaches or providing funds through government systems.

1.2 Methodology

The study was conducted as a desk review, primarily of secondary data.

Country inclusion was determined mainly by whether the Australian aid program had supported a SWAp, sector budget support or used partner government systems in the health sector over the last five years. From the initial list of countries that met the criteria (Bangladesh, Cambodia, Nepal, Pakistan Papua New Guinea, Samoa, Solomon Islands and Timor Leste) we removed Pakistan and Timor Leste. In Pakistan, many donors' country programs have undergone a significant transition

[3] M Pearson, *Impact evaluation of the sector wide approach (SWAp), Malawi*. DFID Human Development Resource Centre, London, 2010 (a), 7.

[4] A Cassels, *Aid instruments and health systems development: an analysis of current practice*, World Health Organization, Geneva, 1995.

following devolution in 2011, and tend to be at early stages of implementation. This also applies to the nutrition multi donor trust fund supported by the Australian aid program. The program under implementation in Timor Leste is also recent (2013-2014), and the information available was not sufficient for an evidence review.

Because of the limited literature on these six countries we extended the five-year timeline slightly to cover documents released or published between 2008 and 2014. For international evidence (beyond the six countries under review) we included literature published over the last decade which remains relevant to this analysis.

We reviewed, assessed and classified a large number of documents (Table 1). The number of documents considered relevant or potentially useful however was much smaller (marked with asterisks in Table 1 and briefly discussed in Table 2). Evaluations were even fewer.[5] In general, only the documents marked as very relevant or relevant were used as references (listed in Appendix 4).

We conducted a review of the international literature separately (summarised in Box 2, Section 3).

Table 1 Availability of information by country

Country	Number of documents reviewed (documentation phase)	Number of documents prioritised for the evidence review	Number of evaluations and reviews
Bangladesh	More than 40	2**, 15*	0
Cambodia	More than 40	3**, 17*	2
Nepal	33	6-8**, 10*	2
Papua New Guinea	32	1**, 10*	1-2
Samoa	20	3**, 10*	2
Solomon Islands	More than 40	4**, 9*	2
Timor Leste	20	1**, 8*	0

* Somewhat relevant or potentially useful
** Highly relevant or potentially useful

Table 2 Summary of main evaluations used

Country	Main evaluations and reviews
Bangladesh	The timeframe of our review focuses on a sector program in a state of transition, when the foundations of the new Health Population and Nutrition Sector Development Program (HPNSDP, 2011-2016) were being laid. No evaluations are available for the period covered by this review. However, there is plenty of evidence from independent reviews of all or parts of the program, since the sector program has been independently reviewed in Annual Progress Reviews and Mid-Term Reviews (MTRs) since 1998. Our main sources of information are: Strategic plan for HPNSDP 2011-2016; Program Implementation Plan (PIP) of the HPNSDP (2011); Annual Progress Reviews 2012 and 2013; Australian aid program documents including a Quality at Entry Report and Aid Program Performance Reviews (APPR).

[5] For the purpose of this paper, we intend 'evaluations' as a systematic assessment, that has been peer reviewed (using the term 'peer' in a broad sense, including for example technical experts and agency staff) and that uses a framework for analysis. We consider 'reviews' those undertaken in the context of a program, sector or SWAp implementation (e.g. annual progress reviews, mid-term reviews and joint assessments).

Cambodia	There have not been any formal evaluations of Cambodia's Sector-wide Management (SWiM). There are however two very good reviews conducted in 2006 and 2011 by Vaillancourt; we have used the latter. There is a considerable body of evidence on the performance of the second Health Sector Program and its related support program. We made extensive use of the 2011 mid-term review, and of prior assessments covering: health financing and contracting in the health sector (Hawkins); human resource development (less relevant for this review); aid effectiveness (Vaillancourt, very relevant); gender issues (Frieson et al). Additional information has been drawn from the DFAT country office, UK Department for International Development (DFID) and the World Bank.
Nepal	There were no formal evaluations for the period covered by this review. However, there are a number of reviews conducted systematically (using an agreed approach and framework). These include two documents by AusAID (the 2012 a Quality at Implementation Report and 2010 Nepal Development Cooperation Report); the 2013 MTR; an assessment by Vaillancourt & Pokhrel (2012); an annual review by DFID (2014) and the World Bank's Project Appraisal Document.
Papua New Guinea	The timeframe of this review captures a national health system in a state of transition to a National Health Plan expected to run from 2011-2020. It also coincides with a major restructuring of the National Department of Health and, on DFAT's side, with the AusAID-DFAT integration. The main documents used are reports commissioned by the Australian aid program, conducted by Janovsky (2010), Foster & Piel (2010), Van West-Charles (2012) and Richards (2012). In 2012 the Health Sector Improvement Program was completely redesigned; the Richards 2012 report articulates how the SWAp adapted to major restructuring.
Samoa	The main sources of information are the evaluations conducted by Vaillancourt (2012, Samoa Appendix) and Davies (2013). Both use an analytic framework, but one (Vaillancourt's) is exclusively desk based while the other (by Davies) included in-country work and interviews with key informants. We consider both as robust evaluations. The Australian aid program funded the Davies evaluation through the Health Resource Facility and co-funded the Vaillancourt evaluation through the Joint Learning Initiative.
Solomon Islands	The two main sources of information are one desk review of the health SWAp in Solomon Islands by Vaillancourt (2012, Solomon Islands) and a mid-term review (Tyson, 2011). Tyson's work was commissioned by the Australian aid program through the Health Resource Facility and involved desk review and in-country work. Vaillancourt's work is a desk-based case study included as part of the Joint Learning Initiative, co-funded by the Australian aid program. To assess progress at sector level we used the independent performance assessment of the health sector support program by Kelly & Tuckwell (2014), and a review of sector wide approaches for health in small island states by Negin & Martiniuk (2011).Important contextual information is also provided in the Australian aid program's aid delivery plan 2012-2016 and in other reports (e.g. Foster) listed in Appendix 4.

Full references for the documents listed in Table 2 can be found in Appendix 4.

Analytical tool. We developed an analytical tool to analyse and summarise the evidence of the effectiveness of SWAps, sector budget support and use of partner government systems in the relevant documents identified.[6] The tool, detailed in Table 3, was developed by applying the 2005 Paris Declaration principles of aid effectiveness[7] to the specific questions for this review which are listed in the terms of reference (Appendix 1). Further information on our approach to documentation is in Appendix 2.

[6] Cassels, 1995; M Foster, A Brown & T Conway, *Sector-wide approaches for health development: a review of experience*. World Health Organization, Geneva, 2001.

[7] *Paris declaration on aid effectiveness: ownership, harmonisation, alignment, results and mutual accountability*. 2nd High Level Forum on Aid Effectiveness, Paris, 2005.

Table 3 Analytical tool to guide the review

SWAp and aid effectiveness components: main questions	Sub-questions covered in this evidence review
Focus on results 1. Did the SWAp increase the focus on results by the Australian aid program and/or for its partners? 2. Were results achieved at sector or program levels?	› Were results defined for the SWAp? Results at what level? › Were these results also defined specifically for the Australian aid program? › Were expected results defined at program or sector levels? Were the results prioritised? › Did the SWAp and its financing instruments increase the focus on results, generally and for the Australian aid program in particular?
Stronger monitoring and evaluation (M&E) 3. Did SWAps improve sector or program monitoring and evaluation?	› What were the main components of the M&E plan or strategy? › Was there a monitoring framework or indicators? › Were the M&E processes undertaken periodically, as expected? Were these described in the literature as effective? › Did the SWAp or financing instruments improve M&E of the sector or program?
Improved joint work and policy dialogue 4. Did SWAps improve joint work and policy dialogue among partners?	› Did the SWAp improve joint working? › Did the SWAp increase and strengthen policy dialogue?
Greater leadership and ownership by the government 5. Did SWAps contribute to greater ownership and leadership by the government?	› What were the extent and quality of ownership and leadership? How did that compare to the situation preceding the SWAp (or use of instruments)? › Was there mutual accountability for results? › Did the SWAp and financing instruments strengthen government ownership and leadership?
Increased alignment of aid and government resources with health policy and financing 6. Did SWAps increase alignment with health policy and financing?	› What was the extent of alignment with government planning and budgeting systems by the Australian aid program and other main donors? › What was the extent of alignment of external financing with the priorities of the plan? › Was a Medium Term Expenditure Framework in place, and was it used? › Did alignment increase in the context of the SWAp and financing instruments? › Did health financing or expenditure become more predictable? › Did health financing or expenditure support incrementally the defined sector priorities?
Enhanced use of government systems 7. Did the Australian aid program increase the use of government systems through the health SWAp?	› What and whose systems were used to finance the plan or program being supported? › Were government systems used for procurement? › Did the SWAp or financing instruments enable, enhance or increase the use of governments systems?

We drew on three main **conceptual frameworks** to ground our analytical tool. These are:

› Walford uses the 'core ingredients of a SWAp' to look at experience across countries (government leadership; a shared sector wide policy and strategy; a medium term expenditure framework; shared processes and approaches, including shared progress reviews and indicators of progress; commitment to greater reliance on government financial management and accountability systems).[8] These are similar to the categories used in the reviews (not evaluations) by Negin[9] and McNee[10] and very similar to the ones we used (Table 3).

[8] V Walford, *A review of health sector wide approaches in Africa*. HLSP Institute, London, 2007.

- In his impact assessment of the health SWAp in Malawi, Pearson uses a simple causal pathway (from inputs to processes, outputs, outcomes and impact), to compare progress against the expectations set out at the time the program was adopted or, as the author puts it, to assess 'whether what has been achieved seems reasonable against what was expected at the time.'[11] While this framework is suitable for individual countries where there is information about the policy objectives of the SWAp it is less appropriate for establishing comparisons across countries.
- The third type of conceptual framework is the one used by Vaillancourt[12] and attempts to answer four questions: (i) are the anticipated benefits of the approach being realized; (ii) are the objectives of national sector programs likely to be achieved; (iii) how is the approach affecting sector program results; and (iv) how is the approach affecting the efficacy of development Partners. This framework employs an objectives-based methodology, whereby aid effectiveness efforts under SWAps and sector development programs are assessed against the specific objectives and indicators set and agreed by the relevant country and development partners. The Development Assistance Committee Criteria for Evaluating Development Assistance guide the review's analysis of the relevance, efficacy, efficiency and sustainability of specific SWAps.[13]

1.3 Summary of findings relating to the evidence available

We found a **limited volume of evidence of sufficient quality** (see Table 1) in the period covered by the review (we used 2009 as the cut off-point, although we slightly extended this to incorporate more documents.)

We found that SWAps developed relatively recently, such as those in the Pacific countries (Samoa, Solomon Island and Papua New Guinea) had not yet generated sufficient or sufficiently robust evidence. Several evaluations and structured reviews focused on the early stages of SWAps, which limited our ability to analyse their effectiveness.

We expected to find a stronger evidence base from the Asian countries (Bangladesh, Cambodia and Nepal) where SWAps were more mature, but in practice this was not the case. Only a small number of specific evaluations were conducted during the timeframe of the review. This meant that we had to rely primarily on annual sector and program reviews and smaller scale analysis. These documents often made assumptions about the attribution of the results to the SWAp when, in fact, such attribution is problematic (as explained in 1.4).

Overall, we also found an **evidence bias** in that a large part of the literature focused on what was not working rather than what was working well.

We also encountered **evidence gaps in baseline data**, such as limited or no baseline information focusing on the SWAps components. Although there was a substantial amount of data relating to health outcomes (or intermediate outcomes/outputs), these data were often not presented systematically, or there was no evidence of their reliability. Some of the documents show ***lack of internal coherence and confusion between indicators, results and monitoring and evaluations***

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[9] J Negin, *Sector-wide approaches for health: lessons from Samoa and the Solomon Islands*, Nossal Institute, Health Policy and Health Finance Knowledge Hub, Melbourne, 2010.

[10] A McNee, *Rethinking health sector wide approaches through the lens of aid effectiveness*. Australian National University, Canberra, 2012.

[11] Pearson, 2010a.

[12] Vaillancourt, 2012, Appendix 2 (Samoa).

[13] Details at: http://www.oecd.org/development/evaluation/daccriteriaforevaluatingdevelopmentassistance.htm

arrangements. This has made it difficult to determine whether the SWAps achieved what they set out to. Further, the expectations of what should be achieved are often implicit rather than explicit.

We found considerable baseline information on sector or program indicators in the three Asian countries where health SWAps have been longer in operation, but also that it had not always been used by the authors of the countries' sector reviews. It was more difficult to find reliable baseline data on outcomes and service outputs pre-dating the SWAp in the Pacific countries, where information from reliable data sources such as Demographic and Health Surveys (DHS) or similar was not available or not used in the evaluations and reviews, with a few exceptions. In general, the quality of information for health outcome indicators was higher than it was for service or program outputs.

The **lack of qualitative assessments of decisions** linked to the management of the health aid portfolio was a main gap while attempting to document how or why the Australian aid programme had adopted a SWAp (covered in Chapter 2). The evidence for assessing the operational approach adopted by the Australian aid program was limited to aid program performance reports and other internal documents. While useful, these documents do not permit an assessment of how or why decisions were made, in part because their purpose is different and they have been written by country officers without external assessment, and partly because they only reflect a fraction of the amount of work undertaken to adapt to SWAps and instruments that were new to the Australian aid program at the time.

It is important to emphasise ***that an assessment of effectiveness cannot be proven to be directly attributed to SWAps or related financing instruments,*** neither is it likely to be feasible if additional research is undertaken. In some cases it has been possible to document some of the results that have been achieved and to make limited judgements about what role the SWAp and related instruments might have played, but such judgements, while made in good faith, cannot be considered as 'evidence'. We explain in detail why this type of assessment is challenging in section 1.4.

1.4 Methodological challenges

There are several methodological challenges and limitations that should be born in mind when interpreting the results from this evidence review. These are briefly summarised below.

1.4.1 Challenges linked to the study approach and timeframe

This is a desk-based study relying solely on available literature. A large part of the literature focused on what was not working rather than what was working well. This is probably because most of the literature that we found consisted of consulting reports commissioned by donor agencies as part of their efforts to improve the functioning of the SWAp or the sector, hence a focus on what is not working and on how it could be made to work better. In addition, it is challenging to understand why an approach has been adopted and the extent of its effectiveness based on a desk review. Reviewing the Samoa and Solomon Islands health SWAps, Vaillancourt argues that much of the official literature lacks candour and is constrained by the rules of diplomacy, while the evidence that might shed light on effectiveness of an approach is contained in confidential, internal documents that cannot be cited or referenced.[14] We faced similar issues while conducting this evidence review.

The lack of qualitative assessments of portfolio management (as described in Section 1.3) was a main gap for this review. Qualitative assessments might have helped to understand how and why the Australian aid program adopted SWAps, how these new aid modalities were managed and so forth.

[14] Vaillancourt 2012, Appendix 2 (Samoa Health SWAp) and 3 (Solomon Islands Health SWAP).

However this would require in-country work, preferably by independent researchers, to interview agency staff and other key stakeholders.

The timeframe of this review has affected the strength (and volume) of the evidence found. This is inevitable when using a limited timeline. In addition, several evaluations and structured reviews undertaken in the Pacific countries (Samoa, Solomon Islands and Papua New Guinea) between 2010-2012 focused on the early stages of SWAps, which in these cases were developed relatively recently. This however limited our ability to analyse their effectiveness.

The paucity of specific evaluations in the Asian countries (Bangladesh, Cambodia and Nepal) where SWAps are more mature, and where one would expect to find more evidence of effectiveness, during the timeframe of the review limited our analysis.

1.4.2 The challenges of measuring SWAp effectiveness

There are a number of challenges linked to measuring SWAp effectiveness that need to be taken into account when interpreting the results. These relate to the lack of explicit causal pathways, of baseline data, and of a counterfactual.

There are a multitude of potential **causal pathways** linking a SWAp to the results achieved at sector or program levels. This challenge is acknowledged in all the main evaluations, assessments and reviews consulted,[15] and should be borne in mind in the case of follow-on evaluation work in countries, where the same limitations will most likely be faced. A useful summary has been provided by Pearson while attempting an impact assessment of the health SWAp in Malawi:[16]

- We know very little about how important SWAp components are individually and how they interact. Often there is also ambiguity on the extent to which they are actually in place. For example, there could be a medium term expenditure framework for the sector, but there may still be doubts as to its effectiveness when there is also significant off-budget funding, and doubts about whether the process actually supports a rational resource allocation process.
- There is often lack of clarity on the results we expect a SWAp to achieve. Even if health outcomes can be measured, evidence suggests that health sector and health systems contribute relatively little to health outcomes and that other factors are more important.[17]
- It is extremely difficult to measure the extent to which intermediate outcomes such as capacity development, improved policy dialogue or increased focus on results have been actually achieved. In principle, it should be easier to attribute any such improvements to a SWAp process if such intermediate outcomes were not in place before the SWAp was established, but the absence of baselines on intermediate outcomes makes such comparison unfeasible most of the time.
- SWAPs can only be effective in delivering health outcomes if the health programs they support are effective.

Measuring the effectiveness of a SWAp requires meaningful **baseline data** such as:

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[15] Vaillancourt 2009; P Davies, *Evaluation of Samoa Health Sector Management Program (Health SWAp)*, AusAID Health Resource Facility, Canberra, 2013; Walford, 2007.

[16] Pearson, 2010a.

[17] See for example: Commission on Social Determinants of Health, *Closing the gap in a generation: health equity through action on the social determinants of health,* WHO, Geneva, 2008.

- Data relating to the SWAp components (focus on results, use of joint M&E systems, etc.) which would provide a direct dimension of the extent to which the SWAp met the objectives for which it was designed.
- Data relating to the health outcomes and intermediate outcomes/outputs that the sector plan or program of work supported by the SWAp were trying to achieve.

These data are not always available. Our findings (described in section 1.3) confirm this observation.

Another challenge relates to the use of **counterfactuals** (i.e. 'what would have happened if the SWAp did not exist?').Counterfactuals are considered good practice in all evaluations. For the approaches under review this is problematic, partly because of the lack of baselines and partly because, as Pearson notes *'... one could argue that a SWAp is an end in itself and, if done well, represents a civilised way of doing business and is a good thing to do irrespective of whether it improves health outcomes or not'*.[18] In other words, the counterfactual of adopting a SWAp cannot be fully established because it is implicit in the approach: SWAps were established *because* of the shortcomings of previous aid modalities and instruments. The implication is that if SWAps achieved results (whether modest or substantial) in addressing such shortcomings then most authors *assumed* that SWAps were effective. However, this is a controversial viewpoint.

The discussion on counterfactual and on baselines permeates all the evaluations consulted, and has complicated our review because some authors have reached very different conclusions on SWAp effectiveness even when looking at the same data. The discussion can be situated within two extreme viewpoints: at one end are those proposing that the effectiveness of SWAps should be measured according to their ability to address the failures of previous aid modalities, at the other are those arguing that the effectiveness of SWAps depends on their ability to improve health and intermediate outcomes and outputs. Unfortunately, there is limited strong evidence to substantiate either viewpoint.

1.4.3 Challenges associated with data sources

The literature on health SWAps, sector budget support and use of partner government systems is prolific. There is an extensive body of knowledge (case studies, literature reviews and synthesis papers) describing the rationale, progress and challenges of developing and implementing SWAps in different contexts, including in fragile states. However, only a handful of robust multi-country reviews have been conducted specifically to assess SWAp performance, effectiveness, and achievement of intended benefits. Most of these pre-date 2010 and tend to focus on sub-Saharan Africa, although there are also case studies from Asia (Bangladesh[19], Nepal[20], Kyrgyz Republic[21]) and a desk review from the South Pacific which includes case studies of the health SWAps of Samoa and Solomon Islands.[22] The specialised fields of sector budget support and use of partner government systems (such as procurement systems) have their own body of literature.[23]

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[18] Pearson, 2010a, page 14.

[19] J Martinez, *Sector wide approaches at critical times: the case of Bangladesh*. HLSP Institute, London, 2008.

[20] D Vaillancourt & S Pokhrel, *Aid effectiveness in Nepal's health sector: accomplishments to date and measurement challenges*, International Health Partnership (IHP+), Geneva, 2012.

[21] D Vaillancourt, Do health sector wide approaches achieve results? Emerging evidence and lessons from six countries, Independent Evaluation Group, World Bank, Washington DC, 2009.

[22] Vaillancourt, 2012, Appendix 2 and 3.

[23] An in-depth review of this literature was not feasible in the time available for this study.

2 How and why has the Australian aid program supported SWAps?

This section looks at how and why the Australian aid program has used SWAps, sector budget support and government systems to improve the health sector in the countries under review.

2.1 How are these approaches supported?

The Australian aid program pioneered the SWAp approach in Papua New Guinea, Samoa and Solomon Islands, and joined an existing SWAp in Bangladesh, Cambodia and Nepal. It provides financing through a pooled fund in all countries except in Solomon Islands where it provides earmarked and un-earmarked sector budget support. Government systems are used to channel pooled fund financing (but not necessarily to account for it) in all countries except Cambodia. Procurement is done through government systems in all countries except Bangladesh and Cambodia. In Papua New Guinea, Australia has a separate procurement agent for large scale procurements, but HSIP procurement is managed using government systems. Technical assistance is procured directly by donors in all countries. A country-by-country summary is in Table 4.

Table 4 Country programs and approaches

Country	What approach has been used in each country? How has the Australian aid program supported it?
Bangladesh	*What approach has been used?* Australia's support to the Health Population and Nutrition Sector Development Program (HPNSDP 2011-2016). This is the third sector-wide program since 1998. It was one of the first health SWAps in the world. *What financing instruments/government systems are used?* A pooled fund. Under the two preceding health sector programs the Australian aid program provided parallel support through project aid. *Do other donors support the above?* 15 donors support the program and SWAp. Australia, Canada, Sweden, the European Union (EU), United Kingdom, and Germany provide support through a Multi-Donor Trust Fund administered by the World Bank. Note: DFAT has withdrawn from the sector program with effect from May 2014 due to cuts to the aid budget. Only the first tranche payment to the trust fund was made (2011/12). The second tranche was deferred, then all payments were cancelled.
Cambodia	*What approach has been used?* Australia's support to the Second Health Sector Support Program (HSSP2), which adopts a so-called sector-wide management (SWiM). The SWiM shares many features of a SWAp. *What financing instruments/government systems are used?* A Multi-Donor Trust Fund administered by the World Bank is in place supporting a program of work that contributes to the Health Strategic Plan of the Cambodia Government. The HSSP2 cannot be said to use government systems as it does not contribute funds directly to the government budget. It is a multi-funded project type arrangement managed by the World Bank, and the Director of Planning and Monitoring of the Ministry of Health as its executive director. *Do other donors support the above?* A Joint Financing Agreement to support HSSP2 was signed in 2008. Members of the Joint Partnership Interface Group comprise: Australia, France, Belgium, United Nations Children's Fund (UNICEF), United Nations Population Fund (UNFPA), and the United Kingdom (which exited at the end of 2013).
Nepal	*What approach has been used?* Australia's support to the Nepal Health Sector Program –Implementation Plan II (NHSP II) 2010-2015. It is implemented through a SWAp by the Ministry of Health and Population (MoHP). The Program is a continuation of the first phase (NHSP I). *What financing instruments/government systems are used?* Australian Government funding is provided

	through the government system through a pooled funding arrangement, governed by a Joint Financing Agreement, since 2008/09. *Do other donors support the above?* There are currently four other pooling donors: United Kingdom, World Bank, Gavi (The Vaccine Alliance, formerly known as the Global Alliance for Vaccines and Immunization), and Germany. The Nepal Government is responsible for managing the pooled fund; the World Bank undertakes the financial oversight. The United Kingdom manages the Technical Assistance component on behalf of all pooling donors.
Papua New Guinea	*What approach has been used?* In 2000 the Australia and Papua New Guinea governments established the Health Services Improvement Program (HSIP) Trust Account as the means of channelling funds to support the health sector plan and the Medium Term Expenditure Framework. *What financing instruments/government systems are used?* It seems from reports that all of the Australian funds in the Trust Account in 2012 were earmarked.[24] Use of the Trust Account is seen by the Australian aid program as a step towards channelling funds through Papua New Guinea Government systems. *Do other donors support the above?* New Zealand joined the HSIP pool in 2003. In 2012 the other donors were: Asian Development Bank, UNFPA, Global Fund to Fight AIDS, TB and Malaria, New Zealand, and the World Health Organization (WHO). The Global Fund began channelling its resources through the HSIP in 2004 although the funds are project-specific and earmarked, rather than pooled and flexible. Australia is now the only development partner to provide funding through HSIP.
Samoa	*What approach has been used?* In July 2008 the Samoa Government entered into an agreement with key donors to establish a health SWAp in support of the first five years of the 2008-2018 health sector plan. *What financing instruments/government systems are used?* A pooled fund was established but we could not establish from the literature if government systems are used for pool fund accounting and financial reporting. Procurement uses government systems. Technical Assistance is procured separately by individual donors using their own systems. *Do other donors support the above?* New Zealand, World Bank, UNFPA, UNICEF and WHO. The Samoa, Australian, New Zealand Governments and the World Bank pool their funds and use government systems for procurement of goods.
Solomon Islands	*What approach has been used?* Australia's support to Solomon Islands health SWAp, launched in 2008. *What financing instruments/government systems are used?* Sector Budget Support, part un-earmarked and part earmarked. It also uses the government's procurement systems. *Do other donors support the above?* While significant funding is channelled through national systems, only the Australian aid program (the largest donor) provides unearmarked budget support. Others (including Australia) also provide earmarked budget support through the 'SWAp account' and/or project assistance. Some donors use national procurement systems for essential medicines and medical equipment. Procurement of Technical Assistance is largely carried out through individual donors.

2.2 Why were these approaches adopted?

Without further consultation, particularly at country level, it is not possible to fully assess the reasons why the Australian aid program adopted the approaches outlined in Table 4. Choices about SWAps and financing instruments appear to be contextual (in the sense that they were considered the best option in the circumstances, particularly if other key donors were doing the same), aligned with the aid policies of the Australian government at the time (explaining why it did not join pooled funding arrangements in some of the Asian countries before 2008) and in the context of an international focus on aid effectiveness (namely the 2005 Paris Declaration on Aid Effectiveness and subsequent commitments). Available information that helps explain the choices made by the Australian aid program is summarised in Table 5.

[24] According to a source from the Australian aid program Australian aid to HSIP between 2006–2011 '*was heavily unearmarked, with modest amounts of funding earmarked for the National Malaria Control Program and construction of STI Clinics. Australian aid to the Trust Account was 'frozen' in 2011 due to adverse audit findings so remaining funds were earmarked and subject to agreed GoPNG-Australia activities*'. Personal communication.

Table 5 Reasons for the Australian aid program's choice of approach

Country	Why were the approaches and/or instruments adopted? In what context?
Bangladesh	Until 2010 AusAID support was delivered through project aid. In 2010 AusAID decided to contribute to the health pooled fund (while maintaining other parallel investments through project aid) mainly in support of maternal and child health program in partnership with the Bangladesh government, other donors (DFID, EU, UNICEF, UNFPA) and the private sector/non-government organisations (NGOs) (e.g. International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR,B) and BRAC- formerly the Bangladesh Rural Advancement Committee). The main drivers for the change appear to be the renewed focus by the Australian aid program on improving aid effectiveness as evidenced in aid program performance reports.
Cambodia	Australia has been a long term partner of the Cambodia Government; in 2012 it was the second largest bilateral donor after the US following the departure of the United Kingdom from the health sector. We found no specific documents explaining why the Australian aid program made the decision to support the health sector program instead of pursuing, for example, discrete project aid. The most likely reasons are however the need for donors to provide joint support to a country that had come out from a severe civil conflict and required reconstruction and institutional development and strengthening.
Nepal	The DFAT country office (AusAID at the time) highlights that the current (and previous) health sector program priorities are aligned with the policy objective on saving lives and health strategy of the Australian aid program. The Nepal health sector program also strongly aligns with the draft Australian aid program Country Strategy objective that 'All Nepalis have improved access to key services delivered by an increasingly effective state'. The Essential Health Care Services (EHCS) (which include maternal and child health) are one of the key priorities of the health sector program. The Country Strategy further explains that 'the involvement of [the Australian aid program] as one of the pooling donors continues to be relevant, to increase efficiency and effectiveness as well as to address fiduciary and other risks. Furthermore, in a politically volatile environment Nepal has been going through in recent times, 'it is important for like-minded donors to stick together and assist the government system withstand the ongoing challenges and continue delivering social services'.[25]
Papua New Guinea	We could not find any specific documents describing why this approach to aid delivery was chosen or the options considered at the time, but we know from other sources and policy documents that the Australian aid program developed a focus on aid effectiveness during the last decade which is consistent with the approach adopted in Papua New Guinea.
Samoa	Aid program performance reports implicitly refer to dissatisfaction with the limitations of project aid within the Samoa Government and among donors, the Government expectation to use a SWAp and move towards sector budget support incrementally, and that pooled funding was seen as a step in the right direction. The context was the renewed focus on aid effectiveness by the Australian aid program, in line with the international development community. This was complemented by a very proactive Samoan Aid Coordination Unit in developing the Pacific Aid Effectiveness Principles and calling for greater harmonisation and aid coordination. Further, Samoa already had SWAps underway in both the water and education sectors.[26]
Solomon Islands	The National Health Strategic Plan (2006-10) outlined the intention to adopt a SWAp. This was in line with the policy direction the Australian aid program and the World Bank were taking. In 2008 the Australian aid program policies enabled the use of pooled funds and sector budget support where circumstances allowed, and for the first time support was provided through sector budget support.

[25] Australian Agency for International Development, *Quality at implementation report for INJ722 Nepal Health Sector Program SWAp (IHP) _Phase II*, AusAID, Canberra, 2012.

[26] J Negin, *Sector wide approaches for health: a comparative study of experiences in Samoa and the Solomon Islands*, Nossal Institute, Health Policy and Health Financing Knowledge Hub, Melbourne, 2010.

2.3 How was analytic work used?

Our observations are mainly based from publicly available documents and should be interpreted carefully in the absence of deeper analysis at country level. We found that the Australian aid program:

- Instigated and commissioned a considerable amount of analysis about the SWAp and/or progress with the national health plans more generally in ***Samoa, Solomon Islands and Papua New Guinea***, where it is a key and/or the largest donor in terms of the volume of aid pledged, and where it led other donors and often the policy dialogue. In these countries it used an inclusive approach to aid delivery, trying to involve other donors, to achieve greater leverage with the government and to balance the risks linked to aid delivery.
- A key donor in ***Cambodia***, it delivered the largest volume of aid after the United Kingdom's departure from the health sector, and commissioned analytic work on the effectiveness of the SWAp and its sector program. Alongside the other main donors (the United Kingdom and the World Bank) it tried to lead other development partners and often led the policy dialogue.
- In ***Nepal*** and ***Bangladesh,*** where SWAps are well established, it did not commission much analytic work because others had done it in the past and used instead the work commissioned by the donors supporting the SWAp.

In all cases the Australian aid program used its partnerships with national and international universities and networks, and the Health Resource Facility for Australia's Aid Program, to finance analytic work. For example, it co-funded the Joint Learning Initiative that produced the report on the health SWAps in the Pacific and the Cambodia assessment. It directly commissioned other reports which are key references for the Pacific countries (see Table 2, 1.2).

2.4 How do practices compare with other donors?

We looked at a limited number of documents from the United Kingdom (a key partner in Cambodia, Nepal and Bangladesh) and the World Bank (responsible for managing most trust fund arrangements supporting SWAps and for overseeing procurement in several countries).[27] We found that the approaches adopted by the Australian aid program converged with those of other donors, and were aimed at maximising leverage and minimising the risks to Australian aid and at delivering its health aid in accordance with the aid effectiveness principles. Australian annual program performance reviews also point to Australia's effective joint working and efforts to unify approaches in policy dialogue with the government and with other 'like-minded' donors. Other documents however mention tensions and ineffective working within SWAp donors (e.g. in Samoa), and tensions emanating from the perceived hierarchy between pooling and non-pooling partners.[28]

Similarly with other donors, we found that although the Australian aid program provided considerable support to country offices (in the form of analytic work and policy guidance), they had to learn by doing, adapting aid policies and delivery strategies to the new realities. Comments about country offices working in a new aid effectiveness environment but using the same aid management practices linked to project aid are common in the literature.[29] Transaction costs to the country offices increased from SWAps. The premise that such costs would be reduced did not materialise, as recognised in many documents on experience with SWAps. This is partly because the premise that managing a

[27] An extensive review of donor practices was beyond the scope of our review.

[28] Negin, 2010.

[29] Vaillancourt 2009; Vaillancourt 2012 (Appendix 2 and 3); S Tyson, *Solomon Islands Health Sector Wide Approach: progress review 2008-2011*; P Davies, 2013 (among others).

single SWAp would impose fewer costs on donors than the management of several projects that preceded the SWAp approach did not take fully into account the complexities involved in developing new ways of working with the government and other donors, and the time and effort required to put in place a range of new processes and mechanisms to monitor and review the effectiveness of the SWAp and the health sector plan that it supported.

3 What is the evidence of effectiveness?

This section assesses the evidence on the effectiveness of SWAps, sector budget support and use of partner government systems in the six countries under review. The assessment is preceded by an overview of international evidence, and followed by a short analysis of the gender focus of the SWAps in the six countries.

This section should be read in the context of methodological issues raised earlier (1.2). Supporting tables detailing the country evidence are in Appendix 3.

3.1 Overview of international evidence

As mentioned in Section 1.4.3, there is a large body of international literature on health SWAps, sector budget support and use of partner government systems. Even though the country contexts are different, the findings are strikingly convergent. There is also broad agreement in the literature around the paucity of rigorous evidence and analysis of effectiveness. Many of the findings related to effectiveness are inconclusive.

Generally there is consensus that SWAps have underperformed relative to their expected objectives and benefits. However, this should be read in the context of a narrow and inconclusive evidence base and in the absence of information or evidence on how the aid modalities and instruments that preceded the introduction of the SWAp actually worked. More detail is provided in Box 2.

Box 2 Key findings from the international literature

The literature on health SWAps, sector budget support and use of partner government systems is prolific. There is an extensive body of knowledge (case studies, literature reviews and synthesis papers) describing the rationale, progress and challenges of developing and implementing SWAps in different contexts, including in fragile states. However, only a handful of robust multi-country reviews have been conducted specifically to assess SWAp performance, effectiveness, and achievement of intended benefits. Most of these pre-date 2010 and tend to focus on sub-Saharan Africa, although there are also case studies from Asia (Bangladesh[30], Nepal[31], Kyrgyz Republic[32]) and a desk review from the South Pacific which includes case studies of the health SWAps of Samoa and Solomon Islands.[33] The specialised fields of sector budget support and use of partner government systems (such as procurement systems) have their own body of literature.[34]

[30] J Martinez, *Sector wide approaches at critical times: the case of Bangladesh*. HLSP Institute, London, 2008.

[31] D Vaillancourt & S Pokhrel, *Aid effectiveness in Nepal's health sector: accomplishments to date and measurement challenges*, International Health Partnership (IHP+), Geneva, 2012.

[32] D Vaillancourt, Do health sector wide approaches achieve results? Emerging evidence and lessons from six countries, Independent Evaluation Group, World Bank, Washington DC, 2009.

[33] Vaillancourt, 2012, Appendix 2 and 3.

[34] An in-depth review of this literature was not feasible in the time available for this study.

Improving the results focus, including monitoring and evaluation of the sector

Studies from Africa, Asia and the Pacific region agree that SWAps have been effective in developing agreed indicators for sector-wide performance (compared to the multiple reporting and frameworks in earlier systems), and that SWAps have provided an important platform for linking indicators from the national strategy to resource allocation. However, SWAps are found to have been less effective in developing country M&E capacity or robust M&E and measurement frameworks that drive results. In addition to measurement challenges, the literature identifies common problems such as: the use of indicators that are overly ambitious and/or unmeasurable, too process-focused or with weak links to the health strategy; delays in developing M&E frameworks or unavailable/delayed data hindering performance reviews; and overall weak country prioritisation to strengthening M&E capacity and systems.

A World Bank study noted that in five out of six SWAps reviewed 'the neglect of M&E capacity building and use, relative to the strong emphasis on procurement, disbursement, and financial management, has resulted in an insufficient results-focus', causing delays in the production of frameworks and results chains. A review from Samoa finds that commitment to a results focus, while captured in dialogue and in program documents, had not been fully translated into reality and that M&E appeared to be a higher priority for donors than the government.

Joint working and harmonisation

There is general acknowledgement that SWAps have been effective in improving the harmonisation and alignment of development assistance, but with shortcomings.

The literature acknowledges that SWAps have put in place and used tools to improve coordination and management of the sector, including sector plans supported by a multi-year budget or medium term expenditure framework. They have largely succeeded in establishing new and different partnerships and dynamics between governments and donors, with more structured discussion on national strategies and overall funding to the sector. Government-led mechanisms have been put in place to ensure regular meetings with donors, as well as technical working groups for coordination and information sharing. Compared to the pre-SWAp era, donors are a better harmonised group.

SWAps are also found to have been instrumental in developing common management and financing arrangements, including some form of pooled funding or budget support (to enable governments to have more control over sector resources), joint annual planning and budgeting processes, joint financial management and procurement, and regular, government-led reviews of progress.

There is evidence that sector budget support conditionalities and use of SWAp structures have been effective in strengthening policy, planning and budgetary processes. Non-financial inputs such as dialogue and technical assistance have supported improvements in upstream policy formulation, planning, financial management and monitoring of high level outcomes.

However there is evidence that SWAps have been less effective than anticipated in reducing transaction costs (both for governments and donors) because of the substantial administrative burden of managing SWAp processes, and the continued use of project-type support by some large bilateral donors and global funds. In addition, SWAps require different ways of working. This takes time, and technical capacity to support policy dialogue has been often found below requirements (e.g. in Samoa). SWAps also appear to have been less effective at ensuring technical cooperation flows through coordinated programs, with specific pooled funds and plans delayed or not coming to fruition.

Supporting greater ownership and leadership of the sector

Reviews suggest that Ministry of Health leadership has been strengthened by approaches such as SWAps and sector budget support in some contexts, with increased ownership over the national health policy agenda, strategic planning and (increasingly) participatory review processes. Sector budget support funds have helped to facilitate policy implementation, which has reinforced ownership. In a few countries, the strategy is required to be also approved by Parliament, taking these approaches beyond the technical level to a broader political dimension.

However, the track record in strengthening wider stewardship of the sector and institutional capacity is mixed, despite considerable efforts in these areas. The World Bank found that SWAps had been only 'modestly' successful in achieving improved sector stewardship, and that despite some evidence of improved ownership of plans, concerns remained about their realism and quality. Similar findings are reported elsewhere. SWAps have been found largely ineffective in establishing incentives to strengthen sector wide accountabilities, with public sector management responsibilities not assessed or addressed, and sector performance information not widely shared with civil society. Performance agreements—both between governments and among levels of government—were often not enforced.

SWAps were designed to strengthen national systems, with a broader aim to build capacity. The extent to which this has happened varies from setting to setting. Individual countries have improved systems for planning, budgeting and procurement, but aside from the widespread introduction of annual sector reviews, 'it is not easy to identify a set of management arrangements that have been consistently strengthened across countries involved in SWAps.'

In addition, SWAps and sector budget support have been criticised for being overly focused on upstream policy and monitoring processes. There is evidence that sector budget support has been effective in supporting the expansion of service delivery through financing inputs, but less effective in addressing implementation capacity constraints at local service delivery level. This gap is often referred to as 'the missing middle'.

Improving alignment of funding to sector priorities

Evidence shows that SWAps and sector budget support have supported donor alignment with sector policies and strategies. The use of pooled funds has provided and protected funds to the health sector and enabled greater control of health resources by governments. At the same time it has reduced risk for donors (in terms of achieving aid returns) and helped them overcome some of the obstacles to channelling funds to government budgets in countries whose public finance and management systems were perceived (by the donor) as not being robust enough to guarantee effective, accountable and transparent use of aid.

Countries note greater reporting and transparency of donor resources (even in project form or in-kind) and provision of more predictable and increased resources for the plan, which may be routed and accounted for through national systems. For example, in Tanzania the U.S. Agency for International Development has been reporting its support in detail to the government, helping to increase the completeness of budget figures. Similar examples have been reported from Rwanda, Mozambique and Bangladesh. A report showed that sector budget support had contributed towards an increase in the quantity of services delivered, typically providing between 10% and 40% of sector expenditure, and sometimes more. Sector budget support had supported the expansion of basic healthcare in Tanzania and the introduction of free basic healthcare in Zambia. The World Bank reported increased capacity to spend budgets and increases in the share of resources allocated to primary care in most SWAps reviewed. In Ghana and Tanzania, SWAp pooled funding arrangements had increased funding for health at district levels.

SWAps have been found less effective in serving as a common framework for all external aid. In most countries there are still stand-alone projects, priorities program and substantial volumes of resources outside pooled arrangements and out of sync with SWAp objectives, and which may or may not be part of national planning frameworks. Progress towards closer sector-wide working has also been slower to develop than anticipated, with pooled funds largely remaining within SWAps (i.e. they do not appear to have widely facilitated the transition to, strengthening and use of government systems). Mozambique merged a number of common funds to become one fund supporting the sector budget but overall, literature and examples of SWAps enabling transition between aid modalities is very limited.

The Organisation for Economic Co-operation and Development (OECD) reports that even in the contexts of well-established SWAps such as Cambodia, Malawi, Mali and Zambia, or in countries with public financial management systems that achieve over and above donors' expectations, there continues to be modest and sometimes inconsistent use of country systems.

Sources:

Walford, 2007; Vaillancourt, 2009; Vaillancourt, 2012; OECD, 2011; Williamson & Dom, 2010; Peters, Paina & Schleimann, 2013; Negin,2010; McNee, 2012; Dickinson, 2011. See Appendix 4 for full list of references.

This report continues by examining in greater depth the evidence for the six selected countries—Bangladesh, Cambodia, Nepal, Papua New Guinea, Samoa, and Solomon Islands.

3.2 Did SWAps increase the focus on results?

In this section we discuss the focus on results relating to the SWAp and to the Australian aid program objectives. Key findings:

- In most countries the results expected from the SWAp were linked to the results measured at sector or program level in the form of health outcomes and service or program outputs, and reflected in M&E or results frameworks. All countries (except Papua New Guinea and Solomon Islands) had defined results frameworks, of varying suitability, by 2011 (the year when most independent evaluations were undertaken).
- Only Cambodia, Nepal and to some extent Bangladesh, defined specific results expected in terms of SWAp components (focus on results, strengthened M&E, etc.). The SWAp-specific results were not necessarily part of the sector results frameworks and were reported qualitatively in the annual sector or program reviews.
- Prioritisation of expected results at sector or program levels was stronger in the older SWAps of Asia and weaker in the Pacific countries (particularly in Papua New Guinea and Solomon Islands). The literature indicates that first generation SWAps tend to define many results at first and become more selective and prioritise results in the second and third generation health plans or programs.[35]
- The Australian aid program defined expected results for its health portfolio in all countries. These results were a subset of the indicators included in the country level results framework, and were reported on in a range of documents (e.g. annual program performance reports or their thematic equivalents, quality at entry and quality at implementation reports). In some countries (Samoa, Solomon Islands and Papua New Guinea) the health information system could not report against all indicators.

The documents we reviewed conclude that SWAps clearly contributed to an increased focus on results, although they qualify this noting the limitations and poor reliability of sector results frameworks. They point out that problems of reporting and achieving robust results are to be expected, particularly in the more incipient SWAps, where strengthening the results focus and the country's health information systems are an integral part of what the approach aims to address. This may explain the weaker results focus in the Pacific countries than in the more consolidated Asian SWAps. The literature also notes the confusion between 'SWAp-specific' results and sector results, and the difficulties of attribution (as we explained in Section 1.4).

These limitations are also reflected in reports from other donors such as the United Kingdom's Department for International Development and the World Bank. They highlight that even an effective SWAp may take years to show sector results, and that even when results occur they cannot

[35] Bangladesh is an example of a SWAp where the original monitoring frameworks included a very large number of indicators which were subsequently prioritised in the second and third versions of the sector program (Independent Review Team, *Mid Term Review of the HNPSP*, 2008).

necessarily be attributed to the SWAp itself. For example, health outcomes and service outputs were improving in Bangladesh between 2005 and 2008, at a time when the SWAp was not working effectively and the sector program was experiencing a crisis of leadership and focus.[36]

Supporting information and references: Appendix 3, Tables A1, A2 and A3.

3.3 Did SWAps achieve the expected sector/program results?

There is considerable evidence that SWAps in the six countries reviewed are contributing to strengthening the focus on results, although the results cannot be attributed to the SWAp itself for methodological reasons.

Key findings:

- Good progress at the health sector or health program level was reported in Bangladesh, Cambodia and Nepal. In these countries progress has been reported on the main defined indicators for the sector. Most indicators (but not all) were on track.
- Mixed results were reported in Samoa, meaning that only some indicators showed progress and were on track. Judging from the more recent information contained in Australian aid program's reports from 2013 it would appear that progress accelerated compared to 2011.[37]
- Very limited or no progress on the defined sector core indicators was reported in the Papua New Guinea and Solomon Islands in 2010 and 2011.[38] More recently (in 2013) some key indicators seem to be on the upward trend judging from Australian aid program reports.

Table A4 in Appendix 3 shows summary progress with indicators at sector/program levels where possible. Careful interpretation of these results is required given the over-simplification of sector level indicators (some of which, but not all, have progressed); difficulties in making cross-country comparisons given the different state of health development; and the fact that assessments undertaken in the three Pacific countries focused on the earlier stages of the sector program, when health information systems were probably less reliable that they may be now.

Attribution of results to SWAps was not attempted by any of the authors of the main independent reviews and evaluations. More detail on results in specific countries is presented in Appendix 3, Table A4

3.4 Did SWAps improve sector or program M&E?

In line with global evidence, M&E of the health sector or programs improved in the six countries as part of the SWAp, at least in comparison with pre-SWAp situations where joint review processes or M&E frameworks were not in place. Annual (sometimes bi-annual) sector review processes were taking place in all countries. While there is evidence that M&E improved or was strengthened, the studies we reviewed provide important qualifications to this finding. For example:

- There is consensus in the literature consulted that M&E clearly improved in the mature SWAps of Bangladesh, Cambodia and Nepal where approaches went through various modifications leading to increasingly prioritised results and strengthened capacity to measure sector indicators more

[36] Martinez, 2008.

[37] Davies, 2013; Vaillancourt, 2012 (Appendix 3).

[38] Tyson, 2011; K Janovsky, *The PNG SWAp review: streamlining and strengthening mechanisms for sector coordination and policy dialogue*, 2010a.

reliably and accurately. Annual reviews took place as expected and involved external, independent scrutiny in Bangladesh[39] and Nepal.[40] In Cambodia only the mid-term reviews included independent reviewers.[41] Information feeding into the M&E reviews was considered quite robust in the three countries.

› Joint review missions also took place more or less as planned in Papua New Guinea, Samoa and Solomon Islands as a result of the SWAp, albeit with limitations (concerning the robustness of the information available and the effectiveness of the review processes. In general, there was poor prioritisation of the reviews' recommendations and management systems were too weak to either validate the information on indicators, or to act on the recommendations. However, shortcomings on the quality of M&E processes and outputs are to be expected in incipient SWAps.

Supporting information and references: Appendix 3, Tables A5; A6; A7.

3.5 Did SWAps improve joint work and policy dialogue?

The overarching conclusion reached by the studies reviewed is that the SWAps supported by the Australian aid program and other donors contributed substantially to more collaborative and joint work and improved policy dialogue between donors and the government. However, as for other SWAp components, systematic assessment of the pre-SWAp situation (where we assume *some* degree of joint work and policy dialogue existed) is lacking.

The evidence suggests incremental improvements over time, with the more mature Asian SWAps showing, in general, greater and more effective joint work and policy dialogue than the Pacific health SWAps. Where information is available from the 2013 aid program performance reviews, the Pacific countries also seem to have improved joint work and policy dialogue compared to assessments carried out in 2010 and 2011.[42]

Policy dialogue and joint work are dynamic processes and changes to their quality depend on the people involved. We found many references to staff turnover (on either the government or the donor side) affecting quality of the engagement and dialogue. Some 'crises'—where joint work or dialogue were not happening as expected—are also reported for all countries.

A key issue found in several reports (Samoa, Solomon Islands, Cambodia) is the extent to which development partners bring the right skills and capacities to support governments in the SWAp process and to carry out a sufficiently rigorous, technical dialogue—individually and collectively.

Key findings from individual countries include:

› In Bangladesh and Nepal there was regular and close engagement among donors and with the government, both through scheduled annual reviews and regular dialogue/interaction as part of the management arrangement.

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[39] Independent Review Team, *Mid-term Review of the Health, Nutrition and Population Sector Programme* (2003-2010): consolidated report, MoHFW, Dhaka, 2008; *Annual Programme Review 2012: consolidated report*, MoHFW, Dhaka, 2012; *Annual programme review (APR 2013)*: Health, Population and Nutrition Sector Development Program (HPNSDP), 2011-16. Consolidated report. MoHFW, Dhaka, 2013.

[40] Vaillancourt & Pokhrel, 2012; Department for International Development, *Annual review of DFID support to the National Health Sector Programme II, Nepal*, DFID, London, 2014.

[41] J Martinez, et al, *Overall assessment for Mid Term Review of Health Strategic Plan 2008-15*, HLSP, London, 2011.; D Vaillancourt, A Land & D Shuey, Aid effectiveness in Cambodia's health sector: an assessment of the sector-wide management (SWiM) approach and its effect on sector performance and outcomes, 2011 (Draft).

[42] There were no independent assessments after that 2011, although some documents are dated 2012.

- In Cambodia there was close interaction between donors and the government through the four main technical working groups.[43] However, the quality of senior level interaction between the Ministry of Health and the donors was often compromised by the rules of courtesy and diplomacy (limiting the candour required to discuss more sensitive policy issues).[44] In short, there was dialogue but it could have been of higher and more strategic quality.
- In Papua New Guinea difficult relations and inadequate dialogue between donors and central agencies linked to the Health Service Improvement Program and its trust account were described as long standing concerns in 2010.[45] More recently, the situation seems to have improved following management reforms and a full re-design of the trust account. Our interpretation of the information is that while policy dialogue may have been difficult at times, it has nevertheless led to decisions and reforms that both the government and its partners are currently supporting. So, in aggregate, joint work and dialogue seem to be working after all through the SWAp. There is no independent assessment after 2011 to verify this conclusion, but the 2013 Australian aid program's performance report seems to point in this direction.
- In Samoa, policy dialogue took place regularly, but is described as too focused on day-to-day management issues. Questions were raised about the extent to which donors had the right skills and capacities to support the SWAp development and engage in appropriate dialogue, either routinely or during sector reviews. Donors were found passive, tolerating slippage in implementation, accommodating missed deadlines and allowing seemingly arbitrary changes to both the format and content of important documents, in turn hindering accountability.[46] It would appear that lack of experience among donors led them to confuse government leadership and poor process management. In addition, lack of meaningful participation of non-pool agencies detracted from a whole sector view and allowed the Samoa Government to seek funding for activities outside the agreed SWAp program of work.[47]
- In Solomon Islands the quality of policy dialogue and joint work was found to be compromised by a collective failure (both by donors and the government) to manage and monitor implementation of past recommendations, and to absorb and account for resources.[48] The Ministry of Health was cited as having significant capacity constraints, limiting its ability to deliver on its SWAp responsibilities. Ministry of Health leadership thus appeared reduced or undermined, with donors visibly dominant and driving the process.[49]

Supporting information and references: Appendix 3: Table A8.

3.6 Did SWAps improve government ownership and leadership?

As with other SWAp components, baselines describing the extent of government ownership and leadership before the SWAp was introduced are almost non-existent. Furthermore, defining and measuring country ownership is notoriously difficult.

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[43] Maternal, neonatal and child health; communicable diseases; non-communicable diseases; health systems strengthening.

[44] Vaillancourt, 2011; Vaillancourt, 2012.

[45] Janovsky, 2010a; K Janovsky et al, The PNG Health SWAp review, 2010b.

[46] Davies, 2013.

[47] Davies, 2013.

[48] Tyson, 2011.

[49] M Kelly & K Tuckwell, *Solomon Islands Health Sector Support Program (HSSP): Independent Performance Assessment (IPA) for 2013*, Health Resource Facility, Canberra, May 2014.

Evidence from the six countries links the SWAp to increased government leadership of the sector and ownership of national health plans. The evidence also contains important qualifications to this broad statement:

- In Bangladesh, government leadership and ownership changed over time and went through periods of crisis during which the sector program and SWAp helped maintain minimum levels of policy dialogue, with the government in control. Accountability for decisions and results improved in recent years, although some reports emphasise that accountability lines often seemed unidirectional, that is, with the government expected to be accountable to a greater extent than the donors, some of whom continued to work in ways that were not consistent with the SWAp or failed to deliver on decisions and pledges. This undermined government leadership.[50]
- In Cambodia, ownership, leadership and accountability by the government were reported as high, but accountability was not found to extend to all areas. A more transparent share of information would have helped better align resources to sector priorities, including the procurement of essential drugs at market prices.[51] Some reports criticise donors for not being accountable for the principles of the SWAp, failing to define specific targets to increase alignment and harmonisation.[52]
- Nepal is reported as an example of a government leading and maintaining open and fluent relationships with its partners, which proved essential during the long periods of civil unrest and political instability. Accountability for decisions and results was also judged to be high.[53] The Australian aid program's annual performance review for 2011 states that '*Donors operating in the country are noted for their commitment to working in a highly coordinated fashion and in ways that build government systems and capacity'.*
- Government leadership in Papua New Guinea was described as very low, particularly until 2010. This was linked primarily to lack of implementation capacity on the government side and to rigidity of the trust account supporting the health sector program. According to Australian aid program's reports leadership seems to have improved somewhat since 2010. A recent report reviewing the Health Sector Partnership Committee[54] in 2014 suggests that a considerable amount of work has taken place to improve government leadership and policy dialogue, but that problems remain.
- Leadership by the Samoan Government is portrayed as very strong in two separate external reviews, and accountability is described as progressing well. [55] '*The Ministry of Health appears to have approached the task of managing the SWAp with energy and enthusiasm. The ability to consolidate interactions with development partners into a single process as opposed to a series of discrete bilateral engagements has supported more efficient and consistent dialogue'.*[56]
- Leadership in the Solomon Islands SWAp is described as weak, because of poor definition of results at either SWAp or sector levels, and because of capacity issues at the executive level (described as 'managing by crisis'). There is limited evidence of effective approaches to define and track accountability for performance.[57] The political sensitivity of the relationship with

[50] Independent Review Team, Annual Programme Review 2007: consolidated report, MoHFW, Dhaka, 2007. Martinez 2008.

[51] Martinez et al, 2011.

[52] D Vaillancourt, 2011.

[53] Vaillancourt & Pokhrel, 2012.

[54] Health Sector Partnership Review, 2014. No author.

[55] Davies 2013; Vaillancourt, 2012 (Appendix 2, Samoa).

[56] Davies, 2013, p19.

[57] Tyson, 2011.

Solomon Islands and pressures to spend the aid budget has made the Australian aid program reluctant to impose sanctions.

Supporting information and references: Appendix 3, Table A9.

3.7 Did SWAps increase alignment?

The concept of alignment encompasses different dimensions, so it is possible for strong policy alignment to co-exist with weak alignment in terms of health financing. We defined the different dimensions of alignment, to guide our document review as, follows:

- Alignment with government planning and budget systems by the Australian aid program and main donors.
- Alignment of external financing with the priorities of the plan and medium term expenditure framework.
- Predictability of health financing and/or expenditure.
- Whether health financing or expenditure supported incrementally the defined sector priorities.
- Whether alignment increased in the context of the SWAp.

Detailed analysis for each dimension is in Appendix 3, Tables A11 to A15.

We found that alignment increased in all the countries reviewed, but with marked differences in the extent of progress. A snapshot of our assessment of progress for each dimension is in Table 6.

Table 6 Summary of progress on alignment

Dimension of alignment	Bangladesh	Cambodia	Nepal	Papua New Guinea	Samoa	Solomon Islands
Alignment with government planning and budget systems by the Australian aid program and main donors	High	Good	High	Low	Fair	Low
Alignment of external financing	Good	Good	High	Low	Fair	Low
Predictability of health financing and/or expenditure	High	Good	High	Low to fair	Low to fair	Low to fair
Health financing or expenditure supporting incrementally defined sector priorities	High	Good	High	Low	Low to fair	Low to fair
Increased alignment in the context of the SWAp	High	Good	High	Low	Fair	Low to fair

Specific observations can be made:

- Countries of the Pacific were in the early stages of the SWAp when the main reviews were conducted. This partly explains why they appeared to have less progress than the mature Asian SWAps.
- Alignment with government plans was generally high in terms of shared sector or program *objectives* between donors and governments. However, this did not always translate into

alignment of donor aid with the *priorities* of the plan. In some cases this type of alignment was low because the plan failed to define clear priorities (Papua New Guinea and Solomon Islands) or because the priorities were poorly developed in terms of measurable results. At times this was combined with limited transparency on the specific allocations made by donors, or the pooled funds, to the sector (Samoa and Solomon Islands).

- Predictability of funding increased as a result of the SWAp. Progress was associated (not in terms of causality) with countries using a medium term expenditure framework, public expenditure reviews, national health accounts and financial management reports. This is in line with findings from the international literature.

3.8 Did SWAps increase the use of government systems?

Until quite recently it was atypical for the Australian aid program to use government systems to channel financing and procurement of commodities and technical assistance. This changed from 2008 when a renewed focus on aid effectiveness led to the development of specific policies that enabled the use of government systems, at the same time ensuring that benefits and risks could be effectively balanced.[58] This is why despite being a member and signatory of the health SWAps in Bangladesh and Nepal since their early stages the Australian aid program did not pool its funds with other donors until 2008.

Table 7 provides a snapshot of the use of government systems by the Australian aid program and other donors in the six countries.

Table 7 Use of government systems

Country	Systems used to finance the plan/ program and for TA procurement	Use of government systems for procurement
Bangladesh	A pooled fund supports an agreed program of work implemented by the government according to a plan and linked to bi-annual annual operational plans and budgets. The Australian aid program contributed only for Financial Year 2009/2010. Government financial management reports are used for accounting. Technical Assistance is procured by individual donors.	The picture is mixed. There has been a steady increase in procurement using government systems under the supervision of the World Bank. Certain commodities are procured through United Nations agencies.
Cambodia	A pooled fund supports a parallel program of work implemented by a Project Management Unit that is not part of the Ministry of Health (MoH) but located in the MoH building. Use of pooled funds is not reported as part of the financial reports prepared by the government. TA is procured separately by donors. Some Australian TA is delivered through the World Health Organization.	Government systems are not being used for procurement. The sector program procures through the World Bank. Fiduciary risks within the public finance management (PFM) system are considered too high by most donors.

[58] The approach is discussed and referred to in several documents including: *Australian aid: Promoting growth and stability: A White Paper on the Australian Government's overseas aid program*, AusAID, Canberra 2006. *Saving lives: Improving the health of the world's poor*, AusAID, Canberra, 2011. *2011–12 Annual Review of Aid Effectiveness*, AusAID, Canberra 2012a; *Helping the world's poor through effective aid: Australia's comprehensive aid policy framework to 2015–16*. AusAID, Canberra, 2012b; *An effective aid program for Australia: making a real difference—delivering real results,* AusAID, Canberra 2012(c).

Nepal	The Australian aid program has supported a pooled fund since 2008. Government systems are used for financial reporting under the supervision of the World Bank. Australia is a key member of the PFM task group. TA is procured by the United Kingdom on behalf of other donors and in consultation with the MoH.	Due to political instability it is not considered safe to procure all commodities through government systems. Where procurement is through the government the World Bank oversees implementation. Other (most) commodities are procured through international agencies appointed by donors.
Papua New Guinea	Nominally there was a pooled fund supporting the SWAp although most funds were project-specific and earmarked (i.e. not a pooled fund or SWAp as generally described). This may have changed since 2012 when the trust account was completely redesigned. TA was procured by individual donors, at least until 2012.	Procurement is done through HSIP and large scale procurements are undertaken through a procurement agent. Indications are that the redesigned trust account will make increased use of government systems for financing and procurement of goods and services, including TA.
Samoa	A pooled fund was established, representing between 9% and 50% of total health expenditure depending on the year. It is not clear from the literature if financial reporting used government systems or was done by the World Bank. TA was procured by donors.	Government systems are used for procurement under the supervision of the World Bank. There is considerable evidence that Australia encouraged other donors to use government procurement systems in order to strengthen them.
Solomon Islands	While significant funding is channelled through government systems, only the Australian aid program provides un-earmarked budget support. Donors (including Australia) also provide earmarked budget support through the 'SWAp account' and/or project assistance. Government financial management systems are used for financial management reporting of sector budget support funds (although changed arrangements are currently under consideration). TA procurement is largely carried out by individual donors.	Some donors including the Australian aid program use national procurement systems for essential medicines and medical equipment. Recent financial and procurement audits demonstrate slow or unsatisfactory progress.

In the next sub-sections (3.8.1-3.8.4) we synthesise the evidence on individual government systems used.

3.8.1 Pooled funding

The Australian aid program has pooled its funds with other donors in five of the six countries, but there are differences in what the pooled fund supports and how funds are accounted for:

- In Bangladesh, Nepal and Samoa pooled funds directly support the national health plan. Funds are deposited into a government account and can then be used as agreed in joint financing arrangements. In Bangladesh, the Australian aid program only contributed to the pooled fund in financial year 2008-2009 and then opted out because of cuts to the aid budget.
- In Bangladesh and Nepal donors rely on government systems for financial reporting and accounting of pooled funds. In Samoa, the information available does not specify whose systems are used for this purpose (the government or the World Bank's).
- In Cambodia and Papua New Guinea (until 2013 in the case of PNG) pooled funds finance a parallel program of work using a separate project management unit financed by the aid programme. The project management unit consisted of a group of advisers recruited to manage components of the health sector program and reporting to the government and donors supporting the SWAp. In this model, funds are earmarked by donors (defining what they can be used for) and

accounted for by the World Bank on behalf of the pooled funders. The attempt by the Australian aid program to pool funding in Papua New Guinea did not work as expected, (as described in sections 3.5 and 3.6).

These examples show that pooled funding does not necessarily use government systems. It is generally described as a *move towards increased use of government systems* when such systems are not perceived as robust enough for full budget support, in a sort of a risk pooling/risk management arrangement. However, the stated intention of moving towards greater use of government financing systems is not supported by evidence or has not yet taken place. For example, Bangladesh and Nepal have used pooled funds for a decade or longer and there are no indications that donors plan to adopt a different financing instrument.[59]

3.8.2 Sector budget support

The Australian aid program only used sector budget support in Solomon Islands, and was alone in providing un-earmarked support (together with some earmarked funds). All remaining donors earmarked their contributions. International evidence suggests that it is unusual for the same donor to use earmarked and un-earmarked sector budget support simultaneously, and earmarking in this context is also unusual. We could not find any evaluations or reviews discussing the justification for the arrangements in Solomon Islands, although the approach by the Australian aid program points to an effort to incrementally aligning their resources to national plans and channelling funds through the national budget that should be recognised.

3.8.3 Procurement of goods and commodities

The picture on use of government systems for procurement is mixed. Exclusive use of government procurement systems was only found in Samoa. In Bangladesh the Australian aid program procures some goods through the government system and others through external agencies, under World Bank supervision. In the Solomon Islands everything is procured through government systems.[60] In Nepal and Cambodia procurement is through the World Bank or external agencies supervised by the World Bank, which is responsible for financial management reporting. In Papua New Guinea, Australia has a separate procurement agent for large scale procurements, but HSIP procurement is managed using government systems.[61] Information available from the Australian aid program did not always specify the reasons for using government procurement systems or not. Some World Bank reports (e.g. project appraisal documents) cite issues including weaknesses in the government's procurement, financial accounting or public finance management systems in general as reasons for not using government procurement systems.

3.8.4 Procurement of technical assistance

In all countries donors including Australia procure technical assistance directly. In Nepal, the United Kingdom procures technical assistance on behalf of SWAp donors. In Cambodia some of Australia's TA is procured through the World Health Organization.

[59] Note from the author: in Bangladesh during the design of the sector program in 2008 there were discussions among donors on using sector budget support; in the end the previous pooled funding arrangements were adopted.

[60] Personal communication from David Kelly, DFAT, in his feedback to an earlier version of this study.

[61] Personal communication from Aedan Whyatt, DFAT, in feedback provided on an earlier version of this study.

3.9 Gender focus and reporting

In the same six countries we also looked for evidence on: whether the health SWAp or national health plans included a specific focus on gender; whether established review processes reported on this; and whether the Australian aid program reported on gender.

We found:

- A clear focus on gender (incorporating dimensions such as equity, voice and reducing violence against women) in the national health plans or SWAp arrangements of Bangladesh, Nepal and Cambodia, where progress was reported regularly (annually) as part of the M&E arrangements, although some reporting was incomplete.
- Some gender focus in the implementation plan for the countries of the Pacific, but translated into specific activities or monitoring indicators only in Solomon Islands. We found no reporting on gender in annual reviews in these countries, reflecting perhaps the early stage of SWAp implementation.
- Reporting on progress with gender objectives *within the Australian aid program* was found to be limited and uneven.

A summary of findings is provided in Table 8. More detailed information is in Appendix 3, Table A13.

Table 8 Focus on gender in the six countries

	Gender focus in the SWAp[62]	Gender reporting in SWAp processes[63]	Gender reporting by the Australian aid program[64]
Bangladesh	Clear gender focus in SWAp documents, and reflected in its objectives, strategies and indicators. Covered under theme: Gender, Equity and Voice.	Progress reported in the 2013 Annual Performance Review (APR). Progress is mixed (but this is the first APR of the new program).	No mention of gender in 2012-13 Annual Progress Performance Report (APPR), the only one covering the SWAp under review.
Cambodia	Gender mainstreaming is a core strategy; objectives and indicators are clearly defined.	Progress is included in the 2011 MTR. Progress is mixed. Australian aid program has commissioned an assessment of gender in health (a first for the country).[65]	No specific references to gender in APPR 2012–13. However the commissioned study on gender in health, indicates the program had a gender focus even if not reported.
Nepal	Gender Equality and Social Inclusion (GESI) is a core strategic component; it contains objectives and indicators.	Progress is mixed but clearly reported in annual and mid-term reports.	APPR 2012-13 makes specific reference to progress achieved on gender.
Papua New Guinea	Some references in the national health plan and in the re-design of the program. Some specific activities are outlined but no indicators are	No reporting on gender in the documents reviewed.	The thematic performance report 2013-14 reports on improved health outcomes for women and increasing women in the workforce as gender equality

[62] Based on SWAp foundation documents and the national health plans they support.

[63] Based on the most recent annual/mid-term reviews conducted independently (by external consultants).

[64] Based on the most recent APPRs, in the section on the health program.

[65] K Frieson et al, *A gender analysis of the Cambodian health sector*, 2011.

	defined.		achievements.
Samoa	The health sector plan has references to gender. The program operational manual contains one indicator for which data is disaggregated by gender (primary care utilisation)	No annual review reports are available. An independent evaluation in 2013 comments on the few explicit references to gender in the SWAp or donor documentation.[66]	No specific reference to gender in APPR 2012–13.
Solomon Islands	Improving the health status of women is a specific policy. Strategies, activities and indicators on reproductive health and domestic violence. Gender mainstreaming within Ministry of Health is specified in program implementation plan with associated activities.	No reporting on gender in the documents reviewed.	APPR 2012-13 states that the program promotes gender equality by supporting victims of gender based violence.

[66] Davies, 2013.

Appendix 1: Terms of reference

A.1.1 About ODE

The Office of Development Effectiveness (ODE), an operationally independent unit within DFAT, evaluates the effectiveness of the Australian aid program producing a high quality and policy relevant program of evaluations and analytical work.

ODE's evaluation strategy and work program is overseen by the Independent Evaluation Committee (IEC). ODE's unique position within DFAT provides it with an in-depth understanding of policies, procedures and processes influencing the effectiveness of aid delivery. ODE evaluation reports include a formal management response from the agency and the evaluation recommendations are monitored by ODE.

ODE reviews and evaluations are highly collaborative projects. ODE appoints an evaluation manager to each evaluation and is committed to the joint production and shared ownership of all products.

A.1.2 Rationale

The Australian aid program has in recent years increased the use of SWAps and allocated a small but not insignificant portion of funding through sector budget support (SBS) and partner government systems. As part of the process of developing its work plan, ODE is commissioning a review of the evidence of the effectiveness of these approaches in the education and health sectors.

A.1.3 Scope of services

A report is required to review the evidence of the effectiveness of donor support for the health sector through the use of SWAps, SBS financing instruments and other approaches, including using partner government systems.

The evidence review will have five components

1. Describe how the Australian aid program has used SWAps, budget support and partner government systems to improve the health sector and compare this with the work of other donors.
2. Analyse the types and quality of evaluation approaches and methods used by both Australia and other donors to assess the effectiveness of this work.
3. Describe, analyse and synthesise the evidence of the effectiveness of the use of SWAps, budget support and partner government systems in the health sector from Australian aid program evaluations, performance reports and reviews. The analysis should include evaluations completed in the last five years.
4. Describe, analyse and synthesise the evidence and gaps on the effectiveness of the use of SWAps, budget support and partner government systems in the health sector from evaluations and reviews of work done by other donors. This work should have a very strong focus on evaluations of work in the Asia Pacific region, particularly countries which receive the bulk of Australian assistance. An overarching consideration in choosing should be the extent to which these findings will be useful in the Australian aid context.

5. Identify any other relevant global evidence if useful.

The review should identify useful conceptual models and definitions, noting any diversity of opinion. The focus of the work and the report should be on components three and four listed above (about 60-70 per cent of inputs). It is anticipated that the evidence review will concentrate on SWAps and budget support (about 40 per cent of inputs each) with the use of partner government systems and comparisons between the three approaches receiving less attention (about 10 per cent of inputs each).

Any gaps in the evidence should be identified. All components of the work should pay attention to the extent to which gender considerations have been appropriately incorporated into programs and evaluations. The priorities and scope of the work will be refined as the work plan is developed in a consultative process involving the consultant/s and ODE. The review may involve limited stakeholder consultation which will be managed by ODE.

A similar evidence review will be undertaken by the Education Resource Facility. If appropriate, ODE may commission a comparative analysis of findings from the reviews for the health and education sectors.

A.1.4 Outputs

- A plan describing the evidence available and work to be undertaken in the evidence review. The plan should clearly identify data sources with some preliminary assessment of their quality. Where sufficient data exists, there should be a focus on Australian aid program evaluations. The priorities and scope of the work will be refined as the work plan is developed in a consultative process involving the consultant/s and ODE. The scope of the work should be explained and justified in the plan. The methodology, search strategy and analytical frameworks/criteria to be used in reviewing the evidence should be outlined. The plan should also specify roles and responsibilities of team members, timelines and budget. The plan should be about eight pages in length with Appendixes used to provide additional information about available evidence.
- A draft report that responds to the scope of services. The report must be in the template provided and compliant with ODE style guide and quality standards.
- A well-written report that responds to the scope of services and is of sufficient quality to be published. The report must be in the template provided and compliant with ODE style guide and quality standards. It is expected that the report will be about 20- 40 pages in length with Appendixes as required.
- An annotated bibliography of available evidence. Annotations should specify donor agencies, describe the methodology used in evaluations/reviews and assess its quality, comment on the usefulness of the evaluation and outline the main findings.

A.1.5 Reference materials

1. Existing DFAT evaluations and reviews at the operational, thematic and departmental levels (ODE). The review should specifically reference the findings of the ODE 2010 evaluation on Service Delivery for the Poor.
2. Other donor evaluations in countries/regions where Australian aid is delivered should also be referenced.

A.1.6 Milestones

Milestone	Description of work	Verifiable indicator	Completion date[67]
Plan for Evidence Review	Identification of data sources and their quality focusing, where sufficient data exists, on Australian aid program evaluations. Consultation with ODE to refine scope and priorities. Preparation of written plan of work.	DFAT acceptance of plan.	May 2014
Draft report and annotated bibliography	Analysis of evidence. Consultation with ODE on analysis and emerging findings. Possible consultation with stakeholders as arranged by ODE. Preparation of draft report.	DFAT acceptance of draft report and annotated bibliography.	June 2014
Final report and annotated bibliography	Responding to and incorporating feedback on draft report provided by ODE. Report writing, analysis and editing. Consultation with ODE to receive feedback/input. Preparation of publication standard report.	DFAT acceptance of final report and annotated bibliography.	June 2014

A.1.7 Inputs

Up to 40 days.

Evaluation team composition:

Ideally the team would be an individual or small team.

At a minimum the team would need to include a combination of the following skills:

- Substantial evaluation experience and knowledge of evaluation methodology and practice;
- Proven experience as the primary author of high quality publications in clear English including evaluation reports, reviews and/or research;
- Postgraduate qualifications in evaluation, or equivalent professional experience;
- Strong health sector knowledge of SWAps, budget support and financial instruments;
- Experience in international development.
- Strong knowledge of the Asia Pacific region.

[67] Please note that these dates were subsequently revised in agreement between the HRF, the reviewers and ODE. The draft report was submitted in early August and the final report in mid-September.

Appendix 2: Approach to documentation

A.2.1 Composition and roles of the evidence review team

The review team comprised:

- Team Leader and lead author (Javier Martinez): the Team Leader's role was to direct the overall approach to the review and analyse the evidence to address the five components of the review. The Team Leader is responsible for all written outputs developed by the review team.
- Aid Effectiveness Expert (Clare Dickinson): worked with the Team Leader primarily to review the international evidence.
- Documentation reviewers (Jane Pepperall, Claudia Sambo and Jody Tate): Collected and summarised relevant material for each country, aiming to guide the Team Leader in selecting the right documents and drawing his attention to important areas. Claudia Sambo prepared the annotated bibliography, reviewed the references, and edited the report.

A.2.2 Approach to document review phase

The documentation review lasted for about four weeks and involved three researchers. The main search was done via internet using the Pub Med database for published, academic literature and Google for the publicly available published and unpublished (also called grey) literature. In addition the researchers searched the database at the Health Resource Facility for Australia's Aid Program in Canberra and the database of the HLSP Institute in London. We also consulted with a limited number of international health consultant colleagues experienced in the topics or in the countries under review to provide additional documents.

With the help from ODE and through the Health Resource Facility for Australia's Aid Program, we approached DFAT country offices in the countries under review. Country offices were informed by ODE about the evidence review and we subsequently requested available documents from them. The types of documents requested from the offices included APPRs, health sector reviews, in-country evaluations, policy papers, discussion documents, internal memoranda on the health program or correspondence held that might shed light on the evidence review.

The next task was to review a considerable amount of documentation in an attempt to identify the most relevant documents and the most salient issues. We used the five components of the evidence review as a proxy for relevance and usefulness. Issues that we looked for included:

1. Do documents describe how the Australian aid program has used the aid and financing instruments under review?
2. What specific evaluations, if at all, have been conducted in country? And how rigorous, relevant, useful do those evaluations look like? We used these questions as a proxy for 'quality of evaluation approaches', noting that all that we have done at this phase is to prioritise the key evaluations and reviews without discarding any of those. Judgements about the quality of the evaluations/reviews was undertaken in the next phase (the review of evidence).

3. Do Australian aid program evaluations, performance reports and reviews, if available, shed light on the effectiveness of the aid and financing instruments under review? At this early phase we assessed, as a marker for effectiveness, whether available documents discussed any or all of the following: the objectives and expected results of the sector program; the prevailing monitoring and evaluation arrangements; the approaches used by donors, governments and other stakeholders to align their priorities and financial resources behind the sector plans and to engage in policy dialogue; any other relevant issues that cannot be classified in the above categories including, for example, contextual factors that affected planning or implementation of the proposed aid and financing instruments.

4. We asked the same questions as in the paragraph above in relation to any other evaluations and reviews undertaken by other donors as well as those undertaken by any other parties including the government, civil society and NGOs and international agencies and organisations.

5. What are the main evaluations and reviews available from the international literature on the aid and financing instruments under review? This part of the review used informal exchanges among the researchers and with colleagues as well as internet searches.

Once country information was prioritised, the researchers carried out a more detailed reading of the documents and summarised the main areas/issues that those documents contained. During the evidence review phase the document summaries of the most relevant documents were developed into an annotated bibliography.

As an exception to the approach outlined above, no attempt was made during the documentation phase to summarise documents pertaining to evaluations, technical reviews, policy, technical or approach papers on the aid and financing instruments within the international health literature. We did use some of the main documents in order to inform the template for analysis. The main reason for not summarising the international literature at this stage - including the literature commissioned by or undertaken by the Australian aid program – is that we assumed that most of it could be relevant (since most of it is either peer reviewed or at least reviewed by commissioning agencies). Therefore, we went through the international literature in more depth during the second phase of the evidence review.

Appendix 3: Country evidence tables

A.3.1 Results focus

Table A1 Were results defined for the SWAp and for the Australian aid program?

Country	Were results defined for the SWAp? Were these defined specifically for the Australian aid program?
Bangladesh	Results were defined for both the SWAp as well as for the sector program being supported (in this case the HPNSDP) in the form of an M&E Results framework of indicators. In addition, the Australian aid program had its own objectives for the health sector support that were reported internally.
Cambodia	The objective of HSSP2 is to support the implementation of the Government's HSP2 to improve health outcomes through strengthening institutional capacity. Australia defined specific outcomes for its aid referred to as the Cambodia Delivering Better Health program with four outcomes: 1) Strengthening MoH health service delivery; 2) Improving health care financing; 3) Strengthening human resources; 4) Strengthening health system stewardship.[68]
Nepal	Results are clearly defined for the SWAp and reflected in an M&E framework of indicators. In addition, the Australian aid program has defined specific objectives and indicators for its aid: 1) Increase access to and utilization of quality essential health care services by women, poor and the marginalised communities. Indicators are: % of children immunized; % of deliveries attended by Skilled Birth Attendants; % of institutional deliveries; Number of skilled birth attendants trained; contraceptive prevalence rate (CPR); Coverage of Antenatal Care, iron folic acid and vitamin A. 2) Improving health systems to achieve universal coverage of the essential health care services. Indicators: % of districts facilities having no stock out of essential drugs for more than one month per year; % of budget executed. 3) Improved Annual Work plan and Budget consultation, with increased # of actions in Governance and Accountability Action Plan (GAAP) and GESI plan been budgeted and implemented
Papua New Guinea	Within the very many results defined in the health sector plan that ran up to 2011 the Australian aid program prioritised the following: 1) An increased percentage of children receiving triple antigen and measles vaccinations; 2) An increased percentage of deliveries being supervised by skilled staff; 3) Reduced malaria prevalence in high malaria endemic districts; 4) Reduced tuberculosis (TB) prevalence in high TB endemic districts.
Samoa	The SWAp is a program of work. The joint partnership agreement (JPA) includes two main objectives: To improve the effectiveness of Government of Samoa (GoS) in managing and implementing the health sector plan (HSP) using performance from sector performance monitoring; To improve access to and utilization of effective, efficient and quality health services to improve the health of the Samoan population. The Australian aid program helped define these objectives jointly with the GoS and other donors. It also defined objectives and indicators (some of which could not be measured annually, as intended) for its health aid to Samoa: Reduced prevalence of diabetes and cancers in Samoa by 2015; Number of children who are fully immunised in Samoa; Increased percentage of total health expenditure allocated for non-communicable disease prevention.[69]

[68] Department of Foreign Affairs and Trade, Aid Program Performance Report 2012–13: Cambodia, DFAT, Canberra, 2014.

[69] Cambodia Annual Program Performance Report 2011, AusAID, Canberra, 2012.

Solomon Islands	No explicit, measurable results were defined for the SWAp as such. the Australian aid program defined explicitly what it expected to achieve from its support to the health sector in its aid delivery plan 2012-16 and in the context of its partnership for development which includes six priority outcomes, the first of which refers to health (and education): Priority outcome one: improved service delivery – health - Objective: To strengthen public health functions that are responsive to community health needs and improve progress towards the MDG targets of 2015.[70] The 2013 Independent Performance Review of the Australian aid program to the Solomon Islands reports on the following indicators set for the Australian aid program: Increased percentage of population with access to a health facility staffed by a health care worker and stocked with appropriate medicines; Reduced malaria incidence and deaths and progress towards emanation in selected provinces; Increased access to water and basic sanitation; Reduced maternal and infant mortality.[71]

Table A2 Were results defined at the sector or program levels? Were results prioritised?

Country	Were expected results defined at program or sector levels? Were the results prioritised?
Bangladesh	Yes, results are defined at sector level in the Results Framework of indicators of the HPNSDP that are well aligned with the program objectives. Still there are many indicators and not all can be measured with the expected periodicity. Annual reviews differ in their assessment of prioritisation, which is considered fair but insufficient i.e. the framework of indicators is considered slightly overambitious.[72,73]
Cambodia	Performance is measured on the basis of indicators described in the HSP2 M&E Framework and the Results Framework laid out in the World Bank's Program Appraisal Document. Prioritisation is considered good.
Nepal	An M&E framework of indicators is an integral part of the NHSP II. It is reviewed every year in the context of the Joint Annual Reviews. The MTR team[74] considered the information feeding into the M&E framework that originates in the Health Management Information System (HMIS) and in the Logistics Management System to be quite reliable by international standards. WHO, Gavi and the Global Fund seem to endorse this view as they too use government systems to report on their portfolios.[75] Prioritisation is fair but could be further improved with fewer 'tracer' indicators.
Papua New Guinea	There were many results defined, but too many of them, poorly prioritised and not measured regularly.[76] It must be noted that this refers to the M&E Plan for 2001-2010. The 2011-2010 health plan prioritises 29 performance indicators (personal communication from Aedan Whyatt, DFAT).
Samoa	Yes, a framework of results and indicators were defined and regularly reviewed. However, Vaillancourt[77] notes; *Samoa has made important strides in developing some building blocks for a sector strategic framework, but the quality and relevance of this documentation fall short of what is essential for facilitating the Swap's goals of efficient resource use for better health outcomes… The Health Sector Plan (2008-2018) is very broad, and the numerous outputs and indicators under each of the six objectives are not clearly defined. It does not articulate a coherent results chain, appropriate indicators, established baselines and targets. This is clearly a work in progress, only two years into an ambitious undertaking (p14)* For these reasons prioritisation is considered weak.

[70] Department of Foreign Affairs and Trade. Aid Program Performance Report 2012-2013. Regional Assistance Mission Solomon Islands. Canberra, 2013.

[71] Independent Performance Assessment Panel, Solomon Islands-Australia Partnership for Development: assessment for 2012, AusAID, Canberra, 2013.

[72] Independent Review Team, Mid-term Review of the Health, Nutrition and Population Sector Programme (2003-2010): consolidated report, MoHFW, Dhaka, 2008

[73] Independent Review Team, Annual programme review (APR 2013): Health, Population and Nutrition Sector Development Program (HPNSDP), 2011-16. Consolidated report. MoHFW, Dhaka, 2013.

[74] Health & Education Advice and Resource Team, Nepal Health Sector Programme II (NHSP II): mid-term review, HEART, 2013

[75] Australian Agency for International Development, Nepal development cooperation report 2010, AusAID, Canberra, 2011.

[76] K Janovsky, *The PNG SWAp review: streamlining and strengthening mechanisms for sector coordination and policy dialogue*, 2010.

[77] D Vaillancourt*, In sweet harmony? A review of health and education sectorwide approaches in the South Pacific, Appendix 2: Samoa Health SWAp,* World Bank, Washington DC, 2012.

Solomon Islands	The National Health Plan had many ambitious indicators at health outcome and service output levels but failed to describe whether or how these would be regularly measured. The absence of a shared set of common indicators to track sector performance and the failure to produce national health data over the past two years means that neither Ministry of Health and Medical Services (MHMS) nor its development partners are able to account for results to their respective government and governing bodies. *The Ministry is not managing effectively to deliver results, but instead appears often to manage by crisis*.[78] Prioritisation is considered weak.

Table A3 Did the SWAp increase the focus on results?

Country	**Did the SWAp or financing instruments increase the focus on results, generally and for the Australian aid program in particular?**
Bangladesh	There is considerable evidence that the SWAp has over the years increased the focus on results by the government of Bangladesh, its development partners and for the Australian aid program in particular. On the other hand it has been problematic to track those results due to a number of technical, resource and capacity issues. For example, some indicators are hard or expensive to measure and it is not always clear who in the government is expected to measure these. Expectations from development partners have often pushed towards an unrealistic number of results.
Cambodia	Cambodia's Sector-wide Management (SWiM) approach has increased focus on results, and progress on this is evident as there are independent reviews and annual program reviews where progress on indicators is routinely reported.
Nepal	Yes, focus on results has improved as a result of the SWAp for both the Government of Nepal (GoN), development partners, including for Australia. This is clearly reflected in both internal performance reports from AusAID (2011, 2012) as well as in joint annual review (JAR) and MTR reports of the NHSP II.
Papua New Guinea	Focus on results increased to some extent, but with many limitations: poor accountability for results in spite of regular joint reviews.
Samoa	*It seems safe to conclude that there was an increased focus on sector level results linked to the SWAp, its main financial instrument (pool fund) and the operational documents and products that were developed as part of the SWAp, including the M&E framework, the medium term expenditure framework, the aide memoirs from review missions, etc. However, the Health Sector Plan supported by the SWAp suffered from limitations in terms of results focus and measurability of those results.*[79]
Solomon Islands	There was increased focus on results but insufficient work undertaken in the initial stages of the SWAp to prioritise among the very many indicators included in the health sector plan or for SWAp partners to define a set of performance indicators. These gaps reduced greatly the expected focus on results of the health SWAp in the initial years covered in this evidence review.

[78] Tyson, *Solomon Islands Health Sector Wide Approach: progress review 2008-2011*, AusAID Health Resource Facility, Canberra, 2011.

[79] Davies, 2013.

Table A4 What results were defined and reported in the SWAp at sector or program level?

Country	What results have been reported?
Bangladesh	At program level the expected results are provided within four main thematic areas: Maternal, neonatal and child health (MNCH); 2. Family planning; and, Nutrition.3. SWAp Financing and Financial Management; 4. Human resources for health (HRH). Indicators were defined for all these, reported in the APRs. The country has been praised in a number of international publications (including *The Lancet*) for its performance in the health Millennium Development Goals (MDGs) and for its track record in reaching (or surpassing) health outcomes and service delivery targets (it is not possible to include these here). Sector results are available and reported on annually. The 2013 Annual Program Review (APR) summarises them as follows: › Maternal, neonatal and child health, family planning and nutrition: the majority of the ten operational plans for these areas are judged to be on track to achieving their objectives. › SWAp financing and financial management: significant progress in sector financing, including the provision of robust operational plan oversight and organisation of inter-operational plan fund reallocations, improving efficiency in the use of available resources. Progress in preparing and approving a health financing strategy, and increasing equity and improving efficiency in the use of resources. Work on National Health Accounts has begun. › Planning, monitoring and evaluation: sufficient progress. › HRH: progress in key areas, e.g. the production of community safe birth attendants and training of midwives, recruitment of nurses, provision of in-service training, and improving quality assurance system. However many HRH challenges remain. Five Operational Plans heavily involved in HRH progressing well, most are on track to achieve mid-2014 targets.
Cambodia	There are three Program Areas and five Strategic Priorities defined for HSP2. The Program Areas are: MNCH and Nutrition; Communicable Diseases; and NCDs. The five strategic priorities are: Health Care Financing; Human Resource Management and Development; Health Service Delivery; Health Information Systems; Governance and Aid Effectiveness. Specific priorities and indicators are clearly stated in HSP2 and reported in the annual reviews, although not independently verified annually – only in the MTR. The reported results can be found in the 2011 MTR. In short: the country is well on course to meet most of its health related MDGs and National Strategic Development Plan indicators (with the exceptions of malaria and nutrition). The reproductive, maternal, neonatal, and child health program area is on track with substantial progress in the previous five years in reducing maternal, under-5 and infant mortality, but less noticeable progress in neonatal mortality and malnutrition of women and children. Cambodia is experiencing a fast epidemiological transition characterised by an increase in the prevalence of non-communicable diseases (NCDs): progress to define, finance and implement the NCD program area has been slow and financing largely insufficient.
Nepal	The objective of the NHSP II is to increase people's access to and utilization of quality essential health care services (EHCS). The EHCS is the priority program of the sector and includes maternal and child health programs. Indicators are defined and reported about annually, and externally verified at least every two years. Despite political instability the Nepal health sector is on track to meet its MDG 4 and 5 targets. Progress in 2011/12 was mixed with achievements recorded mainly in maternal health and immunization. Nepal maintained its good performance on most health indicators. The immunization coverage for basic essential vaccines among children 12-23 months was recorded as 86.6%, above the 85% target. Vitamin A supplementation coverage for children 6-59 months was maintained above the 90% target. Progress was also recorded against maternal health related indicators. Despite overall good progress, the sector faces four major challenges: i) significant disparities in service availability and utilisation across gender, caste, ethnicity and geographic locations. ii) some vital indicators (e.g. infant mortality rate and neonatal mortality rate) have plateaued. The contraceptive prevalence rate has gone down and the unmet need for family planning remains high at 27% (with unmet need among adolescents at 41.5% and youths at 37%). iii) valid concerns are being raised over the quality of services, even though the Service Tracking Survey 2012 inferred 91% clients were satisfied with services at public health facilities. iv) most importantly, the sector faces governance challenges, contributed and compounded by political instability.[80]

[80] AusAID 2012 (Quality at Implementation Report); a more thorough review and analysis is available in Health & Education Advice and Resource Team, *Nepal Health Sector Programme II (NHSP II): mid-term review*, HEART, 2013.

Papua New Guinea	*"The development of a PNG health delivery strategy in 2011 will identify intermediate development outcomes to enable a clearer line-of-sight between Australia's contribution and tangible changes in health sector performance.*[81] The 2011-2015 PNG Health Delivery Strategy clearly defines outcome areas and performance measures in the M&E Framework (personal communication from Aedan Whyatt, DFAT). Poor health outcomes remain static, resulting from a dysfunctional, chronically under-resourced health system, and exacerbated by cultural norms and geographical isolation. Despite increases in outreach clinics and medical officer visits in most provinces, maternal and child health targets are off track. Supervised deliveries did not increase from 40%, and referral rates for emergency obstetric care remain very low at an average of 4%. Progress in immunization is mixed. The proportion of children under one receiving three doses of pentavalent vaccine increased from 66 to 70%, but those receiving the measles vaccine declined from 67 to 58%. Coverage for pentavalent vaccine is well below 2006 levels (88%), and coverage for measles vaccine for the past five years remains constant. Performance against malaria and tuberculosis targets is more positive.[82] Please note that this information dates from 2010.
Samoa	The results expected from the HSP were defined in terms of health outcomes, health service outputs and intermediate results, and in the form of indicators in the M&E framework. Vaillancourt[83] argues that the feasibility of implementing the HSP in light of human and financial resources available to the sector was not fully assessed, nor did the Plan provide any indication of priorities and phasing to accommodate any such constraints. Davies[84] concludes (pages 12 and 14) that 'the SWAp appears to have fallen short of expectations in a number of program outcome areas. Examples include: Slow progress with the three capital work projects – pharmaceutical and medical supplies warehouse, orthotics and prosthetic facility, and primary care centre; Failure to develop and implement a comprehensive health information system, which has had 'knock-on' adverse impacts on the quality of sector activity data for M&E purposes; Delays in establishing improved cervical and breast cancer screening programs. Davies[85] concludes that it is not possible to look at how many of the results changed over time due to poor baselines and inconsistent reporting. He reports that 'there are some health outcome data which relate in broad terms both to the objectives of the SWAp and to the period in which it has operated. Those data, though few in number, point to mixed results' as follows: • Infant mortality rate: falling from 20.4 per 1,000 live births in 2006 to 15.6 in 2011. • Birth rate among women aged 15-19: increasing from 28.6 per 1,000 in 2006 to 38.1 live births in 2011. • Under-5s presenting to TTM and MTII Hospitals with diarrhoea and gastroenteritis: rising from 1,962 in 2008, to 2,157 in 2009, and 2,280 in 2010. • Reported coverage of Diphtheria – Pertussis - tetanus III: almost doubling between 2008 (46%) and 2010 (87%) • No reliable national data on changes in NCD prevalence over the life of the SWAp.

[81] Australian Agency for International Development, Health sector annual performance report 2010, AusAID, Canberra, 2011.

[82] Australian Agency for International Development, *Health sector annual performance report 2010*, AusAID, Canberra, 2011, p 1-2.

[83] Vaillancourt, 2012, Appendix 3.

[84] Davies, 2013.

[85] Davies, 2013.

Solomon Islands	MHMS has articulated ambitious policies in the NHSP including a set of health outcome and service output indicators. However, Tyson[86] and Vaillancourt[87] report the lack of effective systems in place to absorb, distribute and account for development assistance or to measure most of the expected results mentioned in the plan. Little evidence of increased coverage since 2008 (with exception of malaria, hepatitis B and measles vaccination) although pre-SWAp levels in other areas may have been maintained. Little improvement in longstanding high levels of unmet need for family planning. Response to the mounting NCD burden is at an early stage. Falling diarrhoea rates in under-5s. There have been substantial efforts to strengthen critical elements of the health system with varying effects in building capacity and improving business processes, and most progress in planning, finance and least in health information systems.[88] Well-funded targeted programs such as reproductive and child health appear to have maintained the high levels of coverage documented in the 2007 Demographic Health Survey. There have been steady falls in diarrhoea in children, but little effort in improving hygiene and sanitation. There is no evidence of reductions in the high unmet need for family planning or of increases in TB case detection. The HIV/sexually transmitted disease program is slowly rolling out services to prevent mother to child transmission. There is little HIV prevalence data, but concern over the steady increase in sexually transmitted infection rates. The mounting burden of NCDs is the major health problem facing the country, but the program does not attract funding commensurate the disease burden, and the response is at an early stage.[89] According to the 2013 Independent Performance Review of the Australian aid program, health systems have slowly been strengthened and recurrent budgets to provincial services increased. As a result of the partnership 'promising indications of progress towards sustained health outcomes are emerging.'[90]

[86] Tyson, 2011.

[87] Vaillancourt, 2012 , Appendix 3..

[88] Tyson, 2011.

[89] Tyson, 2011.

[90] Department of Foreign Affairs and Trade. *Aid Program Performance Report 2012-2013. Regional Assistance Mission Solomon Islands*. Canberra, DFAT, 2013.

A.3.2 Monitoring and evaluation

Table A5 The components of the M&E plan: was there an M&E framework?

Country	What were the main components of the M&E plan or strategy? Was there a monitoring framework of indicators?
Bangladesh	There is a clear M&E strategy comprising APR, MTR, APR forum. HMIS and surveys are the main information sources. There is an M&E framework linked to the main expected results that is measured annually where indicators allow for this.
Cambodia	HSP2 includes annual program reviews and a mid-term review along the three Program Areas and Five Strategic Priorities. The HMIS is the main information source and is complemented by other surveys (DHS, Multiple Indicator Cluster Survey (MICS)). M&E indicators are defined and a program of work exists for each of these program areas and strategic priorities
Nepal	The M&E plan is an integral part of the sector program (NHSP II) and includes a framework of indicators. In addition, Joint Annual Reviews (JAR) and MTR are held regularly. The HIMS and Logistic Management Information System are complemented by other studies (commissioned as per the recommendations of JAR or through policy dialogue) and periodic surveys (DHS, MICS, Health Facility Survey, among others).
Papua New Guinea	Joint review missions were to take place twice a year. The Plan includes a series of indicators (not strictly speaking a results framework) that have been seldom reviewed or reported about.
Samoa	There were annual reviews and a framework of M&E indicators defined as part of the SWAp. Annual programs of work (PoW) are defined although criteria for prioritisation were not defined in many cases this resulting in an unclear sense of whether the PoW addressed the most important issues or simply responded to contextual changes.[91]
Solomon Islands	A joint (MHMS/development partner- DP) coordination and review mechanism between partners is established, with meetings timed around key dates in the Solomon Islands Government planning and budgeting cycle.[92] There is not a commonly accepted set of indicators to monitor sector performance on a yearly basis. Multiple indicators are detailed in NHSP and Program documents but with inadequate attention to whether data can be generated without resorting to special surveys. [93]

Table A6 Regularity of M&E processes and their perceived effectiveness

Country	Were the M&E processes undertaken periodically, as expected? Were these described in the literature as effective?
Bangladesh	Annual reviews are conducted periodically and on time. They are perceived as being effective by both government and donors. The quality of these reviews has improved year on year. [94]
Cambodia	Review processes are undertaken yearly, as planned, and are considered to be robust, although they do not involve independent annual reviews, which has led to certain areas receiving less scrutiny than they might have, including procurement of certain commodities which is far from transparent. [95]
Nepal	M&E arrangements are described as inclusive, open and robust in the available literature. It is also reported that the information systems used for M&E of indicators are quite reliable: *The HMIS, and Logistic*

[91] Davies, 2013 (p.12).

[92] Tyson, 2011.

[93] Tyson, 2011.

[94] Independent Review Team, 2013.

[95] J Martinez, S Simmonds, L Vinyals, Som Hun, Chhun Phally, Por Ir, *Overall assessment for Mid Term Review of Health Strategic Plan 2008-15,* HLSP, London, 2011.

	Management Information System, remain the main sources of information. These are generated and updated regularly at the local level, and are generally considered robust, reliable and consistent.[96] *The Global Fund takes the data generated by HMIS as a basis, and WHO also confirms its reliability.*[97]
Papua New Guinea	A total of six review missions have been undertaken - one in 2006, two in 2007, two in 2008, one in 2009 when it was agreed that visits should be reduced to just one per year. The results of the missions were informative but bulky reports of varying quality, an increasingly large number of recommendations and, regrettably, an ever growing backlog of proposals which have not been effectively implemented or even taken on board.[98]
Samoa	The main evaluations[99,100] and reviews[101] converge on the fact that many indicators were not regularly measured due to technical, resource and capacity reasons. *'Weaknesses in the SWAp M&E framework have inhibited assessment of both program outcomes and SWAp processes… Specification of performance measures was inconsistent and availability of baseline data was, at best, patchy.*[102]
Solomon Islands	The Solomon Islands Health SWAp timeline (Appendix 1) indicates fairly regular reviews: two in 2009 and three in 2010. Other than the four development partners who signed the JPA, it is not clear to what extent these meetings invited/included civil society/NGOs/FBOs and other development partners who have not signed the JPA.[103] The national health information system has produced little data over the past two years. Progress is gauged from a number of parallel issue/disease specific information systems. Neither MHMS nor its development partners are able to account adequately for results to their respective governments. The lack of a structured management process to monitor recommendations of the Joint Annual Program Reviews (JAPR) limits its effectiveness.[104]

Table A7 Did the health SWAp improve M&E at sector or program levels?

Country	Did the SWAp improve M&E of the sector or program?
Bangladesh	According to most authors of independent reviews[105,106] the SWAp has undeniably improved M&E processes and capabilities. Much of the policy dialogue is triggered by these reviews.
Cambodia	The MTRs of 2006 and 2011[107] converge on the conclusion that the SWiM has clearly developed a culture of results and the processes developed are undertaken regularly and effectively. However, the MTR 2011[108] and Vaillancourt[109] coincide that the M&E process could have a stronger, clearer strategic focus.

[96] HEART, 2013.

[97] AusAID, 2011.

[98] Janovsky, 2010a.

[99] Vaillancourt, 2012.

[100] Davies, 2013.

[101] Negin, 2010.

[102] Davies, 2013; p. 27.

[103] Vaillancourt, 2012, Appendix 3.

[104] Tyson, 2011.

[105] MoHFW, 2012.

[106] MoHFW, 2008.

[107] J Martinez et al, *Overall assessment for Mid Term Review of Health Strategic Plan 2008-15,* HLSP, London, 2011.

[108] Martinez et al, 2011.

[109] D Vaillancourt, A Land & D Shuey, Aid effectiveness in Cambodia's health sector: an assessment of the sector-wide management (SWiM) approach and its effect on sector performance and outcomes, 2011 (Draft).

Nepal	Clearly yes. AusAID reports internally how important regular M&E has been during periods of crisis and political instability[110,111] to enable dialogue and progress reporting. Vaillancourt's report reaches a similar conclusion: *In 2004 the MoHP signed a "Statement of Intent to Guide the Partnership for Health Sector Development in Nepal," co-signed by 12 external development partners (EDPs). Thus, one year before the Paris Declaration was adopted, Nepal and its EDPs had already articulated and launched the implementation of principles and implementation mechanisms for developing and nurturing partnerships for improved health sector aid effectiveness.* [112]
Papua New Guinea	There was some improvement in M&E, but far from the initial expectations. An exercise to track all the recommendations from review missions undertaken in 2009 confirmed that national department of health (NDOH) and development partners found it difficult to cope with the volume of recommendations, and that action lagged far behind.
Samoa	Yes, M&E has improved. However, the indicators from the M&E framework are portrayed in the evaluations[113] as overambitious (31 outputs and 142 indicators were included in the health sector plan). The SWAp process worked with the GoS to reduce the number of indicators to 61 at the time of the Project Appraisal Document (2008) and then to 25 included in the annual reviews from 2009 onwards.
Solomon Islands	M&E has improved as a result of the SWAp although the effectiveness of these reviews was in question due to weak management processes to prioritise among recommendations or to turn these into specific actions.[114] There is not more recent information to report on the SWAp in the Solomon Islands as health is not included in the pillars for the *Regional Assistance Mission to Solomon Islands* transition.[115]

A.3.3 Joint work and policy dialogue

Table A8 Did SWAps improve joint work and policy dialogue?

Country	Did SWAps improve joint work?	Did the SWAp increase and strengthen policy dialogue?
Bangladesh	The Bangladesh SWAp is a large and complex endeavour where joint work is challenging. The APR 2013[116] reports considerable progress in joint work and policy dialogue, particularly around the time of the APR but also in monthly management meetings involving the Ministry of Health and Family Welfare (MOHFW) and representatives of the health DPs. Health DPs also meet and discuss regularly, at least once in a month.	Without a doubt it has strengthened policy dialogue, particularly in comparison with the pre-SWAp era. Policy dialogue has also improved year on year, benefitting from the insights of the independent review teams during the APR.[117]
Cambodia	Joint work among development partners and between these and government improved as a result of the SWiM. Cambodia was coming out of a long civil war that seriously undermined institutional capacity in health as in other sectors. Donors, including Australia, were responsive to	While policy dialogue does take place this is not as open, transparent, regular and focused on key issues as could be. *Partnership structures and processes are necessary but insufficient conditions for productive and respectful sector dialogue. Also critical are mutual trust and an*

[110] AusAID, 2011.

[111] AusAID, 2012.

[112] Vaillancourt & Pokhrel, 2012.

[113] Vaillancourt, 2012 (Appendix 3); Davies, 2013.

[114] Vaillancourt, 2012 (Appendix 3); Tyson, 2011.

[115] DFAT, 2013.

[116] MoHFW, 201.3

[117] MoHFW, 2008; MoHFW, 2012; MoHFW, 2013.

	that context.	*appreciation of the difference between policy decisions (which are the sovereign mandate of Royal Government of Cambodia) and policy dialogue (which is a vehicle for Health Partners to provide evidence-based advice and input to the policy process). Protocols for clear, candid communication also matter.*[118]
Nepal	Joint work is a regular, salient feature of the Nepal health SWAp. Donor coordination and MoHP-Donor engagement improved, and was helped by the pooled fund arrangements. *The Annual Work Plan and Budget (AWPB) consultation process improved through the Joint Consultative Meeting and for the first time in NHSP II, donors and government prepared a note for records outlining the agreements reached in finalizing the AWPB, which included the submission of a consolidated procurement plan. Government has adopted results oriented budgeting, and resources were allocated for priorities like GESI.*[119]	There is considerable evidence that the extent and quality of policy dialogue have improved over time and have been maintained even in the worst episodes of political instability[120], It is also reported by the Australian aid program that. *EDPs and MoHP are working closely together, and having ongoing discussions with the National Planning Commission and Ministry of Finance to find ways to address the budget crisis. This dialogue led to an increase in the health allocation and is expected to increase further should the MoHP be able to absorb this allocation.*[121]
Papua New Guinea	*Difficult relations and inadequate dialogue with central agencies are long standing concerns to be addressed within this Review. It is clear, however, that these problems are not a function of the existing committee structure. Rather, the evolution of the HSIP over time, its inflexible nature and its governance arrangements, have been at the heart of poor relations*.[122] Subsequent reviews further report *weak and poorly functioning mechanisms for sector coordination and policy dialogue with central agencies and development partners, inadequate sector-wide accountability and monitoring.*[123]	The problems faced by both government and donors to make the HSIP work as expected and the existence of committees and structures linked to the HSIP contributed to joint work for resolving standing issues in terms of financing and resource allocation to the provinces. In this sense the SWAp contributed to strengthen policy dialogue in ways that might not have been possible otherwise. Government and donors also worked jointly in the design pf the new health sector plan 2011-2020 during 2010.[124]
Samoa	*DP coordination and interaction, among the three poolers themselves, is working and improving through a learning-by-doing process. It is, however, not clear to what extent DPs bring the right skills and capacities to support government in the SWAp process and to carry out a sufficiently rigorous, technical dialogue-individually and collectively. This might be further analysed through fieldwork…*[125]	Yes, policy dialogue improved and was strengthened as part of the SWAp. However Vaillancourt,[126] argues that '*the focus of DPs' dialogue and scrutiny at the level of input quantities and activity details is thought to be inappropriate by both DPs and GoS. There is consensus that level of detail is best left to implementing agencies and government systems, and that DPs would do best to focus on policy/strategic issues*. (p19)
Solomon Islands	There is an established joint governance process around three annual meetings timed around key stages in the Solomon Islands Government budget cycle. The meetings include an external review (the JAPR) of prior year performance including finance and procurement	Yes, to some extent, although far from what might be necessary to manage for results. The failure to manage and monitor implementation of past recommendations has limited the effectiveness of the JAPR in managing change.[128]

[118] Vaillancourt, 2011; p.22.

[119] AusAID, 2012.

[120] Vaillancourt & Pokhrel, 2012.

[121] AusAID, 2012.

[122] Janovsky, 2010a.

[123] Janovsky, 2010b.

[124] Janovsky 2010a and 2010b.

[125] Vaillancourt, 2012, Appendix 3 p.20.

[126] Vaillancourt, 2012, Appendix 3 p.20.

	Audits. Transaction costs are high for MHMS, in part due to need to bring weak systems up to acceptable standard to absorb and account for resources.[127]		

Table A9 Extent and quality of government leadership, ownership and accountability

Country	What were the extent and quality of ownership and leadership?	Was there mutual accountability for results?	Did the SWAp strengthen government ownership and leadership?
Bangladesh	Ownership and leadership by the government has suffered from ups and downs over the years given the size and complexity of the health sector, the large number of development partners and the fragmentation of some government health structures (one Secretariat, two directorates –family planning and health services- , 30+ line directors, etc.). In spite of these complexities the government has led the sector and owned the health sector program and the objectives of the SWAp.	Accountability was weaker in the initial sector program and has been increasing steadily in recent years through increased focus on results and strengthened review mechanisms. The Independent Review Teams who performed the APRs in 2006, 2007 and 2008 highlighted that the focus of accountability for decisions made was often expected from the government and less so from the development partners, some of whom failed to abide by their pledges and continued to work in their own ways[129]	The health SWAp has clearly strengthened government ownership and leadership, even if these are categories where improvement is always possible.
Cambodia	Leadership and ownership of the HSP2 and HSSP2 by the Government of Cambodia are often reported as being very high.[130]	There is mutual accountability for results (demonstrated, at least, every year) although accountability does not extend to all the areas where additional information would help better align resources to sector priorities, including procurement of drugs and other commodities.	Yes: the MTR of 2001[131] and the health sector review of 2007[132] reported that the SWiM has greatly contributed to increasing government leadership and ownership of the health sector plan.
Nepal	Ownership of the health sector plan by the government is described as very high and increasing in recent years.[133,134] AusAID also states that '*the capacity of the health system has generally improved…with constant assistance from Development Partners, the MoHP is generally able to understand / identify risks and manage them. The MoHP is undertaking a comprehensive organisation and management*	There is considerable accountability for results facilitated by thorough Joint Annual Reviews as regular engagement between senior staff of the MoHP and representatives from development partners.	Clearly yes – there is considerable evidence supporting this view and emphasising how important this was at the time of political instability and crisis. "*The number of donors working in a unified way through donor pools has so far, proven to be effective in Nepal. Donors operating in the country are noted for their commitment to working in a highly coordinated fashion and in ways that build government systems and*

[128] Tyson, 2011.

[127] Tyson, 2011.

[129] MoHFW, 2007, Martinez, 2008.

[130] Martinez et al, 2011.

[131] Martinez et al, 2011.

[132] C Örtendahl, M Donoghue, M Pearson, J Lau, *Health Sector Review 2003-2007*, HLSP London August 2007.

[133] Vaillancourt & Pokhrel, 2012.

[134] Department for International Development, Annual review of DFID support to the National Health Sector Programme II, Nepal, DFID, London, 2014.

	assessment, and important reforms have been initiated…[135]		*capacity"… "It is important that we continue to support this asset through whatever transitions the Nepalese state moves through in the next few years."* [136]
Papua New Guinea	There was very limited ownership by the government of the HSIP and related SWAp. This resulted in many tensions between government and donors. Ownership is consistently reported as weak in most reviews. For example, the Duesbury Nexia HSIP Trust Account Financial Transaction Audit and Process Review (2011) commissioned by AusAID found insufficient staff capacity and a lack of ownership by NDOH to drive the necessary changes.	There was not accountability for results. The annual review missions delivered a large number of poorly prioritised recommendations that neither government nor donors were accountable for or implemented and the HSIP was perceived as a rigid planning, M&E and financing arrangement by both government and donors.	It was not a real SWAp. The government did not feel ownership of it, The situation probably changed during 2011 and 2012 when the government drafted a new plan and donors supported it and developed more aligned and harmonised health financing arrangements. More recent reports (such as the Health Sector Partnership Committee review) point to efforts to improve government ownership and leadership, with mixed results.
Samoa	*The MoH appears to have approached the task of managing the SWAp with energy and enthusiasm. The ability to consolidate interactions with DPs into a single process as opposed to a series of discrete bilateral engagements has supported more efficient and consistent dialogue. The SWAp modality has supported a move away from opportunistic and potentially competitive bidding among (or within) health sector agencies.*[137]	Accountability for performance was weak - both government and donors are reported to have moved away or not delivered on commitments made over time.[138] *It is always a challenge to achieve a balanced dialogue, one that is rigorous and candid on the one hand, and also respectful of government leadership and sovereignty, on the other…*[139]	*The GoS has assumed very strong leadership and ownership of the SWAp and has a strong sense of how they want the SWAp to unfold.*[140] Joint work by partners intensified and improved during and as a result of the SWAp if the situation is compared with the pre-SWAp project era.[141]
Solomon Islands	MHMS leadership is reflected in documentation but it is difficult to see how leadership, strategic oversight and accountability for delivery are assured. The Executive Team meets infrequently, does not monitor progress systematically and therefore fails to address key agendas. Senior managers are thinly spread with many competing demands on their time.[142]	Accountability is weak due to poor definition of results at either SWAp or sector levels and due to capacity problems at the level of the executive. Limited evidence of effective approaches to define and track accountability for performance.[143]	Yes to some extent, although it continues to fail on monitoring progress systematically.

A.3.4 Alignment

[135] AusAID, 2012.

[136] AusAID, 2011.

[137] P Davies, 2013 p. 19.

[138] Davies, 2013.

[139] Vaillancourt 2012, Annex 2, p 20.

[140] Vaillancourt 2012, Annex 2, p 20.

[141] Vaillancourt 2012, Annex 2, p 19.

[142] Tyson, 2011.

[143] Tyson, 2011.

Table A10 Alignment with government planning and budget systems

Country	What was the extent of alignment with government planning and budget systems by Australia and the main donors?
Bangladesh	The alignment with the government plans and budget is very high among the health SWAp donors and particularly among the pooled funders. At the same time annual reviews have drawn attention to the risk of parallel activity by certain donors that is not necessary aligned with government policy.
Cambodia	Alignment of the Australian aid program and that provided by other health donors to the government plan has improved but is considered insufficient in the MTR 2011.[144] Vaillancourt[145] reports that it is unlikely that sector resources and expenditures will be effectively aligned with national priorities in the absence of (a) the full costs of a medium-term implementation plan; (2) medium-term projections of all sector resources; and (3) a reconciliation of the two. Other factors that impede the efficient allocation and use of sector resources at all levels of MoH include the excessive earmarking of development partner funds and the proliferation of various pilot initiatives with no process for sector-wide evaluation or evidence-based decision-making.
Nepal	Alignment of the Australian aid program and that provided by other health donors who are signatories of the joint financial agreement (JFA) is reported as very high. The JFA was signed in 2010 between the GoN and the pool funding donors, although some non-pooling donors have also signed to the JFA. Non-pooling donors such as United States Agency for International Development, UNFPA, UNICEF and WHO are also signatories to the JFA and work through the SWAp by channelling funds outside of the pooling arrangement. India and China are also important actors investing in Nepal's health sector. Their contributions are especially on infrastructure and targeted projects outside of the Health SWAp. In its effort to streamline the program, AusAID Nepal is gradually closing all its parallel health projects outside of the pool, which were set up to complement implementation of the sector program.
Papua New Guinea	In Papua New Guinea 80% of all development assistance comes from one single partner, Australia, and contrary to what might be expected, this aid has so far been supplied in a rather fragmented manner.[146] Health sector financing and planning has been facing numerous challenges over the last decade: donor funds managed outside the government systems through parallel structures and not fully coordinated with the national plan; provincial and local plans not necessarily reflecting national policy; required resources not reaching health service delivery facilities.[147] The situation described dates from 2010 – Australia's current health program seems to be far more targeted according to DFAT sources.
Samoa	Alignment with sector policy is quite high but external aid has been quite fragmented and has failed to adopt a whole of sector view. There is limited prioritisation within the plan which makes alignment of external resources problematic.
Solomon Islands	Little evidence of efforts to coordinate to support joint approaches, reduce duplication and simplify procedures. Numerous uncoordinated regional health mechanisms are a substantial drain on senior MHMS staff time. There has been limited progress on harmonization of donor activities.[148]

Table A11 Alignment of external financing with the priorities of the plan and MTEF

[144] Martinez et al, 2011.

[145] Vaillancourt, Land & Shuey, 2011.

[146] Janovsky 2010a.

[147] Janovsky 2010b.

[148] Tyson, 2011.

Country	What was the extent of alignment of external financing with the priorities of the plan? Was a medium term expenditure framework (MTEF) in place and was it used?
Bangladesh	The HPNSDP supports a number of operational plans that are co funded between the government and the pooled funders. In this sense the alignment is complete. There is an MTEF in place but it is not widely used as government investments outside the sector program are not fully known. There are National Health Accounts in place.
Cambodia	Alignment with the priorities of the plan is high but much more limited in terms of external financing. The MTR 2011[149] reports, for example, that more Health Partners' funds have been channelled through government planning mechanisms like the Annual Operation Plan, and have even been pooled. However, many sources of external funding remain vertical and impose multiple funding and reporting requirements, thereby increasing the administrative burden.
Nepal	There is an MTEF in place. Since the NHSP II includes a series of priorities and indicators for each of its main programmatic areas it can be considered that the funding provided by Australia and other donors through the pool fund is fully aligned with government priorities.
Papua New Guinea	Despite stated intentions, HSIP did not move on from what has essentially been a parallel system supported by a separate project management unit. Most funds were project-specific and earmarked. So, not a SWAp as usually understood.[150] Please note that this information dates from 2010 and may not apply to the current context according to DFAT sources.
Samoa	*From the outset DPs have encouraged the development of a PoW that includes activities and investments from other sources (including GoS revenues) in order to have a comprehensive overview of progress towards the HSP objectives... However, successive PoW have failed fully to adopt a whole-of-sector view, and have tended to focus more or less exclusively on SWAp funded initiatives.*[151] Davies[152] points to inconsistent reporting among donors and GoS to assess SWAp and budget alignment with the MTEF. Expenditure was monitored and reported in the aide memoires.
Solomon Islands	The Plan is linked to annual operational plans for cost centres. All significant funding is aligned with the National Plan but not to national systems. The Plan is not costed but based on available resources. The MTEF sets a multi-year resource framework based on indicative resources, but indicates a mismatch between the policy priorities of NHSP and available resources to 2015.[153]

[149] Martinez et al, 2011.

[150] Janovsky, 2010a.

[151] Davies, 2013, p.24.

[152] Davies, 2013, p.24.

[153] Tyson, 2011.

A.3.5 Financing

Table A12 Did health financing and/or expenditure become more predictable?

Country	Did health financing and/or expenditure become more predictable?
Bangladesh	The MoHFW has prepared and approved a health financing strategy that aims to increase financial resource to the sector as well as increasing equity and improving efficiency in the use of resources. Health expenditure and its sources have become more predictable. In Financial Year 2012/13, pool funds and Japan International Cooperation Agency loan accounted for 82% of External Aid spending reported by Line Directors. The remaining 18% of DP funding was provided for HPNSDP through parallel funds. The majority of DP funding is therefore on plan and on budget.[154]
Cambodia	Health expenditure has become more predictable than it was but predictability could improve considerably through more effective, efficient and transparent processes for budgeting and for expenditure tracking and reporting. For example, government spending on health has increased in recent years, keeping a relatively high (12%) level within total public expenditure. The impact of this increase on results remains unclear as monitoring efficiency of public spending is conditioned by the limited capacity of tracking policy objectives, activities and funds. Coverage by demand-side social health protection mechanisms has increased considerably which has also enhanced predictability of funding.[155]
Nepal	Health expenditure has remained quite predictable, which some analysts from the MTR attribute to the existence of an MTR, the availability of National Health Accounts, the availability of the pool fund and improved monitoring or expenditure and financing by the government.[156] The recently released tentative budget ceiling for MoHP by the National Planning Commission for the next three fiscal years (Financial Year 2013/14 to 2015/16) also indicate an increasing trend in the share and volume of Government allocation and a decreasing share of EDPs funding to the sector. While such a trend is positive and reflects Government's commitment and ownership of the program, it will take a decade or two before financial sustainability can be achieved. With other emerging needs (already discussed), the sector will be in constant pressure to mobilise more resources.
Papua New Guinea	Through the HSIP pooled fund, Australia and other donor support accounted for approximately 36% of all provincial recurrent health spending in 2009. While the pooled fund somewhat improved predictability of funding it did not do so to the extent required, in part due to the rigid nature of the HSIP trust fund arrangements.
Samoa	The picture on health expenditure is mixed and hard to interpret, as follows: • The GoS health spending remained more or less constant during the period at about Samoan Tala (SAT)$70 million. • Contributions from donors (pool funders) increased very markedly between 2009-2011 (from SAT$15 million to SAT$78 million) and then decreased in 2012 and 2013 to SAT$ 65 and SAT$35 million, respectively. • When both GoS and donor spending are put together the picture shows an uneven pattern of SAT$ 83 million in 2009 increasing up to SAT$ 148 million in 2011 to then decrease again to SAT$103 million by 2013. • In terms of total health expenditure (that includes other sources of funding, not just GoS and pool funders) the combined funding by GoS and pool funders represented, approximately, 43% in 2009, 65% in in 2010, 73% in 2011, 68% in 2012 and 52% in 2013. All these values are approximate and taken from Figure 3 in Davies report.[157]
Solomon Islands	Weak linkage between the budget and expenditure across government. The Ministry considers that the DPs have pushed too hard for quick results; is concerned by continuing high demands on senior staff; on slow progress in supporting and working through national systems and in making external funding more transparent

[154] MoHFW, 2013.

[155] Martinez et al, 2011.

[156] HEART, 2013.

[157] Davies, 2013.

	and predictable. They view some DPs, as having committed to a new approach, but carrying on business as usual.[158]

Table A13 Did health financing or expenditure support incrementally the defined sector priorities?

Country	Did health expenditure support incrementally the defined sector priorities?
Bangladesh	Yes, both government and donor health spending have become increasingly aligned with sector priorities. In the case of the pooled funds the entire amount supports the priorities by the government in the PIP and reflected in the bi-annual Operational Plans.
Cambodia	Some health program areas and priorities have received increasing allocations from the budget, but other areas have been and remain grossly underfunded, such as the NCD program area or malnutrition.
Nepal	Yes, the pooled fund supports the priorities of the plan and allocations towards those priorities are annually reported.
Papua New Guinea	To a very limited extent, at least until 2012 when the structure of the trust fund account was completely reviewed and changed and donors moved towards real pooled funding in support of the priorities defined in the health sector plan 2011-2020. In spite of all the reported limitations of the HSIP and SWAp Richards et al[159] report that *the Provincial Expenditure Review (PER) for 2010 has shown that broadly, in the provinces, expenditure on health service delivery is now approaching on average 42% of the actual costs required – up from 25% in 2008 (PER National Economic and Fiscal Commission 2012).*
Samoa	On predictability, flow and use of external assistance Vaillancourt[160] comments that '*overall sector financing is not sufficiently predictable although, within the health sector program, financing is predictable but needs to be managed closely'*. She further expands that '*financing from these three donors (Australia, New Zealand and World Bank) is available, and thus is not a constraint, but outside of the SWAp, the predictability of external funding provided through a ranger of projects and funding assistance is not firm. A whole-of-sector SWAp (and MTEF) would help*.'
Solomon Islands	The health budget has increased substantially since 2007 and expenditure rates are high (95% of government funds and 85% of combined funds in 2010). However, across government there is a weak link between the budget and expenditure.[161]

Table A14 Summary table: Did alignment increase in the context of the SWAp?

Country	Did alignment increase in the context of the SWAp?
Bangladesh	Yes, alignment increased considerably from the time the government had to deal with 120+ donor funded projects.[162]
Cambodia	Yes, alignment has increased but there is a long way to go. For example, the MTR team[163] argue that there was limited visibility of specific actions and decisions taken by the MoH and its partners in relation to advancing the harmonization and alignment agenda and the Sector-Wide Management (SWiM) approach.

[158] Tyson, 2011.

[159] S Richards, G Rupa, L Shaw & I Glastonbury, *Re-design of the health services improvement program (HSIP) Trust Account*, 2012.

[160] Vaillancourt, 2012, Annex 3, 20.

[161] Tyson, 2011.

[162] MoHFW, 2007; MoHFW, 2013.

	Vaillancourt[164] adds that the SWiM approach needs to be transformed into specific requirements for the partners and for the MoH… a clear agenda defining how MoH and its partners are expected to improve their working together, to align their funding, to reduce transaction costs, to become more accountable to each other.
Nepal	Yes it did, as recognised in the Australian aid program internal reports. One of them states*: our participation in SWAps is the best option for the major part of our program. SWAps allow us to build the capacity of a fragile state. They are probably the most effective way to tackle corruption, given the incentive both donors and the government receiving development support have to keep donor money in the pool. Donors working together have leverage to advocate for issues such as inclusion -education is lifting the participation of girls; health programs are targeting women and children. The GoN strongly endorses our participation in SWAps. It would like 100% of assistance to be put through government systems in coming years. The long-term timeframes of SWAps also have an advantage, allowing progress from the basic delivery of services to improvements in the quality of these services, as they mature and evolve*."[165]
Papua New Guinea	Proposals (confirmed from 2012) for moving to a genuine sector-wide approach represent a significant change in delivering aid which in turn requires that development partners adapt their ways of working accordingly. The 2010 review of the PNG-Australia Development Cooperation Treaty and the 2008 ODE review of health service delivery are contributing to the adoption of new ways of working.
Samoa	There is considerable evidence that the SWAp contributed to more systematic, stronger M&E than was the case in the project aid era that preceded the SWAp.[166] Vaillancourt[167] concludes that 'The SWAp is facilitating a move toward greater harmonisation and alignment of development assistance, with progress differing on the various indicators'.
Solomon Islands	Yes, alignment increased although much more would need to be done to define operationally and measure the extent of the alignment.

[163] Martinez et al, 2011.

[164] Vaillancourt, Land & Shuey, 2011, p.22.

[165] AusAID, 2011.

[166] Davies, 2013, chapter 4.2.

[167] Vaillancourt, 2012, Solomon Islands Appendix, p.10.

A.3.6 Gender

Table A15 Focus on gender and reporting on it in annual reviews and in the Australian aid program.

Was there a gender focus in the SWAps/instruments and what was it like? [168]	Was gender being reported as part of the SWAp/annual reviews? [169]	Was gender being reported by the Australian program? [170]
Bangladesh		
There are many references to a strengthened gender focus in the Bangladesh Strategic Plan for HPNSDP 2011-16.[171] For example: With a view to strengthening the health systems, MOHFW during the next sector program, will give priority to addressing issues in the areas of stewardship and governance, legal and regulatory framework, mainstreaming gender, equity and voice in the core programs.(p. ix) There are various mentions of gender in the situation analysis/problem statement in the intro (especially p.2-3). *For example:* › *The reproductive and adolescent health* related priority interventions will include: Improving knowledge of adolescents on reproductive health and gender equity issues. p.11). › Mainstreaming Gender into Nutrition Programming: (p.15). › Gender and Special Care: (p.29). *5.2. Gender, Equity and Voice (GEV).* The Government of Bangladesh has made it a priority to eliminate discrimination against women and girls and promote gender equity. The existing Gender Equity Strategy of MOHFW will be reviewed and revised… Clients' Charter of Rights and patient's duties and responsibilities would be redesigned… The implementation of the Citizen's Charter for health service delivery will be ensured in the health facilities. › Mainstreaming GEV issues in all relevant	**The ANNUAL PROGRAM IMPLEMENTATION REPORT 2012, MOHFW provides progress on M&E indicators, including gender. These are excerpts:** *IEC indicators:* 6. Musical show on Family planning-maternal and child health & gender issues using local team with local dialect organized NOT ACHIEVED. (p.35-36) *Health Economics and Financing* Indicators • EGVNP)strategies developed: NOT ACHIEVED • Number of EGVNP training conducted: 2 (70 people) ACHIEVED • EGNVP Policy research conducted: NOT ACHIEVED • EGNVP Workshops conducted: NOT ACHIEVED • EGVNP and stakeholders issues piloted: NOT ACHIEVED • Analysing health expenditure, service utilization, HR etc. from gender and equity perspectives: 1 PER conducted, focusing gender (achieved). Training, Research, and Development (TRD) of the National Institute of Population Research and Training. *Major achievement of TRD during Financial Year 2011-12:* • One batch of gender and organizational development training conducted.	**Aid Program Performance Report 2012–13 Bangladesh[172]** No mention to gender in the APPR report.

[168] We looked at the SWAp foundation documents and the national health plans they support.

[169] We looked at one or two annual reviews or MTR conducted independently (by external consultants) from as late as possible (2012-2013 preferably).

[170] We searched for gender specific references in the more recent APPRs, in the section where the health program was being covered.

[171] Ministry of Health and Family Welfare, Strategic plan for Health Population and Nutrition Sector Development Program (HPNSDP) 2011-2016, MoHFW, Dhaka, 2011a.

[172] Department of Foreign Affairs and Trade, *Bangladesh Aid Program Performance Report 2012–13*. DFAT, Canberra, 2014.

programs along with capacity development of the service providers and ensuring that they are adequately budgeted for.
- Improving coordination on GEV issues through assigning and strengthening Gender, NGO and Stakeholder Participation Unit as the focal point.
- Ensuring that GEV and accountability concerns are addressed in the objectives, activities and indicators of all operational plans and in the overall results framework (p.33-34).
- HIS: Data will be disaggregated by poverty indicators and gender (p.41).
- SWAp Arrangements and DP Coordination: there will be various joint task groups and technical committees operate under the sector program. GEV will be one of them. (p.52).

The Program Implementation Plan Volume-I also makes many references to how GEV will be incorporated into operational plans such as: Reproductive and Adolescent Health (p.12); **Nutrition and Food Safety (p 14);** Secondary and Tertiary Health Care (p 20); Human Resources for Health (HRH), Training and Nursing Services Priority intervention (p 26); etc.

There are also references to specific studies to be undertaken relating to many topics, including gender. For example:

- Violence against women: measuring the gap between incidence and reporting
- Measure of Unmet need of reproductive health
- Situation analysis of female service providers
- Analysis of different committees of stakeholders' contribution in policy
- Capacity Building on Equity, Gender and Voice, NGO participation (EGVNP) Issues for policy planners, managers, providers and stakeholders:
- Local short training, workshops and seminars.

4.7 PHYSICAL FACILITIES AND MAINTENANCE

Operational plan Indicators: Number of hospitals/health facilities constructed/ renovated to make them gender and disability friendly (ramp, separate commode toilet and sitting arrangement): PARTIALLY ACHIEVED (5%).

IMPLEMENTATION COMPLETION AND RESULTS REPORT, WORLD BANK, 2012

With a strong focus on maternal and child health (MCH) services, the female population has benefitted (e.g. the maternal mortality rate (MMR) was reduced), contributing to better gender balance in health service delivery (p.19).

Cambodia

Second Health Sector Strategic Plan 2008-2015 (HSP2)[173]

The HSP2 Goal 1: Reduce maternal, new born and child morbidity and mortality, and improve reproductive health has several objectives and indicators that are gender related, for example:

1 To improve the nutritional status of women and children.

J Martinez, S Simmonds, L Vinyals, Som Hun, Chhun Phally, Por Ir, Overall assessment for Mid Term Review of Health Strategic Plan 2008-15, HLSP, London, 2011

The MTR team were requested during the scoping visit in August 2011 to include the findings of the gender assessment in its overall assessment of progress. The gender study (Frieson et al, 2011) is reported as the first-ever

Aid Program Performance Report 2012–13 Cambodia[175]

No reference to Gender.

[173] Ministry of Health, *Health Strategic Plan 2008-2015*, Cambodia MoH, Phnom Penh, 2008.
[175] Department of Foreign Affairs and Trade, *Aid Program Performance Report 2012–13: Cambodia*, DFAT, Canberra, 2014.

2 To improve access to quality reproductive health information and services.

3 To improve access to essential maternal and newborn health services and better family care practices.

4 To ensure universal access to essential child health services and better family care practices.

Targets and indicators include: total fertility rate, MMR, CPR, women of reproductive age with low body mass index, anaemia in pregnant women, % of HIV+ pregnant women receiving antiretroviral therapy for prevention of mother to child transmission of HIV/AIDS.

Policy direction: 12. Strengthen public health interventions to deal with cross-cutting challenges.

Strategic area health care and financing: Strategic components and interventions: 5.2 Integrate equity and gender perspective in health financing data collection, analysis and health financing policies.(p.43)

Approach to health program areas: Key reproductive, maternal, neonatal and child health Strategic Components and Interventions: Health Information Systems: Strengthen monitoring of equity and gender relevant data across provinces and ODs (p.59)

Implementation framework: Indicators for M&E. These indicators (on improving health status) are disaggregated to show differences between socio-economic groups, geographical areas as well as gender (p.85)

PROGRAM APPRAISAL DOCUMENT, World Bank, 2008[174]

73. Gender issues. The Program supports the Gender Mainstreaming Strategic Plan of the MoH (2006-2010), and is committed to mainstream gender concerns. It will attempt to ensure that the health system takes into account the cultural and biological differences between men and women. It will support many interventions and reforms that will benefit both women and men, including efforts to increase the affordability and access to health services (p.22).

gender analysis of Cambodia's health sector.

A gender analysis of the Cambodian health sector, Frieson et al, 2011

This study is the first-ever gender analysis of Cambodia' health sector. This gender analysis examines the alignment of gender commitments to policy and implementation in the Cambodian health sector. It identifies key gaps in policy and implementation in order to inform the mid- term review of the Health Sector Strategic Plan 2008-2015 and to provide recommendations for action.

Main points:

- In the health sector, gender equity is still relatively under-developed and not as well reflected in policy and practice as it could be with effort and determined leadership.
- The government's development partners in the main are still not well aware of or understand what gender equity means in the field of health and why it has anything to do with finance, or human resource development, or policy review, among other strategic areas.

Implementation Status & Results Cambodia Second Health Sector Support Program, Apr 2014. Report against indicator: Selected key HSP2 indicators disaggregated by gender and location.

[174] World Bank, Program appraisal document for a Second Health Sector Support Program, World Bank, Washington, DC, 2008.

NEPAL HEALTH SECTOR PROGRAM IMPLEMENTATION

PLAN II (NHSP -IP 2) 2010 – 2015, Ministry of Health and Population, Government of Nepal

3.3 Value Statement

The Ministry believes in: … Gender-sensitive and socially inclusive health services.

3.4 Strategic Directions: Includes Gender equality and social inclusion… (GESI) Data related to intermediate indicators, as well as the outcome indicators, will be disaggregated by gender…(p.13-14)

Health education and communication. In NHSP-2, health education and communication will prioritise certain focused programs of EHCS, such as MCH, adolescent health, communicable and NCDs, tobacco control, emergency and disaster preparedness including pandemic influenza, GESI, and occupational and environmental health (p.37). Actions are specified (p.37).

6.8 Strategies and Institutional Arrangement for GESI. GESI need to be mainstreamed during NHSP-2, and the Government has prioritized the integration of GESI in its policies, programs and plans to make health services accessible to and used by all… (See the detailed strategy framework in Annex 3 or see the Health Sector GESI Strategy, GoN, MoHP, 2009, for further information.)

Improve physical access to health facilities. As coverage increases, the major program and interventions described in Chapter 4 will target their future efforts on reaching communities and groups that are currently making little use of services, or are being missed by promotional and preventive interventions. To increase their coverage, studies and surveys will be carried out to determine the key constraints inhibiting utilisation by the poor and excluded.

Staff will be oriented on GESI principles and practices, and local accountability mechanisms (see section 6.6) will be strengthened, including mechanisms in which the poor and excluded are represented. Mechanisms also will be developed to engage civil society organizations and the private sector for demand creation and improve service delivery.

D Vaillancourt & S Pokhrel, Aid effectiveness in Nepal's health sector: accomplishments to date and measurement challenges, International Health Partnership (IHP+), Geneva, 2012

No reporting on gender except to comment that compliance with GESI is a GoN commitment under the draft joint technical arrangement.

Nepal Health Sector Program II (NHSP II) Mid-Term Review, Health and Education Advice and Resource Team, 2013[176]

Newly presented draft disaggregated data (December 2012) also show important disparities between people from different ethnic groups, by gender, wealth, and by ecological zone.

Table 4: Summary of progress on agreed priority actions of JAR (2012) GESI: In order to put into operation and mainstream the GESI Strategy, the MoHP approved the GESI Institutional Modalities (henceforth referred to as the GESI Guidelines) in September 2012 which unequivocally states that the process of health systems strengthening will define exclusion primarily from four dimensions: i) gender-based, ii) caste and ethnicity, religious minority based, iii) poverty-based, and iv) geographical based. All the main divisions, departments and centres have responsibilities in taking the GESI Strategy forward (p.24).

2.1 NHSP II Output 1: Reduced Cultural And Economic Barriers To Accessing Health Care Services. Progress against targets set for two of the three output 1 indicators of the NHSP Logical Framework has been slow. Reporting from 2012 indicates that it is not likely that 2013 targets for OP1.1 and OP1.3 will be achieved. Targets are then defined for each operational plan.

Selected important developments, 2011-2012 for GESI institutional mainstreaming and targeted interventions in health:

- GESI institutional mainstreaming modality was fully established in MoHP.
- The Population Division was approved in 2011 as the overall GESI Secretariat for the MoHP and a GESI Steering Committee was established with the Secretary of MOHP as Chair.
- GESI related provisions were added in the approved HRH Strategy Plan (2011-15).

Aid Program Performance Report 2012–13 Nepal

Recent gains in gender parity in schools and steady progress in maternal health services demonstrate that national service provision is oriented towards the needs of women and girls. Despite this, needs remain acute with the proportion of births supervised by a skilled birth attendant in Nepal at 46%, and only 18% among Nepal's Muslim population.

Examples of improved practices in GESI in 2012 include updating health training curricula, establishing a Technical Working Group on gender and inclusion in the MoHP, and agreeing on reservations in the 2013 teacher recruitment round for marginalised groups. Australia has been an active member of the thematic group on GESI in health.

[176] HEART, 2013.

Ensure that the collection of data and analysis on disparities in utilisation and the reasons for them are collected and used to inform policy and planning. Capture the service provider voice to better understand barriers limiting change for use in policy development. This analysis can be done through the existing review mechanisms, but will need to be proactively encouraged by the Ministry and Department of Health Services managers.	› One Stop Crisis Management Centres were established. › Social Audits are now an integral part of the health system programming at the facility level. › The AWPB of MoHP now have budget provision for GESI issues and the Business Plan for 2012/13 has incorporated GESI related activities (p.28-29). *Review of NHSP II, Annex 2 (GAAP) objectives, in relation to GESI. This Annex provides considerable information on objectives and progress against all areas included in the GESI strategy.*	
	Papua New Guinea	
RE-DESIGN OF THE HEALTH SERVICES IMPROVEMENT PROGRAM (HSIP) **TRUST ACCOUNT, 2012, Sue Richards (Team Leader), Gima Rupa, Lea Shaw and Ingrid Glastonbury.** The re-design team acknowledges that activities must be designed to reach women and men equitably according to their specific needs. The priority strategy selected is to reach the facility level with funds and capacity development to encourage more people to access health facilities, particularly in poorer districts, thus improving the health outcomes of rural people: › Targeted in-service training will benefit staff of health facilities (officer in charge, nurses, community health workers and midwives) where female staff often predominate. Training in health management provided by Divine Word University has been evaluated as equitably delivering for both women and men. › Targeted enabling funding for rehabilitation of existing infrastructure will ensure a more accessible facility for all people, particularly women who are traditionally frequent users of health facilities for themselves and their children. › Emergency transfers of obstetric patients can save the lives of pregnant women and impact maternal mortality rates in the long term. › Targeting the poorest districts will deliver benefits for rural women often disadvantaged by remoteness and isolation from services. › At the completion of the program, some improvement in the Human Development Index and the Gender Development District Index is expected. › It will be difficult to further specify gender related outcomes as there is no gender analysis provided in the sector performance	**THE PNG HEALTH SWAP REVIEW, 2010, Review Team: Katja Janovsky (Team Leader), Mick Foster, Eric Kwa, John Piel, Kate Lollback** No mention of gender. **Review of Health Sector Improvement Program Trust Account, Mick Foster & John Piel, June 2010** No mention of gender. **Independent Annual Sector Review, Accelerating Health Improvement in Poor Performing Districts, 2012, Dr Richard Van West-Charles, John A Piel,** **Dr Urarang Kitur, and Dr Kandi Lombange, Theo Vermeulen** No reporting on gender.	**PNG Health and HIV Sector Performance Report 2013-14** Gender Equality Achievements: › In 2013, Susu Mamas conducted 77 rural outreach clinics and eight settlement clinics. 1,656 women accessed rural outreach services and 16,985 women attended Susu Mamas urban integrated family and youth health service (an 18% increase on women accessing services in 2012). › Australian funded operational research into accessing maternal health services in rural areas and Human papillomavirus and cervical cancer screening will directly impact national policy and future roll out of vaccines, testing and

annual review.

National Health Plan 2011–2020, Vol 1, policies and strategies, 2010, Government of Papua New Guinea

Essential Values of the Health System includes:

- Equity: Striving for an equitable health care that is independent from political decision making, and being fair in all our dealings, irrespective of age, gender, ethnicity, religion, and political affiliation.

Key Result Area 5: Improve Maternal Health

screening.

- Australia has improved gender equality through targeting an increased proportion of women (71% in 2014) to participate in health workforce training through the in-country Australia Awards program.
- In 2013-14 Australia completed the refurbishment of four midwifery schools, funded eight CMFs to improve midwifery education, supported new midwifery curriculum and addressed outstanding registrations for nurses and midwives.
- In 2013, the reproductive health training unit trained 342 health workers.
- The 2013 independent evaluation of medical supplies found that an increase in medicines availability is plausibly contributing to better case management and increased survival for women in Papua New Guinea.
- Gender considerations in the design of new facilities funded by DFAT are visible and can be seen in the separation of male and female consultation

		facilities at health facilities. Better lighting and water will provide an appropriate environment for safe delivery.
	Samoa	
Health Sector Plan 2008 - 2018 (the Plan), Ministry of Health, Samoa No mention of gender. **PROGRAM OPERATIONAL MANUAL For Health Sector-Wide Approach (SWAp) Program, 2008** Intermediate Results: Quality Health Services: Improving the quality of health services through strengthened human resources, standards, supplies, equipment and infrastructure. Results Indicators: Primary care utilization by gender, age, domicile.	**Health Sector Plan 2008-2018** **Mid-term Review Report, 2013** No mention of gender. **Evaluation of Samoa Health Sector Management Program (Health SWAp), Phillip Davies, 2013** Few explicit references to gender equity or disability inclusiveness in SWAp-related documentation (HSP, PoW, M&E etc.) or in aides memoirs prepared by DPs. PoW includes a strategy to 'Improve maternal and child health' but progress appears to be slow – IFR for December 2012 indicates only 0.3% of budget for planned cervical screening program had been disbursed.	

Solomon Islands

National Health Strategic Plan The Ministry of Health & Medical Services SOLOMON ISLANDS GOVERNMENT 2011-2015

Substantive National Health Policies

The health sector and health-related sectors will improve the health status of the age and gender population groups especially women and children considered to be the highest priorities. Rank order: 7.

Strategy: Do Better reproductive health.

Objective: Provide expanded family planning & other services, particularly for adolescents.

Indicator: 20% increase in CPR by 2015 to 41.5; maternal mortality reduced by 75% from 1990 (550) to 2015 (last know at 100/100,000 in 2009) (MDG 5.1 is already achieved) Increase % of births attended by skilled health personnel from 86% in 2009 to 92% by 2015 (MDG 5.2).

Strategy: Do More & Better domestic violence prevention & enforcement and child protection.

Objective: Reduce domestic violence and improve child protection.

Monitoring indicators: By gender for HIV, mental health.

Solomon Islands Ministry of Health and Medical Services Health Sector Support Program

HSSP 2007 – 2012, PROGRAM IMPLEMENTATION PLAN, 2007

(iv) Supporting socio-behavioural research on behaviour change...The promotion of awareness of gender issues and their mainstreaming will also be addressed.

1.15 Gender Issues

MoH's commitment to gender mainstreaming is articulated in the NHSP. Within the eight key strategic areas are a set of organisational and social values, some of which refer to gender equality. Goal 1 of this plan, '[t]o promote a people centered approach to health', states '[i]ncrease implementation of a people focus and gender mainstreaming within health care services at all levels' as an objective.

Solomon Islands Health Sector Wide Approach Progress Review 2008-2011, Dr Stewart Tyson, 5 October 2011

No mention of gender.

Solomon Islands: Support for the 2011 Annual Health Conference and Joint Annual Performance Review, Interim Report, Dr Stewart Tyson, 31 August 2011

No mention of gender.

Solomon Islands Health Sector Support Program Health Sector Support Program (HSSP) Independent Performance Assessment for 2013,

Marion Kelly (HRF) and Keith Tuckwell (John Fargher & Associates Pty Ltd.)

8 May 2014

No mention of gender.

Aid Program Performance Report 2012–13 Solomon Islands[177]

The health program promotes gender equality through a focus on MDG 3, promote gender equality and empower women, and MDG 4, reduce child mortality. It does this by supporting victims of gender-based violence; rural water sanitation and hygiene, and malaria control and elimination. Staff issues—including vacancies—in the maternal health division held back greater progress in maternal health in 2012.

[177] DFAT, 2013.

Although gender mainstreaming is established within the MoH institutional discourse, its translation into planning, management and the delivery of services has yet to take form.

1.15.1 Gender and organisational change

Analysis of available data shows that in 2005, women represented around 49% of the total workforce engaged by the MoH74. However, with regard to MoH management levels, women's representation is a mere 10% at the executive level.

There is recognition within the MoH that the inclusion of a more gender sensitive approach to delivery should be addressed with the main institutions that provide nursing and medical qualification in the Solomon Islands.

1.15.2 Data collection on health

To date, the absence of sex-disaggregated data within the HIS does not allow any further investigation into who uses the health services and the gendered characteristics of ill health within the population.

1.15.3 Gender mainstreaming in MoH

The HSSP will support the MoH in its implementation of gender mainstreaming in the health sector through key initiatives within the program activities. These initiatives will incorporate the following recommendations:

- Taking an integrated approach to gender in all facets of health service delivery.
- Establishing inter-departmental partnerships between the MoH and other relevant government departments.
- Establishing partnerships between MoH and civil society organisations.
- Establishing a gender focal point within the MoH.
- Collecting improved sex-disaggregated data.

Appendix 4: List of references

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Appendix 5: Annotated bibliography

This bibliography includes only documents that were selected by the researchers for full consideration by the reviewer. A much larger number of documents was examined for each country; as these documents were not considered relevant or useful for the purpose of this study they are not included in this list. The annotation does not attempt to provide a full summary, but rather an indication of usefulness, or key points made in the document.

1 Australia's policy documents

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The Comprehensive Aid Policy Framework (CAPF) was developed to put into effect the aid policy (*An effective aid program for Australia*, 2012). Bringing together the aid spending of all federal agencies (i.e. not only AusAID), the CAPF contains a four-year budget strategy with indicative regional and global aid allocations, aligned to three tiers of key results to be achieved by 2015–16 (namely, the MDGs, the aid program's five strategic goals, goals related to the efficiency and effectiveness of delivery) and the way they will be reported.

Australian Agency for International Development, *An effective aid program for Australia: making a real difference—delivering real results*, AusAID, Canberra, 2012.

This document outlines the Australian Government's response to the Independent Review of Aid Effectiveness and sets out the Government's overall aid strategy through to 2016-17. It covers: purpose of the aid program, how effectiveness is to be enhanced, the geographic and thematic focus, and the systems, methods and partners to deliver aid that achieves results and value for money.

Australian Agency for International Development, *2011–12 Annual review of aid effectiveness*, AusAID, 2012.

This document examines the performance of the Australian aid program against the commitments made in the 2012 comprehensive aid policy framework (CAPF, see below), including operational effectiveness and the four-year rolling budget strategy. It finds that the program broadly on track with good progress made.

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The purpose of this review was to thoroughly examine the aid program, determine the effectiveness and efficiency of the program's current systems, policies and procedures, and give advice (crystallised in 39 recommendations) on how to make the program more strategic, presenting a vision that covers the geographical allocation of Australian aid, sectors and flagships, and the use of the various channels available.

Australian Agency for International Development, *Saving lives: improving the health of the world's poor*, AusAID, Canberra, 2011.

This thematic strategy outlines Australia's strategic approach to development assistance for health. It states that assistance should be context-specific and evidence based; it should target the main causes of poor health among poor and vulnerable; promote leadership and accountability in partner

countries and support efforts by government and civil society to address health priorities. Where appropriate and practical to do so, forms of assistance may include providing health budget support, supporting pooled funding arrangements and working with other donors on joint programs. The strategy affirms the intention to work with partner governments to align Australia's investment with national priorities and systems.

Australian Agency for International Development, *Australian aid: promoting growth and stability: a white paper on the Australian Government's overseas aid program*, AusAID 2006

This white paper provides a 10-year strategic framework for Australia's aid program and a comprehensive account of the approach to doubling the aid budget (representing the first multi-year increase). It states the commitment towards the principles of the Paris Declaration on Aid Effectiveness, and to looking for opportunities to use partner country processes and systems in aid program delivery.

2 Country documents

Bangladesh

Australian Agency for International Development, *Quality at Entry: Bangladesh Health, Population, Nutrition Sector Development Program*, AusAID, Canberra, 2011.

This is the document that gives the go-ahead to program implementation. It provides a realistic assessment of current status and what can be expected, but as it follows a standard template it is very brief.

Department for International Development, *Business case: Health Sector Development Programme (HSDP)*, DFID, London, 2011.

The business case provides the rationale for DFID's engagement in the program; it is useful for this review mainly in that it captures substantial background information.

Independent Review Team, *Annual programme review (APR 2013): Health, Population and Nutrition Sector Development Program (HPNSDP), 2011-16:* consolidated report, MoHFW, Dhaka, 2013.

The APR for the second year of the program examined four thematic areas: 1. MNCH, family planning and nutrition; 2. SWAp financing and financial management; 3. Planning, M&E; 4. HRH.

This consolidated report summarises progress and challenges in these four areas against the results framework and provides recommendations. It is not an analytical report and does not include any data (which can be found in the individual thematic reports).

Independent Review Team, *Annual Programme Review 2012: consolidated report*, MoHFW, Dhaka, 2012.

This is the first APR for the third sector-wide program. The focus of this APR was "less an assessment to determine whether the program had achieved its overall objectives for year one, although it did do this too, than it was a due diligence review of the program's institutional, financial, technical and management infrastructure." As such, this APR does not provide a full assessment of the sector, although it contains more detail than the APR for the following year (see above). The report concludes that: progress is roughly where it should be taking into consideration the late start; the magnitude of the SWAp, the many stakeholders involved, and the normal implementation 'hiccups'.

World Bank, *Program appraisal document: Bangladesh Health, Nutrition, and Population Sector Development Program*, World Bank, Washington DC, 2011.

This document provides key background information on the program, and includes the results framework.

Cambodia

Department of Foreign Affairs and Trade, *Aid Program Performance Report 2012–13: Cambodia*, DFAT, Canberra, 2014.

This is an assessment of overall support to Cambodia, offering limited detail on health sector programs. In relation to health, the report notes that lack of progress on certain indicators "implies that resources are not being allocated within the public health system to where they are most needed – nor are they being used as efficiently as they could be. Further reforms to improve the transparency of MoH expenditure will be required […]". It also notes significant improvement in terms of donor harmonization, but "very little movement on significant policy issues, notably MoH procurement budget transparency".

Department of Foreign Affairs and Trade, *Quality at implementation report: Cambodia Delivering Better Health project*, DFAT, Canberra, 2014.

This report explains what worked in the program, and what did not and why. Due to the nature of the document it is very succinct and forward looking, rather than an analysis of previous years. It notes that program had very good outcomes in some service delivery components, that the Trust Fund has been an efficient mechanism overall, and that full alignment of sector monitoring mechanisms has been achieved.

J Martinez et al, *Overall assessment for Mid Term Review of Health Strategic Plan 2008-15,* HLSP, London, 2011.

In this document chapter 4.5 on health systems governance and aid effectiveness are particularly relevant. In line with the SWiM assessment of 2011(see below), it expresses concerns that in spite of substantial progress (e.g. in relation to aligning health financing and strengthening budgeting) there is still a long way to go. It states that in order to make sector investments by both the MoH and health partners more effective, efficient, predictable and aligned, and for health partners to harmonize their work, there is a need to focus on a number of key areas including: project design; review missions; monitoring and reporting arrangements; planning and management of TA.

D Vaillancourt, A Land & D Shuey, *Aid effectiveness in Cambodia's health sector: an assessment of the sector-wide management (SWiM) approach and its effect on sector performance and outcomes*, 2011 (Draft).

The study was conducted to inform and support the MoH's efforts to assess and strengthen the effectiveness of development assistance to the health sector, and covers the period since the previous SWiM review in 2007. It argues that the anticipated benefits of the SWiM have only been partially achieved, with very little progress in SWiM implementation and in improving aid effectiveness since 2007. Likely reasons for this are cited as weaknesses of both MoH and Health Partners on a number of fronts, including: level of commitment, ownership, mutual trust, respectful candor of their dialogue, mutual accountability, clear rules of the game, and action planning and follow-through.

World Bank, *Implementation completion and results report: health sector support project,* World Bank, Washington, DC, 2012.

This document covers the first HSSP (which is outside the scope of this review), but because funding was extended from 2007 to 2011 there is some overlap. It gives a full picture of the context at the time, a detailed program description and overall assessment against results framework, and also why this type of support was chosen including by main co-financiers (unfortunately not Australia; see Annex 7).

Nepal

Australian Agency for International Development, *Nepal development cooperation report 2010*, AusAID, Canberra, 2011.

This document examines the performance of the overall Nepal's aid program. It explains the rationale for Australian involvement in health through a sector wide approach and that the number of donors working in a unified way through donor pools has so far, proven to be effective in the country, with commitment to working in a highly coordinated fashion and in ways that build government systems and capacity". The report states that "it is important that we continue to support this asset through whatever transitions the Nepalese state moves through in the next few years."

Australian Agency for International Development, Quality at implementation report for INJ722 Nepal Health Sector Program SWAp (IHP) Phase II, AusAID, Canberra, 2012.

This document provides a very useful short description and assessment of the SWAp and sector performance from AusAID's perspective, and the rationale for Australia's involvement in the program.

Department for International Development, *Annual review of DFID support to the National Health Sector Programme II, Nepal*, DFID, London, 2014.

The document (together with annual reviews from previous years) is useful to understand DFID's perspective on program progress.

Health & Education Advice and Resource Team, *Nepal Health Sector Programme II (NHSP II): mid-term review*, HEART, 2013.

The MTR is a key document on NHSPII performance. It finds that good progress has been made across most areas (healthcare access, health sector management, service delivery, health knowledge and awareness, M&E and information systems, physical assets and logistics management), but more limited progress against the three key areas of human resources, health governance and financial management, and sustainable health financing.

D Vaillancourt & S Pokhrel, *Aid effectiveness in Nepal's health sector: accomplishments to date and measurement challenges*, International Health Partnership (IHP+), Geneva, 2012.

This is a key document (together with the Mid Term Review, although possibly it is slightly dated as the research was conducted in 2011. The report addresses three questions: 1) To what extent have aid effectiveness principles been put into place? 2) Has this contributed to better results, notably: (i) more efficient aid; (ii) strengthened health systems; (iii) improvements in health services? and 3) What was critical for achieving these results?

World Bank*, Project appraisal document on a proposed credit to Nepal for a second HNP and HIV/AIDS project*, World Bank, Washington, DC, 2010.

This is a useful background document explaining the rationale for World Bank involvement, including a useful program description and the results framework.

Papua New Guinea

K Janovsky, M Foster, E Kwa, J Piel & K Lollback, *The PNG Health SWAp review*, 2010.

This report presents and overview of the objectives, findings and recommendations of the SWAp review. Key messages include: the need to disburse more donor resources for health through government systems as sector budget support; the need improved mechanisms for sector coordination and policy dialogue; the importance of strenghtening institutions and creating incentives (i.e. the enabling environment).

K Janovsky, *The PNG SWAp review: streamlining and strengthening mechanisms for sector coordination and policy dialogue*, 2010

This is one of three reports which together form the core of the Papua New Guinea SWAp Review. The focus of this specific report is on structures and processes that support harmonization and alignment in accordance with the Paris, Accra and Kavieng Declarations. It reviews the roles, responsibilities and comparative advantage of the various (SWAp) governance structures and partnership forums; and makes recommendations for change.

S Richards, G Rupa, L Shaw & I Glastonbury, *Re-design of the health services improvement program (HSIP) Trust Account*, 2012.

The Trust Account holds development partners and government funds and plays a vital role in funding rural health services, but over the past decade concerns have been expressed about its performance. This report is the outcome of the re-design mission.

Samoa

P Davies, *Evaluation of Samoa Health Sector Management Program (Health SWAp)*, AusAID Health Resource Facility, Canberra, 2013.

This report captures progress with the SWAp to early 2013, also encapsulating material from all the aide memoires and key background documents to that point. Table 6 summarizes the assessment of the SWAp against 14 key questions set in the TORs. It argues that 'weaknesses in the M&E framework and its application, the absence of valid baseline measures and incomplete documentation in some areas make formal, rigorous evaluation of SWAp achievements problematic.' Section 4.2 and Annex 6 capture SWAp process monitoring indicators, however the small amount of data point to some achievements in terms of SWAp processes but are of limited value as a basis for assessing the success or otherwise of the SWAp as an aid modality. The review finds that development partners' ability to contribute to meaningful policy dialogue over the life of the SWAp has been very limited, and that the lack of meaningful participation of non-pool players detracts from a whole sector view.

J Negin, *Sector wide approaches for health: a comparative study of experiences in Samoa and the Solomon Islands*, Nossal Institute, Health Policy and Health Financing Knowledge Hub, Melbourne, 2010.

This paper describes the origin and implementation of SWAp processes in Samoa and the Solomons Islands, and provides information for the analysis of policy development processes in terms of actors, power dynamics and influences. The author writes that in Samoa there is a strong sense of independence and sovereignty, and the government has actively led the reform process within and beyond the health sector. However the establishment of the SWAp appears to have been a rushed

process that was dominated by procedural and contractual matters, rushing to meet an artificial deadline of June 2008 (the date set for a World Bank board meeting).

D Vaillancourt, *In sweet harmony? A review of health and education sectorwide approaches in the South Pacific, Appendix 2: Samoa Health SWAp*, World Bank, Washington DC, 2012.

This is a thorough review, conducted as a desk study, covering Samoa Health and Education Sectors and Solomon Islands Health Sector. In summary, it concludes that at the midpoint of the Health Sector Program implementation period, some of the anticipated capacity and efficiency benefits of the SWAp had been partially realized, but most had yet to be achieved. The study pulls together preliminary information and lessons through a selective review of relevant aid effectiveness and SWAp documentation and limited interviews and consultation, undertaken in 2010 and early 2011. It employs an objectives-based methodology, whereby aid effectiveness efforts under SWAps and sector development programs are assessed against the specific objectives and indicators set and agreed by the relevant country and development partnerss. OECD evaluation criteria guide the review's analysis of the relevance, efficacy, efficiency and sustainability of specific SWAps.

Health Sector Plan 2008-2018 Mid-term Review Report, Samoa Ministry of Health, 2013.

This review assesses progress in implementing the health sector plan and uses the indicators defined in the M&E framework as the main tool for assessing progress. There is very little discussion of SWAp processes, and or information to assess the success of the SWAp as an aid modality.

Solomon Islands

M Kelly & K Tuckwell, *Solomon Islands Health Sector Support Program (HSSP): Independent Performance Assessment for 2013*, Health Resource Facility, Canberra, May 2014.

Following the 2012 IPA, the Ministry of Health and Medical Services (MHMS) and DFAT selected six performance indicators and targets for 2013 related to: unattended births, essential drug availability, malaria incidence, executive meetings, provincial budgets, and Public Financial Management. This report reviews progress against each of them and translates progress into DFAT performance payments to the sector. These arrangements are specific to DFAT and there is still a need to establish a SWAp results framework and SWAp performance management plan.

J Negin & A Martiniuk, Sector wide approaches for health in small island states: lessons learned from the Solomon Islands, *Global Public Health*, 7(2):137-48, 2011.

This qualitative research paper explore the establishment and implementation of the health SWAp in the Solomon Islands as a specific case study with lessons learned for the region as well as for aid architecture in fragile states more generally. An interesting read on motivations and processes in the early days of the SWAp – characterized by consultant-led processes, sub-optimal relationships between key donors and the nascent SWAp being pushed by donors in a project-type fashion.

S Tyson, *Solomon Islands Health Sector Wide Approach: progress review 2008-2011*, AusAID Health Resource Facility, Canberra, 2011.

One of the most useful papers on the Solomon Islands, it presents a good synopsis of the state of play. It documents a) progress against the commitments and principles of the SWAp and b) progress in strengthening health systems and in improving delivery of health services since the launch in 2008.

SD Vaillancourt, *In sweet harmony? A review of health and education sectorwide approaches in the South Pacific, Appendix 3: Solomon Islands Health SWAp*, World Bank, Washington DC, 2012 (b).

This desk study covers the health SWAp in the Solomon Islands and is one of the key references for the ODE review. It employs an objectives-based methodology (see Samoa for further details. It highlights issues that are specific to the Pacific Islands, among which are: the very small size of ministry staff vis a vis the heavy workload of SWAps; the challenges of managing an especially large volume of TA; the relatively smaller pool of DPs involved and the very prominent role played by one or two bilateral DPs.