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SECTOR WIDE PROGRAMMES AND POVERTY REDUCTION

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Acronyms

ASIP	Agricultural Sector Investment Programme
BESSIP	Basic Education Sub-Sector Investment Programme
BMC	Budget management Centre
DALY	Disability Adjusted Life Years
DFID	Department for International Development
DHS	Demographic and health Survey
ESP	Education Strategic Plan
GEAR	Growth Employment and Redistribution Strategy
GER	Gross Enrolment Ratio
HPSP	Health and Population Sector Programme
IMR	Infant mortality rate
MTEF	Medium Term Expenditure Framework
MTR	Mid Term Review
MMR	Maternal Mortality rate
MoH	Ministry of Health
MoF	Ministry of Finance
NGO	Non Governmental Organisation
NHS	National Health Service
PAF	Poverty Action Fund
PAP	Priority Action Programme
PEAP	Poverty Eradication Action Plan
PMA	Programme for the Modernisation of Agriculture
PPA	Participatory Poverty Assessment
PoW	Programme of Work
PRSP	Poverty Reduction Strategy Programme
RDP	Reconstruction and Development Programme
SACMEQ	Southern African Consortium for Monitoring of Educational Quality
SDS	Service Delivery Survey
SWAp	Sector Wide Approach
UPE	Universal Primary Education
UPPAP	Uganda Participatory Poverty Assessment Project
UNESCO	United Nations Education, Scientific and Cultural Organisation
QoL	Quality of Life

Executive Summary and Conclusions

The current study is based on a fairly 'quick and dirty' review of material on a range of sector programmes selected by the availability of material to the authors. In view of the necessary limitations of the approach, the conclusions we seek to draw are mainly limited to presenting information on how the current generation of SWAps is addressing poverty concerns, and some necessarily tentative judgements on effectiveness.

Is poverty reduction the central objective of SWAps?

Improving the access to services by poor and marginal groups was a strong or central objective of most of the sector programmes we have reviewed. The main exceptions have been in the agricultural sector, where growth objectives have been equally or more important, and the specific case of the education sector in South Africa, where poverty objectives were in competition with investment in higher level skills to support economic growth and increased black participation in the economy. As one might expect, poverty issues are more satisfactorily addressed in those SWAps where benefiting the poor is stated as a central objective, and has political endorsement.

Poverty and the design of SWAps

The SWAps which have been most successful in benefiting the poor have recognised the need to understand the specific constraints which influence whether poor people are able to access services or not. This requires quantitative material on the coverage of services, and qualitative investigation of the underlying reasons for use or non-use of services, preferably linked to action research to investigate approaches to overcoming constraints. In the face of a disappointing public response to the expansion of primary health services, Ghana and Bangladesh have researched the causes of unequal access and are developing more specific strategies for reaching the poor. Zambia and Cambodia have focused basic education interventions on understanding the barriers to enrolment by the poor and introducing specific policies to address them. The problem of cost to parents was identified as a major barrier in all but one of our education cases (most dramatically in Uganda), and a key intervention has been to reduce costs to parents.

Poverty and the allocation of public expenditure

Traditional incremental budgeting institutionalises structures and priorities that exclude the poor by in effect rationing services to those already enjoying access. The step of identifying and costing expenditure programmes that can be universalised, and prioritising to ensure that poverty priorities are protected, is radical but essential.

A critical test of commitment to address poverty issues within a SWAP is the willingness of Government to commit resources to pro-poor expenditures within the sector, at levels comparable with high performing peer countries facing similar budgetary constraints. Most of our education or health sector programmes succeeded in focusing a high share of sector expenditure on primary education or primary and preventive health services. In the education sector, Uganda and Cambodia facilitated the required shift in priorities by encouraging increased reliance on private sector finance and private sector providers at higher secondary and tertiary level.

Although several of the health SWAps have made progress in achieving a high share of the budget for primary services, maintaining this position can be politically difficult. Tertiary hospitals still represent more than half of the health budget in Mozambique and Tanzania. The tight caps on the budgets for regional and tertiary hospitals which were introduced in Uganda to release funds for primary health services have had to be relaxed following the political decision to end fees at point of service. Ghana has also decided to end charging at point of use. These various pressures recall the earlier case of the Zambia health SWAp, where initial progress in increasing the share of spending at primary level was subsequently reversed.

Financing of health services

The fundamental health sector problem remains the unaffordability of universal free provision of even a basic services package delivered through primary level facilities. The consequences have been low quality services with limited coverage, due to factors such as low salaries causing low staff availability and motivation (Tanzania, Uganda), and shortages of drugs and other consumables (Bangladesh, poor parts of Mali where cost recovery has not proved financially viable).

Cost recovery has been used to help overcome funding shortfalls, but has been a major impediment to utilisation of health services by the poor. Mali has gone for relatively full cost recovery through community financed and managed schemes, but has seen inequality in service provision and low utilisation. Ghana has also made heavy use of cost recovery, but with exemptions for a limited range of key interventions (under 5 services, ante-natal care, infectious diseases such as TB), and for the poor. This has achieved some success in boosting coverage of the exempted interventions, though the budget for exemptions has been inadequate, and utilisation had been low (though improving in 2000). Abolition of user charges in Uganda has seen a surge of utilisation by the poor.

Most of the countries examined are trying to expand insurance approaches as a way to expand the available funding without excluding the poor, though (other than Mali) most of these are at the design or pilot stage, with relatively low coverage.

Are the poor benefiting?

There is a mixed picture on the extent to which the poor are benefiting, and much of the evidence relates to changes that pre-date the start of a full SWAP. In summary, education sector programmes appear to be succeeding in significantly increasing primary enrolments, with a focus on the poor. Within the health sector, the trends are more varied, and more difficult to interpret:

- Ghana appears to have improved immunisation coverage and antenatal care, and is beginning to see evidence of improved utilisation of curative facilities, despite little overall increase in health expenditure. Though other factors such as rising living standards may be partly responsible, there is also evidence of significant advances in infant and under 5 mortality, though major inequalities remain.

- Mozambique, reflecting improvements during the 1990s before the SWAp, seems to have achieved improvements in vaccination and antenatal care through doubling of health staff and a focus on outreach.

- Uganda has only recently started a formal SWAp, but policies being implemented since the mid 1990s have contributed to some improvements in utilisation of curative care, and major

- achievements in reducing HIV/AIDS infection rates. Poor rates of immunisation and antenatal care have not improved, and infant and child mortality have worsened, possibly reflecting HIV/AIDS. Key problems have been low staff availability, and cost barriers to patients seeking treatment.

- Mali has faced falling utilisation of curative care, associated with poor financial viability of services and staff shortages.

- Bangladesh faces low quality and low utilisation of services with little evidence of improvement, high and uncertain formal and 'informal' charges for low and variable quality being a major factor influencing people to prefer NGO services.

The influence of SWAps and the PRSP process on sector poverty policies

More encouraging than the results achieved is the evidence that the joint reviews conducted as part of the SWAp process have generated analysis and debate that has helped to sharpen the focus on poverty in Ghana and Bangladesh health, and Bolivia agriculture, while each of the education cases have to some extent involved Government and donors working together to identify and resolve problems affecting the access of different groups to education.

The positive influence of the PRSP process on the poverty content of sector programmes has been most powerful in Uganda, helped by strong links to the budget. It is unclear to what extent the PRSP or future joint SWAp reviews may help improve those SWAps where the treatment of poverty is currently weaker, for example Tanzania health.

Co-ordination with other sectors and with local government

Cross-sectoral coordination has been stronger in the planning phase than in the execution of SWAps, and has also been a strong feature of the PRSP process in a number of countries, enabling health strategies to be located within an overall approach which also reviews the contribution of clean water, education etc (Uganda, Ghana). Coordination has been more ad hoc in implementation. Though cross-sector committee structures often exist in name, it is difficult to make them effective in promoting a change in behaviour that may offer few rewards to the staff of the line ministry.

Working with local Government has faced problems of differing priorities, and several of our SWAps have used highly conditional approaches to ensure that funds intended for schools or front line services are not absorbed in other local Government spending.

Many of the SWAps are experimenting with decentralisation to facility or community level, in the hope that accountability to the users may be stronger. In the health sector, Mali has strong community involvement in decision-making and in management, but Mozambique, Bangladesh, Tanzania and Ghana are also reported to be developing approaches to helping communities to commission services on their own behalf. Education SWAps in Uganda, Zambia, and Cambodia are providing funding directly to schools, though the degree of community influence on how the head teacher uses them may in practice be limited. It is reported from Zambia that there is some positive evidence that increased budgets under school level management have had a positive impact on the quality of education.

There are concerns expressed from Mali and Bangladesh that community management needs to take account of inequalities at local level, and ensure that the vulnerable do not become excluded from

access, especially in the health and agriculture sectors where (unlike education) services are more individual and access is more directly competitive.

Working with the private sector and NGOs

SWAps are often criticised for giving too little attention to the appropriate roles of private financing and private service providers. We found numerous examples where SWAps have involved NGOs in planning and monitoring of SWAps, and have channelled funding to NGO or private for profit service providers where they are more cost-effective. There are several examples where SWAps are seeking to expand the scope of NGO and private involvement.

In the education sector, highly subsidised primary education is widely accepted as necessary if universal enrolment is to be achieved, but private schools are also tolerated, community schools may receive Government financial support as in Zambia, and the role of the private sector in expanding higher education is promoted in part in order to release Government resources for the lower levels.

Most of the health sector programmes have been forced to address issues of what services they should be financing and how they can best be provided, and many of them procure some services from non-Government sources. A broad range of approaches to the financing and provision of health services are under consideration, with a proliferation of attempts to promote formal or community based health insurance, and experiments with empowering users to commission services from a range of sources.

In agriculture, the early Zambia ASIP was criticised for a strong focus on Government service provision. More recent programmes, such as the programme for the modernisation of agriculture that Uganda is currently developing, have been far more eclectic, and envisage enabling farmer groups to procure extension services, for example, from private suppliers. The Bolivia programme works closely with NGO and private sector actors as well as local Government.

Targets, monitoring and feedback

There are some good examples of monitoring indicators that are well structured to relate outcome targets back to specific outputs, and the inputs and resources required to achieve them. There are also some cases where quantified goals and targets are effectively meaningless because the actions required to achieve them and the resources needed have not been defined and allocated. In order to understand how effectively SWAps are reaching the poor, administrative data needs to be supplemented with information relating to the wider population including non-users: household and community surveys, demographic and health surveys, service delivery surveys, and participatory assessments to explore the underlying reasons for the choices people make, have been the most important sources for assessing whether the poor are benefiting, and what needs to be done.

In most cases, the main flow of monitoring information appears to be towards the centre. For motivation purposes, it is important that monitoring information be made available to staff at all levels, to enable them to compare their performance with their peers. Accountability to users can also be helpful: Penrose reports that School Performance Appraisal Meetings have been held in Ghana, with parents given access to the results of tests of class performance in English and Mathematics. He quotes examples of parents pressing successfully for action to improve the

management and performance of individual schools.[1]

Reforms of public expenditure management

Tracking studies have been helpful for identifying problems in ensuring resources are used as intended (Uganda, Tanzania). Approaches to addressing problems have included an emphasis on transparency and access to information to enable officials to be held to account (Uganda), and linking resource allocation to the quality of planning and to submissions of acceptable accounting and performance reports, at each level from facility, to district, or sector reporting (Ghana health, Uganda, Tanzania health).

From a poverty perspective, it is important that districts unable to meet financial accountability criteria do not lose funds. Ghana health simply has them managed differently, e.g. by the region rather than the district. Tanzania provides additional help to enable weak districts to meet the criteria for funding.

Protecting poverty relevant expenditures from in-year budget cuts, as Uganda does, has a triple benefit, ensuring that programmes are not disrupted, improving the incentives for sector managers to prioritise poverty to protect their budget, and giving managers the confidence that effort devoted to plans and budgets will not be wasted. The main cost is that protection of poverty budgets amplifies the variations which other budget holders have to manage.

Staffing and management

The problem of how best to attract staff to work in rural areas is fundamental and widespread, especially in Africa where skilled staff are scarcer, and the communities in which the poor live are more remote and face worse living conditions. Paying more for staff to live in difficult posts, as Uganda is doing, may be part of the answer, but staff interviewed in Ghana took the view that amenities also need improvement before they would contemplate living and working in a remote rural location. Other incentives have also been contemplated, such as accelerated promotion, or bonding staff to a rural posting as a condition of completing their training. There is increasing use being made of staff with lower formal qualifications, either through policy or necessity, but willing to live within the poorer communities, and given more intensive supervision and in-service support. This trend is evident both in health and education.

Management reforms have aimed to achieve more of a performance related assessment at all levels, as in the Ghana approach of 'performance contracts' cascading down the system from the agreement of MoH with the Ghana Health Service to, ultimately, the process for assessing the performance of individual staff. It will take time to make such approaches credible in situations where promotion has traditionally not been dependent on performance, and where the ability to perform well may be limited by unreliable budgets or other factors outside the control of the individual. Alternative approaches to at least check abuses, strongly emphasised in Uganda, have relied on giving the population access to information on budgets and what they are to be spent on, and channels for complaint and redress if there are abuses. Another approach which several countries are looking at has been to go further towards giving communities some control over the resources, and increased choice on where they obtain services. This recognises the existing pattern

[1] Penrose (2001).

of preferences, though the management and Governance challenges of using Government funds in such a system are formidable.

1. Introduction

This report was originally commissioned by the Government of Finland on behalf of the like-minded donor group, in order to:

- Collect information on how effectively sector wide approaches are tackling poverty reduction objectives;

- Identify some lessons drawn from current good practice on how they can do so more effectively in future.

It is a follow up to a previous CAPE paper on the Status of SWAps, commissioned by Ireland for the like-minded donor meeting in Dublin in 2000. The current paper has a narrower focus, and readers are referred to the earlier paper for a more general review of the SWAp experience[2] We adopt a slightly modified version of the working definition used in the 'Status of SWAps' paper. The defining characteristics of a SWAP are that all significant public funding for the sector supports a single sector policy and expenditure programme, under Government leadership, adopting common approaches across the sector, and progressing towards relying on Government procedures to disburse and account for all public expenditure, however funded. The working definition focuses on the intended direction of change rather than just the current attainment. We have adopted a liberal interpretation of this definition in order to enable us to capture interesting experiences of sector coordination that may yield lessons for more effective poverty reduction.

Discussion at the Helsinki seminar for which this report was prepared raised fundamental questions about the definition of a sector, and the extent to which the traditional SWAp approach should be modified to recognise that, in many sectors, public expenditure is not central. This is evidently true in agriculture, but even in core social sectors such as health and education, the role of non-Government finance and non-Government service providers is often larger than that of Government. Participants also emphasised that decentralisation challenges the top-down sector ministry model, and that cross-cutting issues may require co-ordination across institutions.

We recognise that all of these issues are important, and we have tried to discuss the broader context of SWAps in the section on poverty reduction and sector strategy. Most sector programmes that we reviewed have given some attention to examining the role of Government relative to other actors, and have begun to consider alternatives to public funding and provision of services. Nevertheless, the main focus has been on improving the effectiveness of the Government role within sectors in which that role has been important if not central. SWAps have developed as a response to a dysfunctional public expenditure management system, and an important objective has been to bring Government and donors within a single sector policy and expenditure programme, preferably integrated within the Government budget. Though the objectives of the present generation of SWAps may be narrowly drawn, our view is that a review of how effectively these programmes are delivering improved services to poor people should still be of interest to Government and donors.

The report is a synthesis based upon a combination of replies to a questionnaire, reproduced as Annex 10, interrogation of documents on the referenced sector programmes, and comments and corrections offered after circulation of a first draft. The information on which this synthesis is based is reproduced in tabular form at Annex 1. More detailed case studies have been prepared for seven sector programmes, and these are reproduced in Annexes 2-9. Replies to the questionnaire were commissioned from key informants in Government, supplemented in some cases with invited

[2] Brown, Adrienne, Mick Foster, Andy Norton and Felix Naschold (2001)

replies from donors and others with knowledge of the programmes. Information available to us varied in completeness, and only one reply was received in relation to a Francophone country.

2. Poverty Diagnosis

Our assumption is that the starting points for ensuring poverty-focussed sector programmes are: good knowledge of who the poor are; what access they have at present to services provided under the sector programme; what priority they give to improving access; and what constraints need to be overcome in order to get improved services to them. There are some examples of good practice within our case studies (Box 1).

Box 1: Good Practice in Poverty Analysis for an Education SWAp

Zambia basic education started with relatively high baseline levels of primary education enrolment (85% in 1998).[3] Though equal numbers of boys and girls are enrolled in Grade 1, girls are more prone to drop out, with a gender gap appearing at grade 2 and widening in subsequent years. The focus of the diagnostic phase was therefore on the reasons for non-enrolment or low attendance and for dropout, particularly by vulnerable and poor groups, and on what was needed to improve educational outcomes.

The living standards monitoring survey data was used to analyse the relationship between school attendance and the economic status of the household, but was supplemented with action research which used more qualitative, participatory methods to explore the reasons and in some cases to pilot approaches to overcoming constraints.

Standards achieved in literacy and numeracy are measured, together with indicators of socio-economic status, through national assessments and through a regional scheme (SACMEQ). Though there are methodological problems, an attempt is made to make cross-country comparisons, and identify problems of low achievement by specific groups.

The annual school census has collected, in addition to enrolment data, data on the reasons for children dropping out from school.

On the inputs side, studies were undertaken of the condition of school infrastructure, and budget monitoring and expenditure tracking has focused on checking that resources reach the facility level and are spent appropriately.

Data on school performance has been linked to analysis of the factors influencing that performance, to help in identifying the key inputs required.

Though there are some weaknesses in the timeliness and reliability of information, BESSIP has tried to build the programme on analysis of who the poor are, what problems they face in getting access to schooling, which interventions are most effective in overcoming them, while information is also being collected to monitor the impact of the programme on enrolment, attendance, and progress in attaining literacy and numeracy.

A significant problem is that BESSIP is managed as a separate programme covering only part of the needs of the sub sector. There is weak co-ordination with the overall education budget, and especially the implications for secondary and higher education.

[3] Alternative estimates in some studies suggest enrolments considerably lower than this. (Steve Packer, personal communication.)

In many sector programmes, the poverty analysis was initially based on a priori reasoning, in some cases backed up by incidence analysis to reveal who benefits from current patterns of public spending. The critical assumption is that the poor are more likely to benefit from primary education expansion, or from basic primary and preventative health services and public health interventions. Though the figures need careful interpretation,[4] SWAps have allocated a high, and in many cases increasing, share of total spending to primary services (Table 1).

Table 1: Expenditure on primary services

Sector	**Proportion of Govt expenditure to Primary services in SWAp**
Uganda Health Sector	PHC share sharply increased to 2/3^{rds}
Tanzanian Health Sector	Only 1/3rd to primary health care
Ghana Health Sector	District share 26% 97, 46% 99.
Bangladesh Health Sector	65% to essential services package.
Uganda Education Sector	65% + allocated to primary level
Cambodian Education Sector	70% allocated to primary level
Ethiopian Education Sector	Primary up from 54% in 97 to 65%

However, Governments implementing sector programmes are increasingly recognising that simply increasing the share of the budget spent on primary services is insufficient, and more focused efforts are needed to overcome the specific problems which exclude poor and vulnerable groups from access to services. The involvement of Government and donors in a regular joint review of policy and process has helped to facilitate increased attention to improving the poverty analysis over time (Box 2). In several of our cases, information collected for the reviews is showing that the initial focus on supply driven improvements to Government services is not reaching the poor, and the focus is shifting towards understanding the specific constraints and needs of poor and vulnerable populations.

There is increasing recognition that charging for services has a major negative impact on their utilisation by the poor. The dramatic response of school enrolments to the abolition of charges in Uganda simply confirmed the evidence of participatory research and household surveys that cost is a major barrier to access to schooling for the poor. There is now a broad international consensus that achieving universal primary education will require the costs to parents to be minimised.

[4] For example, though Ghana increased the share of spending at district level and below, 60% of this is taken by district hospitals plus administration, and the absolute level of non-salary spending per head fell in the late 1990s. In other cases, part of the increased primary services share of public expenditure may reflect improved recording of donor flows brought onto the budget.

Box 2: Poverty analysis and Bangladesh HPSP

Bangladesh health and population started from an assumption that poverty concerns could be addressed by defining an essential services package for delivery largely through local level (Upazilla) facilities, and focusing an increased share of resources on delivering it. However, though the poor make more use of Government facilities than the rich and are receiving additional benefits as a result of the programme, Service Delivery Surveys have highlighted some of the more specific constraints on access by the poor.

For example, the poor wait longer and receive worse services while paying a larger share of their income. Gender discrimination is such that women are less likely than men to be able to seek treatment, while the poor in any case prefer to use NGO facilities where they are better treated. Public expenditure analysis by the health economics unit has revealed inequitable regional and urban-rural distribution of resources. Recognition of these problems has prompted moves towards a specific strategy for improving the focus of health and population services on the poor.

In the health sector, the charging issue is more difficult. In the low-income countries in our sample, the funds available for public health services are insufficient to finance universal access to even a basic package of health services. In Tanzania, for example, health financing studies in the early 1990s revealed that nominally free services were not reaching the poor, despite physical access to facilities. Chronic underfunding meant that drugs and staff were frequently not available, or services were only offered for illegal informal payments. This diagnosis led to conflicting views among the donors as to how to proceed. Some bilateral donors argued for increased funding, with a bigger share devoted to free delivery of a basic package of health services to all. The World Bank argued for cost recovery at all levels, including community financing for basic level services, with the community given more discretion to purchase services from non-Government providers in recognition of the poor quality and inadequate coverage of Government services. The outcome was to introduce cost recovery for higher levels of service provision, but to pilot community financing schemes. Cost recovery has not made the contribution initially expected of it, and accounts for only 2% of the sector budget.

Cost recovery does make a significantly bigger contribution in Mali and Ghana, but not without cost to the poor. In Mali, where basic health services are community based and largely funded and managed by the community, poorer communities have found it more difficult to establish and sustain services. In Ghana, where user charges finance 11% of public sector health spending, dramatic increases in utilisation of services were achieved by regions making energetic use of exemptions for the poor and vulnerable, in contrast to low utilisation elsewhere. In Uganda, the decision in 2001 to abolish user fees for health services was motivated by survey evidence that they represent a barrier to access by the poor, and has been vindicated by increased demand from the poor, including evidence of people seeking earlier (and therefore more effective) treatment.

Defining the role of Government and of the private sector and NGOs in the provision and financing of services has been difficult enough in the health and education sectors, and has probably not received the attention it deserves. These issues are even more central, and far more difficult, in agriculture. The role of Government in the sector is more contested, there is more emphasis on broader concerns to contribute to the economic growth on which sustaining social services depends, the interventions which are most effective in raising the livelihoods of poor farmers may lie outside the responsibility of the line ministry, and agricultural interventions need to address cross-cutting issues such as the environment and be responsive to location-specific concerns to a far greater

degree.[5] Poverty has not been a leading concern in the agriculture sector programmes we looked at. The poverty focus of Bolivia agriculture was added at the urging of the bilateral donors quite late in the preparation process; in Uganda it was pressure from the finance ministry that raised the profile of poverty concerns. Of the five major goals of Zambia ASIP, only 'ensure national and household food security' might be thought to have any direct poverty content. The Zambia programme was introduced into a difficult environment, with Government withdrawing from input supply and marketing in favour of the private sector. Farming in remote areas had developed in ways that depended on Government subsidies for survival. The mid-term review argued that remote areas, where the poorest farmers live, suffered disproportionately from the discontinuation of subsidies, and from the unwillingness of the private sector to take up services previously provided by Government. Though the Zambia ASIP had an extended planning process with numerous working groups and background studies, and access to a 1994 poverty assessment which highlighted some of the issues, the problems of resource poor farmers in a new, liberalised policy environment were not initially prioritised in the planning process. In part, this may reflect simply the lack of any policy consensus on what to do about the problem.

The focus on poverty in the evolving PRSP process is having an influence in sharpening the poverty analysis that underpins sector programmes. This is most successful where it is allied to a budget process that is committed to rewarding or punishing ministries for the extent to which sector budgets reflect good poverty analysis. Uganda is the only case we have found where there is clear evidence that the strength of the underlying poverty rationale has had a significant influence on budget allocations. There is some evidence in the case of Ghana to support the view that the process of preparing the Ghana poverty reduction strategy has helped to raise the profile of poverty issues in sector policy. For example, the renewed awareness and commitment to reducing regional inequalities in Ghana health occurred in parallel with a PRS process which was focusing public awareness on the problems of the far North. Similarly, the Ministry of Agriculture is finally beginning to give serious attention to the previously ignored problems of the poorest, disproportionately concentrated in the North and among food crop farmers.

[5] Brown, Foster and Naschold (2001).

3. Poverty Reduction and Sector Strategy

3.1 Poverty content of SWAps

The sector programmes which appear most convincing in their approach to addressing the problems of the poor do appear to be those where reaching the poor with improved services is an explicit and major objective, if not the over-arching objective of the programme: -

- The three education case studies prioritise poverty, recognise the international evidence that parental contributions (direct and indirect) are a major barrier to access by the poor, and have in all cases reduced these costs significantly. All three case study countries are seeking to develop approaches to attracting and retaining teachers in the more remote areas where the excluded poor are concentrated, though the success of these efforts cannot yet be predicted. Classroom construction is based on inventories to assess which areas are most in need.
- In Uganda, the overwhelming response of enrolments to abolition of primary school fees has eliminated gender and parental income biases in enrolment. Efforts are now focusing on raising quality sufficiently to sustain the gain that has been made. Zambia and Cambodia started with higher primary enrolment ratios, and are focusing additional measures on overcoming the constraints to enrolling those children still not in school, while improving the quality of the education they receive. Zambia has tried to identify causes of low attendance and dropout by poor and vulnerable children, conducting action research to test which interventions are most cost-effective in overcoming the problems. Zambia and Cambodia have introduced school health and nutrition programmes in some poor communities, to both improve incentives for attending school, and improve learning in school.
- The health programmes in Uganda and Bangladesh were each based on defining an essential package of services to be provided to all, including the poor, and implementing a commitment to increase the share of resources focused on that essential package. Ghana health was also based on making more resources available for primary and preventive services, defined to include first level referral hospitals. The share of resources spent on primary services has indeed been significantly increased, to around two thirds of the total in Bangladesh and in Uganda.
- Tanzania health, in contrast, has continued to spend 60% of a small health budget on hospital care. In spite of a smaller per capita health budget, Bangladesh spends more per head on primary level services than Tanzania. The problem is evident from the goals of the programme, which mention the roles of primary, secondary and tertiary services with no explicit commitment to changing the pattern of spending, and only a weak and general statement of the need for greater ‘equity’ in spending. The programme has remained committed to maintaining a range of infrastructure and attempting to finance a range of services that is evidently not affordable with the resources available. Cost recovery has been discussed as a long-term solution, but has yet to produce a significant financial contribution, while the effects on access by the poor remain of concern.
- Mali health does not emphasise poverty, based in part on the argument that 70% of the population are poor and extending coverage is sufficient. Though there is an overall sector programme, most support is in project form with emphasis on infrastructure development, with community contributions. This has reproduced many of the problems of the project world, with risks of expanding health facilities mainly in better off areas, while unavailability of staff and the limited ability of poorer communities to finance drugs and other recurrent costs are resulting in unviable, poorly utilised services in poor areas, together with increasing dependence on donor and NGO management and financial support. Some of these problems are recognised, and revised subsidy regimes are under consideration but not yet implemented.

- Agricultural sector programmes have had particular difficulty focusing on poverty, given their origins in growth and productivity objectives, and the problem of rethinking the public sector role in the sector. In Zambia, Bolivia (and proposals in Uganda), part of the response has been through providing support to community groups through investment capital, infrastructure, training and information services. The cross-sectoral nature of these interventions, and the close working with NGOs and community based organisations, reflects the need for demand driven and integrated approaches, but questions have been raised in Zambia and Uganda as to why agriculture ministries should be running what amounts to a micro projects scheme. In Zambia, coverage has been limited, and the elite have captured some of the benefits. Following the Zambia ASIP mid term review, which focused attention on the problems of small farmers in remote areas who had lost access to Government services which the private sector had been loath to replace, Government has also re-entered the business of supplying agricultural inputs, through a programme targeted at resource poor and vulnerable farmers, though not the poorest third of small holder farmers. The poorest will receive safety net benefits via the Ministry of Community Development and Social Welfare, presumably recognising that agriculture may not be a viable option in purely economic terms and the key issue is how best to protect them from poverty. It could be questioned whether re-entering the business of subsidising farmer inputs represents the most cost effective way to support the incomes of poor households into the medium term.

3.2 Sector strategy and overall poverty reduction strategies

Uganda was the first country to produce a full PRSP, and still represents best practice for reinforcing the poverty focus of sector programmes by integrating them within a coherent Government poverty strategy. Key elements of the approach are: -

- Poverty analysis identifies key priorities and Government role in responding to them in a poverty eradication action plan (PEAP);

- Medium term budget framework is derived from the priorities of the PEAP, and applies simple criteria to assessing the poverty content of sector programmes. Those expenditure programmes which deserve high priority based on their impact on the lives of the poor are identified and 'ring fenced' in a 'virtual' poverty action fund, which is no more than a device to label some parts of the budget for special treatment. The PAF part of the budget has doubled since 1997/98 to one third of total public expenditure, and is protected from in-year cuts, facilitating effective planning and management of poverty spending. The criteria for inclusion in the PAF have recently been promulgated (Box 3), and a poverty working group organised by finance assesses the eligibility of budget lines.
- Those sectors that prioritise poverty have received an increased share of the total budget. Thus the education share has significantly increased to fund primary education expansion, but spending on University education has been constrained, with Government calling on private funding to achieve a tripling of numbers. The health sector has reallocated expenditure towards primary and preventive services by capping the budget of the tertiary hospitals. The total share of the health sector was not increased until the share of primary and preventive services reached more reasonable levels, increasing from a derisory 8% in 1997/98 to over half in 2000/2001. The reallocation within health has nevertheless permitted a rapid increase in expenditure on primary health, albeit from a low baseline.
- Donors and other stakeholders are brought within the planning and budget process, working with Government on joint sector working groups to improve sector planning and budgeting. In return, donors have increased the share of their funding given as overall or sector budget support, to more than half of total aid flows.

- To ensure that funds get to where they are intended to be spent, Government uses the media to publicise budget releases, requires the display of notices at facility level, and promotes independent monitoring approaches including participatory poverty assessments, fund tracking studies, service delivery surveys, and involvement of donors and NGOs in verifying formal monitoring.

Box 3: Uganda Poverty Action Fund: Eligibility Criteria[6]

For an intervention to qualify as a PAF programme it must meet all of the following four criteria:

- It is in the Poverty Eradication Action Plan
- It is directly poverty reducing (raising incomes or improving the quality of life of the poor)
- It is delivering a service to the poor (it addresses the needs of the poorest 20%, and is accessible to them recognising barriers of e.g. cost)
- There is a well developed plan for the programme (a costed strategy with clear monitorable targets)

3.3 SWAps and inter-sectoral co-ordination

SWAps have usually been under the leadership of one key Government Ministry or agency responsible for co-ordinating the preparation, financing, and implementation of the sector strategy. For example, although most analysts would accept that health indicators might be more sensitive to investments in clean water, sanitation, education and nutrition than to health service interventions, health sector SWAps have focused on health ministry interventions. The problem has been that the incentive structure provides few rewards to officials for behaving in a cross-sectoral way. The multi-sectoral vision tends to get increasingly diluted as the programme moves towards detailed design and then implementation. Committees involving stakeholders from other sectors may be established but rarely meet, officials prioritise maximising their sectoral budgets and achieving the sector-specific objectives for which they are directly accountable. Exceptions are hard to find.

One of our sources argued that the success which Uganda has achieved in reducing infection rates for HIV/AIDS, arguably the most serious single problem requiring a cross-ministry approach, is an example of a programme led from within a sector Ministry that achieved sufficient coordination to be effective.[7] Ethiopia also presents an interesting example of joint preparation of health and education sector programmes, though we have no information on the practical outcomes in terms of design of the programme, nor on whether coordination has continued. Mali health reports reasonable coordination so far between the two ministries implementing the programme, and with decentralisation authorities, while coordination at district level has been facilitated by cross-sectoral NGOs. There are some interesting examples emerging in the agricultural sector, though it is too early to judge their success. In Uganda, the Programme for the Modernisation of Agriculture has been prepared as a cross-cutting programme of interventions to support rural development, coordinated by finance and planning rather than agriculture. Despite these few exceptions, our

[6] Government of Uganda, Ministry of Finance and Economic Planning (2001).

evidence suggests that co-ordination between sectors has generally been weak, a problem not confined to low income countries.

3.4 The role of government, the private sector, NGOs – and households

There are active private markets in virtually every sector in which SWAps have been attempted, including health and education. The problem from a poverty perspective is that the private sector usually does not meet the needs of the poor. This may be caused by some form of market failure that prevents the private sector supplying the services that are needed, or may simply reflect the effects of poverty on the ability of the poor to purchase services that are available.

Government has a wide range of options on how to react to these problems:

- **Who pays?** Government has choices over what services it chooses to pay for from general taxation. Government may attempt to finance universal free provision of comprehensive health or education services, or may focus on universal free provision of a more narrowly defined range of services (e.g. primary education, basic preventive and primary health interventions). Alternatively or additionally, Government may try to target the subsidies on particular groups within the population, possibly those unable to pay, or (if they are too difficult to identify) proxies such as the very old or those living in deprived communities.
- **Who provides?** Even if Government finances the services, it may procure some or all of those services from private or NGO not for profit service providers. Conversely, Government may organise to provide a service but recover some or all of the cost from the user.
- **Who regulates?** Even if Government is neither financing nor providing the service, it may have a regulatory role, for example inspecting private schools, or ensuring safety by certifying medical practitioners. Especially where Government is itself a major supplier, it may be important to set up independent channels to inspect and regulate the quality of services being provided, through routes such as an Ombudsman, or an independent Audit Office reporting to Parliament, or by empowering media, NGOs and other civil society organisations to hold Government to account.
- **Who decides?** The hierarchical model, in which central Government policy determines what resources should be available to each sector and how they should be spent, is only one alternative. Decisions (and resources) can be decentralised to local Government, or to communities, or even to individual households, with more or less freedom to decide what services will be purchased, and from whom. If taken to the logical extreme, this approach would conflict with the whole concept of a sector approach, with decentralised decision-makers free to prioritise between roads or education services or other locally determined needs, and with scope to address cross-cutting issues such as the environment by local-level co-ordination of inputs across a range of sectors and institutions.

Although most SWAps have in practice emphasised a public sector financing and supply model, the wider menu of options outlined above is increasingly coming onto the table, partly in order to more effectively address poverty.

Regarding 'who pays?', Governments have recognised that the growth of private for profit services or public private partnerships can be helpful in meeting middle class demands for a broader range of higher quality services, leaving Government free to focus more of its resources on the needs of the poor. Private involvement in higher education in Uganda and Cambodia has been encouraged

[7] The extent of cross-sector collaboration has been questioned, with some observers giving the main credit to the public debate started by the president (Bella Bird, personal communication).

explicitly to release resources for primary schools. Hospitals in Uganda had their budgets capped, but were allowed to increase their charges, including premium services for those willing to pay premium prices. In the Ghana health sector, increased overall reliance on user charges has been accompanied by concentrating free provision on a narrow range of high priority and cost-effective interventions, together with an attempt to exempt from any charges those unable to pay. The approach of subsidising only a narrow range of services may meet political resistance however: both Uganda and Ghana have abolished all health user fees in the aftermath of elections, and Zambia health also had to reverse reforms aimed at reducing public spending on tertiary hospitals.

Regarding 'who provides?', there are many examples of Government funds being used in order to procure services from non-Government service providers. This is a major feature of the Ghana health programme. Uganda health channels some funding to NGO service providers in order to avoid duplicating facilities. In Mozambique health, it is envisaged that Government will overcome capacity constraints by commissioning services from a range of public, NGO, and private providers. Education programmes frequently provide funding and in some cases staff for schools financed by the community or by faith based organisations.
In a tight budget situation, allowing some of that budget to go 'outside' can meet resistance from Government officials. The issue of providing financial support to community schools in Zambia faced initial resistance, and local Government in Uganda has been reluctant to pass on budget resources intended to help finance NGO health service providers.

Our impression is that the question 'who regulates?' has received little attention in SWAps per se, partly reflecting weak Government capacity. Uganda has given a great deal of attention to efforts to empower communities and NGOs to hold Government to account, with transparency of information, channels of complaint and redress, 'whistle blower protection' in the legislative programme, and involvement of NGOs and donors in monitoring.

The issue of 'who decides' is receiving increasing attention, and is especially important to poverty reduction. One response to poor quality services which do not meet the needs of users is to move decision-making closer to the people, and allow them increased say over the type of services they receive. Decentralisation to local authorities has not always resulted in more accountable Government. In Uganda, spending on primary health collapsed, and Government subsequently imposed detailed, prescriptive conditional grants to ensure that national priorities were respected. More generally, sector Ministries have resisted the loss of power implied by decentralisation, and have preferred to decentralise decision-making to local level staff who remain primarily answerable to the sector authorities.

Accountability seems to be stronger where decentralisation has been to the lowest tiers of Government most visible to local populations. Good results are reported from efforts to decentralise budgets to individual schools, or to sub-district level and below, especially where supported with efforts to give users information and 'voice' to hold Government officials to account, as Uganda has sought to do.

A number of sector programmes are experimenting with ways to give users more direct influence over how funds are spent, with scope to procure services from a range of public or private providers. In Mali, the system at community level is largely financed and managed by communities, draws heavily on NGO support, while communities are free to purchase care from any service provider. Bangladesh, Tanzania and Mozambique are experimenting with communities commissioning health services from public or NGO sectors. Ghana envisages moving strongly towards community health insurance to finance health services. Uganda agriculture modernisation envisages farmer groups commissioning research or extension services from private suppliers, though the details are yet to be worked out. Though the intention to move in these directions is

becoming increasingly common, none of our country cases has yet solved the formidable logistical, governance and capacity problems that will need to be overcome if more decentralised and community driven approaches are to work in ways that ensure access by the poor.

4. Poverty Reduction, Sector Expenditure, and Poverty Impact

4.1 The cost of reaching the poor

Budgets are traditionally prepared on an incremental basis, assuming continuation of last year's spending patterns plus something for inflation and for growth in demand for services. This works against the interests of the poor. The poor are most likely to lack access to Government services at present, and they are most likely to be expensive to reach with services due to remoteness or the need for higher subsidies to bring services within their reach. A radical reorientation of spending priorities will be required in order to reach them. It is important to explicitly identify what costs will be incurred in bringing services to the poor, compare those costs with the resources available to Government and donors, and find a way to match resources to costs while retaining the focus on reaching the poor.

This is fairly straightforward to achieve in the case of primary education. Teachers are the dominant cost, often representing around 90% of recurrent expenditure. The key determinants of achieving universal primary education are thus the number of children to be enrolled, the class size, and the costs of teachers. It is important for quality reasons to also ensure adequate supply of books and teaching materials, but these are not a major cost compared to the cost of teachers. There are costs and trade-offs between teacher salaries and qualifications and the cost of in-service training and teacher supervision, but they are not in principle difficult to estimate. The capital costs are dominated by classroom construction and rehabilitation. This is again in principle easy to estimate once an inventory has been taken of the condition of existing schools, though there are choices to be made on how quickly to overcome a backlog, what technology to use and who should decide, how much to rely on community contributions of labour and materials, how much use can be made of temporary buildings or double shifting. There are difficult issues concerning what proportion of students should be assumed to progress to secondary level, and what parental contributions should be required at that level. Costing at higher levels is in principle trickier, and there are more opportunities for relying on private sector financing and private sector service providers. However, in principle, it is not difficult to model the likely costs of achieving universal primary education, and the Uganda case makes a reasonable fist of estimating those costs, based on assumed increases in teacher salaries and reduction in class sizes and in the pupil: book ratio.

Costing is more of a challenge in the health sector. Private contributions to health care costs usually exceed those of Government, even though recorded user fees typically represent a small share of the budget. It is in principle feasible to estimate the costs of delivering the essential health package, based on the cost of establishing, staffing, and providing drugs and other consumables for the operation of fixed and outreach services from health facilities within (say) a 5km walk of each population centre, and with norms adjusted to population and to health characteristics (e.g. extra weighting for malarial areas). Similar exercises can in principle be undertaken for referral services, based on their catchment areas. In practice, the exercise is more complex. People have a choice about whether to seek health care and where to seek it, and modern public sector providers meet only a fraction of the demand. The costs of any attempt to reach full coverage with even basic services will be substantially beyond the per capita budgets of $5 or less available in Tanzania or Bangladesh: the World Bank figure of $12 at 1993 prices for funding an essential services package can be criticised, but the existence of a substantial resource gap for complete coverage is unarguable. Given the limited health care budgets available, reaching the poor clearly requires a narrow definition of the services that Government will finance for all, and a strong focus on channelling resources towards those services.

Bangladesh and Uganda both attempted to cost their health sector programmes with respect to the services they were attempting to provide. In both cases, the costs exceeded the resources that could be made available by a significant margin. Similar conclusions have been drawn by the 1999 joint review of the Ghana programme, based on more limited but nevertheless persuasive analysis. Actual budgets made available have had to be adjusted to the available resources. It has proved difficult to ensure that necessary adjustments are made in ways that preserve a focus on the core priorities, rather than implementing cruder cuts to needs based planning figures. In all cases, the inadequacy of the budget implies that free primary health services can not be given to everyone. The implications for the poor of the de facto rationing which is inevitable given the budget shortfall, are nowhere analysed. Both Governments and donors have yet to face up to the need for choices to be made, while the low demand which results from poorly targeted and under-funded services has helped to disguise the problem. Nevertheless, the low access to curative health services by the poor in each of our sample countries, with little evidence of improvement, confirms the importance of explicitly tackling the issue.

The sector programmes typically include targets for outcomes. In the health sector, the linkages between targets for maternal or infant mortality, and the interventions intended to bring them about, are very indirect, and whether the targets are achieved may bear little relation to the successful implementation of the programme, especially in situations where the growth of the AIDS epidemic is in any case likely to overwhelm progress made. Interventions in nutrition, water and sanitation or in girls' education may in any case have greater impact. It would in principle be possible to base the targets on the expected impact of specific interventions: immunisation coverage, bed nets and other malaria interventions, improved coverage of ante-natal care. The essential services package on which the Bangladesh HPSP is based largely derives from analysis undertaken during the design phase of the programme by the health economics unit in Bangladesh. This explored the cost effectiveness of alternative interventions in contributing to the targets, based on estimation of Disability Adjusted Life Years (DALYs) saved.[8] The main problem with the approach has been the relatively weak empirical foundation for some of the estimates, and the lack of subsequent verification of actual performance. Where the programme is based on more decentralised management of services, as in Ghana, the specification of targets for specific interventions and estimation of their impact becomes even more problematic, though Ghana also undertook research into DALYs saved by alternative interventions.

One of the biggest impacts of health sector expenditures on the poor may well be through helping households to avoid catastrophic consequences for household livelihoods when breadwinners are sick. Service delivery surveys suggest the poor often do not use modern medical facilities when ill, and that cost is a major consideration. Pilot studies of community health insurance in Bangladesh confirmed that the poor would only be willing to pay if hospital costs were covered, a common finding from willingness to pay studies. This aspect is receiving increasing attention in the SWAps, with increasing focus on developing pilot schemes for pre-payment or community financing of health costs. The Bamako approach as used in Mali goes furthest in this regard, though poorer communities and possibly some poor individuals may not be covered.

The authors are not competent to comment on the relative merits of alternative health intervention strategies, but it may also be worth mentioning the limited evidence from Ghana and Mozambique that outreach services may be more cost-effective than facility based services in reaching poor populations.

[8] Mick Foster, November 1999, Project Completion Report of Health Economics Unit and Output to Purpose Review of Strategic Investment in Health Economics.

The ASIP in Zambia bases the cost estimates on an activity based budget, which does link resources to the cost of achieving objectives. However, the lack of poverty focus, or of clear objectives related to the coverage or reach of services, limits the usefulness of this from a poverty perspective. The Bolivia agriculture programme is based on basket funding of interventions undertaken in partnership with other stakeholders, but our information does not reveal to what extent there is a linkage from the individual interventions to national objectives for the population to be reached.

4.2 Implementing expenditure plans

Several of the programmes protect spending on the poor from cuts due to unexpected shortfalls in funding during the budget year. Uganda does this through a virtual fund, the Poverty Action Fund, which ring-fences the budgets for all of the poverty priorities identified in the poverty eradication action plan. This commitment, in place since 1998/99, has been kept, and has given a powerful incentive to sectors to prioritise poverty programmes, and increased confidence to plan them in the expectation of receiving the required budget. Tanzania has a similar arrangement. At the level of individuals, exemption schemes in health have aimed to shield the poor from costs, though they have faced problems of inconsistent implementation and the success of targeting is unclear from our case studies.

The problem of resources not reaching the intended point of service delivery has been repeatedly experienced – especially where decentralisation of services has enabled local Government to access resources. In Bolivia, municipalities favour infrastructure investments over services, while in Uganda, administrative decentralisation was accompanied by falling expenditure on primary healthcare.[9] Tracking studies found that a high percentage of funds intended for primary healthcare and for primary education were not reaching their intended target.[10] The Ministry of Health introduced very detailed conditions on how funds were to be used (conditional grants) in order to ensure that local authorities allocated funds for primary services. Education similarly introduced conditional grants allocated to specific schools, and reinforced the pressures on local Government to ensure they were used as intended by publicising each fund release in newspapers and on local radio, and calling for notices to be displayed at schools and local Government offices. The approach has worked: the most recent tracking study showed 90% of funds now reaching the schools, though financial management capacity at school level is weak and there are some questions as to how cost-effectively funds have been used. Zambia BESSIP takes a similar approach, with some funding sent directly to schools to reduce risks of them being diverted to other uses.

Decentralisation is commonly accompanied by a requirement for districts to meet certain requirements in return for managing funds. Ghana, Tanzania and Uganda health all require district plans to be produced, and place obligations on budget centres to meet certain criteria of planning and accountability before funds are released. The Bamako approach used in Mali health also places major financial obligations on communities in return for support. The poorest districts usually have most difficulty in meeting both types of criteria, and additional support to enable them to comply will be important if the conditions are not to lead to increased discrimination against poor areas. If a budget management centre in Ghana fails the test, Ghana health avoids an anti poor bias by channelling the same funding via another route (e.g. with the region managing the funds), while additional support is used to help them to achieve the standard.

[9] Brown, Adrienne (2000).
[10] Foster and Mijumbi (2001).

4.3 Have the poor benefited?

Evidence on actual benefits to the poor is becoming available for some of the more long-established programmes, or those where Government has itself been collecting good performance data before the advent of the SWAp. We have not limited ourselves to changes that occurred after the SWAp was introduced. We have tried to identify any influence which the SWAp process itself has had on the treatment of poverty, but we believe the broader donor interest should be to establish whether the sector strategy they are supporting is producing the hoped for level of benefits. If some of those benefits result from pre-existing policies and programmes, the evidence is still helpful in indicating that the SWAP is supporting a successful strategy to which Government is committed. Of our case study cases:

- Uganda education has dramatically raised primary enrolment and eliminated both wealth and gender biases in enrolment; Ethiopia has raised primary enrolment from 30% to 50% since the mid 1990s, with improvement in some quality indicators such as books per pupil, but major problems of inequality and of low demand persist.
- Zambia education builds on a successful increase in primary enrolments in the 1990s, from 68% to 85%, and is now focusing on measures to reach the excluded groups.
- Bangladesh health and population service delivery survey reports only 10% of households using Government health services for treatment compared to 43% using private or NGO facilities in the month before the survey. Some 22% of households did not seek care for ill members. The poor make more use of Government services than the non-poor, though biases in coverage against the poorest, against women, and against rural areas remain. The 2000 survey appears to show a decline in satisfaction with Government services and increased use of private or NGO facilities compared to the previous year, with drug availability a particular problem. Comparability is an issue, but the surveys provide an uncomfortable picture of a health service with poor coverage, where the poor face longer waits and are less likely to be provided with medicines, and with no evidence to suggest that the situation is improving.
- Tanzania health is new, but takes place against a backdrop of deteriorating services and a low share to primary services, so the auguries are not encouraging.
- Uganda health presents a mixed picture. The average community now has a better maintained clinic (percentage 'well maintained' up from 30% to 59%), closer to the community centre (average distance from 6.7 to 4.6 km – though half the population is still more than 5km from a health facility), slightly better stocked with drugs, bandages, needles and vaccines, and with access to a doctor also marginally improved. Where qualified staff have been recruited, utilisation rates have increased markedly. The proportion of the population receiving medical services from modern medical facilities when ill appears to have increased from 63% in 1992 to 78% in 1999. Use of pre-natal care has increased from 74% to 80%, and post natal from 42% to 49%. The incidence of stunting and underweight children has fallen, though overall reporting of illness and of days lost to illness has increased, possibly reflecting the impact of HIV, and increased health demand by a wealthier population.[11] The most significant achievement is the reduction in HIV, where infection rates have halved nationally due to a rapid fall in urban areas, thanks to a relentless public education campaign on behaviour change which was largely led by the health sector. Infection rates have also begun to fall in rural areas. Immunisation coverage has stagnated or fallen since 1995/96. Only 38% of children are reported as fully immunised by their 1st birthday.[12] Most depressing of all, infant and under five mortality has increased since 1995.[13]

[11] Deininger (2001).
[12] DFID *et al* (2000-2005).
[13] Bella Bird, personal communication quoting preliminary DHS survey results for 2001.

- Ghana health has achieved some improvements in vaccination rates and in ante-natal care, and outcome indicators show continued progress in reducing infant and child mortality. Utilisation of curative services had been falling in the 1990s, but appear to have increased significantly in 2000, though maintaining that improvement will be a challenge given the bleak short-term outlook for the budget. Overall, though there are marked inequalities in spending and in achievements between regions, the results are encouraging against a background of little real growth in health sector spending.
- Mozambique, reflecting improvements during the 1990s before the SWAP, seems to have achieved improvements in vaccination and antenatal care through doubling of health staff and a focus on outreach.
- Mali has faced falling utilisation of curative care, associated with poor financial viability of services and staff shortages.

5. Poverty Reduction and Sector Management

We can hypothesise that sector programmes are more likely to benefit the poor where:

- The views and priorities of the poor are taken into account in the design of the sector programme.
- The poor have some voice in the management of the services that they directly use.
- Competent staff are in place, including in remote areas where the poor live, and are paid and managed in such a way that they have adequate incentives to provide the services that the poor demand.
- The planning and budget process enables staff to plan and implement effective services, making available the budget required to implement services in full and in time.
- Managers at all levels have available the information to assess their performance and learn how to improve it.

Uganda and Zambia have both undertaken participatory poverty assessments that have influenced Government policy, and have established a permanent capacity to apply participatory techniques to inform Government policy. The PPA conclusions often seem obvious once they are written down, but PPAs consistently draw attention to important, but ignored, problems that affect community access to services. In the case of Uganda, the UPPAP project is located within the Ministry of Finance and Economic Planning, with a recognised role in the budget process via the poverty working group, which reviews budget submissions. The PPA was one of the sources that identified the high priority that the poor give to improved health services and to access to clean water. Evidence from the PPA on the importance of cost barriers was influential in decisions to abolish user fees in primary education and, more recently, in health services. It also reinforced the importance of market access for agricultural development while confirming the limited reach of agricultural services, leading to a different approach to the programme to modernise agriculture.

The PPA, together with tracking and service delivery surveys, identified problems of corruption and of resources not reaching communities, leading to more conditional approaches to local Government finance, and to approaches which delivered resources directly to communities and facilities and encouraged them to hold officials to account. In Zambia also, the PPA resulted in the identification of problems at sector level, including the need to avoid charging school and other fees during the hungry period of the year, and the adverse consequences for access by the poor of health charges and rude health staff. Zambia has gone further in education, using participatory consultations and action research to explore the effectiveness of different responses to identified problems. The 1994 Ghana PPA also collected valuable material on the health sector, but was conducted by the World Bank and was not well disseminated. The findings were not used in the design of health policy, though many of the same points resurfaced later in work on health inequalities commissioned for the 2000 Joint Review.

The issue of moving management closer to the point of delivery, and giving communities increased say, needs care. Devolution to district level in Uganda was still too remote from the poor, and District Government was found to be less willing than national Government to prioritise poverty concerns. Better results appear to be being achieved through decentralisation to the lowest tiers of Government and to individual facilities, where accountability to communities is more realistic. The process can be assisted through emphasis on transparency of financial and management information, and through encouraging independent monitoring and channels of redress.

In countries that are highly unequal and divided at village level, as in Bangladesh and parts of Mali, decentralisation to the village level can be disastrous for the poor, who may be excluded and

exploited by the land-owning elite or by dominant ethnic groups. If women and the vulnerable excluded groups are to be covered, the Bangladesh HPSP has recognised that targeted measures are needed to secure their access to services.

Recruiting staff to live and work in the more remote areas is a problem in all of the African cases. In addition to overall salary reforms or other incentives such as housing, a variety of different approaches have proved successful in different environments:

- The NGO BRAC in Bangladesh education,[14] and NGO providers in the health sector in Uganda, have shown that it is possible to achieve higher performance than Government staff despite paying lower salaries. In the education sector, locally recruited teachers or teacher assistants can reduce costs and improve teacher availability. In the Bangladesh education case, teachers with lower qualifications and lower salaries (and hence lower costs) were able to achieve better results when more intensively supervised and provided with access to lively teaching materials.
- Bangladesh health is one of a number of health programmes that makes effective use of community level volunteers with limited training to deliver some key interventions at a fraction of the cost. Some countries have made service in rural areas a requirement for being registered as a doctor or other health professional, a form of bonding that has dual benefits of producing better trained health professionals as well as helping overcome the rural staffing problem.

The problem of giving staff appropriate incentives has been tackled in a range of ways. Uganda is trying to introduce a formal performance appraisal system, based on civil service reform models used in the UK and other developed countries. Ghana has similarly introduced a system of performance management based on 'contracts' which cascade down through the management chain from the contract between the Ministry and the Ghana Health Service, to individual managers responsible for specific budget management centres. Achieving the necessary change in culture to convince staff that the previous patrimonial systems of promotion have been replaced by a more performance based approach will take time. Meanwhile, other approaches can help to reinforce a performance culture in Government. A stronger role for communities in management, transparency of decision making, league tables to enable districts and facilities to assess and compare their performance, and conditional grants dependent on performance have all been applied in one or more of the sector programmes reviewed, with varying levels of success.

None of these approaches will work if a dysfunctional budget process means that managers are unable to do their jobs effectively because resources do not arrive on time. Aspects of this have been a problem in each of our cases. Even in Uganda, where the budget for poverty spending is protected and released in full, administrative problems have caused delays of several months before new recruits receive any pay, and the excessively detailed guidance in health sector conditional grants have made it impossible for district staff to access the funds in a timely manner. In Ghana, poor budget discipline has undermined the attempt to put in place an effective medium term budget framework, though astute financial management by the health sector has enabled them to achieve better budget predictability than other sectors. In Tanzania, the unpredictable budget releases under the cash budget system has undermined the attempt to introduce a realistic medium term planning and budget approach.

If sector managers are to be held accountable for the effectiveness of the sector in achieving objectives related to improving the lives of the poor, then they need specific objectives, and information to enable progress towards those objectives to be tracked. This is being done in a number of ways. Household survey data is being used to indicate the proportion of the population making use of different services, and can reveal how this differs according to the level of income

[14] Mehrotra and Buckland (1998).

poverty of the household. In the case of Uganda, it has been possible to use successive surveys to track changes over time, while the community survey which accompanies the household survey has enabled data on distance to and condition of nearest health facility or primary school to be added in.

Household survey data can reveal national and regional trends, but will not reveal the reasons for the patterns observed. Bangladesh and Uganda have used repeated service delivery surveys, employing a combination of focus group and direct interviews, in order to explore why people did or did not make use of services, and their experience and opinions of them. It seems likely that overall satisfaction levels will not prove helpful as an indicator of performance since we can not easily judge how assessments react to extraneous events and influences ('feel good' factors), but the surveys have proved very helpful in assessing the coverage and quality of services, and revealing the extent of problems such as discrimination, harassment, illegal charging, absent staff, and unavailability of supplies.

In addition to regularly repeated surveys, several of the sector programmes have demonstrated the usefulness of establishing a permanent capacity to undertake policy research in order to explore problems and find solutions. Zambia education has made extensive use of action research. Bangladesh has established a health economics unit, which has undertaken both regular surveys such as the health public expenditure review, and more ad hoc studies such as investigations into the cost-effectiveness of facilities at different levels. The Poverty Monitoring and Analysis Unit in Uganda performs a similar function, but addressing poverty policy issues across all sectors.

These sources can provide a cross-check on regular reporting collected from administrative records, and help to place the management reports into the broader context of how effectively Government services reach the population as a whole.

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Annex 1: Summary Table of SWAps

Sector programmes and poverty reduction

Country and Sector	Ugandan Education Sector[15]	Cambodian Education Sector[16]	Zambian Education Sector[17]
Time period covered	1998-2003	2001-2005	1999-2000
Poverty diagnosis & sector design	Cost barrier to enrolment was identified, but policy was then driven by need to cope with massive enrolment increase after the 1996 political commitment to free UPE. Information from tracking studies has proved helpful in overcoming problems of getting money to schools.	Analysis informed by detailed information with a specific pro-poor focus, including work on teachers' status and income; consultations with provinces; survey on parents and teachers' satisfaction; NGO information.	Clear analysis of the specific problems of the poor in accessing quality education, using information on enrolment by socio-economic status, inputs at school level, pupil attainment in literacy and numeracy, and action research to test specific interventions. Participatory design process led to a strong emphasis on achieving gender and locational equity.
Sector programme and PRSP strategy	Fully integrated planning and budget framework is in place from PRSP priorities to MTEF to SWAp.	The sector contributed to the improved Interim PRSP, and policies are consistent with it. However the full PRSP process has encountered problems with coordinating planning, finance and line ministries.	BESSIP predated PRSP, but emphasises poorer groups. BESSIP is a partial programme, not fully integrated with sector planning and budget, and has had to overcome coordination problems.
Cross sector co-ordination	Seems to have been good on HIV/AIDS, though mainly reflects leadership commitment	There is some co-ordination, but it is hampered by the political situation	Co-ordination within education sector has been challenging at times, authors unaware of coordination with other sectors.
Defined targets	Focus on 3 key quality targets: class size; teacher pupil ratio; (unambitious) pupil book ratio.	Numerical targets for enrolling out of school children; number of teachers to receive professional development; number of communities to benefit from increased access to primary and secondary schools.	Specific targets and indicators were developed to ensure programme responds to needs of poor. Includes improved physical access through construction of classrooms in underserved areas; improved availability of trained teachers in rural areas.

[15] See Annex 2.
[16] See Annex 3.
[17] See Annex 4.

Country and Sector	Ugandan Education Sector[15]	Cambodian Education Sector[16]	Zambian Education Sector[17]
The role of the private sector & NGOs	The involvement of private sector at University level increased enrolments while releasing resources for primary education.	Expansion of private enrolments at higher levels is encouraged, to release Govt funds for basic education. NGOs represented on reviews, involved in training, Govt is reviewing expanded NGO role in capacity building, monitoring, channelling of funding.	The private sector participates in joint reviews & in programmes for training of teachers. Both Govt and Community Schools receive Govt grants, and some community school teachers are on Govt payroll.
Pro-poor programme measures	Reduced cost of UPE to parents; more classrooms; incentives for teachers in rural areas; measures to make Govt accountable to parents for use of funds.	The whole programme is centred on being pro-poor. Most significant is the reduction of basic education costs to parents	Pro-poor measures include decentralisation (direct funding to schools for basic school needs began in 2001); piloting of a school Health and Nutrition Programme; the bursary scheme; targeting the building programme in underserved areas.
Costing and targeting	The sector is fully costed, teacher salary adjustment needs phasing in. Big increase in primary education spending, education 27% of budget.	The sector programme is fully costed and relates costs to targets, but confirmation of funds available still uncertain.	There has been a shift from incremental to activity budgeting. BESSIP was fully costed and funded, but is not integrated in the Govt budget. Additional funding is being sought for the recently added HIV/AIDS component..
Provisions to protect the poor from funding shortfalls	Primary education spending fully protected through poverty action fund (PAF).	The Priority Action Programme (PAP) protects key poverty expenditures.	BESSIP is a programme outside the budget, and implementation capacity is the main constraint e.g. they did not spend the whole 2000 budget. However, the number of vulnerable children is increasing due to HIV/AIDS so there will be need for additional funding for bursaries.
Proportion costed to pro-poor	65% plus of education budget for primary.	70% of recurrent spending for primary and junior secondary	Unclear, BESSIP is only part of the sector expenditure.
Evidence of changes in utilisation of services	UPE has increased primary GER to 82% reducing gender and wealth biases	Not yet started.	Too early to comment on, but enrolments increased in 1990s.

Country and Sector	Ugandan Education Sector[15]	Cambodian Education Sector[16]	Zambian Education Sector[17]
Poverty reduction and sector management	Following efforts to empower parents & headteachers through funds direct to schools and greater transparency, 90% of intended budget now reaches schools. Involvement of donors and NGOs in monitoring. Efforts to improve linkage from results to performance are at an early stage. Teacher shortages and weak payroll management undermine sector performance.	Innovative PAP decentralises budgets, gives authority to vire funds to meet programme targets.	Joint Steering Committee monitors and supervises BESSIP through twice-yearly joint reviews. There is more accountability and improved monitoring, data collection and analysis activities focus on whether the target groups are benefiting. Decentralisation pilot has improved services to the poor & is being extended.

Annex 1: Summary Table of SWAps ctd

Sector programmes and poverty reduction

Country and Sector	South Africa Education Sector[18][19]	Ethiopia Education Sector[20]
Time period covered	2000-2004	
Poverty diagnosis & sector design	Considerable poverty diagnosis, based on analytical work and consultation on the conditions and needs prevailing in the system, particularly regarding access and participation by the poor. Relies on work done in the context of broad poverty surveys and qualitative work.	There was little poverty diagnosis in the design of the programme and virtually no community level participation or consultation with poorer groups. Supply led (eg. increase the number of schools), it does not address low demand for schooling due to lack of post education opportunities[21].
Poverty reduction and sector strategy	There were tensions between the social development goals of the RDP[22] (focusing on redress) and the goals of the GEAR[23] Strategy (human capital development for growth).	Pre-dates the PRSP.
Sector programme and PRSP strategy	Inconsistencies occurred because of tensions between goals of RDP and GEAR, competing priorities between eg higher education and basic education	.
Cross sector co-ordination	Coordination between DoE and Department of Labour facilitated through permanent standing committees. Social development government cluster – includes DOE, health and social development	The health and education SWAp preparation stages were carried out simultaneously. Unclear if there is still cross sectoral co-ordination
Defined targets	Sector uses UNESCO targets and process & input targets (e.g. formulation of policies and strategies, establishment of management and governance structures, teacher training, safety review and special attention to HIV/Aids). No specific poverty targets.	Targets improvement in indicators of quality (e.g. teachers in post, student pass rates); equity (by region and gender); efficiency (drop out and repetition); access and budget/expenditure. Targets have been criticised as over ambitious within the time frame and available budget.[24]
The role of the private sector & NGOs	NGOs are increasingly engaged in collaboration with the national and provincial DoEs, but their role is limited. Private sector role is greater at secondary and higher levels of education and focussing on clients who can pay.	According to Diessen, NGOs feel alienated from the SWAp and have not been involved in the design or implementation of the programme

[18] Main source: Dr Wim Hoppers, Netherlands Ministry of Foreign Affairs/Regional Education Adviser, Pretoria, South Africa, wim.hoppers@minbuza.nl
[19] This is a sector programme in so much as the Department of Education has since 1994 embarked upon an educational transformation programme that is contributed to by most donors.
[20] Main sources: Diesen et al (1999); Preparation of Education Sector Development Programme; ESDP Second Joint Review.
[21] Diesen et al. (1999).
[22] Reconstruction and Development Programme (South Africa does not have a PRSP).
[23] Growth Employment and Redistribution strategy.
[24] Diesen et al (1999).

Country and Sector	South Africa Education Sector[18][19]	Ethiopia Education Sector[20]
Pro-poor programme measures	Decentralisation of school/teacher support services; promotion of local education resource and community education centres; introduction of ICT applications into townships and rural areas; development of low cost supplementary teaching/learning materials in remote areas; progs for the development and dissemination of multilingual language programmes and to enable schools to respond to diversities in schools.	There is no mention of any specific pro-poor measures – understandably given extent of poverty and low current enrolments.
Costing and targeting	The sector programme is not costed	Poor coordination of capital investment with recurrent cost implications due to split responsibility at national and regional level. Regional budgets were unrealistic due to lack of timely information on budget ceilings and poor information transfer between all levels on policy decisions with budget implications. Regions not prioritising education within overall constraint on Central Govt transfers. Because of the current system, schools have no/ little resources (rec. non-salary) to manage themselves. Drought, war risk make funding shortfalls likely.
Provisions to protect the poor from funding shortfalls	Unknown	There does not seem to be any provision to protect spending on primary education from shortfalls
Proportion costed to pro-poor	Is estimated that 57% of total budget is spent on the poorest 40% of the population	Primary share has increased from 54% to 65% since 1996/97
Evidence of changes in utilisation of services	Some increase in enrolment of the primary level age group (net enrolment 87% in 1997). Exam results seem to be improving. Data on actual participation and completion by the poor are unavailable	Primary GER increased from 30% in 1995/96 to 50% in 2001/2002, but is only 25% in most underserved areas. Certain quality indicators have improved e.g. student textbook ratio is at 1:1 compared to 5:1 in 1995/96.
Poverty reduction and sector management	There is greater area-focused intervention. However, there are still major problems with regard to ensuring efficiency gains. It has been difficult to monitor educational change and outcomes.	Timeliness of reporting and feedback is hampered by problems of communication within departments and between different levels. Regular reports are provided on financial and physical progress. Feedback is increasingly being provided from higher to lower levels either through a discussion meeting or correspondence. However human capacity in Zone/Woreda/school levels is very weak

Annex 1: Summary Table of SWAps ctd

Sector programmes and poverty reduction

Country and Sector	Uganda Health Sector[25]	Tanzanian Health Sector[26]	Mozambique Health Sector[27]
Time period covered	2001-2005	1999-2000	1998-
Poverty diagnosis	Govt poverty strategy has a good diagnosis, which confirmed that health is a major concern of the poor, but Govt health services were failing, NGOs were preferred. In response to PPA findings that the poor identify cost as a major constraint to accessing services, the Govt abolished user fees.	Household surveys and financial tracking studies provided a clear picture of a public sector health system in which facilities starved of cash and staff no longer provided meaningful services, especially in rural areas. However there was little in the way of gender or poverty analysis.	Analysis of disaggregated data collected from facilities since 1990, plus baseline information from DHS survey, shows uneven but remarkably high service coverage, despite low spending & low staffing. Admin data also shows improved coverage since mid 1990s, possibly due to doubling of staff numbers, though the improvement may be overstated because the budget allocation formula gives an incentive to exaggerate performance.
Poverty reduction and sector strategy	To bring donors and Govt within SWAp. Focused on essential service package, increasing the budget share to primary and preventive services, using conditional grants to local Govt and tertiary hospital budgets capped.	Major concern was to integrate donor projects into a coherent strategy. There has been a focus on user fees, but sums collected have been insignificant compared to the potential for reallocation and efficiency gains within the system.	To overcome skill shortages and reduce inequality in coverage e.g. North-South, based on decentralised service delivery using a range of providers.
Sector programme and PRSP strategy	Fully integrated planning and budget framework is in place.	Sector programme predated the PRSP and there is currently little coordination.	The documents state that the sector programme is consistent with priorities of PRSP – evidence of practice is unavailable
Cross sector co-ordination	Seems to have been good on HIV/AIDS, less so on water/sanitation.	Some as part of annual budget cycle and public expenditure review process.	There is coordination on an adhoc basis
Defined targets	General targets such as: To double the coverage of health facilities to one fully staffed in every parish; to increase immunisation coverage from 33% to 80%; to slash child and maternal mortality.	There are no specific poverty targets, overall targets lack definition of actions and resources to achieve them. There is an assumption that the poor will be covered through improved access	Target since 1995 has been to increase coverage to 70% of the population by 2001. Disaggregated progress indicators cover resource allocation (e.g. per capita recurrent expenditure on health); Inputs[4] (e.g, proportion of health posts lacking trained staff); outputs (e.g. coverage of vaccinations & antenatal care per year – first visit). There are no specific poverty targets.

[25] See annex 5.
[26] See Annex 6.
[27] Main Sources: Devereux et al (1999); Mozambique PRSP Paper; Medium Term Expenditure Framework; Fozzard (2001).

Country and Sector	Uganda Health Sector	Tanzanian Health Sector	Mozambique Health Sector
The Role of The Private sector & NGOs	Some government funding is available to enable NGOs to provide subsidised services on behalf of the Government	Few NGO service providers, Govt. finance goes predominantly to Govt. services. But Govt. is keen to develop private role in financing services through formal & community health insurance.	Within a decentralised health service, the MoH contract services from the NHS, NGOs, private, independent and mission services.
Pro-poor Programme measures	Focus on preventative and primary health care. In 2001, abolition of charges.	Primary level curative and preventative services (but allocation of resources remains skewed towards hospitals).	Emphasis on reducing inequalities in coverage, given near universal rural poverty; greater attention for rural areas, primary health care, community care and essential drug programmes.
Sector Expenditure			
Costing and targeting	Full coverage not affordable with available finance, implying continued low access by the poor.	The sector programme is not costed, the exercise would be difficult given uncertain response to improving an under-resourced, under-utilised system.	Targets not so far costed and linked to budget. Skills shortages and financial sustainability are binding constraints on further expanding coverage, given the risks of further increasing dependence on donors for recurrent costs.
Provisions to protect the poor from funding shortfalls	Primary and preventative healthcare share has increased from negligible levels to 2/3 of spending, and is protected from in-year budget cuts. Charges ended.	There is some effort to ring-fence priority areas. However, these are not necessarily to benefit the poor	Information N/A
Proportion costed to pro-poor	2/3rds of expenditure is targeted on minimum healthcare package. Only when MoH strategy addressed PRS priorities did finance allocate additional resources.	This is unclear, although as an indication 1/3rd of expenditure goes to primary health care	50% of health sector recurrent expenditure goes to hospitals for mainly curative care
Evidence of changes in utilisation of services	Some increased utilisation, but not for immunisation, ante-natal, malaria. U5MR & IMR are increasing. Positive response to ending fees, including earlier treatment being sought for e.g. malaria.	Too early to be sure, but utilisation of services was falling.	Administrative data shows increases in coverage of vaccinations and pre-natal consultations to 80% plus, plausible given DHS baseline, doubling of staff, and use of outreach brigades.
Poverty Reduction and Sector Management	Prescriptive, centrally driven approach introduced because local Govt did not prioritise PHC, but is too bureaucratic.	Health staff prepare & MOH approves district health plans, little participation. Salaries too low to motivate staff.	This is unclear

Country and Sector	Uganda Health Sector	Tanzanian Health Sector	Mozambique Health Sector
Change in public expenditure due to reforms	Strong budget planning process led by MoF and Economic planning has been central to reorientation of pattern of health spending	Limited progress in health, but integration of public expenditure review and dialogue with donors as part of budget process has helped to focus attention on spending pattern of Govt, reinforced by PRSP.	This is not clear
Institutional Improvement to meet the needs of the poor	Conditional grants aim to ensure funds reach intended use, but reporting and accounting requirements make them hard to use, and the reform and simplification of the conditional grant system is on the agenda.	Devolving authority to districts and community level is considered to help meet the needs of the poor. However, in practice there is little consultation within districts and little participation by civil society.	Communities will establish their own priorities through District development planning process, which will cover health. Unclear how this will be coordinated with MOH procuring services from a range of public, NGO, or private providers, with performance payments to providers to encourage efficiency, and assistance to those provinces or institutions that miss their targets.
Impact assessment and feedback to policy	Impact is assessed through: - Regular HH expenditure and health surveys - Regular reporting by the districts - Donor and NGO involvement - Service Delivery Survey - Tracking study planned However, there are problems of weak capacity in preparing monitoring reports.	Previously the emphasis of reviews was on expenditure rather than achievement. Performance indicators are currently being developed (rather late in the day).	

Annex 1: Summary Table of SWAps ctd

Sector programmes and poverty reduction

Country and Sector	Bangladesh Health Sector[28]	Mali Health & Social Development[29]	Ghana Health Sector[30]
Time period covered	1998-2003	1998-2002	1997-2001 2002-2006 under preparation
Poverty diagnosis & Sector design	Quantitative DHS and benefit incidence analysis drove initial supply-led approach. Service delivery and exit surveys subsequently raised awareness of the need for more targeted interventions to reach the poor.	No specific poverty analysis. Recent priority to diseases of the poor (e.g. malaria) prompted by opportunity to access aid, not local analysis. Evidence that poor communities are least able to contribute to capital, or maintain viable services based on cost recovery.	Design is the result of 3-4 year analysis and consensus building process by MOH and stakeholders. Analysis showed poor quality services, the poor benefiting least and excluded by high cost of services. More recent data and analysis has reinforced awareness of unequal access by region, between urban-rural, and within regions.
Poverty reduction and sector strategy	Essential services package based on analysis of health problems of poor and the health facilities most utilised by them. More targeted poverty strategy for health now under preparation.	Based on Bamako Initiative, emphasis on community contributions to capital costs, self-financing community health services. Some priority to poorer areas (& some controversy on which areas really are poorer).	Improve access to primary and outreach services while improving quality of care and efficiency of resource allocation, and protecting critical interventions & the poor from charges. Reducing inequality is the main challenge for the next 5Y-POW
SWAp & PRSP	The Sector programme seems to be consistent with the analysis and priorities of the PRSP and it is hoped will be the basis of a health section of the PRSP- but health is not represented on the PRSP committee.	PRSP process addressing cross-sectoral HIV/AIDS policy formulation.	The health programme is co-ordinating with the preparation of the Poverty Reduction Strategy.
Cross sector co-ordination	PRSP does not comprehensively cover health (urban, nutrition outside). Limited coordination outside the sector.	Seems good between the 2 ministries, meetings also with decentralisation authorities, stronger with education etc at district level where NGOs play facilitating role.	Broad concept of health in initial planning got diluted in execution, limited inter-sectoral co-ordination in practice. The main focus of coordination is via intersectoral poverty working groups relating to the PRSP process. Little LG influence, decentralised within health service.
Defined targets	There are 50 national indicators and IMR and MMR thought to be good proxies for poverty sensitivity. However, most program targets are not poverty disaggregated.	Objectives to reduce social marginalisation of destitute or handicapped people as well as to increase the incomes of socially disadvantaged and vulnerable. Revised document will have more specific targets.	Targets for shifting resources to lower levels, improving coverage and quality of service, such as outpatients visit per capita, EPI coverage, couple years of protection, % children using bednets. Targets for exemptions spending.

[28] See annex 7.
[29] Main Source: Marius W. de Jong, Ministry of Foreign Affairs, Netherlands.
[30] See Annex 8.

Country and Sector	Bangladesh Health Sector[28]	Mali Health & Social Development[29]	Ghana Health Sector[30]
The role of the private sector & NGOs	The sector is working on innovative approaches to commissioning private and NGO services.	The policy is to increase participation of NGO's and private sector. Heavy focus on projects, many executed by NGO's.	The private, non-profit sector has an important role in executing the health programme, especially in rural areas. Although capacity to engage in private sector is weak, it remains strong on the agenda.
Pro-poor programme measures	Integrated health and family planning services through new community clinics serving 6000 population, with community involvement in planning and management. Maternal mortality as a key outcome target. Community insurance pilots. Client Charter of Rights. More specific strategy to target the poor is under development.	Strategy to subsidise non-viable health facilities in poor areas not yet implemented, health insurance and pre payment also expected to benefit poor people.	Resources and staff directed to lower level facilities and outreach services; exemption policy; paupers fund, and pricing policies favouring primary healthcare. Priority to key interventions, e.g. for safe motherhood, training TBAs, malaria, TB, HIV/AIDS and guinea worm. Posting health staff in the community.
Costing and targeting	Ad hoc adjustment to initial unaffordable costing has resulted in inadequate non-salary budgets, exacerbated by inefficiencies within the system, e.g. chronic over-prescribing.	Strategy is costed and financed, but the emphasis on investment causes problems of facilities understaffed & underresourced, & therefore under used and not financially viable. Poorest communities are least well served.	The MTEF process costs activities at each BMC, but weak linkages of resources to national targets. Budgets are based on realistic forecast of funds available.
Provisions to protect the poor from funding shortfalls	Lack of drugs a major problem in Govt facilities, impacting especially on poor users.	Some attempt to subsidise poorer areas unable to afford cost recovery, pre-payment to shelter households from unexpected costs, help to destitute.	Exemptions should protect services to the poor, but the policy is not uniformly applied, real exemptions spending shrinking.
Proportion costed to pro-poor	65% of budget to ESP, though evidence from SDS shows that impact on the poor is limited .	Unclear	Expenditure on primary healthcare has not been calculated. Resources allocated to district level and below increased from 26% to 46% but 28% for admin and hospitals, only 12% for health centres.
Expenditure and sector plan	A review of ESP found that most of expenditure is accounted for in salary and allowances and that there are inequalities in distribution of public spending by geographical region.	No data found on actual utilisation of resources.	Expenditures match priorities set in the Sector Plan and Budget, but with higher than expected reliance on user charges (11% of budget, while estimated at 6%).
Evidence of changes in utilisation of services	Surveys suggest utilisation of services by the poor is very low, & is not improving. The poor face longer waits and are less likely to be provided with medicines.	Falling use of curative care, due to costs and poor quality. Immunisation rates though have been sustained.	The utilisation of curative services only began to improve in 2000, outreach coverage has improved but not everywhere, inequality is a major concern. Antenatal and vaccination coverage has improved, dramatically in two poor regions where attention was given to exemptions.

Country and Sector	Bangladesh Health Sector[28]	Mali Health & Social Development[29]	Ghana Health Sector[30]
Poverty Reduction and Sector Management	Centralised budget process lacks flexibility	Decentralised, community driven model, but also dependence on donor or NGO managed projects to sustain services.	Decentralised budget/planning subject to check of capacity to manage funds. The linking with output targets and performance incentives is not yet well developed.
Change in public expenditure due to reforms	Budget process centralised, Govt spending has been cut.	Unclear.	MTEF not effective due to macro problems, real per capita spending on health has not grown, decentralised health budget management has been a success.
Institutional improvement to meet the needs of the poor	Services closer to community with more stakeholder involvement; strategies to overcome specific problems of access and quality of services to the poor are under preparation.	Beneficiaries' health committees run services at health centre level (supervised by the district authorities that are paid for by public funds). Unclear if this benefits or excludes the poor.	Quality assurance processes have been introduced in some regions although there is no stated focus on meeting the needs of the poor. Public participation is weak as are incentives to focus on the poor.
Impact assessment and feedback to policy	Little demand for analysis of poverty problems from Govt managers, but policy unit provides rich source of data and analysis to inform policy, and joint review process is focussing more attention on poverty issues.	Unclear.	Studies commissioned for joint reviews have influenced the decision to focus the next POW on quality & responsiveness to consumer needs and more specific measures to reduce inequality & cater for the needs of the poor.

Annex 1: Summary Table of SWAps ctd

Sector programmes and poverty reduction

Country and Sector	Zambian Agricultural Sector[31]	Bolivia Agriculture[32]	South Africa Water Services[33]
Time period covered	1996-2001	2000-2005	2001-2004
Poverty diagnosis & sector design	Participatory Poverty Assessment, household surveys and beneficiary assessment informed numerous studies during the extended preparation phase. Studies drew attention to problems of marginal farmers losing access to subsidised services, but they were not the major focus.	Impact studies and evaluations and national consultation process revealed poor performance of projects and strong demand for a new approach. No specific poverty analysis from Government, but the issue is being urged by bilateral donors involved during the further operationalisation of the programme.	Assumption that the goal of delivering water services is welcomed by the poor and that water service delivery is a key instrument for poverty reduction. Poor not directly consulted, although "civil society" sits on a steering committee. However, focus is on three most impoverished regions from a water service delivery point of view.
Poverty reduction and sector strategy	ASIP does not focus on poverty, main focus on overcoming inefficiencies of project approaches, need for coherent sector strategy, re-drawing the role of the State.	The sectoral programme is based on the establishment of joint ventures between the private sector and civil society organisations on one hand and the government on the other	
Sector programme and PRSP strategy	ASIP pre-dates the PRSP. It is hoped that the next phase will be closely linked with PRSP	Fully consistent, though PRSP lacks clear vision for agriculture role in poverty reduction.	South has a Reconstruction and Development Programme (RDP) rather than a PRSP. Water sector is consistent with RDP's targets
Cross sector co-ordination	In principal there is much co-ordination – not sure in practice	Coordination with Ministries of Finance, Economic Affairs, Commerce and Sustainable Development, and with indigenous organisations, NGO's working in the field of agriculture and rural development.	Poverty reduction is not the main driver for coordination. However, despite lack of adequate capacity, here is an effort to involve different players through participation in national and regional steering committees. Also awareness workshops carried out by Water Affairs Department and local govt.

[31] Annex 9.
[32] Main source: Marten de Boer, Netherlands' Embassy, La Paz (Bolivia); Specialist on Productive Rural Development, marten-de.boer@minbuza.nl
[33] Main source: Questionnaire reply, Ministry of Foreign Affairs, Netherlands.

Country and Sector	Zambian Agricultural Sector[31]	Bolivia Agriculture[32]	South Africa Water Services[33]
Defined targets	No specific poverty targets.	Objectives include contributing to sustained solution to rural poverty through integrated, participatory approaches.	No specific poverty focused targets.
The role of the private sector & NGOs	Limited (see below)	The programme places major emphasis on the role of the private sector and NGO's in the execution and monitoring of activities	Role of private sector is acknowledged
Pro-poor programme measures	Govt withdrawal from input supply and marketing has been a major poverty issue. Programme has been dominated by Govt service provision, but not poverty focused.	Specific focus and criteria for facilitating access of poor and marginalized groups to activities; special fund for strategic activities in marginalized areas.	The emphasis on community participation and gender mainstreaming is thought to significantly benefit poor groups
Costing and targeting		The sector programme is costed and has sufficient funding, in the form of a co-ordinated donor basket fund, to cover all of its aspects.	The programme is costed and relates specific outputs to the budget. Targets seem realistic.
Provisions to protect the poor from funding shortfalls	Limited investment to offset adverse impacts, limited coverage, leakage to non-poor. The Programme does not target the very poor.	There are sufficient provisions to protect the poor from funding shortfalls.	All spending relates to programmes from which the poor are expected to be beneficiaries, as they are targeted to poor rural provinces.
Proportion costed to pro-poor	N/A	No breakdown has been made according to categories of beneficiaries, as the major part of the programme is directed towards the rural population, of whom over 85% are considered poor.	N/A
Expenditure and sector plan	Hoped for level of support has not materialised.	Too early to assess actual spending patterns.	This appears to be a regional programme, rather than support to the sector as a whole?
Evidence of changes in utilisation of services	No data found.	Too early.	N/A
Poverty reduction and sector management	Unclear.	Ministry reform plan envisages decentralisation, focus on core functions.	

Country and Sector	Zambian Agricultural Sector	Bolivia Agriculture	South Africa Water Services
Changes in public expenditure due to the reforms	Unclear.	Decentralisation has increased availability of funds at the local level, but municipal councils have prioritised infrastructure, with limited impact on the quality of services provided.	Decentralisation of responsibility to municipalities, expected to cover the cost of water services from cost recovery and taxes in order to provide sustainable services. In the short term this may result in lower service levels and higher costs.
Impact assessment	Unclear.	Too early. A monitoring system with clear indicators is being designed to closely follow the impact of the programmes.	Mid term QoL audits are carried out to measure effect on the ground. The impact on the poor is one of the effects measured. This information flows back to steering committee which then decides on strategy and policy (process not yet running)

Annex 2: Uganda Education

Uganda Education (ESIP) 1998-2005

The authors alone are responsible for the opinions and for the accuracy of the facts included in this case study. However, for replies to questionnaires and detailed comments, they are indebted to: Bella Bird and Malcolm Seath, DFID Uganda. The case study also draws heavily on research carried out in February/March 2001 by Mick Foster.[34]

Achievements of the ESIP

- UPE has succeeded in achieving a big increase in enrolments to 82% of the primary age group, eliminating both gender and wealth biases in enrolment
- Children from the lowest income decile are now as likely to enroll as those from the highest decile
- The average distance to school has declined from 1.8km in 1992 to 1.4km in 1999
- The proportion of classrooms in good condition has increased from 10% to 25%
- 90% of intended funds are now reaching primary schools[50]

Abbreviations

ESIP	Education Sector Investment Programme
LTEF	Long Term Expenditure Framework
MoES	Ministry of Education and Sports
PEAP	Poverty Eradication Action Plan
PRSP	Poverty Reduction Strategy
UPE	Universal Primary Education
UPPAP	Uganda Participatory Poverty Assessment Project

1. Poverty diagnosis

Education policy has been driven less by analysis than by the largely unexpected consequences of the 1996 commitment to Universal Primary Education, though the policy was informed by repeated studies showing that cost was the most significant barrier to access. The sharp reduction in costs to parents resulted in a massive overnight increase in primary school enrolments, and policy has been driven by the need to cope with the consequences while trying to maintain and increase the quality of primary education.

Tracking studies undertaken in the mid 1990s found that funds intended for primary schools were not reaching them. This led directly to a change of approach to funding primary education.

[34] Based on Foster and Mijumbi (2001).
[35] Deininger (2001); UBOS (2001); Foster & Mijumbi (2001).

2. Poverty reduction and sector strategy

The big increase in enrolments has not been matched by an increase in teachers, with the result that Uganda now has some of the largest class sizes in the world. Books, a key quality enhancing input, are in very short supply, with one book between six, which can be compared with India, where a less costly school system manages to provide a full set of textbooks for every primary pupil.

The World Bank, DFID and other donors provided early support to assist in developing an education sector programme, to help in financing the additional classrooms, recruiting and training the additional teachers, and making available at school level the additional resources needed to cope with the consequences of increased enrolments while sustaining and improving the quality of education. The education sector programme establishes targets to be achieved by May 2003: reducing the pupil-teacher ratio (from 63 to 48), the pupil-classroom ratio (from 121 to 92), and the pupil-textbook ratio (from an appalling 6:1 to a still grossly inadequate 3:1).[36]

Universal Primary Education has been in resource allocation terms the most significant expenditure programme within the Government Poverty Eradication Action Plan. The Ministry of Education has focused an increased share of resources on achieving the primary education goals, while developing alternative approaches to funding higher and secondary education, with University enrolment tripling due to private funding without requiring any increase in the share of the education budget. The clear focus of the education sector on priorities consistent with the PEAP has been rewarded with an increased 27% share of the national budget, two thirds of which is accounted for by primary education, which is included in the Government Poverty Action Fund and thereby protected from the risk of cuts within the year.

Primary education is the responsibility of local government. In order to ensure that funds reach schools and are spent in line with national priorities, funding has been provided in the form of conditional grants, specifying how they are to be used. Some funds go directly to schools, and Government publicises fund releases and requires public display of notices in schools and local Government offices. This plus NGO and donor involvement in monitoring appears to have solved the previous problem of diversion of funds, and 90% of intended funding is now reaching schools.

The task facing Government is to cope with the children currently in school. The key poverty objectives at present are to ensure that those in school can achieve a worthwhile learning experience, and thus the focus is on recruiting teachers to work in rural areas, improving the physical infrastructure, and making more resources available.

The Government has made attempts to get teachers into the most disadvantaged areas by offering a difficult post allowance and this may have the desired effect. Only 25% of trainee teachers graduate from the Pre-Service College seven though 90% complete their teaching practice successfully. The whole system of teacher training needs to be overhauled.

Not all Government decisions have been helpful: the recent decision to double the subjects in the curriculum makes little sense when basic literacy and numeracy is not assured, and when there are appallingly low levels of teachers and books available. Government has also faced criticism for slow progress in overcoming the long-standing problems preventing new teachers from accessing the payroll without long delays, and for slow progress in recruiting teachers.

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[36] Although the textbook pupil ratio is poor the situation is made worse by the fact that those books that are available do not seem to be in use. It is not clear why this should be the case and futher investigation is required (Malcolm Seath, personal communication).

3. Poverty reduction and sector expenditure

Sector programme costing

As part of the Government's Long Term Expenditure Framework (LTEF) an initial attempt has been made to cost the public expenditure implications of the entire PEAP. The costs are indicative, and will need to be refined over time, but meeting the PEAP targets implies an immediate 60% increase in total public spending. Primary education would require one third of the additional funds in order to achieve targets for classrooms, pupil teacher ratios, teacher pay, and textbooks.

The implication is that progress towards the targets of the PEAP will need to be phased in. Teacher pay is the largest single component, and various approaches to managing it are being considered: double shifting in schools, use of teachers with lower initial qualifications, phasing in of the 76% real increase in salaries which is planned. Based on evidence from other countries on what matters for achieving improved educational outcomes, there would be merit in accelerating progress towards getting more books and teaching materials into schools at the cost of marginally slower progress in bringing down the pupil teacher ratio.

The recent household survey data shows that UPE has succeeded in achieving a big increase in enrolments to 82% of the primary school age group, eliminating both gender and wealth biases in enrolment: children from the lowest income decile, only half of whom were enrolled in 1992, are now as likely as those from the highest income decile to be enrolled in school. The high cost of schooling remains the leading cause of drop out from primary school, but the increased enrolment of children from low income households and the closing of the enrolment gap between rich and poor shows that the cost barrier is now far lower than in 1992, when households met more than half the cost of schooling.[37] Attention to overcoming gender barriers has included a focus on latrines (important for girls reaching puberty), and MOES are working up a more specific policy for education for disadvantaged children, preparing for a transition to the more targeted interventions which will be needed to reach the children who are still outside the school system.

Impact assessment

The effort to construct more classrooms is reflected in a decline in average distance to school, from 1.8 km in 1992 to 1.4 km in 1999, with the proportion of classrooms in good condition increasing from 10% to 25%. This partly reflects the classroom construction effort, but may also indicate that the ending of school fees released community resources to improve the fabric of the school buildings. It may also indicate the success of the conditional grant system in ensuring that resources intended to reach the school are actually spent there. The 2000 tracking study found 90% of funds intended for expenditure at school level are now reaching their intended schools, though there are question marks over how they are used and accounted for at school level.[38] This represents a big improvement on the 1996 tracking study and the 1998 education audit, both of which found long delays and a large share of the funds being held back.[39]

The quality effects of UPE are not yet apparent, though the PRSP acknowledges some evidence of declining quality, and we were told that tests at grade 3 appear to show a decline in performance when comparing the first post-UPE cohort with their pre-UPE predecessors: 'While the 1998 National Integrity Survey found that 60 percent of parents were satisfied with the quality of their children's education, the UPPAP investigation found widespread concern with schooling quality

[37] Deininger (2001). Also, UBOS (2001).
[38] MES (2000).
[39] Price Waterhouse (1998).

among the poor communities contacted. This is borne out by more formal investigations of schooling quality. The heavily burdened primary schooling system cannot meet the immediate demands for classrooms, teachers, and teaching/learning materials.'[40] This negative assessment needs to be considered in the context that the big increases in enrolments have been in rural areas where the poorer schools are located, hence exam results would drop on average even if the quality of education within individual schools had been maintained.

The effects of the education investment on income poverty and productivity are more difficult to assess. Cross section household survey data does appear to show a positive association of the education level achieved by the household head and the expenditure of the household. However, this could reflect the fact that education, before UPE, was a luxury good, from which the poor were excluded on cost grounds: the causality may run from income to education as a consumer good, not from education to income. A preliminary analysis of panel data from 1992 and 1999/2000 appears to show no relationship between the 1992 level of education of the household head and subsequent growth in household expenditure. Part of the problem may be lack of opportunities to utilise education: it is interesting that the conflict affected North, where economic activity was most disrupted, continued to report far higher levels of non-attendance at school due to 'lack of interest', which may reflect recognition of lack of opportunities.

4. Poverty reduction and sector management

The approach to improving the management of performance rests on the introduction of output oriented planning, budgeting and evaluation by all public agencies, and objective and open performance appraisal of personnel.[41]

For the moment, these remain largely targets and good intentions for the future. A recent survey of decentralised personnel management found that, although both district and facility level staff claim that performance is an important factor in promotion decisions, only 12% of teachers reported having their performance evaluated annually. Poor performance appears to be widespread. Three quarters of district level staff reported that sanctions had been imposed on teachers within the last year for misconduct, corruption, insubordination, poor performance, or abuse of students. In some ways, this could be viewed as a positive indication that action is taken when poor performance requires it, though, in one quarter of cases, effective action was prevented, usually by councillors.

The sector programme has emphasised just three simple objectives for evaluating performance at sector level. The problem for the line ministries has been that they are responsible for delivering on the targets, but need to do so via local government structures which may not share the same goals, which lack capacity, have exhibited poor accountability for their actions, and may be only weakly committed to improving performance management.

The highly prescriptive conditional grant system has been an attempt to ensure that local Government implements national policy, supported by mandatory publicity to empower communities to hold officials to account. However, school management committee members may be illiterate and innumerate, and neither they nor often the head teacher have much notion of bookkeeping. Few schools keep good financial records, and such information as was available from the tracking study suggested that schools were paying too high prices for short deliveries, with some risk that head teachers may be supplementing their incomes in this way. Lack of noticeboards meant that many notices were placed in staff rooms or the head teacher's office, not available for general inspection. Where the display of information is having an impact, it is through a few individuals who are well placed to understand the notices: Parish Development Committees, and

[40] Government of Uganda
[41] World Bank (2001).

school and health centre management committees may in some cases have some awareness, the general public mostly not. Greater transparency does seem to offer potential as part of an overall strategy for raising the effectiveness of public spending, and if sustained may eventually succeed in beginning to alter the culture in which decisions are made, and the balance of power between provider and user of services.

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Annex 3: Cambodia Education

Cambodia Education Sector (2001-2005)

The authors alone are responsible for the opinions and for the accuracy of the facts included in this case study. However, for replies to questionnaires and detailed comments, they are indebted Catherine Dom, Director DT Consulting, dtconsult@synet.be

The Government and Ministry of Education, Youth and Sport (MoEYS) is committed to a policy-driven education programme aimed at implementing key reforms for equitable access, quality improvement, managing and financing of education services at all levels.[42] *The Education Sector provides a good example of a sector wide strategy that has been informed by analysis of current access to services by different groups within the poor. It also has a strong poverty focus. As it is so early on in the programme, however, it is impossible to make a judgement on its impact.*

Cambodia Education Sector

- The primary schooling phase is 6 years
- There are significant regional disparities with 100%
- GER in some areas compared to between 45% and 60% in more remote areas
- GER for primary education is 90%
- NER for primary education is 70%
- The mean GER for girls is 84% compared with the combined ratio of 90%

Abbreviations

ADB	Asian Development Bank
CSES	Cambodia Socio-Economic Survey
ESP	Education Strategic Plan
GER	Gross enrolment ratio
MEF	Ministry of Economy and Finance
MoP	Ministry of Planning
MoEYS	Ministry of Education, Youth and Sport
MTEF	Medium Term Expenditure Framework
NER	Net enrolment ratio
NGO	Non Governmental Organisation
PAP	Priority Action Plan
PRSP	Poverty Reduction Strategy Paper
SEDP	Socio Economic Development Plan
WFP	World Food Programme

[42] Education Strategic Plan (2001)

1. Poverty diagnosis

In designing the sector programme a large body of detailed information and previous analyses were used with a specific pro-poor focus, including:

- Data from national Cambodia Socio-Economic Surveys (CSES) 1997 and 1999. This was a very detailed, household level sample allowing analysis down to commune level[43]
- Several special medium-size surveys e.g. by WFP. Older small-scale surveys undertaken for the education sector were also consulted.[44]
- Work on teachers' status and incomes[45]
- During preparation of the ESP, there were large nation-wide consultations with Provincial authorities and involving districts, schools and parents.
- Survey of parents' and teachers' satisfaction.
- Tracer survey of secondary students, which yielded interesting, results in terms of the impact of poverty constraints.
- The use of much NGO information

2. Poverty reduction and sector strategy

ESP and PRSP

The ESP policies and strategies are consistent with and contributed to the Interim Poverty Reduction Strategy Paper (IPRSP) that was approved in late 2000. The ESP strategies are reproduced almost literally in the two documents.

However, one difficulty is that there is also a 5 year Planning System (inherited from the communist Vietnamese regime) and, with ADB support, the Government recently completed a second five year Socio Economic Development Plan (SEDP 2001-2005) also focusing on poverty reduction. Attempts to reconcile the two processes have failed. The SEDP process was not participatory, due to the target of completing the exercise before the June 2001 CG meeting. The I-PRSP process was more participatory i.e. involving a lot of officials from all ministries and provinces and a few NGO people. The process was led by the Ministry of Economy and Finance (MEF), which is more powerful than MOP with better human resources. However, it has now been decided that for consistency purposes the preparation process for the full PRSP is going to be under MOP. Meanwhile, MEF is talking of introducing an MTEF, but it is not yet clear how the planning process, the PRSP, and the medium term budget priorities will be coordinated.

The role of Government, NGOs and private sector

For several years after the country was open again to the outside world, NGOs and UN organisations were the only agencies to be active. The result is a proliferation of NGOs, some of them long established within their areas of operation, and subject to only the loosest regulation or control by Government. MoEYS commissioned a study on partnership with NGOs, which was well conducted and well received. As a result, NGOs are now organising themselves through a membership organisation that will have a Board accountable to its members and in charge of representing the NGOs as MoEYS interlocuteur. An interim Board is in place and will be a full member of the first joint annual review of the ESP in June 2001. Several priority programs that will be appraised explore options on how NGOs could be used effectively as agents for decentralised

[43] 1600 communes in 180 districts in 24 Provinces and Municipalities
[44] E.g. cost of primary schooling by Mark Bray in 1996/97
[45] PASEC – EU project, 1997; France Kemmerer under preparation of EQIP LIL WB 1999

capacity building, independent program monitoring, or even for channelling funds (given the scarcity of banks up-country!) NGOs are also very active in vocational training in areas where there is no Government coverage, an activity that, from 2002, will be partly subsidised from the Ministry's budget.

MoEYS has also pursued partnership with the private sector, encouraging the growth of private enrolment especially in upper and post-secondary education, with a view to protecting the focus of public funding on basic education.

Cross-sector coordination

Poverty reduction requires the sector authorities to coordinate with Ministries or institutions outside the sector. The Education sector feels the need to establish coordination mechanisms that will ensure that the commitment is a Government commitment. In its policy loan, the ADB is pushing for the establishment of an education sector Financial Management Group, involving staff from the education and finance ministries.

Pro-poor targets

The immediate beneficiaries and targets of the programme are stated as:

- An estimated additional 100,000 children will be able to access schooling as a result of new facilities
- 50,000 teachers will receive professional development
- 5,000 MoEY officials, provincial and district officials to receive short-term training
- 50 MoEY officials will receive longer term training
- Communities in 100 districts will benefit from increased access to secondary schools
- 500 communes will benefit from new or expanded primary school facilities
- Pupils in every public school will benefit from sustained access to text books
- Every student will benefit from the improvements in the curriculum and textbooks that will eventually be published.[46]

Measures included within the programme that are pro-poor

The whole strategic plan is pro-poor. Many of the measures could be related to the poverty concern, one way or another. However, the most significant ones are the reduction of the basic education costs to parents. For the first time since before the Khmer Rouge, public money is going to schools thus off-setting part of the school needs, and scholarships are being provided. There are efficiency gains but any cost savings are off-set by the intention to increase considerably the per pupil spending. Specific poverty oriented strategies include:

- Reduction of average parental contribution to basic education costs through increased public funding of school operating budgets, already started in 2000
- Setting up scholarship programs at all levels (presumably targeted on disadvantaged pupils, the authors have no information on the eligibility criteria);
- The criteria for investment in school facilities favour villages without primary schools, completion of small incomplete schools, secondary schools in districts with none, special attention to remote areas. Though the emphasis is on improving physical access, the

[46] First Draft ESP

assumption is that poorer districts and communities are disproportionately represented among those currently lacking adequate facilities.

- Establishing special schemes for teacher training and deployment to ensure the presence of teachers in remote/ethnic minority areas
- WFP school feeding program in very poor communities
- Expansion of post-basic education through public/private partnership

3 Poverty reduction and sector expenditure

Sector programme costing

The Sector programme is costed, and relates costs to targets. However it is too early to say whether the forecast of funds available is realistic or not.

Provisions to protect the poor

The Priority Action Program (PAP) is meant to correct any problems with available funds and to protect the poor. This is a new programme-based and output–oriented modality for implementing the national budget. The funding is meant to be 100% disbursed, and the Ministry of Education has based a lot of its reform plan on extensive use of this mechanism.

Proportion of expenditure that is pro-poor

Recurrent spending for basic (primary and first three years of secondary) education is maintained at around 70%. The Ministry of Education projects that 72% of the development spending over 5 years should be directed to selective primary and secondary school expansion.

4. Poverty reduction and sector management

It was planned that decentralisation of educational services would enable disbursement of funds to schools throughout the country to improve the quality of instructional delivery. It is also intended to increase community involvement in financial planning and accountability, and ensure due consideration is given to the poor in policy and implementation at district, commune and school levels.

The key management innovation is to make extensive use of the new Priority Action Program, basically a new, program-based and output-oriented modality for implementing the national budget. The PAP envisages quarterly releases of funds to identified budget managers, based on the submission of plans, which specify the agreed outputs to be delivered. In principle, budget managers have the freedom to vire funds from one item to another provided it is justified by program requirements. This is a revolution in a highly centralised system in which prior approval is required for all expenditure higher than 125 US$. Making the new system work is a major challenge, but it is seen as the way forward by the Ministry of Finance. PAP funding is also meant to be 100% disbursed, and therefore protected from the risk of budget cuts. The Ministry of Education has based a lot of its reform plan on extensive use of this mechanism.

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Annex 4: Zambia Education

Basic Education Sub-Sector Investment Programme – BESSIP – Zambia (1999-2002)

The authors alone are responsible for the opinions and for the accuracy of the facts included in this case study. However, for replies to questionnaires and detailed comments, they are indebted to: Mrs Barbara Y. Chilangwa, Ministry of Education, Deputy Permanent Secretary (TC), bychilan@zamnet.zm, with additional material from Richard Arden, DFID and from Abby Riddell

Developed in 1998, the Basic Education Sub Sector Investment Programme (BESSIP) forms one of Zambia's major strategies for poverty alleviation. Its principal objective is to ensure that every child can complete the seven-year primary education cycle, and that the education is relevant to its needs. Developing human resources is a component of the Zambian Government's Economic Plan, which intended to allocate at least 36% of domestic expenditure (excluding debt service) to the social sectors in 1999-2000 (although actual release was only 32% for January to May 1999)[47]. The BESSIP was able to draw lessons from other sector wide programmes that had pre-dated it including health and agriculture.

Abbreviations

BESSIP	Basic Education Sub-Sector Investment Programme
CSO	Central Statistical Office
EFA	Education For All
ESIP	Education Sector Investment Programme
JSC	Joint Steering Committee
PAGE	Programme for the Advancement of Girls Education
PIP	Programme Implementation Plan
PRSP	Poverty Reduction Strategy Paper
PTA	Parent teacher Association
SACMEQ	Southern African Consortium for Monitoring and Educational Quality

1. Poverty diagnosis

Current education policy was informed by a series of studies conducted under projects in the mid 1990s. Starting with relatively high primary enrolment, with a gender gap from grade 2 upwards, the focus of the diagnostic phase was on reasons for non-enrolment, low attendance and student dropout rates. The BESSIP was informed by a comprehensive diagnosis of who the poor are, what problems they face and which interventions are most effective in overcoming them. However, as a sub-sector-programme, it does have weak integration with the implications for secondary and higher education.

Sources of information and surveys

Sources of information used to inform the diagnosis were:

- The Zambia Education Rehabilitation Project (ZERP)
- The Programme for the Advancement of Girls Education (PAGE) – a detailed situation analysis conducted by Professor M. J. Kelly

[47] Kelly (1999)

- The Zambia Capacity Building Project (ZECAB)
- A situation analysis prepared during the production of the 1996 Education Policy document "Educating our Future";
- The Education For All mid-term review
- The Education Sector Implementation Programme (ESIP) Pre-appraisal mission of 1997.

The studies included extensive consultation with stakeholders including NGOs, parents, children and rural/urban population. They were both qualitative and quantitative in nature and to a large extent, they were action oriented and participatory. The primary areas of focus were the household and the classroom levels. In addition, data from the National Census of 1990 and the biennial household surveys conducted by the Central Statistical Office (CSO) were used.

The diagnosis was based on data on gross and net enrolment rates; retention and drop out rates; literacy and numeracy competence surveys; and data collected by the Ministry of Community Development and Social Services prior to the establishment of the Public Welfare Assistance Scheme.

Surveys used to inform the diagnosis were:

- Household surveys (by CSO) which sought to establish the level of participation in the education services by establishing the rates of attendance and the factors affecting it from the household perspective.
- Action research, (under PAGE) which involved qualitative and quantitative research focused on the quality and level of girl's education.
- The Southern African Consortium for Monitoring of Educational Quality (SACMEQ) literacy and numeracy studies which provided information on the reading levels of pupils at the middle and basic levels, and factors that were associated with it.[48]

The processes used to consult the stakeholders who included the poor were focus group discussions, interviews, and seminars and workshops. Provincial and District personnel were also extensively consulted. These were in addition to the traditional questionnaire and test data collection techniques.

Analysis

The analysis examined the quality of education and factors influencing enrolment, in order to identify specific actions needed to address sector issues relevant to the poor. The Ministry aims to provide a solid empirical foundation upon which to formulate policies and strategies that are pro-poor. Key strategies have included:

- Removal of statutory fees, though user fees agreed by schools with PTAs remain in place, and have caused some confusion for parents as the policy was implemented.
- Involving parents and other stakeholder in the management of institutions as well as implementation of the programme through the establishment of education boards; and
- Ensuring that the Ministry has good feedback information on the impact of the prevailing socio economic status of the people on both the quality of education and access to education.

[48] The SACMEQ methodology has been criticised as inappropriate for drawing causal inferences as to the factors influencing low performance. See Riddell, A, (1997).

The overall objectives of the programme aim at increasing enrolments, reducing disparities between urban, peri-urban and rural areas, achieving equity in enrolment by gender and socio-economic status, and enhancing learning achievements for all pupils.[49] It was based on:

- Analysis of condition of schools
- Analysis of factors influencing performance in schools
- Analysis of factors affecting school enrolment and dropping out of school
- Analysis of performance of donor supplied projects
- Public expenditure review
- Analysis of school effectiveness and benefits of learning.

Equity and Gender

The BESSIP places a high emphasis on equity and gender. In order to translate this into action, an equity and gender focal person is appointed within the education ministry to manage this. The implementation and management structures of the programme include an equity and gender sub-committee which helps ensure that the equity dimension stays in the fore of all of the programme components.

2. Poverty reduction and sector strategy

The sector programme began before the process of developing the National Poverty Reduction Strategy Paper (PRSP). It was therefore mostly informed on poverty issues by CSO household surveys and the Public Welfare Assistance Scheme data. Though it can not be said to be consistent with the PRSP, it is a pro-poor programme in that it is targeting vulnerable groups like girls, the rural community, orphans, the disabled and the poor. There are inconsistencies in the sense that BESSIP is a Sub-Sector programme targeting the first seven years of education while the PRSP also looks at issues surrounding high school, vocational skills and tertiary education.

BESSIP has been prepared and managed as a separate programme within the education Ministry, but not mainstreamed with Government plans, budgets and procedures. Co-ordination between BESSIP and the planning department of the Ministry has not always proved easy. The difficult economic and budgetary situation facing Zambia has made it difficult to introduce reforms which threaten Ministry jobs or Ministry control over financial resources. Pro-poor policies such as support to the Community Schools, which serve AIDS orphans and other poor and vulnerable groups, faced initial opposition given the severe constraints on the Ministry budget for Government schools. Decentralisation also faced resistance and has only recently made progress.

Cross-sector coordination

There is awareness that poverty reduction requires a strong coordinating mechanism involving all stakeholders including Research Institutes, community based organisations and other line ministries outside the sector like the Ministry of Finance. Currently under BESSIP the Joint Steering Committee (JSC) is the Co-ordinating and policy body. To strengthen cross-sector co-ordination, the education sector chapter of the Poverty Reduction Strategy Paper (PRSP) "Zero" draft recommends the creation of a National Education Sector Authority (NESA) to co-ordinate education sector programmes, paying particular attention to poverty reduction.

[49] Ministry of Education (1998)

Targets and targeting

Specific targets and the interventions to achieve them were:

- To increase enrolment by 260,000 pupils during the initial four years of BESSIP
- To enhance enrolment and the quality of education by improvement in the provision of infrastructure, learning materials, capacity building, teacher pre-service training reform and comprehensive in-service training, curriculum development and targeted interventions in the areas of equity and school health and nutrition. These would be measured by an improved annual school survey and a national assessment.[50]

BESSIP targets most of its interventions on the rural and peri-urban areas where most of the poor live. Under the Infrastructure and Teacher Development, Deployment and Compensation Components of BESSIP the targets are to construct nearly 2000 classrooms and teachers' houses in rural and peri-urban schools, ensure reduced walking distances to schools, and improve the availability of trained teachers in those areas.

The BESSIP has a Primary Reading Programme, which focuses on initial literacy in a local language. A school Health and Nutrition Programme in Eastern Province (rural) should raise enrolments and improve the learning experience in school, particularly for poor pupils. Other components of particular relevance include a Community Participation pilot in Southern Province (rural) and a gender and Equity Component which through the Programme for the Advancement of Girls Education (PAGE) and other interventions is targeting girls, orphans, rural children, children with special learning needs and the poor. Under this Component there is a bursary scheme, which currently caters for 30,000 basic school children. Furthermore, statutory fees, and grade seven examination fees have been abolished.

Public-Private Partnership

BESSIP specifies the roles of public and private sectors including NGOs as partners in the provision of basic education. The targets for enrolment and learning achievement include the efforts of non-Government service providers. The private sector and NGOs are not represented on the Joint Steering Committee, but they are invited to participate in the twice yearly reviews of the BESSIP programme, and in the case of Community Schools, joint programmes for training of teachers and other workshops are organised regularly. Educational materials and grants sent to Government schools are also sent to Community schools, and some teachers in these schools are on the Government payroll.

Pro-poor measures in the sector

The following measures within BESSIP are assumed to benefit the poor:

- Decentralisation, which involves the creation of Boards at District level, is intended to ensure that resources reach the poor. Grants have been sent to all basic schools with effect from January 2001. By specifying grants for the schools, the risk of funding becoming absorbed in administration costs is reduced.
- Most of the infrastructure activities are demand driven and require community participation. This should empower local communities particularly in rural areas to make decisions on the location of schools, security of children and female teachers etc. It is unclear whether the

[50] Ministry of Education (1998)

emphasis on community participation will disadvantage poor communities less able to contribute resources or free labour.
- The School Health and Nutrition Programme is being piloted in a rural province and will be scaled up with focus on the rural poor children.
- The bursary scheme and community schools under the Equity and Gender Component will benefit the poor.

3. Poverty reduction and sector expenditure

Sector programme costing

BESSIP has a fully costed programme implementation plan and logframe, which is fully financed from Government and donor grants and credits, but it covers only part of the sector, and only a portion of sector expenditure, with teacher salaries and some other recurrent costs outside the definition of the programme. The main SWAp like features are the emphasis on a joint programme with common monitoring arrangements, but the coverage is partial and the funds are separately managed. BESSIP therefore has the characteristics of a project rather than a classic sector programme, and there are dangers that BESSIP expenditures may distort the budget for the sector as a whole.[51]

The proportion of expenditure that is pro-poor

BESSIP covers only a portion of the education sector, and we have not collected information on the proportion of education sector expenditure spent on primary or basic education. About 75% of the BESSIP expenditure relates to programmes from which the poor are the major beneficiaries, and this share is said to be increasing, but this percentage is meaningless when considered in isolation from the budget for the sector as a whole. The Ministry reports that there is presently increased budget allocation by government to the education sector, with an increased share going to Basic Education. The disbursement of funds directly to the schools, districts and through NGOs (for part of the bursary scheme) will protect the funds meant for the poor.

The pro-poor components of BESSIP include rural school rehabilitation and construction, School Health and Nutrition, PAGE, bursaries, HIV/AIDS, Teacher Development, and the Primary Reading Programme. Before BESSIP there was no funding for programmes specifically for the poor. Under BESSIP there are grants sent directly to schools.

Sector planning and expenditure

The design for the BESSIP programme is primarily focused on two areas: Improving access to basic education and improving its quality, with a particular stress on activities to improve the attendance of the poor in general and rural girls in particular.

[51] Foster et al, The Status of SWAps, and Box 3.

4. Poverty reduction and sector management

Public expenditure and management

There is currently no comprehensive Medium Term Expenditure Framework. A process for the development of the Medium Term Expenditure Framework and Strategic Plan nonetheless has been initiated. However, for the BESSIP, a Programme Implementation Plan (PIP) for the period 1999-2002 has been developed and fully costed.

As a result of recent reforms in public expenditure, the Ministry has moved away from incremental budgeting systems to the activity based budgeting system. The activity based budgeting system begins around March each year with all activities and priorities defined by the levels at which the expenditures are going to take place. Decision-making has been decentralised to the province, districts, schools and colleges. Budget releases from the national treasury are made in respect to the above levels. Budget releases are reported regularly in the financial abstracts as well as provincial reports.

Pro-poor institutional measures

Decentralisation has been piloted in Copperbelt province since 1998, and is in 2001 being extended to 4 more provinces. During field trips prior to the 2001 BESSIP semi-annual review, it was observed that decentralisation has had a positive impact on services reaching the poor, brought about through increased participation of local stakeholders. Resources now reach the poor at the points of delivery. Decisions on cost sharing and other policies that affect the poor are taken at the local community level, taking into account the ability to pay, and the needs of the vulnerable children. There is more accountability and improved monitoring, though capacity for formal accounting, procurement, planning and auditing remains weak, and the boards are not yet fully resourced as a result. The Ministry has put in place training programmes to enhance the capacity of staff in accounting, planning and budgeting. It has further strengthened the auditing and inspection functions.

Impact assessment

From the inception in 1999, the BESSIP programme commissioned a number of studies to provide baseline information, though some of the information needed to assess trends is only now beginning to become available. It also on a continuous basis supports and funds a number of data collection and analysis activities. These primarily focus on seeking evidence that target groups such as the poor, girls, and persons with learning disabilities are benefiting.

Specifically the assessment is done by and through the following surveys:

- *Living conditions monitoring surveys*, which amongst other things collect data on socio economic status and how it relates to school attendance or participation.
- *The National Assessment and SACMEQ exercise* which collects information on pupil learning achievement, and how it relates to background factors such as socio-economic status.
- *The Annual School census survey* which collects information on enrolments by grade, gender, and locality (rural/urban). The Annual School Census survey has only just been completed for the year 2000 by Planning Unit and not yet analysed. They are hoping to catch up with themselves for the 2001 survey by end of this year. The 1996-1999 trends showed stagnation rather than improvement in enrolment and drop-outs. Since commencement of the BESSIP programme in 1999, we are yet to see reliable indicators of progress, but hope this will be in

place by end of 2001. Additional information is also collected about those that drop out by reason. One positive finding, according to the Ministry, is that, though overall levels of drop out have not fallen since the commencement of the BESSIP Programme, the category of those dropping out on account of economic reasons has been declining.

- The Ministry is also able to assess the amount of money that is directly going to the vulnerable groups through the bursary scheme annual returns from the schools.

BESSIP is reviewing its core indicators with a view of ensuring that the activities are more focused on achieving the set targets.

It is hoped that the Strategic Planning process will actually deal with the important gaps in data (such as real unit cost of education in each district), and provide a better foundation than is available at the moment for formulating policies and strategies.

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Annex 5: Uganda Health

Uganda Health – 2000/01-2004/05

The authors alone are responsible for the opinions and for the accuracy of the facts included in this case study. However, for replies to questionnaires and detailed comments, they are indebted Bella Bird, and Ros Cooper, DFID Uganda. The case study also draws heavily on research carried out in February/March 2001 by Mick Foster.[52]

Uganda Health Sector Achievements: 1992 and 1999 compared

- Percentage of communities with 'well maintained' clinic doubled to 59%, average distance 5km.
- Marginal increase in qualified staff, big increase in utilisation where staff are in place.
- Percentage of population using modern medical facilities when ill increased from 63% to 78% in 1999, but private and NGO facilities are still the first choice.
- Use of pre-natal care has increased from 74% to 80%, post natal from 42% to49%.
- The incidence of stunting and underweight children has fallen.
- National HIV infection rates have halved due to successful campaign for behaviour change in urban areas, but similar results have yet to be achieved in rural areas.

But

- U5MR and IMR increased since 1995, no improvement in immunisation coverage (only 38% of children are reported as fully immunised by their 1st birthday)[53], or in 38% of births attended by trained medical personnel.
- Overall reporting of illness and of days lost to illness has increased, possibly reflecting the impact of HIV, and increased health demand by a wealthier population[54].

Abbreviations

DANIDA	Danish International Development Agency
HIPC	Highly indebted poor country
HSD	Health Sub-District
HSSP	Health Sector Strategic Plan
IMR	Infant mortality rates
LTEF	Long Term Expenditure Framework
MoH	Ministry of Health
MR	Mortality rates
MRC	Medical Research Council
MTEF	Medium Term Expenditure Framework
PEAP	Poverty Eradication Action Plan
PHC	Primary Health Care
PRSP	Poverty Reduction Strategy Paper

[52] Based on Foster and Mijumbi (2001).
[53] DFID *et al* (2000)-2005.
[54] Deininger (2001).

1. Poverty diagnosis

Ill health was the most frequently cited cause and consequence of poverty within the Uganda participatory poverty assessment of 1998/99. The PRSP also quotes figures suggesting that the poor suffer disproportionately, for example under three mortality declined significantly for higher income groups between 1988 and 1995, but the poorest groups showed negligible improvement.[55] The PRSP also recognises that higher incomes, better educational attainment for women, and improved water and sanitation services may be the most critical interventions for narrowing the gap between the health status of the poor and the more wealthy. Nevertheless, the poverty action plan does accord an important role to the provision of health services.

In the mid 1990s, the quality of Government health services was extremely poor. The 1996 tracking survey showed low utilisation of a system in which poorly qualified and motivated staff offered few services, while drugs and other materials were diverted to private practice. Primary health spending had plummeted since decentralisation, representing only 8% of health sector spending in 1997/98 (though donor projects are not included in this figure), with local Government administration absorbing budget resources intended for health services. Government spending was dominated by curative care. The population voted with its feet, preferring NGO services.

2. Poverty reduction and sector strategy

Uganda has a strong poverty reduction strategy, headed by a Ministry of Finance and Economic Planning which has established a strong track record in increasing and protecting the poverty content of the budget. HIPC debt relief channelled via the ring-fenced Poverty Action Fund has reinforced policies which Government was already implementing.

The Minister of Health decided on the need for a new health policy and strategic plan in late 1997, with increased emphasis placed on improved equity of resource allocation, and with recognition of the need for improved Government and donor co-ordination around a common strategy. The Health Sector Strategic Plan required a long process of consultation. It was not finalised with funding secured until 2000, and was launched in the 2000-2001 financial year.[56] However, some of the key policy changes were being put in place before the formal launching of the HSSP. As part of the annual budget cycle the Health Ministry had to defend their plans and budget to a Ministry of Finance and Economic Planning which (at least from 1998/99) was giving increasing emphasis to poverty concerns. Although the sector programme is very recent, there are useful lessons to be learned from looking at the development of the health sector over a longer period from 1997.

The plan focuses on putting in place the management systems and resources required to deliver a minimum health care package which includes preventive and primary health care interventions aimed at the ten major causes of morbidity and mortality which are responsible for three quarters of lost life years. Specific targets include raising immunisation coverage from 33% to 80%, and slashing child and maternal mortality.

Over two thirds of public health expenditures are targeted to be spent on the minimum health care package, of which roughly 80% will be for recurrent costs. A key component of the new health policy is the creation of health sub-districts (HSDs) – each with either an upgraded health centre (adding on a theatre, doctor's house and better lab) or a hospital (where one exists), which will both act as an interim referral level (between outpatient clinics and district hospital) and be responsible for planning, budgeting, managing and supervising all health centres and outreach services in their

[55] Government of Uganda.
[56] Brown (2000)

catchment area. The conditional grants which the Ministry provides to finance primary health care are disbursed to the sub-district. This decentralisation is aimed to bring referral services and doctors nearer to communities and to improve the planning and coverage of supervision. There is also a target to double the coverage of first-level health facilities to one fully staffed in every parish.

Resources from Government and donors are not expected to exceed $6.50 per capita per year during the life of the HSSP, far short of the level required to provide even the minimum health package to all. Discussion with donors has focused, among other issues, on the balance between raising the low utilisation of existing health facilities and expanding coverage to unserved populations. Expanded coverage is a political imperative for Government, as well as a poverty priority if the least served districts are also the poorest. However, the recurrent cost and staffing implications of the expansion in the number and range of facilities will strain the resources available.

Costing

As part of the Government's Long Term Expenditure Framework (LTEF) an initial attempt has been made to cost the public expenditure implications of the PEAP. The costs are indicative, and will need to be refined over time. If the proposed pay reform increases were to be awarded immediately in full and if provision were made for other incremental recurrent costs and for every capital programme, assuming an even rate of spending over the five to ten year period envisaged, then total expenditure would need to increase by 60% above what is currently provided in the 2000/01 budget. Health is one of the major contributors to the shortfall, requiring major increases to provide for the investment in new health facilities and to provide for operating budgets, staffing and pay reform.

Public-Private Partnership

Though the gap may be narrowing with recent improvements, participatory poverty assessments in Uganda have suggested that, where they have a choice, users have a strong preference for NGO health facilities. Though formal charges are higher, patients visiting an NGO facility face fewer uncertainties over illegal fees and over whether the facility will be open, staffed, and with drugs available. They pay their staff less, yet appear to achieve higher utilisation and better quality services. Ironically, recent Government actions to raise the salaries of public sector health staff have resulted in a skills drain from the NGO sector to Government facilities, where health staff arguably are able to achieve less.

NGO facilities are increasingly integrated within the public funded health system. An NGO facility will get delegated funds from GOU for their general operations and, in addition, some NGO facilities have been designated as the lead facility within their sub-district, and will receive the PHC conditional grant funds- though the local authorities who administer the funds have in some cases proved reluctant to release them to NGOs.

3. Poverty reduction and sector expenditure

Funding for the primary and preventive services included in the essential services package is included within the poverty action fund, which is a ring-fenced part of the budget which is protected from budget cuts.[57] This has been an important factor in persuading line ministries such as health to give increased priority to primary services. The total share of the health sector was not increased until the share of primary and preventive services funded from the PAF reached more reasonable levels, increasing from a derisory 8% in 1997/98 to over half in 2000/2001. The reallocation has permitted a rapid increase in expenditure on primary health, albeit from a low baseline. Despite a declining overall health share, the share of total Government spending devoted to primary health quadrupled to 2% in the first year of the Poverty Action Fund, has doubled again to 4% of the 2000/2001 budget, and is planned to reach 6% by 2002/2003. The share of Government budgeted spending devoted to the health sector is now planned to increase over the MTEF period, in support of the 2001-2005 health sector strategic plan which has now been finalised, though there may be little overall increase in share once allowance is made for reduced donor project commitments as donor finance is increasingly provided as sector budget support.

The reallocation of the health sector budget towards primary and preventive services has been facilitated by capping the budgets of the regional and tertiary hospitals which previously dominated public sector health expenditures. This has permitted the growth in primary spending, but the necessary reforms in funding arrangements and improvements in efficiency which will be required if this policy is to be sustainable have yet to be achieved, and the hospital sector is feeling the strain of the constrained budget.

Following the experience of low commitment by local Government to sustaining primary and preventive health services, health sector funding is now provided to local government in the form of highly conditional grants, with formidable reporting and accounting requirements. The primary health care conditional grant was the main vehicle for trying to turn around the performance of the sector, with the majority of the funds going to sub-district level where most PHC services are provided. The focus was on trying to raise staffing levels from the 33% level to which they had sunk, rehabilitate health units at sub-district level, and improve service delivery and management including paying increased attention to monitoring. The freeze on new recruitment introduced under civil service reform was ended for key health workers, budgets for staffing were increased, and a substantial lunch allowance was paid to help overcome the constraint which civil service pay posed for new recruitment. User fees collected and retained at local level also appear to have made an increased contribution, though user fees were subsequently abolished in March 2001.

The bureaucratic burden of complying with the requirements for using conditional grants has proved burdensome in the health sector, resulting in difficulties in the timely and effective utilisation of the theoretically available funds. The quarterly monitoring reports prepared for the Poverty Action Fund and household survey data nevertheless appear to show significant improvements in health sector performance since the mid 1990s. Findings from MoH monitoring are corroborated by household survey data from 1992 (before decentralisation and the collapse of PHC spending) and 1999/2000. The average community now has a better maintained clinic (percentage ‘well maintained’ up from 30% to 59%), closer to the community centre (average distance from 6.7 to 4.6 km- though half the population is still more than 5km from a health facility), slightly better stocked with drugs, bandages, needles and vaccines, and with access to a doctor also marginally improved. Where qualified staff have been recruited, utilisation rates have increased markedly. Under a DANIDA programme, essential drug supplies are provided quarterly

[57] The PAF budget lines include all development and recurrent costs at sub-district level and below, plus central support programmes (e.g. blood transfusion, malaria control, reproductive health). It excludes district and tertiary hospitals and MoH running costs.

to each district. There have been delays, but the primary health care conditional grant has enabled districts to overcome emergencies by purchasing on their own behalf from the private sector.

The proportion of the population receiving medical services from modern medical facilities when ill appears to have increased from 63% in 1992 to 78% in 1999, but private and NGO facilities are still the first choice even of the poor. Use of pre-natal care has increased from 74% to 80%, post natal from 42% to 49%. The incidence of stunting and underweight children has fallen, though overall reporting of illness and of days lost to illness has increased, possibly reflecting the impact of HIV, and increased health demand by a wealthier population.[58]

The most significant achievement is the reduction in HIV, where infection rates have halved nationally, mainly due to a rapid fall in urban areas, thanks to a relentless public education campaign on behaviour change which was largely led by the health sector. Recent MoH surveillance data and MRC studies suggest that HIV infection rates are now reducing in rural areas too.[59]

Less positively, preliminary results from the 2001 DHS survey show that U5MR has increased from 147 in 1995 to 152 in 2001, while IMR has grown from 81 to 88. The proportion of births attended by trained medical personnel has stagnated at 38%. Immunisation coverage has suffered from logistical problems and non-payment of staff allowances, and (other than for polio) seems to have stagnated or fallen since 1995/96. Only 38% of children are reported as fully immunised by their 1st birthday.[60]

Both the participatory poverty assessment, and the service delivery survey, identified cost as a major constraint to accessing services. The Government had therefore decided to abolish user fees in facilities at sub-district level and below, and had budgeted for extra funds to meet the shortfall. However, the change was brought forward to March 2001 (whereas the budget increase was only provided from July), and the policy was extended to abolition of all user fees except for private wings in hospitals. It is too early to fully assess the impact, but anecdotal evidence collected in the sector review suggests a large increase in demand for services, with staff reporting the majority of the new patients as drawn from the poor. The nature of the demand is also reported as changing in a very positive way, with for example parents bringing children with malaria for treatment at a much earlier stage, which increases the chances of recovery and reduces the costs of achieving a successful outcome. The initial increase in demand was not sustained once facilities began to run out of drugs. The intention is to overcome this problem by increased budgets through the Poverty Action Fund. The direct loss of revenue from the lower levels of the system was not that significant, though the need to meet the increased demand following removal of the cost barrier will present more of a budget challenge. Nevertheless, those within the system judge that the welcome increase in the utilisation of facilities at sub-district level and below should be manageable with the increased budget made available.

Though the problem may be manageable in the short term, the contradictions in trying to deliver the full ESP package with grossly inadequate funds will become increasingly evident. The sustainability of the shift towards primary care which has been achieved must also be in doubt if the hospitals are now denied access to funds from cost recovery. The hospitals do not get PAF funds, and had come to rely much more heavily on user fees to finance drugs and staff. The budget for

[58] Deininger (2001).
[59] Ros Cooper, personal communication.
[60] Preliminary data from DHS 2000/01.

health has been increased in order to make up for the shortfall in funding, but the increase may not be sufficient.

Overall, there is some limited evidence of improved performance of the health sector as a consequence of re-orientation towards primary health care, with good prospects for further advances as the HSSP focuses both Government and donor flows on a coherent, poverty focused program. However, given the constrained level of finance, a blanket 100% subsidy of Government services does not look sustainable, unless Government services are to be severely rationed in a way which is unlikely to lead to effective services which benefit the poor. If the poor are to benefit, a strong focus on public health and preventive interventions may need to be accompanied by some continued reliance on private contributions, but with more transparency on prices charged and services offered, and attention to eliminating or minimising the burden of charges on the poorest.

4 Poverty reduction and sector management

The strong budget and planning process led by the Ministry of Finance and Economic Planning has been central to achieving the reorientation of the pattern of health spending. It has been underpinned by the PAF as a device to encourage poverty focus and protect allocated budgets for poverty relevant spending.

Partly in reaction to the experience of decentralisation, health is perceived as highly centralised, using highly detailed guidance to retain control over how funds are spent. This is widely regarded as having been taken too far, and the reform and simplification of the conditional grant system is on the agenda. The key to unlocking the problem is seen to be a shift towards making local Government accountable for service delivery, with appropriate incentives to ensure that they deliver on agreed targets. Achieving this in practice will be difficult.

Impact assessment

Impact is assessed through a variety of routes. The regular household expenditure and health surveys are supplemented by regular reporting by the districts, and this is in turn supplemented by NGO and donor involvement in monitoring. A service delivery survey was undertaken in 2000, to assess views on the quality of health services, and access to them, and a tracking study, to explore problems in utilisation and accounting of funds, is planned for 2001. The major problem is arguably the over-burdening of weak local Government capacity in preparing monitoring reports.

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Annex 6: Tanzania Health

Tanzania – Health Sector (1999-2004)

The authors alone are responsible for the opinions and for the accuracy of the facts included in this case study. However, for replies to questionnaires and detailed comments, they are indebted to: Maximillian Mapunda, Senior Economist, Ministry of Health, contact: maxmapunda@hotmail.com & Paul Smithson, DFID, P-Smithson@dfid.gov.uk

In June 1998, The Ministry of Health of Tanzania agreed to pursue a sector-wide approach to health reform. The stated aim of the Health Sector Policy is to provide all Tanzanians with equitable access to quality health services by increasing priority to primary health care.

Impact of Health Sector Reforms on Poverty Reduction

The actual contribution of the Health Sector Reform strategy to poverty alleviation is unclear, but likely to be limited:

- 60% of a small budget goes to hospitals, which also absorb the bulk of staff and other resources[61].
- Staff costs of less than 30% of spending on primary care indicates severe problems of retaining staff at existing salaries. Primary facilities are able to deliver few services and face low utilisation[62]
- The Gwatkin study shows that those with higher incomes have better access, higher utilisation, and better outcomes from health services.
- More positively, advances have been made in family planning, polio, measles surveillance and in introducing the new malaria and IMCI protocols[63].

1. Poverty diagnosis

Various studies on overall client perception and satisfaction were carried out to inform the sector programme. However, little was done on differential access by different groups. Results from an exit survey found that free medical care was not protecting the poor as had originally been believed. Though there was physical access, the system was characterised by chronic shortages of drugs and other medical supplies. The poor were also faced with costs associated with waiting time and travel costs. The study recommended user-fees and National Health Insurance as alternative options for financing health services.

In response to this study, the government adopted a cost-sharing policy in 1993 which was in part incorporated into the Health Sector Programme of Work initiated in 1999.[64] One of the focuses of the new programme was to generate additional revenue to the health sector from those who can afford to pay for health care, while retaining subsidies for the poor through exemption arrangements. However, revenue from cost sharing has not exceeded 2% of the total health budget.

[61] Tsikata (2001)
[62] Smithson
[63] Ministry of Health, Tanzania (2001)
[64] Mapunda

A Financial Tracking Study was also carried out to assess how funds are utilised in the health sector, though it did not include any gender or poverty analysis.

Little analysis was undertaken of the specific actions needed to address sector issues relevant to the poor.

The Programme of Work and the Medium Term Expenditure Framework both mention gender mainstreaming as one of their objectives, but the Sector Review comments that there has been "insufficient systematic documentation of gender inequalities" in health outcomes or access to health services. A gender situation analysis that that had been budgeted for 1999/2000 has yet to be carried out, and gender analysis has had little impact on policy formulation and priority setting.

The Technical Review (2001) barely deals with poverty and gender issues, which feature as only a minor subheading allocated a joint box, with very little information or analysis

2. Poverty reduction and sector strategy

The health sector and PRSP

The Sector Programme predated the PRSP. Although there was some consultation with the Health Sector, there was no coordination of targets and indicators.[65] Nevertheless, both the health sector plan and the PRSP share the core objectives of reducing infant and under five mortality, increasing the percentage of children immunised by their 1st birthday and increasing the proportion of districts with active HIV awareness campaigns.

Cross sector coordination

According to Mapunda there is coordination across the Ministries partly as a result of awareness that most health impacts are also a contribution of other sectors. At a more formal level, the Planning Commission and the Budget Section of the Ministry of Finance coordinate the plans and budgets of various ministries by convening planning and budget sessions annually, as part of the budget process.

Pro-poor targets?

The sector targets an undemanding annual expenditure increase of US$0.05 cents per capita per year in addition to the current public health expenditure which is around US$5.0 per capita per annum. If taken literally, this target implies that Tanzania will take a century to double per capita spending to a level which would still be far short of that needed to pay for a minimum services package for all. In addition to an unambitious increase in spending, there is little in the way of specific targets to increase the proportion of health spending which benefits the poor. There is an assumption that the poor will be covered through improved access and improved quality, and primary level curative and preventive services are assumed to benefit the poor.

It is also stated that poorer groups are expected to benefit from:

- Strengthening the drug supply system by adopting Community Health Funds. These are intended to improve the finance available for community health services, while performing an insurance function, enabling community members to make regular payments and avoid

[65] Smithson

catastrophic health costs when illness strikes. However, these are still on a pilot scale, they are a management challenge, and the coverage is low.
- Drug Revolving Fund and Drug Indent System.
- Reinforcement of the exemption mechanism. However, this is hard to make work when the system is starved of cash and health sector staff are not paid a living wage.

The Mid Term Review targets included:

- Reducing infant mortality from 88/1000 live births to 84/1000
- Reduce under 5 mortality rate 137 of 1996 to 133 by 2003
- Reduce maternal mortality ratio from the range of 200-700 per 100,000 (1996) to the range of 200-500 per 100,000 by the year 2003
- Ensure the availability and accessibility with equal opportunities of health services within 10km from 72% in 1984 to 90% by the year 2003
- To increase life expectancy of males from 49 years in 1996 to 50 years by 2003 and females from 51 in 1996 to 52 in 2003
- To increase community awareness, knowledge and practice for the management of common health problems from 50% in 1996 to 70% by 2003 with a gender perspective
- To strengthen human resources in highly demanded health cadres through skills development with gender perspective from the 1998 level of 82% to 87% by the year 2003

It is unclear how any of these targets are linked to interventions and resources required to achieve them. The (non) achievement of these targets would reveal little about the performance of the health sector in delivering health services in general, or in relation to the poor. It is unclear to the authors whether the impact of HIVAIDS is taken account of.

3. Poverty reduction and sector expenditure

Sector programme costing

Given the current low availability of staff, it is clear that substantially higher salaries are essential before the sector can deliver services effectively. Utilisation of facilities is extremely low at primary health level, and future costing would need to forecast what effect improved staffing might have on demand and on the need for other consumables. What is clear is that combined public and donor spending of $6 or so per head, of which 60% is on hospitals, is too low and too poorly allocated to provide realistic access to health services by the poor. Views have differed on what role user fees should play in closing the gap, with the World Bank focusing strongly on this issue. Ironically, the quantitatively more significant issue of raising the share of spending on primary services has not been tackled explicitly in the programme, despite the fact that Tanzania appears to spend a relatively high proportion of the health budget on hospitals.

There is some effort to ring-fence areas that are seen to be of priority such as the provision of drugs, essential medical supplies and equipment, vaccinations, rehabilitation of health facilities and equipment, strengthening Primary Health Care (1/3rd of Government spending goes on primary healthcare), Mother and Child Health services, capacity building and HIV/AIDS/STI. The poor are intended to be exempt from payment, though anecdotal and household survey evidence both suggest that exemptions have not been effective in shielding the poor from charges.

4. Poverty reduction and sector management

Poverty planning in Tanzania predates the PRSP and the SWAP initiative, with the National Poverty Eradication Strategy, The Tanzania Assistance Strategy, the Medium Term Expenditure Framework and the Public Expenditure Review. However, at present the timetables related to poverty planning and the regular budget cycle are not synchronised. Nor are the set of core targets under the PRSP and the sector outcomes outlined in the sector MTEFs co-ordinated.

Tanzania introduced in 1998 a Medium Term Expenditure Framework, and localised the public expenditure review process as part of the annual budget cycle. The public expenditure review process, and the dialogue with donors which has taken place through sector working groups and annual discussions on the budget as a whole, have helped to focus attention on the spending pattern of the government and provided strong arguments for considering re-allocation of resources towards the poor.

Decentralisation to local Government is intended to devolve authority to district and community authorities. However, in practice, there is currently little consultation within districts or ministries, and very little participation by civil society. The basket funding provided under the health sector SWAp supports district health plans, but they are prepared by district level health staff and approved by the line ministry.

Monitoring and evaluation

The emphasis of the reviews has tended to be on expenditure rather than achievement. Similarly, according to the Second Annual Health Sector Technical Review M&E Subgroup many of the indicators that have been used in the past have been biased towards supply rather than demand issues.

Nevertheless, in the past two years there has been a greater emphasis on diagnosing and monitoring poverty and a number of institutional arrangements for monitoring and evaluating poverty reduction strategies are currently being developed.[66] The performance-monitoring indicators will aim to start the monitoring process moving and encourage linkages to other poverty monitoring activities.

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Annex 7: Bangladesh Health

Bangladesh – Health and Population Sector Programme – HPSP (1998-2003)

The authors alone are responsible for the opinions and for the accuracy of the facts included in this case study. However, for replies to questionnaires and detailed comments, they are indebted to: Tim Ensor, Senior Economist; Priti Dave Sen, Associate Economist and Atia Hossain, Local Consultant on behalf of Health Economics Unit, Policy & Research Unit and Ministry of Health & Family Welfare, Dhaka, Bangladesh.

The Government of Bangladesh, Health and Population Sector Programme (HPSP) is a $3.2 billion, five-year sector-wide programme that was initiated in 1998. This case study covers two and half years of a five-year plan that has adopted a sector-wide approach with a significant health sector reform agenda built into it. A central rationale of the HPSP is to improve the health status of the population and in particular of its most vulnerable groups.

Health Services in Bangladesh

- HPSP has shifted resources towards an Essential Services Package, targeting the needs of the poor through making local facilities more accessible to them.
- However, coverage is low and not increasing. The service delivery survey reports that only 10% of households are using Government health services for treatment compared to 43% who had used private or NGO facilities in the month before the survey. Some 22% of households did not seek care for ill members.
- The poor make more use of Government services than the non-poor
- **BUT**, they wait longer, are less likely to receive medicines[67] , and pay a bigger percentage of income (& sometimes more in money).
- Inefficiencies remain prevalent, e.g. chronic over-prescribing reduces the drugs available for those most in need.
- Only one tenth of national spending reaches the poor, and there are biases towards urban residents, and towards men[68]
- Geographic targeting of needier areas appears weak[69]

Abbreviations

DHS	Demographic Health Survey
ESP	Essential Services Package
HEU	Health Economics Unit
HPSP	Health and Population Sector Programme
LGD	Local Government Department
MOHFW	Ministry of Health and Family Welfare
MTR	Mid Term Review
PIP	Programme Implementation Plan
PRSP	Poverty Reduction Strategy
SDS	Service Delivery Survey

[67] HEU
[68] Mid Term Review
[69] Ferdousi (2001)

1. Poverty diagnosis

The stated central objective of the HPSP is to improve health and family welfare status among the most vulnerable groups; women, children and the poor.

This is done by focusing on the rural areas where most of the poor live, and on the services most used by the poor, which are those delivered at the sub-district (*Upazila*) level and below. The programme also concentrates resources on the Essential Services Package (ESP), which focuses on services of high cost-effectiveness that are used disproportionately by the poor. Though the focus on rural areas seems appropriate, it is recognised that the urban poor are becoming relatively more important, and the ability of the urban poor to access health services may be lower than it seems because of higher costs in urban areas.

The Essential Services Package (ESP)

This was developed to respond to the needs of vulnerable groups (women, children and poor). It aims to maximise health benefits per Taka spent, meet felt needs of clients, strengthen service delivery and improve system management. It has come about through an overhaul and reorganisation of the service delivery system and is divided into five sub-components:

- Reproductive health
- Communicable Disease
- Child Health
- Limited Curative Care
- Behavioural Change Communication

In 2000, spending on the ESP was between 60% and 70% of total spending[1]. According to the HEU, services at ESP facility levels are mostly used by the poorest income groups. However, it should be born in mind that the ESP services are also delivered in hospitals and that many of the resources spent at *Thana* levels are not used effectively.

The HPSP uses an essentially top down approach. Most of the information used in the design was based on national level quantitative statistics, though some civil society groups (in some cases representing primary stakeholders) were involved through membership of specialist task groups.

A Demographic and Health Survey (DHS) yielded information on the utilisation of health services as well as some information on household socio-economic characteristics. This was used to estimate approximate income levels of households by calibrating it against household expenditure survey data, using characteristics that appeared to be closely correlated with income. Though approximate, this yielded powerful information to support the view that expenditure had been heavily skewed away from the poor, and helped to gain acceptance of the strategy laid out in the HPSP. Subsequently, full national health accounts were estimated, showing total spending on health from Government, private, and donor/NGO sources, and the providers from whom care was purchased.[70]/[71]

[70] Yazbeck (1999)
[71] BBS (1999)

Analysis of the specific actions needed to address sector issues relevant to the poor

Since the start of the programme, further analysis has focused more precisely on problems of access and quality affecting specific target groups, through the use of regular household and focus groups surveys.[72]

A Benefits Incidence Analysis that was carried out supported the conclusion that it is the primary services that are most likely to be pro-poor. This analysis of the use of facilities by the poor[73] under pins the emphasis on services below sub-district level. It also found that, excluding reproductive health services, benefits to men and boys exceed those to women and girls. Overall, benefits to the poorest income quintile exceeded those to the richest suggesting that attendance at Government facilities is generally pro-poor. However the results need to be adjusted to take into account evidence from exit surveys suggesting that in fact the poor receive lower quality services, and benefits to them are therefore over-stated.[74]

The Service Delivery Survey Second Cycle, (Cietcanada, 2000) examined the use of services using a household survey methodology, supplemented with discussions with gender specific focus groups and with *Upazila* health management teams. This yielded qualitative information to provide further insight into the quantitative findings.[75]

Some of the key findings of the SDS were[76]:

- One in ten households think health and family planning services are "good", around half think they are neither "good nor bad" and 41% think they are "bad" (in 1999, 37% of households rated the government services as "good")
- As in 1999 the most commonly cited problem of government services is lack of medicine
- The most commonly cited problem with private/NGO services is expense, especially having to pay for medicine
- Very poor households are less likely to use government, private, or NGO health services
- The prominent reasons for choosing government health services are that they are less expensive, and access is good
- Very poor users of government health services are less likely to be satisfied with the way the service providers treat them
- A woman with a health problem during delivery is more likely to be taken to a health facility if she is from a metropolitan area, if she is not very poor and if she is literate

2. Poverty reduction and sector strategy

HPSP and PRSP

The HPSP refers and relates to a number of initiatives being undertaken during the course of the current five-year plan. Reducing mortality and improving nutritional status of the poor are both seen as key elements of broader government strategy and embodied in the five-year national plan.

[72] CIET (1999) and CIET Canada (2000)
[73] GOB (1998)
[74] Begum et al (2001)
[75] CIET Canada (2000)
[76] CietCanada, 2000

The recently published health policy places emphasis on health services for the poor. The second of fifteen aims is a requirement to develop a system that is easily accessible to all 'particularly the poor people of rural and urban areas'.[77]

Although the poor are a central concern of the HPSP, there remains a concern (supported by the CIET and other surveys) that services are still not reaching the most vulnerable. There is also a concern that the HPSP does not place sufficient emphasis on broader ways of improving access to the health sector by the poor by, for example, increasing access to risk pooling for catastrophic risk and increasing participation of the poor in decision-making. To help address these issues, the Mid-term review suggested the development of a health poverty strategy to prioritise how HPSP (and its successors) can best help the poor. A concept note for this strategy[78] has been developed and the Policy and Research Unit, MOHFW have convened a small technical group. The strategy will be developed by the end of 2001. It is hoped that this strategy could form the health section of the PRSP now being developed.

A PRSP is currently being prepared by the planning commission in collaboration with the World Bank. Neither the health nor education sector is represented on the committee responsible for developing the strategy. The extent of Government ownership has been questioned, with some commentators arguing that Government sees the PRSP process primarily as a requirement of the World Bank that the Government must fulfil in order to get further IDA credit.

Cross-sector coordination

The new health policy recognises the importance of linking health strategy to a wider poverty reduction strategy (including education)[79]. However, coordination to date has been limited to areas where MoHFW requires the approval of other departments. For example, the Ministry of Establishments had to approve unification of the health and family welfare directorates. Finance had to approve the transfer of staff from the development to the recurrent budget, and finance also had to agree to proposals to retain user fee revenue.

There is little coordination over general policy and health/poverty strategy. For example, the Local Government Department (LGD) is responsible for health in urban areas, but was excluded from HPSP. The MoHFW and LGD have little interaction. This may be remedied under the next programme (due to start in 2003) when urban health will probably be included.

The National Nutrition programme has to date been outside of the sector programme. However, it is likely to be included in the next phase of H (N) PSP.

Pro-poor targets

There are 50 national indicators that are used to monitor the impact of HPSP on an annual basis. These include inputs, processes and outcomes. A number of outcome indicators that are measured in aggregate are thought to be particularly good proxies for poverty sensitivity. For example Maternal Mortality Rate and Infant Mortality Rates are two such proxies, and are considered appropriate as they fall disproportionately on the poor. However, they have the disadvantage of being infrequently measured and (more fundamental) only indirectly related to health interventions.

The main financial indicator of interest is the proportion of health spending that is spent on essential services, defined crudely as all services provided at sub-district and below. However this is

[77] Government of Bangladesh (2000)
[78] Ensor & Sen (2001)
[79] Government of Bangladesh (1998)

problematic, as there is an assumption that money spent on service levels used by the poor will reach the poor in the form of effective services. In reality, as mentioned above, while the poor visit these facilities, their experience of the process of care (waiting time, out-of-pocket payments) is often inferior to the non-poor.[80]
In the case of outcomes, although mention is made of the desirability of disaggregating by income group this is not actually measured or targeted on a regular basis, and would be difficult to do. As Gwatkin has pointed out, under the current system it would be possible to improve some of the indicators by targeting the relatively rich rather than the poor.[81]

Public-Private Partnership

In the Revised Programme Implementation Plan it is clearly stated that the HPSP will look at the sector as a whole including NGOs or other agencies. NGOs currently play a big role in reproductive services in Bangladesh and are increasingly delivering primary health services with considerable collaboration at the community level. The successful implementation of the HPSP requires effective partnership between government and NGOs. However, the programme does not specify the roles of either public or private sectors in achieving their targets, and nor is there collaboration at higher levels.

One element of HPSP (part of the DFID supported component) is to develop public-private partnerships in a number of pilot areas. The aim is to develop commissioning community groups who will contract for ESP services from the public, NGO and government providers. Implementation is now proceeding and there is good community ownership. However, the pilots are still at an early stage and substantive results are not expected until the end of the HPSP or even into the next five-year programme.

Measures to benefit the poor

Key interventions targeting the poor are: -

- ESP package – focus of spending on essential services delivered at facilities most used by the poor.
- Emphasis on reducing maternal mortality as a key outcome.
- Introduction of new tier of health service delivery – called community clinic (serving approximately 6,000 population) that aims to provide integrated health and family planning services.
- Systems of social protection, through introduction of community health insurance
- Development of channels for stakeholder involvement in planning and monitoring health services (e.g.. Community Clinic Committees, as well as committees at other levels of service delivery (hospital, thana level etc). Stakeholder Strategy currently being developed.
- Introduction of Client Charter of Rights

3. Poverty reduction and sector expenditure

Sector programme costing

Detailed bottom estimates (at least for equipment and supplies) were developed by the Programme Planning Cell (now the PCC) in the run up to HPSP. These were based on estimates of rural

[80] Begum et al (2000), Ensor et al (2001), CIET Canada (2000)
[81] Gwatkin (2000)

morbidity for the main ESP disease components. Staff spending was based on current national spending at the time. These estimates led to a total that considerably exceeded the most optimistic projection of the resources available from Government and development partners. The estimates were partly cut back although it was also envisaged that additional revenue would be mobilised through insurance and user fees during HPSP. This has not materialised.

The GoB's spending on health and population has more than tripled in the past decade, but there is still a need to mobilise additional funds to achieve the "Health for All" target set by the government. The country has relied on donor support to assist total public spending to rise to approximately US$3.5 per capita (this is less than one third of health expenditures overall in Bangladesh). Analysis conducted for the last review of HPSP suggested that the additional donor support has been partly fungible, and has been offset by reduced Government commitment to the sector.

An annual public expenditure review (conducted by the Health Economics Unit in the MOHFW) tracks the pattern of spending relative to HPSP targets and priorities.
A review of the ESP costing points to the fact that the lion's share of expenditure is accounted for in salary and allowances[82] and there are still inequities in the distribution of public spending by geographic region.[83]

Proportion of the expenditure that is pro-poor

It was hoped that the poor would be major beneficiaries by targeting 65% spending on ESPs at sub-district (and below) levels, targets that were exceeded during the first two years. Despite this, however, the Service Delivery Survey[84] found that over a period of two years the perceptions about the quality of services changed very little. Indeed the 2000 CIET survey found that more households either did not seek care, or sought care in the NGO or private sector compared to the 1999 survey. This partly reflects the inadequacy of the total budget, but is also a reflection of the waste and inefficiency embedded in the centralised, inflexible system of budget planning and management in Bangladesh, together with entrenched practices such as over-prescribing.

Evidence of improved utilisation of services by the poor

The 2000 SDS and HEU surveys appear to show a decline in utilisation and satisfaction with Government services and increased use of private or NGO facilities compared to the previous year, with drug availability being a particular problem. The differences may not be statistically significant, but at minimum we can say that the surveys provide no evidence of improvement between the two years.[85] The HEU survey also provides an uncomfortable picture of a health service with poor coverage, where the poor face longer waiting times, are less likely to be provided with medicines, and with no evidence to suggest that the situation is improving.

4. Poverty reduction and sector management

Change in public expenditure as a result of SWAp

The focus on the proportion of spending going to sub-district level services is intended to work in favour of the poor. Further, it could be argued that the SWAp reforms have led to a demand for financial information that permits the impact on the poor and poor areas to be tracked. For example,

[82] Ferdousi (2001)
[83] HEU (2000)
[84] CIET (1999) and CIET Canada (2000)
[85] CIET Canada (2000)

new financial information systems that, for the first time, permit spending to be tracked by geographical area have thrown up wide disparities in per capita spending allocations that cannot be explained by aggregate measures of need.

It is less clear, however, that there is any substantial demand for poverty related analysis from most of government, particularly the line directors responsible for service planning. The Service Delivery Survey provides annual information on the utilisation, experience and perceptions of health services by the Bangladesh population, but the sample is too small to permit disaggregation of the data. The many problems suggested by the SDS might be expected to prompt demands for more in depth study to explore the causes and what can be done about them, but this has not happened.

The top-down, hierarchical management style means that local realities are not fluidly transferred up the line, and the annual planning process is relatively uninformed by what is happening locally. The Annual Performance Review is the main opportunity to review progress and decide future support.[86] Much of this consists of output performance measured against planned activities. Though there is some emphasis on collecting 'Community and stakeholder perspectives', this could not be said to be systematic.[87]

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Annex 8: Ghana Health

Ghana – Health Sector (1997-2001)

The authors alone are responsible for the opinions and for the accuracy of the facts included in this case study. However, for replies to questionnaires and detailed comments, they are indebted to: Tony Seddoh (Policy Unit, Ghana Health Service) Tony.Seddoh@hru-moh.org, and Liz Gaere (DFID Ghana) lizgaere@africaonline.com.gh, with additional material based on research conducted by Mick Foster in June 2001.[88]

Abbreviations

BMC	Budget Management Centre
CWIQ	Core Welfare Indicators Questionnaire
CPHS	Community Based Planning and Health Service
DHS	Demographic and Health Survey
GLSS	Ghana Living Standards Survey
GoG	Government of Ghana
GPRS	Ghana Poverty Reduction Strategy
HMIS	Health Management Information System
MoH	Ministry of Health
MTEF	Mid Term Expenditure Framework
MTHS	Medium Term Health Strategy
NDPC	National Development Planning Commission
PoW	Programme of Work
PRA	Participatory Rapid Appraisal
PRSP	Poverty Reduction Strategy Paper
TBA	Traditional Birth Attendant

1. Poverty diagnosis

The MTHS was developed over a two-year period of focal group discussion and brainstorm sessions, informed by a range of analytical work mainly based on survey data. Key among these were the DHS,[89] Twum-Baah et al, 1994[90] and Demery et al 1995.[91]

Detailed consultations with staff at all levels on the problems of the health sector and what could be done to address them were also influential in persuading the MoH to implement a major decentralisation of decision making and budget authority to district level and below. The series of workshops and consultations were so elaborate that some commentators[92] thought the two-year period it took to build consensus was overstretched.

A key insight informing the MTHS was the recognition that the initial pattern of health spending was biased against the poor. Per capita public health expenditure on the richest 20% of the population was 2.8 times higher than on the poorest, with the poorest 20% receiving only 12% of

[88] Foster and Zormelo, 2001.
[89] Demographic and Health Survey, 1994
[90] Twum-Baah et al (1994)
[91] Demery et al (1995)
[92] Cassels A and Janovsky K (1996)

public sector health expenditure.[93] The quality of services was judged as poor and the service package at the primary level did not meet community expectations.

The analysis also recognised that the user fee system[94] was regressive, and contributed significantly to low utilisation of services by the poor.

It is interesting that the MTHS did not make significant use of the 1994 participatory poverty assessment, carried out by the World Bank as part of their poverty assessment 'Ghana, Past Present and Future.' This partly reflects the fact that the Bank themselves gave little emphasis to the PPA findings, focusing instead mainly on the quantitative analysis. The conclusions were not therefore widely disseminated, yet they captured a number of problems and themes, some of which were recognised in the design of MTHS, but others of which became increasingly emphasised in the subsequent evolution of the programme. The PPA drew attention to high charges for poor services, reluctance to 'pay twice' when drugs were not available, regional inequalities in access, poor staff attitudes discouraging use of facilities and poor administration of user fees leaving patients uncertain as to whether they were being asked for bribes or for legitimate payments.[95]

Subsequently there has been a range of research and analysis on poverty-related issues to inform annual programme implementation and to feed into the design of the follow-on 5 Year PoW. To date this has included:

- An analysis of inequalities in health access, outcomes and contributory factors including poverty.[96] This drew on quantitative data from the CWIQ, DHSS and GLSS surveys.
- A community assessment using PRA.[97] This study did not specifically target the poor; however there was a focus on ascertaining the views of communities with poor uptake of health services (presumed, rightly or wrongly to be "deprived").
- A policy analysis study, reviewing the extent to which health policy in Ghana has had an equity focus (poverty, gender, disability etc). [98]
- A review of the implementation of the exemptions policy [99]
- Development of a gender equity framework identifying gender-related issues affecting access to health care and health outcomes.[100]

The interesting conclusion from the way the process has developed is that the Government-donor partnership has provided a ready means for commissioning work on topics related to the effectiveness and equity of health services, while the joint reviews have provided a forum for discussing them and an opportunity to take forward action on their findings. The act of jointly reviewing performance has facilitated deeper analysis and understanding of the problems and what can be done to address them. The contrast between the World Bank driven PPA, which had little influence, and the in-house analysis of inequality is striking.

2. Poverty reduction and sector strategy

The MTHS was designed to be complementary with national poverty reduction objectives as outlined in the Ghana Vision 2020 document.[101] Poor health status is recognised as both a cause and

[93] Finance Sub-Team Report, 1995 in Seddoh, A (2000), Decentralisation as Comprehensive Service delivery; Myth or Truth; MoH
[94] Hospitals Fees Law; Legislative Instrument of 1986; LI 1313
[95] Norton et al, 1995
[96] Bosu, W.K.; Nsowah-Nuamah, N.N.N.; Ward, P.M. (September 2000)
[97] Amekudzi et al (2000)
[98] Addai, E., Agbe L., Awittor.E, Gaere, L., Osei, E., Tinorgah, A. (2000)
[99] Garshong, B; Ansah, E; Dakpallah, G et.al. (2001)
[100] MOH Health Research Unit (1999). Promoting gender equity in health: A framework for action.

a consequence of poverty, while it is implicit that the definition of poverty should include lack of access to the means to maintain a healthy life. The MTHS recognised that improvements in health services were only one factor in achieving improvements in the health of the population, and it would be at least as important to reduce income poverty, reduce population growth, raise female literacy, improve nutrition, and improve access to water and sanitation. The MTHS recognises that income is an important determinant of access to 'food, education and health care – the essential elements of health'.[102]

The poverty emphasis of the initial policy document[103] is not carried through as strongly in the Programme of Work, which does not fully address the specific needs of the poor in relation to health and access to health care. The broad objectives defined in the 5 Year PoW 1997-2001[104] are to improve access, quality, and efficiency of services, foster partnerships, and reduce financial barriers to access to services.

The POW does however try to address the two fundamental issues of expenditures biased against the poor, and the regressive impact of user fees on access by the poor. The fundamental strategy for overcoming the regressive bias of public expenditure on health was to shift the emphasis of spending away from tertiary hospitals disproportionately used by the better off urban population, in favour of expanding access to more cost-effective primary and preventive services at district level and below.

An expanded Exemptions Policy was introduced in 1998 to cater for those who could not afford to pay. The policy design targeted universal coverage of key public health interventions (antenatal care, under-5s treatment, treatment for priority public health diseases such as TB) with an assumption that this would impact upon the health needs of the poor. Alongside this, the facility for free treatment of "paupers" as introduced with the user fees policy in 1986 was maintained.

In those regions that have made most use of exemptions, and particularly in the poorest and most deprived Northern regions, the implementation of the policy has been associated with fairly dramatic improvements in the uptake of public health services. Nevertheless, the overall impact of the policy on access by the poor has probably been quite limited.[105] It has proved difficult in practice to target exemptions on those who most need them. For example, there is no standard definition for 'paupers' [106] and funds meant for this group are sometimes used to exempt prisoners and absconders. The most recent sector review report shows big regional variations in the implementation of the policy.[107] The real value of exemptions spending has fallen by one third since 1998, while the contribution of user fees to health expenditure has increased, and finances a larger share of public spending than envisaged in the PoW.

Though poverty was emphasised as an issue in Vision 2020 and in the first health sector programme of work (1997-2001), the preparations for the PRSP have reinforced this emphasis. The health ministry and the Ghana health service have participated fully in the PRSP (GPRS) process of consultation, something that has not been as true of some of the other sector ministries. There is broad convergence of health sector strategy and the PRSP in terms of achieving a more pro-poor focus although the details of what this means in implementation terms are still being worked out (e.g. enhanced geographical targeting). The health sector, influenced by the inequality studies undertaken for the 1999 health sector review, had already reached the conclusion that reducing

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[101] Ghana Vision 2020; National Framework for Medium Term Development – 1997 – 2001
[102] Medium Term Health Strategy; Towards Vision 2020; August, 1999 (Revised Version)- MoH/Ghana
[103] Health Sector Priorities and Policies; 1994/1995, MoH; Ghana
[104] MoH (1996)
[105] Addai et al 2000 (ibid)
[106] Garshong et al (ibid).
[107] MoH (2001)

inequality in access to health services and in health outcomes would be the main focus of the next 5 year programme, and thus they were in tune with the goals of the poverty reduction strategy.

A gender-mainstreaming plan is presently being implemented by the sector, as part of the development of the overall framework for action on inequalities in health.

Cross sector coordination

Although intersectoral collaboration and partnership building is considered to be critical to achieving the objectives of the MoH, the most recent review of the programme points out the low achievement to date. The review suggests that the lack of a body below the cabinet with the mandate to promote such collaboration has been a constraint, while Ministries have no specific budget for joint working and inevitably prioritise their own concerns. The policy hearings undertaken as part of the annual budget cycle, in which social sector ministries are grouped together to discuss the budget and the MTEF, have not succeeded in promoting cross-sector working in part because the discussions are inevitably related to a competitive budget process.

Similar problems occur at District level. District Directors of health are active in the social services sub-committees of district assemblies, but health staff continue to resist co-ordination by the district authorities, seeing their prime allegiance to their health sector managers. Specifically to address poverty, linkages were to be forged with communities and households to enable local needs and those of vulnerable groups such as the poor, the young and the elderly to be identified. The need to give this more emphasis is acknowledged, with proposals to prepare a community participation strategy.

Nationally, the main locus of coordination is now via the intersectoral poverty working groups convened by the National Development Planning Commission (NDPC), as part of the PRSP process. There is a plan to strengthen coordination to support the PRSP process via a “poverty and health” working group.

Pro-poor targets

In the MTHS, the issue of increasing coverage and quality of services for the poor is primarily addressed by the strategy to enhance financial and geographical access. This is translated into a number of implementation strategies, some of which have specific targets attached. These include shifting resources to the lower levels, increased outreach programmes, price discrimination in favour of primary care, the “pauper’s” fund and exemptions policy. However, the need to focus on access for the poor as a specific priority group can be said, in retrospect, to have not been specified clearly enough. Apart from the exemptions policy, the emphasis has been more on universal coverage and quality improvements.

Within the MTHS there are core national target indicators. These are:

- Infant Mortality Rate
- Under-Five Mortality Rate
- Maternal Mortality Rate
- Life Expectancy
- Adult Mortality.

Of these, the first three are considered as poverty-sensitive indicators of health outcomes, and significant progress has been achieved. A key issue has been to try to track these indicators by socio-

economic group (poverty quintile) as well as by geographical location. Significant improvements have been achieved overall, with rural areas including the poorest Northern districts sharing in the gains, though some other regions have experienced a deterioration in performance in the 1990s.

Target Indicators, and Progress Achieved			
	1997 Baseline	2001 Target	1998 Actual
IMR	66	50	61
UMR	132	100	110
MMR	214	100	

The most recent sector review[108] report recommends that targets to reduce inequalities in health are set for the next 5 Year PoW and that there is a priority focus on ensuring that health care is accessible to, and meets the expectations and preferences of, the poor.

Public-Private Partnership

As mentioned earlier, one of the main pillars in the Programme of Work is intersectoral collaboration and partnership building. This is meant to engage the private sector and non-governmental organisations in service delivery. The key tools for this were supposed to be contracting of services to these institutions using a memorandum of understanding. As implementation experience has shown, the healthcare service based institutions have been favourably engaged, and a significant share of Government funding supports mission hospitals and other not-for-profit services. Liaison with NGOs and with the private for profit sector has so far been largely limited to the preparation of strategy documents[109]. Some efforts have also been made to support and strengthen non-formal and traditional practitioners.

These roles are to be more clearly defined in the next PoW. The key role of civil society in health policy and implementation to address poverty and health linkages has been recognised for further strengthening.[110]

Pro-poor measures

As noted earlier, a range of measures under the first 5 Year PoW have been developed with both implicit and explicit assumption of benefiting poorer groups.
These include:

Financing:
- Exemptions policy
- Paupers fund
- Pricing policies favouring primary health care
- Shift of resources to district and sub-district level
- Review of national resource allocation formulae

Management:
- Decentralisation of planning and budgeting to BMCs [111]

[108] Health of the Nation, ibid
[109] For example: MoH, 1998 (NGO Strategy document), MoH, 1999 (Private Sector Strategy document).
[110] MoH (2001) – ibid.
[111] Identified as a key element of poverty policy in Booth, D (1999)

Service delivery:

- Public health outreach, provision of appropriate transport to support this (motorbikes, boats)
- Strengthening of sub-district level facilities
- Community-based Health Planning & Services (CHPS) Initiative – placing of healthcare workers in priority communities
- Safe Motherhood, training of TBAs; regulation of private providers such as chemical sellers

3. Poverty reduction and sector expenditure

The programme is costed overall on a five-year basis (5 Year POW) and annually on a three-year basis via the MTEF process. In theory this is based on agreed targets but in practice the linkage is relatively weak. [112]

The health sector programme was launched at a time when Ghana was experiencing lower economic growth and a loss of macro-economic control which has seen public expenditure squeezed by an increasing debt burden. Across the budget as a whole, the real level of per capita spending excluding interest and personal emoluments has declined continuously since 1993, and by 2000 was around 62% of the level reached in 1993. Against this background, it is not surprising that Government spending on the health sector as a share of GDP declined from around 1.5% of GDP in 1992 to less than 1% in about 1997, before recovering in 1999. As a share of discretionary Government spending, health has fluctuated around 5-6% of the total. The contribution of external donors has not met expectations, resulting in falling total spending as a share of GDP since 1997. In per capita terms, Government spending remains below $5 per head excluding aid, and (including aid) has declined from $8.14 in 1997 to less than $7 per head in 1999. The decline was less marked in local currency terms due to exchange rate changes. Nevertheless, the achievements of the health sector programme need to be evaluated in the context of shrinking per capita resources available for the health service.

Good financial management within the health sector has been recognised, and the health sector has fared better than other departments in securing the relatively full release of the annual budget. Sector financial statements and audit reports do suggest that allocated funds reach the various BMC levels although there can be hold-ups in the flow of funds.

Whilst there has been a degree of protection of the health sector budget from within-year cuts at the national GoG level,[113] there is no specific provision to protect services to the poor from funding shortfalls at the operational level. This is because the sector's mechanism for evaluation of the performance of the lower levels of the health system does not presently include any disaggregation of the population covered. Thus managers are not presently required to ensure or protect service delivery to vulnerable groups within the community. Sector monitoring at present focuses on tracking key performance indicators, which broadly represent sector priorities. There is no detailed analysis of expenditure against the various priorities other than tracking of the budget by level and line item.

The PoW targeted to increase the percentage of the budget spent at district level and below (presumed to be pro-poor expenditure) from 16 per cent to 42 per cent over the Five-years. This has been met and even exceeded. The District share in total health spending has increased from 26% in 1997 to 46% in 1999, but this is a poor indicator of focus on primary services benefiting the poor, since 60% of district spending is on hospitals and administration.

[112] MoH & Health Partners (2000)
[113] MoH, 1998 Memorandum of Understanding Between MoH and Partners, April

A frequent problem with exemption policies is that facilities bear the cost of free treatment on their budgets, and they are therefore reluctant to grant exemptions. Ghana overcomes this problem by making specific budget provision, earmarked for meeting the cost of exempting from payment some categories of user, and some types of health intervention. The exemptions budget in 2001, when adjusted for inflation, has fallen to two thirds of the level achieved when the new, expanded coverage of exemptions was introduced in 1998. Exemptions now account for less than 3% of Government health spending. The amounts budgeted for exemptions have proved in some regions to be far below what is actually required.[114] In other regions, 'paupers' budgets have been used to fund treatment for prisoners or those who absconded without paying. The proportion allocated to 'paupers', intended to protect the poor, has suffered from the sharpest decline.

There is presently a question mark over the future of the exemptions policy. The Government that took power after the December 2000 election has decided to scrap user fees at the point of service delivery. The present policy shift is towards new health financing mechanisms focusing primarily on health insurance. In this context, how best to protect and promote access by the poor is a key issue, and one which will take time to resolve in principle, and still longer to establish and disseminate working alternatives to the present approach.

3.1 Evidence of improved utilisation of services by the poor

A recent analysis has concluded that health sector expenditure overall is still neither equitable nor efficient.[115] The PRA study and other anecdotal evidence also suggests that there is still widespread dissatisfaction with the quality of public health care e.g. attitudes of health workers. Quality of care is a relevant consideration for the poor and is reflected in use of private and traditional as opposed to public providers. Considerable geographical inequalities in access exist (worst affected are the poorer northern regions). Though improvements in health status have taken place, the spread of the gains has not been equal.[116]

Household survey evidence suggests that overall utilisation of curative health services remains low and is not improving, with the poor and those living in rural areas having particularly low access[117] (Table 1). Less than 20% of the rural poor report consult modern health services when ill or injured, and the proportion seems to have fallen since the early 1990s.

[114] Northern Regional Review Report (2000)
[115] Canagarajah, S & Xiao Ye (2001) * *NB – It is considered by a number of experts some of the conclusions of this report need further clarification*
[116] MoH (2001) ibid
[117] Ghana Statistical Service (1999)

Table 1 Trends in consultation practices by those who were ill or injured in the two weeks preceding the survey, 1991/92 and 1998/99

	% not consulting anyone		% that consulted a doctor or pharmacist		% that consulted in a hospital	
	1991/92	1998/99	1991/92	1998/99	1991/92	1998/99
All households, by locality:						
Accra	44.9	35.2	50.5	58.4	22.2	16.1
Urban Coastal	41.7	51.0	48.9	32.9	30.2	28.0
Urban Forest	34.4	46.3	46.9	41.3	30.5	27.5
Urban Savannah	55.9	54.1	15.5	25.5	9.3	24.0
Rural Coastal	47.7	53.3	30.3	20.4	19.0	12.5
Rural Forest	52.3	62.3	24.2	16.7	18.2	12.1
Rural Savannah	63.4	61.4	11.2	8.2	9.8	7.3
ALL GHANA	50.7	56.2	28.2	22.4	18.6	15.0
Urban households, by standard of living quintile						
Lowest	37.0	56.3	50.0	25.0	17.4	20.8
Second	53.9	58.3	28.1	20.5	21.1	18.0
Third	46.4	50.5	36.1	30.5	22.1	24.2
Fourth	50.6	46.6	36.1	39.3	21.4	24.7
Highest	33.9	40.1	50.7	51.8	28.6	28.2
ALL URBAN	42.5	46.6	42.3	39.9	24.5	25.0
Rural households, by standard of living quintile						
Lowest	61.0	66.5	13.5	7.5	11.4	5.2
Second	58.0	61.7	18.7	12.4	14.3	8.9
Third	56.5	60.9	21.9	15.3	14.8	10.8
Fourth	50.4	59.8	26.4	16.8	19.3	12.3
Highest	44.5	48.8	29.8	27.2	20.8	19.8
ALL RURAL	54.7	60.2	21.6	15.1	15.8	10.9

Source: Mackay and Coloumbe (2001) calculation from the Ghana Living Standards Survey, 1991/92 and 1998/99.

This picture is offset by a more positive pattern of significant improvement in the coverage of preventative services. Vaccination coverage seems to have improved significantly, associated with increased outreach facilities, more births are being attended by trained staff, and there has been a significant decline in infant mortality, despite continuing high levels of malnutrition (Table 2). The role of outreach facilities in achieving this despite limited overall spending deserves further study. The latest sector review suggests that outreach and community-based service delivery may be more effective than facility-based approaches in reaching the poor.[118]

The household and DHS survey figures are broadly consistent with the performance indicators summarised in the 2001 review of the programme, though the administrative data used for the review suggests that, after stagnating or declining to 1999, utilisation of curative care increased sharply in 2000, an improvement which was too late to be picked up in the GLSS. Out patient visits per capita increased from 0.32 to 0.42. Where it has functioned well the exemptions policy has been well received by the public and there have been significant increases in uptake e.g. of treatment for under 5s and ANC. However, it seems unlikely that this is the sole explanation, given the falling real level of exemption spending.

[118] Research from the Navrongo District in northern Ghana for example demonstrates the effectiveness of community-based service delivery strategies in increasing uptake and reducing mortality rates.

Table 2 Non-Monetary Welfare Indicators from the DHS Surveys (1993 & 1998)

	Urban		Rural		Ghana	
	1993	1998	1993	1998	1993	1998
Health						
Infant Mortality	54.9	42.6	82.2	67.5	74.7	61.2
Delivery at a Health Facility	79.3	75.7	28.0	33.1	42.2	43.4
Delivery by:						
a Doctor	16.5	19.0	2.7	4.5	6.5	8.0
a Nurse	64.7	57.3	26.8	29.6	37.3	36.3
a trained TBA	4.7	11.5	19.4	28.3	15.3	24.2
Fully Vaccinated	71.1	72.3	47.8	58.0	54.8	62.0
Stunting	15.7	14.3	30.1	29.7	26.0	25.9
Wasting	8.6	6.5	12.6	10.5	11.4	9.5

Source: Mackay and Coloumbe (2001) calculation from the Ghana Living Standards Survey, 1991/92 and 1998/99.

4. Poverty reduction and sector management

Public expenditure management

The Ministry of Health has been a leader in introducing improvements in planning and budgeting, financial management, procurement, and especially decentralised budget management.[119] The introduction of the Medium term Expenditure Framework by the Ministry of Finance should have provided a more reliable basis for planning and prioritisation around agreed strategic objectives for the sector, with a more reliable forecast of the medium term resources available. In practice, weak macro-economic management has undermined the credibility of the budget process in general, and the longer term forcasts of the MTEF in particular. The new Government is giving renewed attention to improving budget management, which may hold out the hope of a return to more predictable budget planning in the medium term, though the difficult short-run fiscal situation will mean resources will continue to be very tight, and planning will be subject to considerable uncertainties.

There is also a renewed emphasis on relating the budget process more closely to the priorities of the poverty reduction strategy paper. A more effective central challenge function would help to reinforce the pro-poor revision of policy emphasis in the health PoW, and might help to reinforce the weak cross-sectoral linkages in policy.

Institutional measures to meet the needs of the poor

Monitoring of service delivery to assess changes in responsiveness to the needs of the poor has been very weak. Quality assurance processes including client feedback have been introduced in some regions and districts, although there is not a stated focus on assessing how the needs of the poor are being met.

Public participation in health facility and health service planning and management is presently very weak and there is no process in place to enable participation of the poor and vulnerable groups.[120] A civil society participation strategy is however being developed for the sector and it is intended that this will have a strong pro-poor focus.[121]

[119] Addai E and Gaere L, (2001) (IHSD paper, forthcoming)
[120] Addai et al (2000)
[121] DFID and the Ministry of Health (2000)

Incentives to ensure a focus on delivering quality health care for the poor are presently weak (e.g. there are no institutional incentives for facilities to ensure that their exemptions budget performs well; indeed delays in reimbursement of exemption expenditure to date have acted as a disincentive).

Impact assessment

The impact of the programme on the poor is not assessed via routine health service data, as this does not include any element of poverty monitoring. Hence GoG survey data has been used to date, but there are problems with this such as (1) timeliness of the various surveys in relation to sectoral monitoring requirements, (2) inadequacy of the data e.g. limitations of the questions asked, (3) limitations of sample sizes (e.g. the CWIQ can not yield data below regional level), (4) access to the data for more detailed analysis by health sector analysts.

A strategy to strengthen poverty and equity monitoring in health via a combination of enhanced HMIS systems and enhanced use of GoG surveys is being developed.[122]

The various inequalities studies conducted can be said to have had a significant impact on sector policy and strategy, in so far as a major rethink of sector strategy for the next five year PoW is now underway with an emphasis on 'bridging the health inequality gap'.[123]

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Annex 9: Zambia Agriculture

Zambia Agricultural Sector Investment Programme – ASIP (1996-2001)

The authors alone are responsible for the opinions and for the accuracy of the facts included in this case study. It draws on referenced reports, plus replies to our questionnaire.

The first efforts to create an integrated Agricultural Sector Investment Programme (ASIP) in Zambia began in 1992. However, it proved difficult to reach agreement on the policy framework and the role of Government, and the programme was not officially launched until January 1996. This case study will examine the extent to which the design and implementation of the programme have considered the poorer sections of society.

Impact of ASIP on Poverty Reduction

Agricultural sectoral reforms have failed to have any significant impact on poorer groups. An independent assessment carried out as part of the Mid Term Review in 1998 concluded that implementation performance had been disappointing and, as a result, the programme had little credibility with most stakeholders[124]. The Mid Term Review and Nokkala[125] have both observed a lower level of expenditure during ASIP compared to the pre-ASIP levels. Indeed Nokkala points out that "Instead of contributing to greater equality in the income distribution the programme has done the opposite by weakening the income received from the traditional sector of production…policies have shifted away from exploiting agricultural production but at the same time there is no clear progress towards rural development policies".

Abbreviations

ASIP	Agricultural Sector Investment Programme
MTR	Mid Term Report
PRSP	Poverty Reduction Strategy Paper
ACF	Agricultural Consultative Forum
RIF	Rural Investment Fund

1. Poverty diagnosis

At the design stage the five main goals adopted by the ASIP were to: -

- Ensure national and household food security
- Maintain and improve the existing agricultural resource base
- Generate income and employment opportunities by fulfilling domestic and export market potential
- Contribute to sustainable industrial development

[124] IESR (1998)
[125] Nokkala (2001)

- To expand agriculture's contribution to the national balance of payments.[126]

There is no explicit reference to poverty alleviation as a key objective of the sectoral strategy.

ASIP was introduced in a context in which Government had been withdrawing from widespread involvement in agricultural marketing, input supply, direct production activities and pricing policy, in order to concentrate on a narrower range of services in support of a private sector dominated agricultural sector. The sector was also characterized by numerous donor projects, often geographically based, and adopting inconsistent approaches.

Pre-ASIP studies included a situation analysis, which was based on Priority Surveys, Living Conditions Monitoring Surveys and Beneficiary Assessments. All of these revealed poor performance of the agricultural sector due to inappropriate policies and lack of a well-coordinated sector strategy. There had been minimum local ownership and participation and a high dependence on external technical assistance according to some reports.

The diagnosis of the mid term review was that remote areas, where the poorest farmers live, suffered disproportionately from the discontinuation of subsidies and from the unwillingness of the private sector to take up services previously provided by the Government. Though the ASIP had an extended planning process with numerous working groups and background studies, the lack of sufficient analysis of the problems of resource poor farmers in a new, liberalised policy environment appears to have contributed to a failure to anticipate the implications for the remote areas.

Gender

In the formulation phase of the programme, gender was considered to be a crosscutting issue, and an advisory committee was set up whose members were attached to several of the ASIP task forces. They provided various guidelines, none of which were adopted. The integration of gender issues into the ASIP framework was very weak, and the role of women in agriculture was barely mentioned at policy, objective, activity or monitoring level.[127]

2. Poverty reduction and sector strategy

ASIP & PRSP

At the time of formulating ASIP I a detailed Poverty Reduction Strategy Paper (PRSP) had not yet been developed. Anti-poverty measures in ASIP were a palliative afterthought and not core objectives. However, it is hoped that the next phase of ASIP will be more closely linked to the PRSP. The discussions for the formulation of the second phase of ASIP are more comprehensive and take into account poverty and gender issues.[128]

Pro-poor targets

Indicators to assess performance were defined at the start of the programme. They give little indication of the impact on the poor.

[126] IESR (1998)
[127] GTZ
[128] GTZ

Sector Performance Indicators

- Aggregated indicators that track developments in the overall sector performance and are loosely connected to the overall objectives of the ASIP.
- Sub-programme indicators that are related to indicators appearing on individual sub-programme logical framework documents.
- District key performance indicators that are a mixture of agriculture performance and socio-economic indicators for each district. These are meant to provide the basis for establishing key development issues and strategies for district based interventions.

There are three main problems with these indicators as identified by Balzer and Chiwele.[129] Firstly, some of them are inconsistent and it is therefore difficult to make comparison. Secondly, they are "hardly focused on the main strategy and intervention areas of the ASIP" and therefore seem irrelevant. For example the number of female-headed households does not seem to be directly related to the performance of the ASIP. Finally, the authors point out that the Indicators cover only average values at national or District level, and do not attempt to distinguish between recipients benefiting from the programme and those who do not.

Pro-poor measures

Although there is a clear commitment at policy, objective and activity levels to address smallholder constraints, the translation of this intention into implementation and impact has been stifled by numerous institutional, financial and capacity constraints.[130] However, ASIP does have two components that directly benefit smallholders, and thus may have a pro-poor focus. These are the Rural Investment Fund (RIF), and the provision of agricultural inputs to the poor (see Boxes). The coverage and targeting of the former, and the appropriateness of the latter as a response to rural poverty, have both been questioned.

[129] Balzer and Chiwele (1999)
[130] GTZ

The Rural Investment Fund (RIF)

Conceived in response to constraints facing smallholder farmers in disadvantaged areas of Zambia, the RIF was intended by Government to provide direct and indirect support to organised farmer groups through the provision of investment capital, infrastructure development, and training and information services. The farmers identify their own problems and constraints and solutions. The RIF is credited with providing direct assistance to farmer groups, and as one of the few ways Government was trying to ease the process of economic liberalisation.

Between 1996 and 1998, it provided funding for 83 individual projects with a total estimated value of nearly ZK1.6billion.

However, according to the MTR there was evidence of elite groups siphoning off the benefits. The lack of knowledge and staff capacity led to the uneven performance of individual projects. The RIF has a separate investment fund located within MAFF, and according to the MTR could have just as easily been implemented by for example a micro-projects unit. The impact of the project is minimal as it is still just a pilot scheme

Provision of Agricultural Inputs to the Poor in Rural Areas (PAIPRA)

In recognition that the ASIP programme is unable to deal sufficiently with the poorest groups, MAFF is in the process of preparing a special programme targeted at resource poor and vulnerable farmers. It will be implemented under ASIP's Extension sub-programme, with the aim to cushion the effect of liberalisation and privatisation of government services on smallholders. Out of approximately 600,000 farmers, the programme hopes to cover the top 400,000. The 200,000 small-scale farmers at the bottom of the scale are thought to be out of reach of agricultural development programmes and are to be targeted by the PAIPRA under the Ministry of Community Development Sector Welfare[1].

Sector programme costing

The programme bases the cost estimates on an activity-based budget, which links resources to the cost of achieving objectives. However, the lack of poverty focus, or of clear objectives related to the coverage or reach of services, limits the usefulness of this from a poverty perspective.

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Annex 10: Poverty in sector wide approaches questionnaire

Replies to this questionnaire will contribute to an assessment of how the introduction of a Sector Wide Approach can contribute to a more effective poverty reduction focus within the sector. Respondents are requested to provide brief answers to each of the questions under each section. If it is possible to also send e mail copies of documentation bearing on the questions, that would be extremely helpful, for example copies of the last programme review or other relevant reports, data or analysis. Respondents may contact Adrian Fozzard or Mick Foster at a.fozzard@odi.org.uk and m.foster@odi.org.uk for further clarification if necessary. Replies will only be identified by name with permission.

Name
Employer & Position
E-mail address
May we quote you? (Y/N)

1. Basic Details

1.1 Country and Sector

1.2 Time period covered by the sector programme

.3 Main sources of finance

2. Poverty Diagnosis

2.1 To what extent has the design of the sector programme been informed by analysis of the current access to services by different groups within the poor, the constraints limiting their access, their views regarding the quality and relevance of sector services, and the priority they give to improving them?

2.2 What information is the diagnosis based on? What types of survey were used, what processes of consultation were used to seek views from the poor?

2.3 What analysis was undertaken of the specific actions needed to address sector issues relevant to the poor?

3. Poverty Reduction and Sector Strategy

3.1 Is the sector programme fully consistent with the analysis and priorities of a national Poverty Reduction Strategy? Comment on the consequences of any inconsistencies.

3.2 Does poverty reduction require the sector authorities to coordinate with Ministries or institutions outside the sector? How is this achieved?

3.3 What if any specific targets does the Sector programme define for improved coverage or quality of services for the poor?

3.4 Does the programme specify the roles of the public and private sectors (including NGOs) in achieving those targets?

3.5 What measures included within the programme are expected to significantly benefit poor groups?

2. **Poverty Reduction and Sector Expenditure**

4.1 Is the Sector programme costed? Does it relate the costs to the targets and to realistic forecasts of funds available? Is there provision to protect services to the poor from funding shortfalls?

4.2 What proportion of sector programme expenditure relates to programmes from which the poor are expected to be major beneficiaries (e.g. primary education, primary health, rural water supplies)? How has the share of pro-poor spending changed, how is it forecast to change in future?

4.3 Do actual expenditures match the priorities set in the sector plan and budget? Is there evidence e.g. from tracking or service delivery surveys that resources reach the facility level, and that the poor have access to them?

4.4 What evidence is there of relevant changes in utilisation of services (including by the poor), or in their satisfaction with services, or in outcomes such as health, nutrition, education attainment.

5. Poverty Reduction and Sector Management

5.1 How have recent reforms in public expenditure management affected the poverty focus of public expenditures in the sector? (For example, medium term expenditure frameworks, decentralisation, more open and participatory budget process, strengthened monitoring and accountability, output targets and performance incentives, etc).

5.2 How have institutional measures changed the responsiveness of services to the needs of the poor? (For instance: management closer to point of service delivery; participation of clients and communities in management; incentives for services to attend the needs of the poor).

5.3 How is the impact of the programme on the poor assessed? How does this information influence sector policy and strategy?