THE SECTOR WIDE APPROACH (SWAp) AND ITS IMPLICATION FOR HEALTH NGOs IN DEVELOPING COUNTRIES; A CASE STUDY OF KENYA.

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DECLARATION

Where other people's work has been used (either from a printed source, internet or any other source) this has been carefully acknowledged and referenced in accordance with departmental requirements.

The Thesis the Sector Wide Approach (SWAp) and its Implication for Health NGOs in Developing Countries; A Case Study of Kenya is my own work.

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ABSTRACT

Background: With the implementation of the Sector Wide Approach in donor funding and activities, NGOs are hanging in a precarious situation. This is especially so for those that used to receive project funding. With bilateral and multi lateral agreements, donors prefer to pool their funding according to government plans and expenditure frameworks. This can be counterproductive in health service delivery as it changes delivery of services to centralised priorities and resource allocation. This paper aims to point out the challenges envisioned and/or experienced by implementing countries as well as achievements with a regard of offering recommendations for successful implementation.

General objective: is to examine the effect of SWAp in Kenya on health service planning and in particular on the role played by NGOs'.

Specific objectives:

- To determine the role played by NGOs' and the state of health service delivery in developing countries since the introduction of SWAp in health planning and management.
- To establish how the SWAp approach has affected the role played by NGOs' in planning and delivery of health services where they have been introduced.
- To draw lessons and offer practical recommendations on how implementation of SWAp can be used to improve planning, management and delivery of health services in Kenya based on study findings.

Methodology: study design is a retrospective non intervention study. It is descriptive in nature with some comparative design using country examples to describe the situation since introduction of SWAp. As the SWAp process is still ongoing, the study will be looking at the trends over time. The data will be collected through a literature review using the KIT library, government reports and online material from websites including PUBMED, ELDIS, LANCET, ODI, WHO and Google SCHOLAR. Related links will be followed where available and relevant.

Key Words: SWAp, Kenya, Developing countries, Health NGOs, Harmonisation, Ownership, Alignment, Results Based Management and Mutual Accountability.

Results: The study has come up with results indicating the implementation of SWAp analysis according to the five principles of Paris Declaration. There are efforts to engage NGOs in SWAp implementation although they could further be used to achieve the principles of ownership, alignment, harmonisation, results based management and mutual accountability.

Conclusion: SWAp can be used positively to engage NGOs in health service delivery. This will call for institutionalisation of structures and modalities of partnering and future involvement. NGOs' have a role to play in SWAp implementation especially when they realise they are an integral part of the country's health system.

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GLOSSARY

LIST OF ABBREVIATIONS

AOP	Annual Operating Plan
CDF	Comprehensive Development Framework
CHAK	Christian Health Association of Kenya
DANIDA	Danish Development Agency
DFID	Department for International Development
DHMT	District Health Management Team
DHMB	District Health Management Board
DHSF	District Health Stakeholders Forum
ERS	Economic Recovery Strategy
GAVI	Global Alliance for Vaccines and Immunisation
GFATM	Global Fund to fight AIDS, TB and Malaria
GOK	Government of Kenya
HSCC	Health Sector Coordinating Committee
HIV/AIDS	Human Immuno Deficiency Virus/ Acquired Immuno Deficiency Syndrome
JDM	Joint Design Mission
JPWF	Joint Programme of Work and Funding
JSP	Joint Support Programme
KCS	Kenya Catholic Secretariat
KEMSA	Kenya Medical Supply Agency
KEPH	Kenya Essential Package of Health
KPHF	Kenya Policy Health Framework

MOH	Ministry of Health
MTEF	Medium Term Expenditure Framework
NGO	Non Governmental Organisation
PER	Public Expenditure Review
PRSP	Poverty Reduction Strategy Paper
SIDA	Swedish Development Agency
SIP	Sector Improvement Programme
SWAp	Sector Wide Approach
RBM	Results Based Management
VHC	Village Health Committee

DEFINITION OF TERMS

In the context of this paper, the following terms will be defined as stated.
SWAps - has been defined as the entire significant sector funding that supports a single policy and expenditure programme with the government in the lead and it adopts common approaches across the sector while progressing towards relying on government systems for disbursing and accounting for all funds (Foster *et al.,* 2001). It is also defined as shifting external bilateral and multilateral funding from individual projects to the implementation of a country strategy and programs to deliver the strategy" (IHSD, 2000).
The sector wide approach calls for a single sector policy, a single strategy and a single expenditure framework, under government leadership, that is supported by all significant funding for the sector. It also incorporates greater alliance on government's own financial management and accountability systems (NHSSP II, 2005). This is the definition that will be operationalised in this paper as it covers aspects that can be related to the conceptual framework to be used namely: ownership, harmonisation, alignment and mutual accountability. The term sector programmes will also be used interchangeably with SWAps.

NGO - A Non Governmental Organisation is a not for profit making organisation that is outside direct control of the State. It can either be a religious organisation, international organisation or an in-country organisation operating in a developing country (Green & Matthias, 1997).

Ownership - Countries exercising effective leadership of the SWAp process and implementation strategies. It will also be reflected by how much the priorities are supported by budgetary allocation Brown *et al,* 2001*)*.
The indicators to be used to measure ownership will be existence of:

- Essential Health Packages
- Medium Term Expenditure Frameworks and National Health Plans of which the government is taking a lead role (NHSSP II, 2005; Paris Declaration, 2005).

Harmonisation - This will mean that donors are working together by having similar reporting procedures with an objective of reducing the administrative burden on governments. The indicators for measuring this will be:

- A single implementation/intervention framework for government and donor agencies where in this case its the health strategic plan
- Donors having common performance indicators
- Common reporting formats (World Bank, 1997).

Alignment - This will be taken to mean congruence of the SWAp approach with the priorities of the country health strategic plan. It will also mean donors linking their funding to a single framework of conditions (Paris Declaration, 2005). The indicators used to be used to measure this will be:

- Alignment with government agenda
- Use of government financial system

Results Based Management - This will mean effective use of resources and improved decision making. The indicators to be used to measure this will be presence of Performance Based Contracts for Health Personnel under the SWAp approach, focusing on results based reporting which use indicators that are manageable and for which data is cost effective to measure in the strategic health plan (Paris Declaration, 2005).

- Presence of performance based contracts
- Common assessment framework indicators

Mutual Accountability - Donors and countries should be both accountable for development results under the SWAp approach. The indicators for this will be availability of country mechanisms to mutually assess the progress of the activities being implemented (Paris Declaration, 2005).

THESIS OUTLINE

CHAPTER ONE - BACKGROUND

This chapter gives an overview of the background of the study and why it has revolved around SWAps and NGO health service provision.

CHAPTER TWO - PROBLEM STATEMENT

This chapter gives a description of the subject of discussion. It describes why the researcher thinks the advancement of SWAp affects NGOs.

CHAPTER THREE - PROBLEM JUSTIFICATION

The researcher goes ahead to justify why this subject is a health issue that deserved attention and why it was researched on.

CHAPTER FOUR - STUDY OBJECTIVES

This chapter states the general and specific objectives that guided the study.

CHAPTER FIVE - METHODOLOGY

This chapter describes in detail the study methodology that was utilised in the research.

CHAPTER SIX - LITERATURE REVIEW

A literature review that explores the thinking around the study subject is presented in this section.

CHAPTER SEVEN - FINDINGS AND DISCUSSION

This chapter gives the study findings and goes ahead to include the discussions that engage the researchers' thinking about the subject of study.

CHAPTER EIGHT - CONCLUSION AND RECOMMENDATIONS

This final section concludes the paper by summarising the topic of discussion and gives recommendations.

CHAPTER ONE: BACKGROUND TO THE STUDY

Non Governmental Organisations (NGOs) have been in the forefront of health delivery in many developing countries. The sector has seen extraordinary expansion with estimation that they reach 15 – 20% of the poor (Fowler, 2000). It is approximated that the non-profit sector now provides 40% of all healthcare and education services in Ghana, Zimbabwe and Kenya (Pollard, 2000). Due to the changing health needs of many countries especially in regard to HIV/AIDS, there had been a lot of pressure on health systems that required a different response resulting in a growth of the NGO sector (Green & Matthias, 1997).
NGOs in most developing countries have relied on direct donor project funding to carry out their activities. They have also been increasingly fronted as an alternative to the State when it comes to health care provision. They are proposed to achieve the same objectives but with fewer cases of inefficiency and resource challenge (Gilson, 1999).

Increasingly, donors are adopting a sector-wide approach (SWAp)[1] system. SWAps are commonly defined in terms of its aim: "to achieve sustainability and national ownership by shifting external bilateral and multilateral funding from individual projects to the implementation of a country strategy and programs to deliver the strategy" (IHSD, 2000). This shift from direct donor project funding to pool funding is meant to improve accountability and enhance sustainability that has been found to be lacking in project approach (Shacter, 2001). SWAps replace donor specific project funding by overall sector funding (Cassels, 1997). SWAps were developed in the 1990s as a solution to an increasing multiplicity of poorly coordinated donor projects (Elsey *et al.* 2005).

Development NGOs in most developing countries have relied on bilateral funding to carry out their activities and they are seeing the shift towards sector support as having a threat on their sustainability (De Renzio, 2005). There could be marginalisation of some groups in access for health where NGOs work could penetrate areas where government services had been lacking. SWAps generally concern themselves with priority setting and resource allocation at the national levels thereby centralising decision making (Elsey *et al.* 2005). In addition, there is a fear that when revenues decline, the first casualties will be public health programmes especially those that benefit the poor as it is believed that with donor funding there was security for special programmes (Cassels, 1997).

What makes SWAps attractive is that they are perceived as being able to strengthen governments' ability to oversee the entire health sector, develop policies and plans, and allocate and manage resources. They envisage a different and expanded role for Ministries of Health, for example, where policy-makers will look beyond the public sector, to explore the potential role of other stakeholders, whether service deliverers in the private sector or financiers (Walt, 1999). On the other hand, with reduced players in health service provision, there could be a risk of two tier system being created in countries where there will be

[1] SWAp is a move towards pooling of funding in one 'basket' by bilateral donors and agencies and giving control of allocation to the government. The government is in control of priority setting and resource allocation.

services provided at government facilities and those provided at private for profit facilities.

CHAPTER TWO: PROBLEM STATEMENT

Green (1987) classifies NGOs into: religious organisations, international NGOs, local NGOs, unions and trade and professional associations and non-profit making organisations. This study is going to focus on non profit making organisations and faith based organisations in health service delivery which can also be local or international.

SWAps are accredited with a shift in priority making in health care. The provision of health care is at a risk of changing with other health needs becoming more important than others. With health, a shortcoming envisaged with SWAps is a concentration on primary health care delivery or district services at the expense of other levels of care. This creates a risk of funds being used for those activities perceived to be attractive to external agencies and neglecting other needs (Cassels, 1997). Additionally if caution is not exercised, there is risk of heavy investment in systemic changes at the expense of disease related priorities (Hill, 2002).

With this new approach, there has been a decrease in direct donor project funding to NGOs. This has meant that most NGOs which relied exclusively on donors for their activities will phase out eventually. NGOs have also, traditionally, been important because they have served the most vulnerable populations, improving access and coverage (Gilson, 1999).

The sector-wide approach (SWAp) has been preferred as opposed to the traditional project approach due to foreseen advantages including: greater coordination in the health sector as well as stronger government leadership and ownership in the process. This is supposed to improve country management of their systems and decrease duplication of donor projects thereby lowering transaction costs and for the health sector it is envisaged to improve effectiveness, efficiency, equity and promote sustainability (Hutton, 2004). The SWAp approach developed from a concern by health specialists that direct donor project support was not having sustainable outputs as they used expatriate technical assistance and absorbed human resources from the public sector whilst their activities had limited coverage (Foster, 1999).

The SWAp approach is further encouraged as donors will not choose the projects they finance but rather have a say in overall sector development and be recognised as partners in development who can negotiate how resources are allocated (Cassels, 1997). On the other hand, with Swaps, there is a danger of limited incorporation of NGOs since donor funding and priority setting has moved to governments meaning that specific health needs or target groups of which was the core of their foundation can be compromised. Governments have been known to insufficiently recognise the role NGOs play in delivery of health services (Hill, 2002).

This is despite the fact that critics view SWAps as state oriented, centralised and top down and concerned with upstream policy issues and supply of services rather than incorporating mechanisms to allow the poor address their demands for better health (Cassels, 1997). Some studies have pointed out the fact that with advancement of SWAps, the role of NGOs risk becoming ambiguous and that for the countries that have attempted to involve them, they have been claimed to get less support than government facilities (Jeppsson, 2002).

In light of this, the researcher wants to conduct a literature review in the issue of the implications of the SWAp approach on health provision by NGOs. The researcher's primary question will be: Do NGOs have a chance to survive and offer competitive services with reduced or without donor funding? What implications have the SWAp approach had on health delivery in developing countries, has there been an effect on health delivery?

This study seeks to answer the above questions by critically examining the health delivery since the introduction of SWAp to illuminate the current position of NGOs utilising the Paris Declaration on aid effectiveness to analyse the implications.

The next chapter will go ahead to give a justification of why the researcher thinks the topic needs to be studied.

CHAPTER THREE: PROBLEM JUSTIFICATION

There is need to understand the health sector reforms that have been ongoing and how introduction of SWAp in particular is affecting health service delivery. The study aims to do this by taking the case of Kenya and where possible relating it to the experience from other developing different countries.

In addition, the study seeks to link the theories with practices in health systems management, which will be done by borrowing concepts from the course work and literature review to analyse this study.

CHAPTER FOUR: OBJECTIVES OF THE STUDY

General Objective

To examine the effect of SWAp on health service planning and in particular on the role played by the NGO's in Kenya.

Specific Objectives

- To determine the role played by NGO's on health service delivery in developing countries since the introduction of SWAp in health planning and management.
- To establish how SWAp approach has affected the roles played by NGO's in planning and delivery of health services where they have been introduced.
- To draw lessons and offer practical recommendations on how implementation of SWAp can be used to improve planning, management and delivery of health services in Kenya based on the above findings.

RESEARCH QUESTIONS

- What role can NGO's play in promoting the five principles of the Paris Declaration in relation to SWAp implementation?
- Do governments and donors recognise that NGO's have a role to play in promoting these principles?
- Do the NGOs' themselves make an effort to engage in promotion of the principles in SWAp implementation and what implications does it have on their activities?

Having laid out the study objectives, the researcher is now going to describe the methodology employed in conducting the study in the next chapter.

CHAPTER FIVE: METHODOLOGY

The study design is a retrospective non intervention study.
It is descriptive in nature with some comparative design using country examples to describe the changes since SWAp was introduced. The country examples are aimed at reinforcing discussion points and act as points of reference. As the SWAp process is still ongoing in these countries, the study will be looking at the trends over time. It has utilised different developing countries data to look at the changes either positive or negative that have been attributed to SWAps.

The study is a literature review and has utilised both hard and soft data. The literature review was conducted sequentially starting with an overview of articles and chapters in course handbooks. It then moved to identify important authors in the field and searched for important articles on the topic. Other important authors and relevant articles were sourced. These authors and articles were determined by referring to the course material. According to the topic, the main alternative approaches to SWAp have been identified, this is then followed by the debated issues around SWAps and finally the different schools of thought that have emerged about SWAp are presented.

Hard data used has been in form of books and government reports while soft data has been in form of online materials.
The KIT library catalogue was used in the study.
The websites utilised included: WHO, ELDIS, LANCET and ODI.
WHO and ODI websites were used with the intention of finding out what has been experienced in developing countries as they have been pivotal in steering and documenting health interventions.
ELDIS and LANCET have also been credited with publishing material from developing countries.
The search engines used were: GOOGLE SCHOLAR, PUBMED.
PUBMED was mainly used to find out the related articles that have been written in regard to the study in question as it is quite useful in providing related links as well as peer reviewed journals.
Google scholar was used to find out any related articles that may have not made it to any of the mainstream scientific search engines or websites.

The search words were: SWAp, Harmonisation, Alignment, Ownership, Mutual Accountability, Results Based Management (Paris Declaration principles), developing countries, Kenya, Health NGOs, and HIV/AIDS. Related links were followed where available. The five principles of the Paris Declaration were included in the search in order to bring out issues that have been documented concerning them. The inclusion criterion was for articles that focused on health and developing countries in respect to SWAps and the five principles. Studies that have included other specific health components for example gender mainstreaming were excluded as the implications are supposed to be for health in general.

The literature used dates back to January 1997 when the Danish government hosted a meeting of key bilateral and multilateral agencies and the World Bank

to reach consensus on SWAps because it is from the meeting that a handbook (A Guide to Sector-Wide Approaches to Health Development by Andrew Cassels) on how to implement SWAps was developed and is crucial in the history of SWAp development.
Developing countries in the context of this paper refer to Sub-Saharan African countries and they are being used to draw comparisons in their SWAp implementation.

LIMITATIONS OF THE STUDY

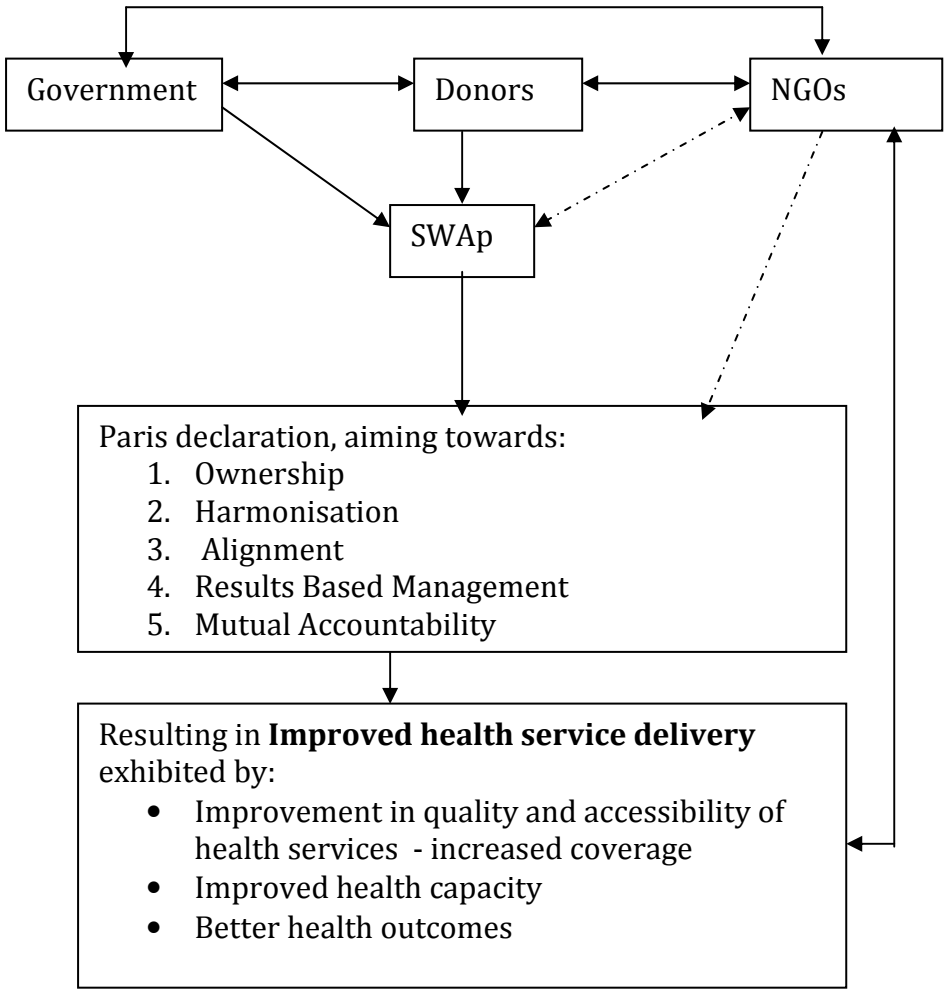
- It's not easy to operationalise variables that capture the five principles adequately without conducting a field study although efforts have been made to measure their extent in country situations from literature. Also some of the indicators of progress cannot be accessed as they are available in print government reports which the researcher has not been able to access.
- Availability of literature that is specific on SWAps especially on Kenya has not been easy as it seem as the country is not fastidious in documentation that is specifically available on internet but attempts have been made to make an association with the available literature. A lot of current developments have not been documented and this has led to over reliance on a few literatures in some cases.

After the above description of the study methodology and limitations, the next section is going to illustrate and describe the conceptual framework utilised in the study.

CONCEPTUAL FRAMEWORK

This study will utilise the five principles of the Paris Declaration on Aid Effectiveness to analyse the SWAp approach qualitatively according to the above objectives. The five principles are: Ownership, Harmonisation, Alignment, Results Based Management and Mutual Accountability.

Figure 1 Conceptual Framework illustrated.



As illustrated above, the study is going to use the 5 principles of the Paris Declaration as a framework to analyse the SWAp implementation.
The SWAp process is going to be symbolised by the government and donors and NGOs. With application of the five Paris Declaration principles to SWAp, the researcher aims to answer the objectives of the study.

Both SWAp and NGOs aim at improving health service delivery of the populations they serve. The broken linkage between SWAp and NGOs is to signify the lack of a clearly defined relationship or association between the two regardless of the fact that they aim for a similar objective.
The other linkage between NGOs and the five principles of the Paris Declaration is supposed to signify that they can have a role to play in their achievement if sufficiently involved.
The next chapter is going to give a literature review around the subject.

CHAPTER SIX: LITERATURE REVIEW

SWAp has been defined as an approach that calls for a single sector policy, a single strategy and a single expenditure framework, under government leadership, that is supported by all significant funding for the sector. It also incorporates greater alliance on government's own financial management and accountability systems (NHSSP II, 2005).

The origin of SWAps can be found in response to discontent with inadequately performing public expenditure systems with an objective to bring main stakeholders namely the government and donors into a single expenditure framework institutionalised within the governments' own financial system. This was meant to reduce transaction costs for both the donors and the recipient countries. Secondly it also emerged from discontent by health professionals that the traditional project approach was not producing sustainable results in health service delivery. They felt that projects were responsible for introducing changes in health systems which could not be maintained as some were high cost, small scale and short term interventions (Foster 1999; Mackintosh-Walker, 2001).

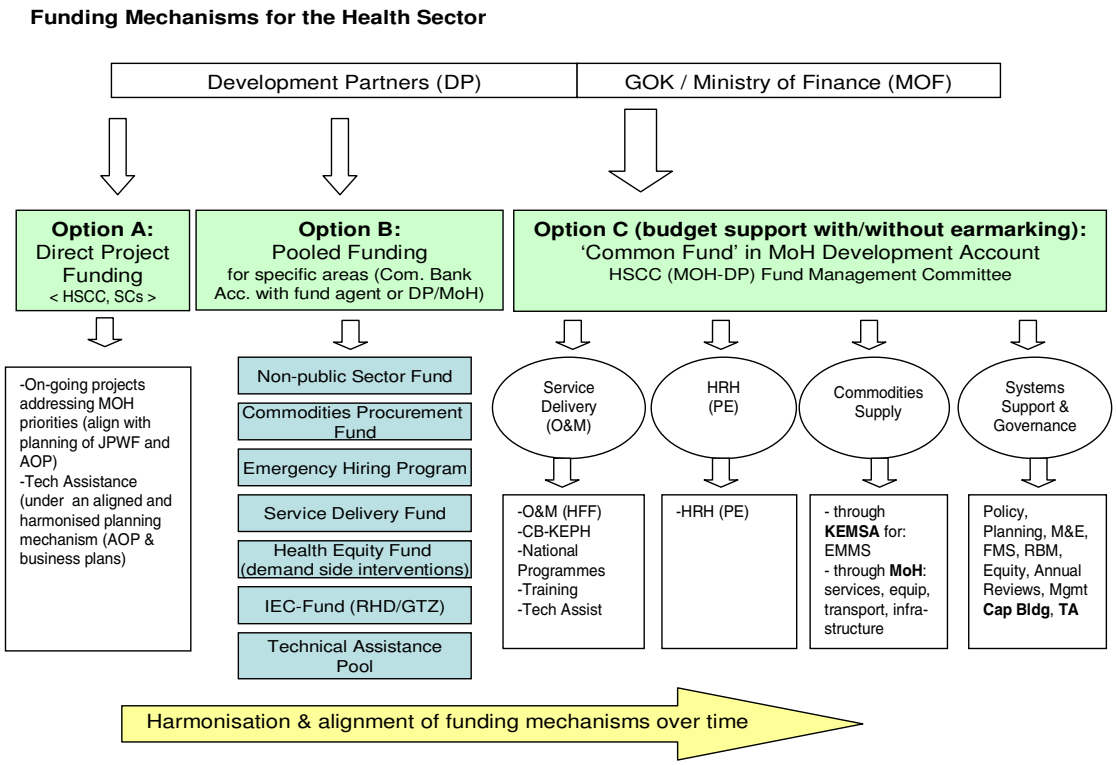
In addition, a SWAp implies, amongst others, that donors no longer engage in single projects. There are three levels of donor engagement: project support, sector support and budget support (refer to figure 1 below). Negotiation has now moved to national government level which implies that implementation strategies are supposed to suit the country's capacity, managerial and financial systems. With SWAps, the donors are now meant to be engaged in policy decision making at sectoral level and this is different from the individual interventions they were used to (Cassels, 1997).

SWAps have also been branded as the 'next generation' approach to funding where the recipient country governments are proposed to be partners and drivers of the process which provides a broad context of organising resources in a logical manner which is a shift from direct donor funding where the donors were the decision makers and recipients the implementers (Walt *et al.,* 1999).
Furthermore, SWAps have been related to shifting the level of collaboration between donors and governments a notch higher because previously while primary health care pushed for involvement in service delivery at district level, with SWAp the integration has moved to the centre with pooling of funds and participatory planning of policies (Hill, 2002).

It is also noted that sector programmes are found in highly aid dependent countries because in cases where governments are able to adequately provide for their recurrent budgets, it is ideal avoid high transaction costs both on donor and government side. Reduction of transaction costs was one of the reasons that SWAp was strongly advocated. Moore (2003) conducted a study which supports this argument that SWAps are more suited as a coordination mechanism for donors and recipients in countries with lower economic performance because the administrative burden of dealing with individual donors is reduced (Foster, 1999; Foster, 2000; Walt *et al.,* 1999).

On a more critical note, SWAps have been blamed for not being involved in the role of the public sector in health and not on health as a whole meaning that they have at times concentrated on primary health care at sub sectoral level and of being incremental in nature which means that the more trust is instilled in donors, the more the funds they pool (Seco & Martinéz, 2001).

Figure 2 Showing the three types of donor engagement that are being implemented by the health sector in Kenya. It shows the three different funding mechanisms available to the donors and how they are injected into the health system (Adapted from JDM, 2007).



Main alternative approaches to SWAps

To give a background picture of why SWAP was advocated for, the researcher is going to describe some of the alternative approaches of donor funding that had been in use before uptake of SWAp. This is to give an idea of the developments especially shortcomings of the other approaches that could have led to the shift towards SWAp.

Until the initiation of SWAp the project format had dominated the development sector. This is especially in cases where donors didn't have much trust in national governments; they preferred dealing with NGOs (Dante, 2002). It was also because they could hold NGOs accountable to their requirements and being that the NGOs depended on them for continued funding, then they had to adhere

to agreements made. Donors had a right to discontinue funding when they felt their regulations were not being followed or funding was being misused.
Another approach fronted by World Bank to shape aid was the Comprehensive Development Framework (CDF) in which a matrix is developed that is supposed to give a holistic visual representation of the state of development assistance a country has received (Foster, 2000; Dante, 2002). Nevertheless, experience has shown that the CDF is World Bank or donor driven with different donors' having time specifications and procedures for their interventions which is a burden to many recipient countries as they have to adhere to different reporting formats and procedures which consumes a lot of resources. Countries at times fail to satisfy all the requirements as they are many and different (Dante, 2002).

There is also the direct budget support which should be clearly distinguished from SWAp. The difference is that with budget support, the donor funding is added to the recipient country's government funds and therefore they have greater flexibility in determining its usage whereas with SWAp, the funds are pooled specifically for a defined sector and or purpose. With both types of funding there exists the potential of fungibility which means donor funds are used for other needs other than intended needs or fiduciary risk where the funds end up being misused like in corruption. Some donors have even requested commitment from the government in Kenya that this is not going to be the case especially when it comes to procurement, expenditure controls and audits (Lavergne & Alba, 2003; JDM, 2007).

World Bank had also endorsed a funding programme known as Sector Investment Programme (SIP). Although SIPs and SWAps share more general attributes, SIPs had more stringent financial and legal repercussions and they had been seen as "the bank's operational instruments for implementing the broader sector approach to investment lending" (Seco & Martinéz, 2001). SIP is a programme which comes with an attached budget of its implementation with priorities already decided and resources allocated while SWAp is a process which strives to ensure broad consensus in its formulation and results in a strategic plan and budget.

There are no definite criteria of saying which approach has been better than which as all of them had justification for introduction when they were initiated and there is no determining what the situation would have been without any of them. Although the different approaches have illustrated the challenges for instance administrative and sustainability components that used to be faced by the donors as well as recipient countries and the developments have gradually been towards minimising them. Critics say that all the approaches are the same just dressed in different terminology, but that is a rather superficial judgement. Nonetheless, SWAps can be accredited as an attempt of placing recipient countries in the forefront of the development agenda.

Debated Issues

It is believed that SWAp will promote ownership, partnership, flexibility in funding and strong national ownership that was not necessarily the case with

direct donor project funding (Dante, 2002). This is because project funding was associated with donor regulations, priorities and interests. Flexibility was an issue as donors decided what they wanted to do and if it was not accomplished then in some cases ceased funding. On the other hand, with SWAps, since its national governments and a collection of donors involved, the rules have changed to slightly favour national governments.

Projects were presupposed to cause disintegration and replication in service delivery particularly in cases where donor activities were spread out in different geographical areas of a country (Cassels & Janovsky, 1998). They were also thought not to have enough authority to be in control of policy planning areas beyond the scope of their projects as well as increasing administrative load of governments due to different donor reporting procedures (Lavergne & Alba, 2003). This is because projects were operating in isolation of like minded projects in the same area and there could be several donors doing similar projects in the same area but with no coordination. Donors had also been more comfortable with direct donor project support as they could get attribution of their funding and demand accountability.

Moreover, it has been found that despite SWAp, donors have retained their previous working mechanisms simply because their wants are incompatible with the principles of SWAp like harmonisation, alignment and national ownership (Dante, 2002). In addition, it is believed that SWAps stand a better chance of success in countries with a strong macro economic and financial management capacity which is not a characteristic of many developing countries. In such a case, it would be wiser for donors to fundamentally support macro economic reform and budget improvement rather than develop sector programmes (Foster, 2000). Such systems are less permeable and cases of mismanagement of funds would be minimised or lacking.

There is also a risk that support previously given to special programmes like HIV/AIDS, Malaria, TB will not continue and these programmes therefore run a risk of their technical quality being compromised (Cassels, 1998). These special programmes are thought to be better protected by donor earmarking[2] than sector support (Foster, 2000). On the other hand, vertical programmes have been associated with drawing high level professionals from the public sectors to the private so it might instead increase effective government coverage of these special needs (Lavergne & Alba, 2003). Moreover, funding that is pooled together does not necessarily increase health spending as it can on the other hand be used for other priorities. SWAp also promotes recurrent expenditure funding which is not usual for donors (Cassels & Janovsky, 1998).

Furthermore, donors have at times been blamed of rushing governments to make decisions so that they can observe changes before the end of their missions and this sometimes leads to implementation delays as some planning stages have been overlooked as was the case for example in Ethiopia and Tanzania (Foster,

[2] Earmarking is when a donor gives funding for a specific purpose or special programme and this cannot be altered. It is often used to protect funding for projects thought to be at risk of being insufficiently recognised by implementing countries.

2000). This has in some cases led to unnecessary delays in implementation of programmes as the planners have been forced to go back to the drawing board to take care of issues that had been overlooked in the planning stage. There is also concern on the effect of SWAps on decentralisation[3]. With decentralisation there is shift of control from the centre to the periphery whilst SWAps tend to recentralise resource allocation and priority definition. Lack of coordination between the two processes is a potential cause of conflict (Hutton, 2002).

Still with SWAps there exists other external funding to the health sector for example Global Alliance for Vaccines and Immunisation (GAVI) as well as the Global Fund to Fight AIDS, TB and Malaria (GFATM) which have to be managed outside the pooled funding and their effect has to be taken into account (Jefferys & Waldorf, 2003). In some cases, this has been found to affect the implementation of the SWAp as with these different funding sometimes known as 'off budget' funds coming from these initiatives there has been confusion in which requirements to adhere to as they are not part of the basket funding (NHHSP II, 2005).

The integration of NGOs in SWAps is still not clearly defined as differences have been found in their involvement for example in some cases mission hospitals in some countries have been integrated whilst non mission hospitals have not, therefore threatening their existence because of reduced funding (Hutton, 2002; Jeppsson, 2002). Furthermore, in some countries NGOs have been involved in the planning process but not in implementation and monitoring evaluation (Jefferys & Waldorf, 2003). Additionally, the NGOs can be involved in planning alone but studies have not shown that they are involved in budgeting too.
Even though SWAps have been advocated to help in equitable resource allocation, there is concern that they are involved in resource allocation at macro levels as opposed to detailed resource allocation which is done at local levels and this brings about the danger of the better representation in decision making an area has, the more the resources it can be allocated (Seco & Martinéz, 2001).

These debated issues will be addressed in more detail in the study findings as they will form the basis of discussion.

Main Schools of Thought

There are proponents and opponents of SWAp and direct donor project funding. This is according to the interpretation of the researcher.

First School of Thought

Proponents of this argue that although direct donor support has its shortcomings, they don't see anything significantly different with SWAps.
Direct donor project support has been suggested to weaken the institutional capacities of the systems they are supposed to build as they have been known to

[3] Decentralisation is the allocation from the central government to the periphery the management of political, administrative, financial and administrative systems of the health. It can be in form of devolution, delegation, bureaucratisation, deconcentration and privatisation.

attract qualified staff from national governments to work in their projects and this has led to creation of parallel systems where donors have separate management units (Cassels, 1998). Nonetheless, civil society organisations that include NGOs are increasingly concerned that if there is no deliberate effort to earmark funds for their involvement in implementation of services, then they risk being locked out of access to funding as has been mentioned earlier that they may not be involved in the budgeting process (Land & Hauck, 2003). It has been shown that there is a decrease in funding of projects and programmes outside basket funding (Bruijn & Horstman, 2005).

On the other hand, sector support is thought appropriate in highly donor dependent countries. This is because they can be constructive in improving policy consistency and reduce inefficiencies associated with donor projects but in low aid dependent countries then direct donor projects are more feasible (Foster, 2000). Direct donor projects are more feasible in low aid dependent countries as the donors can identify the specific intervention they want to carry out, which in such countries is more likely to be a short term intervention then they can exit. Additionally, there is concern that with SWAps, there will be neglected areas of health because it is claimed that they focus on curative services heavily as opposed to other areas like water and sanitation (Jeppsson, 2002).

Second School of Thought

This school proposes that the benefits of SWAps far outweigh the challenges of its implementation. Although there is also a probability that SWAps are viewed as a panacea to all donor aid management issues and there could be many expectations than they can deliver. Introduction of SWAps has been observed to interfere with other reforms in the civil sector for example in Ghana, Tanzania and Uganda, whilst at the same time some donors prefer to adhere to the previous systems they were used to (Dante, 2002). SWAps can either be introduced in a country as part of health sector reform as well as a different approach in donor funding without necessarily being a health sector reform.

However, with SWAp there is a shift from individual project achievements to sectoral achievements focusing on improved health outcomes because the discussions between the donors and governments go a level up from planning and management of projects to policy, structure and resource settings in which health care is provided (Cassels & Janovsky, 1998).

Moreover, SWAps have been found to increase resource allocation, improve capacity and involvement of stakeholders in policy planning and implementation by allowing development of inclusive plans and strategies (Foster *et al.,* 2000). Additionally, SWAps tend to be linked with more equitable resource distribution as priority setting is done at the national level and avoids the influx that could have been associated with NGOs in one particular region of the country hence improving the competence and coverage of health services (Walford, 1998).

Furthermore, SWAps are envisioned to help governments with weak management systems and on overflow of funding streamline their policies, priorities and service quality. This is because of the different partners involved and the level of commitment envisioned by the stakeholders like for example in Ghana, when SWAp was introduced, districts were required to introduce adequate financial management systems before funds were disbursed to them and only districts that succeeded in setting up such systems received funding (Foster, 2000).
With the background information on evolution of SWAp and the trends over time, the study goes on to give an analysis of the approach in developing countries.

SWAp IN HEALTH IN DEVELOPING COUNTRIES

The SWAP approach was endorsed by the World Bank from the late 1980's although most bilateral donors and recipient governments adopted them in the mid 1990s. They are instruments through which delivery of agreed on health policies is supposed to take place as well as management of aid and local resources in a logical and most favourable way (Walt *et al.,* 1999).

With the health system having moved towards decentralisation in these countries, there is potential conflict with the SWAp approach. This is because if the Ministry is the one that is going to send earmarked funds to the local authorities with instructions on how to use them, it will undermine the local authority as they will not have freedom to set their own priorities because donors provide funds for specific purposes (Cassels, 1997). This is also due to the fact that decentralisation and SWAp in most countries are starting at the same time as part of health sector reforms so there is no clear separation between the two procedures which can result in confusion for the implementers. In addition, SWAps tend to give power to the hands of a few for example senior policy makers and reformers at the expense of individual project leaders and this may lead to resistance from these quarters (World Bank, 2001).

It is important to note that not all donors have adopted SWAp as their funding approach. Donors like USAID still disburse a large percentage (72%) of their funding through NGOs and other forms of off budget support whereas France and Japan governments mostly disburse their funds through SWAps in form of projects (100 and 97% respectively). The main funding providers are European Union, CIDA, World Bank, DFID and Netherlands (45%, 48%, 57% 65% and 71% respectively). This is for all sectors of development and not health specifically. Health got about 20% while NGOs and other off budget support got 24% according to this study (Lavergne & Alba, 2003).

At the moment, even in countries considered to be model SWAp countries, it has been found that donors still prefer to work with distinct groupings instead of pushing for greater collaboration and this can be due to a number of issues like lack of confidence in country systems or loss of attribution that comes with SWAp (Bruijn & Horstman, 2005).

Similarly, it is important to note that not all NGOs are funded bilaterally or with funding agencies. Some are funded by faith based institutions or private donors but financing mechanisms for the different NGOs will not be discussed further as it is not within the scope of this paper.

DFID (2002b:8) identified the following obstacles impeding effective participation of NGOs in SWAp implementation:

- "Insufficient access to information about policy processes, institutional development and public sector reforms.
- Inadequate opportunity to involve in policy dialogue, programme design and implementation.
- The action orientation of most NGOs which limits their role in the production and dissemination of knowledge in the public domain.
- The disparity of NGOs manifested in terms of individual interests, identities and funding modalities at the operational level.
- The preference of many NGOs themselves to work along traditional project lines, cater to their own constituencies and pursue their own often innovative approaches.
- Suspicion of government -private sector initiatives."

However, some studies have shown that in some cases like in Ghana, SWAps have deliberately involved NGOs in their activities for instance procurement of services from them when they consider it more cost effective (Foster & Mackintosh-Walker, 2001). In Kenya they are being contracted for social marketing and franchising which should be further encouraged as it is a way of ensuring their continued participation in health service delivery (JDM, 2007).

One of the reasons that the SWAp approach was fronted was because it was expected to reduce transaction costs that were associated with the direct donor support projects. Studies have found that this has not necessarily been the case as the process has involved a lot of meetings with donors and usually it's not on government priority needs. Evidence from World Bank indicates that supervision costs for SWAps are, in some cases 50% higher than those for direct donor projects (Brown *et al.,* 2001).
In health, it has been found that SWAp mostly concerns itself with public sector therefore representing less than half of the total spending in the health sector as they have not factored the role of the private sector, insurance schemes and not for profit organisations that is NGOs and FBOs (Foster, 1999).

After this background information of SWAp and specifically in developing countries, the next chapter of the paper is going to give study results and findings that will also pertain to Kenya.

CHAPTER SEVEN: STUDY FINDINGS AND DISCUSSION

7.1 HEALTH SERVICE PROVISION IN KENYA BY NGOS

NGOs have a mandate to promote health and well being of populations especially the poor and marginalised in partnership with governments (WHO, 1996).
National NGOs as well as international NGOs have been involved in provision of health care either as direct providers or for international NGOs as funding partners to national NGOs (Green, 1997). Their activities can be categorised as: service provision, research, support services, policy advocacy, fund raising and coordination (Green & Matthias, 1997).

In Kenya, the government owns 51% of the health facilities - with Ministry of Health (MOH) ensuring their management - whilst the other 49% is owned by non governmental agencies: the Faith Based Organisations (FBOs) and other NGOs (together 20%) and the for profit private enterprises (29%). These figures were recorded in 1998 and they could have changed by now, although there is no documentation of the current situation as the current health plan still uses this reference. The Kenya Catholic Secretariat (KCS) is the largest health provider in the NGO sector (Wamai, 2004). The Christian Health Association of Kenya (CHAK) is also has a wide coverage of 38% and the two are instrumental in shaping the health system coverage although they operate independently (NHSSP II, 2005; Wamai, 2004).

The tables below show distribution of health institutions among provinces as well as by provider.

Table 1 The distribution of health institutions and hospital beds and cots by province.

Table 1.1 Health institutions and hospital beds and cots by province, 2002/03

	Number of health institutions						Total		Hospital beds and cots			
	2002			2003*					2002		2003*	
Province	Hospi-tals	Health centres	Health sub-centres & disp	Hospi-tals	Health centres	Health sub-centres & disp	2002	2003*	Number	No per 100,000 pop	Number	No per 100,000 pop
Nairobi	56	53	376	58	54	381	485	493	4891	21.2	5,011	21.6
Central	63	86	368	65	89	372	517	526	8,191	22.4	8,314	22.9
Coast	64	40	331	64	42	334	435	440	7,687	30.6	7,998	31.4
Eastern	63	79	689	65	80	692	831	837	7,412	15.3	7,822	15.4
N/Eastern	7	11	65	8	12	68	83	88	1,707	14	1,914	14.2
Nyanza	97	114	328	98	117	333	539	548	11,922	23.1	12,545	23.2
R/Valley	98	159	1,002	100	161	1,006	1,259	1,267	12,390	16.2	12,832	16.5
Western	66	92	192	68	94	196	350	358	6,457	19.1	6,971	19.4
Total	**514**	**634**	**3,351**	**526**	**649**	**3,382**	**4,499**	**4,557**	**60,657**	**19.2**	**63,407**	**19.5**

* Provisional.
Source: MOH health management information system (2004).

Adapted from NHSSP II, 2005.

Table 2 Health facilities distribution by type and provider.

Table 1.3 Distribution of health facilities by type and provider, 1998

Health facility	MOH		FBO/NGO		Private		Total
	Number	%	Number	%	Number	%	
Hospital	109	50.0	67	30.7	42	19.3	218
Health centre	460	80.0	100	17.4	15	2.6	575
Dispensary	1,537	60.9	595	23.6	391	15.5	2,523
Nursing & maternity home	0	0.0	11	58.0	180	94.2	191
Health centre/Medical centre	43	0.1	72	10.2	592	83.7	707
Total	2,149	51.0	845	20.1	1,220	29.0	4,214

Source: NHSSP I, 1999–2004. MOH figures correspond with 2004 Human Resource Mapping.

Adapted from NHHSP II, 2005.

Although some NGOs have been blamed to be weak in technical capacity, managerial capabilities, running parallel programmes and having an unreliable resource base, in some instances it has been found that they are more committed, participative, innovative, non-hierarchical and able to reach the poorest in the population (Mburu, 1999; Diskett, 1992 & Clark, 1991). NGOs have been found to exist in the most marginalised areas of countries and to come up with innovative approaches to handling local situations as some have tried to involve local populations in the implementation of their activities.
In respect to HIV/AIDS, the Kenya AIDS NGO Consortium (KANCO), engineered development of health policy and still continues to influence changes in the same (Wamai, 2004). However, HIV/AIDS programmes have been found to rely heavily on donor funding and this to some extent has questioned their sustainability (MOH, 2005).

7.2 SWAp IN HEALTH IN KENYA

The onset of SWAp in Kenya can be traced from September, 2005 when the Joint SWAp Coordinating Committee initiated the development of the Kenyan SWAp. It is being implemented in conjunction with the Joint Support Program (JSP)[4].
"The sector wide approach calls for a single sector policy, a single strategy and a single expenditure framework, under government leadership, that is supported by all significant funding for the sector. It also incorporates greater alliance on government's own financial management and accountability systems." (NHSSP II, 2005; Brown *et al.,* 2001).
A phased approach is envisaged of which the first phase aims at concentrating on adoption of a harmonised planning mechanism, monitoring and evaluation and reporting mechanism as well as harmonised funding and procurement

[4] A Joint Support Programme is a product of the Joint Design Mission and its purpose is to provide an overall programme framework for interested parties to support the implementation of the Joint Programme of Work and Funding to achieve its objectives to ensure that the country's SWAp is advanced in a gradual and sustainable way.

mechanism (JDM, 2007). The country has already initiated the Kenya Health Policy Framework (KHPF)[5], a national heath strategic plan (NHSSP II) and a Mid Term Expenditure Framework (MTEF) has been adopted together with an Economic Recovery Strategy (ERS) and annual Public Expenditure Reviews (PERs). These are all prerequisites to fostering a government led sustainable relationship with stakeholders (NHSSP II, 2005).

Nonetheless, there has been a realisation that the above measures cant stand alone in implementing an effective SWAp and the government has taken up an additional approach known as the 'Three Ones' (one plan and budget, one monitoring system and one coordinating framework) to operationalise SWAp. This means that a process of joint annual planning and budgeting has been established under the leadership of MOH and other stakeholders. Also, a joint monitoring system has been commenced as well as harmonised reporting procedures based on jointly settled indicators. One coordinating framework implies strengthening capacity and performance of existing coordination framework to reflect future direction of effectively implementing policy objectives (GoK, 2005).

The Kenyan government had a meeting with development partners in 2003 to map the way forward with the SWAp approach. After which, a Harmonisation, Alignment and Coordination group was formed. The group mapped out what structures and country assisting strategies were in existence to facilitate coordination between the government and the donors. However, there was no agreement on common reporting formats as well as the documents to be signed by both parties (GoK, 2004). On the other hand, the current strategic plan clearly outlines the stages that should be followed to establish SWAp in the health system. This includes having joint annual planning and review system which should be participatory, all inclusive and adopt a bottom up approach to planning and review. The health ministry has also shown commitment to SWAp and has put in place related coordination structures, planning guidelines and identified a monitoring and evaluation framework (NHHSP II, 2005; JDM, 2007).

There will also be a planning for each new Annual Operating Plan (AOP)[6] at the end of each year which will summarize decisions and come up with content and priorities that will guide the next AOP. There have been two AOPs carried out so far with the first one being completely top down and non inclusive process dominated by the MOH. The second AOP was bottom up as it incorporated inputs from District Health Management Teams (DHMTs). The third AOP has been highly inclusive of stakeholders and it was a bottom up approach which collected information from the grassroots including: health facilities, Village Health

[5] The Kenya Health Policy Framework (KHPF) reinforces government commitment to improve health of population and its objective is to decentralize management provision and financing of healthcare by transforming the role of MOH from a service provider to policy maker and regulator of health service provision (Odongo, 2004).

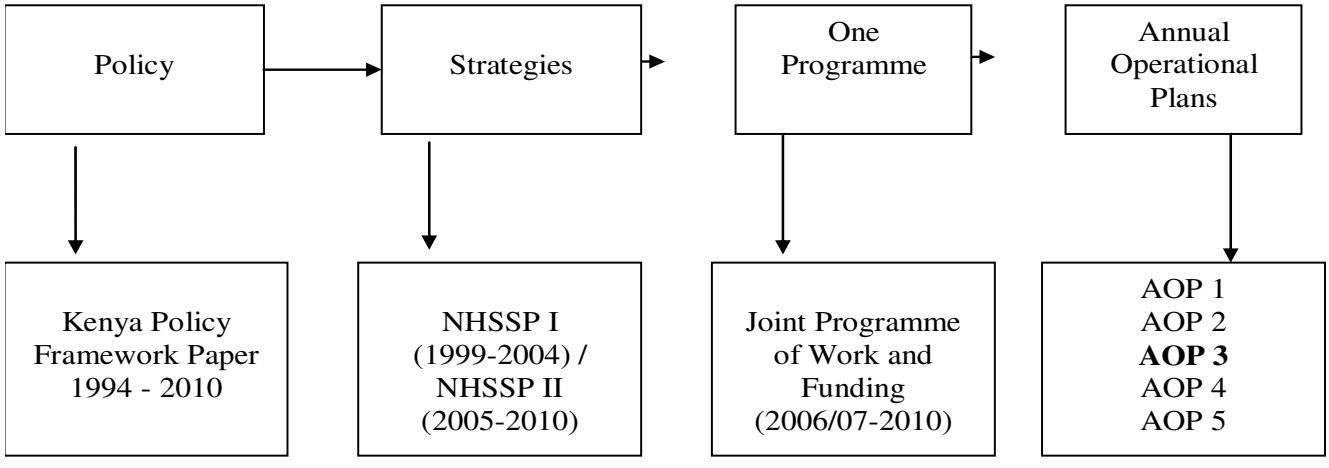
[6] The AOP indicates priorities, activities, targets and resource requirements for the sector in a particular year, based on lessons from previous years and the ideals and targets of the NHHSP II and Joint Programme of Work and Funding (JPWF) (JDM, 2007).

Committees (VHC) through the District Health Stakeholders Forum (DHSF) and the ministry (JDM, 2007).
One of the conditions necessary to effectively implement a SWAp is inclusion in the budgetary system of the country. This can be done through incorporation into the Medium Term Expenditure Framework (MTEF)[7]. This is supposed to be used for incorporating policy with planning and budgeting. Unfortunately this has not worked well in Kenya as the MTEF process and the annual budgeting process operate independently as parallel processes rather than together and the MTEF has been largely used as a planning tool than a budgeting tool which doesn't even specify intersectoral priorities. There is need for a closer linkage between the MTEF and Ministry of Finance to derive a comprehensive budget that is able to allocate resources by intervention level and identify resource shortfalls where additional funds are needed based on clearly stated priorities (GoK, 2005; JDM, 2007).

The budgeting system in the country is largely incremental with no significant allocations to high priority areas (GoK, 2004). However, the current AOP III has also made an effort to link the MTEF with the functional MOH budget and also to link findings from MOH performance report and the Joint Design Mission (JDM)[8]. The MTEF planning process has become more inclusive with a broader scope with sector heads and development partners being more participative. The ministry is aware of the shortcomings and is making efforts to harmonise budgeting and planning system under AOP III (JDM, 2007).

The current planning approach in the health sector

Figure 3 The diagram depicts the process the government has taken to link policy to strategy, program and operational plans which is culminating into the sector approach. The government has a policy paper which led to development of the current health strategic plan. They also have the joint programme of work and funding as well as the annual operating plans of which currently they are at the third.



[7] A Medium Term Expenditure Framework (MTEF) is the current budgetary system that links policy making with planning and implementation of budgeted projects in a three year rolling framework (Odongo, 2004).
[8] The Joint Design Mission (JDM) is an effort between six major donors namely: DFID, World Bank, the German Development Cooperation (GDC), DANIDA, SIDA and the United States Government (USG) to try and harmonise their operations and align themselves to Government of Kenya GOK/MOH procedures and guidelines.

The health strategic plan recognises the importance of forming partnership with NGOs/FBOs. The ministry acknowledges that they are an im Adapted from ETC Crystal, 2007. health service delivery and has stipulated that consensus is needed to arrive at a joint framework of operation. It further concedes that there are gains and loses to be made from both parties. The NGOs stand to gain by negotiating financial support and sharing of staff in the periphery and this will improve service provision. The government on the other hand will offer them assured funding from development partners. On the other hand, NGOs stand to lose their autonomy as there is a potential of interference in their internal policy and decision making (NHHSP II, 2005).

Discussion

The health service provision by NGOs cannot be ignored as it has been found to have a large coverage as well as penetration of some of the areas not easily accessible and marginalised. They have also been accredited with bringing innovative approaches which are locally designed to health service delivery. Given this coverage that the NGOs have had in health service provision, it can be construed that they are an indispensable part of the health system.
Regardless of the advent of SWAp, it is still envisaged that a number of projects or project based mechanisms will be implemented at least in the medium term though with gradual capacity building and sector support at central, provincial, district and service delivery level they will be phased out (JDM, 2007).

Jeppsson (2002) found that in Uganda, with implementation of SWAp, the external funding to NGOs reduced significantly and that especially church missions were experiencing severe resource constraints. It should be pointed out that this cannot be fully attributed to the funding shift alone. Church funded organisations have seen a decline in their external funding as their funding partners are changing their areas of focus in some instances like in Kenya, for example some of them are changing from health to other areas like policy and governance. Development partners have also been known to change their areas of focus for example SIDA is considering shifting from health but prefers the basket funding (JDM, 2007).

Nonetheless in Kenya, there seems to be an effort to involve NGOs in SWAp as was evidenced by the third AOP which was an inclusive bottom up approach that saw inputs from community organisations, some of them NGOs and FBOs incorporated into the District Health Plans (DHPs). The health ministry has also been credited with recognising their importance as full participants in the policy arena. They have also changed their approach in service delivery by decentralising to the districts and involving DHMTs, health facilities and FBOs and NGOs (JDM, 2007).

There is a lot of capacity possessed by this sector that their involvement in health service delivery only serves to strengthen the existing service delivery. Forming partnerships with them will be beneficial to both the NGOs as well as the government as then they can transfer their skills to the government while at the same time guaranteeing their continued operation and involvement in health

delivery. Their approach to service delivery can also help in reducing costs of offering health care as well as improve quality as they have been associated with being cost effective and practical.

One drawback of the direct donor funding to NGOs was that it did not ensure equitable coverage and this could result in a mushrooming of NGOs in one area of the country as opposed to other areas. This led to better development in health outcomes of some areas and improved health infrastructure. With the introduction of SWAp, it is envisioned that it will help in equitable resource allocation and priority setting. Hill (2002), states that SWAp extends a 'blanket' claim over the whole health system in two ways, first by pooling all the significant funding to the sector into a single expenditure framework and secondly by instituting sectoral policies and strategies that define priorities and conclude resource allocation.

Unless resource allocation is done in a clearly formulated manner, which has not been stated in the health strategic plan, there is still a potential for undue influence. SWAp can be used as an avenue for clearly institutionalising mechanisms for resource allocation. One method of ensuring equitable resource allocation in the country is to base it on population and health needs where disease patterns and the population of a district can be determinants of resource allocation.

SWAp also seems to be having a few challenges like lack of agreement on reporting formats and documents signatory between the donors and the government. This can be a result of lack of trust of each other or lack of understanding of what the process will really entail and what modalities should be institutionalised to ensure that both parties' interests are protected. It could also be that the shift from donors dealing directly with NGOs whom they can influence and discontinue funding at any time if there is no agreement, to a point of dealing with national governments, where there are contracts to be signed and a multitude of players involved, is not being taken on board lightly by both.

In addition, it can also explain why not all donors have adopted SWAp and some still want to continue their activities through direct project funding. The movement towards SWAp has ensured that donors will have to give up some demands in order to be part of the larger sectoral policy and decision making (Cassels, 1997). This compromise has not been necessarily easy for all donors and even presently in Kenya; there is still no harmonisation and pooling of funds of the major donors although efforts are being made at working together and this has already led to formation of the Joint Design Mission (JDM). The JDM is a working arrangement of the six major donors in the country being United States government, DANIDA, SIDA, German Development Cooperation, DFID and World Bank to try and harmonise their funding and reporting systems with the governments'. There has been involvement of NGOs in meetings held between the government and the JDM (JDM, 2007).

Furthermore, it has been shown that rolling out two concurrent processes can result in parallel implementation. The case in point here is the MTEF and the annual budgeting process which appear to be running independent of each other. The annual budgeting process has been blamed for being largely incremental without taking regard of resource allocation that reflects the demands of high priority areas. This means that with the dynamic nature of health, being that new demands arise frequently, the resource allocation could be based on archived data and not current conditions. This is counterproductive to improving the health system as a system should be flexible to reflect the changing needs of the population its serving but if the resources available cripple these changes, then it renders it ineffective. This is probably where the NGO service delivery comes in handy as they have been known to be flexible and adaptable to the needs of the communities they serve. On the other hand, the fact that the health strategic plan clearly outlines how the sector is going to implement SWAp is a positive indicator of the country's receptiveness to this approach.

Therefore, according to the five principles of the Paris Declaration, the following are the findings of this study:

7.2.1 OWNERSHIP

The concept of national ownership means that the government is in the lead although it allows for negotiation between the government and its donors after evaluation of policies and spending priorities and when an agreement is reached, and then they both take collective responsibility for success and failures of the process (Cassels, 1997).
In this study, ownership is measured by the presence of

- District Annual Health Plans
- National Health Strategic Plan
- Medium Term Expenditure Framework (MTEF) (NHSSP II, 2005; Paris Declaration, 2005). It will also be measured by the steps the government is taking to lead the process.

The country has a National Health Strategic Plan that is for a five year period and the process of its formulation was consultative and participatory involving clients, service providers, civil society groups, the private sector, development partners, government stakeholders and its states the modalities and structures of cooperation with development partners (NHSSP II, 2005; WHO, 2004).
A MTEF also exists along which health expenditure is planned and executed according to priorities and resource allocation ceilings set although it does not factor in resource flow to the non-public health sector (JDM, 2007).

The MOH is presently advocating and promoting community ownership through the District Health Management Boards (DHMBs)[9] and Facility Committees at different levels. These bodies have a mandate to engage in implementation of the

[9] A District Health Management Board coordinates health service delivery in the districts through coordination of the district health management teams which are responsible for among others developing and implementing district health plans as well as coordinating the district health stakeholders' forum (NHHSP II, 2005).

Kenya Essential Package of Health (KEPH), resource allocation and local priority setting (NHHSP II, 2005). There has been a positive progress in the SWAp approach because the government has a clear vision and have engaged in successful consultation with stakeholders while taking lead of the process (GoK, 2004).

The Permanent Secretary has also taken lead of the process and is involving all stakeholders up to the local levels through the district health plans which eventually are presented at DHSF and included in the AOP. The district meetings are held quarterly. There is representation of the local communities as the districts and other local organisations are involved in the District Health Stakeholders Forum (DHSF)[10] after which their inputs in form of plans are sent to the provincial level and then to the central ministry (JDM, 2007).

It is important to note that local ownership is dependent on available local capacity. The country has to have the necessary capacity to develop and lead development programmes as well as leadership commitment. With sectoral programmes, the level of operations is more advanced as it includes a multiplicity of donors as well as higher scope of activities (Lavergne & Alba, 2003). This does not mean abdication of responsibility by donors but that ownership is expanded to include all stakeholders and giving them a feeling of responsibility towards outcomes (Singh, 2002).

In Uganda for example it was found that government and donor views differed when it came to health provision as the government had political pressure to provide health to poor populations whilst the donors wanted the existing facilities strengthened ending in development of a plan that addressed both but whose feasibility and sustainability is in question(Brown *et al*, 2001).

Jones and Williams (2002:10) sets out conditions that need to be in place as evidence of local ownership:

- "Development policies and programmes are defined and directed according to the recipient government.
- Donors respond to initiatives made by the government not imposing their own ideas.
- Commitment to a country's development policies and programmes is widely shared across society."

On the other hand, SWAps can increase the national ownership of sectoral development by allowing greater control over technical assistance and policy making. Governments have been known to make demands of donors that they were previously not able to do under direct donor support (Cassels, 1997). Additionally, SWAps represent a new shift to aid funding where all resources are coordinated and managed in partnership with the beneficiaries in the forefront (Walt, *et al.,* 1999). This is meant to foster ownership of the process.

[10] The District Health Stakeholders draws representation from public and private sector health providers. It provides linkage for joint planning, monitoring and evaluation at district level. It is supposed to link community and vulnerable groups to the wide array of health providers (JDM, 2007).

A lot also depends on the capability and readiness of the government to form national policies that reflect the priorities and needs of the people and their capability in implementing them (Lavergne, 2002). Ownership also implies efforts to foster capacity building, participation of stakeholders and accountability (Lavergne & Alba, 2003).

Discussion

Ownership is a concept that should be understood by both the national governments as well as the donors. It has been shown that in some cases there is a different expectation from both parties when it comes to this and that the concept is highly context specific.

Although they have at times been accused of importing their priorities to the communities and implementing the activities they deem fit the communities best, more than governments, NGOs, especially community based ones are easily accessible and linked to the local communities therefore better able to engage in community representation and fostering ownership. They have been known to endeavour to include the local communities they serve in their implementation and this has been in form of involving the communities in designing their programmes for example using participatory approaches to define community needs. This participation has however been known to end at activity level and does not extend to including community representation in their decision making organs.

With the advancement of SWAp, the level of ownership has been moved higher, from local communities to national governments. This can come as an unusual event for governments that were used to receiving donor funding with instructions of use and conditions attached. Being that they are now supposed to define the priorities they need funded and allocate funds accordingly can be an extraordinary experience for them which can be expected to experience some teething problems. In addition, donors have been blamed for largely influencing priority setting, sector strategy and government agendas by leveraging their financial capability and that some specific programmes are receiving more funding than others (Hill, 2002; Sundewall & Sahlin-Andersson, 2006).

The Kenyan government has already shown leadership by developing clear policy documents and engaging in broad consultations with various stakeholders. They have also managed to involve local communities through AOPs and their inputs have been considered. The government is also committed to improving its planning and budgeting process to reflect the changes in service delivery (JDM, 2007). This can be implied to mean they have a sense of ownership of the process.

7.2.2 HARMONISATION

There is no clear cut definition when it comes to harmonisation although it has been proposed to relate to increased coordination and streamlining of different aid organisations (De Renzio, 2005).
This study defines harmonisation to mean that donors are working together by having similar reporting procedures with an objective or reducing the administrative burden on governments. The indicators for measuring this will be:

- A single implementation/ intervention framework, for government and donor agencies; in this context it will be the health strategic plan
- Donors having common performance indicators
- Common reporting formats

Lack of harmonisation and coordination of project aid was said to cause ineffectiveness in service delivery as in some instances a multiple number donors could fund the same purpose in an area whereas if they could be coordinated they could cover many other areas or several activities (Hill, 2002).
Harmonisation is a challenge as it involves many different donors who each have their degree of autonomy and may in some instances have to give up some of their freedom to cooperate on similar practices and this is greatly dependent on their convenience and opportunity available (Walt *et al.,* 1999).
Nonetheless, in some countries like Tanzania, it has been found that the government's financial procedures are being used as well as joint reviews of progress and using common indicators and reporting system (Foster *et al.,* 2000).

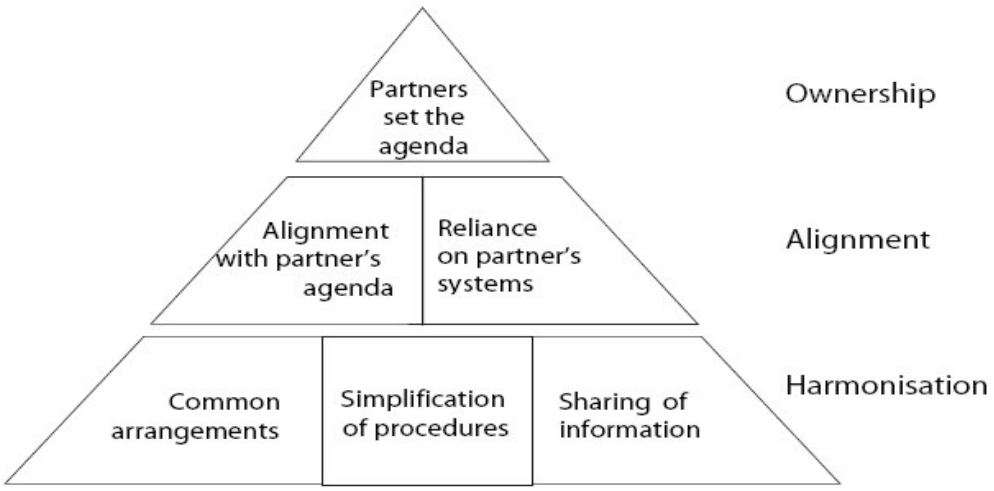
Additionally in Ghana, which is fronted as being a strong SWAp country, it has been found that they have made an effort of collaboration between sectors and forging partnerships specifically with NGOs and the private sector by for example engaging them in their program of work. They have also strived to procure services from them and this has also been observed in Uganda which does the same in order to avoid duplication of facilities (Bruijn & Horstman, 2005; Foster & Mackintosh-Walker).

The situation in Kenya is one of inexperience with the SWAp funding system and the ministry was to hold a joint consultative process and visits to performing countries under the SWAp was to be considered and then a decision was to be made mid last year (2006). Concern has also been stated about management of 'off budget' funds that have different reporting formats and that are considered to complicate priority setting and resource allocation (NHHSP II, 2005).

The government had a meeting with development partners in 2003 to map the way forward with the SWAp approach. After which, a Harmonisation, Alignment and Coordination group was formed. The group mapped out what structures and country assisting strategies were in existence to facilitate coordination between the government and the donors. However, there was no agreement on common reporting formats as well as the documents to be signed by both parties (GoK, 2005).

The challenge with harmonisation in the country at present is the existence of different performance indicators. There are three sets: those of the strategic health plan, those of the Joint Programme of Work and Funding and those of the Monitoring and Evaluation theme group (JDM, 2007). This is despite the fact that one of the objectives is to simplify procedures and have common arrangements with donors as well as information sharing. It is not often that governments possess sufficient capacity to coordinate effectively the activities of a large number of donors. The higher the degree of decentralisation, it is perceived the better the harmonisation will be. This is because the system is more able to collaborate effectively with other organisations on the ground as they respond to local situations (De Renzio, 2005).

Figure 4 As denoted by De Renzio (2005) below, harmonisation will involve existence of common working arrangements between the donors as well as simplified procedures and information dissemination.



Adapted from De Renzio, 2005.

Studies have shown that harmonisation should be context specific but point out that the most effective mode of harmonisation is that which takes place in the field under government leadership as well as utilising government systems for administering aid (Lavergne & Alba, 2003).
Currently, there still seems to be no clear link between harmonisation and development outcomes (De Renzio, 2005).

Discussion

Harmonisation is also a challenge experienced by NGOs. This is because different NGOs often exist in the same areas, doing similar activities but with no coordination between them. This is partly because each NGO tries to achieve something very specific and attribute any success to its own specific intervention. Different donors want to be linked with specific achievements in an area and partnering can mean that their involvement cannot be clearly picked

out. It can also be that the donors enjoy their degree of autonomy which implies that they can pull out of any project when they deemed fit. Another reason is that they can control the process by having specific reporting formats and requirements to be adhered to by the NGOs.

However, currently in Kenya, NGOs have endeavoured to put up a united front in their activities through the formation of the Health NGOs Network (HENNET). This has a mandate to foster dialogue on policy with the government as they stand a better chance of recognition because it registers health NGOs and acts like their mouthpiece (JDM, 2007).
Likewise, with SWAp, the harmonisation challenge is still in fore. There are many donors with different degrees of autonomy and similarly with different financial abilities. Thus bringing their funding to one pool will mean that once their money is in the pool, their contribution loses significance of being identified with them and they all become equal. It has been mentioned afore that some donors are not part of the process and this can be one of the reasons. SWAp also means a lot of compromises which some donors may not be ready for like having similar reporting formats. This was the case in Kenya when the donors and government met and failed to come up with common reporting formats. The current situation is that there is no pooling of funds of major donors yet.

NGOs have had experience with dealing with different donors and different reporting formats for a long time. This means that they possess the capacity to handle the different donors and this can be a good point of entry of partnering with the government as fears have been raised of the capacity of government to handle a large number of donors. With harmonisation, there is expected to be information sharing between the different stakeholders. Donors have at times been blamed for having more power over their aid recipients due to information asymmetry.

Another issue with harmonisation will be how to convince donors who are not flexible about which reporting format to be adapted. This will mean agreement about all their different requirements that should go into the single document that the government will use to report on the progress of the approach.

Management of off budget funds that complicate priority setting and have different reporting formats is also an issue that needs addressing by the government and donors. This can complicate service delivery if resources have already been allocated and donors come with unplanned funds that they want added to the budget. How to start factoring in the new fund into activities that are on going can lead to fungibility and subsequent mismanagement of funds. All funds should be planned for in advance to avoid such.

Decentralisation can also be an avenue of strengthening harmonisation. This is because greater coordination at local levels can enhance participation of different stakeholders. Although the centre should also possess sufficient information on the harmonisation process and what requirements it entails so as to adequately inform field offices as they are also part of the reporting system. The government has taken control of the process and is responsible for offering

avenues for implementers to have their inputs incorporated like through the DHSF.

7.2.3 ALIGNMENT

In the context of this paper this will mean congruence of donor approach with the priorities of the country health strategic plan. It will also mean donors linking their funding to a single framework of conditions (Paris Declaration, 2005).
The indicators to measure this will be:

- Alignment with the governments' agenda
- Use of government financial system (De Renzio, 2005).

Alignment of donor activities is meant to reduce transaction costs that were associated with bilateral arrangements as now; the donors can meet the government together as opposed to single missions having individual meetings that have previously been the norm rather than the exception (Foster *et al.,* 2000).
Donors have different administrative and financial reporting requirements that impose a burden on the country's system and with alignment and coordination, it is foreseen that there will be reduction in duplication or fragmentation of efforts which undermine the effectiveness of aid (Lavergne & Alba, 2003).

There are efforts being made by six major donors to have their funding and priorities aligned with the governments through creation of the JDM. They are striving to have pooled funding which will be managed by the government's systems. Although there are still conditions to be fulfilled by the government in ensuring that there will be no loopholes that can lead to fiduciary risk before this is done. The delay in aligned financial systems is the concerns with fiduciary risk as well as the dilemma of development partners in which funding modality to choose. The government would prefer that their funding is factored in the budget as on budget support and that they utilise government procedures. The development partners also want to comply with the Paris Declaration but their legitimate concerns must be addressed first (NHHSP II, 2005).

There is also linking of donor funds to the priorities of the JPWF[11]. Apart from that, the ministry has also realised that the MTEF needs to be linked with the annual budgeting system and is trying to have this done although there are no institutional arrangements currently of how budgeting and resource allocation will be harmonised (JDM, 2007).

Discussion

Alignment of donor activities with governments' is a positive move towards reducing the costs of dealing with several different donors as this takes time and increases administrative costs.

[11] The JPWF is an action oriented work programme to implement the NHHSP II. It's supposed to guide activities and investment decisions of the government, development partners and institutional partners from 2005 – 2010. It also provides a basis for development of AOPs that define actions to be taken by all stakeholders during each fiscal year (JDM, 2007).

Alignment could be proving to be a challenge because of the different country backgrounds of donors. This should instead be an advantage in that they can bring in their different experiences and try to come up with a blue print of constructive points from their experiences as well as negatives to be avoided.

In addition, donors should be ready to rely on the government's systems as well as align their activities with the national agenda and use their financial systems. This may not be as easy as sometimes they perceive the recipient country as having incapable systems of adequately sealing loss of funds. This is not an unfounded concern as the country has struggled with corruption and it still remains a challenge to be dealt with. Also the technical capacity in developing countries is lacking in many cases and therefore this calls for greater collaboration so that the donors can help build up the capacity of the country to be capable. Nonetheless, there is a positive development with the formation of the JDM as it shows that development partners are increasingly gaining confidence in the government.

NGOs have also struggled with alignment of their activities to the country agenda. This is because the funding they receive comes with specific instructions on what it should be used for and they have not been known to consult with the government in order to know the national agenda. The government agenda is similarly too broad that the NGOs can't be involved in all aspects. They have also been viewed as alternatives to the government where inequity in service provision exists. However, with the formation of HENNET, they are trying to be more incorporated in the current developments in the health sector as they were part of the meeting with the JDM as well as active participants in SWAp (HENNET, 2007).
Alignment has a lot of benefits if achieved for both national governments and development partners as it will help reduce transaction costs which are one of its major objectives as well as build capacity of the country system.

7.2.4 RESULTS BASED MANAGEMENT

In this paper, this will mean effective use of resources and improved decision making. The indicators to be used to measure this will be

- Presence of performance based contracts for health personnel under the SWAp approach, focusing on results based reporting which use indicators that are manageable and for which data is cost effective to measure in the strategic health plan (Paris Declaration, 2005).
- A common performance assessment framework.

"Results based management is a management philosophy, approach and set of tools designed to improve management effectiveness and strengthen accountability" (Lavergne & Alba, 2003).
Health planning in the country has been changing in response to government's approach of Results Based Management (RBM). This has seen health services customised to fit health needs of specific age groups. A reporting and review process has only been recently installed by the permanent secretary for

reviewing performances of the districts, provinces as well as the centre against indicators of JPWF and holding District Medical Health Officers (DMOHs) personally responsible for performance against signed performance contracts (JDM, 2007).

RBM is used to provide continuous feedback to project managers' at all different levels of operations so as to aid in decision making, encourage learning and facilitate performance reporting and accountability. With it there is a shift of focus from inputs to results (Lavergne, 2002). A national performance management framework that aims to institutionalise the RBM approach has been taken up by the Public Service and this will hold individuals and institutions responsible for service delivery and achievement of targets. The government has also recently approved implementation of a performance appraisal system for the public service to improve performance management at individual and system level (JDM, 2007). Effective aid management should be a shared phenomenon between the donors and the recipients. In addition, results based management can favourably work where the government is committed to being liable and receptive to the needs of its people (Lavergne, 2002).

There is recognition of this by the government and the health ministry in Kenya as evidenced by performance contracts whereby the employees are measured against their achievements and this shows that results based performance is taken as an important step. There is also public signing of the contracts by all levels of staff from the Permanent Secretary to the lower levels which are reviewed annually. Performance improvement has also been adopted where performance gaps are linked to improvements in capacity and support systems and not on rewards and punishment. (JDM, 2007).

Discussion

NGOs have been practicing RBM in their implementation for a period of time. This is because the funding agencies use this as one of the conditions for sustained funding. They have been commended for being effective in their service delivery in some quarters and have even been contracted in some aspects like social marketing (JDM, 2007).

Being that this is a relatively new concept to the government, they can be instrumental in helping the government in building its capacity around the same. RBM is supposed to focus on what the activity performed was meant to achieve and not necessarily the process it went through to get the results.
The government has done well to outline the process it will take to achieve this and how the development agencies will be involved. RBM calls for establishment of efficient feedback mechanisms between policy makers and implementers as it is supposed to ensure continual feedback to all project mangers at different levels of operation. It is good that this is institutionalised by the feedback channels that exist from the lower levels to the centre through such bodies like DHMBs, Village Health Committees and DHSF.

With this kind of management it becomes easier to recruit the right people for specific positions as they will be the most experienced for the work. SWAp will involve selection of the right human resources in the health system to ensure its success. The selection and recruitment of health staff remain a highly centralised function which can be a challenge for decentralised units as they have to depend on the centre to deploy staff to them (JDM, 2007). It also calls for flexibility in implementation so as to achieve the best results. This also calls for using performance based contracts in the workplace which monitors staff performance. However this can create some resistance in government quarters as employees are used to public service conditions and job tenure. On the other hand it can foster effective service delivery as it will do away with bureaucracy that was the hallmark of the traditional model of government management.

It should be pointed out that this kind of management is not a panacea for all managerial ineffectiveness as it can also be misused to victimise staff and care should also be taken that the right kind of indicators are developed so that the management does not end up focusing on achievement of results by non representative indicators. Indicators should aim at measuring effectiveness and quality and measure outcomes instead of inputs.

7.2.5 MUTUAL ACCOUNTABILITY

Accountability can be classified into two: external and internal accountability. External accountability refers to accountability by the government to its donors while internal accountability refers to the government's accountability to its own people on its projects, policies and outcomes (Mfunwa, 2006).

Accountability has four core dimensions namely: participation, transparency, complaints and redress and evaluation (ODI, 2005).

7.2.5.1 Transparency

SWAps have managed to have public expenditure defined to reflect macro economic policy and sector priorities in a transparent manner in order to reinforce the national budget process resulting in the MTEF which is meant to protect priority areas in events of resource shortfalls (Seco & Martinéz, 2001).
In some countries, the role of the civil society has been strengthened with introduction of SWAp and in Uganda for example, transparency has been ingrained into the institutions so that clientele can now hold the government responsible for service delivery (Foster *et al.,* 2001).

In Kenya, there was publication of a policy framework paper and a national meeting of stakeholders was held to discuss the direction policy should take in the early stages of the SWAp process. This was meant to foster transparency of the process (NHSSP, 2005). In addition, engaging in SWAp runs the risk of loopholes forming in the some procedures like procurement and also fiduciary risk which is the reason some development partners like World Bank and

German Development Cooperation have stalled engaging in SWAps until efficient systems that will avoid such are put in place (JDM, 2007).

Nevertheless, success is not out of reach as has been observed that there is more commitment by the ministry and all staff involved in carrying out a transparent process and these efforts are the ones that led to the development partners' willingness to start aligning their activities with the government (JDM, 2007). There should also be efforts to address information sharing, timely reporting and open involvement of the civil society and this should be done by the local development partners. This can be displayed by the amount of freedom the civil society is given to question the activities of the government especially when it comes to resource allocation (Lavergne & Alba, 2003).

7.2.5.2 Participation

Some studies have shown lack of participation of major stakeholders in the SWAp process. Brown *et al (*2001*)* found that there are a few cases of SWAp emerging after broad national debate and that participation was a reserve of senior government officials. However they found out that Uganda is attempting a participatory approach but this is still at a very minimal scale and at times there has been some government resistance to help financing NGO health service providers (Foster & Mackintosh-Walker, 2001).
On the other hand, with the Ghana health service it has been found that the process is participatory in nature with bottom up involvement of staff from the headquarters down to the districts and there is understanding of the process (Foster *et al.,* 2001).

In Kenya, the Health Strategic Plan states that there will be an attempt by the government to foster participation of NGOs as well as the private sector. Currently, their involvement is assured through the AOPs which at district levels include the local organisations in their planning meetings which are held quarterly and also in the DHSF. HENNET has also been included in meetings with the JDM (HENNET, 2007; NHHSP II, 2005; JDM, 2007).

7.2.5.3 Complaints and redress

Establishment of a complaints and redress mechanism is one of the manifestations of mutual accountability.
Moreover, with increasing number of donors in SWAp, the higher the threat of withdrawal from the pooled funding as other means of funding to the health system have already been committed to the pool and this gives the donors power especially due to the fact that there is no sanction mechanism for defaulting donors (NORAD, 1999; Foster, 2000). The current health strategic plan does not address this issue although it can mean that the country is still in an early developmental stage with SWAp and will continue constituting some requirements when they become necessary.

7.2.5.4 Evaluation

The institutionalisation of evaluation can be seen as an important aspect of good governance and a positive attempt to address corruption when need arises as it helps enhance a culture of continuous learning, improvement and accountability (Lavergne, 2002). SWAps have been accredited with developing systems under which performance can be monitored and this has excelled in cases where there is an efficient feedback mechanism between the planners and implementers in the ministry, agency or government under a single budget (Seco & Martinéz, 2001).

In Kenya, there is recognition of a joint monitoring of performance through annual reviews and joint meetings, which will be held biannually, that are intended to discuss the performance results of the sector with all stakeholders. The monitoring and evaluation (M&E) is transparent and participatory and combines internal and external reviews. The ministry has also developed an M&E framework to monitor the sector and this includes routine data collection and will eventually include an in-depth health services research component (NHHSP II, 2005). There is also performance monitoring which is closely linked to performance and production of annual reports while institutionalising a timeframe for quarterly reports from districts through the DHSF. The JDM also conducts independent reviews of the sector and reports its finding at an annual health summit held to inform stakeholders on progress being made (JDM, 2007).

Nonetheless, evaluation under SWAp has proved problematic as it involves intense and lengthy negotiations in order to come up with common indicators of progress as well as agreement on how to integrate it into the system (Peters & Chao, 1998; Garner *et al.,* 2000). This is already a challenge being witnessed as there are three sets of indicators currently in existence, the ones for the strategic plan, the M&E theme group's and the JDM's. This has been blamed on lack of clear leadership on the path to follow. However, the government has made it a priority to measure results against objectives, targets, reporting and disseminating the information to stakeholders and using information for continual learning and improvement as well as accountability (JDM, 2007).

Discussion

NGOs have been argued to be accountable to the populations they serve as well as to their funding organisations. This means the concept of accountability is not new to them.
On the other hand, with SWAp, the onus is on the government to achieve accountability. This has been divided into external and internal accountability. With external accountability, the government is answerable to the funding agencies on how its resource allocation and priority setting is effected. Being that the funding agencies hold the purse strings tips the balance of power into their favour. However, SWAp has also ensured that governments have a bargaining chip and can accept or reject interventions that they deem unnecessary. This somehow introduces some balance. The government on the other hand can be

willing and ready to be answerable to the donors in order to keep good relations and maintain sustained funding.

What is going to be a new addition is internal accountability. This means governments being accountable to their own people. Mechanisms that are in place right now that ensure this in the country are not so clearly stated. One way of ensuring accountability is having open communication channels between the government and the population that can facilitate asking questions about activities. This involves open and fair information sharing where the government can allow the public to access information on what plans they have and allow for feedback. This can be exhibited by visiting government offices and seeing what kind of information is accessible to the public especially on notice boards as it's the common practice with NGOs to have clearly stated mission and objectives on their notice boards.

On the issue of transparency, this has also been a challenge for NGOs which have been at times accused of squandering donor funds and not effecting any changes in the communities they serve. Some have been blamed to have been formed in the euphoria of HIV/AIDS crisis and just sent proposals for funding and when they received the funding then they dissolved. With this kind of behaviour, it can be that with SWAp there is a gain as at least its national governments being dealt with and contracts are signed to ensure commitment. On the other hand, the government also needs a check and balance for its activities and this should come from the civil society sector. The civil society should be strengthened and allowed freedom to ask questions and receive answers. They should also be allowed to make follow up on the responses they receive.

Participation is not a new concept in health service delivery. The national health strategic plan states that the process of SWAp will be highly participatory and will involve all stakeholders. NGOs have formed HENNET which can send representatives to the meetings that they are required to. The third AOP was also more participatory in nature and involved the local levels which included NGOs in the DHSF. Their inputs were incorporated in the district health plans which were forwarded to the centre so there is an effort to make the process participatory.

Implementation of SWAp means bringing donors that had previously not worked together to work together. The government is also going to have to deal with all the donors at the same level while previously they could deal with them individually. Such a situation can lead to conflict. This will mean that there should be a system to ensure that complaints are addressed when they arise. It has been mentioned that there is no mechanism existing to address donors who default after committing to SWAp. Such a mechanism should be instituted but this will mean intense negotiations and agreement on how such a structure should be constituted and how the representatives will be selected. It is a process that still needs time to formulate properly the mechanisms required.

Evaluation of NGO activities is a normal phenomenon and is carried out under donor request as part of the funding conditions. This can either ensure sustained funding or stop it. They are therefore used to the modalities of evaluations.
Evaluation of SWAp on the other hand is a new approach although it is also advocated as a means of promoting continual learning and allowing for improvement of implementation. When it comes to overall evaluation of SWAp, it is not clear how this will be done, when it will be appropriate to do it and who will do it. Are the donors or the national governments going to commission it? Nonetheless SWAps have been accredited with developing appropriate systems for evaluation and performance monitoring.

The Kenya health strategic plan states that all districts will be expected to adopt and use same performance indicators which will be introduced throughout the system. Districts are also supposed to add more specific indicators where necessary to monitor the performance in their respective fields. The government has taken cognisance of reviewing performance and has constituted joint annual reviews which will allow for reflection on performance and charting of future activities (NHHSP II, 2005).
The next chapter is going to summarise the paper and give recommendations.

CHAPTER EIGHT: CONCLUSION AND RECOMMENDATIONS

In Kenya, with the advancement of SWAp, there remains to be seen the changing face of health service planning and implementation in the country. Although it should be realised that the process is just beginning and as such there will be areas that are not clearly delineated at present.

Before the SWAP implementation, the NGO sector played and still continues to play a significant role in health service delivery.
NGOs were viewed as an alternative to the government especially for some income groups specifically the low income, marginalised and socially challenged. The government recognised their contribution but did not sufficiently acknowledge it as they were not working together. They were in fact viewed as short term solutions to long term problems as their activities were not sustainable due to the time bound nature of their funding. In some instances they were blamed for attracting health personnel from the government to work for them and this was not taken well.

Since the implementation of SWAp, a lot has changed in the relationship between the government and NGOs. They are being acknowledged and recognised as partners in health service delivery as evidenced by their inclusion in the health strategy as well as AOP III. Further steps are being made to foster their continual involvement with the government looking for ways to include their funding into its current planning and budgeting framework.

As it currently stands, there is an attempt to involve NGOs in SWAp. The government has made great effort in their planning to include them in service provision and plans are underway to include their funding in the MTEF. Additionally, NGOs themselves have taken a proactive role to be engaged in the process. The formation of HENNET and its inclusion in AOP and JDM meetings is a strong indicator of their recognition and needs further encouragement. Governments should continue forming constructive partnerships with NGOs so as to sustain their contribution in health care services. Such a partnership is a win-win situation for both because the NGOs will bring their expertise, while the government will ensure their sustainability both financially and operationally. It is more encouraging that they both strive to ensure better health outcomes of their beneficiaries.

SWAp has managed to streamline planning in the health sector and it has tried to include all stakeholders from the local levels to the central through the AOPs. Government has made efforts to be efficient and inclusive in its service delivery and their efforts have been commended by the JDM. In countries that have been considered strong SWAp countries for example Uganda and Ghana, it was found that a lot of factors contributed to their successful implementation to the approach. One of the key factors was commitment by the country leadership itself to seeing the process work. Another key factor was that the countries waited until the right conditions for implementing the approach were available. This included engaging in lengthy but necessary preparatory phases. These countries also aimed at broad stakeholder participation in the process which

promoted a high degree of ownership that ensured all the partners aimed at its success.

Kenya seems also to have waited for the right conditions to be present before engaging in SWAp as now the health plan recognises the need of the approach and the part the government should play to ensure positive development of the process. The government has also exhibited strong leadership and ownership of the process while striving to achieve as wide a consultation with stakeholders as possible.

Therefore, in regard to positive progress by the government and in recognition of the fact that a lot more needs to be done to strengthen this relationship, the following recommendations have been made:

Policy Recommendations

- It is imperative to continue including the NGOs as key stakeholders in health service delivery notwithstanding the advancement of SWAp. This should not be done as a parallel function but concurrently. One important factor is to realise that there is a need to strengthen partnering with them and enhanced coordination. The onus is on the government which should continue facilitating this process as they are in the lead of SWAp.
- Lack of capacity to manage and lead SWAp by national government system can be used as an opportunity to strengthen government systems. The enhancement of efficient financial management systems in order to push forward donor engagement in SWAp should be instigated.
- There should be clear description of the functions of some of the prerequisites to SWAp implementation. This is specifically the MTEF which has been claimed to be used largely as a planning tool as opposed to a budgeting tool and that it doesn't even specify intersectoral priorities.
- The budgeting process in the country has also been faulted for being incremental and lacking significant allocation to high priority areas. There should be a channel to address this to the Finance ministry which is responsible for resource allocation so that health priorities are recognised and addressed. There should be greater inter ministerial coordination of the health and finance ministry to ensure this.
- The government should continue creating opportunities for NGOs to involve in policy dialogue, programme design and implementation. This should be institutionalised in the health service delivery so that structures to ensure it are in place and recognised. It should be clearly separated from enhancing donor coordination. Their involvement should not just be restricted to invitations to stakeholder meetings but service delivery as well.

Intervention Recommendations

- The public private partnership developing between the government and NGOs which includes social marketing and franchising should be further

encouraged as it is a step in the right direction and ensures sustained participation of NGOS in health service delivery.

- NGOs should engage in advocacy with an aim of production and dissemination of knowledge in the public domain so as to ensure that they are custodians of the public when it comes to monitoring government performance in health service delivery.
- There should be a clear coordination and organisation between NGOs so that they avoid chasing their own individual interests, identities and funding modalities at the operational level in order to have a united body that can negotiate and act as a block. Organisations like HENNET should be given adequate support and recognition of its activities.
- The government should clearly conduct information awareness for its own staff and other concerned parties on what exactly SWAp will entail and how they will be involved in the process. This will serve to reduce hostilities that can be associated with introduction of tools like performance contracts.

Research Recommendations

- The role of other health sector reforms taking place in the country especially decentralisation should be examined in relation to strengthening the implementation of SWAp. Decentralisation has been commended for enhancing SWAp especially in cases of planning and management at district level. On the whole, further research into how the two processes are being carried out and how they can complement each other is needed.
- A field study into how the relations between the government and the funding agencies has changed after implementation of the SWAp is needed in order to know if there is an actual gain with the shift in funding style.
- The progress the country is making so far and the successes and challenges that have been experienced until present need to be researched on and documented to inform future studies.

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