

The sector-wide approach: a blessing for public health?

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There is compelling evidence that improved health system performance is key to improved health, and hence to meeting health-related international development targets such as the Millennium Development Goals (1). In contrast, the strategies on how this is achieved are still open to debate. Since the mid-1990s, a new approach to health sector development has taken hold in a number of developing countries: the sector-wide approach (2).

There are persuasive arguments for supporting a sector-wide approach (SWAp) as opposed to the traditional project approach: increased health sector coordination, stronger national leadership and ownership, and strengthened countrywide management and delivery systems. These are variously claimed to reduce duplication, lower transaction costs, increase equity and sustainability, and improve aid effectiveness and health sector efficiency. Furthermore, the SWAp has become an integral part of poverty reduction strategies, and its ideology has enjoyed a growing acceptance from donor agencies as well as aid recipients (3).

To understand the potential impact of this approach on population health, four key areas are strengthened which indirectly, but importantly, have implications for public health: country leadership and ownership, institutional and management capacity, flow of resources, and monitoring and evaluation (2, 4). The evidence is generally mixed from health sectors that have embarked on a SWAp, as illustrated below (5–11).

First and foremost, a SWAp explicitly mandates the ministry of health with the leadership. However, this role has been partly problematic owing to limited leadership capacity (e.g. Rwanda), poor relationship with the ministry of finance (e.g. Mozambique), slow shift of ownership (e.g. Cambodia), change of senior management (e.g. Zambia), little ministry of health leverage to secure additional funds (e.g. the United Republic of Tanzania), and low priority of cross-sectoral collaboration.

Second, a SWAp emphasizes strengthened health sector management through the development or adaptation of management tools, combined with strengthening of implementation capacity. For example, under SWAps greater attention is given to health sector planning, financial management, and improved health information systems. SWAps also tend to emphasize strengthening district level management capability within existing decentralization policies (e.g. Ghana, Uganda and the United Republic of Tanzania).

Third, under a SWAp, recipient governments and donors only fund activities in the national health sector plan. Donor funds are pooled and earmarked for high priority activities, such as essential health package (e.g. Uganda, Tanzania). Importantly, pooled donor funding supports government budgets, giving a much needed boost to recurrent expenditures (1). Furthermore, donors are responsible for synchronizing their own planning, review and monitoring processes with government systems, and give long-term projections of aid pledges. These positive developments, however, are under threat in many SWAp countries, where global health initiatives are redefining modalities of aid delivery.

Fourth, monitoring and evaluation of the health sector become institutionalized under a SWAp. The “one voice” of donors has strengthened their position to create conditions. The once or twice yearly joint review meeting is an important instrument providing an open forum to review the progress and performance of the health sector. These large meetings are complemented by more frequent meetings with key development partners. The success of these processes depends mainly on the people involved and their experience, expertise and sensitivity to developing partnerships.

Given the wide range of activities initiated or supported by a SWAp and the high level of support given by donors and recipient governments, the dearth

of evidence on health impact is surprising. What is clear from the case studies reported is that there emerge patterns under which a SWAp can and will work, while other conditions are less favourable (9). Being engaged in a SWAp implies a commitment to a direction of change, rather than the comprehensive attainment of all its elements from the start (1).

Sustained reform takes time. Nevertheless, if development partners are to continue supporting SWAps there has to be a point where tangible benefits to population health can be demonstrated. Unfortunately, no such standard exists, nor is one possible. The starting conditions and the evolutionary path of SWAps have been so varied in different contexts that it is impossible to say what health impacts should be expected and when, particularly in view of fluctuations in health indicators. Accurate and comprehensive monitoring programmes tailored to specific system contexts must be set up, preferably based on demographic surveillance systems such as those of the In-Depth network (12).

Given these challenges and the dilapidated state of the health sector in many of the countries where SWAps are in progress, it may take 5–10 years of sustained implementation before any sizeable impact on health outcomes can be demonstrated. This point is now being reached by several countries, and we should be able to look forward soon to reading about health impact of SWAps. ■

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