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HEALTH SECTOR REFORM IN SUB-SAHARAN AFRICA: A SYNTHESIS OF COUNTRY EXPERIENCES

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HEALTH SECTOR REFORM IN SUB-SAHARAN AFRICA: A SYNTHESIS OF COUNTRY EXPERIENCES

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ABSTRACT

Health sector reform is 'a sustained process of fundamental changes in national health policy, institutional arrangements, etc. guided by government and designed to improve the functioning and performance of the health sector and, ultimately, the health status of the population'. All the forty six countries in the African Region of the World Health Organisation have embarked on one form of health sector reform or the other. The contexts and contents of their health reform programmes have varied from one country to another.

Health reforms in the region have been influenced largely by the poor performance of the health systems, particularly with regard to the quality of health services. Most countries have taken due cognizance of the deficiencies on their health systems in the design of their health reform programmes and they have made some progress in the implementation of such programmes. Indeed, some countries have adopted sector-wide approaches (SWAps) in developing and implementing their health reform programmes. Since countries are at various stages of implementing their health reform programmes, there is a lot of potential for countries to learn from one another.

This paper is a synthesis of the experiences of the countries of the Region in the development and implementation of their health sector reform programmes. It also highlights the future perspectives in this important area.

Key words: Health sector reform, fundamental changes, achievements, sector-wide approaches (SWAps), future perspectives.

INTRODUCTION

Most countries of the African Region generally enjoyed a stable political environment and favourable economic conditions that made it possible for them to embark on, and achieve, remarkable socio-economic development after independence. In the health sector, service coverage increased as a result of the development of new health facilities and expansion in the training of various cadres of health workers.

The economic downturn in developed countries which followed the oil shocks of 1973 and 1979 ultimately led to a profound world recession that left many of the economies of the countries in the Region almost in total disarray. Huge national debts, among other factors, forced most of them to embark on economic reform measures. One form of reforms involved the development and implementation of structural adjustment programmes whose components included

currency devaluation, cuts in government spending, and trade liberalisation. The social sectors, particularly health and education, were hardest hit by the consequences of economic decline and the way economic reform programmes were implemented. Not only did the measures slow down the pace of health development in most African countries, they also weakened their health systems to the point of near collapse.

The adoption of the Three-Phase Health Development Scenario (1985) and the Bamako Initiative (1987) were the first attempts made by the African Health Ministers to revive their health systems. Subsequently, individual countries made additional efforts to strengthen the health systems.

The World Development Report (1993) demonstrated that investing in health is a prerequisite for sustained development. The World Bank-sponsored study, Better Health in Africa (1994), set forth a vision of health improvements that were achievable through health sector

reform, thereby reinforcing the correctness of the efforts that had been made in that direction by some of the countries of the Region. The inter-country meeting held in Arusha in 1995 provided a forum for twenty two countries to share experiences on the development and implementation of their countries' health sector reform programmes.

The UN Special Initiative on Africa (UNZIA) was launched in March 1996 with a view to strengthening country-driven strategies as the primary basis of donor assistance. The health sector component of UNZIA is aimed primarily at coordinating the resources of different agencies of the United Nations system and other health development partners in order to accelerate the development and implementation of comprehensive health sector reform programmes in African countries. In adopting the implementation strategy for the health sector component that was jointly developed by the WHO Regional Office for Africa (WHO/AFRO), the World Bank, UNDP, UNFPA, UNESCO, UNICEF and the African Development Bank (ADB), the Ministers of Health of African countries, in September 1996, urged that inter-country meetings be organised to share experiences and to build a consensus among Member States. The meeting in Cotonou, Benin (13-15 October 1998) was the first in a series of three meetings, the Addis Ababa meeting (4-6 May, 1999) was the second, and the Maputo meeting (20-22 July, 1999) completed the first round of inter-country meetings on the health component of the initiative.

The multi-sectoral team of participants from each country was expected to prepare a country paper on their health sector reform experience. Thirty nine of the forty six countries in the Region prepared and submitted their country papers. These constituted the 'data' that were analysed to prepare this paper, which is a synthesis of the country experiences in health sector reform and in the development/implementation of Health Sector-Wide Approaches (Health SWAs) in the Region. The approach adopted involved a content analysis (of the individual country reports) as well as the construction of a table to capture the major messages contained in the reports on each of the various aspects of the countries' health sector reform programmes. The rationale for adopting this approach was to be able to provide a clearer but more holistic picture of health sector reform experiences in the Region than would have been the case if the experiences were merely summarised country by country. The results of the approach adopted have been largely used to complete the remaining sections of this paper.

Specifically, after providing an operational definition of health sector reform in Section II, the 'synthesis' with respect to the context, content and actual implementation of countries' health sector reform programmes are presented in Sections III, IV and V respectively. Since some of the countries have already developed sector-wide approaches

in health (i.e., Health SWAs), Section VI reviews the experiences of such 'advanced' countries. Finally, Section VII, the concluding section of this paper, presents the way forward.

II: A DEFINITION OF HEALTH SECTOR REFORM

Health sector reform has been defined as a sustained process of fundamental change in national health policy and institutional arrangements guided by government and designed to improve the functioning and performance of the health system and, ultimately, the health status of the population. The words "national" and "system" in the definition imply the entire health care delivery system in a country, that is, preventive, curative, promotive and rehabilitative services at the primary, secondary and tertiary levels and the public, private for-profit and private not-for-profit sub-sectors. This operational definition which was first used by the participating countries in the Inter-Country Meeting on Achieving Evidence-Based Health Sector Reforms in sub-Saharan Africa held in Arusha, Tanzania, 20-23 November 1995, was adopted by the Regional Committee for Africa at its forty ninth session in Windhoek, Namibia, in September 1999. This definition has the advantage of focusing on a long-term process in which government has a key role. The ultimate purpose of the process is to achieve significant health improvement. The definition also has the advantage of not being tied to specific components or policy instruments as defining the reform process. It, therefore, allows for a wide range of different country contexts.

Although most of the health sector problems addressed by the reform are institutional, technical and managerial, designing and implementing health sector reform is, by and large, a political process. Consensus building among all stakeholders is very crucial, particularly because of political diversity in many countries. Successful consensus building on every component of the reform process will facilitate implementation of the reform agenda, even in a situation of political change.

III: THE CONTEXT OF HEALTH SECTOR REFORM IN THE REGION

The General Environment

The lack of good governance has contributed to the low priority accorded to health development as a part of sustainable human development in many countries. Political instability, civil strife and wars have also played a major role in disorganising already weak health systems and increasing the burden of disease and disability.

Countries of the Region have had to struggle over the same period with deteriorating economic conditions that called for the development and implementation of macroeconomic policies, including structural adjustment

programmes which, among other things, curtailed public spending in the social sectors, particularly health and education. The implementation of the first generation of structural adjustment programmes negatively impacted on national health systems.

Closely linked with the political and economic changes have been the new ideological orientations, based on liberalism and the market economy, that have tended to question the efficiency of the State and to reinforce belief in the dominance of market forces. These ideological orientations have tended to reconsider the relative responsibilities of the State and the private sector in health care delivery.

Progress in education and the rapid development of information technology have also increased awareness of people of information on health technologies. The advent of democratic regimes and the emergence, as well as the strengthening, of participatory democracy over the last ten to fifteen years have led to demands for quality health services by a better-informed population.

Health Problems and Health Systems

There have been profound changes in health problems and in the health status of the people in the Region. The incidence of a number of diseases, such as tetanus, onchocerciasis, measles, pertussis and poliomyelitis has decreased. At the same time, however, there has been a resurgence of other diseases that had been controlled, such as tuberculosis and trypanosomiasis. Emerging epidemics, such as HIV/AIDS and viral haemorrhagic fevers, are causing havoc to the health systems. Non-communicable diseases are on a significant increase and making the African Region to face an epidemiological transition, characterised by the double burden of communicable and non-communicable diseases.

The health problems occurred at a time when the health systems needed to be adapted to rapidly changing political, social, economic and physical environments. Some weaknesses, such as the lack of a long-term vision as the basis for policy formulation, lack of evidence to support a policy making process, weak financial support, weak management of health resources, and inability to anticipate the consequences of growing poverty, have all been noted. Nevertheless, where the health systems did address priority problems, with clearly defined targets and adequate strategies, the health status of the people has improved. There is evidence that "vertical" approaches to the control of some specific diseases were effective in some places, that decentralisation and operational integration of health interventions at the peripheral level of health services were generally positive, and that co-management by, and partnership between, public services and communities partially contributed to the solution of some problems. However, most of public health problems persist and call

for more concerted action.

Policy Features

The process of health development in the Region has gone through many phases and has been influenced by various global and regional policy orientations, prominent among which are the following:

- the first effort in 1974 to develop a long-term framework for health development in the Region covering the period 1975 to 2000;
- the global agreement reached in Alma-Ata in 1978 to achieve health for all by adopting the primary health care strategy;
- the adoption of the Three-Phase African Health Development Scenario (the African Regional Committee of the World Health Organisation, 1985) which later became the framework for health development in the Region;
- the adoption of the Bamako Initiative (the African Regional Committee of the World Health Organisation, 1987);
- the agenda for health sector reform enunciated by the World Bank in 1987;
- the two World Bank publications (*World Development Report* and *Better Health in Africa*) in 1993 and 1994 respectively;
- the development of the WHO/AFRO Framework for Technical Cooperation with Member States (1995);
- the inter-country or sub-regional meetings organised by WHO in Livingstone and Arusha (1995) on the strengthening of district health systems and on the role of health systems research in health sector reform respectively;
- the launching of the United Nations Special Initiative on Africa (1996), especially its health component;
- the launching of the new global health-for-all policy for the 21st century (1998);
- the development of a regional (African) health policy for the 21st century (2000); and
- The World Health Report 2000.

Country-Specific Information on Contextual Factors

Using the information that has been presented above as the general context of health sector reform in the Region (i.e., the general environment, the health problems and health systems, and the policy features), the information provided by each country on context was analysed to see the extent to which the general context presented coincided with the context described by the countries themselves.

The summary of the results of the analysis is presented in Table 1. It shows, among other things, the number of countries that have indicated which contextual factor was most important for their health sector reform programmes.

Table 1: Specified Contextual Factors for Health Sector Reform in the African Region of WHO

Serial No.	Contextual factor	Number of countries that indicated factor*
1	Political/Policy/Ideological factors (e.g., no clear definition of roles and functions, civil disturbance and destruction of health infrastructure, influence of international initiatives/slogans, democratisation and its effects, new political impetus supporting change, concern raised by donors/international organisations, reforms in other sectors)	15
2	Economic factors (e.g., economic crisis and macroeconomic reforms, rapid economic and social development, inadequate resources, inefficiencies in resource utilisation)	10
3	Health problems (e.g., poor health status, increasing demand for services as a results of growing populations, emerging diseases e.g., HIV/AIDs, epidemiological changes)	16
4	Health systems and services (e.g. inequities in access, poor quality of services, inefficiencies in the running of facilities, inadequate community participation, poverty/access, existence of vertical programmes, uncoordinated service delivery by providers, lack of drugs and supplies, inadequate financing, poorly motivated health workers, institutional weaknesses, health systems not responsive to consumer needs)	33
5	Others	3

*The numbers do add up to more than 39 (i.e. the number of countries that submitted country reports) because each country indicated more than one contextual factor

One major point observed from the results of the analysis is that the contextual factors leading to the undertaking of health sector reform programmes varied from country to country. Another major point is that contextual factors relating to politics/policy/ideology, the economy, health problems as well as health systems and services, are interrelated and mutually reinforcing. However, it is clear from Table 1 that the state of the health systems and services in the last twenty years (contextual factor number 4) has provided the greatest impetus for countries of the Region to undertake health sector reform. Next to the factor and, indeed, not surprisingly so, are factors relating to health problems (i.e., poor health status of the population and the need to improve it). For most of the countries, increased demand for services as a result of growing populations was happening at a time when the health systems were weakest. This situation was compounded by emerging diseases as well as changing disease patterns owing to epidemiological changes.

IV: THE CONTENT OF HEALTH SECTOR REFORM Major Objective and Policy Orientations

The major objective of health sector reform in the

countries of the Region is to positively influence the performance of the health system with regard to equity, access, efficiency, quality and sustainability, and ultimately to improve the health status of the population. This major objective has been set out in greater detail as strategic objectives by many countries, more or less as follows:

- (i) to promote equity in health, in access to and use of health services, and in health financing;
- (ii) to improve the quality of health services, both from the technical standpoint and the users' perspective;
- (iii) to increase the efficiency of health interventions and improvements in the allocation and management of health resources; and
- (iv) to ensure the sustainability of the management and financing of health interventions.

The country-specific reports were examined to see how many countries specifically indicated each objective as part of the content of their health reform programmes. Table 2 contains the results of this exercise.

Table 2: Major Strategic Objectives of Health Sector Reform Programmes of Countries in the African Region of WHO

Serial No.	Major/Strategic Objective	Number of countries that indicated objective*
1	Improve health status of the population	19
2	Improve access and coverage (equity)	28
3	Improve efficiency	12
4	Improve quality of services	20
5	Revitalise district health system	2
6	Mobilise more resources	6
7	Improve community participation/consumer satisfaction	4

*The numbers add up to more than 39 because each country indicated more than one objective

Since the most dominant contextual factors specified for undertaking health sector reform were related to health systems health services and health problems (Table 1), it is not surprising that improvements in coverage and access, improvements in quality of services, and improvements of the health status of the population have been the most popular objectives of reform programmes of countries in the Region.

Reform Agenda Items and Strategies

In order to attain their objectives, health sector reform programmes were usually undertaken to address four major agenda items. These relate to: the stewardship of health systems, the organisation and management of health services, the provision of quality health care, and the financing of health services. Multiple strategies have usually been designed to implement each of the agenda items. Table 3

summarises the information obtained from countries about the major items of their reform programmes as well as the various strategies to implement each item.

The highlights of the information summarised in Table 3 are as follows:

- (i) In order to enhance the functions pertaining to the stewardship of health systems, the most important aspects addressed by countries are the development of relevant policies and strategies, legislations, inter-sectoral collaboration, partnership coordination and decentralisation. Other aspects include a re-definition of roles and functions, such as the restructuring of the Ministry of Health, and improvements of management support systems.

Table 3: Major Health Sector Reform Agenda/Strategies in Africa

Serial No.	Reform Agenda items/strategies	Number of countries that indicated reform
1	HEALTH SYSTEM STEWARDSHIP	
	1.1 Redefinition of roles and functions, including restructuring of Ministry of Health	12
	1.2 Review/Formulation of necessary policies, strategies, legislation, etc.	19
	1.3 Decentralisation	22
	1.4 Management of support systems	12
	1.5 Extension of coverage	3
	1.6 Intersectoral action for health	6
	1.7 Coordination of partners	9
2	ORGANISATION AND MANAGEMENT OF HEALTH SERVICES	
	2.1 Promotion of a public-private mix	9
	2.2 Integration of services/promotion of comprehensive services	8
	2.3 Promotion of community participation	9
	2.4 Definition of minimum package of services	13
	2.5 Strengthening the PHC approach in health care delivery	8
	2.6 Strengthening institutional capacity	10
3	PROVISION OF QUALITY HEALTH CARE	
	3.1 Human resources for health development	17
	3.2 Availability of essential drugs	17
	3.3 Improvement of quality of services	4
	3.4 Undertaking of operations/essential research	4
4	FINANCING OF HEALTH SERVICES	
	4.1 Increased budgetary allocation	0
	4.2 Broadening resource base	27
	4.3 Improved management of resources	4
	4.4 Use of cost-effective interventions	0

(ii) In order to facilitate a better organisation and management of health services, the most important strategies have been the definition of a minimum package of services, strengthening institutional capacity, promotion of a public-private mix, promotion of community participation and coordination of partners. Other strategies have been the integration of services/promotion of comprehensive care, strengthening the PHC approach, and promotion of intersectoral action for health.

(iii) In order to enhance the provision of quality services, strategies to ensure adequate number/ mix of trained staff as well as guarantee the continuous supply of essential drugs, have been the most important.

(iv) Given the limitations of reliance on general tax revenue and dwindling external aid, the major strategy that has been adopted to address adequate and sustainable financing of health services is broadening the resource base (involving private health

insurance schemes, national health insurance schemes, prepayment schemes, etc). Only few countries adopted improved management of resources as a relevant strategy for this agenda item and, surprisingly, no country has put emphasis on increased budgetary allocation or the use of cost-effective interventions as part of their financing strategies.

V: THE IMPLEMENTATION OF HEALTH SECTOR REFORM

The Reform Process

The developmental stages of health sector reform (i.e., the health sector reform process) are generally viewed as consisting of the following:

Stage 0:	No reform
Stage 1:	Health sector appraisal
Stage 2:	Health sector plans
Stage 3:	Achieving consensus
Stage 4:	Funding
Stage 5:	Implementation of reform agenda
Stage 6:	Actual implementation

WHO/AFRO (1999) characterised the health sector reform process and its stakeholders and also emphasised the following aspects of the process:

- (i) it is not a linear process;
- (ii) all stakeholders have to be involved in the various phases of the process; and
- (iii) monitoring, evaluation, continuing advocacy and consensus building are central to the process.

From the benchmarks on the health sector reform processes of the eleven countries provided in Annex 1, the following observations are worth noting:

- The country benchmarks have not generally followed the six developmental stages indicated above.
- The 'key-starters' of the reform process varied from country to country. For Ghana, it was institutional strengthening (especially the strengthening of the

district health systems); for Senegal and Ethiopia, it was the development of a national health policy; for Niger, it was the development of the health plan (even before the development of a policy!); for Nigeria and Cameroon, it was the implementation of PHC; for Kenya and Tanzania, it was the liberalisation of some policies; and for Sierra Leone, it was a national seminar aimed at identifying the strengths and weaknesses of the health care delivery system.

- Whilst noticeable reform efforts (or commencement of the reform process) dated back to over fifteen years in countries, such as Ghana, Mali, Benin, Nigeria and Cameroon, it has been relatively recent in some other countries, such as Senegal, Niger, Ethiopia, Sierra Leone, Kenya and Tanzania.
- Countries that have adopted the sector-wide approaches (which will be discussed later) have not been generally those with the longest history of health sector reform.

Major Reform Achievements

The information provided by countries on their reform agenda items and strategies in which they have recorded some achievements in their health sector reform programmes are summarised in Table 4. Achievements have been greatest in the reorganisation of the Ministry of Health, the decentralisation and strengthening of the district health systems, the development of a national health policy or sector strategy, the development of a drug policy or an essential drugs list, improving the financial resources for quality health services, the development of a national health plan, the enactment of relevant legislation and the definition/implementation of a minimum health package. The development of sector-wide approaches (SWAs) is another area of achievement by a few countries. Given the importance of a health SWAs as a framework for undertaking health sector reform, this development will be taken up later in this paper. In the rest of this section, brief comments, largely based on country-specific reports, are made on each reform agenda item and some of the associated strategies.

Table 4: Areas of Major Achievements in African Health Sector Reform

Serial No.	Area of Achievement	Number of countries indicating area
A	HEALTH SYSTEMS STEWARDSHIP	
	Development of national health policy or sector strategy	13
	Development of national health plan	8
	Development of sector-wide approaches	5
	Enactment of legislation	7
	Coordination of health partners	3
	Improved management systems	2
	Reorganisation of Ministry of Health and regional structures	12
Decentralisation and strengthening of district health systems	15	
B	ORGANIZATION AND MANAGEMENT OF HEALTH SERVICES	
	Integration of services	2
	Contracting of services	4
	Increased access/coverage	5
	Greater community participation	2
	Definition/implementation of the minimum health package	6
Promotion of a public-private mix	4	
C	PROVISION OF QUALITY SERVICES	
	Development of a drug policy or an essential drugs list, etc.	11
	Human resources for health policy/plan developed	4
D	FINANCING OF HEALTH SERVICES	
	Adequate financial resources provided	13

The appropriate reorganisation or restructuring of a country's ministry of health has a direct impact on the success of health sector reform. This is partly because the ministry of health has a major role to play in the promotion of dynamic leadership and the provision of an enabling environment in order to ensure the complementarity of other institutional factors. Ministries of Health in many countries have, in order to improve their effectiveness and efficiency, attempted to reduce the scope of their interventions in the provision of health services. They have restricted their role to the formulation of policy, coordination, regulation, monitoring and evaluation. The restructuring of ministries of health has, however, not been without problems in some countries. Problems have arisen from: inadequate capacity to manage, supervise, evaluate and regulate; weak control of human and financial resources; structural obstacles (such as the existence of vertical programmes); the absence or inadequacy of real managers; low motivation of health workers and their resistance to change; lack of relevant legislation to back up some reform policies; decentralisation of ministries of health going beyond general administrative/political decentralisation; and ineffective inter-sectoral collaboration and action for health.

Decentralisation has been viewed as a relevant means for the implementation of primary health care because

communities and districts are involved in priority setting and decision-making. Decentralisation has a spectrum: from deconcentration through devolution to delegation and privatisation. It is often equated with the devolution of responsibility to local government agencies, or taken as a dynamic process of changing relationships between the centre and the periphery. The functions which are being decentralised and the actors involved vary from country to country. The way decentralisation has been implemented has also varied widely in the Region. Examples include Zambia's most radical intention in the planning for the election of autonomous District Health Boards, which are expected to receive extensive powers from central government in areas of resource allocation, manpower recruitment and management. In Mozambique, decentralisation has so far taken place within the health sector itself. In Botswana, Nigeria and Tanzania, the process has taken the form of transferring sectoral responsibilities to elected lower-level governments. Effective implementation often proves difficult for various reasons, including: reluctance by the central level of government to transfer the necessary powers, non-transfer of resources to the local level, lack of the right management skills and, sometimes, because the accompanying changes/supporting roles that are needed at the central level (e.g., monitoring), are not in place.

The need to ensure greater collaboration between the public and the private sectors (for-profit and not-for-profit) has been generally realised in most national health sector reform programmes. It is believed, among other things, that greater involvement of the private sector would enhance effectiveness and efficiency by allowing the state to concentrate on health promotion and the provision of essential services. The status of cooperation between churches, non-governmental organisations and the public sector in the delivery of health services is good in some countries. However, many countries are still experiencing difficulties in defining the scope of the private sector or in harmonising private sector activities with national health objectives. Appropriate legislation and regulations are absent or inadequate in many cases.

Contracting out of services entails shifting partial or complete responsibility for the provision of health care to the private sector, while the responsibility for financing remains with the public sector. For a country's internal markets to work well, a minimum level of information and managerial skills are required. This is to enable the purchaser, the Ministry of Health, or the District Health Board, to identify the best providers and to negotiate contracts with them. Several countries in the Region have some experience in contracting out services with the private for-profit sector. The experience of Lesotho in contracting out non-medical services, such as catering, is relevant to many other developing countries. However, owing to the small size of the country's private sector and limited access to capital, only two companies could bid for the contract. The supplier, being in a powerful position, was able to charge more than the competitive rates. In Uganda, NGOs and private health care providers are developing contractual relationships with the state. In Zimbabwe, the contracting out of support services is on the drawing board, and a unit has been created which would be responsible for market-testing, drawing up contracts and monitoring the implementation of the contracts to be drawn up for hospital security, catering, cleaning and laundry services. For practical reasons, the Zimbabwean exercise will be limited to large central hospitals, which are located in urban areas where the private sector is relatively strong. Some examples of contracting out of medical services are available in a variety of forms elsewhere. In Namibia, surgical care in rural areas is often carried out by medical teams in private practice under contract with the MoH. Such teams are remunerated on the basis of the workload (sessions) and the number of procedures undertaken. Zambia and Zimbabwe have experience in developing contracts with many hospitals to provide services to their eligible populations.

Many countries have adopted the strategy of defining a package of essential health services and have started its implementation. A number of activities have been undertaken

within this context such as: conducting necessary surveys, defining health profiles of states/provinces and districts/local government areas, and conducting assessments of implementation. Two major reasons why countries have defined packages of essential health services are to enhance access by the population to essential health care and to improve the allocative efficiency of health care delivery facilities. While the packages defined are similar across African countries, varying approaches have been adopted in defining them. Two approaches seemed most popular, however. Some countries have simply adapted the district health package, as defined by WHO/AFRO, to their local realities. Other countries have, however, done their own independent assessment of their priority areas, through analytical assessments of the burden of disease and the cost-effectiveness analysis of interventions. Most countries expect the packages to be delivered in public health facilities. Uganda is one of the few countries that is encouraging the private sector to be involved in the provision of the defined services by providing support to NGO facilities for the delivery of the defined package of services.

Many countries are moving towards integrated service delivery, which they see as sustainable, efficient and convenient for both providers and users. Many, however, have tended to adopt different approaches to integration. Ghana has tried to integrate vertical programmes into functional groupings linked in a single entity; integrated health centres in Cameroon have tried to enhance the integration of promotive, preventive and curative services; the emphasis in Botswana is on the integrated planning of comprehensive services; and Tanzania has adopted the 'supermarket' approach for the integration of all essential health care interventions for mothers and children. However, integration of health services versus vertical programmes is a major challenge in the Region and service fragmentation is still a serious problem. The Integrated Management of Childhood Illness, Integrated Approach for TB/HIV Patients, the Mother and Baby Package, and the Integrated Vitamin A and Anti-polio Vaccination, are some of the encouraging examples being implemented in the Region.

The health facilities which provide primary health care at the base are rapidly expanding and, thereby, enhancing access to health care. In some countries, however, these facilities have been neglected. The rate of use of public health facilities is still generally low as a result of difficulties relating to accessibility and poor quality of services, both in terms of technical quality and users' perception of quality.

The success or failure of many health reform measures depends on the way they affect people's perception of service quality. Access to drugs and to functioning equipment, proper location of health facilities, properly trained health workers who are polite and sympathetic to patients, a clean facility environment, reasonably short waiting periods for service,

are some of the factors that contribute to quality as perceived by the consumer. Many countries have attempted to enhance quality by: introducing user fees and allowing a facility to retain some or all of the revenue it generates; developing a national drugs policy and or an essential drugs list to ensure greater access to essential drugs at affordable prices; and improving the planning and management of the acquisition of health services' physical infrastructure and equipment. Inadequate financial resources for health care delivery, inadequately motivated health workers, absence of relevant policies, and lack of appropriate management/technical expertise are some of the reasons why significant improvements in the quality of health services is beyond the reach of most countries in the Region.

In the face of increasing demands for health services, all countries in the Region are anxious to further mobilise public budget resources and at the same time explore new modalities of financing. Even so, not many countries have succeeded in putting in place sustainable health care financing policies and strategies. The health budget of most countries is still small, hardly exceeding 6% of the overall public budget and in many cases the allocated budget is poorly managed from the central level. The efforts of ministries of health to obtain more public funds are hampered by the fact that health is still accorded a low priority in many African countries.

Only a few countries have been able to adequately re-orientate their budgets, particularly capital budgets, towards primary and preventive health care. Generally, African countries are still highly dependent on external funding since they have not been able to adequately broaden their financial resource base. The management of available health resources is improving generally, but inefficiencies persist.

Cost-recovery measured have been frustrated by low household incomes and the poor quality of care, particularly in the public sector. The introduction of fees has also temporarily excluded the poor from benefiting from essential health services, especially where exemption policies are either not clear or difficult to effectively enforce.

Very little experience has been acquired with any form of implementing the risk-sharing strategy in the Region. Eight countries have had some form of social health insurance. Among them, only Kenya has a sizeable scheme, although it is limited to coverage of hospital services. At least five other countries (Ethiopia, Ghana, Mozambique, Nigeria and Zimbabwe) have started or are about to start social health insurance schemes. Some countries are considering extending the range of benefits provided under existing social security systems. Others have community-based schemes (Burundi, Guinea-Bissau and Zaire) already established while such schemes are still at the pilot stage in some countries, such as Tanzania. Mali has established

Table 5: Specified Factors Constraining the Implementation of Health Sector Reform Programmes in African

Serial No.	Factor	Number of countries that indicated factor
1	Political instability and civil strife	10
2	Lack of national policy/plan/legislation/reform guidelines	5
3	Lack of political will and commitment	2
4	Frequent changes in the Ministry of Health	1
5	Lack of appropriate health information system	6
6	Ineffective coordination	2
7	Inadequate human resources/absence of human resources for health plan	14
8	Inadequate financial resources	14
9	Inadequate private sector involvement	1
10	Resistance to change	8
11	Poverty	7
12	Inadequate participation of the people	2
13	Inadequate institutional capacity	9
14	Ineffective inter-sectoral collaboration	2

community health centres as an innovative way of financing and providing services. The Bamako Initiative has been implemented with varying degrees of success in most countries of the Region.

Problems of Implementation

Although, as seen in the preceding sub-section, some progress has been made by various countries in the implementation of their health sector reform programmes, much still remains to be done in order to adequately improve the performance of health systems and services and appreciably improve the health status of African populations. The limited achievements are attributable to a number of factors that have constrained the implementation of health sector reform programmes in the Region. Table 5 summarises the relative importance of such constraining factors as indicated by the countries themselves.

The table shows that the most significant constraining factors have been: inadequate human resources/absence of human resources for a health policy/plan; inadequate financial resources; political instability and civil strife; inadequate institutional capacity; resistance to change, even by potential beneficiaries of health sector reform outcomes; increasing poverty; lack of an appropriate health information system; and lack of clearly defined national health policy/plan/legislations/reform guidelines. This means that African countries would need to direct their efforts at overcoming the identified problems if their health sector reform programmes are to achieve the desired goal and objectives.

The Lessons Learned

In the course of the development and implementation of their health sector reform process, African countries indicated some lessons that they had learned. The major ones are grouped into four categories and presented below.

General

- Health sector reforms are neither cheap nor easy to implement.
- Health sector reforms need a multi-sectoral approach to succeed.
- The reform process involves a long period of learning.
- Reforms involve a complex, dynamic and long-term process, which should be implemented in a systematic way.
- There is no universal or standard methodology for conducting health reforms.
- Reform, being a process of innovation, always meets resistance, even among those who are supposed to be its beneficiaries.
- Consensus building is a stage whose achievement requires time and perseverance and it is always necessary to work towards maintaining it.

- The views of all stakeholders are important and must be respected to achieve and maintain consensus-building.
- The clarity of health development strategic objectives, to which all sectors and other stakeholders are equally committed, is important.

Programme development

- Reform must be evidence-based.
- A national health policy, strategy or framework is necessary to guide reform.
- Realistic priority setting enhances a successful health sector reform.
- Health sector reform must be undertaken within the context of an overall public service reform.
- Peace and stability in the political arena is important.
- An appropriate legal framework is crucial.
- Learning from other countries' experiences can be very useful.

Process

- The reform process should be driven by Government.
- Donors can play a crucial role in the reform process, but they must not lead it.
- Political will and commitment at the highest level is needed to start and sustain the process.
- The reform process involves a long period of learning.
- Social participation in the reform process is critical to its success.
- The involvement of health staff of all cadres is crucial.
- Consensus building among all stakeholders, throughout the process, is important.

Implementation

- Adequate financial and technical donor support is crucial for implementing health sector reform programmes.
- The need for capacity building, including institutional strengthening, is vital.
- Reasonable stability of the main economic parameters and transparency in finances is very important.
- Monitoring and evaluation, as well as developing benchmarks for assessing progress, are important.

VI: THE ADOPTION OF SECTOR-WIDE APPROACHES (SWAPs)

History of Sector-Wide Approaches

There has been increasing recognition by some countries, together with their partners, that reform requires a comprehensive or holistic perspective of the sector.

In those settings, clients/countries have assumed increased power and confidence in dealing with development partners. In some countries, donors who have been advising clients to take a more comprehensive perspective in response to clients' appreciation of need, began to take a similar perspective of how they organised their assistance to the sector. The coherence in the thinking of both recipients and donors of aid has led to the development of new approaches that have been given various names, among which are sector-wide approaches (SWAs), sector investment programmes (SIPs), sector development programmes (SDPs), sector expenditure programmes (SEPs) or sector aid. While these concepts do not mean exactly the same, they share some common characteristics. For our purpose, the concept of SWAp is used to depict a new approach to reforming/developing a sector (e.g., health) and managing development assistance. The ultimate objective of most SWAs is budgetary support i.e. all sources of public financing (donor and government) would be disbursed against a comprehensive MoH budget. There are no recognised examples to date, however. This is because budget support can only result when the client country can persuade the partners to accept its goals for the sector, and that they it has credible track record in designing, implementing and monitoring a programme which is likely to achieve the stated goals.

Why SWAs?

The concept of sector-wide approaches (SWAs) has evolved for two major reasons. Firstly, is the shift in dialogue between donors and governments from overall structural adjustment towards public expenditure management. Secondly, sector-wide approaches have been viewed as a way of overcoming the limitations of the project-by-project approach or programme aid. Such limitations include: the difficulty in developing and implementing a coherent, single sectoral policy; the recurrent cost problems usually attributable to the project-by-project approach; the overstretching of national capacity as a result of multiple missions and different donor requirements; the need to staff separate project management units; undermining of organisational capacity-building because of the existence of parallel systems; the creation of 'islands of excellence in an underfunded sea'; and the problems associated with ownership and sustainability.

Major Characteristics of SWAs

What makes a SWAp preferable to the project-by-project approach lies in the following major characteristics of the former: a coherent policy exists for the sector; the practice of earmarking of money for a specific health activity (e.g., reproductive health) is eliminated or drastically reduced; external financing does not go directly to a project/

programme unit but to overall budget support; government-set priorities are followed rather than those set by donors or the global community; the development of comprehensive plans and budgets, common execution and monitoring arrangements, consolidated reviews and reporting processes become the norm; there is clear evidence of stakeholders' involvement in policy/programme design; and emphasis is on the institutional strengthening of the client, rather than strengthening the implementation-unit's capacity to manage projects.

The Development and Implementation of Health SWAs in the Region

From the country reports presented at the three inter-country meetings on the implementation of health sector reform programmes in the African Region of the World Health Organisation, several countries are either already implementing or developing health SWAs which are now seen as the ultimate stage that every country should strive to attain in their health sector reform efforts. The current list of African countries adopting the health SWAp (including those moving towards it) includes: Zambia, Ghana, Uganda, Ethiopia, Tanzania, Senegal, Mozambique, Sierra Leone, Lesotho and Uganda. Sierra Leone and Zambia were the first countries in the Region to develop Health SWAs. However, Sierra Leone could not start any serious implementation before the outbreak of civil strife. Zambia started in 1993 but the process became stalled after about five years of implementation. Ghana seems to be the most frequently quoted among the Health SWAp countries, while the potentials for its successful implementation in Uganda, Ethiopia, Tanzania and Lesotho seem higher than the Zambian experience.

Annex 1 shows country variations in the development and/or implementation of health sector reform programmes. Annex 2 contains the major benchmarks in the process of developing and/or implementing of Health SWAs in Zambia, Lesotho, Tanzania, Ethiopia, Ghana and Uganda. Annex 2 clearly shows country variations in the development and/or implementation of Health SWAs. It is yet too early, however, to speculate on the extent to which the variations might determine the successful implementation paths of the Health SWAs.

Changes Resulting from the Development and Implementation of Health SWAs

As a result of the development and implementation of Health SWAs, the following changes have been reported in some Health SWAp countries:

- improved diagnosis of problems of service delivery and access by the poor (Uganda, Tanzania and Zambia);

- linkage to a credible medium-term expenditure framework (MTEF) and a civil service reform process (Uganda, Tanzania, Mozambique, Ethiopia, Ghana);
- clear linkage between policy and implementation (most of the Health SWAps countries);
- policy thrust towards primary level services is beginning to be reflected in actual resource shifts (Ghana) and planned shifts (Uganda, Tanzania);
- per capita funding has increased for some governments adopting the SWAps strategy (Ghana and Ethiopia; planned increases in Uganda, Tanzania and Mozambique);
- decentralisation to the district level provides capacity development in financial and service management for the health sector (Ghana, Uganda, Tanzania, Ethiopia); and
- fund disbursement is taking place through government systems with joint reporting to government and donors (Tanzania, Mozambique).

VII: LOOKING AHEAD

The Challenges

Despite the ongoing reform efforts, the majority of the people in many countries of the Region still have limited access to quality health services. Community, intra-sectoral and inter-sectoral linkages are still weak. In addition, the existing health sector reform efforts are not adequately linked to both civil service and macroeconomic reforms. Dealing with these and other limitations of the existing health reform efforts constitutes one of the main challenges of health sector reform in many countries of the Region.

Most countries of the Region are still implementing vertical programmes or special health projects. The project approach has had many limitations, among which are: the fragmentation of health development project assistance; distortions in the allocation of resources; lack of broad-based sectoral policies and practices; weakening, rather than strengthening, of the national capacity to pursue health development; and the promotion of donor-driven health priorities, policies, and programmes. Getting donors to buy into national health development and health sector-wide development plans instead of supporting projects also constitutes a major future challenge.

With the introduction of more structured, more comprehensive health sector reforms in many countries, project managers have felt somewhat neglected and there is, indeed, the feeling in some countries that priority public health programmes have been sidelined. No country can afford to sideline priority public health programmes if its ultimate objective for undertaking health sector reform is to positively improve the health status of the population.

Therefore, an additional area of challenge is to ensure that public health programmes are accorded their rightful place in health care delivery systems and within the context of Health SWAps.

Donors are still playing the leading role in some of the countries of the Region; indeed, reform efforts are still seen as donor-demanded and driven. The national stakeholders, particularly the government and its people, are not yet playing the leadership role expected of them. Reversing this trend remains an important challenge.

National capacity (especially at the level of the ministry of health) for the development, implementation, monitoring and evaluation of health sector reform is still weak in many countries. Technical assistance for reform still comes largely from outside the country, even where there seems to be some potential capacity in national research and training institutions to provide much of the needed technical and managerial support to national health reform efforts. A major challenge is to optimally use internal resources to strengthen the national capacity for undertaking health sector reform.

The rising incidence of HIV/AIDS and its devastating effects in the African region represents the biggest threat to health and health systems. The increasing demand in the Region for health care is beyond the capacity of the health systems, in terms of the resources required for the provision of basic quality care. The demographic, economic and social effects of the pandemic pose a huge challenge to the operability and performance of health systems in most parts of the Region.

Future Perspectives

Governments should assume a leadership role in developing and implementing health sector reform programmes; thereby confining the role of the donor community to the provision of support to, rather than leading, the process. Donors would then be made to work within the framework of the strategic plan defined by the country to support the country's health reform efforts. The adoption of sector-wide approaches to overall country reform efforts might be the best way of forging successful partnerships. Such trend would also be facilitated by the successful approach to the implementation of the health component of the UN Special Initiative on Africa.

For African governments to successfully assume their leadership role, more attention will have to be paid to institutional development and support in the form of training, institutional building, and accountability and transparency, in funding. Successful reform does require countries to develop their capacities for analysing, monitoring and evaluating health systems and the outcomes of reform initiatives. Donors need to make long-term commitments to institutional support.

Appropriate and timely data, information, and knowledge are crucial to the conduct of health sector reform, and especially information generated through research and the exchange of ideas. The strengthening of the capacity of African countries to undertake and use research results as a basis for developing and implementing health sector reform programmes, and encouraging intra-country and inter-country exchanges of data, information, and knowledge in order to share experiences from health sector reform efforts, will be very important in future.

African Governments will have to develop new partnerships and strengthen existing ones in order to facilitate the successful development and implementation of health sector reform programmes, including:

- partnerships within the health sector (intra-sectoral partnership) in order not only to ensure the strengthening of the linkage between the central, intermediate and district/local systems, but also to empower all the elements of the health system to optimally contribute to the development and implementation of health sector reform programmes;
- partnerships with the public sector (inter-sectoral partnership) to provide other health inputs for the successful implementation of health sector reform programmes and also to minimise, if not eliminate, the possible adverse health effects of development programmes and investments in other sectors. The health sector is also expected to contribute to the development of other sectors such as education, agriculture and industry;
- partnerships with the community (including civil society) in order to ensure social participation and consensus-building for the health sector reform agenda; this will not only facilitate ownership but also foster the sustainability of reform programmes;
- partnerships with academic and research institutions and professional associations to provide verifiable evidence to guide the formulation and evaluation of health sector reform (in the case of academic and research institutions) and to formulate codes of ethics and maintain norms and standards in the delivery of health services (in the case of professional associations);
- partnerships with the private sector (including industries) for the provision and financing of health services, the conduct of research and the provision of support to development-related activities for the poor, in order to reduce poverty and enhance health development;
- partnerships with the media, since they offer some of the most cost-effective ways of advocacy and consultation with the people, policy makers and other key stakeholders, and also since they have the potential to inform, educate and even contribute to changing the health-related behaviors of the people and;
- partnerships with international organisations (bilateral and multilateral, including UN agencies) in order to mobilise and coordinate their resources (financial and technical) to support, rather than lead, the reform process.

From the varying country-specific experiences on the development and implementation of health sector reform programmes and Health SWAps, it is clear that countries in the Region are at different stages in the two different but related processes. Indeed, some countries are already identified as 'leaders' in certain areas of health sector reform. Some of the identified areas, with the corresponding 'advanced' countries are:

- the pooling of funds for health development (Zambia and Ghana);
- decentralization and management at Primary Health Care level (Zimbabwe, Seychelles, Tanzania, Zambia, Nigeria, Botswana);
- integration of community-based health and social services (Seychelles);
- development and implementation of Health SWAps (Lesotho, Ghana, Zambia, Mozambique, Tanzania, Ethiopia, Uganda, Senegal);
- promotion of a public-private mix (Lesotho, Zimbabwe, Malawi, Uganda);
- establishment of a national health insurance fund (Kenya);
- establishment of a community health fund (Tanzania);
- outsourcing and contracting out in the health sector (Lesotho, Namibia, South Africa, Uganda, Zimbabwe);
- definition and costing of essential health packages (Tanzania, Uganda); and
- budget support to provinces (Mozambique).

The noticeable or recognised differences among countries should be exploited to provide a basis for promoting or strengthening technical cooperation among the countries of the Region, through the exchange of visits and/or experts. As indicated below, WHO certainly has a critical role to play on this issue in terms of encouraging and facilitating such exchanges.

The Future Role of WHO

WHO, being more proactive in supporting countries, could concentrate on the following:

- (i) providing technical support for the generation of information and knowledge for health policy development;
- (ii) assisting countries to formulate and develop national health policies and relevant long-term health development plans that are consistent with the global Health for All policy and the regional health policy for the 21st century;
- (iii) supporting ministries of health to strengthen their leadership role in the health sector reform process;
- (iv) providing adequate support for the establishment of structures and mechanisms for the coordination of all partners involved at the country level;
- (v) contributing to the strengthening of country capacities, infrastructure and technology that can be sustained with available resources;
- (vi) facilitating technical cooperation among countries on issues related to health sector reform;
- (vii) developing guidelines for the monitoring and evaluation of health sector reform at country-level and providing necessary support to countries to adapt the guidelines to their individual context; and
- (viii) documenting 'best practices' with regard to health sector reform for the purpose of dissemination.

**ANNEX I:
HEALTH SECTOR REFORM IN
COUNTRIES IN THE AFRICAN REGION OF
THE WORLD HEALTH ORGANISATION**

Major Benchmarks of Some Countries

1 GHANA

- Strengthening of district health systems in the late 1980s that built on the PHC strategy
- National meeting on integration of services (the Sogakofe Forum of 1991)
- National meeting on decentralisation (Akosombo 1992)
- Reorganisation of the MoH (1993)
- Development of a medium-term health strategy
- Development of a 5-year Programme of Work

2 SENEGAL

- Adoption of the national health policy (1989)
- Creation of health districts and definition of the referral role of a health centre (1991)
- Preparation of the first decentralised health and social plans (1991-1995)
- Evaluation of the decentralised plans (1996) and realisation of the limitations of the project approach
- Development of the National Health and Social Development Plan as well as the Integrated Health Development Programme (1997)

3 NIGER

- Development of the Health Development Plan for 1994-2000 period (1994)
- Adoption of a health sector policy (1995)
- Assessment of the implementation of the health development plan (1998)

4 MALI

- Definition of the establishment of health structures at various levels of the health pyramid modeled on the country's administrative divisions (Social and Health Development Plan, 1981-1990)
- Adoption of a new health policy (1990)
- Preparation of a five-year Health and Social Development Programme (1998-2002)
- Preparation of a ten-year Health and Social Development Plan (1998-2007)

5 BENIN

- Adoption of the 1985-1989 Operational Strategy initiated the reform process
- Development of a new national health strategy for the period 1989 to 1993

- Reorganisation of the Ministry of Health
- Sectoral roundtable conference 1995
- Development of the national health policy and strategy for the 1997-2001 period

6 NIGERIA

- Introduction of primary health care programmes in place of the existing basic health services scheme (1986)
- Launching of the national policy and strategy to achieve health for all Nigerians (1998)
- Full devolution of the responsibility for the management and provision of PHC to local governments (1990)
- Setting up of the National Primary Health Care Development Agency (1992) after an external evaluation of the implementation of PHC for four years
- Organisation of a National Health Summit (1995) to critically examine the status, problems and challenges facing the health care delivery system in the country, with a view to charting a course for future action
- Development of the new national health policy (1996-2010)

7 ETHIOPIA

- Establishment of a National Health Policy Task Force (1992)
- Approval of a national health policy (1993)
- Development of a broad health sector strategy (1995)
- Various health sector studies conducted (1995-1997)
- Development of a health sector development programme consisting of a twenty-year framework, with rolling five-year programme periods
- Transformation of the existing six-tiered, centralised health system into a four-tiered system with appropriate functional linkages

8 CAMEROON

- Official adoption of the Alma-Ata Declaration and the implementation of the PHC strategy with the social objective of Health For All by 2000 (1982)
- Evaluation of the national health system (1998) and the birth of reform known as 'The Re-orientation of PHC'
- Adoption of a health sector policy (1992)
- Reorganisation of the Ministry of Public Health (1995)
- Development of the National Health Development Plan (1998-2008)

9 SIERRA LEONE

- National seminar involving all stakeholders aimed at reviewing the delivery of health care in the country (1992)
- Launching of the National Health Policy and Action Plan (1994)
- Revision of many laws and the enactment of new ones to legalise relevant sections of the National Health Policy

10 KENYA

- Introduction of cost sharing measures (1989)
- Development of the Health Strategy Note for the Republic of Kenya (1993)
- Development of the Kenya Health Policy Framework Paper (1994)
- Action plans to operationalise the Kenya Health Policy Framework Paper and the establishment of a Health Sector Reform Secretariat (February 1996)
- Reorganisation of the MoH (December 1996)
- Reconstruction of the Ministerial Reform Committee to oversee the implementation of the reform process (1997)
- Development of the National Health Sector Strategic Plan (1999-2004)

11 TANZANIA

- Liberalisation of the procurement of pharmaceuticals as a result of a drug policy (1991)
- Re-introduction of private practice, which had formally been banned in 1967 (1991)
- Introduction of cost sharing measures in level-three hospitals, followed systematically by level two and level one hospitals (1993)
- Formulation of a health strategy note as a result of the dissemination of "Investing in Health" brokered by the World Bank (1993)
- Formulation of the proposals for health sector reform (1994)
- Developing a health sector action plan which had been reviewed from time to time (1995)
- Development of the programme of work and plan of work for health sector reform, 1998-2001 (1997)
- Revision of the Health Sector Reform (HSR) programme, 1996-1999, and the development of an HSR plan of work, 1999-2002, taking into account the use of Sector- Wide Approach. (SWAps) - 1998
- Development of a sector plan of action incorporating government and donor funding, with some donors agreeing to the pooling of funds at both central and district levels (1999)
- Development of the financial system for the management of the joint basket funds (1999)

**ANNEX II: THE MAJOR BENCHMARKS IN THE
ANNEX II:
THE MAJOR BENCHMARKS IN THE
DEVELOPMENT AND IMPLEMENTATION OF
HEALTH SECTOR-WIDE APPROACHES (SWAps)
IN THE AFRICAN REGION**

1 ZAMBIA

- 1991: The new government inherited the following problems in the health sector: low-level confidence, poor quality, capacity, and financing, and epidemics including, HIV/AIDS, etc.
- 1991 (January): Health Sector Policy Conference in Livingstone
- 1991 (Nov/Dec): Translation of the MMD Manifesto into Radical and Reforming National Health Policies and Strategies (Health Reforms)
- 1992 (March): The adoption of a Blue print-Corporate Plan Framework
- 1992 (June): The write-up of a Corporate Plan by a Task Force (Agenda for Health Reforms)
- 1992 (October): Cabinet adopted the National Policy Document
- 1992 (December): Creation of a Health Reforms Implementation Team
- 1993 (Jan-March): Consultations with Districts and Provinces for the initiation of a needs assessment
- 1993 (April): Ministry of Health issues Statutory Instruments
- 1993 (to date): Implementation of a Health SWAps

2 LESOTHO

- 1979: Adoption of PHC
- 1980: Adoption of the HSA Concept
- 1981: Creation of DHMT and HSAT
- 1982: District Management Improvement Project launched
- 1993 (July): National Health Policy Workshop
- 1995: Round Table Conference
- 1995: Setting up of Task Force
- 1995-1996: Creation of a Health Reform Team
- 1997-1999: Working Groups on Health Sector Reform formed
- 1998-1999: Health Sector Workshops
- 1999 (May): Pre-Appraisal mission
- 1999 (July-Sept.): Consensus Workshops
- 1999 (October): Adoption of HSIP
- 2000-2001: Implementation of the HSIP

3 TANZANIA

- 1994: Development of the proposal for health sector reform
- 1995 (February): Proposal for health sector reform turned into the Strategic Health Plan for 1995-1998
- 1995 (October): Joint mission of the Government and donors to appraise the Proposals and Strategic Plan for Health Sector Reform
- 1996 (May): Development of the Health Sector Reform Action Plan for 1996-1999
- 1996 (July): Implementation of Reform Plan started
- 1997 (Beginning): Decision to broaden the scope of the reform plans in view of on-going trends to develop a sector-wide improvement programme (SIP)
- 1999: Development of Health Sector Programme of Work (PoW) for July 1999 - June 2002 in order to implement Tanzania's health policy, building on the earlier health sector reform proposals and plans. The PoW was not a new plan, but a framework plan that broadens the scope of earlier plans to sector-wide approaches (SWAs)
- 1999: Translation of the three-year PoW into a more fundable Plan of Action (PoA) covering one year (July 1999 to June 2000) and based on the result of joint MoH/Partners consultations

- Projection of the financial requirements for the implementation of health sector programs
- Projection of macro-economic growth for the next decade
- Participatory assessment, problem identification, and development of the first five-year health development plan for all the eleven administrative units and the central government
- Required resources to implement the sector programmes identified, quantified and pledged by all stakeholders
- Pre-appraisal, appraisal and negotiation missions conducted for IDA and ADB sources
- Common implementation arrangements, system of governance, monitoring and evaluation developed and agreed among all stakeholders. Various documents detailing these, such as regional and central plans, the Programme Action Plan (PAP) and a Programme Implementation Manual (PIM) developed
- Management structures established, including the Central Steering Committee, Regional Steering Committees, HSDP Secretariats at MoH, and Regional Health Bureaus
- Indicators for monitoring and evaluation developed and agreed upon by all stakeholders

4 ETHIOPIA

- Establishment of a National Health Policy Task Force mandated to evaluate the current status of health services, identify major health problems and develop a health policy within the framework of the Government of Ethiopia's policy of democratisation and decentralisation
- Review and revision of the Task Force's draft report by a selected group of people
- Adoption of the health policy
- Assessment of the health sector carried out in 14 different studies
- Development of a broad health sector strategy. Development by a Task Force of a health sector development programme, consisting of a 25-year framework, with rolling five-year programme periods

5 GHANA

- Introduction of District Health Management Teams (DHMTs) in recognition of the need to move away from vertical programming and to improve horizontal links and coordination between programmes (1978)
- Regulations hospital fees (Legislative Instrument 1313) introduced in 1985 in an attempt to improve health sector financing, marked the beginning of the present wave of health sector reform measures in Ghana
- Strengthening District Health Services started in 1988 to provide additional planning and management skills for DHMTs
- Ministry of Health recognised the need to develop an effective health sector plan in 1989, but realised it lacked capacity to do so and, therefore, started a capacity-building programme for senior-level staff

to provide the requisite planning and management skills for the new approach. The MoH also started a more serious policy dialogue with a number of health sector donors.

- National meeting held in 1991 to consider issues of integration and coordination of services and also to review and revise national health policies
- The Ministry of Health conducted a seminar for regional directors and divisional heads at Akosombo in 1992 as a follow-up to the 1991 national meeting. The outcome of that seminar has become popularly known as the 'Akosombo recommendations'. A national health policy unit was established at this stage
- A national, broad-based consultative meeting on health and development was held in September 1993, which set an agenda for the review of national health policies in Ghana. The deliberations eventually resulted in the setting up of working Groups to consider future strategies for health sector development. The initiative is considered to be the beginning of the process to develop a health sector strategy framework
- Preparation of a short-term document, entitled *Policies and Priorities for Health Sector 1994-1995* (at a time when donors were increasingly less concerned with single projects and more with longer-term sectoral and institutional developments for health)
- Development of the Medium-Term Strategic Framework (MTSF) for Health Development, 1996-2000, with the assistance of the World Bank, DFID and UNICEF
- The evolution of the MTSF into the Medium-Term Health Strategy; Towards Vision 2020 which set out to provide a more focussed framework for guiding reform and development of the health sector
- The Medium-Term Health Strategy was operationalised by the development of a five-year Programme of Work (PoW), the backbone of the health sector-wide programme
- The enactment of the Ghana Health

Service (GHS) and Teaching Hospital Act 525 (1996), the key institutional reform under PoW, establishing the Ghana Health Service to administer and manage institutions in the health service. The Act also provides for District Health Committees (DHCs), a new structure outside the present District Assemblies. The main thrust is to: separate service delivery from policy and planning for the sector as a whole, replace centralised planning with a decentralised management, and move towards the management by objectives (MBO) strategy

- A draft Memorandum of Understanding (MU) between the Ghana Government and the major partners of the donor community, and common implementation strategies agreed in principle, later for 1997
- A Code of Conduct for all partners worked out by consensus to guide the behaviour of the MoH and its health partners concerning the sharing of information, technical assistance, financial management, performance monitoring and the annual review process
- A revised Memorandum of Understanding for cooperating partners (those organisations that support the common Health Account) now in operation

6 UGANDA

- Introduction of the concept of a sector-wide approach to GoU, donors and other stakeholders (April 1997);
- Undertaking of a joint review by SIDA, WHO and DFID to determine whether conditions were favourable for adopting a sector-wide approach (September 1997);
- Invitation of GoU to donors to support a Health SWAp (January 1998);
- Drafting of a health sector investment and strategic plan (September 1998);
- Development and signing of an aide memoire outlining consensus on how the SWAp should be approached (October/November 1998)
- Holding of a Consultative Group Meeting to review programme development plans (December 1998);

-
- Holding of a Joint MOH/Donors Workshop to develop programme goals, objectives, targets and indicators and also to draft the programme logframe (April 1999);
 - Holding of GoU/Donors Consultative Meeting in Geneva; endorsement of the new health policy as the basis for the SWAp; and agreement by some donors to contribute to a Partnership Fund in order to support SWAps development (May 1999)
 - Finalisation of the national health policy and its approval by Cabinet (September 1999);
 - Holding of GoU/Donors Consultative Meeting in Kampala to review progress on preparation of the Health SWAps. Signing of Statement of Intent by some of the development partners present and soft endorsement of revised strategic plans given by donors (October 1999);
 - Holding of First Joint GoU/Donors mission to plan next steps with regards to cost and financing SWAp process priority technical programmes and procurement and drug management (October 1999); and
 - Finalisation of the Health Sector Strategic Plan (HSSP), 2001/1 – 2004/5 (August 2000)