

Translations of Sector-Wide Approach Programmes

A comparative study of the organizing and coordinating of development cooperation in
Bangladesh, Uganda and Zambia

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Introduction

Bilateral and multilateral development cooperation agencies are to an increasing extent promoting and adopting a sector-wide approach (SWAp) in their development cooperation. The Swedish International Development Cooperation Agency (Sida), for example, joined their first sector-wide approach cooperation in the late 90s, and today they are involved in SWAps in countries in Africa, Asia and Latin America and they are in the planning phase for collaborating in setting up SWAps in an additional number of other countries. Many other development agencies are also moving in the same direction. The idea of a sector-wide approach has so far been most frequently adopted in health sector development but the approach is spreading to other sectors, like education and infrastructure development, as well.

Since the idea was first conceptualised in 1997 there has been an increasing number of articles, reports and evaluations published concerning sector-wide approaches¹. While much has been written about the SWAp idea, there are however still limited documented experiences of how this method works in practice. This paper reports on a comparative analysis of the health sector SWAps in Zambia, Uganda and Bangladesh where we analyse how various partners and stakeholders are integrated in the sector-wide approach programmes

¹ See for example; Cassels, 1997; Foster et al 2000; Peters and Chao 1998; Walt et al 1999a; Hill 2002

and to what extent they share views of aims and procedures of SWAp. We also analyse who is involved in the coordination process, what they are coordinating and how this coordination under a SWAp evolves in practice.

A SWAp to health assumes and seeks to add to an extended coordination between and among stakeholders to health sector development. The aim of a SWAp is to base development activities on an analysis of the sector as a whole and in such a way take all stakeholders and aspects of a sector into account. Increased coordination is supposed to generate national ownership of the development process for the government and allow for a more efficient use of resources. Our analysis shows that meanings and implications of SWAp differ considerably between and within countries. In Uganda, Zambia and Bangladesh, more or less every development partner and government representative we interviewed for this study supports working with a sector-wide approach. Over and again, in meetings and interviews, the majority manifest their strong commitment towards a sector-wide approach. When we met with them individually, however, to ask about their views on, and experiences with, SWAp we found that the view of SWAp is far from identical among the different actors. A group of representatives defined SWAp as being a coordination and partnership approach to development cooperation. They used formulations like: “SWAp is agreed upon strategies and agreed upon priorities”, “inclusion of all funding agencies in the SWAp is more important than making everybody provide budget support” and “a SWAp is making all partners work in the same direction” when defining SWAp. Other representatives expressed the view that a SWAp implies that all partners should commit to pool their financial resources into a common basket for the health sector or that all development partners should provide untied general budget support if they are adopting a sector-wide approach.

The analysis of how SWAp is defined differently by different actors shows that depending on how SWAp is understood, different aspects of coordination and of policy development appear important. Depending of how SWAp is translated into action, the roles of the actors involved, and ways of coordination differ.

To understand how coordination under a SWAp evolves in practice we need, first, to more closely examine the ideas promoted with the concept of a sector-wide approach. The sector-wide approach concept was developed as a response to the dissatisfaction with project aid and the aim was to address the perceived shortcomings of working mainly with projects in

development cooperation.² Contrary to project aid, a sector-wide approach aims at being *sector-wide* in character, to *increase ownership* of the partner government and *increase coordination* of procedures, activities and funds of stakeholders in the health sector. We will now look closer at these three terms to see how a sector-wide approach is supposed to improve efficiency and effectiveness in development cooperation.

Sector-wide – Project aid was considered to be too narrow in focus and too vertically oriented, not taking into consideration sectoral development as a whole. Projects were often aimed at targeting a specific problem, for example maternal mortality or HIV prevalence, in a specific region. In a sector-wide approach, the government and its’ development partners are supposed to consider the strategic development of the entire sector. There is supposed to be a jointly agreed upon analysis of the sector that gives a common picture over the current situation and provides strategies for how to work together to achieve the development goals. A problem when discussing sector-wide however is: How do you define the sector boundary? Problems with water and sanitation for example have large implications on people’s health, but it is usually not considered as a part of the health sector.

Increased Ownership – Being largely driven by the development agencies, project aid was seen, by those promoting SWAp as an alternative, as undermining ownership for the partner government over sectoral development. When project aid dominated, the government was not in control of activities in the sector. Projects were often initiated and driven by the development partners and the government lacked influence over setting priorities. With a SWAp, the partner government is supposed to be in the “driver’s seat”, taking the lead in sectoral development. But what exactly does “increased ownership” mean and, and what happens if there is a conflict of interest between the development partners and the government?

Increased Coordination – With project aid, the projects that were run by different multilateral and bilateral agencies were often being criticised for being uncoordinated with the activities of other development partners, the government, NGOs and other health service providers. With a sector-wide approach, the aim is to increase coordination of all stakeholders in the health sector, the development partners, the government, NGOs, private providers, mission

² Peters and Chao 1998

hospitals, civil society etc. to avoid duplication and instead create an overview of existing needs and available resources in the sector. Increased coordination is thereby supposed to allow for more efficient use of available resources. The ambition to increase coordination is appealing but it raises several questions that we will address; What should be coordinated? How should it be coordinated? And, who should be responsible for coordinating?

The three SWAp features presented above provide the structure for the comparative analysis in this paper. The review of how the SWAp concept, in respect to *sector-wide, increased ownership* and *increased coordination*, is defined in literature, in a country context and in action allow us to analyse how coordination evolves in practice in Uganda, Zambia and Bangladesh. We can see that in order to achieve a sector-wide approach that increases government ownership and increases coordination of stakeholders, frameworks for coordination have been built in each country. A comparative analysis of the translation of SWAp, and coordination within the SWAp framework, adds to our understanding of differences between the initial concept of SWAp and how it operates and evolves in practice.

In the first empirical part of this paper we will start off by looking closer at what the idea behind a sector-wide approach is. We then move on to examine how the SWAp concept has been translated into a country context and finally how it is translated into action among stakeholders in the health sector. The second part focuses on how different stakeholders are coordinated in a SWAp. We examine who is involved in the coordination of the SWAp, what they are coordinating and how they are coordinating it. The analysis that follows is concerned with how the concept of SWAp is translated into action in the country context and how these translations affects how coordination of a SWAp is organised in a country context. Finally we present a case about an event in Bangladesh that has put the concept of sector-wide approach to the test. This case serves to illustrate how the different translations of SWAp surface and create obstacles when there is a conflict between involved partners. In our concluding remarks, we reflect around possible explanations for the attractiveness of adopting a sector-wide approach to health.

This paper builds on a literature review, interviews and participation in various committee meetings, review missions and policy dialogues. Literature reviewed consists of research papers, reports and evaluations on sector-wide approaches as well as a review of official documents concerning health sector development in Uganda, Zambia and Bangladesh.

The literary review provides an understanding of how SWAp was first defined in a general context but also how it has been formally translated into a country context. It also provided information about how the SWAp coordination framework is designed in each country.

One month was spent on location in each country to conduct interviews and sit in on meetings. We visited Uganda in October 2002, Zambia in November 2002 and Bangladesh in late February/March 2003. During our visits we met mainly with representatives for development partners³ and the government. We also conducted a limited number of interviews with various NGOs. In Uganda and Zambia, a number of interviews were also made with representatives for local sector administration and hospital and health centre staff. In Uganda and Bangladesh, we participated in both regular meetings between development partners and the government as well as the larger, annual (Bangladesh) and bi-annual (Uganda), review meetings between a large number of stakeholders in the health sector. In Zambia, we participated in three weekly meetings held between the government and the development partners. The interviews and the participation in various meetings provided information on how SWAp is being defined in action and how coordination of different stakeholders evolves in practice. We have chosen not to disclose which development partner, government representative or other stakeholder that has made what statement. Before turning to our data we present a framework for analysing translations of a trend such as SWAp. In presenting this framework we will draw some parallels to what we see as similar processes in the sense of models and ways of organizing that have spread around the world.

SWAP: a global trend that displays variations

We have noted a remarkable increase in writings about SWAp. The approach has become widely referred to and promoted, to the extent that one can talk about the proliferation of this form for development cooperation as a more or less global trend. Features of the model, its circulation and the way it is being adopted and pursued in practice partly resemble several other models for organizing, coordinating and pursuing development that have been widely circulated and thus form such more or less global trends. The models we are thinking of are not only models for multilateral development cooperation, but more generally widely circulated models for how to manage, develop and reform certain organizations, societal

³ Development partners are defined as those bilateral and multilateral development agencies that are formal partners to the government in health sector development in each country (i.e. the development partners that have signed the a Memorandum of Understanding with the partner government).

sectors or administrative structures. From the late 1980's national public services around the world have been reorganized in ways that are at least similar enough to fit under the same label: "New Public Management"⁴. During the last decades, governments around the world have established specific agencies for science policy – and these establishments have been designed in strikingly similar ways, even when governments and nations appear extremely different. Specific state science bureaucracies and state science policies have spread to the extent that this reconstruction of governments forms a global and globalized trend⁵. Not only national governments, but organizations more generally, tend to reform in similar ways during certain periods of time, so that they come to appear as increasingly similar – at least in the way they are formally structured, the way in which they present themselves and the way in which they are identified and perceived by others (cf Meyer and Rowan 1977).

Such trends are formed as several country administrations introduce reforms along similar lines. In addition to the reforming units, there are a number of observers and mediators of reform ideas and experiences, such as international organizations, researchers, consultants and other expert groups. They produce and provide information and comparisons, report on and propose initiatives for change and act as arenas for the exchange of experience, ideas and ideals. They assess reforms and publish guidelines for how to reform. These mediators do not only report about and transport ideas and experiences between reformers. They turn their attention to certain reforms and to certain aspects of reforms, and when doing this they also direct others' attention to certain aspects of the reforms. Moreover, they frame ideas and experiences, transforming them in the process, and they teach countries how to reform⁶. Thus, parallel to and interwoven with local reforms, which are pursued in individual settings, more or less global templates are produced by the many observers, assessors, researchers and international organizations tracking such reforms. These trends thus takes the form of a kind of transnational network where similarities and differences among countries partly follow from the way in which international organizations, researchers and other experts present the models to be followed and the settings in which models are to be introduced. In such a world where ideas are frequently transported between distant settings, and where local practices are monitored at large distances, presentations of reform ideas as well as of local practices become extremely important.

⁴ See e.g. Hood 1995, Christensen and Laegreid 2001

⁵ Finnemore 1996; Drori et al 2003

⁶ Finnemore, 1996.

Apparently, some models for development and for organizing have flowed more rapidly and extensively than others and they have flowed better in some settings than in others. Once we start analysing and comparing models, however, it is difficult to distinguish any intrinsic success criteria for models that will “make it”. Widely spread models are usually argued for in terms of positive consequences. In line with such arguments one might expect that late adopters of models follow in steps of early adopters, as the consequences of adopting the model became evident. However, even though writings about widely spread models normally abound, it is generally difficult to find systematic reports of effects of such popular reforms. This is partly due to the fact that it appears very difficult to measure the effects of adopting the widely spread models, and to compare effects. As we will describe in somewhat more detail below, models turn out to be very different in practice and the consequences of adopting and pursuing individual models are usually clearly difficult to distinguish from other contemporary changes⁷. It appears not so much a case of models flowing because they are powerful, but rather, of models becoming powerful as they flow. For example, some ideas seem to become popular, not primarily because of their properties but because of who transports and supports them and how they are “packaged”, formulated and timed⁸. Certain models become popular, legitimate, and even taken for granted as being effective and indispensable as a result of having been adopted by some actors in the field⁹.

We can, however, identify a few characteristic features of recent globally spread models. These models are clearly associated with science in at least two ways, and hence they express an ongoing scientization of society¹⁰. They are argued for with scientific arguments and with the help of expertise. It is almost unthinkable that a model would claim universal applicability in today’s world without being associated with or supported by the reference to scientific expertise and scientific studies. Secondly, models for organizing, developing and coordinating tend to contain large portions of analytical and rational procedures. Ways of analysing certain settings and circumstances usually form the first step of prescribed procedures, and the measuring of results form a concluding step. The SWAp concept is clearly formulated along

⁷ This statement should, of course, not be read as an argument against systematic studies and comparisons of consequences. Rather the reverse, this paper should be read as an argument for more comparisons and studies of models in practice, even if such studies and comparisons are often impaired with difficulties and somewhat unclear results.

⁸ Czarniawska and Joerges 1996; Røvik 2002; Sahlin-Andersson and Engwall 2002

⁹ Tolbert and Zucker 1983; Westphal et al. 1997

such lines as the coordination assumes a comprehensive analysis, on which all partners agree, of the sector, its problems and prescribed measures to take in order to solve the problems that have been identified.

Acronyms such as TQM (Total Quality Management) and NPM (New Public Management) have become so widely known that they almost appear as part of ordinary vocabulary. When it comes to more precisely define the meaning or content of these acronyms, however, these widely spread models appear much less precise. A brief look at such widely disseminated ideas and ideals for how to manage and organize shows that they consist to a large extent of well-packaged and labelled techniques or models that seem to travel easily between settings and spheres. They are ascribed acronyms so that they can easily be referred to and recognized. They are often summarized in terms of checklists, procedures and techniques that are easy to present and seemingly easy to apply. At the same time such ideas are formed in very general terms in such a way as to claim almost universal applicability. This means that those models appear appropriate and possible to apply in many, also quite different settings, but it also means that the models are so generally formulated that they do not give very precise directives for those seeking to use widely spread models as guidelines for how to act. The vagueness of widely spread ideas makes them attractive and applicable for many to adopt, but it also means that ideas are being translated differently by different actors and in different settings. So, widely spread ideas combine specificity and vagueness. They tend to be precise in the way they are labelled (with acronyms) and many widespread models are associated with a few key words, checklists and also prototypical examples. As such models are being applied in different settings, they tend to be understood very differently. Sometimes widely spread models are imported, but do not trigger changes in the local setting. The way in which local practices are presented may change, but procedures and practices remain the same as they have been previously – under a different label. In other settings and at other times, the adoption of such models entail more fundamental changes in local practices and structures.

Each time when an idea – whether in terms of mediated experiences or more structured models – is transferred from one setting to another, this same idea is subject to translation. Those presenting ideas structure and edit them in ways that are shaped by their willingness not adapt their presentation to the listener or their audience and by their experiences and their

¹⁰ Drori et al. 2003).

situation more generally. And the listener or reader similarly translates the model in relation to their situation, wishes and expectations¹¹. Clearly, we cannot presuppose that just because a country or a set of organizations announce that they are reforming along a certain model their practice is formed along the lines of the model as it is understood by mediators or other adopters of the same model, or along the lines of their announcement. Many models may give rather precise directives for how to present and account for activities and practices, but to restructure such practices may be a different matter. Even if techniques for how to proceed and to account, checklists and references sometimes appear quite precise, the aims and norms of the models may be subject to fundamental transformations as models spread. Moreover, as emphasized above, widely spread models are normally framed and formulated in general and vague terms and thus have to be translated and filled with meaning as they are adopted and pursued locally. Studies of widespread models, and how they are pursued and followed in practice, have repeatedly found decouplings between talk and action, between formal plans and practice, between activities and accounts, between managers and operations, and between various groups of actors¹².

Comparative studies of how SWAp is organized and introduced and the consequences hereof thus need to be open to the different translations made in different settings and situation. We have designed this study so that it will be open to different translations of SWAp and to what consequences for coordination and action that such differences in entail. The design of the study can be summarized in the following table:

	ZAMBIA	UGANDA	BANGLADESH
SWAp: the general idea	General documents published by researchers, experts and multilateral organizations		
Swap definitions in a county context	Formal documents and agreements published in the country	Formal documents and agreements published in the country	Formal documents and agreements published in the country
Swap in action	Observations of meetings, interviews with individual actors in order to explore and analyse how SWAp is translated in active situations, and	Observations of meetings, interviews with individual actors in order to explore and analyse how SWAp is translated in active situations, and	Observations of meetings, interviews with individual actors in order to explore and analyse how SWAp is translated in active situations, and

¹¹ Czarniawska and Joerges 1996; Sahlin-Andersson 1996, 2001; Sahlin-Andersson and Engwall 2002.

¹² See e.g. Brunsson and Olsen 1993; Brunsson 2003

	what consequences for coordination that such translations entail	what consequences for coordination that such translations entail	what consequences for coordination that such translations entail
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Figure 1: Design of study

Developments and definitions of SWAp

Before SWAp was conceptualised in the mid 90s, the most widely used form of development cooperation in the health sector was project aid, where development agencies financed and supported individual projects in the health sector. The development of SWAp was stimulated by the dissatisfaction with the effectiveness of traditional, project-based, development assistance¹³. Supporters of SWAp claim that project aid carries with it a set of negative effects like inefficient use of resources and lack of sustainability in development cooperation and SWAp has been marketed as a way of coordinating development cooperation in order to overcome these drawbacks. The World Bank has been promoting SWAp since the late 1980s, but it was not until the mid 90s they started to get positive response from development agencies¹⁴. To illustrate the need for reforming development cooperation, and move away from project aid, the World Bank presented a study where they showed that 60% of all the World Bank's projects did not meet their objectives¹⁵.

The demand for increased coordination in development cooperation was raised in the 90's largely due to the increasing number of development partners that were undertaking development activities. The number of projects led to an unmanageable situation for the partner government and inefficient use of resources¹⁶. Under project aid, for example, each donor usually requires separate reports and evaluations of each project. Due to the lack of national institutional capacity the workload becomes overwhelming and a lot of time and resources are spent writing reports and conducting evaluations for each development partner. Under a SWAp, the government ideally only produces one report to the entire community of development partners and the administrative workload is thereby supposed to be significantly decreased. One of the main arguments is therefore that increased coordination of development cooperation activities will lead to increased efficiency. The increase in coordination is

¹³ Peters and Chao 1998

¹⁴ Walt et al 1999b

¹⁵ Johanson 2000

¹⁶ Walt et al 1999b

subsequently appealing to all partners in the health sector because it, in theory, offers a potentially more efficient use of resources.

Cassel's *A Guide to Sector-Wide Approaches for Health Development* is considered to be the basic SWAp definition publication. It provides an idea on how to conceptualise working with a sector-wide approach to health and addresses differences with a SWAp versus traditional project based aid. The UK Department for International Development, the European Commission and the World Health Organisation commissioned the publication and representatives from these agencies, other development agencies as well as representatives from aid receiving countries were involved in the creation. The definition offered by Cassels states that a sector-wide approach to health development is:

“A sustained partnership, led by national authorities, involving different arms of government, groups in civil society, and one or more donor agencies with the goal of achieving improvements in people’s health and contributing to national human development objectives in the context of a coherent sector, defined by an appropriate institutional structure and national financing programme, through a collaborative programme of work... with established structures for negotiating strategic and management issues, and reviewing sectoral performance against jointly agreed milestones and targets.”¹⁷

Cassel's definition puts emphasis on the partnership nature and long-term sustainability of sector-wide approaches. It also focuses on the context and goal of the approach. Since the context is unique for each country Cassels writes only in general terms about the necessary framework for achieving the goals, which is to contribute to national human development objectives. Foster, Brown and Conway offer another definition that is more focused on the future evolution of development expenditure in a country context. They argue that the defining characteristics of a SWAp are that:

“All significant funding for the sector supports a single sector policy and expenditure programme, under government leadership, adopting common approaches across the sector, and progressing towards relying on government procedures to disburse and account for all funds.”¹⁸

Foster's et al definition does not address the goal of a sector-wide approach. Instead it focuses on SWAp being a tool for coordinating of funds to the health sector under a common

¹⁷ Cassels 1997

¹⁸ Foster et al 2000

expenditure framework. It also puts less emphasis on the long-term partnership and sustainability aspects than Cassels.

Apart from the two definitions presented above, few attempts have been made to define what a sector-wide approach to health is. However, numerous articles have discussed the concept as stated by Cassels (and then redefined by Foster et al) and various interpretations have been presented. Peters et al see SWAp as a way of building partnerships around technical elements like clear sector-wide policies and a medium-term expenditure programme¹⁹. Angers describes SWAp as a transition from donor-led, project dominated aid to a country-led national development strategy²⁰. Walt et al present SWAps as a next generation approach to aid that sets out to provide a broad framework within which all resources in the health sector are coordinated in a coherent and well-managed way, in partnership, with the partner government in the lead²¹. The Swedish International Development Cooperation Agency defines SWAp as a form of long-term development assistance partnership that embraces a single sector policy and expenditure programme in order to achieve sector objectives and ensure national ownership.²²

Tyson et al have also addressed the question about how to define SWAp and they argue that SWAp defines a way of working between development agencies and the government and should not be viewed as a funding instrument. At the same time however they consider it desirable that such trust evolves between the government and the development partners so the development partners feel confident in providing most of their resources as unconditional budget support.²³

Both Foster's et al and Cassel's definitions of SWAp are very broad in character, conveying a way of looking at development cooperation rather than providing a blueprint for how to implement a sector-wide approach. The interpretations above also put emphasis on SWAp as a view of health sector development rather than providing concrete tools for how to achieve a sector-wide approach. How to define what exactly falls under "sector-wide" is vaguely defined in all the presented definitions. Cassels write about "achieving national human

¹⁹ Peters and Chao 1998

²⁰ Angers 2000

²¹ Walt et al 1999b

²² Swedish International Development Cooperation Agency 2000

²³ Tyson 2000

development objectives in the context of a coherent sector” but he does not get more specific than that. Also Foster and the other scholars quoted above refrain from more clearly stating what exactly is sector-wide should include. They write about “sector-wide policies” and “national development strategies” but they do not provide any suggestions to where the sector boundary could, or should, be drawn.

Cassels, Angers and Walt state that increased ownership is achieved through placing the partner government in the lead of health sector development. A SWAp is supposed to increase ownership by placing the government in the “drivers seat”, giving them the lead and making them responsible for coordinating and managing health sector development. The government, with the support of development partners should be responsible for developing policies and strategies for sectoral development. And all activities undertaken in the health sector should be in line with the overall sector strategy. This lead role will supposedly increase ownership for the government and thereby, increase their commitment for carrying out the programme. Something that appears in each of the definitions and interpretations is the view that with a stronger role given to government for coordinating sectoral development, development partners should take a step back from their role as coordinator. Each definition also mentions that under a sector-wide approach, the aim is to bring together and coordinate a larger number of stakeholders in sector development. One of few differences that can be found is that Tyson and Foster view SWAp as a way of making the government responsible for coordinating funds while others argue that SWAp is a method for coordinating all available resources in the health sector.

With an understanding of how SWAp has been defined in the literature, we will now look closer at how Uganda, Zambia and Bangladesh has defined sector-wide approach in the context of their own country.

SWAp Definitions in a country context

The three countries in this study, Uganda, Zambia and Bangladesh, all started working with a sector-wide approach to health fairly early. In Zambia, a SWAp-like structure (with increased coordination of resources and activities) has been in place since the early 90s even though it was not formally described as a SWAp until the concept was introduced in the late 90s. Uganda and Bangladesh also embarked on a SWAp fairly early and introduced it to the health

sector in the late 90s. In none of the three countries has the adoption of a sector-wide approach led to complete abolishment of projects. Many development partners are still funding individual projects. There has, however, been a decline in projects since more and more agencies providing direct monetary support. The projects that are already running, or new projects that are initiated, are also supposed to be in line with the overall strategic plan for the sector.

When formalising the sector-wide approach, a number of joint documents were produced in all three countries. For example, in all three countries Memorandum of Understanding was signed between the development partners that were intending to participate in the SWAp and the respective government. Some kind of strategic plan, or programme plan, was also produced describing what priorities and strategies for sectoral development that had been agreed upon for the next few years.

When looking more closely into what is written about sector-wide approaches in the Memorandum of Understanding and the strategic or programme plans we found few attempts to define what working with a SWAp in each country includes. The documents do not always provide a clear definition of a sector-wide approach in the respective country setting. Sometimes the SWAp term is used, not necessarily in conjunction with a definition but still with indications to how SWAp is defined in each country. The main issue here however is that the definitions of sector-wide, increased ownership and increased coordination presented below are all taken from documents that are jointly agreed upon between the development partners and the respective government. In the case of Bangladesh one definition is taken from the policy dialogue in February 2003, developed by a working group that comprised of both government and development partner representatives. Therefore, all definitions presented below can be interpreted as attempts to jointly define what a sector-wide approach is in the context of each country.

Sector-Wide

In all three countries, the sector-wide approach to health has been limited to the mandate of one ministry. In Uganda and Zambia, development partners work with the Ministry of Health and in Bangladesh it is a partnership with the Ministry of Health and Family Welfare. In Bangladesh in particular, this leaves out a substantial part of the health sector since the

Ministry of Health and Family Welfare only covers rural health care, while another ministry manages urban health care. Bangladesh currently experiences a rapid urbanisation and therefore a larger part of the population is now outside the health sector SWAp. Apart from being limited to one ministry, the health sector in all countries is also dependant on other sectors. For example, the access to fresh and safe drinking water has large implications on health and the education sector has an important role in educating the youth about safe sex.

For the upcoming programme in Bangladesh (the Health, Nutrition and Population Sector Programme, HPNSP), which is due to start July 1 2003, the sector has been defined according to the title of the programme. The new programme aims to improve health, nutrition and population outcomes for the population of Bangladesh, which includes addressing public health problems and family planning issues. The role of the Ministry of Health and Family Welfare in urban health care is also supposed to be strengthened. They aim to be more active in policy setting for the entire health sector and work to increase funding for urban health care.²⁴

In Uganda and Zambia, the same division of responsibility for health services between ministries does not exist. Instead, it is only one ministry that is responsible for the entire health sector and whatever activities fall under their mandate is also defined as the health sector.^{25, 26}

When defining the health sector, partners in development can choose to include all activities that have an impact on people's health. Doing this would mean that a number of ministries would have to be involved in health sector development. In Uganda, Zambia and Bangladesh, the sector-wide approach has instead been limited to one ministry. Furthermore, defining the sector is not only about identifying the sector boundary, it is also about creating a common understanding of the programme of work. By analysing the current situation in the sector, the expected development, possible problems and available measures, partners in development are supposed to reach a common starting ground and agreed upon guidelines to work from.

²⁴ Government of Bangladesh, 2002, *Conceptual Framework for Health, Nutrition and Population Sector Programme (HNPSP) July 2003-June 2006*, final draft

²⁵ Government of Uganda, 2000, *Memorandum of Understanding*

²⁶ Government of the Republic of Zambia, 1999, *Memorandum of Understanding*

This process is very time and resource consuming, but is seen as necessary for successfully achieving a sector-wide approach.

Increased Ownership

In all three countries, official documents rarely address the question of increased ownership for the government. The Memorandum of Understanding in Zambia states that the government and its' cooperating partners should accept shared responsibility for the degree of progress achieved in the sector. The Ministry of Health is also responsible for managing monetary support from the development partners²⁷. The same document in Uganda states that the government should provide overall leadership in planning, administration and monitoring of the strategic plan. They should also ensure that all districts are working in line with the strategic plan²⁸. The Health and Population Sector Strategy of Bangladesh indicates that adopting a sector-wide approach places larger responsibility on the government for strategic planning and budgeting. It also states that monitoring is crucial in a sector-wide approach for correcting problems and therefore, jointly agreed indicators for this monitoring process have to be developed²⁹. The increased responsibility for health sector development of the governments in all three countries can be seen as a way to increase government ownership.

Increased Coordination

In Zambia, the National Health Strategic Plans emphasises that SWAp provides a mechanism for coordinating financial resources and for organising different management procedures related to them³⁰. Another jointly agreed upon document describes the ultimate aim of any SWAp to be for all cooperating partners to provide joint budgetary support to an agreed upon, vision, health policies, strategies and medium-term and annual plans. It also mentions that central aspects of a SWAp are transparency, reliable financial and budget systems and adherence to the programme of work from all partners³¹. In the Memorandum of Understanding in Zambia, the Government of Zambia and its' development partners have agreed that the adoption of a sector-wide approach will allow for all financial resources to be used within the framework of the National Health Strategic Plan. While all development

²⁷ Government of the Republic of Zambia, 1999, *Memorandum of Understanding*

²⁸ Government of Uganda, 2000, *Memorandum of Understanding*

²⁹ Government of Bangladesh, 1997, *Health and Population Sector Strategy*

³⁰ Government of the Republic of Zambia, 2000, *National Health Strategic Plan*

³¹ Government of the Republic of Zambia, 2000, *Joint Identification and Formulation Mission for Zambia*

partners are moving towards allowing this however, earmarked funds (i.e. funds that are only allowed to be used for a special purpose or activity in the strategic plan) will be accepted³².

In Uganda, the National Health Policy puts emphasis on sector-wide approach as a tool for stronger donor coordination. Key national development objectives should be agreed upon between all stakeholders to health and common frameworks for planning, budgeting, disbursement, accounting, reporting etc. should be promoted³³. Similar to Zambia, the Ugandan SWAp encourages all development partners to fund the Health Sector Strategic Plan through central budget support. Since this is not currently feasible for all development partners, other funding modalities are accepted, but the Government of Uganda expects all development partners to move towards providing central budget support in the future³⁴.

Official documents in Bangladesh rarely discuss the concept of sector-wide approach and there is no clear definition to be found of what SWAp really means. Recently, the need for a more clear definition of the SWAp concept in Bangladesh was realised and at the latest Policy Dialogue in February 2003, (a meeting between the Ministry of Health and Family Welfare, the development partners and various other stakeholders) a definition was proposed. The definition stated that a SWAp is achieved when there exists a sector-wide strategy (macro framework, sector policy and agreed priorities. It also stated that activities like planning, financing, implementation, monitoring and evaluation have to be sector-wide in character. As far as funding is concerned, the working group that proposed the definition concluded that any method of funding is acceptable in a sector-wide approach.

The presented definitions of a sector-wide approach to health from all three countries share many of the same characteristics. They are emphasising that SWAp means that all involved partners should agree on common formats for reporting, budgeting, monitoring etc. It is also expressed that strategies and visions that every partner shares should be developed and that all partners should consider the sector as a whole in their work. Such common frameworks for action depend upon and presume the performance of comprehensive analysis of the present situation of the sector. Such analyses are highly dependent upon suggestions and advice of technical experts. This expertise and input is, in all countries, mainly provided by the

³² Government of the Republic of Zambia, 1999, *Memorandum of Understanding*

³³ Government of Uganda, *National Health Policy*

³⁴ Government of Uganda, *Health Sector Strategic Plan 2000/01 – 2004/05*

development partners who brings in technical experts to function as a support mechanism for the government. One of few differences between the countries is that while in Uganda and Zambia, it is clearly stated that the aim of a SWAp should be to move towards all development partners providing general budget support, the door is still left open for other types of funding in Bangladesh.

In comparison to the general definitions of sector-wide approach, the definitions in a country context are, in certain regards, more specific. While the literary definitions of SWAp discuss little about where the sector boundary should be drawn, the country context definitions have limited the boundary to the mandate of one ministry. Both the general and country context definitions are unclear about what increased ownership means. In the general definitions, increased ownership in SWAp is defined as when the partner government is in the lead of the development process. The country context definitions on the other hand focus on how a SWAp increases the responsibility of the development process for the government. As far as coordination is concerned, the country context definitions in Zambia and Uganda are more specific about the desire that all development partners should move towards providing budget support in the future.

SWAp in action

After having looked at general definitions of SWAp and definitions of SWAp in a country context, we will now to examine how individual development partners and government representatives define sector-wide approach in action. The definitions in action are taken from interviews with development partners and government representatives where we asked them to define what a sector-wide approach is. We also observed and listened to how different partners defined SWAp in meetings with other partners. Contrary to the definitions of SWAp in a country context, the definitions in action are not definitions that are jointly agreed upon. Instead they illustrate how individual partners in development define SWAp in their daily work. As mentioned in the beginning, we were given almost as many different definitions of SWAp as people we interviewed. We could however see common traits in the different definitions and the examples below serve to highlight the most apparent differences and the discussions they generated.

Sector-Wide

Among government representatives and development partners, the definition of SWAp and what exactly should be included in a sector-wide approach differs. Different partners have differing definitions concerning where the sector boundary should be drawn and what working with a SWAp includes. A discussion concerning institutional reforms illustrates the different definitions of SWAp. A few development partners argue that a SWAp does not necessarily imply or include institutional reforms. They claim that institutional reforms were being undertaken long before SWAp was introduced and are therefore not a specific feature of a SWAp. In Uganda, for example, what is today defined as the SWAp, started out as a district decentralization project to improve local influence over health service delivery and planning. The decentralization reform is therefore not a reform that was an effect of the adoption of a SWAp. In Bangladesh, the same discussion exists and a couple of development partners argue that the reform package in Bangladesh is not a part of the sector-wide approach. Other development partners and government representatives claim that there are a number of different reforms that have been agreed upon in the SWAp, and therefore the reforms have to be seen as parts of the sector-wide approach.

A number of development partners in Zambia and Bangladesh also argue that a number of recent institutional reforms can clearly be linked to the adoption of a SWAp, like for example the development of common management and financial information systems. In order to create the overview expected from a SWAp, partners agree about the need for uniform systems that are utilised throughout the sector. Also, the coordination of all stakeholders in a SWAp requires creating committees and forums for dialogue that have not previously existed. Development partners therefore claim that this indicates that under a SWAp the country is expected to undertake institutional reforms. So even though it is not explicitly stated in the general or country context definitions, adopting a sector-wide approach to health imply major institutional reforms.

Another example of how different partners define the sector boundary different concerns the traditional healers. Many people still turn to traditional healers when they fall ill, both out of tradition as well as out of mistrust towards, or disappointment with, the public health facilities. Since people turn to them for care and treatment they constitute a large part of the health sector, and some argue that they therefore should be coordinated along with other

stakeholders in the sector. In a couple of districts in Uganda that we visited the government is trying to register these traditional healers. A couple of representatives told us that they think it is important to try and get a picture of what traditional healers do and why people go to see them instead of utilising the health centres. Even if they do not believe in their practices, they meant they must respect and manage that a lot of people in Uganda still do. Other partners were more sceptical to spending resources on coordinating the traditional healers since the services they provide are usually not recommended or used in western medicine.

Increased Ownership

The general definitions presented earlier put strong emphasis on government ownership in a sector-wide approach. The issue of government ownership was also frequently used as an argument when the concept was introduced to developing countries in the late 90s. In action however, how government ownership is defined is harder to ascertain. A handful of development partners in Bangladesh for example are dissatisfied with government leadership and rate of progress in the current sector programme. Health services have not improved the way they had hoped for and therefore they were considering bypassing the government and find alternative ways for providing health services for the poor. This might, for example, include more comprehensive contracting of NGOs for provision of services. They did not see this as undermining government ownership, nor did they see it as moving away from working with a sector-wide approach. Other development partners in Bangladesh, on the other hand, believed that a SWAp by definition means that the government should be in the “drivers seat”. If development partners are bypassing the government, they are undermining the ownership idea of a sector-wide approach, even if the activity they undertake is in line with the overall sector strategy.

Another discussion on how to increase ownership concerns who controls the funds. In all three countries, a number of development partner representatives, who are providing direct monetary support, argue that in order to achieve increased ownership for the partner government, they have to be in control of the money. Now, some development partners are providing monetary support, while others are still working mainly with projects. These development partners argued that as long as the government are not fully controlling and coordinating funds, a sense of strong ownership cannot be established. Other partners claimed that letting the government coordinate and control the funds does not create ownership.

Instead, ownership is created by placing the government in the lead of the development process creates increased ownership. If the government leads the creation of the overall sector strategy, and all other partner adheres to it, then ownership will be strengthened, no matter who controls the funds.

The creation of a common strategic plan is a lengthy and complicated process that requires extensive analysis, discussion and negotiation. All partners should reach consensus on what the sector looks like, what needs to be done and what the risks and opportunities are. Both government and development partner representatives, in all three countries, sometimes question the national ownership over strategic documents. They argue that the country's sector strategy is not always completely owned by the government, even though it is officially considered to be. The sector strategic plan is considered to be a document developed by the national government, and that the priorities and activities stated in the strategic plan are priorities decided set by them. Government officials, as well as development partner representatives, however argue that there are times when development partners, by leveraging their financial power, influence priorities and strategies for the sector. Development partners can, for example, demand that the government undertake certain activities in order to receive any funding. Even though the activities might not have been identified as a priorities by the government.

Increased Coordination

Most actors in the health sector in Uganda, Zambia and Bangladesh seem to agree that increased coordination leads to less risk of conducting duplicating activities or projects. They also agree that increased coordination provide greater possibilities for achieving better and more sustainable improvements. Critics, however, claim that the increase in coordination is very time and resource consuming. In order to reach consensus between the development partners' community and the partner government, many hours are spent negotiating and discussing various approaches. A question raised by critics is if the adoption of a SWAp really reduces the administrative workload or if it merely moves the use of institutional capacity from evaluating, monitoring and reporting to negotiating, discussing and coordinating. Other critique that has been voiced is that, in a SWAp, large resources are spent on strengthening the managerial and institutional infrastructure at the expense of the quality of

health services. Should large amounts of money be spent on training accountants and district managers when there is not enough money to procure essential drugs?

In Zambia, the National Health Strategic Plan states that by 2005 the government hopes to have achieved a “full SWAp”, but when asking representatives from the ministry, the central board and the development partners about what they consider a full SWAp to be, we received very different answers. About half of the development partners, and the majority of government officials, that we met consider a full SWAp to be when each partner puts their funds in a common basket and lets the government set the priorities for how they are to be spent. Other representatives consider a full SWAp to be achieved when every activity carried out in the sector is in line with the overall strategic plan that is agreed upon by all partners. The differing views can be attributed to whether partners in development see SWAp as mechanism for coordinating funds or for coordinating activities. Some representatives believe that whether the funding goes through the national budget or not is irrelevant, while others consider the channelling of funds through the existing structure as a core feature of a SWAp.

In Zambia, a number of representatives for development partners and the government defined SWAp as a “Basket of Activities” referring to that in a SWAp, there are a number of activities that the government is planning to undertake and development partners should be free to pick and choose which of these they would like to fund. Other development partners and government officials defined a SWAp as a “Basket of Funds” claiming that in a SWAp, the goal is to pool all financial resources and then trust the government with spending it on the objectives stated in the National Health Strategic Plan. The role of the development partners is instead to monitor funds and progress, and to provide technical assistance in strategy and policy setting. A number of development partners have also made it clear that they will never provide direct monetary support. For a few development partners this has to do with national legislation or institutional regulations, which prohibits monetary support. Others refrain from it because of lack of confidence in the governments monitoring and auditing systems.

A multitude of translations

The overview of existing SWAp translations shows that there are significant differences in how *sector-wide*, *increased ownership* and *increased coordination* is defined in different contexts. The literature suggests that policy and strategy should be sector-wide but offers little

guidance on where to draw the sector boundary. In a country context, we can see that the sector is typically defined as what falls under the ministry involved in the SWAp. In action it is apparent that there are differing definitions among actors about whether SWAp implies institutional reforms or not. We could also see that different actors have different definitions on where the sector boundary should be drawn.

According to the literature, increased ownership will be achieved by placing the government in the lead of sector development, but exactly what this lead role includes is not clearly stated. On a country level, the issue of ownership is addressed by emphasising the increased responsibility for the government. When it comes to how increased ownership is defined in action, there is a debate about what influence over policy and strategy formulation that development partners have and what influence they should have. There are also differing views regarding whether government control over all available funds is a prerequisite for achieving stronger national ownership.

Finally, the SWAp idea states that increased coordination is achieved by moving from individual projects to national sector programme and by including a larger number of stakeholders in sector development. On country level, the increase in coordination is focused around developing common strategies and formats for monitoring and evaluation. It is also stated that a SWAp aims at coordinating funds rather than activities. In action, coordination is viewed positively since it reduces the risk of duplication. There is however disagreement on what it is that should be coordinated – funds or activities.

With an understanding of the multitude of translations of sector-wide approach, and the room for interpretations and translations for the concept that exist, we will now move on to examine what the framework for coordinating the sector-wide approach looks like in each country and how coordination within this framework evolves in practice.

Coordinating the SWAp in Uganda, Zambia and Bangladesh

The adoption of sector-wide approaches in Uganda, Zambia and Bangladesh has led to the introduction of new coordination structures. By SWAp coordination framework we are here referring to coordination mechanisms that have been introduced in the three countries after they embarked on a sector-wide approach. These coordination mechanisms consist of both

official documents that are jointly agreed upon by all formal partners (for example a Memorandum of Understanding and a National Health Policy) but also of various committees, meetings and other forums for dialogue between stakeholders to health. In the next part of this paper we will analyse what the coordination framework looks like in Uganda, Zambia and Bangladesh in order to examine *who* is involved in the *coordination* process, *how* *coordination* under a sector-wide approach is conducted, and *what* is being *coordinated*. This analysis will allow us to establish whether this framework share similar traits in the three countries or if they have chosen different ways for coordinating their respective SWAp. It will also illustrate how the different translations SWAp affect how coordination under a SWAp evolves in practice.

The coordination framework – who is coordinating?

The main actors in the sector-wide approaches in Uganda, Zambia and Bangladesh are undoubtedly those who have signed the Memorandum of Understanding. In all three countries, the signatories of the Memorandum of Understanding comprise of the main development partners and the government. These actors are those who are responsible for coordinating the sector-wide approach programme.

The adoption of a sector-wide approach has led to an increased responsibility for coordination for the Ministry that manages the SWAp³⁵. Previously, when project aid was most common, individual development partners assumed more responsibility for managing funds and conducting training, monitoring and evaluation. Now, this role is in the hands of the Ministry together with the development partners. It is their responsibility to coordinate activities in the SWAp and also to facilitate coordination of stakeholders in the health sector. The development partners still have a prominent role in coordination, but their role is more to coordinate their work with the work of the Ministry and also to coordinate their financial and technical support with the support provided by other development partners.

There are in Uganda, Zambia and Bangladesh similarities regarding what the government should be coordinating under in a sector-wide approach. In all three countries it is stated in policy and strategic documents, that the sector wide approach should include other health

service providers when planning for health sector development. Among these we find private providers, religious organisations, NGOs and traditional practitioners. All these are important providers of health services in Uganda, Zambia and Bangladesh and the government should coordinate their own activities with those of other providers to achieve the expected sectoral overview that a sector-wide approach is expected to generate. Apart from other providers, civil society is also considered a key stakeholder in health sector development. It is seen as necessary to obtain input from the people who utilize the health facilities in order to establish what clients expect and demand but also to adjust services according to regional needs. All in all, the SWAp in all three countries aims at bringing together all stakeholders to health in the planning and execution of the strategic plan.

The coordination framework – coordinate how?

Coordination of stakeholder in the SWAp in all three countries is conducted through a number of documents, but also through various formal committees and consultative meetings. There are also in some cases coordinating bodies. Different stakeholders are coordinated in different ways. Coordination of development partners in Zambia for example is conducted through formal agreements but also through regular meetings and through the Ministry of Health's coordinating bodies. To coordinate other stakeholders, the government usually facilitates forums for dialogue to give them an opportunity to provide input to the programme.

Coordination through documents

All three countries in this study have a National Health Policy, which states the general goals and main challenges for the health sector. They also have a strategic or programme plan that outlines the planned sectoral development in a 3-5 year timeframe. Finally, the governments in Uganda and Zambia have signed a Memorandum of Understanding with a number of development partners (in Bangladesh there exists no Memorandum of Understanding. Instead, the development partners and the Government of Bangladesh have signed a similar document called "Development Credit Agreement"). These three documents are the main steering documents for the sector-wide approach in each country.

³⁵ In Uganda and Zambia, the SWAp is managed by the Ministry of Health and in Bangladesh the sector-wide approach is managed under the Ministry of Health and Family Welfare.

By signing the Memorandum of Understanding, all development partners and the partner government, show that they formally support and endorse the country's strategic or programme plan for health sector development. Even though The Memorandum of Understanding is not a binding agreement between the government and its development partners and it still constitutes an important coordination mechanism. If one partner acts in violation with the Memorandum of Understanding, other partners can refer to the Memorandum as an argument for reconsidering their commitment to the programme.

When looking at the content of the Memorandums of Understanding in Uganda, Zambia and Bangladesh we found many similarities between them. All of them express similar visions with a sector-wide approach. For example, they state that all available resources should support the strategic plan or programme plan, that all partners will consider the health sector as a whole in their planning and that all partners accept shared responsibility for progress achieved. The Memorandum of Understanding in all three countries also expresses how coordination between the government and the development partners is supposed to be conducted. It is stated what committees that will act as the link between the development partners and the government and the responsibility of these committees. In Uganda the Memorandum of Understanding also contains a Code of Conduct, which states what the spirit of the partnership should be and how conflicts are supposed to be handled and resolved. In Bangladesh there is currently no Code of Conduct. Both the government and the development partners however have identified the need for creating a Code of Conduct. In Zambia, there is no Code of Conduct either, but the Memorandum of Understanding states how disagreements should be handled.

Coordinating through meetings

Apart from the main coordination documents, stakeholders to health are also coordinated through various committees, meetings and other forums for dialogue. There are, in Zambia and Uganda, regular meetings between the government and the development partners. In Zambia, the government meet the representatives for the development partners weekly while in Uganda, these meetings occur on a monthly basis. In Bangladesh, there is no regular meeting between the government and its' development partners.

In Bangladesh and Uganda there are also regular meetings where representatives for the development partners meet each other. The development partners meeting in Uganda is open only to those development partners that have signed the Memorandum of Understanding with

the government. They meet monthly to discuss issues that the development partners think should be raised when meeting with the Ministry of Health and to reach consensus on how to present their position. At the meeting, the development partners also inform each other about what activities they are undertaking. The set-up in Bangladesh is similar to the Ugandan but they have two separate development partner's forum, one where partners that provide budget support meet and one where all development partners meet. At the meetings they discuss issues of concern and try to form a common strategy on how to communicate with the Ministry of Health and Family Welfare. In Zambia, the development partners do not have a formal meeting. Instead individual development partners arrange meetings with other development partners when they deem it necessary. These invitations do not necessarily go out to every partner. One agency, for example, told us that when they call for a meeting they usually invite only development partners who provide direct monetary support and therefore, to a larger extent, share a similar view of development cooperation.

There is also, in all three countries, some sort of annual or bi-annual programme reviews. In Uganda, two Joint Review Missions are held annually. At these meetings, a larger number of stakeholders meet together with the government and development partners. Present are representatives from district administration, NGOs, related ministries and members of parliament. Similar review missions exist in both Zambia and Bangladesh, but they do not bring together the same diversity of stakeholders.

Coordinating through coordination bodies

In Bangladesh, there is no regular meeting between the development partners and the government. Instead, auxiliary governmental bodies, which serve as links between the Ministry of Health and Family Welfare, conduct most of the coordination of development partners. In Zambia, the Ministry of Health has appointed one person to be responsible for donor coordination. The role of the donor coordinator is to be the link between the development partners and the government as well as facilitating forums for discussions between the ministry, the central board and the development partners. The role of the donor coordinator is also to try to solve disputes, misunderstandings or concerns that are raised by the development partners.

The coordination framework – coordinate what?

We have established that the main responsibility for coordination in a SWAp lies with the partners government and its' development partners. We have furthermore shown how coordination in a sector-wide approach takes place through various documents, meetings and coordination bodies. As far as what they are actually coordinating we have identified five different groups, namely; *Stakeholders, Analyses, plans and policies, Activities, Resources and Monitoring and evaluation*

Coordinating stakeholders

Coordination of local sector administration in Uganda and Zambia is conducted through different channels. District and provincial representatives are participating in the regular programme reviews where they have a chance of providing input and raise concerns. Both Uganda and Zambia have also adopted a bottom-up planning process, which is supposed to be the channel for input from both local administration but also from civil society. The bottom-up planning process, in short, means that planning for the upcoming year should start at grass-root level and travel up through the bureaucratic structure, because the districts are considered more capable of determining the specific needs of the population in their region. According to the district officials we have met it is a good idea but it does not always work in reality. Varying capacity and willingness to participate among community leaders and health centre staff generate excellent participation in some districts while in other districts, civil society is not represented at all.

In Bangladesh, the health service structure is a lot more centralised. Due to the lack of a local structure responsible for planning there is no easily accessible channel for input from civil society. Instead, stakeholder consultative meetings were established when the current sector programme was set-up in 1998. These meetings were supposed to be a forum where stakeholders to health, including community leaders, met with the government to discuss issues of concerns. From what we learned during our visit, these meetings have not taken place with the intended continuity and there is not yet a regular forum established for obtaining input from civil society.

There is a large difference in the level of decentralisation of health services among the countries. Uganda, for example, has a very decentralised system for health service delivery, where districts are responsible for the provision of primary health care. The districts are also

responsible for coordinating the lower-level health, which includes monitoring funds and collecting data for health indicators. In Bangladesh on the other hand, the system is very centralised and most coordination currently takes place at central level. One reason for decentralising coordination in Uganda is to simplify coordination of stakeholders that have an impact on health but who do not currently fall under the control of the Ministry of Health.

In both Zambia and Uganda the churches play an important role in providing health services. The Churches Health Association of Zambia runs about 1/3rd of all public health facilities in Zambia and is a close partner with the government. They are, just like the government facilities, funded by the Ministry of Health and they follow the same policies and guidelines and fall under the same scrutiny. The Churches Health Association of Zambia is also an active partner in the quarterly HSC meeting and they have regular consultative meetings with other development partners and the government.

In Uganda, the different religious Medical Bureaus run 27 hospitals and about 200 lower level health centres. The Bureaus also works in close collaboration with the government, but they are not as integrated as the Churches Health Association of Zambia is. The difference is that the Uganda Catholic Medical Bureaus facilities are only subsidised by the government and they do not have the same demands regarding reporting and following government guidelines. The Bureaus also participates in the policy dialogues and also attend the monthly government/development partners meeting. A couple of district officials expressed dissatisfaction with the subsidies given to the Bureaus's facilities and think that the government should instead take over these facilities and fully integrate them into the public health care system. The Uganda Catholic Medical Bureaus however does not see this as an alternative. They consider themselves to be on a mission and they have intention of giving up control over their facilities.

Coordinating analyses, plans and policies

All the meetings, documents and coordinating bodies that were mentioned earlier fill an important role in coordinating analyses, plans and policies. It is seen as important that the development partners and the government in each country have a share opinion about the current situation. In order to reach a common agreement on the situational analysis of the sector, the strategic plan for the upcoming programme and the policies needed to achieve them, extensive time and resources are spent on analysing, discussing and negotiating.

Coordinating activities

An issue of concern for the partners in health sector development in Uganda, Zambia and Bangladesh is the position of the Global Fund to fight Aids, Tuberculosis and Malaria, in a sector-wide approach. The Global Fund is a vertical disease control programme and the aim of a sector-wide approach is to move away from these types of uncoordinated vertical activities. During our visits to Uganda and Zambia many questions were raised about how resources from the Global Fund, if granted, will be coordinated with health sector development in large: Will they be channelled through the health budget? How will activities financed by the Global Fund be coordinated with other activities in the health sector? And what will happen after few years – will there be more money coming in from the Global Fund in the future?

The SWAp in Uganda, Zambia and Bangladesh, also aims at increasing coordination of activities like for example training. In Uganda, many of the district officials interviewed raised concerns about the lack of coordination of training from central level. They were frequently required to attend workshops and training while at the same time they were trying to find time to do their job in the district.

Coordinating resources

The adoption of a sector-wide approach has also led to increased coordination of available funds and resources in the health sector. Some development partners do this by channelling their funds directly through the Ministry's budget, others by funding specific activities in the country's strategic plan. The change from previous arrangements however is that the Ministry of Health have a better overview of available resources in the sector, which simplifies the budgeting and planning process.

With the adoption of a sector-wide approach and the move away from project-based cooperation, the partner government has gained more responsibility for the distribution and coordination of funds. Previously, funds were distributed and monitored mainly by the partner involved in each project. Under a SWAp, some development partners have chosen to channel monetary support directly through the budget of the ministry that manages the SWAp. The ministry then distributes the funds to the districts through their own distribution mechanisms. During our district visits in Uganda and Zambia we could see varying success in building well

functioning fund distribution mechanisms. Some problems are related to problems with infrastructure. For example, the nearest bank might be hours away and the districts only vehicle might be broken or used for other purposes. Some areas are completely inaccessible during the rain season because and they could therefore not access funds at the bank during this period. Other problems are more related to the bureaucratic structure. When funds are released from the Ministry of Health it has to travel through the bureaucratic structure and this could often take a few weeks. Along the way, a number of signatures are needed and the process is easily delayed if one of the signatories is away on other duties.

Coordinating monitoring and evaluation

District officials in Uganda have also raised concerns about the lack of coordination regarding monitoring and evaluation visits from the Ministry of Health. They explained to us that a team from the Ministry of Health could come one week and ask questions and then, the week after, another team from the Ministry of Health could show up asking the same questions. All the ministry visits, together with other activities mentioned before take a lot of time away from their daily work in the district and make their workload unmanageable.

Our review of how SWAps are coordinated in Uganda, Zambia and Bangladesh show that the structures for coordination are similar between the countries. In all three countries, the main actors in coordination are the national governments and its' development partners. Coordination is also conducted through similar documents, meetings and coordination bodies. Regarding what is being coordinated, we can say that the government has gotten a more prominent role in coordinating resources and activities are coordinated to a larger extent. As our examples show though, even if the structure for coordination is similar, coordination in action sometime takes different forms in Uganda, Zambia and Bangladesh.

Similar structures – difference in action

The above review of definitions and coordination of a sector-wide approach show both similarities and differences across countries, actors and settings. There is genuine support for working with sector-wide approach among most of the people interviewed for this study, but their definitions of what SWAp is are far from identical. There are differences in definitions between partners in the three countries, but also within each country. The most apparent difference was whether SWAp is mechanism for coordinating funds or for coordinating

activities, but there were also different opinions about the role of the government and the development partners and what activities that fall under the sector-wide approach. The broad and general character of the initial SWAp concept can possibly explain the differences in definitions in action. Since the concept is so general in character, it is easy for a partner to state that they support it, because they can translate it to fit their preferences. A partner that is in favour of moving more towards budget support will argue that a SWAp implies moving towards every partner providing budget support. A development partner that does not favour, or is not able to provide, direct monetary support on the other hand can claim that a sector-wide approach is mainly a tool for coordinating activities.

In spite of the fact that different development partners and government representatives in each country have differing views of what a sector-wide approach is, the structure and coordination framework of a sector-wide approach in all three countries however is very similar. The coordination framework of each SWAp rests on similar documents. There is a Memorandum of Understanding a health policy and a strategic or programme plan. The structure for coordinating stakeholders is also similar with strategies for how to coordinate different stakeholders and resembling committees and forums for dialogue have been established.

The SWAp idea came from the development partners as a response to critique against project aid and it was marketed as a more efficient and ownership-generating approach to development cooperation. Being globally driven by bilateral and multilateral agencies provides a possible explanation for the similarities in the coordination framework in all three countries. In the process of setting up SWAps, these agencies conduct sector-wide approach seminars where participants learn about what the typical features of a SWAp are. For example, the Inter Agency Group has developed a handbook that is used in SWAp seminars, which explains that elements typically found in a sector-wide approach include a health policy, a strategic plan, a signed Memorandum of Understanding and a medium-term expenditure framework.³⁶ This is exactly what exists in the SWAp in all three countries in this study.

The fact that the SWAp concept is so general in character has probably helped making it popular among partners in health sector development. Since involved partners can edit and

³⁶ IHSD 2001, p.45

translate it to fit their preferences it is easy to support it. In a situation where relations between development partners and the government are harmonious, the differences in definitions do not seem to create problems. It is possible to build an agreed upon framework for coordination of the SWAp. It is possible to unite behind common strategies, policies and priorities. It is possible to work together even though there are different opinions among partners about what the sector-wide approach should include, how increased ownership should be achieved and what it is that should be coordinated.

However, in a situation where relations are strained, the differences can become apparent and might then create difficult obstacles to overcome. In the case that follows we look at an event in the SWAp in Bangladesh when the government, in February 2003 decided to reverse one of the, since long, agreed reforms concerning the ministry and service delivery structure. This stirred up emotions, especially among the development partners and brought to surface the different opinions on development cooperation under a sector-wide approach. Especially the question about what government ownership over the development process actually means.

SWAp to the test

Background

The current health sector programme in Bangladesh, the Health and Population Sector Programme (i.e. the Bangladesh health SWAp), commenced in 1998 and included a number of intended reforms in health service delivery. One of the agreed reforms of the programme was to unify the two directorates under the Ministry of Health and Family Welfare (Ministry of Health), Health Services and Family Planning. At current, the two wings are separated at both administrative and service delivery level and unification was seen as desirable to increase efficiency in health service delivery in Bangladesh.

The current, de-unified, set-up was introduced in the early 1970s shortly after independence in order to give priority to family planning activities. At that time, fertility rates were very high and the potential problem of a rapidly increasing population if the rates did not decline was recognised. If the population were allowed to continue to grow at the same rapid rate, all other development goals, e.g. poverty reduction and improved education, would be undermined. By setting up a separate directorate for family planning, and by targeting family planning issues

through separate health facilities, this problem was given special attention and fertility rates were significantly reduced during the following 20 years. Bangladesh success in reducing fertility rates so rapidly is considered a remarkable achievement and has received a lot of international attention.

When setting up the Health and Population Sector Programme in 1998, development partners were of the opinion that the de-unified structure of administration and health services was no longer preferable. Achievements had undoubtedly been made in reducing fertility, but to take the next step and increase efficiency in service delivery, a merger of the two structures was desirable. Therefore, it was suggested that the two structures were to be unified. The unification was supposed to start at service delivery level, where health centres for family planning and clinical services were to be merged. Later in the process, unification of the central level administration within the Ministry of Health was to be implemented.

The suggested reforms met a lot of internal resistance within the Ministry of Health, especially from employees under the directorate of Family Planning. Employees were both concerned about losing their jobs but also about their role in the new hierarchy that would be created. Family Planning workers felt that they would be “eaten” by the directorate of Health Services and that it was not a merger of equals. They were also concerned about losing credit for the great achievements that had been made during the last 20 years and they were worried that family planning services would be neglected in the future.

All the internal resistance made the reform process move slowly, and in reality, no unification was taking place. Development partners were pushing for the unification to be implemented but the Ministry of Health was struggling with overcoming internal resistance. In 2002, the Ministry of Health decided to initiate two independent studies of the unification issue in order to decide how to deal with it in the future. It was said that after the studies were presented, the Ministry of Health would consult the development partners before taking any decision on how to proceed with the issue of unification. The studies were scheduled to be presented in the beginning of 2003.

Reversing the reform

During 2002, not much happened, but at the Annual Programme Review Policy Dialogue in February 2003 the Ministry of Health delivered a message to the development partners. They said that there would be no unification of the current structure, neither during the remainder of the current programme (which ends 30 June 2003), nor during the next programme (which runs from July 1 2003 – June 30 2006). Health services will, also in the future, be delivered through the existing, de-unified, structure even though they will work more closely in collaboration.

Development partners were taken by surprise by this message and a few of them immediately raised a number of concerns and objections. Their main concerns was that this decision was not taken in collaboration with the development partners and they also claimed that it was taken contrary to the recommendations given by the Independent Technical Team (ITT) Report (an annual programme evaluation conducted by an independent team of consultants). Since the decision was contrary to the recommendations by the ITT, development partners asked the Ministry of Health to clarify what their basis for the decision was. Furthermore, a few development partners stated that reversing the decision on unification might be violating the agreement that was signed (each development agency usually have separate development agreements with the partner government) between Ministry of Health and their agency. The reaction from the development partners brings up the question of coordination. Development partners questioned the coordinating role that the government had taken and argued that any decision to reverse a reform should be taken in collaboration with the development partners.

While a handful of development partners reacted very strongly to the announcement from the Ministry of Health, others were not as concerned. It became particularly clear in the closing statements of the policy dialogue. The chief of mission of one agency was very critical to the entire programme. He said that: “We have invested millions of dollars, and uncountable hours during the Health and Population Sector Programme and what results can we show? Not much. Then why should development partners continue to invest in the Health, Nutrition and Population Sector Programme (the upcoming programme)?” Another chief of mission spoke right after him giving a completely different view. He reaffirmed his agency’s commitment towards working with the Government of Bangladesh and he said that he was pleased to see that the government had taken the lead in developing a conceptual framework for the next programme, which he thought indicated strong ownership over the process. The policy

dialogue ended without any clarification being given by the Ministry of Health regarding the decision to reverse unification. The statements from the two chiefs of mission shows that there are large differences among development partners in how they define what a sector-wide approach is. While one of them indicated that he considered the programme to be a failure because of lack of improvement in health services, the second chief of mission was more positive towards the SWAp since he had witnessed what he considered to be an increase in government ownership.

During the week after the policy dialogue, two meetings between development partners were scheduled; The Health and Population Support Office Steering Committee (which consists of the development partners that provide budget support) and the Consortium meeting (which is open to all development partners in the health sector). These meetings came to be completely dominated by the Ministry of Health's decision not to unify the two structures. At the Steering Committee meeting, the discussion from the policy dialogue continued and a number of different opinions were expressed. One group of development partners considered the government to be in material breach with the agreement they have with the government while others did not. The same partners also stressed the importance of taking action and showing the government that breaking an agreement leads to consequences and they suggested that development partners should cancel their funding to the health sector for the remainder of the programme. Or at least until the Ministry of Health had provided clarification regarding on the issue.

This discussion continued at the consortium meeting a couple of days later. Also in the consortium, it was clear that not all partners were of the same opinion. The discussion drifted off to various other aspects of the programme, other reforms that had not been undertaken, indicators that had not improved etc. during the last five years. The Unification issues ignited the discussion, but as it went along, it became more and more apparent that there were many other concerns among the development partners and that the current situation might make some development partners reconsider their commitment for the next programme. Eventually, agreement was reached to draft a letter to the Ministry of Health. It was decided that the letter should not focus on the unification issue, instead it should be focused around the need for a good partnership and an open dialogue. The letter would also ask for clarification on how the Ministry of Health are planning to reach the expected benefits, that unification was supposed to generate, in the current structure.

A few days later, in response to the request made by the development partners, the Secretary of the Ministry of Health called for a meeting with the development partners. He stated that the meeting was to be seen as a start of a more extensive dialogue regarding the unification issue between the development partners and the government. At the meeting, the Ministry of Health distributed a working paper that, in short, provided justification and rationale for the decision not to unify the two structures. It also presented how the Ministry of Health was planning to achieve the benefits that were expected through a unified structure. The Secretary of Ministry of Health explained that the basis of the decision was mainly political and was taken by the Prime Minister after a briefing from the Health Minister. The Secretary claimed that the political economy did not, at the moment, provide possibilities for unifying the two structures. While most development partners were not convinced with the arguments presented they all agreed that the meeting was a step in the right direction – to improve dialogue and relations between the Ministry of Health and the development partners.

Partnership vs. Ownership

The issue of unification brings up the question of ownership. At the Policy Dialogue, the Health Minister of Bangladesh said “when you (the development partners) campaigned for the SWAp, you offered us the driver’s seat”, indicating that he was of the opinion that the Ministry of Health should be in the lead of health sector development. Other representatives from the government also argued that the Ministry of Health in a SWAp has the right to, and should, take whatever decision they deem necessary for improving the health sector. If the development partners do not accept that, they are free to pull out, but the Ministry of Health cannot let the development partners dictate the rules. The development partners that reacted most strongly to the decision on the other hand argued that all decisions should be taken in the spirit partnership. Of course, the Ministry of Health has every right to take sovereign decisions, but then they must also be prepared to face the consequences of their decision.

A week or so later there was an extra Consortium meeting. The meeting had been called to discuss about how development partners are considering their involvement in the upcoming programme. Focus had been shifted from dealing specifically with the unification issue to a more general view of Development Partner’s involvement in the health sector. A few development partners made it clear that, because of the deteriorating relationship between the

Ministry of Health and the development partners, they were considering pulling out of the health sector and not fund the next programme. The mistrust was not based solely on the decision regarding de-unification, but on other actions taken, or not taken, by the Ministry of Health as well. Other development partners however made it clear that they would not cancel their funding or reconsider their commitment because of this.

On March 30 2003 however, the World Bank led International Development Agency (IDA) and its co-financiers (i.e. those agencies that provide budgetary support) decided to partially suspend their contribution to the health sector. They decided to suspend an amount of 123 million US dollars, mainly because the decision not to unify the two Ministry of Health structures had been taken without any prior consultation with involved partners. The IDA also stressed that the decision not to unify was merely one of several agreed reforms that had not been undertaken. In response to the suspension, the Health Minister said that the suspension would not hurt the government and that the IDA and the other development partners had not made any significant contribution to the health sector over the last five years. He also stressed that the government would continue to go by their needs and not abide by dictates from the IDA.

The issue of unification is interesting in several aspects. The disagreement with the Ministry of Health instigated a discussion among the development partners where they tried to reach consensus on how to respond. The more they discussed however they realised that there were many different views on what should be done. While some thought that tough remedies should be taken others were more concerned about focusing on restoring the lack of confidence between the development partners and the government and establishing a sound dialogue. While some were seriously considering pulling out of the health sector, others were not even considering this as an alternative. As the dialogue continued, it also became apparent that there were many different views on development cooperation among the development partners. There was consensus among all partners that they wanted to work with a sector-wide approach but there were many differing views of what this meant in reality. A few development partners were of the opinion that maybe the government is not the best channel for providing better health outcomes in Bangladesh and that alternative modalities should be investigated. Other partners were of the opinion that the fundament of a sector-wide approach lies in working through the government and they were not considering other alternatives.

Again, this brings up the different views on what government ownership means. In the definitions presented earlier in this paper SWAp is defined as a “partnership led by national authorities” and a “country-led national development strategy”. In action however we can see that the view on ownership is very different among partners. In spite of these wide differences in how to define ownership, they have managed to work together, as a group, with the government when relations have been stable. When a conflict arises however, the differences among the development partners became more apparent and it also brought to light how the Bangladeshi government had interpreted the offer of having the “driver’s seat”.

Conclusions

Although almost every document and evaluation published about SWAp describes it as an approach and not a blueprint for development cooperation, the striking similarities in the coordination framework between Uganda, Zambia and Bangladesh indicate that there is an established idea of how a sector-wide approach should be structured. Greater variations were found in the understanding of the basic features the model aims at, namely to achieve sector wide analysis and impact, increased coordination and increased ownership for the partner government. Both understandings of what was implied with these aspects of the model, and how to reach them differed. Variations in understanding were found between countries and within countries. These differences are really not surprising. As our brief comparison with other kinds of global trends showed that such variations in understandings are almost always found upon closer examination of widely spread ideas. Widely spread ideas are generally formed in generalized, universal and vague ways. And they are translated as they are transferred from one setting to another. The vagueness means that actors who are adopting and developing a model in a local setting may read in their own wishes and expectations in the models. Moreover, models are adapted to fit in local structures and models.

The notion sector-wide, in sector-wide approach is the notion that seems to be the least clearly specified, and here differences among countries, but also among stakeholders and partners in each country, differ. Moreover, it seems quite difficult to build SWAp-specific structure boundaries. Instead, we find in all three countries that sector boundaries are set according to the structure of the health ministry. This means among other things that state structures are reconfirmed, and possibly strengthened with the introduction of SWAp, and it seems quite difficult to include in the sector all activities and stakeholders (regardless of their institutional

affiliation, whether they are connected to the state, NGOs, traditional healers or other private actors) that are of relevance for health care. Our case studies indicate that SWAp may not have the potential, as it is formed today, to open up the sector beyond the institutional boundaries of state ministries.

Clearly, as is often the case with widely spread ideas, the main arguments behind the introduction of SWAp have been formulated in contrast to systems dominated by project aid. It seems to be more clearly expressed, in writings and partly in interviews, what SWAp is not, than what it is. This means that it may be difficult to see where the development is heading. Different partners and stakeholders appear to have different expectations for the future developments of SWAp. One could expect SWAp to be one step towards full budget support, where government ownership and the coordination of resources would be increasingly emphasized. This development, however, does not seem likely since interviews, as well as observations, indicate that a number of development partners are not able or willing to move in this direction. National and/or institutional regulatory constraints, as well as lack of trust in monitoring and auditing systems from various development partners, indicate that if SWAp should be a move towards full budget support, major institutional reforms are required from a number of development partners and the respective partner governments.

We have noted quite fundamental differences as to what SWAp is, what it aims at and where the model is heading. One conclusion to draw from such observations might be that partners should put more efforts into reaching a common agreement on what SWAp is. We would not like to support such a conclusion. First, what we have observed is that definitions and understandings of SWAp differ, not only between partners and between individual, but also between situations. Even though a partner, or a group of partners formally have defined a SWAp in one way in a country context, SWAp in action may turn out quite differently. This is largely due to the fact that SWAp cannot, of course, be delimited from the context in which development activities are pursued or from other processes going on simultaneously. We would also like to point to the vagueness and openness of the concept as a possibility for developing models that fit the different structures and need of different sectors and different countries.

The vagueness and the differing views of SWAp do not appear to be a problem, but rather a possibility, as long as partners are confident with each other and with the development, but

our concluding illustrative example showed that this same vagueness does not seem to be able to handle conflicts. A possible explanation for the problems with conflict management might be that in a SWAp, the roles of actors have changed. As stated in the general and country context definitions, the national government should now be in the lead of the development process and the development partners should take a step back from their role as coordinator. Since these new roles are not clearly defined, and since they are also different from the previous roles that different actors had, a conflict situation might create confusion concerning responsibilities and duties for partners in development.

As we have seen through the examples of how SWAp is defined in different contexts, there is no unanimous definition of the concept. When it comes to the question of coordination, the different translations of SWAp that we have presented show that there are different views among partners in development on what that should be coordinated. We have received definitions ranging from SWAp being equal to budget support to actors saying that a SWAp is achieved when all partners are working towards a common goal. We have shown that in practice, in all three countries, both funds and resources and activities are being coordinated side by side and there is also coordination of other stakeholders, policy development and monitoring and evaluation. So the question remains about what that should be coordinated in a SWAp. Should a sector-wide approach be interpreted as a mechanism for coordinating funds and resources, a mechanism for coordinating activities or perhaps a mechanism for coordinating an agreed upon strategic assessment and problem analysis of the sector?

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